INTERAGENCY PSYCHOSOCIAL EVALUATION PROJECT

FINAL REPORT

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**Interagency Psychosocial Evaluation Report, 2011**
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This document has been prepared to provide an interagency psychosocial evaluation report that is a pilot model of tools for the monitoring and evaluation of psychosocial interventions for children. It will inform programming in the occupied Palestinian territory and globally, in areas where crises of a long-term nature persist.

A special thanks to Columbia University for carrying out this evaluation, and sincere appreciation to Dr. Amanda Melville and Paraskevi Stavrou for finalising it. Our deep appreciation to the Mental Health and Psychosocial Working group members who participated in this study and a special thanks to all children, parents, teachers and counsellors who enriched this evaluation. Our sincere gratitude to the Humanitarian Aid and Civil Protection department of the European Commission, whose financial contribution made this evaluation possible.

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INTERAGENCY
PSYCHOSOCIAL EVALUATION
List of Acronyms

CFTA – Culture and Free Thought Association

DG ECHO – Humanitarian Aid and Civil Protection department of the European Commission

IASC – Inter-Agency Standing Committee

MHPSS – mental health and psychosocial support

M+E – monitoring and evaluation

NGO – non-governmental organization

oPt – occupied Palestinian territory

PA – Palestinian Authority

PCBS – Palestinian Central Bureau of Statistics

PLO – Palestinian Liberation Organization

ToT – trainer-of-trainers

UNICEF – United Nations Children’s Fund

UNFPA – United Nations Population Fund

UNRWA – United Nations Relief and Work Agency
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Foreword

Humanitarian Aid and Civil Protection department of the European Commission, Jerusalem

This study is the culmination of a joint endeavor steered by UNICEF and supported by the Humanitarian Aid and Civil Protection department of the European Commission (DG ECHO). Research has taken place in the Occupied Palestinian Territory (oPt) over a period of two years, including numerous workshops aimed at developing outcome indicators for psychosocial response in protracted crises. The product is a pilot model of tools for the monitoring and evaluation of psychosocial interventions for children, which will inform programming in the oPt and can also be used in other areas globally where long-term crises persist. Multiple national and international stakeholders have taken part in this effort.

The study is best understood as a minimal set of requirements for the design of outcome objectives and indicators in psychosocial projects. These outcome indicators are intended to measure a child's emotional and social well-being, as well as acquisition of skills and knowledge. The design of evidence-based monitoring and evaluation tools for psychosocial programming makes it possible to design more effective interventions and activities for children and their families.

Though much of the work is behind us, the study is open for review in the coming years. Insights and feedback on best practices and the application guidelines should also be developed.

DG ECHO would like to thank UNICEF, Columbia University and all the national and international organizations that have worked together to produce this study, often under challenging circumstances. While applauding this joint venture, DG ECHO recognizes the effort as an important milestone in the wider child protection community, not only in East Jerusalem, the West Bank and the Gaza Strip, but the world over.
**Executive summary**

**Introduction**

Children in the occupied Palestinian territory (oPt) have been born into one of the most complicated and protracted conflicts in the world, encompassing over 60 years of conflict and 42 years of military occupation. As they grow up, they are exposed to military incursions, political violence, home demolitions, displacement and home searches. With their access to normal routines and activities often restricted, such as school and play, children must learn to navigate a complex system of permits, barriers and checkpoints.

In order to support children's mental health and psychosocial well-being within this particular context, governmental bodies, non-governmental organizations (NGOs) and UN agencies have implemented a range of interventions across the oPt. This report presents the findings of the first interagency evaluation of psychosocial interventions in the oPt. The evaluation process was supported by UNICEF and carried out by Columbia University. It was funded by ECHO and conducted in partnership with the multiple agencies across the West Bank and Gaza.

**Methods**

This evaluation used a quasi-experimental, pre-test/post-test design. A common survey tool was administered to children in programmes at the beginning and end of agency programme cycles, and in comparison groups of children who had not yet taken part in the psychosocial programmes. This closed-ended survey tool was developed using a brief ethnographic approach, which identified local definitions and indicators of psychosocial well-being through consultations with children and parents in the West Bank and Gaza. Qualitative measures were not included in the study, a limitation of the methodology.

The survey questionnaire was administered to a sample of approximately 1,900 Palestinian children and adolescents living the West Bank and Gaza by programme staff from participating agencies. Each agency\(^1\) used their programme rosters as their sampling frame. In all but one case, random sampling strategies were used, and questionnaires were administered to at least 80–100 children in programme groups and in comparison groups. In the one case in which random sampling was not used, the agency relied on convenience sampling. Programme groups comprised children who were participating in psychosocial interventions and comparison groups, comprising children who were on waiting lists to participate in programmes.

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\(^1\) Thirty-five organizations (some through their implementing partners not listed here) agreed to participate in the study as follows: American Near East Refugee Aid (ANERA), Enfants du Monde-Droits de l’Homme (EMDH) / Bethlehem Arab Society for Rehabilitation (BASR), Medicine Du Monde (MdM), Ministry of Education (MoE), Ministry of Health (MoH), Ministry of Social Affairs) MoSA, Palestine Red Crescent Society (PRCS), Terre des homes (Tdh), United Nations Development Programme (UNDP), United Nations Relief and Works Agency (UNRWA), Young Men’s Christian Association (YMCA), Ard Al Ensan, Center for Mind-Body Medicine (CMBM), Community Training Centre for Crisis Management (CTCCM), Islamic Relief, Medical Relief, Mercy Corps, Ministry of Education and Higher Education (MoEHE), Palestinian Center for Democracy and Conflict Resolution (PCDCR), Beit Al Mustaqbal, Culture and Free Thought Association, Sharek Youth Forum and El Wadad. However, this was reduced to the following: YMCA, ANERA, PRCS, Save the Children, PRMA, UNRWA, MOE, and PCDCR. Data for the study were finally provided by five organizations in the West Bank and three in Gaza – EMDH/BASR, MdM, PRCS, Tdh, YMCA, Save the Children, PCDCR and El-Wedad Association.
The data analysed in this evaluation were collected by five agencies in the West Bank and three agencies in Gaza at the beginning and end of each agency’s programme cycle. Data in the West Bank were collected between September 2008 and July 2009. In Gaza, the data were collected between September and December of 2008, prior to Israel’s military campaign, Operation Cast Lead, which was conducted between 27 December 2008 and 18 January 2009.

Post-intervention responses of children in programme groups and in comparison groups were compared to their mean scores at baseline in order to measure increases in the following seven psychosocial outcome areas: a child’s general resilience, level of engagement at home and with their family, engagement in school, engagement in the community, social relations, problem solving abilities, and reduced troubling thoughts and feelings. Mean differences in each of these outcomes were tested for statistical significance. These outcomes among children in programme groups and comparison groups were then further analysed by age, gender, location and programme type.

Results
The main findings of the evaluation were as follows:

- **Baseline scores of children in psychosocial programmes were relatively high**
  The children’s well-being was first assessed during the baseline data collection phase, using the common questionnaire before he or she began actively participating in a psychosocial programme. One of the main findings of the evaluation is that children’s overall mean scores across all seven outcomes were relatively high at baseline. On a scale of 0–100, all mean scores at baseline were above 50. This indicates that before children entered into psychosocial programmes, they reported relatively high scores for their level of engagement at home, in school and in the community, as well as with their problem-solving skills, their social relations, and their ability to reduce their troubling thoughts and feelings.

  The children in the intervention group and the children in the comparison group were similar at baseline on all of the seven outcomes. That is, the average pre-test scores for each outcome of children enrolled in psychosocial programmes did not differ significantly from the average scores of children who were in wait-listed comparison groups in the West Bank and Gaza at baseline.

- **Psychosocial programmes in the oPt are promoting child and adolescent well-being**
  Comparisons between pre- and post-intervention results show children’s levels of resilience increased and risks to psychosocial well-being significantly decreased during the time they participated in psychosocial interventions in West Bank and Gaza. All seven outcomes significantly increased at a 5 per cent alpha level for children who participated in psychosocial interventions in the West Bank. In Gaza, all outcomes increased significantly except for reduced troubled feelings.
  
  - Most significant improvements: level of engagement at home, in community, social relations and problem solving
  - Less change was observed in resilience outcome, engagement in school, and reduced troubled thoughts and feelings

  The psychosocial well-being outcomes for the children in the comparison groups across all levels was not as high, and in fact decreased in some areas (engagement at home and at school, social relations, community engagement and problem-solving).

  Overall, participating in a psychosocial programme resulted in a demonstrated difference in child well-being as defined by the participating organizations at the
baseline, and as measured by the survey questionnaire developed for this evaluation research.

- **Data from parents supports results children’s findings**
  Non-representative data were collected from parents. Because of the comparatively low rate of response from parents (46 per cent), the information from parents is not representative and cannot be analysed using tests of statistical significance. Consequently, questionnaires from parents were analysed qualitatively in order to support the quantitative findings from the children’s questionnaires. Their responses broadly support the findings from children’s data regarding improvements in interactions at home, in school, and ability to reduce troubling thoughts and feelings.

- **Children’s psychosocial outcomes varied by demographic factors, such as age, gender and location**
  While all outcomes improved significantly as a result of participation in psychosocial programmes, levels of increase varied by factors such as age, gender and where the child lives.
  - **Age:** adolescents (13–18 years) in psychosocial programmes in both the West Bank and Gaza improved on fewer outcomes than younger children, especially resilience, engagement in school, reduction in troubling thoughts and feelings
  - **Gender and location:** Children’s outcomes improved in the West Bank between baseline and post-test, regardless of gender. In Gaza, however, improvements in outcomes differed by gender. While boys’ outcomes improved significantly across the board, girls in programmes in Gaza did not experience significant improvements in their level of resilience, engagement in school, and reduced troubling thoughts and feelings.
  - **Age and location:** younger children (8–12 years) in West Bank improved in all seven outcomes; in Gaza, younger children did not improve significantly on engagement in school and in their ability to reduce troubling thoughts and feelings.
  - Adolescents in Gaza did not improve significantly when compared to comparison group regarding engagement at school and their ability to reduce troubling thoughts and feelings

- **Psychosocial outcomes improved regardless of programme design, but some appear more effective than others**
  - While all outcomes significantly improved for children in all types of psychosocial programmes, children in Gaza who were enrolled in psychosocial programmes that included a clinical counselling component in addition to recreational activities did better than children who were in programmes that only involved recreational activities. Children in Gaza who received some clinical counselling did better on two outcomes: levels of engagement at home and reduced troubling thoughts and feelings. There were no significant differences between the two types of programming within the five other outcomes. The reverse was true in the West Bank, where children in programmes that focused on recreational and group activities only did better. Additionally, in the West Bank, children who were in short-term programmes experienced greater improvements than children who were enrolled in longer-term interventions.

Further investigation is required before accepting this finding: the majority of the interventions sampled where short-term in nature (shorter than six weeks) thus having a possible bias against counselling interventions which are typically longer term, and only short-term interventions were evaluated in Gaza. In addition, not enough information was given describing the different psychosocial interventions sampled and how they were categorised.
Insufficient data analysis was done comparing different types of psychosocial interventions and cross-correlating the age, gender, type of intervention and location variables.

**Conclusion**
The findings support the value of a social ecological approach, which stresses the importance of supporting the internal resources within Palestinian culture and society that contribute to children's resilience. Despite the conditions that have made life increasingly difficult in both the West Bank and Gaza, the findings indicate that children who participate in psychosocial programmes come into programmes with a high degree of self-efficacy and social support from their families and school environment. Additionally, children's outcomes improved across the board — regardless of age, gender, location, or programme design — as a result of participation in psychosocial programmes. Further, it is important to note that the post-test scores of children in wait-listed comparison groups significantly decreased after baseline. This last finding further supports the need for psychosocial programming as part of a coordinated response in improving the lives of children and their families in the oPt.

This evaluation both supports the general effectiveness of psychosocial interventions in oPt and challenges programmes to consider how they might better meet some of these particular needs in both the West Bank and Gaza. This study offers evidence of the continued need for psychosocial programming, and argues for more programming to foster essential pre-existing supports that allow children to prosper in an extremely adverse environment. Children in the oPt continue to be exposed to military incursions, political violence, home demolitions, displacement and home searches. As governmental bodies, NGOs and UN agencies across the West Bank and Gaza continue implementing interventions to support children’s mental health and psychosocial well-being within this context, studies such as the one presented in this report can provide critical insights to inform policy and programming.

This interagency evaluation process was the first of its kind, and reflects an important step in a coordinated effort to improve programming and build the evidence base for future interventions. Lessons learned from the process of the evaluation itself and the limitations of the data hold important implications for future research. Process-wise, the evaluation brought together a number of key actors working in the field of psychosocial response who were eager to learn more about the impact of their programmes — and to do this together. These pioneering efforts reflect an important step in a coordinated effort to improve programming and build the evidence base for future interventions to:

- institutionalize quality evaluation and programme learning systems
- build the evidence base for effective psychosocial programming
- harmonize agreed strategies and standards for implementation, and
- work towards national coverage in the oPt.

This evaluation is the second part of a three-stage process: (i) the interagency commitment to common evaluation; (ii) the interagency psychosocial baseline and evaluation research, and development of measures of children’s psychosocial well-being, which is being reported upon in this document; and phase (iii) whereby, over a 12–18 month period, the participating agencies agree to commit to using the evaluation approach and tools, and convene at the end of a pre-determined period to assess the relevance and appropriateness of the psychosocial evaluation approach, the guidelines and the tool kit to the situation in the oPt.
In terms of the way forward, it is recommended that UNICEF and the implementing agencies plan for and commit to phase three of this important and pioneering interagency initiative.

**Recommendations**

**Direct interventions:**
A consideration of more:
- school-based psychosocial approaches and interventions
- psychosocial interventions for adolescents (15–18 years)

**Research:**
More research is required comparing psychosocial programming:
- between the West Bank and Gaza
- between different approaches and types of interventions
- between younger children and adolescents
- between girls and boys (and the integration of gender markers and awareness in psychosocial programming)

**Plan phase three of the Interagency Psychosocial Evaluation:**
1. Adapt survey questionnaire and finalize the quantitative and qualitative monitoring and evaluation (M+E) measurement tools of children’s psychosocial well-being in the oPt, based on the interagency psychosocial outcomes and indicators
2. Mainstream M+E tools into UNICEF and participating agencies’ existing frameworks
3. Conduct further interagency research, to be co-ordinated by a locally based NGOs
4. Evaluate the effectiveness of shared tools, adaptations necessary and value in the field
5. Assess the relevance and appropriateness of the psychosocial evaluation approach, the guidelines and the tool kit
6. Publish the oPt Interagency Psychosocial Monitoring and Evaluation Guidelines and Tool Kit.
Introduction

The compounded crises of the humanitarian emergency, prolonged political and military violence and inequity at multiple levels (e.g., movement obstacles and difficulties in accessing basic services) in the occupied Palestinian territory (oPt) impacts upon children on a massive scale. The field of psychosocial programming for children affected by crises (e.g., natural disasters and armed conflicts) and protracted political and military violence is still young, but is maturing steadily. Much work needs to be done to systematize the work being done and to strengthen the quality of supports for children, including children and families living through the particular difficulties facing Palestinians in the oPt.

A priority is to expand the evidence base with regards to appropriate and effective psychosocial interventions. A persistent problem is that this area of intervention often relies on assumptions, does not have a sufficient empirical body of evidence, and is lacking in recognized and agreed upon measurement systems and tools. The capacity to conduct inter-agency training workshops, undertake rigorous programme evaluations, and develop appropriate tools and approaches is essential to institutionalize quality evaluation and programme learning systems, and to build the evidence base for effective psychosocial programming.

A major development in the effort to standardize monitoring systems for psychosocial programming has been the Inter-Agency Standing Committee (IASC) Taskforce on Mental Health and Psychosocial Support. Guidelines have been produced that outline appropriate minimum responses in emergencies, which bridge the traditional divide between mental health and psychosocial programming. The interagency standards on mental health and psychosocial support (MHPSS) represent the consensus of the international humanitarian community on appropriate psychosocial support and mental health programming in emergencies.²

This interagency evaluation followed the IASC MHPSS guidelines. The IASC MHPSS guidelines are an effort to ensure that findings are both rigorous and reflective of the ways in which children and adults experience and understand children’s well-being in a particular context. A conceptual and methodological challenge facing the development of such international guidelines and standards is that they have to strike a balance between being sufficiently global to guide a myriad of approaches and interventions and enable comparisons between regions and agencies and different types of interventions, yet also be local enough to adequately measure children’s psychosocial well-being within their everyday political, cultural and socio-economic context.

Representatives from 35 agencies in the West Bank and Gaza worked with UNICEF and Columbia University over a period of two years to put together the framework for this interagency evaluation of psychosocial programming in the oPt. A series of interagency consultations, technical training workshops and baseline research culminated in the

² One measure demonstrating this success are the guidelines that have been finalized by the Inter-Agency Standing Committee Taskforce on Mental Health and Psychosocial Support, which outlines appropriate minimum standards for psychosocial responses in emergencies.
interagency evaluation research. The findings presented in this report are from eight psychosocial programmes in the oPt and, in part, represent the diversity of approaches in the field of psychosocial response. While psychosocial and mental health programming has become a systematic part of humanitarian response, this has included a wide and often divergent set of activities and methodological approaches. The psychosocial interventions evaluated within this report range in their approach from offering activities such as individual clinical counselling with children and parents, group counselling with children and recreational activities, to community workshops for parents, children, and teachers. Some approaches do not include clinical or psychological counselling, but include group therapeutic play, involving drawing, theatre, music, dance, sports and recreation for children. Some programmes focus on children in the context of their classrooms, and others work with children within their communities. Some of the agencies evaluated respond immediately to crises and provide short-term individual and group counselling, whereas other agencies provide longer-term psychological and/or psychosocial support. See Annex 1 for an outline of the different types of psychosocial interventions that were sampled for this interagency evaluation.

