Kathleen Kostelny, Ph.D., was commissioned by CCF to conduct the research and write the report. Keri McGeehan, M.S., Christian Children’s Fund, collaborated on the field research.

Acknowledgements:

Special thanks go to all the children, parents, caregivers, camp leaders, community members, Child Activity Leaders, and Child Well-being Committee members who participated in the research and gave their time and energy to this study. The research would not have been possible without the hard work and commitment of the Uganda research team: Geoffrey Akena, Thomas Akena, Fiona Apio, Julius Odida, and Francis Oola. Members of CCF’s child protection team -- Wayne Bleier, Ann Edgerton, Martin Hayes, Christie Scott, Luc Theron, Mike Wessells, and Wendy Wheaton – provided valuable help and insight throughout the various stages of the research process. In addition, Patricia McWilliams and Ellie Whinnery provided valuable feedback and editing of the report. The research team particularly wishes to thank Hasaan Hajaii and the CCF Emergency Response Team in Uganda for their excellent support for the research, and Maureen Duffy, who organized the myriad logistical needs of the project.

Photos by Kathleen Kostelny
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Executive Summary

Child Centered Spaces (CCSs) are a widely used tool to address the protection and psychosocial needs of children in emergency situations. The approach engages communities to create safe spaces for children and youth to play, socialize, learn basic skills of literacy, numeracy and hygiene, and express themselves in a caring, supportive and normalizing environment. To date, there has been little research on the tangible protection and psychosocial benefits of such programs.

This study presents findings from research that compared the psychosocial well-being and protection of three to six year old children in similar communities in Internally Displaced Persons camps in Gulu, Uganda. The children in the intervention group participated in three CCSs, staffed by trained community members, and supported by Christian Children’s Fund. In the comparison group, the community in the camp had no organized activities for young children. In the aftermath of conflict and natural disasters, international organizations increasingly organize child centered spaces (also called child-friendly spaces, safe spaces, or emergency spaces for children) for children.

The study, carried out in April 2007, used both qualitative and quantitative methods. The qualitative methods included eight focus group discussions conducted with 92 caregivers and community members. Quantitative data were collected using a child well-being questionnaire in 294 one-on-one interviews with parents and other caregivers. The child well being questionnaire was generated from three sources: the Strengths and Difficulties Questionnaire (a Western developed screening tool for emotional and behavioral difficulties), a tool based on locally derived indicators of child well-being in the Northern Ugandan context, and indicators developed by CCF’s child protection staff.

The study addressed the following questions:

- Do child centered spaces protect children from risks and threats in their environment?
- Do child centered spaces improve children’s psychosocial well-being?
- Do child centered spaces increase children’s knowledge and life skill levels?

Findings

Tangible, meaningful benefits for children occurred in several domains: protection, psychosocial well-being, and life skills.

1. Participation in a CCS led to a more protective environment for children. Participation in CCSs increased children’s safety in their homes and in the camps by providing a supervised place for children to gather and offering safe activities to keep children occupied. The study found that 52.8% of children were reported to “be safe always” in the camps in the CCF intervention area as compared to 22.9% who were “safe always” in the comparison group. Specific protection risks that were reported to be reduced were sexual exploitation in the form of rape and attempted rape, exposure to
sexual behavior and pornographic videos, and injuries from road accidents, house fires, and dangerous objects.

2. **Children who participated in CCSs realized greater psychosocial well-being.**
   Children who attended CCSs were reported to exhibit less emotional distress and fewer problems of behavior, attention, and peer relations that the comparison group of children. The reduced incidence of emotional distress included less unhappiness (16.5% vs. 46.6%), fewer worries (19.3% vs. 52.5%), less nervous and clingy behavior (49.4% vs. 70.3%), and less fearfulness (55.7% vs. 67.8%). Behaviorally, children who attended the CCSs were reported to exhibit fewer problems, including less fighting with other children (16.5% vs. 49.2%) and less disobedience (4.0% vs. 22.0%). Also, children who participated in CCSs demonstrated fewer problems with peers, including less solitary behavior (7.4% vs. 19.5%) and being bullied less by other children (38.6% vs. 58.5%).

Children attending CCSs also displayed more prosocial behavior --considering others’ feelings (86.9% vs. 71.2%), sharing with others (89.2% vs. 61.9%), being helpful if someone was hurt or upset (52.8% vs. 33.1%), and helping other children (86.9% vs. 62.7).