The findings from this evaluation reflect an evaluation process that was the first of its kind, and serves to build the evidence base for effective psychosocial programming in the complex environment of the oPt, where child protection issues are compounded by the protracted structural, political and military violence that they experience.

**Background**

**Situation background: the occupied Palestinian territory**

Children in the oPt are growing up within a population that is predominantly youthful and which is growing quickly at a combined growth rate of 3.3 per cent.\(^3\) Of the estimated four million people who live in the oPt, an estimated 49 per cent are under the age of one, and 45.7 per cent are under the age of 15.\(^4\)\(^5\) Between the West Bank (including East Jerusalem) and Gaza, approximately two million children and adolescents live in the oPt.

Most of these young people were not yet born when the Middle East “peace process” began. Following the signing of the Oslo accords in 1993 between Israel and the Palestinian Liberation Organization (PLO), resulting in the creation of the Palestinian Authority and open, direct talks between Israel and the PLO, efforts towards a peace agreement ultimately fell in 2000, with the impasse at the Camp David Summit and the outbreak of the second *Intifada*. Children in the oPt have grown up during this period of failed peace negotiations and renewed conflict, Israel’s construction of the ‘Barrier’ between Israel and the West Bank, the encroachment of Israeli settlements, the split between Hamas in Gaza and Fatah in the West Bank and, more recently, the 22-day Israeli military campaign in Gaza known as ‘Operation Cast Lead’.

Palestinian history is a story of continual displacement and survival, as connections to land, homes and community have been disrupted, more recently as a result of the Israeli

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\(^4\) Based on 2007 estimates and projections from the Palestinian Central Bureau of Statistics (PCBS).

Currently, approximately half of the population of the oPt, or 1.8 million people, are registered as refugees with UNRWA. Since the beginning of the second Intifada, young Palestinians and their families have faced increasingly high levels of poverty, unemployment and dependency on outside aid. As conditions become more and more difficult, some argue that the social fabric of Palestinian society has become frayed. With the more recent internal division, a peaceful resolution to the conflict often appears increasingly illusive, and the family and community ties that have long held Palestinians together have been weakened and are becoming increasingly vulnerable.

Other qualitative studies conducted in the oPt, however, offer evidence which suggests that Palestinian children demonstrate a high degree of self-efficacy and a "guarded optimism" concerning their current situation; in other words, while Palestinian young people may be pessimistic about the future, they are optimistic about their own personal potential. Further, self-efficacy, such as taking active measures to improve oneself, succeed in school, participate in recreational activities and community life, can be understood as closely correlated with a high degree of resilience. It is within this particular social context that agencies sought to understand how best to support children's resilience and to evaluate the effectiveness of their interventions.

The West Bank

Geographically separated from Gaza by Israel, the West Bank is growing at a rate of 2.9 per cent, and is home to approximately 2.5 million people. As an occupied territory, an estimated 38 per cent of the West Bank consists of Israeli military bases, outposts, settlements, and Israeli-designated nature reserves. These areas are controlled by the Israeli military and are off-limits to Palestinians.

As a result of the 1995 ‘Israeli-Palestinian Interim Agreement on West Bank and Gaza’, the West Bank was divided into three areas: A, B and C. Area A comprises major cities in the West Bank and is home to 55 per cent of the population, and is under full Palestinian Authority (PA) civil and security control. Area B is primarily rural, under partial PA civil control and Israeli security control, and is home to 41 per cent of the population in the West Bank. The remaining four per cent of the Palestinian population lives in the Israeli-controlled Area C, which comprises an estimated 60 per cent of the land and cuts through Areas A and B, dividing them into 227 smaller areas. Area C contains approximately 150 settlements and an estimated 250,000 Israeli settlers, as well as roads, buffer zones, and almost all of the Jordan Valley and the Judean Desert.

More recently, daily life in the West Bank has become increasingly restricted by the construction of the ‘Barrier’ between the West Bank and Israel, 57 per cent of which is

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7 UNRWA, 2008.
8 Batniji, R et al., op.cit., p. 1139.
9 Batniji, R et al., op.cit., p. 1140.
11 ibid.
12 World Bank, op.cit.
now complete, and 79 per cent of which controversially cuts into the West Bank. Given this complex geography of occupation, children and their families in the West Bank navigate systems of checkpoints, border crossings and closures on a daily basis, often facing delays, uncertainties and harassment by the Israeli military.

Palestinians in the West Bank also face the encroachment of Israeli settlers and settler attacks – attacks in which children are directly targeted on their way to and from school, for example, which prevents them from accessing education. During the process of this evaluation, the administration of questionnaires was postponed on at least two occasions due to settler attacks on targeted villages and schools.

**Gaza**

Stretched along the Mediterranean coast, and surrounded by a heavy system of military checkpoints and barriers along its borders with Israel and Egypt, Gaza is home to approximately 1.5 million residents, more than half of whom are under the age of 18. Unlike the West Bank, Gaza is incredibly urban and dense. Gaza City, with a population of over a half a million people, is the largest Palestinian city in the oPt. Seventy per cent of Gaza’s residents are registered refugees, and more than half of these refugees live in the three large camps, Jabalia, Rafah, and al-Shati.

Differing from their counterparts in the West Bank, the daily lives of children in Gaza have been profoundly affected by the blockade. Despite Israel’s unilateral disengagement from Gaza in 2005, Gaza’s land borders, territorial waters and airspace remain tightly controlled by the Israeli military. More recently, after Hamas took control of the Gaza Strip in 2007, Israel further intensified this military blockade along the borders between Gaza, Israel and Egypt, in an attempt to weaken Hamas and to end rocket attacks against Israel. At the time of writing, items allowed into Gaza are restricted by the Israeli military: only basic humanitarian supplies – food, groceries, and medicine – are allowed in, and items such as building materials have been strictly prohibited. Moreover, due to the continued blockade, people are only able to leave Gaza if they obtain rare medical or religious permission, which has led to an effective “locking-in” of Gaza’s 1.5 million residents and the frequent characterization of Gaza as “the world’s largest outdoor prison.”

Conditions were made even more difficult in Gaza when, on 27 December 2008, the Israeli security forces launched ‘Operation Cast Lead’ against Hamas in Gaza, which lasted for 22 days. The 1612 Monitoring Group on Grave Violations against Children reported that an estimated 350 Gazan children were killed, and another 1,800 were injured. According to OCHA/oPt, 1,383 deaths of Palestinians were confirmed by two independent sources. Thirteen Israelis were killed in the offensive.

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15 Ibid.

16 Personal correspondence, date, MdM.


20 Ibid.

21 Ibid.

22 Ibid.
In addition to fatalities, an estimated 6,400 homes were destroyed in the offensive and approximately 120,000 people were rendered unemployed. As a result of increasing poverty, an estimated 75 per cent of the population became “food insecure” from an already high 56 per cent as the result of a reduction in the consumption of higher-cost, protein-rich foods and an increase in the consumption of lower-cost, high-carbohydrate foods. Because 18 schools were destroyed and 280 were damaged, schools become overcrowded. Agencies working in Gaza reported: “[N]ot only are large numbers of children exposed to violence and injury, but countless others growing up are deprived of their physical and emotional needs, including the structures that give meaning to social and cultural life. All of these circumstances affect the Palestinians, especially children, who are deprived not only of recreation, but also of the basic requirements needed for life.” It is within this continually changing political, social and economic context that the outcomes of psychosocial programmes in Gaza and the West Bank were evaluated.

**The psychosocial situation of children and families in the oPt**

The impact of continued fighting, the expansion of illegal settlements in the West Bank, settler violence against children and their families, military incursions, increasing demolitions of homes, the continuing Israeli blockade of the Gaza Strip and the increasing restrictions on movement have had severe impacts on the psychosocial well-being, development, education and health of children. The number of children requiring support is increasing whilst parents and other caregivers who are also affected by the effects of the on-going conflict find it difficult to support their children and seek the support they themselves need. Acute levels of stress and insecurity are evident in children and their caregivers. Since the beginning of the second Intifada in late September 2000 until January 2009, a total of 1,475 Palestinian children were killed and thousands more were injured as a result of conflict.

Following Operation Cast Lead, assessments have shown a high level of psychosocial distress among communities and families in Gaza. In an assessment carried out by the United Nations Population Fund and the Culture and Free Thought Association (UNFPA-CFTA) in January 2009 immediately after the ceasefire and in the months following the crisis, 20 per cent of women were identified as suffering from psychological disorders; 98 per cent of youth interviewed stated that they were having difficulty sleeping and problems with aggression; 40 per cent of young people interviewed said they took the drug, Tramadol, to help them sleep and reduce anxiety. Women interviewed made recommendations for immediate and medium- to long-term support, which included “psychological support for entire families” and psychosocial support for youth to enable them to “deal with their feelings.” Importantly, in the same study, men asked for psychosocial support and awareness-raising on how to deal with their families following the war. The Palestinian Central Bureau of Statistics found in November 2009 that 77.8

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25 ibid.
26 ibid.
27 Personal Correspondence, date, PCDCR Gaza
28 UNFPA-CFTA, 'Gaza Crisis: Psychosocial Consequences for Women, Youth and Men, Executive Summary', April 27th 2009.
29 Palestinian Central Bureau of Statistics (PCBS), 'Impact of War and Siege on Gaza Strip', November 2009.
per cent of households surveyed in Gaza had at least one person suffering from psychological problems resulting from the war—and, despite the fact that the war is over, communities are still feeling the effects, such as fear, insecurity, sleeping problems and stress. In a joint UNFPA-FAFO study following Operation Cast Lead, 23 per cent of adults questioned said they often felt so depressed that “nothing could cheer them up” and 24 per cent felt “deeply hopeless”. Twenty-one per cent of children stated that they had concentration difficulties, which had started during the war. In the 10–14 year age group, nine per cent of children questioned said they had started bed-wetting during the war.

The United Nations Fact Finding Mission on the Gaza Conflict (known as the Goldstone Report) notes that: “International aid providers should step up financial and technical assistance for organizations providing psychological support and mental health services to the Palestinian population” (para 1772). It also states: “Many women felt helpless and embarrassed at not being able to protect and care for their children. Others felt frustrated, invaded in their personal space and powerless when their houses and possessions were destroyed or vandalized. Those feelings contributed to their psychosocial suffering” (para 1275).

**Conceptual framework: children's resilience and social context**

This conceptual framework for this evaluation focuses on children's resilience and the importance of the social context in child development. The resilience approach conceptualizes children as active agents and makers of meaning who engage with life challenges and attempt to cope and adapt in the face of adversity and cope with difficulties. The resilience approach contrasts with the more typically used but increasingly questioned *deficits approach*, which emphasizes children’s psychological problems such as post-traumatic stress disorder, depression, and anxiety, placing 'problems' into a medical dimension of diagnosis and treatment. A central tenant of the resiliency approach is the acknowledgement that not everyone is affected in the same manner by an emergency, and that communities or populations cannot be defined as being 'affected' or 'traumatized'. The resilience approach recognizes that Palestinian children have been affected by war, displacement, oppression, blockades, and a multitude of daily sources of distress such as chronic and worsening poverty and restrictions on movement. However, the resilience approach recognizes that Palestinian children, youth, and adults have coped remarkably well despite the many hardships they face.

A resilience approach is an appropriate conceptual framework for this evaluation because it reflects the adaptive capacities of Palestinian people and avoids the unintended harm that can arise through the use of a deficits approach. In the present situation, taking a deficits approach would risk pathologizing people who are struggling and, for the most part, coping with great difficulties, and it could also contribute to the sense of hopelessness. In addition, a resilience approach offers significant advantages from a programmatic standpoint. A resilience approach identifies and builds on what people...
naturally do to support themselves and each other, and these existing assets and supports are the best foundation on which to build sustainable psychosocial support. The resilience approach recognizes that a minority of children will require focused, specialized support, and allows for this support to be provided in the context of the different, complementary layers of support that underlie focused MHPSS responses and are recommended by the IASC MHPSS Guidelines. The deficit approach is based on ‘treating’ disorders, and does not take into account the fact that the majority of people have internal, community and family resources that support their ability to cope.

**Intervention pyramid for mental health and psychosocial support in emergencies.** (For an explanation of the different layers, see pages 12–13 of ‘IASC Guidelines’.)

This evaluation is also grounded in an appreciation of the importance of the social context or environment in influencing children’s development. Palestinian children’s development is situated within their social ecology, comprising their relations with families, neighbours, peers, teachers, community and religious groups. This, in turn, is situated within the broader socio-political and economic context, which is characterized by distrust and violence, displacement and restrictions on daily living. These various groups, particularly the family, provide social support and guidance for Palestinian children amidst difficult situations. How well an individual Palestinian child is doing depends in no small part on the quality of relations within the family and the family’s ability to support the child to achieve particular developmental tasks such as achieving good relationships with others or learning and achieving mastery. For example, a child whose home had been attacked and destroyed might adapt and continue to cope well if she were still with her family and receiving their support. In this sense, positive family relations can be a protective factor that promotes healthy development and well-being. Palestinian children may also derive support and protection from their peers and being able to participate in appropriate, meaningful roles such as that of a student, success in which enables mastery, develops self-confidence and builds hope for the future.

However, social contexts also consist of risk factors at multiple levels (e.g., family, peer, and community levels and the broader political levels) that can cause harm. Within stressed Palestinian society, many stressors exist for children, such as child abuse,
violence in school and home, as well as stressors due to the occupation, such as settler violence, military incursions and arrests. When protective factors outweigh risk factors, children tend to be resilient, whereas a preponderance of risk factors can limit children's healthy development and cause psychological harm. From a programmatic perspective, a significant task is to minimize the risk factors in children's environments while simultaneously strengthening the protective factors. It is hoped that this evaluation can contribute to this effort.

**Background and methodology of the Interagency Psychosocial Evaluation Project**

**Background and timeline**
Evaluating the effectiveness of programmes in an environment of on-going structural, political and military conflict provides a host of challenges, and this is especially true for psychosocial and mental health programming.

Effective psychosocial programming depends on the use of appropriate measures of psychosocial wellbeing. The identification and development of such measures has proved challenging. Agencies interested in evaluating their programmes have found that, while there are many measures of mental health and psychological wellbeing, these have usually not been validated in the context in which they are working, and may not address the issues of concern to the community in that area.

In 2005, before the interagency psychosocial evaluation took place, Columbia University and UNICEF conducted an extensive review of existing measures and tools to evaluate change in behaviours, attitudes or distress levels among war-affected children. The review concluded that none of the existing measures – or the underlying constructs being measured – were uniformly meaningful and appropriate for the diverse set of conditions affecting children in war zones around the world.

In order to develop psychosocial constructs and tools that are contextually relevant and appropriate, the review identified an ethnographic approach developed by Jon Hubbard as the most useful means of collecting information about the needs, beliefs and strengths of the local populations, explained in more detail below.

**Interagency consultations and consensus-building**

In early 2007, UNICEF and Columbia University agreed to field-test the ‘Guide to the Evaluation of Psychosocial Programming in Emergencies‘ and conduct an interagency evaluation of psychosocial programmes in the oPt. Following an initial consultation and orientation of psychosocial programme evaluation, it was proposed that an evaluation of psychosocial programmes be conducted in order to better understand what approaches are most effective in supporting children’s resilience and psychosocial well-being within the context of the West Bank and Gaza.
<table>
<thead>
<tr>
<th>Date</th>
<th>Phase 1: Consensus-building, piloting research/evaluation tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2007</td>
<td>Agreement between UNICEF oPt and UNICEF HQ NY to pilot common well-being indicators, and launch IASC guidelines on mental health and psychosocial support in emergencies</td>
</tr>
<tr>
<td>January 2008</td>
<td>Psychosocial Working Group formed in the oPt, comprising 35 agencies in the West Bank and Gaza</td>
</tr>
</tbody>
</table>
| March 2008         | Interagency workshops held in the West Bank and Gaza, with over 60 participants from approximately 25 agencies, in which the group:  
|                    | • developed a draft set of agency outcomes and indicators  
|                    | • reviewed individual agency M&E tools and strategies  
|                    | • developed and agreed upon good practice guidelines for research in the oPt (Annex III); and  
|                    | • developed a joint, interagency M&E plan |
| April–June 2008    | Ethnographic survey: 600 interviews conducted with children, parents and teachers to identify local definitions of well-being; 300 in the West Bank and 300 in Gaza |
| July 2008          | Results of interviews were analysed and categorized to develop a common set of questionnaires for children, parents and teachers |
| July–August 2008   | Interagency workshops held in the West Bank and Gaza in order to:  
|                    | • train 30 trainer-of-trainers (ToT) on how to use the common questionnaire  
|                    | • train 22 participating agencies on research methods (including random sampling and comparison groups)  
|                    | • assist individual agencies with planning for baseline data collection; and  
|                    | • finalize a sector-wise evaluation plan |

Initial phases of the project involved a review of all psychosocial activities in the oPt, and the formation of the Psychosocial Working Group in early 2008, comprising representatives from 35 agencies in the West Bank and Gaza. UNICEF and Columbia University supported this group with a series of technical assistance workshops and individual agency consultations, with the goal of assisting sector agencies in producing work plans, and developing indicators and monitoring and evaluation mechanisms. As a result of these workshops, agencies developed a set of common sector-wide objectives, outcomes and indicators for psychosocial programmes. These were aligned to ensure compatibly with the agencies’ own objectives, outputs and activities. A capacities and needs assessment was conducted, assessing the agencies’ monitoring and evaluation systems and tools (Annex IV). The findings of the capacities and needs review indicated that:

- Very few agencies established adequate baselines during design phase
- No agency used control groups as part of the evaluation plan
- Most common evaluation tools were focus group discussions (FGD) and questionnaires. All agencies believed staff capable of high quality evaluations if

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31 The draft set of agency outcomes and indicators has since been developed into a core set of outcomes and indicators for use in psychosocial programming in the oPt. Please see Annex II.
provided with training and support in mixed-participatory methodologies, random sampling comparison groups and data analysis.

The interagency consultation process culminated in a consensus to collaborate in an interagency evaluation project, where all agencies would use common tools and methodologies to evaluate their psychosocial programmes.

**Development of the common survey instrument**

The survey instrument used in this evaluation was developed in several phases, starting with the ethnographic research into local perceptions of children’s psychosocial well-being.

In order to develop a questionnaire relevant to the context of the oPt, Jon Hubbard’s ethnographic interviewing approach was taken to understand the local meanings of what is meant for children to be doing well and children having problems (Annex V). This technique involves using a brief, semi-structured interview, framed around a question, to systematically collect information on a specific topic of interest from a community or population. Members of the target group or community are randomly sampled and asked to think of someone representative of the population of interest they know (e.g., a child) who, in their view, is ‘doing well’, and then list the things about this child that indicate to them that he or she is doing well. The process may be repeated to ask about children of both genders and in different age groups to further specify the construct. A similar question may be used that asks individuals to list indications that a child is ‘not doing well’.

This approach allows for the development of culturally appropriate evaluation tools based on local definitions of what it means to be doing well, and also identifies the primary problems children face, using the language of children, parents, and teachers. In doing so, validity and reliability of the tools are built into the process. Participants are asked to describe the characteristics of real children, the indicators are likely to be attainable and realistic, rather than abstract ideals.

The characteristics that emerge from this process can then be used to more fully understand the constructs that emerge from the data. The responses collected with the interview become ‘data’ which can be summarized through a variety of human and/or statistical means to identify common underlying themes. Repeated above

One of the two primary benefits of the Hubbard approach is that it allows for a quick and systematic approach for gathering data regarding the two areas of consideration for the psychosocial evaluation: how children do well and what problems children have due to the current situation in the oPt. Through semi-structured interviews, the data collected can be used to identify the common issues and responses related to children’s resilience. This data is then used to create common questionnaires to evaluate psychosocial programmes.
The second is that the approach allows for the development of culturally appropriate evaluation tools that are based on local definitions of what it means to be doing well and the primary problems children face and it utilizes the language of the children, parents, and teachers in the evaluation tools. In doing so, the validity and reliability of the tools are built into the process. Because these local definitions would be based on direct, unfiltered comments from members of the West Bank and Gaza communities, the research team believed they would reflect local ideas and beliefs more accurately than those included on standardized measures.

A questionnaire for children was developed based on the Hubbard ethnographic interviewing manual. A shorter questionnaire was developed for parents and another for teachers. Since key problems of children revolved around domestic and school violence, and the prevailing political oppression and military violence, the parent and teacher questionnaires focused on their role in fostering and supporting the resilience of children.

The ethnographic research took place in April to June of 2008. Using simple random sampling, open-ended questionnaires were administered by field staff to 600 respondents – 300 in the West Bank and 300 in Gaza (150 with children and 150 with adults) – in all governorates over a two-week period. Responses were then compiled and pile-sorted into related categories. Through the sorting process, the following emerged as categories of what it means for a child to be ‘doing well’. Categories of risk, or what it means for a child to be ‘having problems’, were expressed as the opposite:

- **Parental support**: parents are active in the child’s life (structured home life, homework time, parents visit school and teachers even when there is not a problem), or parents are not incarcerated (in the West Bank) or have not been killed (more commonly in Gaza);
- **Teacher-child relationships**: the child has positive relationships with his or her teacher and feels s/he can do well in school
- **Friendships**: the child has friends, including close friends that they can confide in and share secrets with
- **Self-efficacy**: the child believes s/he can achieve positive outcomes when s/he tries hard
- **Social and recreational activities**: the child is able to participate in recreational activities
- **Economic support**: parents are employed, able to provide child with spending money
- **Violence**: the child is not exposed to family violence, violence in school, or violence in the community

Questions for the evaluation were then developed from these categories, and programmes were evaluated based on their ability to support resilience and ameliorate risks. Economic categories were largely eliminated because the psychosocial programmes did not attempt to address these aspects of children’s lives. Once responses from the ethnographic exercise were sorted and categorized, these categories were then compared to the following existing common evaluation outcome measures shared by participating agencies:

- Reduced troubling thoughts and feelings
- Increased resiliency
- Improved social relations in the home
- Improved social relations in school
- Improved social relations in the community
- Increased engagement in school or the community
- Increased self-expression
- Increased problem solving skills
Two agencies—one in the West Bank and one in Gaza—then drafted the interagency evaluation instrument based on the responses and categories of resilience and risk that emerged through the ‘brief ethnographic interview’ and a realignment of the shared agency outcomes. This resulted in the following seven outcomes in the interagency evaluation instrument:

- Resilience
- Engagement at home
- Engagement in school
- Engagement in the community
- Social relations
- Problem-solving
- Reduced troubling thoughts and feelings

Indicators for each of these outcomes and the common evaluation survey instrument for children appear in Annex V. Surveys were also created to be used quantitatively with parents and teachers to triangulate findings from the children’s report. This plan, however, was later amended based on time and logistical constraints. The additional data collected from a non-representative sample of parents were analysed qualitatively and used to support the children’s quantitative results.

**Interagency evaluation project questionnaire for children**

It is important to note that this survey questionnaire is a tool designed to give a general measure of the psychosocial well-being of children living within the oPt, assessing the three broad psychosocial domains relevant to a child’s life – emotional and social well-being, and the acquisition of skills and knowledge. This survey tool establishes a baseline and subsequently, a final evaluation of the psychosocial well-being of children, allowing for a before and after comparison of the impact of the psychosocial intervention on the child’s well-being.

This interagency survey questionnaire does not assess the following two aspects that are critical to the overall functioning of programmes, and further evaluation methods and tools are required to evaluate these programming elements:

- The specific psychosocial intervention implemented by the agency (e.g.: a psychosocial intervention working with adolescent youth who have survived detention, or a mother and pre-school children’s group)
- The operational, organizational and management aspects of the programme

In July 2008, a second set of interagency workshops were held in the West Bank and Gaza in order to train 30 trainer of trainers from participating agencies on how to use the common questionnaire: between July and August of 2008, over 220 field workers from agencies in the West Bank and Gaza were trained on how to use the common questionnaire. Over 20 participating agencies were trained on research methods (including random sampling and comparison groups), and individual agencies were provided with technical assistance in planning for baseline data collection and in finalizing a sector-wide evaluation plan.
Out of the 26 agencies that initially planned to participate in the evaluation, 11 were unable to do so, either due to programmatic delays in collecting baseline data or a lack of internal agency approval. Of the 15 remaining agencies that were able to collect baseline data, five agencies in Gaza did not collect post-test data. This was largely due to Operation Cast Lead. For programmes that ran from late 2008 and into the next year, the military incursion in Gaza between December 2008 and January 2009 severely disrupted normal programming and the data collection process, and rendered it impossible for agencies in Gaza to collect meaningful data. As a result, some baseline and post-test questionnaires were re-administered by three agencies following the military incursion in Gaza; however, these data were not linked to individual respondents and the duration of the interventions were too short to be considered, rendering the data non-comparable. Comparable, usable data – that is, data that included both pre-test and post-test values for both programme groups and comparison groups – were therefore collected by eight agencies conducting psychosocial programmes in the oPt for use in this evaluation: five in the West Bank, and three in Gaza. Each agency that participated in the evaluation used the same common questionnaire.

Quasi-experimental design

This evaluation used a quasi-experimental design that included pre-tests and post-tests with intervention and comparison groups. At the beginning and the end of agency programme cycles, a common survey instrument was administered to children enrolled in programmes, and simultaneously administered to children in comparison groups. The responses of children in programme groups and in comparison groups were compared in order to measure differences in the seven psychosocial outcome areas.

Sampling

Each agency used current programme participant rosters as their sampling frame for the intervention group. After receiving training on random sampling methodologies from UNICEF, all but one agency employed simple random sampling strategies. For these agencies, a representative sample size for each agency was calculated to be between 80 and 100 respondents\(^{32}\) for the programme groups and the comparison groups, and each agency randomly selected respondents to achieve this sample size. According to the research, in most cases, saturation was reached after interviewing 80 to 100 individuals regardless of population size.\(^{33}\) Therefore, for the oPt evaluation project, it was recommended for agencies to target 100 beneficiaries per population for their sample.

\(^{32}\) Sample size determinations were based on the draft UNICEF Psychosocial Evaluation guide – field-testing version.

For some agencies, every other name on a roster was selected, and for others every fifth name on the roster was selected. The agency that used convenience sampling administered the questionnaire to all programme participants present on the day when the survey was scheduled to be administered. If all of the children enrolled in the programme were present on the day of the survey and took part in the process, no bias would have been introduced. However, if some children were not present, which is more likely, this is likely to have biased the results for this one agency.

The comparison groups comprised children who were on waiting lists to participate in psychosocial programmes. It was determined that this group would serve as the best comparison group for most agencies, as it was thought that these children shared the same characteristics as the children already in programmes. It was also deemed to be the most ethical choice of a comparison group since these children would eventually receive the programme services. Children were selected from rosters of waiting lists in the same manner in which children were selected into the intervention group.

Parents of all children in programme and comparison groups were invited to participate in the study. Fewer than half of the invited parents provided additional insights into their child’s well-being both at the time of pre-test and post-test.

**Data collection**

In total, five agencies in the West Bank and three agencies in Gaza collected the data that inform this evaluation. This analysis contains data from two points of data collection. Pre-test (T1) and post-test (T2) data were collected in the West Bank and Gaza roughly during the same time period, in late 2008 and early 2009, at the beginning and end of each agency’s respective programme cycle. Post-test data analysed in this evaluation were collected in December 2008, prior to the military operation Cast Lead. It is important to note that some of these programme cycles lasted only for a few weeks, while other longer-term interventions lasted for between two and eleven months.

Field staff from each agency led the data collection process, administering the questionnaire to wait-listed and current participants in their own programmes. Between August and September 2008, four two-day interagency trainings were held in Gaza and five in the West Bank, in which over 220 field staff were trained on the common survey instrument and on interview good practice guidelines (Annex I). Children were interviewed individually by field staff – comprising social workers, animators, mental health officers and assistants – in private locations within centres or in schools, and each child was assured of the confidentiality of his or her responses. Informed consent was explained and obtained first from parents on behalf of their children and then from the children, themselves, before each interview began.

In cases where a female respondent was over the age of 13, the interviewer was female. It was explained to children that there were no right or wrong answers. Responses to each question on the questionnaire were measured on a four-point scale of: “never”, “sometimes”, “most of the time”, and “always.” This response format was explained and practised with children before the interview began. Questionnaires with children were administered orally and interviewers read each question exactly as written. Each interview lasted approximately 30–45 minutes.

Upon giving their informed consent, participating parents were given self-administered questionnaires in separate areas within schools and centres. Support from field staff was provided, where needed.
**Data analysis**

The statistical analysis for this evaluation was completed by a statistician in New York, at Columbia University, and a statistician in Ramallah, West Bank. The statistician in the West Bank received the questionnaires from UNICEF as they arrived from agencies, and was responsible for entering the data from questionnaires into an MS Access database, cleaning the data, exporting the data into SPSS and conducting preliminary analyses.

Data from agencies in the West Bank and Gaza were exported into a file in SPSS. Once all data were entered and cleaned, this file was sent to a statistician in New York who completed the analysis of the data in SPSS. The statistician, together with the rest of the Columbia University team in New York, determined what data could and could not be analysed with sufficient statistical rigour.

**Table 1.**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>West Bank (5)</td>
<td></td>
<td>1280</td>
<td>1174</td>
</tr>
<tr>
<td>Gaza (3)</td>
<td></td>
<td>619</td>
<td>494</td>
</tr>
</tbody>
</table>

Respondents for whom data were missing (i.e., data indicating whether the respondent was in the programme group or in the comparison group) were excluded. Additionally, questionnaires that were not clearly identified as pre-tests or post-tests in the database were excluded from analysis (see Annex VI).

In the West Bank and Gaza, 59 per cent and 79 per cent of the same children, respectively, completed the post-test questionnaire that had completed the pre-test questionnaire. This was deemed a sufficient response rate to analyse the results.

Because of the comparatively low rate of response from parents (46 per cent), the information from parents is not representative and cannot be analysed using tests of statistical significance. Consequently, questionnaires from parents were analysed qualitatively in order to support the quantitative findings from the children's questionnaires. These findings were analysed according to the themes that emerged from the questionnaire: how parents support their children's education; interactions within the family and home; and how parents protect children and support them in the larger community.

Question items were used to create scales to inform on the seven outcomes – resilience, increased engagement at home, at school, and in the community, social relations, increased problem-solving skills, and reduced troubling thoughts and feelings. In order to determine whether these individual question items reliably constituted a scale, Chronbach’s alpha coefficients were calculated. These coefficients were then used to assess the reliability of the scale measures of each of the seven outcomes. The outcomes, associated questionnaire items, and alpha coefficients are presented in Table 2 below.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Associated questionnaire items</th>
<th>Chronbach’s Alpha West Bank</th>
<th>Chronbach’s Alpha Gaza</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased resilience</td>
<td>I have close friends I can play with I have close friends with whom I can share secrets I am able to solve my daily problems I feel I can improve my performance in school I do my homework without my parents asking me I know what to do in dangerous situations</td>
<td>.58</td>
<td>.72</td>
</tr>
<tr>
<td>Increased engagement at home</td>
<td>My parents encourage me to participate in recreational activities My parents help me to solve difficult problems My parents [do not] yell at me My parents [do not] hit me My family treats me the same as they treat my siblings My parents listen to me and respect my opinion I [do not] fight with my siblings I feel that my parents can protect me from danger I [do not] feel that other children are happier than me because their parents are able to buy them more things</td>
<td>.67</td>
<td>.79</td>
</tr>
<tr>
<td>Increased engagement in school</td>
<td>Other children [do not] hurt me at school I participate in my classes My teachers [do not] yell at me My teachers [do not] hit me My teacher listens to me and respects my opinion</td>
<td>.64</td>
<td>.72</td>
</tr>
<tr>
<td>Increased engagement in community</td>
<td>I solve my problems with other children without fighting I help other children who have problems I can ask people I trust for help when I need to</td>
<td>.48</td>
<td>.60</td>
</tr>
<tr>
<td>Increased problem-solving skills</td>
<td>My parents help me to solve difficult problems My family listens to me and respects my opinion I resolve my problems with other children without fighting I help other children when they have problems I can ask people I trust for help when I need to</td>
<td>.59</td>
<td>.65</td>
</tr>
<tr>
<td>Improved</td>
<td>Other children hurt me at school</td>
<td>.43</td>
<td>.50</td>
</tr>
</tbody>
</table>
According to Shrout and Fleiss\textsuperscript{34}, when evaluating reliability, a coefficient of 0.40 or lower is considered poor, and the associated items should not be considered to constitute a scale. A coefficient between 0.40–0.75 is considered a sign of moderate reliability. Because all of our reliability coefficients were above the cut-off of 0.40, it was deemed reasonable to progress with analysis based on the proposed outcome categories.

As mentioned above, responses to each question on the questionnaire were measured on a four-point scale of: “never”, “sometimes”, “most of the time” and “always.” Items were grouped for each outcome category, such as engagement in school, and a mean score was derived using a 0–100 point scale. Higher scores indicated higher levels of resilience or overall well-being; conversely, lower average outcome scores indicated less resilience, or risk.

In order to measure the effects of psychosocial programmes on children’s well-being, changes in outcomes from baseline among children in programme groups were measured against the changes from baseline of children in comparison groups to test for significance. Furthermore, because there may have been differences in outcomes due to a child’s age, his or her gender, or where s/he lives in the oPt, the mean differences in outcomes between children in programme groups and comparison groups were tested for significance by age, gender, location and programme type. Two-sample t-tests with equal variances and the p-values of mean differences were calculated for each outcome.

Results

Study population

This evaluation focused on the psychosocial well-being of a sample of nearly 1,900 Palestinian children and adolescents living in the West Bank and Gaza. Approximately 80 per cent were younger children (8–12 years old) in the West Bank, 50 per cent were younger children in Gaza, and the rest were adolescents (13–18 years old).

Table 3. Age breakdown of study sample population

<table>
<thead>
<tr>
<th>Age</th>
<th>West Bank Programme (n)</th>
<th>Comparison (n)</th>
<th>Total (n)</th>
<th>Gaza Programme (n)</th>
<th>Comparison (n)</th>
<th>Total* (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8–12</td>
<td>1544</td>
<td>988</td>
<td>2532</td>
<td>116</td>
<td>113</td>
<td>318</td>
</tr>
<tr>
<td>13–18</td>
<td>50</td>
<td>633</td>
<td>683</td>
<td>150</td>
<td>129</td>
<td>295</td>
</tr>
<tr>
<td>Total</td>
<td>1003</td>
<td>2177</td>
<td>3215</td>
<td>266</td>
<td>242</td>
<td>613</td>
</tr>
</tbody>
</table>

There were an approximately equal number of girls and boys in both programme groups and comparison groups in the West Bank and Gaza (Table 4).