3. **Children's participation in CCSs led to increased knowledge and life skills.**
   Locally determined indicators of child well-being highlighted the importance of hygiene, numeracy, and communication knowledge and skills for children. 93.7% of children from the CCS community were reported by caregivers to “know how to use the latrine properly” as compacted to 57.5% from the comparison community, which resulted in decreased exposure to disease and sickness. Children who participated in CCSs knew how to count and recite the alphabet, and knew how to greet and communicate with adults more than children who did not attend the CCSs. These positive elements highlight the importance of looking beyond deficits to children’s assets, including their pro-social skills, which are an important component of children's resiliency.

These results suggest that appropriately designed and implemented CCSs have specifiable benefits to children’s protection and well-being. This study offers encouragement for the use of Child Centered Spaces as a child focused intervention in emergency or transitional situations affected by armed conflict. Caution is advisable in interpreting the results, since they involved only one country and were based on self-reports. Moreover, although this research shows the value of CCSs in protecting children and promoting their well-being, it is important to recognize that the establishment of CCSs alone cannot ensure children’s care and protection. In the wider context of northern Uganda and most war zones, it is important to establish holistic, multi-level systems of child protection. CCSs are best regarded as only one element in the wider protection systems that are needed to protect children’s rights and well-being in zones of armed conflict. Although further research is needed to identify which specific elements and approaches to implementing CCSs yield the greatest benefits for children, these findings encourage the use of CCSs as first-line supports for children in emergency settings.
## List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAL</td>
<td>Child Activity Leader</td>
</tr>
<tr>
<td>CCF</td>
<td>Christian Children’s Fund</td>
</tr>
<tr>
<td>CCS</td>
<td>Child Centered Space</td>
</tr>
<tr>
<td>CFS</td>
<td>Child Friendly Space</td>
</tr>
<tr>
<td>CWBC</td>
<td>Child Well-Being Committee</td>
</tr>
<tr>
<td>CWBQ</td>
<td>Child Well-Being Questionnaire</td>
</tr>
<tr>
<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally Displaced Persons</td>
</tr>
<tr>
<td>INEE</td>
<td>Inter-Agency Network on Education in Emergencies</td>
</tr>
<tr>
<td>LRA</td>
<td>Lord’s Resistance Army</td>
</tr>
<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
</tr>
</tbody>
</table>
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Psychosocial and Protection Outcomes of Child Centered Spaces: Research on Young Children in Northern Uganda

Background and Aims

Child Centered Spaces (CCSs), also known widely as Child Friendly Spaces (CFSs) and Safe Spaces, are a widely used intervention to address the protection, education, and psychosocial needs of children in emergency situations. The CCS intervention is a recommended part of global guidelines, such as The Interagency Network for Education in Emergencies Minimum Standards for Education in Emergencies, Chronic Crises, and Early Reconstruction and The Interagency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency.1,2 Despite the growing use of CCSs globally, there has been little systematic research to date to assess the impact of these interventions on children and their role in the family and community. More broadly, the fields of child protection and psychosocial support in emergency settings are limited by a paucity of hard evidence about which interventions are effective. In the research that does exist on this topic, there has been a tendency to rely mainly on Western derived measures that have not been validated in the local context and may not be appropriate in many emergency affected countries.

In April 2007, Christian Children’s Fund (CCF) undertook research to assess the outcomes of CCS interventions in Northern Uganda in order to help guide future efforts to support the protection, education, and psychosocial well-being of children in Uganda and other countries. The research sought to look beyond the often used process indicators such as “the numbers of children who participated in CCSs” in order to measure the tangible benefits CCS participation offer to children. The research used a variety of outcome indicators to examine the specific outcomes for children. The research did not examine the long-term impact of CCSs on children, which would require longitudinal study and was outside the scope of this research. The research is part of a wider movement in this nascent field to strengthen the evidence base for emergency interventions on behalf of children.3

The purpose of the research was to investigate the outcomes of Child Centered Spaces in regard to young children, ages 3 to 6 years, who are typically among the most vulnerable people in emergencies. The research aimed to answer the following questions:

- Do Child Centered Spaces protect children from risks and threats in their environment?
Do Child Centered Spaces improve children’s psychosocial well-being?