Table 4. Gender breakdown of study sample population

<table>
<thead>
<tr>
<th>Gender</th>
<th>West Bank Programme</th>
<th>Comparison</th>
<th>Total</th>
<th>Gaza Programme</th>
<th>Comparison</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1082</td>
<td>644</td>
<td>2213</td>
<td>127</td>
<td>150</td>
<td>330</td>
</tr>
<tr>
<td>Female</td>
<td>1127</td>
<td>604</td>
<td>2249</td>
<td>139</td>
<td>92</td>
<td>283</td>
</tr>
<tr>
<td>Total</td>
<td>2209</td>
<td>1248</td>
<td>4462</td>
<td>266</td>
<td>242</td>
<td>613</td>
</tr>
</tbody>
</table>

Children who participated in the evaluation lived in all areas of the West Bank and Gaza. The highest number of participants came from Hebron (23.6 per cent), Nablus (16.6 per cent) and Bethlehem governorates (15.2 per cent) (Table 5). In some governorates, however, there was a high proportion of respondents for whom their group – programme or comparison – was unknown.
As detailed in the methods section above, a child's well-being was first assessed using the common questionnaire before he or she began actively participating in a psychosocial programme. Overall, the average pre-test scores for each outcome of children enrolled in psychosocial programmes did not differ significantly from the average scores of children who were in wait-listed comparison groups in the West Bank and Gaza at baseline (Figures 1 and 2).
There were no statistical differences between the two groups in all seven outcomes at the five per cent level of significance. As such, we can conclude that the children in the intervention group and the children in the comparison group were similar at baseline on all of the outcomes of interest.

Finding one: children’s resilience at baseline was relatively high

One of the main findings of the evaluation is that children’s overall mean scores across all seven outcomes were relatively high at baseline. On the scale used, 0 functions as the centre-point of the scale; scores below 0 are a negative indication of well-being and scores above 0 are a positive indication of well-being. All mean scores at baseline were above 50. This indicates that before children entered into psychosocial programmes, children in both the West Bank and Gaza reported relatively high scores for their level of resilience, engagement at home, in school and in the community, as well as with their problem-solving skills, their social relations, and their ability to reduce their troubling thoughts and feelings.
Within both their school and home environments, children reported feeling a relatively high sense of engagement and agency – or their own ability to determine their own outcomes – at baseline. The composite score for engagement at home indicates that, on average, children had positive interactions with parents and other siblings at home, and felt supported and protected by their families. The composite score for the outcome of engagement in school indicates that, on average, children responded as though they could improve their performance in school, frequently did their homework without being asked by parents, and had relatively positive interactions with their classmates and teachers.

Finding two: psychosocial programmes across the West Bank and Gaza are promoting child and adolescent well-being

Another important finding is that psychosocial programmes – regardless of agency, programme design or location differences – are supporting positive developments in child and adolescent well-being in the oPt. Children’s and adolescents’ overall resilience increased, and risks to their psychosocial well-being were significantly reduced during the time that they participated in psychosocial activities in both the West Bank and Gaza. Statistically significant increases in pro-social behaviours in the home, in school and in the community were reported across the board by children in programme groups compared with children in comparison groups (p<0.001).

Children in the programme groups in the West Bank reported statistically significant (p<0.001) increases in mean scores across all seven outcomes when compared with the comparison groups (Table 6).

Table 6. Mean differences in outcomes between baseline and post-test scores in the West Bank

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th>COMPARISON GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>Resilience</td>
<td>616</td>
<td>374</td>
</tr>
<tr>
<td>Mean diff b/t pre-test and post-test</td>
<td>11.7 (10.0-13.3)</td>
<td>2.6 (0.7-4.5)</td>
</tr>
<tr>
<td>95% CI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement at home</td>
<td>616</td>
<td>374</td>
</tr>
<tr>
<td>Mean diff b/t pre-test and post-test</td>
<td>6.9 (5.6-8.3)</td>
<td>-1.0 (-2.4-0.5)</td>
</tr>
<tr>
<td>95% CI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement at school</td>
<td>615</td>
<td>374</td>
</tr>
<tr>
<td>Mean diff b/t pre-test and post-test</td>
<td>4.9 (3.4-6.5)</td>
<td>0 (-1.6-1.6)</td>
</tr>
<tr>
<td>95% CI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement in community</td>
<td>616</td>
<td>373</td>
</tr>
<tr>
<td>Mean diff b/t pre-test and post-test</td>
<td>8.1 (6.0-10.2)</td>
<td>-2.5 (-4.6-0.3)</td>
</tr>
<tr>
<td>95% CI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social relations</td>
<td>615</td>
<td>374</td>
</tr>
<tr>
<td>Mean diff b/t pre-test and post-test</td>
<td>8.5 (6.7-10.2)</td>
<td>-0.9 (-2.7-1.0)</td>
</tr>
<tr>
<td>95% CI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem-solving</td>
<td>616</td>
<td>373</td>
</tr>
<tr>
<td>Mean diff b/t pre-test and post-test</td>
<td>9.2 (7.4-11.0)</td>
<td>-1.1 (-3.2-0.9)</td>
</tr>
<tr>
<td>95% CI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall significance between groups</td>
<td></td>
<td>p&lt;0.001</td>
</tr>
</tbody>
</table>
Reduced troubled feelings 616 6.3 4.8-7.8 373 0.4 -1.3-2.1 p<0.001

While outcomes improved significantly for children who participated in psychosocial programmes in the West Bank (p<0.001), children in comparison groups reported less of an increase in all seven outcomes and, in fact, some mean scores for outcomes decreased between pre-test and post-test. For example, as displayed in the table above, mean scores for community engagement increased by 8.1 points in the programme groups between baseline and post-test. In contrast, community engagement scores decreased by 2.5 points in the comparison group.

Increases in scores of children who were in programmes in Gaza were also statistically significant for all outcomes (p<0.05), except for reduced troubling feelings, when compared with children in comparison groups (Table 7).

Table 7. Mean differences in outcomes between baseline and post-test scores in Gaza

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th>COMPARISON GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
</tr>
<tr>
<td>Resilience</td>
<td>200</td>
<td>5.1</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>198</td>
<td>3.8</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>201</td>
<td>2.8</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>200</td>
<td>4.4</td>
</tr>
<tr>
<td>Social relations</td>
<td>201</td>
<td>4.4</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>200</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>4.0</td>
</tr>
</tbody>
</table>

These mean scores indicate the following improvements among children who participated in psychosocial programmes in the West Bank and Gaza. In response to individual questions regarding their relationships with peers, children who participated in psychosocial programmes reported increased positive peer interactions, in general, as well as in their interactions with close friends. At the end of programmes, children
reported feeling as though they had more close friends with whom they could play, share secrets and personal experiences with at the end of programmes than was reported by children in comparison groups in the West Bank (p<0.001) and Gaza (p<0.01).

Children’s responses to individual questions also indicate that children in programmes felt that they were better able to resolve problems with other children without fighting, and better able to help other children when they had problems at the end of programmes than children in comparison groups (p<0.01). Children’s self-reliance and problem-solving skills improved after going through a programme cycle. Individual responses indicate that these children believed they had the skills necessary to handle dangerous situations. They also reported that they could go to someone they could trust to discuss a problem more frequently than children in comparison groups (p<0.01). Overall, the outcomes of resilience and problem-solving skills of children in psychosocial programmes improved significantly more than children in comparison groups in both the West Bank (p<0.001) and Gaza (p<0.01).

As stated above, children in comparison groups experienced less improvement across almost all seven outcomes. Whereas the mean differences between baseline and post-test scores for resilience show an increase of 11.7 points (95% CI 10.0–13.3) for children in psychosocial programmes in the West Bank, and an increase of 5.1 points (95%CI 2.4–7.9) in Gaza, the mean differences between baseline and post-test scores for children in comparison groups show lesser increases of 2.6 points (95% CI 0.7–4.5) in the West Bank and 0.5 points (95% CI -2.4–3.3) in Gaza.

In fact, in some outcome areas, the scores of children in comparison group grew worse between the pre-test and post-test. While the mean difference in baseline and post-test scores for the outcome of problem-solving was 9.2 points (95% CI 7.4–11.0) in the West Bank and 4.2 points (95% CI 1.3–7.1) in Gaza for children who had participated in programmes, the mean problem-solving scores of children in comparison groups decreased between pre-test and post-test by 1.1 points (95% CI -3.2–0.9) in the West Bank, and 4.4 points (95% CI -7.2–-1.2) in Gaza.

Within their families, following their participation in psychosocial interventions, children reported an increased level of their engagement at home in both the West Bank and Gaza when compared with children in comparison groups (p<0.001; p<0.01). The mean difference in scores for engagement at home for children in programme groups and comparison groups in the West Bank and Gaza, however, shows that children’s level of engagement at home in fact deteriorated among children who were not in psychosocial programmes. While the mean difference in scores between baseline and post-test indicate an improvement of 6.9 points (95% CI 5.6–8.3) for children in programmes in the West Bank, the mean difference of scores of children in comparison groups shows a decrease of 1.0 point (95% CI -2.4–-0.5). Similarly, in Gaza, while the mean scores of children in programmes improved by 3.8 points (95% CI 1.4–6.1), the mean scores of children who were in comparison grew worse by 2.2 points (95% CI -4.5–-0.1).

The increased mean score for engagement at home indicates that children who were enrolled in psychosocial programmes reported significant improvements in their relationships with siblings, felt more as though their parents treated them the same as their siblings, and fought less with their siblings, than when they first entered psychosocial programmes and when compared to children in comparison groups. In both the West Bank and Gaza, these improvements among children in programmes were statistically significant when compared with children in the comparison groups (p<0.001; p<0.01).

Children’s responses also indicate that there were significant decreases in negative interactions – or, important reductions in risks – between parents and children within the
Responses to individual questions indicate that children who went through psychosocial programmes reported that their parents less frequently hit them or yelled at them compared with children in comparison groups (p<0.001). Children’s perception of their parents’ support and protection of them improved, as children in programmes reported that they felt as though their parents were better able to help them to solve difficult problems and protect them from danger. The differences between mean scores in this outcome of engagement at home between children in the programme group and in the comparison group in the West Bank and Gaza were statistically significant (p<0.001), and reveal that while children in programmes experienced significant improvements between the time they took the pre-test and the post-test, the level of engagement at home of children who were in comparison groups in the West Bank and Gaza, once again, deteriorated.

Within their schools, children in psychosocial programmes reported greater increases in confidence and self-assurance than children in comparison groups in the West Bank (p<0.001) and Gaza (p<0.05). As with other outcomes, however, children who were in comparison groups showed no increase in their levels of engagement in school between pre-test and post-test. The mean difference in scores for children in comparison groups in the West Bank was 0 (95% CI -1.6–1.6), and -0.7 (95% CI -3.6–2.3) in Gaza.

Following participation in psychosocial programmes, increases in engagement in school indicate that children had greater perceptions that their teachers listened to them and respected their opinion, and tended to participate more in the classroom than children in comparison groups (West Bank p<0.001; Gaza p<0.05). This increased sense of agency – or ability to determine one’s own outcomes – was also evident in children’s belief that they could improve their performance in school, and that they did their homework without being asked by parents. In addition to these improvements in school, scores indicate that there were reported reductions in negative interactions between children, teachers and their classmates. Following participation in psychosocial programmes, children less frequently reported that their teacher hit or insulted them, or that other children bullied or did “bad things” to them at school, when compared with children in comparison groups in both the West Bank and Gaza (p<0.001; p<0.05).

In addition to improvements in pro-social behaviours, there were significant improvements in children’s emotional outcomes between baseline and post-test among children in programmes, particularly in terms of reduced troubling thoughts and feelings, when compared to children in comparison groups in the West Bank (p<0.001). After participating in programmes, children’s responses to individual questions concerning reduced troubling thoughts and feelings revealed that they were able to sleep better and had fewer nightmares as compared with children in comparison groups (p<0.001).

Reported results also indicate that children felt more loved and experienced less isolation, felt less lonely, less angry, had fewer intrusive thoughts and were more able to concentrate when studying than children in comparison groups in the West Bank (p<0.001). Changes in outcomes of reduced troubling thoughts and feelings, however, were not statistically significant for children in programmes in Gaza when compared with children in comparison groups (p>0.05).

Finding three: data from parents support children’s findings

While the data collected from parents are not representative, they do broadly support the findings from children’s data. Parents of children in programmes reported that they spent more time talking with their children about issues that were important to their children.
Parents of children in programmes also reported fewer negative interactions between themselves and their children within the home compared with parents of children in the comparison group. These same parents more often responded that they hit their child less when they did something wrong, used more verbal criticism, and more frequently praised their child when they did something well. Parents also responded that they less frequently fought with their spouse, and that their children fought less with each other after participating in the psychosocial programme.

In terms of engagement within the school, at the end of programmes, parents expressed that they encouraged children to participate in more recreational activities, and that they encouraged their children’s performance in school by supporting their studies at home, visiting their children’s schools and meeting with teachers.

Finally, reports of parents following children’s participation in programmes also show that parents observed that their children were better able to sleep through the night and had fewer nightmares when compared with parents of children in the comparison group. All of these findings appear to support the data collected on children.

Finding four: child and adolescent psychosocial outcomes vary by age, gender and location

While the psychosocial well-being of children enrolled in psychosocial programmes improved significantly overall, and in comparison children in comparison with groups, some children did better than others. According to the analysis, this is due, in part, to how old the child was, whether the child was male or female, and where the child resided.

Age
Positive increases in the well-being of younger children aged 8—12, in psychosocial programmes in the West Bank were statistically significant across the board, in comparison with children of the same age in comparison groups (p<0.001) (Table 8). As seen in the table below, mean scores for children aged 8–12 who were in programmes improved for all outcomes. In contrast, the scores of children in comparison groups aged 8–12 decreased in all but two of the outcome areas.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th></th>
<th>COMPARISON GROUP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t</td>
<td>95% CI</td>
<td>n</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pre-test and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>post-test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>590</td>
<td>11.1</td>
<td>9.5-12.9</td>
<td>456</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>589</td>
<td>7.0</td>
<td>5.6-8.5</td>
<td>456</td>
</tr>
</tbody>
</table>
In Gaza, changes in outcomes of children aged 8–12 in psychosocial programmes were statistically significant (p<0.05), except for increases in their level of engagement in school and their reduced troubling thoughts and feelings (Table 9). Increases for these two outcomes were not statistically significant when compared to children in the comparison group. This indicates that, despite their involvement in psychosocial programmes, children aged 8–12 in Gaza did not experience significant improvements in the degree to which they felt engaged in school or had positive relationships with their classmates and teachers as a result of participating in psychosocial programmes. Additionally, despite participating in programmes, children in Gaza aged 8–12 did not improve significantly in their ability to reduce troubling thoughts and feelings, sleep better at night, and concentrate on their studies in comparison with their counterparts not in programmes (p>0.05).

Table 9. Outcomes by age, 8–12, Gaza

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th>COMPARISON GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
</tr>
<tr>
<td>Resilience</td>
<td>96</td>
<td>7.2</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>95</td>
<td>5.5</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>96</td>
<td>3.7</td>
</tr>
</tbody>
</table>
Adolescents aged 13–18 who participated in psychosocial programmes in the West Bank reported significant improvements in their levels of engagement at home (p<0.001), engagement in community (p<0.01), their social relations (p<0.001), problem solving abilities (p<0.01), and their ability to reduce troubling thoughts and feelings (p<0.05), when compared with children in comparison groups. Adolescents in the West Bank did not report statistically significant improvements, however, in their resilience and their level of engagement in school, as compared with children in comparison groups (p>0.05) (Table 10).

Table 10. Outcomes by age, 13–18, West Bank

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th>COMPARISON GROUP</th>
<th>Overall significance between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
<td>95% CI</td>
</tr>
<tr>
<td>Resilience</td>
<td>226</td>
<td>7.1</td>
<td>4.7-9.6</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>225</td>
<td>3.9</td>
<td>1.9-5.8</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>227</td>
<td>1.7</td>
<td>-0.7-4.1</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>226</td>
<td>3.9</td>
<td>0.5-7.2</td>
</tr>
<tr>
<td>Social relations</td>
<td>227</td>
<td>5.9</td>
<td>3.2-8.6</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>226</td>
<td>4.0</td>
<td>1.2-6.7</td>
</tr>
</tbody>
</table>
Adolescents in Gaza reported improvements at the end of programmes in their level of engagement in community (p<0.05), their social relations (p<0.01), and their problem solving abilities (p<0.05) (Table 11). However, adolescents in Gaza did not experience significant improvements in their resilience, level of engagement in school, or in their ability to reduce troubling thoughts and feelings when compared with adolescents in comparison groups (p>0.05).

Table 11. Outcomes by age, 13–18, Gaza

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th></th>
<th>COMPARISON GROUP</th>
<th></th>
<th>Overall significance between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-</td>
<td>95% CI</td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>test and post-test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>104</td>
<td>3.3</td>
<td>-0.1-6.6</td>
<td>95</td>
<td>4.4</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>103</td>
<td>2.2</td>
<td>-0.9-5.2</td>
<td>95</td>
<td>-1.3</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>105</td>
<td>1.9</td>
<td>-1.5-5.4</td>
<td>95</td>
<td>-0.6</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>104</td>
<td>2.3</td>
<td>-2.3-6.8</td>
<td>95</td>
<td>-5.4</td>
</tr>
<tr>
<td>Social relations</td>
<td>105</td>
<td>4.9</td>
<td>1.1-8.6</td>
<td>95</td>
<td>-2.6</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>104</td>
<td>2.8</td>
<td>-1.1-6.7</td>
<td>95</td>
<td>-3.4</td>
</tr>
<tr>
<td>Reduced troubled feelings</td>
<td>104</td>
<td>3.1</td>
<td>-0.2-6.3</td>
<td>95</td>
<td>-0.1</td>
</tr>
</tbody>
</table>

Overall, it appears that children of all ages in psychosocial programmes in both the West Bank and Gaza experienced significant improvements in their level of engagement in community, social relations, and problem solving abilities. As a result of being in psychosocial programmes, younger children aged 8–12 experienced improvements in all outcomes in the West Bank, and in all outcomes except for engagement at school and reduced troubling thoughts and feelings in Gaza.

In both the West Bank and Gaza, adolescents experienced improvements in their levels of engagement in community, social relations, and problem solving abilities, but did not see significant improvements in their level of resilience and engagement in school. As
with their younger counterparts in Gaza, adolescents in Gaza also did not report any significant improvements in reduced troubling thoughts and feelings.

**Gender**

The improvement in boys’ scores in psychosocial programmes were statistically significant for all outcomes when compared with boys in comparison groups for both the West Bank and Gaza (p<0.01). Consistent with other findings, while the mean scores of boys in psychosocial programmes increased, the outcomes of boys in comparison groups, in fact, decreased between baseline and post-test (Table 12). The outcomes with the greatest observed increase among boys were in resilience and problem solving (p<0.001).

**Table 12. Mean differences in outcomes, boys, West Bank**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th>COMPARISON GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
</tr>
<tr>
<td>Resilience</td>
<td>393</td>
<td>9.0</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>393</td>
<td>5.4</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>394</td>
<td>4.7</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>394</td>
<td>6.1</td>
</tr>
<tr>
<td>Social relations</td>
<td>394</td>
<td>6.5</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>394</td>
<td>7.0</td>
</tr>
<tr>
<td>Reduced troubled feelings</td>
<td>394</td>
<td>5.6</td>
</tr>
</tbody>
</table>

As in the West Bank, the mean scores of boys who participated in psychosocial programmes in Gaza improved across the board, including their ability to reduce troubling thoughts and feelings (p<0.05). When disaggregated by gender, it appears that, for boys, the change observed in mean scores for reduced troubling thoughts and feelings is, in fact, statistically significant when compared to boys in comparison groups in Gaza (p<0.05) (Table 13).
**Table 13. Mean differences in outcomes, boys, Gaza**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Overall significance between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
<td>95% CI</td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
<td>95% CI</td>
</tr>
<tr>
<td>Resilience</td>
<td>97</td>
<td>6.6</td>
<td>2.6-10.7</td>
<td>118</td>
<td>0.1</td>
<td>-3.1-3.3</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>97</td>
<td>3.5</td>
<td>0.3-6.7</td>
<td>118</td>
<td>-3.1</td>
<td>-5.6-0.6</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>98</td>
<td>4.7</td>
<td>0.8-8.5</td>
<td>118</td>
<td>-1.3</td>
<td>-4.8-2.2</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>98</td>
<td>7.0</td>
<td>2.1-11.9</td>
<td>118</td>
<td>-1.7</td>
<td>-5.9-2.5</td>
</tr>
<tr>
<td>Social relations</td>
<td>98</td>
<td>6.9</td>
<td>2.6-11.3</td>
<td>118</td>
<td>-2.0</td>
<td>-5.7-1.6</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>98</td>
<td>6.4</td>
<td>2.2-10.5</td>
<td>118</td>
<td>-2.6</td>
<td>-5.6-0.4</td>
</tr>
<tr>
<td>Reduced troubled feelings</td>
<td>98</td>
<td>5.0</td>
<td>1.5-8.5</td>
<td>118</td>
<td>1.3</td>
<td>-1.4-4.0</td>
</tr>
</tbody>
</table>

Similar to their male counterparts, all outcomes for girls in programme groups increased significantly in the West Bank, while the outcomes of their counterparts in comparison groups decreased (p<0.001) (Table 14). The greatest amount of increase among girls in programme groups in the West Bank was also in **resilience** and **problem solving** when compared to girls in comparison groups (p<0.001).
Table 14. Mean differences in outcomes, girls, West Bank

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th>COMPARISON GROUP</th>
<th>Overall significance between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
<td>95% CI</td>
</tr>
<tr>
<td>Resilience</td>
<td>423</td>
<td>11.0</td>
<td>9.1-13.0</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>421</td>
<td>6.9</td>
<td>5.2-8.5</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>422</td>
<td>4.2</td>
<td>2.4-6.0</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>422</td>
<td>8.3</td>
<td>5.8-10.7</td>
</tr>
<tr>
<td>Social relations</td>
<td>422</td>
<td>8.4</td>
<td>6.3-10.5</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>422</td>
<td>8.9</td>
<td>6.8-10.9</td>
</tr>
<tr>
<td>Reduced troubled feelings</td>
<td>422</td>
<td>5.8</td>
<td>4.0-7.7</td>
</tr>
</tbody>
</table>

In Gaza, the outcomes of girls improved in terms of their level of engagement at home, engagement in the community, social relations, and problem solving abilities when compared with girls in comparison groups. The outcomes of girls in programmes did not significantly improve as compared to girls in comparison groups, however, in terms of resilience, their level of engagement in school, and their reduced troubling thoughts and feelings (Table 15).
### Table 15. Mean differences in outcomes, girls, Gaza

<table>
<thead>
<tr>
<th>Outcome</th>
<th>PROGRAMME GROUP</th>
<th>COMPARIISON GROUP</th>
<th>Overall significance between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
<td>95% CI</td>
</tr>
<tr>
<td>Resilience</td>
<td>103</td>
<td>3.7</td>
<td>-0.1-7.5</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>101</td>
<td>4.0</td>
<td>0.6-7.5</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>103</td>
<td>1.0</td>
<td>-2.8-4.8</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>102</td>
<td>1.9</td>
<td>-3.3-7.1</td>
</tr>
<tr>
<td>Social relations</td>
<td>103</td>
<td>2.1</td>
<td>-1.9-6.0</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>102</td>
<td>2.2</td>
<td>-1.9-6.3</td>
</tr>
<tr>
<td>Reduced troubled feelings</td>
<td>102</td>
<td>3.0</td>
<td>-0.5-6.6</td>
</tr>
</tbody>
</table>

Overall, children’s outcomes improved in the West Bank between baseline and post-test, regardless of gender. In Gaza, however, improvements in outcomes differed by gender. While boys’ outcomes improved significantly across the board, girls in programmes in Gaza did not experience significant improvements in their level of resilience, engagement in school, and reduced troubling thoughts and feelings.

**Location**

Where a child lived also made a difference in terms of children’s overall well-being, as reflected by differences in outcome by governorate. While not all governorates were comparable, some differences were observed in the increases from pre-test to post-test between children in programmes and those in comparison groups. As observed in analyses above, many scores of children who were in the wait-listed comparison groups decreased between the time they took the pre-test and when they took the post-test, while the scores of children who were enrolled in programmes increased.
In Nablus, increases in mean scores of children in psychosocial programmes between baseline and the time they took the post-test were significant in terms of resilience (p<0.01), engagement at home (p<0.01), problem solving (p<0.05) and reduced troubling feelings (p<0.01), when compared to children in comparison groups. Increases in children’s mean scores were not significant in levels of engagement at school, engagement in community and social relations (Figure 3).

In Qalqilya, increases in the scores of children enrolled in programmes differed significantly from those in comparison groups in terms of their level of resilience (p<0.01), engagement at home (p<0.01), engagement in community (p<0.05), their social relations (p<0.01) and problem solving abilities (p<0.01), but did not differ significantly from children in comparison groups in terms of engagement at school and reduced troubling thoughts and feelings (Figure 4).
In Bethlehem, children’s scores at post-test only differed significantly in terms of their level of engagement in community (p<0.05), their social relations (p<0.05), and their problem solving skills (p<0.05), and they did not differ significantly in their levels of resilience, engagement at home, engagement in school, or in reduced troubling thoughts and feelings (Figure 5).

For the governorates of Jenin, Salfit, Ramallah, Jerusalem, Tulkarem, Tubas and Hebron, the sample size of children in comparison groups was not large enough to draw statistically valid conclusions (n<30).

In Gaza, change in outcomes observed between children in programme groups and comparison groups were significant in four of the five governorates. Outcomes in the Gaza governorate, however, did not differ significantly between those enrolled in programmes and comparison groups.

In North Gaza, significant increases among children in programmes, when compared with children in comparison groups, were observed for all outcome areas at a level of five per cent (p<0.01) (Figure 6). However, consistent with previous analysis, the outcomes of children in comparison groups in North Gaza significantly deteriorated over the time between pre-test and post-test, particularly in their levels of engagement in community, social relations, and problem solving abilities (p<0.001).
In Rafah, increases in children’s levels of engagement at home (p<0.05), engagement in community (p<0.01), in their social relations (p<0.01) and problem solving skills (p<0.01) differed significantly from those in the comparison groups, but children in programmes did not differ significantly from children in comparison groups in terms of resilience, engagement in school and reduced troubling thoughts and feelings (p>0.05) (Figure 7). As in North Gaza, however, children’s outcomes markedly deteriorated among those who were in comparison groups in Rafah in their reported level of engagement in community, social relations, and problem solving abilities (p<0.01).

In Khan Yunis, children who were in programmes experienced significant increases in nearly all outcomes, except for resilience, when compared with children in comparison groups. Children’s mean scores between pre-test and post-test improved in their level of engagement at home (p<0.001), engagement in school (p<0.05), engagement in community (p<0.01), as well as in their social relations (p<0.01), problem solving abilities (p<0.01) and reduced troubling thoughts and feelings (p<0.01) (Figure 8). Consistent with previous analyses, however, the scores of children in comparison groups significantly decreased between pre-test and post-test for these same outcomes in Khan Yunis.
In Dier El Balah, however, children who were in programmes seem to have experienced marked decreases in their scores between pre-test and post-test when compared with children in comparison groups. Differences in scores were only statistically significant for engagement at home. However, in contrast to findings from other governorates, while the scores of children in comparison groups increased for their level of engagement at home, children in programme groups’ scores decreased in this same area (p<0.01) (Figure 9).

Overall, the outcomes of children in psychosocial programmes increased in most governorates in the West Bank and Gaza, but some increases were more significant than others when compared to children in comparison groups in the same governorates. In the case of Dier El Balah, further investigation may be required to better understand the negative outcomes of children in programmes in this particular region of Gaza. In general, however, it appears as though significant increases were seen in most governorates among children who participated in programmes, most commonly in children's levels of engagement at home, engagement in community, social relations and problem solving. Less change was observed in resilience, engagement in school, and reduced troubling thoughts and feelings.

**Finding five: children’s psychosocial well-being improved regardless of programme design but some appear more effective than others**

The fifth and final finding is that while children’s psychosocial outcomes improved, regardless of programme design, there were some significant differences in the amount of improvement that children achieved between programmes. Specifically, there were some differences between programmes that incorporated clinical counselling work compared with those which focused exclusively on recreational and group activities, and between programmes which were shorter than one month compared with those longer than one month.

**Recreational activities and clinical counselling**

The outcomes of children improved significantly both in programmes that had recreational activities only and in programmes that incorporated clinical counselling work with recreational activities. In the West Bank, the improvements of children who were enrolled in programmes which only involved recreational components and group activities were
greater than those that also incorporated clinical counselling (p<0.05) Children who were enrolled in programmes that incorporated clinical counselling experienced less of an increase in psychosocial outcomes than children who were enrolled in programmes which focused on recreational and group activities only (Table 16).

Table 16. Outcomes in the West Bank by programme type

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Counselling activities</th>
<th>Recreational activities</th>
<th>Overall significance between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
<td>95% CI</td>
</tr>
<tr>
<td>Resilience</td>
<td>566 6.8 5.2-8.4</td>
<td>424 10.1 8.1-12.2</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>566 2.7 1.4-4.1</td>
<td>424 5.6 4.0-7.2</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>566 1.6 0.1-3.1</td>
<td>424 5.0 3.3-6.8</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>565 2.5 0.5-4.5</td>
<td>424 6.4 3.8-8.9</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Social relations</td>
<td>565 3.2 1.5-4.9</td>
<td>424 7.3 5.1-9.4</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>565 3.6 1.9-5.4</td>
<td>424 7.5 5.3-9.7</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Reduced troubled feelings</td>
<td>565 3.2 1.6-4.8</td>
<td>424 5.3 3.7-6.9</td>
<td>p&lt;0.05</td>
</tr>
</tbody>
</table>

In Gaza, however, the findings were somewhat different. There was little difference between children who were enrolled in either type of psychosocial programming, and there were differences in only two of the seven outcomes. Interestingly, and in contrast to the West Bank findings, children receiving some clinical counselling did better on those two outcomes. The findings from Gaza show significant differences in children's levels of engagement at home (p<0.05) and reduced troubling thoughts and feelings (p<0.001) (Table 17). Within the five other outcomes, resilience, engagement at school, engagement in community, social relations, and problem solving, however, there were no significant differences between the two types of programming.
Table 17. Outcomes in Gaza by programme type

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Counselling activities &amp; other activities</th>
<th>Recreational activities only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean diff b/t pre-test and post-test</td>
<td>95% CI</td>
</tr>
<tr>
<td>Resilience</td>
<td>309</td>
<td>3.0</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>308</td>
<td>0</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>310</td>
<td>0.8</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>309</td>
<td>-0.4</td>
</tr>
<tr>
<td>Social relations</td>
<td>310</td>
<td>-0.2</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>309</td>
<td>0.4</td>
</tr>
<tr>
<td>Reduced troubled feelings</td>
<td>310</td>
<td>1.3</td>
</tr>
</tbody>
</table>

**Longer-term vs. short-term interventions**

The improvements of children both in programmes that were longer than six weeks and those that were shorter six weeks were statistically significant in the West Bank. However, the improvements in all outcomes of children in programmes with programme cycles lasting fewer than six weeks were, perhaps surprisingly, greater than those who were enrolled in longer-term interventions (p<0.05) (Table 18).
Table 18. Length of interventions, West Bank

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Interventions 4–6 weeks</th>
<th>Interventions &gt;6 weeks</th>
<th>Overall significance between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean diff b/t pre-test and post-test</td>
<td>95% CI</td>
</tr>
<tr>
<td>Resilience</td>
<td>202</td>
<td>12.2</td>
<td>9.8-14.6</td>
</tr>
<tr>
<td>Engagement at home</td>
<td>202</td>
<td>8.2</td>
<td>6.1-10.3</td>
</tr>
<tr>
<td>Engagement at school</td>
<td>202</td>
<td>5.4</td>
<td>3.0-7.8</td>
</tr>
<tr>
<td>Engagement in community</td>
<td>202</td>
<td>11.0</td>
<td>8.2-13.8</td>
</tr>
<tr>
<td>Social relations</td>
<td>202</td>
<td>9.9</td>
<td>7.5-12.4</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>202</td>
<td>9.1</td>
<td>6.6-11.6</td>
</tr>
<tr>
<td>Reduced troubled feelings</td>
<td>202</td>
<td>11.2</td>
<td>8.8-13.5</td>
</tr>
</tbody>
</table>

This analysis was not possible in Gaza, however, as all interventions analysed in this evaluation in Gaza were shorter than four to six weeks.

Methodological challenges and limitations

While implementing the evaluation project, a number of challenges arose regarding the understanding of the conceptualization of psychosocial interventions within the child protection approach in the oPt and the evaluation design itself.

Interagency collaboration: It has been noted in the report that some agencies’ data could not be used in the study, as they had omitted to complete certain information – whether the questionnaire was pre- or post-, whether the child was from a control or participant group, which agency the child was from, etc. While some of these omissions can be attributed to gaps in supervision of the fieldworkers, a small number of agencies refused to provide this information as they felt that it would be used to comparatively rank their individual evaluations, thereby limiting their opportunity to receive funds from donors. There was also reluctance on the part of some organisations to participate in what was considered to be a donor-led initiative, under the control of a UN agency.

Sample: It must be noted at this point that in the development of a common survey tool to measure children’s psychosocial well-being in the oPt, a sample limited to children participating in psychosocial programmes and a group of children waiting to take part has
an inherent bias. The different criteria used by the eight agencies taking part in the survey for selecting children to participate were not made clear in this report. Accordingly it is difficult to assess if the most vulnerable children were included in the study, or if the children participating reflect in part children with greater access to resources.

**Lack of qualitative tools:** Because of limitations placed on agencies due to time and money constraints, some agencies resisted using more tools when carrying out the evaluation. This resulted in a tool being developed for children, but for the parents and teachers, the survey questionnaire focused solely on their behaviour, and was short and not in-depth. It would have been advantageous to develop questionnaires for parents and teachers to enquire about the child, thus adding value to the evaluation of the child’s well-being, but it was not feasible to do this because of a lack of resources.

Related to the above, the interagency evaluation did not include qualitative tools in the evaluation process. During the questionnaire development process, a qualitative tool, the Spider Diagram (Annex VI), was considered in order to learn more about children’s support networks and to further involve children in the process. However, while agency staff felt this tool could be useful during interventions, they were against using another tool in the interagency evaluation due to time and staff constraints. The mixed methods approach, where qualitative tools are used in addition to the quantitative tool, is a good practice in evaluations, strengthening the validity of the results achieved from using one tool only. This report includes the Spider Diagram as well as another qualitative tool, the My Emblem, and recommends including these qualitative measures in future evaluations of psychosocial programmes.

- My Emblem generates information about the child’s self-image, future orientation, personal sources of strength and resilience.
- The Spider Diagram generates data about children’s social networks and the people that they may turn to for help with different situations/problems. It does not tell us if they receive the type of support they seek and/or need, or if they have resolved any of their concerns.