Do Child Centered Spaces increase children’s knowledge and life skill levels?

Description of Child Centered Spaces

Emergencies, such as armed conflict and natural disasters, pose enormous challenges to families and communities to care for and protect their children.4,5 To help mobilize communities on behalf of children during and after emergencies, CCF has developed a child protection approach that employs CCSs as a means of reaching and organizing multi-sectoral supports for children. This approach engages communities to create safe spaces for children and youth to play, socialize, learn basic skills of literacy, numeracy and hygiene, and express themselves in a caring, supportive, and normalizing environment6. Not intended to be a stand-alone approach to protection, CCSs are not designed to address the entire array of protection threats, including separation, poverty, and family violence. CCF typically uses them selectively, where assessment data warrant their use and where there is low risk of protection threats such as attacks and recruitment. In conjunction with other interventions such as Child Well-Being Committees (CWBC), community run committees that address children’s protection and psychosocial needs, and the organization of formal education, livelihood, health, and other supports. Children’s access to CCSs is called for by existing guidelines, such as those produced by the Inter-Agency Network on Education in Emergencies (INEE) and the Inter-Agency Standing Committee (IASC), as a useful emergency first response and means of supporting the fulfillment of children’s rights in emergencies.7,8

Child Centered Spaces are safe, physical spaces for children affected by conflict or disasters to gather, providing protection and psychosocial support. Through community mobilization around children’s needs, Child Centered Spaces provide regular, structured activities for children, adolescents, and parents of young children under the supervision of caring adults from the community. These caring adults are selected by the community, and are people whom the community trusts, who are good with children, and who the children like.

Child centered spaces are designed to allow children to participate in activities where they can play, express their feelings, thoughts and opinions, and learn new things from adults and other children. For the majority of young children who have previously had access to education, participation in these activities provides a sense that “things are getting back to normal again.”9,10,11,12 For all children, CCSs provide structure to the day as well as help them learn important social skills such as sharing and cooperation through interaction with other children. CCF’s intention through the CCS intervention is to help children learn about risks in their environment and build life skills such as literacy and non-violent conflict resolution. CCSs also bring children’s needs into prominence by mobilizing communities on behalf of children and by engaging parents and other
caregivers in effective interactions with children. This approach reflects CCF’s philosophy of holistic support for the well-being of children through community mobilization and attention to their protection, psychosocial, educational and development needs.

Finally, CCSs provide a platform for additional assessment and programming to support child protection and well-being. CCSs can be established following a rapid assessment, and they offer a means of providing an immediate, multi-sectoral response to children’s needs. This immediate response avoids the lengthy delays in program support that often frustrate communities in difficult circumstances. Established in a participatory manner, they provide a foundation for conducting the more detailed assessment needed to guide programs and they enable communities to organize themselves around meeting children’s needs.

**Research Design**

*Description of Study*

The study was designed to document the outcomes of young children’s participation in CCSs in Gulu District, Northern Uganda. This research explored the viability and impact of CCSs in one of the more difficult and invisible countries affected by armed conflict. Northern Uganda has endured nearly two decades of armed conflict with a large part of the population continuing to live in internally displaced persons (IDP) camps in difficult living conditions with few supports for children.
The study used a quasi-experimental design in order to separate intervention outcomes from those attributable to other variables. Not uncommonly, outcome studies measure children’s behavior before and after an intervention. Unfortunately, this pre- and post-comparison leaves open the possibility that any improvements in children’s behavior or well-being are a result of changes in the camp setting or to wider improvements in the health, economic or political environment rather than the CCS intervention. To overcome this limit, this study compared the effects of the CCS intervention in Unyama IDP camp with a comparison group in Paicho IDP camp. The comparison group had similar demographic characteristics, and was also severely affected by the armed conflict, but had no organized activities for young children. For ethical reasons, this was not a planned comparison in which child support was extended to one camp and intentionally denied to another camp. Rather, it was a naturally occurring comparison condition that arose from the fact that limited resources made it impossible to develop CCSs in all the camps. The data from the comparison community provides important information about needs and protection that can be used to guide programs in the future.

Data were collected in April 2007 by the principal investigator, program associate, and four independent research assistants from Gulu district who understood the local language, culture, and situation. A project coordinator, also from Gulu district, assisted with translations and organizing entry into the communities.