**Unclear item reliability of the survey questionnaire:** Further work is needed to test the survey questionnaire. It was not clear how each indicator corresponded to each outcome in the actual survey tool and in the data. Some of the outcome categories are lower on the reliability spectrum of the Chronbach’s alpha coefficients (e.g., improved social relations), and more analysis is needed in order to determine whether these individual question items reliably constituted a scale (e.g., an item Factor Analysis). The results related to the low Chronbach’s alpha coefficients (0.50 to 0.40 and lower) should thus be considered carefully.

**Not all agencies used random sampling methods:** While all agencies were trained on random sampling, one agency opted to use convenience sampling. The agency that interviewed a convenience sample of children who showed up for their programme that day may have introduced certain biases into the data. One cannot be certain of the types of biases that may have been introduced, but in the case of the oPt, it is reasonable to hypothesize that children who were not present on the day of the survey may have also been absent other days as well. In that case, we would expect that those children who were absent would have had lower rates of improved change when compared with the children who attended all of the sessions. This would mean that the results presented for children in the intervention group are slightly higher than they would have been if they had included children who were not regularly at the sessions. Additionally, it seems reasonable to hypothesize that the children at higher risk may have had a harder time making it to the programme on a regular basis (for example, if they did not have parents who were supportive to make sure they attended every session). In that case, more
vulnerable children may also have been missed as a result of the convenience sampling. This would also have resulted in inflated values for the effectiveness of interventions.

Reduced sample size: The planned sample size was reduced due to the fact that many children’s surveys were not accurately marked as pre-test, post-test, comparison group or intervention group. This resulted in a lot of lost data. Additionally, missing items on questionnaires led to even further reduced – and often disproportionate – sample sizes when results were analysed by age, gender, location and programme type.

Younger respondent bias: Three quarters (74.4 per cent) of the children sampled where between 8 and 12 years old (45.7 per cent of the Palestinian population is under 15 years old). This serves to bias the results towards the capacities and needs of younger children, as well as towards interventions more appropriate for younger children. This makes it difficult to adequately assess the impact of programmes on adolescents. There is no description of the different approaches used with adolescents. However, this bias reflects the situation on the ground where there is a lack of adolescent-friendly and focused psychosocial interventions.

Facilitator bias: An interagency decision was taken for programme staff to administer the surveys. It is quite likely that whether intentional or unintentional, staff created another source of bias. It is only natural that programme staff would want results of their programme evaluation to yield positive results. Given this tendency, it is likely that field staff may have given unconscious signals to the children during the administration of the survey, which may have affected the way participants answered the questions. Similarly, children may have instinctively wanted to ‘do well’ for the interviewers, and may have introduced social desirability response bias. Social desirability response bias describes the tendency of respondents to reply in a manner that they believe will be viewed favourably by others. This generally takes the form of over-reporting good behaviour and under-reporting bad behaviour. One way this might be avoided in future evaluations of this sort would be to have outside evaluators carry out the interview administration or to have field staff switch and interview participants enrolled in programmes other than their own programmes.

However, there is also the argument for involving field staff in their own evaluations to increase capacity and learning. The field staff were trained on the methodology used in this study in order to support their participation, involvement and motivation.

Limited triangulation data: Only 46 per cent of parents completed the post-test, so the data obtained from parents cannot be considered a representative sample. Ideally, data from parents would have been used to provide quantitative data on children from another viewpoint, serving to triangulate and verify the self-reports from children. Instead, the data from parents can only be used to indicate trends or suggest areas of support or disagreement with the children’s data.

Short-term programming bias: The data collection period from baseline to end-of-intervention evaluation was over a four month period. Only short-term interventions (below four to six weeks’ duration) were evaluated in Gaza. This biased the sample towards shorter interventions and immediate programme outcomes.

The sustainability potential of the programme outcomes was not considered.

Limited analysis on comparisons between different interventions: There is limited description and analysis of the different types of intervention used during the study time frame. This limitation, together with the bias towards short-term interventions, makes it difficult to:
• identify which interventions targeted which outcome levels, for example, engagement at home, and which were school-based
• Make comparisons and cross-correlations between different interventions and the different age, gender and location variables.

Discussion

Overall, the findings of this evaluation support the general effectiveness of psychosocial programming within the changing cultural and political context of the oPt. Not only were the improvements in psychosocial outcomes of all children overall significant when compared to children in comparison groups, the evaluation found that the outcomes of children who were not in programmes—in the wait-listed comparison groups—often deteriorated over time and became significantly worse.

One important finding from this evaluation is that children's overall level of resilience upon entering programmes was relatively high, even without intervention. This indicates that despite the current conditions that have made life increasingly difficult in both the West Bank and Gaza, children who participate in psychosocial programmes appear to come into programmes with a high degree of self-efficacy and social support. This is consistent with findings from other qualitative studies conducted among young people in the oPt, and might reflect the important internal resources within Palestinian families, culture and society that contribute to children's responses to adversity.35,36

The measured resilience among children participating in the study needs further examination. Within the context of the oPt, where children, families and communities have adapted over generations to protracted political and military violence, and to the long-term impacts of the economic blockade, dislocations and travel restrictions, resilience becomes an adaptation in the face of adversity—a normal reaction to abnormal events. However, experience and research have shown that the long-term consequences of such adaptation to persistent threats to the well-being of individuals and social groups can result in deep-rooted individual and societal difficulties. The challenge for psychosocial programming within such a context is to situate response and interventions within a holistic, rights-based approach, where evidence-based practice can help strengthen the protective environment for children and thereby contribute to structural changes in the situation of children—for example, by creating better access to equitable, quality services.

All interventions that were evaluated in this report worked with both children and caregivers, and therefore could not be compared with interventions that did not. However, among these programmes, improvements in all psychosocial outcomes were statistically significant across the board. This potentially supports a general effectiveness of methodological approaches that go beyond individual approaches, and work both with children in groups and with their families within the existing context of their social worlds. The social ecological approach acknowledges the importance of supporting children's psychosocial well-being through their existing mechanisms of support within their family and the broader community.

35 Arafat, C and Muslch, T, op.cit.
The social ecological approach also acknowledges that risks and protective factors that contribute to a child’s psychosocial well-being are not fixed or static, but instead are rooted in a child’s changing cultural and political landscape. Moreover, demographic factors, such as how old a child was, whether or not the child was a boy or a girl, and particularly where he or she lived in the oPt influenced children’s levels of overall resilience following participation in psychosocial programmes.

When analysed by age, the findings show that younger children, aged 8–12, experienced improvements across the board in the West Bank, and younger children in programmes in Gaza experienced improvements in resilience, engagement at home, engagement in community, social relations, and problem solving. Younger children in programmes in Gaza did not, however, experience significant improvements in their level of engagement in school or in their reduced troubling thoughts and feelings.

Among adolescents aged 13–18 in psychosocial programmes in both the West Bank and Gaza, significant improvements in their relationships at home within their families, with their community, in their social relations, and problem-solving abilities were observed. Adolescents in the West Bank also experienced improvements in their emotional health and in reductions in their troubling thoughts and feelings; adolescents in Gaza, however, did not. Moreover, significant improvements in resilience and engagement in school were not observed among adolescents in either the West Bank or Gaza. This indicates that for adolescents in programmes, an increased sense of close relationships with peers, with teachers and with classmates was not a significant result of participating in psychosocial programmes. As mentioned above, various methodological limitations, like the younger sample age and no description of the different approaches used with adolescents, makes it difficult to adequately assess the impact of programmes on adolescents.

In general, both younger children and adolescents in the West Bank reported feeling safer, sleeping better, and feeling more able to concentrate on their studies. Among children of both age groups in Gaza, however, this was not the case. While children of both age groups experienced improvements in most outcomes, children in Gaza did not report significant improvements in reducing troubling thoughts and feelings following participation in psychosocial interventions.

Children’s outcomes improved in the West Bank between baseline and post-test, regardless of their gender. In Gaza, however, this was not the case; improvements in outcomes of resilience, engagement in school, and reduced troubling thoughts and feelings differed by gender. While boys’ outcomes improved significantly across the board for all outcomes, girls in programmes in Gaza did not experience significant improvements in their level of resilience, engagement in school, and reduced troubling thoughts and feelings. Furthermore, when analysed by gender, the findings show that it is girls, and not boys, who do not report a reduction in troubling thoughts and feelings in Gaza.

Where a child lived in oPt also made an important difference in his or her amount of improvement between the time that s/he took the baseline questionnaire and the post-test. The outcomes of children in psychosocial programmes increased in most governorates in the West Bank and Gaza, but some increases were more significant than others when compared to children in comparison groups in the same governorates. In general, it appears as though significant increases were seen in most governorates among children who participated in programmes, most commonly in children’s levels of engagement at home, engagement in community, social relations and problem solving. Less change was observed in resilience, engagement in school, and reduced troubling thoughts and feelings.
Finally, given that all outcomes of children who participated in programmes improved significantly, which approaches were more effective? The difficulty with this analysis is that many of the programmes included in this evaluation are relatively similar in approach or in their general structure, and therefore difficult statistically to compare. What is important to note, however, is that this evaluation found that the psychosocial interventions evaluated in this report result in positive outcomes for children in the oPt, regardless of programme type or design.

Results were analysed to determine whether or not a clinical counselling component makes a difference, or if recreational activities make a difference in the amount of increase in psychosocial outcomes. All outcomes improved significantly for children in all programmes in the oPt across the board, but the results were different in Gaza and the West Bank. In Gaza, children who participated in programmes that included a clinical counselling component experienced a greater amount of change in two outcomes of their level of engagement at home and in reduced troubling thoughts and feelings. In the West Bank, children who were in programmes that mainly focused on recreational and group activities experienced a greater amount of increase in all outcomes compared with children in programmes that included only clinical counselling. Moreover West Bank programmes were also examined in terms of implementation time frames. Children who participated in shorter-term interventions experienced significantly greater improvements in all psychosocial outcomes than those who participated in longer-term interventions.

Plausible explanations for both of these findings will require further investigation. The study only examined short-term interventions in Gaza. This biased the sample towards shorter interventions and immediate programme outcomes. Consequently the result that short-term projects are more successful in Gaza is misleading and needs further study. Stakeholder's feedback to this report asserted that the majority of organizations deliver projects that are longer than six weeks, yet these were not reflected in the study. In addition, it also needs to be taken into account that the impact of a long-term programme takes longer to appear. There is no definition of 'short-' and 'long-term', or the cut off point for either. It is necessary to establish if the selection criteria for short- or long-term programmes are different, as this would impact significantly on the results – children who participate in a long-term intervention may be more troubled, for example. There is no information on the status of the children in the programmes, if their level of distress was mild or severe and, again, more information is needed on the type of interventions.

**Conclusion**

This study offers preliminary evidence of the continued need for psychosocial programming, and the need to assess the long-term impacts of such programming. It also reveals a need for additional programmes that support key elements of children’s social ecologies that are directly linked to their resilience and well-being. These elements include children’s parents and households, teachers, schools and mentors, and extra-curriculum programmes. Indeed, the longer children in the oPt continue to be exposed to occupation and incursions, the more important it is for the organized assistance to focus not only on mental health and psychological concerns, but

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37 Gaza interventions were four to six weeks in length, and thus this same time element could not be examined in a meaningful manner.
also on statutory (policies) and social supports that buffer children from the most harmful effects of structural violence and economic duress.

Lessons learned through this interagency evaluation should also help to inform future learning endeavours. The evaluation process brought together a number of key actors working in the field of psychosocial response who were eager to learn more about the impact of their programmes – and to do this together. These pioneering efforts reflect an important step in a coordinated effort to improve programming and build the evidence base for future interventions, to:

- Institutionalize quality evaluation and programme learning systems
- Build the evidence-base for effective psychosocial programming
- Harmonise agreed strategies and standards for implementation, and
- Work towards national coverage in the oPt.

The evaluation process revealed a number of methodological constraints that limited the evaluation’s ability to make in-depth efficacy comparisons of different programme approaches. The involvement of different agency staff over an extended period of time resulted in a considerable amount of data being lost.

Issues around interagency coordination were present; however, the MHPSS actors remain engaged in the process and ready to continue to work with the tools. The process and outcomes of this study clearly indicate the need for a locally based research manager to supervise field workers and manage the data collection and data management process. This is particularly pertinent given the high staff turnover rate during the lifespan of the study – there was little institutional knowledge about the study among the participating agencies a year on from initial involvement.

With these limitations in mind, this evaluation underscores both the general effectiveness of psychosocial programmes across the board and the need to consider how programmes could be more specifically tailored to meet the different realities in Gaza and the West Bank. Programmes in different areas of Gaza and the West Bank that combine three or more supports (individual, family and school, for example) could be more carefully compared with programmes in these same areas that offer one support (counselling and/or recreation, for example. A more structured comparison between the West Bank and Gaza would also be useful. Additionally, there is a need for closer examination of the influence of gender on psychosocial outcomes – particularly for girls in Gaza – and adolescents’ levels of engagement in school.

This evaluation is the second part of a three-phase process:

(i) Interagency commitment to common evaluation
(ii) Interagency psychosocial baseline and evaluation research and development of measures of children’s psychosocial well-being
(iii) Over the next 12–18 month period, the participating agencies agree to commit to using the evaluation approach and tools, and to convene at the end of a pre-determined period to assess the relevance and appropriateness of the psychosocial evaluation approach, the guidelines and the toolkit (Annex VII) to the oPt situation.

An addendum to this report should be noted: in October 2010, participating agencies came together to agree on a set of core outcomes and indicators to guide psychosocial programming in the oPt. Please see Annex VII.

In terms of the way forward, it is recommended that UNICEF and the implementing agencies plan for and commit to phase three of this important and pioneering interagency initiative.
Recommendations

Direct interventions:
A consideration of more:
- school-based psychosocial approaches and interventions
- psychosocial interventions for adolescents (15–18 years)

Research:
More research is required comparing psychosocial programming:
- between the West Bank and Gaza
- between different approaches and types of interventions
- between younger children and adolescents
- between girls and boys (and the integration of gender markers and awareness in psychosocial programming).

Plan phase three of the Interagency Psychosocial Evaluation:
vii. Adapt survey questionnaire and finalize the quantitative and qualitative monitoring and evaluation (M+E) measurement tools of children’s psychosocial well-being in the oPt, based on the interagency psychosocial outcomes and indicators
viii. Mainstream M+E tools into UNICEF and participating agencies’ existing frameworks
ix. Conduct further interagency research, to be co-ordinated by a locally based NGOs
x. Evaluate the effectiveness of shared tools, adaptations necessary and value in the field
xi. Assess the relevance and appropriateness of the psychosocial evaluation approach, the guidelines and the tool kit
xii. Publish the oPt Interagency Psychosocial Monitoring and Evaluation Guidelines and Tool Kit.
Annexes
Annex 1

Breakdown of types of psychosocial interventions sampled

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Activity</th>
</tr>
</thead>
</table>
| **Recreational activities, or “Fun days”** | - Sports and group games  
- Art – mask making, painting, murals, etc.  
- Music, including folklore and cultural songs  
- Folkloric dancing and cultural activities  
- Swimming for younger children (Gaza)  
- Dram – devising plays about issues or specific themes |
| - Most commonly carried out during holiday periods  
- Numbers of up to 100 children involved  
- Can involve children of varying ages from one community in a “one off” day  
- Children involved in ongoing programmes involved plus “guests”  
- Divided by gender if adolescents involved |
| **Group-based activities** | - Art and creative approaches  
- Discussion and themed role plays  
- Class-based intervention  
- “Butterfly Technique”  
- Communication skills, coping with conflict, negotiation skills  
- Group counselling  
- Referral of children in need of more focused support  
- Confidence building  
- Thematic sessions – mine risk education, ‘Say no’, cultural days, etc.  
Usually follow a set session plan of specific topics, not based around individual needs |
| - In groups of between 15–20 children  
- Sessions from between two weeks intensive to one year |
| **Individual sessions** | - How to recognize signs of children not doing well  
- How to support children demonstrating signs of distress  
- Communication skills  
- Supporting children at school, i.e., encouragement to approach teachers to discuss progress etc.  
- Alternative methods of discipline |
| - One-on-one sessions of counselling with a psychologist, social worker or trained counsellors (paid para-professional counsellors)  
- Carries on for an indeterminate number of sessions  
- Children will normally have participated in group sessions first, been referred from the group, and can attend group and individual sessions concurrently |
| **Caregiver group sessions** | - Can be parents of children attending sessions or not  
- Sometimes attend sessions with children, in a session designed to increase communication between them  
- Can be identified through school, mothers groups, community centre |
| - How to recognize signs of children not doing well  
- How to support children demonstrating signs of distress  
- Communication skills  
- Supporting children at school, i.e., encouragement to approach teachers to discuss progress etc.  
- Alternative methods of discipline |
or voluntarily come forward (e.g., call help line)
- Majority mothers
- Fathers identified in non-traditional ways, and are therefore less likely to be parents of children who are also receiving support (mosques, etc.)

<table>
<thead>
<tr>
<th>Teacher sessions</th>
<th>Coping with stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Identified through school-based programmes</td>
<td>- How to recognise children in distress</td>
</tr>
<tr>
<td>- Identified as part of emergency intervention in high risk areas (regular incursions, school at risk of demolition, etc.)</td>
<td>- How to support children psychosocially</td>
</tr>
<tr>
<td>- Can be one off “counselling days” or regular sessions</td>
<td>- How to deal with stress and how to support each other</td>
</tr>
<tr>
<td></td>
<td>- Alternative methods of discipline</td>
</tr>
</tbody>
</table>
ANNEX II

Core outcomes and indicators for child-centred psychosocial programming in the oPt – October 2010

Measuring children’s psychosocial well-being

It is important that the stated objectives of psychosocial projects should provide the clearest definition of what the interventions seek to achieve. Much time, energy and money is spent on these projects, thus programmers must ensure that there will be an actual positive change for children as per the stated aims and objectives.