The informed consent of participants was obtained through the research assistants who read the participants a description of the study, explained carefully that the participants were free not to participate, and asked them to make their mark with their thumbprint if they consented. Confidentiality was ensured by assigning a code to each participant, not associating any names with the responses to questions, and keeping the code key in a locked place that only people with a need to know could access.

**Description of Study Population**

The children and caregivers that are the focus of the study live in Unyama and Paicho IDP camps in Gulu District, Northern Uganda. Paicho IDP Camp is located approximately fifteen kilometers from Unyama IDP Camp. Gulu District has experienced 20 years of continued violence, mass displacement, a culture of fear and mistrust, and a host of problems inherent to pervasive poverty. Because of the conflict, most of the population has been forced to live in IDP camps. Both camps were within 20 kilometers of the majority of camp residents’ original homes, which had been destroyed during the conflict. In April 2007, the populations continued to live in the camps because of the insecure situation and the fear that they would be attacked by the LRA if they returned home. Because LRA attacks occurred primarily at night, people in both camps walked in the morning hours to work in their gardens near their villages, or to work on rented land in order to obtain food for themselves or to sell in the market.

Both groups lived in similar thatched roof housing, and had primary schools available for children aged seven years and over. Unyama and Paicho IDP Camps were both
established in 1996. The population in 2006 was recorded as 12,593 for Unyama IDP Camp and 9,104 for Paicho IDP Camp, with more than half of the population less than 15 years of age. In both camps, approximately 60% of the caregivers participating in the study had lived there 10 or more years, while approximately 20% had come to the camps in the last three years due to increased fighting and insecurity in the region. In both camps, people have difficulty meeting basic needs owing to a shortage of basic services. Many young children are malnourished and are exposed to an array of diseases and illnesses including malaria, cholera, and respiratory illnesses.

### Table 1
Demographic Characteristics of the Population

<table>
<thead>
<tr>
<th></th>
<th>Mean Age of Child Participant</th>
<th>Mean Caregiver’s Age</th>
<th>Mean Number Children in Household</th>
<th>Percent Primary Caregivers who were mothers</th>
<th>Percent Primary Caregivers who were fathers</th>
<th>Percent Primary Caregivers who were grandmothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCS Group</td>
<td>4.3</td>
<td>32.1</td>
<td>4.2</td>
<td>80.1%</td>
<td>9.7%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>4.6</td>
<td>33.3</td>
<td>3.8</td>
<td>80.9%</td>
<td>6.2%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Children who were between the ages of three and six years and who attended the CCSs were the focus of the research and served as the intervention group. The mean age of children was 4.3 years in the intervention group (Unyama Camp) and 4.6 years in the comparison group (Paicho Camp). In each group, 48% of the children were males and 52% were females. The age of the caregivers ranged from 18 to 76 years, with a mean age of 32.1 years for Unyama Camp and 33.3 years for Paicho Camp. As shown in Table 1, both groups were similar in regard to who served as the primary caregivers and also the number of children per family.

**Description of CCSs in Unyama IDP Camp**

In an effort to strengthen community systems of protection for children, CCF established three CCSs in April 2006 in response to ongoing issues of protection, especially sexual violence. The CCSs provided a safe, adult-supervised place for young children between three to six years of age. While primary schools were available for children beginning in first grade (P1) for children seven years and older, supportive, developmentally appropriate activities were lacking for children under seven years of age. Without a CCS, these children would have been left alone at home or in the care of older siblings while their caregivers left the camp to work in their gardens during the morning. Many of the young children, who had presumably been left in the care of older siblings, ended up at home alone since the older siblings often left younger children unsupervised.
In April 2007 there were 1361 registered children who attended the three CCSs: 760 children in Center A, 240 children in Center B, and 361 children in Center C. The children had regularly been attending the CCSs from April 2006 through April 2007. The CCSs conducted activities for children from 7:30 a.m. to 12:00 p.m. Monday through Friday. Activities at the CCSs included singing, counting, reciting the alphabet, listening to stories, learning hygiene skills, free play, and helping pick up litter. The children were divided into groups according to their age (3 years, 4 and 5 years, and 6 years) with activities specifically geared to each age group.