<table>
<thead>
<tr>
<th>Work that seeks changes in the psychosocial well-being of children means that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family, community and individual issues are addressed</td>
</tr>
<tr>
<td>• There is a deliberate and explicit focus on bringing together psychological factors and social inclusion, and not focusing only on either material, psychological, spiritual or welfare support</td>
</tr>
<tr>
<td>• The key underlying idea to psychosocial interventions is that participation in psychosocial activities assists children and their families who have experienced severe stress to begin to re-stabilise their social and psychological health and prevent more long-term social and mental health problems</td>
</tr>
<tr>
<td>• The primary focus of psychosocial interventions is on supporting the natural healing and recovery process by strengthening resilience in the face of challenging circumstances and the stability of an entire affected community</td>
</tr>
</tbody>
</table>

Psychosocial wellbeing exists at the individual, family and community levels.

Individual level:
- Ability to form and maintain positive relationships with caregivers, peers and positive role models
- Sense of security, trust, self-confidence, meaning and hope for the future
- Life skills/empowerment

Family level:
- Ability to protect, care and support children and other family members
- Ability to address and reduce the stresses of poverty and violence

Community/society level:
- Community mobilization to address psychosocial concerns, and how to address them
- Community cohesion, social support and tolerance

Psychosocial interventions plan for positive change for children within the three core psychosocial areas or domains of skills and knowledge, emotional and social wellbeing. In addition, depending upon the agency and the type of programme, objectives and outcomes of psychosocial interventions may include the broader domains impacting
upon the wellbeing of children, their families and communities – as outlined by Williamson and Robinson in their overlapping circles model:

People responsible for psychosocial programming should be able to specify the objectives of their work in relation to the three domains of psychosocial well-being. This will ensure that programming addresses an appropriately broad range of issues influencing children’s well-being. These domains may be reflected in different ways in different cultures but they represent the common core of most psychosocial work.

| Psychosocial domains and key indicators
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial domain</td>
<td>Description</td>
<td>Key indicator</td>
</tr>
<tr>
<td>1. Skills and knowledge</td>
<td>For example: life skills, using culturally appropriate coping mechanisms, vocational skills, conflict management</td>
<td>Some measure of acquisition of skills</td>
</tr>
<tr>
<td>2. Emotional well-being</td>
<td>For example: feeling safe, trust in others, self-worth, hopeful for the future</td>
<td>Some measure of improved emotional adjustment</td>
</tr>
<tr>
<td>3. Social well-being</td>
<td>For example: attachment with caregivers, relationships with peers, sense of belonging to a community, access to socially appropriate roles, resuming cultural activities and traditions</td>
<td>Some measure of improved social functioning</td>
</tr>
</tbody>
</table>

The indicators below are directly linked to the psychosocial well-being tools included in this interagency evaluation and can be used as a guideline for minimum standards of design, monitoring and evaluation frameworks and tools. Additional well-being indicators may be included which are directly linked to the particular outcomes of the specific interventions implemented by the agencies.

---

39* A guide to the evaluation of psychosocial programming in emergencies. UNICEF, 2007.*
**Core outcomes and indicators for child-centred psychosocial programming in the oPt**  
October 2010

**Impact:** improved well-being for children and families in oPt  
**Impact indicator:** strengthened psychosocial well-being of children

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| **Emotional Wellbeing:**  
1. *Reduced troubling thoughts and feelings*  
2. *Children show more self-confidence*  
3. *Increase of children’s ability to cope with stress* | 1.1 – Percentage increase in the psychosocial well-being score of children who participated in the psychosocial intervention as measured by the oPt Interagency Psychosocial Evaluation Questionnaire for Children.  
Additional:  
Percentage decrease of children who have bad dreams as reported by children and parents  
2.1 – Percentage increase of children who can name three things that they are good at and proud of about themselves as reported by children (measured by the My Emblem tool).  
3.1 – Percentage increase in the number of daily life (social, cultural, recreational) activities that children enjoy doing in one week as reported by children, parents and teachers (tool development required)  
3.2 – Percentage increase of children who do their homework without being asked as reported by children and parents (as measured by the oPt Interagency Psychosocial Evaluation Questionnaire for Children).  
Additional:  
Percentage increase in classroom attendance as measured by school records  
Percentage increase in school performance as measured by school records |
| **Social well-being: improved social engagement**  
4. Improved social relations in | 4.1 – Percentage decrease in negative (verbal and physical) interactions at home as reported by children and parents/caregivers (self reports as measured by the oPt |
<table>
<thead>
<tr>
<th>home</th>
<th>Interagency Psychosocial Evaluation Questionnaire for Children).</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Improved social relations at school</td>
</tr>
<tr>
<td>6.</td>
<td>Improved social relations in the community</td>
</tr>
<tr>
<td></td>
<td>4.2 – Percentage increase in the number of people the children go to for help to solve their problems as reported by children (measured by the Spider Diagram).</td>
</tr>
<tr>
<td></td>
<td>5.1 – Percentage increase in cooperative behaviour with peers and teachers at school as reported by children and school staff (tool to be developed, and as measured by the oPt Interagency Psychosocial Evaluation Questionnaire for Children)</td>
</tr>
<tr>
<td></td>
<td>6.1 – Indicator and measurement tool to be developed.</td>
</tr>
<tr>
<td></td>
<td><strong>Increased skills and knowledge:</strong></td>
</tr>
<tr>
<td>7.</td>
<td>Increased positive self-expression amongst children</td>
</tr>
<tr>
<td>8.</td>
<td>Increased problem-solving skills</td>
</tr>
<tr>
<td></td>
<td>7.1 – Increased active participation of children in classroom and workshop activities as reported by children, parents and teachers/facilitators (tool to be developed, and as measured by the oPt Interagency Psychosocial Evaluation Questionnaire for Children)</td>
</tr>
<tr>
<td></td>
<td>7.2 – Percentage increase in the number of children able to share feelings and opinions with other children, parents and teachers as reported by children, parents and teachers (as measured by the oPt Interagency Psychosocial Evaluation Questionnaire for Children)</td>
</tr>
</tbody>
</table>

**oPt Interagency Psychosocial Monitoring and Evaluation (M+E) Tools**

**A set of interagency psychosocial outcomes and indicators with M+E Toolkit will:**

- Provide a clear idea of the extent to which participating agencies accomplish their objectives, or not, to protect and promote children’s psychosocial well-being in the oPt
- Provide concrete means of tracking and measuring activities, achievements, setbacks and lessons learnt
- Enable better understanding and articulation of agencies’ technical and operational capacities and needs
- Enable greater integration of psychosocial approaches and interventions into child protection objectives and outcomes
- Result in a more standardized and systemic approach to the psychosocial component of child protection and well-being in the oPt
<table>
<thead>
<tr>
<th>Types of assessment</th>
<th>Psychosocial M+E tools</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| 1. Current child resilience status | 1. *The Interagency Core Psychosocial Outcomes and Indicators*  
2. *The oPt Interagency Psychosocial Questionnaire*: 3x children, parents, teachers (quantitative)  
3. Spider Diagram (qualitative)  
4. My Emblem (qualitative)  
2. Conduct ethnographic study of local perceptions of child well-being and distress |
| Status: Agency tools and systems exist. Interagency essential psychosocial outcomes and indicators matrix, the Psychosocial Questionnaire and FGD protocol developed, piloted, but require adjustment and further testing. Data collection, management and analysis guidelines need to be developed. Need to develop Interagency assessment criteria for children participating in psychosocial programmes. |
| 2. The identification of children in need of focused MHPSS support and referral systems | 1. *The Mental Health and Psychosocial Support Referral Pathway* | 1. Case management tools, e.g.: psychological assessments appropriate for oPt population (norms and values according to RCT) do not know  
2. Referral criteria re: more specialized psychological care and support, e.g.: family assessment and support, individual counselling, group therapy, psychiatric assessment |
| Status: Agency tools and systems exist. Interagency MHPSS Referral Pathway requires adaptation for the oPt |
| 3. Monitoring trends | 1. *The Interagency Core Psychosocial Outcomes and Indicators* (minimum programming and service delivery mapping and monitoring)  
2. Psychosocial well- | 1. MHPSS planning and service delivery mapping and monitoring  
2. Psychosocial well- |

- **Psychosocial M+E tools**
  - *The Interagency Core Psychosocial Outcomes and Indicators*
  - *The oPt Interagency Psychosocial Questionnaire*: 3x children, parents, teachers (quantitative)
  - Spider Diagram (qualitative)
  - My Emblem (qualitative)
  - *The Ethnographic Child Competence and Child Risk and Resiliency Interview.*
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>The Mental Health and Psychosocial Support 4xW (MHPSS WWWW - what, who, where, when),</td>
<td>being performance targets established to assess the resilience status of children participating in psychosocial interventions within and across Gaza and West Ban, over time allows for contextualization / comparisons with national / regional data</td>
</tr>
<tr>
<td>3.</td>
<td>The Interagency MHPSS Guidelines for Evaluating Psychosocial Programmes in Humanitarian Emergencies</td>
<td></td>
</tr>
</tbody>
</table>

**Status:** Agency tools and systems exist. Guidelines for developing targets based on the Minimum Essential Interagency Psychosocial Outcomes and Indicators need to be developed. The MHPSS 4xW requires adaptation for oPt.

<table>
<thead>
<tr>
<th>4. Programme review/evaluation/operations research</th>
<th>1. The Interagency Core Psychosocial Outcomes and Indicators</th>
<th>1. To determine whether the programme is effective in reaching its outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. The oPt Interagency Psychosocial Questionnaire: 3x children, parents, teachers (quantitative)</td>
<td>2. To conduct end-of-programme evaluation</td>
</tr>
<tr>
<td></td>
<td>3. Spider Diagram (qualitative)</td>
<td>3. To compare alternative programme models and approaches</td>
</tr>
<tr>
<td></td>
<td>4. My Emblem (qualitative)</td>
<td>i. Data analysis</td>
</tr>
<tr>
<td></td>
<td>5. The Ethnographic Child Competence and Child Risk and Resiliency Interview.</td>
<td>ii. Cost analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. Model analysis</td>
</tr>
</tbody>
</table>

**Status:** Agency tools and systems exist. Guidelines for data collection, management and analysis need to be developed.

<table>
<thead>
<tr>
<th>5. Data management system</th>
<th>1. Development of data management and analysis system, and</th>
<th>1. Collected by staff, field workers, community health workers at pre-determined dates (on quarterly and</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Linkage to Management Information System</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Training on data collection</td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Collected by staff, field workers, community health workers at pre-determined dates (on quarterly and</td>
</tr>
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<td></td>
</tr>
<tr>
<td></td>
<td>annual basis)</td>
<td></td>
</tr>
<tr>
<td>ii.</td>
<td>Checked for quality</td>
<td></td>
</tr>
<tr>
<td>iii.</td>
<td>Entered and stored into a computerized database</td>
<td></td>
</tr>
</tbody>
</table>

**Status:** Agency tools and systems exist. Interagency guidelines for data collection, management and analysis need to be developed.
Annex III

Interagency Evaluation Project
Interview good practice guidelines

Meeting and greeting the child:
Purpose: Placing the child at ease

- Meet responsible adult – re-establish purpose; show letter of introduction, state agency affiliation and obtain consent
- Introduce yourself when you meet the child
- Meet with the child in private (separate from their parents or other adults in the household); ensure privacy of interviews to the maximum extent possible
- Breaking the ice: be friendly, use positive and respectful body language; reduce tension and place the child or adult at ease; make the child feel comfortable
- Establish communication with the child by using open-ended questions
- If the children meet in a common location (i.e., a school), play a game with the children before interviewing each child individually
- Model respect for the child or adult
- Offer a drink or snack if available
- Engage young children through simple and concrete words
- Do not be rigid in the process: in the greeting, maybe discuss the purpose briefly and then go to an ice breaker
- If girl is 13 or over, interviewer should be a woman
- Adopt culturally appropriate interviewing approaches. For example, women can interview boys and girls. Men can interview only boys
- Be prepared to refer individuals and families with serious problems
Explaining the purpose of the interview and obtaining consent

- Explain that the purpose of the interview is to help the agency understand how to improve its programme and that the agency is interviewing a number of children for this end
- Be clear about the objective of the interview exercise. Emphasize that participation in the interview will not affect services (do not create false expectations); rather, it is an effort to improve existing services in the future
- Be unbiased and explain to the child that there are no right or no wrong answers
- Ensure confidentiality (but do not over-emphasize or repeat it often): the information obtained will not be shared with parents, teachers, or others
- Receive Informed Consent: the participant can agree or not agree to participate. Give the child enough time to think and make a decision in an informed way
- Summarize all key points at the end to ensure everything is covered

Conducting the interview

- Make sure there is a quiet, comfortable and safe place, with privacy, to conduct the interview
- Explain the interview process: number of statements; the rating scale and what it means; the amount of time needed for the interview
- Start with several easy practice questions to ensure children understand the scale. Practice questions should lead to different answers in the scale.
- Create a non-threatening and comfortable atmosphere between the child and interviewer (i.e., sit down in order to speak with the child at his/her eye level)
- Mark responses (1 through 5) clearly in the standard questionnaire in order to allow for consistent data entry
- If the child responds with answers unrelated to the scale, the interviewer should ask the child to which one of the answers in the scale they are referring.
- Use participatory methods with all children
- Be neutral: do not have strong reactions to responses, other biases or offer clues – every answer is an appropriate answer
- Start and finish the interview in one sitting
- Remain focused on the interview and have no distractions (i.e. no cell phones; no people coming in and out of interview space)
• Listen! Listen! Listen! Be ready to pause if questions raise emotions in the child; pace interview accordingly

• Make it an enjoyable experience

Ending the interview
Purpose: bring closure to the interview process

• Towards the end of the interview, let the child know that it is almost over (i.e. there are two remaining questions)

• Thank the child and let her know she has been very helpful and that the document is complete

• Remind the child about when the programme will be starting; if the child is on the waiting list, let him/her know that it will start in the near future

• Reassure the child that this will remain confidential and will be used only to help improve the programme

• Make sure the child is emotionally okay and is ready to return to her regular activities

Guidelines for managers regarding the interviewing process

Planning the interview

• Decide who will be interviewed: interventions vs. wait-listed groups; age, gender, location, etc.

• Understand the purpose of the interview

• Inform the child’s caregiver that this will take place

• Decide when and where to conduct the interview – consider child or adult’s needs for privacy and confidentiality

• Be prepared for the interview and ensure a common understanding of the questionnaire and practice skills needed for interviewing

• Interviews should be conducted individually

• Be familiar with the interview tool in advance, including the questionnaire statements and rating scales
• Prepare and practise interview techniques well in advance of interviews

• Develop a coding system in advance so we can identify interviewees from the baseline data collection to the final evaluation conducted

• Have an idea regarding the time needed for the interview

• Understand how to explain the purpose and procedures to the child: make sure s/he knows what it is, and agrees (or not) to participate

• Staff preparedness: anticipate issues or challenges that may come up during the interview and practise responding to possible issues

• Understand the local context and culture

• Be aware of the education levels of population and use appropriate words and language with the interviewee

• Work in teams: female and male interviewers together

• Do not have female interviewers enter unknown houses alone

• Female interviewers should interview women and girls; and male interviewers should interview boys and men

• Ensure random sampling plans are followed – do not deviate without evaluation supervisor’s approval

• Interviewers need to understand how to follow the sampling plan

• Have letters of introduction indicating agency affiliations and purpose of the interview

• Plan on holding feedback sessions to review interviews and improve practices
### Annex IV

**Capacity and needs assessment results**

<table>
<thead>
<tr>
<th>West Bank</th>
<th>Baseline</th>
<th>Comparison group</th>
<th>Methods</th>
<th>Sampling strategy</th>
<th>Capacity to implement evaluation</th>
<th>Analysis</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>YMCA</td>
<td>Partial</td>
<td>Not currently. Requested assistance</td>
<td>Pre-post survey (Requested assistance)</td>
<td>Requested assistance</td>
<td>Yes</td>
<td>Requested assistance</td>
<td>New Programme cycle in July</td>
</tr>
<tr>
<td>ANERA</td>
<td>Yes, but displeased with current baseline</td>
<td>Not currently. Requested assistance</td>
<td>Pre-post survey, focus groups (Requested assistance)</td>
<td>Requested assistance</td>
<td>Yes</td>
<td>Yes</td>
<td>New Programme cycle in July</td>
</tr>
<tr>
<td>Red Cross</td>
<td>Yes</td>
<td>Requested assistance</td>
<td>Pre-post survey, focus groups (Requested assistance)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>New Programme cycle in August</td>
</tr>
<tr>
<td>Save the Children</td>
<td>Yes, but displeased with current baseline</td>
<td>No</td>
<td>Pre-post structured interviews, focus groups, mapping, PRA activities</td>
<td>Convenience sampling</td>
<td>Yes</td>
<td>Requested assistance for quantitative analysis</td>
<td>Seeking funding for next programme cycle</td>
</tr>
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<td>-------------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Comparison group</th>
<th>Methods</th>
<th>Sampling strategy</th>
<th>Capacity to implement evaluation</th>
<th>Analysis</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMRS</td>
<td>Yes</td>
<td>No</td>
<td>Interviews, case management forms, FGD and questionnaires and WHO functioning form (Requested assistance for PS component)</td>
<td>Not for internal evaluation but experience as part of external evaluation</td>
<td>Yes</td>
<td>Yes</td>
<td>Internal evaluation in Jan/Feb</td>
</tr>
<tr>
<td>UNRW A</td>
<td>Partial</td>
<td>Requested assistance</td>
<td>Satisfaction rating, observation by teachers, measures of social functioning, academic achievement and quality of life</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Ongoing 6 month cycles</td>
</tr>
<tr>
<td>MOE</td>
<td>Partial (problems faced by students)</td>
<td>No</td>
<td>Case management forms, monitoring problems and counsellors performance (Requested assistance)</td>
<td>No (requested assistance)</td>
<td>Yes</td>
<td>Yes</td>
<td>Four monthly monitoring cycle starting in July</td>
</tr>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td>PCDCR</td>
<td>Yes, but displeased with current baseline</td>
<td>Requested assistance</td>
<td>Pre-post questionnaires, focus groups, case management forms, interview, PRA (with support from Save)</td>
<td>Conveniency sampling</td>
<td>Yes</td>
<td>Requested assistance for quantitative analysis</td>
<td>New programme cycle begins in July</td>
</tr>
</tbody>
</table>
Annex V

Psychosocial programmes, oPt
Interagency evaluation project
Questionnaire for children, parents and teachers

Background information

1.1.1 Date of interview: ________________________

1.1.2 Interviewer name: ____________________________________

1.1.3 Data collected for:
   _____ Baseline (pre-test)   _____ Final evaluation (post-test)

1.1.4 The child is in the:
   _____ Programme   _____ Comparison group

1.1.5 Full name of child being interviewed: _____________________________________

1.1.6 Gender: ____ Boy   ____ Girl

1.1.7 Age: _______

1.1.8 Location where the child being interviewed lives: ____________________________

1.1.9 District: _______________________

1.1.10 Full name of child’s parent (if the child’s parent is in the programme or comparison group):
       ____________________________________

1.1.11 Full name of the child’s teacher/school counsellor (if the child’s teacher/school counsellor is in the programme or comparison group):
       _________________________________
Programme information

1.2.1 Agency code: ____________________

1.2.2 Type of programme intervention: (group activities, individual counselling...): ____________________

1.2.3 Number of sessions per week: ____________

1.2.4 Length of each session (i.e. 1 hour, 2 hours): ______________

1.2.5 Total number of children participating in the sessions (size of group): _________

1.2.6 Total number of sessions: ____________

1.2.7 Length of programme (start and end dates): __________________________

Questionnaire for children

Outcome: increased resilience

1.3.1 I have friends that I play with.


1.3.2 I have friends that I can share secrets with.


1.3.3 I am able to solve my problems.


1.3.4 I feel I can improve my performance in school.

1.3.5 I do my homework without being asked by my parents.

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

1.3.6 I know what to do during dangerous situations

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

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**Outcomes: improved social relations, increased problem solving, and increased engagement in home, school and community**

1.4.1 My parents encourage me to participate in recreational activities.

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

1.4.2 My parents help me to solve difficult problems

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

1.4.3 My parents yell at me.

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

1.4.4 My parents hit me.

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

1.4.5 My parents treat me in the same way as my siblings

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

1.4.6 My parents listen to me and respect my opinion.

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

1.4.7 I fight with my brothers and sisters.

- 1. Never
- 2. Sometimes
- 3. Most of the time
- 4. Always

Ahlal Wajbiyat bi-dun ta'loy min Ahli

أنا أتأصر في حال الخطر

أنا أتأصر في حال الخطر

أنا أتأصر في حال الخطر

أنا أتأصر في حال الخطر

Ahlali yasadaoni fi Hal Mikhalati Al-Subah

Ahlali yasadaoni fi Hal Mikhalati Al-Subah

Ahlali yasadaoni fi Hal Mikhalati Al-Subah

Ahlali yasadaoni fi Hal Mikhalati Al-Subah

Ahlali yasadaoni fi Hal Mikhalati Al-Subah
1.4.8 I feel that my family is able to protect me from danger.


Iأشعر بأن الأطفال الآخرين أكثر سعادة مني، لأن أهله يوفرن لهم أشياء أكثر.

1.4.9 I feel other children are happier than me, because their parents can buy them more things.


الأطفال الآخرين يؤمنوني في المدرسة

1.4.10 Other children do bad things to me at school.


أنا أجل مشاكل مع الأطفال الآخرين بدون مشاجرة

1.4.11 I resolve problems with other children without fighting


أنا أساعد الأطفال الآخرين الذين لديهم مشاكل

1.4.12 I help other children when they have problems


أطلب مساعدة شخص أثق به عند الحاجة

1.4.13 I can go to someone I trust to help me when I need to


أشارك في الحصة

1.4.14 I participate in the classroom


معمل/تي/تشتمني

1.4.15 My teacher insults me.


معمل/تي/تضربني

1.4.16 My teacher hits me.


معمل/تي/تستعماليو/تحترماني

1.4.17 My teacher listens to me and respects my opinion.


أحب المشاركة في المناسبات الاجتماعية

1.4.18 I like to participate in social events
### Outcome: reduced troubling thoughts and feelings

1.5.1 I feel lonely

1. Never  
2. Sometimes  
3. Most of the time  
4. Always

1.5.2 I can sleep well.

1. Never  
2. Sometimes  
3. Most of the time  
4. Always

1.5.3 I cannot concentrate when I try to study.

1. Never  
2. Sometimes  
3. Most of the time  
4. Always

1.5.4 I do not feel safe.

1. Never  
2. Sometimes  
3. Most of the time  
4. Always

1.5.5 I feel angry.

1. Never  
2. Sometimes  
3. Most of the time  
4. Always

1.5.6 I feel loved

1. Never  
2. Sometimes  
3. Most of the time  
4. Always

1.5.7 I feel sad and worried because my relative/s has/have arrested or killed

1. Never  
2. Sometimes  
3. Most of the time  
4. Always

1.5.8 I have bad dreams

1. Never  
2. Sometimes  
3. Most of the time  
4. Always

1.5.9 I do not feel safe because of the current situation.

1. Never  
2. Sometimes  
3. Most of the time  
4. Always
Psychosocial Programmes, oPt
Interagency evaluation project
Questionnaire for parents
Child resilience knowledge and practice

Background information
2.1.1 Date of interview: ______________________
2.1.2 Interviewer name: _____________________
2.1.3 Data collected for: ______ Baseline (pre-test) ______ Final evaluation (post-test)
2.1.4 The parent is in the: ______ Programme ______ Comparison group
2.1.5 Full name of parent being interviewed: ____________________________________
2.1.6 Gender: ____ Male ____ Female
2.1.7 Location where the person being interviewed lives: _________________________
2.1.8 District: _______________________
2.1.9 Full name of parent’s child (if the parent’s child is in the programme or comparison group): ________________________________

Programme information
2.2.1 Agency code: _____________________
2.2.2 Type of programme intervention: (group activities, individual counselling…):
2.2.3 Number of sessions per week: ___________
2.2.4 Length of each session (i.e., 1 hour, 2 hours): ______________
2.2.5 Total number of parents participants in the sessions (size of group): ___________
2.2.6 Total number of sessions: ___________
2.2.7 Length of programme (start and end dates): ________________________

Questionnaire for Parents
2.3.1 I spend time talking with my child about what is important to them
2.3.2 I support my child’s studies at home
2.3.3 I meet with my child’s teachers and visit the school
2.3.4 My child and I argue
2.3.5 My child and his/her siblings fight
2.3.6 I use verbal criticism to discipline my child
2.3.7 I praise my child when she/he does something well
2.3.8 I hit my child when she/he does something wrong
2.3.9 My spouse and I argue

الدراسي العام أثناء أخرى نشاطات أو أي الترفيهية النشاطات في بمارأون ابنائي

2.3.10 My child participates in recreation or other activities during the school year

آخرى عاطفية واعتراض اللارادي والتبول الكوابس من أولادي يعاني اجتياح، أي بعد

2.3.11 After an incursion, my child suffers from nightmares, bedwetting or other emotional problems.
Psychosocial Programmes, oPt
Interagency evaluation project
Questionnaire for teachers and/or school counsellors
Child resilience knowledge and practice

Questionnaire background information
3.1.1 Date of interview: ______________________
3.1.2 Interviewer name: ____________________________________
3.1.3 Data collected for: _____ Baseline (pre-test) _____ Final evaluation (post-test)
3.1.4 The teacher/school counsellor is in the: ___ Program sample ___ Comparison group
3.1.5 Full name of teacher/school counsellor being interviewed:

3.1.6 Gender: ____ Male ____ Female
3.1.7 Location where the person being interviewed lives: _______________________
3.1.8 District: _______________________

Programme information
3.2.1 Agency code: ____________________
3.2.2 Type of program intervention: (group activities, individual counseling...):

3.2.3 Number of sessions per week: ____________
3.2.4 Length of each session (i.e., 1 hour, 2 hours): _______________
3.2.5 Total number of teachers/school counsellors participants in the sessions (size of group): ___________
3.2.6 Total number of sessions: ____________
3.2.7 Length of program (start and end dates): __________________________

Questionnaire for teachers and/or school counsellors

3.3.1 I use verbal criticism to maintain discipline in the classroom

3.3.2 I use praise to maintain student interest in their studies

3.3.3 Physical punishment is a necessary disciplinary tool

3.3.4 I give equal attention to girls and boys in the classroom

3.3.5 I initiate communication with parents of students who have not initiated contact with me

3.3.6 I identify students who have lost parents or have other family problems

3.3.7 I identify students who seem isolated and without good friends

3.3.8 I observe students teasing or bullying other students

3.3.9 I advocate for after school play and recreation programmes for students at my school

أنا أشجع وأدعم وجود ودعم أنشطة ترفيهية ولعب بعد الدوام المدرسي للطلاب.

3.3.10 I visit the homes of students who need extra attention or support

أتور ومساعدة في الظهيرة للممنوعين الذين يحتاجون إلى الدعم والمساعدة.

3.3.11 After an incursion, I spend time helping my students calm down and resettle into routines

بعد أي اختراق، أقضي وقتًا إضافيًا معاً لمساعدة الطلاب في الاسترخاء والعودة إلى الروتين.
**Possible programme type comparisons and constraints**

### Programmes which were school-based vs. non-school-based/community-based

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<th>West Bank</th>
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<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Not comparable. Only one programme evaluated was not school-based, and this was the agency that used convenience sampling.</td>
<td>Not comparable. All programmes evaluated were community-based.</td>
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### Programmes which were longer than one month or shorter than one month

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<tr>
<td></td>
<td>OK</td>
<td>X</td>
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<tr>
<td></td>
<td>Comparable.</td>
<td>Not comparable. All programmes evaluated were shorter than one month (and roughly the same amount of time).</td>
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### Programmes which targeted Children and Parents as unit vs. those which worked with children and parents separately

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<td></td>
<td>X</td>
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<tr>
<td></td>
<td>Not Comparable. Reasoning: even if some of the parents of kids in the 'Not as unit' categorization received some sort of intervention, this dilutes what we are measuring. Similarly, if we look at our comparison group of children who have not had an intervention, but somehow their parents DID get an intervention, this also could confound our results and allow us to draw incorrect conclusions about these types of interventions.</td>
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### Programmes which had recreational activities only vs. those which incorporated a clinical counseling component

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<td>Comparable.</td>
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Annex VII

oPt psychosocial well-being evaluation qualitative tools:
Two expressive activities for child participants (8–18 years)

The facilitator is responsible for:
• explaining the exercise to the participants
• obtaining their consent to take part
• guiding them through the exercise
• putting the children at ease
• helping them generate information
• providing opportunities for discussion and reflection.

Group discussion facilitation guide

1. Try to get participants to talk about their own stories and experiences rather than to talk only generally about what others think or what they think should happen. One way of doing this is to ask: “Can you give me an example of a time when that happened?”
2. However, use the group to look through the eyes of the participants to describe not only their own experiences, but also stories of other people in their community whom they have access to and which are relevant. If you are not sure how widespread a perspective is, ask: “I wonder if there are people in your community who would feel differently about this?”
3. Be aware of the tendency in groups to focus on extreme or unusual stories and try to get a sense of the normal, everyday experiences of participants, as well as the more dramatic experiences.
4. Ensure that you access the range of perspectives and experiences within the group.
5. Draw in those who are shy or who only speak a little. Watch the group dynamics and ensure that the discussion is not dominated by one or two outspoken people, and that everyone gets a chance to share their story.
6. Manage the time well so that you get through the questions in the agreed upon time.

Introduction

1. Brief introductions and explanation of purpose. Explain that as a group, you will be doing two or three exercises together. The exercises will involve the group talking about their lives, what they like doing, about their friends, family and their neighbourhood/community. The ideas the group has will help in the planning and the evaluation of psychosocial activities – how to do them, how well they work for children and families, and how to improve these projects and activities.
2. Explain the procedure: exercises, sharing the drawings, questions and discussion.
3. Explain confidentiality and note-taking. The children’s ages need to be recorded on the sheet that is passed round, but reassure that names are not taken and will not be written into any reports.

Steps:

1. Facilitate the My Emblem first, then have a little break with water or juice.
2. Follow up with the Spider Diagram.

My Emblem

Aim:
To generate information about the participants self-image, future orientation, personal sources of strength and resilience

**Participants:**
- This activity can be used effectively with children over 8 years of age, with groups of 6-12 persons

**Facilitators:**
- 1 facilitator and 1 co-facilitator/translator

**Materials:**
- 1 A4 sheet of paper per person with an Emblem (badge) and a Motto Scroll already drawn on it.
- Pencils

**Instructions:**
1. Each child to get an Emblem.
2. Each child to write their name, age, school grade and location (district, community) on the back of each paper.
3. The child to write the following in each quarter of the Emblem and in the Motto Scroll below:
   - Things I like about myself...
   - Things I like doing...
   - Something I am proud of about myself that I have achieved...
   - What I want to be doing in 5 years’ time...
   - My Motto in the scroll below: a few words or a sentence that describes me
4. General discussion, children volunteer to present their personal Badge and discuss it with the group.
5. Facilitators record and rank answers on flipchart paper. Discuss most commonly cited situations and worries.
6. The facilitators keep a visual record of these Emblems and Mottos but make sure the children can keep their original drawings.

**Data Analysis:**
1. Decide on your disaggregated groups, e.g.: gender, location, age, intervention.
2. General: list all –
   - Things I like about myself...
   - Things I like doing...
   - Something I am proud of about myself that I have achieved...
   - What I want to be doing in 5 years time...
   - Mottos.
3. General: rank all except the personal Mottos (most commonly to least commonly cited).
4. List average number of ‘Things I like about myself’ per child: disaggregated by group categories.
5. List average number of ‘Things I like doing’ per child: disaggregated by group categories.
6. Identify patterns and themes, e.g.: change in the number, type and quality of things children like about themselves, like doing and are proud of; a greater or lesser degree of realism in the children’s vision of their future, change in the type of Mottos.

7. Compare all of above between pre- and post-test scores and themes: quantitative and qualitative difference in changes.

8. Compare all of above between comparison and intervention group scores and themes: quantitative and qualitative difference in changes.

**Spider Diagram**

**Aim:**
To generate data about children’s social networks and the people that they may turn to for help with different situations/problems. It does not tell us if they receive they type of support they seek and/or need, or if they have resolved any of their concerns.

**Participants:**
- This activity is suitable for children aged 8–14.
- The work is carried out individually at first and can work with a group of up to 10.
- It is helpful to split the groups up, so as to have the boys and girls working separately.

**Facilitators:**
- 1 facilitator is needed for each group of 10 children.
- It is not possible to run 2 groups in parallel with only one facilitator.

**Materials:**
- A4 paper and pens.

**Instructions:**
1. Ask the children to sit on the floor and give everybody a piece of paper and a pen. Introduce the activity by saying something like: ‘This is a nice activity because we are going to draw people who are helpful to us in different ways.’ Explain that we will do this by drawing a spider.

2. Ask the children to draw a circle in the middle of the paper and write their name or draw a picture to represent themselves. This is the body of the spider. The legs of the spider are the problems that they face and the feet are the people they go to for help. People who help a lot can be shown by drawing bigger feet to represent them. Explain to the children that sometimes the legs might not have a foot attached because they might not know who to go to right now, or they might feel shy or worried about approaching someone, so it is OK to have legs with no feet for the moment.

   **Note to facilitators:** There may be some children who are ‘missing feet’, which indicates that the child has nobody to turn to for help with a particular problem. Take a moment in private after the exercise to briefly speak to the child about the problem. If the problem is serious, please refer onwards.

3. Encourage the children by drawing a spider yourself, but do not write down anything on the legs or feet. If the children are still finding this activity difficult, it may help to go round to children individually and ask them about a problem they face and then who they may go to for help. Remind them that there are no right or wrong answers.

4. When everyone has finished drawing, and you have had time to talk to each child individually, call everyone back together for a focus group discussion. This is intended to aid reflection on problems
and people who can provide assistance. Explain that the children only have to share the problems that they noted in the group discussion if they want to. Then ask those who are willing to share their problems, and who they go to for help, with the rest of the group.

5. The facilitators keep a visual record of the Spider Diagrams but make sure the children can keep their original drawings if they want.

Data analysis:
1. Decide on your disaggregated groups, e.g.: gender, location, age, intervention.
2. General: list all problems and the corresponding sources of support.
3. General: rank all problems (most commonly cited to least common).
4. General: rank all sources of support.
5. List average number of problems per child: disaggregated by group categories.
6. List average number of sources of support per child: disaggregated by group categories.
7. Identify patterns and themes, e.g.: change in the type of problems and the type of support sought; all children seek most of their support from family members; girls tend to seek more support from friends than boys do; boys tend to have fewer sources of social support than girls.
8. Compare all of above between pre- and post-test scores and themes: quantitative and qualitative difference in changes.
9. Compare all of above between comparison and intervention group scores and themes: quantitative and qualitative difference in changes.