Facilitating the activities in the CCSs were 30 Child Activity Leaders (CALs), who were volunteers selected by the community as people who were trustworthy, motivated to support children, and whom children and parents naturally turned to when children needed support. Following an initial training by CCF staff, the CALs met weekly to plan activities for the children in the coming week, incorporating a new theme each week (for example, teaching the children to wash their hands or teaching them the zone they lived in). The new theme was then incorporated into the various activities – such as playing, singing, counting – throughout the week.

In addition, Unyama Camp had a CWBC composed of nine community members, including men, women, and youth. The CWBC oversaw the CCSs, visiting them daily to monitor activities and support the Child Activity Leaders. The CWBC also facilitated monthly community meetings to discuss topics such as children’s rights, children’s hygiene, malaria control, and camp cleanliness. In addition, they monitored and reported cases of child rights violations and abuses which occurred in the camp. The CWBC members and CALs received food and non-food items on an intermittent basis to motivate them and compensate them for their time.

**Methodology**

The methodological strategy was to use a mixture of qualitative and quantitative research methods that took advantage of the strengths of each approach.

**Qualitative Method**

The qualitative data consisted of narratives from eight focus group discussions with 92 participants. The focus group discussions were conducted with elderly caregivers, single mothers and widows, and camp leaders in both groups. In Unyama Camp, focus groups were also conducted with CCS, CALs and CWBC members. The principal investigator and program associate conducted the focus group discussions, which were translated into the local language Luo.

**Quantitative Method**

**Sample.** In Unyama IDP Camp, 176 households from the three CCS centers were randomly selected from the CCS register. In Paicho IDP Camp, 118 households with
children aged three to six years of age were randomly selected from all of the ten zones in the camp. The goal was to obtain from each of the three CCSs and the comparison group a sample size sufficient for conducting meaningful statistical analyses.

The Child Well-Being Questionnaire. The quantitative data were collected using a measurement scale—the Child Well-Being Questionnaire (CWBQ)—constructed specifically for this population. The CWBQ consists of 66 questions administered by Ugandan research assistants during a 30-45 minute interview with the child’s primary caregivers. Because of low literacy levels of the caregivers, the questions were read aloud to the participants. Caregiver reports were used as the primary data, as young children often cannot understand questions or articulate clearly. To manage the limits of self-report data, which are discussed later in the report, the study used triangulation methods of cross checking with multiple data sources, thereby boosting confidence in the accuracy of the data. Before the research began, the research assistants piloted the CWBQ with a group of caregivers, who easily understood the questions.

The CWBQ collected basic demographic information including the age and gender of the child, relationship to caregiver, number of children living in the household, and the length of time the caregiver had been living in the IDP camp. The CWBQ also included items about child well-being identified by three sources.

1. The first source, designed to elicit culturally grounded understandings of children’s well-being, were identified through focus group discussions with caregivers and CWBC members. The participants were asked what qualities are exhibited by children who were doing well, and who were not doing well, respectively. The items for which there was majority consensus were included in the CWBQ (see Table 2).

2. The second source was the Strengths and Difficulties Questionnaire (SDQ), which is a 25-item behavioral screening questionnaire comprised of 5 scales: emotional distress, behavioral difficulties, hyperactivity and attention difficulties, difficulties with peers, and pro-social behavior. For each item there is a 3-point Likert scale (“not true”, “sometimes true” and “certainly true”). This tool was selected because it had been used widely in different contexts, reflected existing literature on children’s well-being, and went beyond a deficits approach to also include assets. The CWBQ included all 25 core items of the SDQ.

Although the SDQ is a Western tool, its appropriateness for the Ugandan context was suggested by the overlap between SDQ items and those identified by Ugandan caregivers. As Table Two shows, for both the SDQ and the Ugandan caregivers, used as indices of non-well-being for children items such as “being sad,” “misbehaving,” “being aggressive and fighting,” and “exhibiting solitary behavior.” Similarly, both the SDQ and Uganda caregivers agreed that items that indicated children’s well-being included “being obedient,” “sharing,” and “being considerate of other’s feelings.”

At the same time, the difference between the SDQ and locally generated items cautions
against taking Western tools off the shelf and using them without adaptation to local context. Some of the items that were identified by the Ugandan caregivers, but were not part of the SDQ were: ‘helps other children,’ ‘shares with others’ (versus sharing with children only on the SDQ), ‘has a good appetite,’ ‘communicates needs,’ ‘is clean and has good hygiene.’ Few Western psychologists would think of items concerning hygiene and appetite, yet the psychosocial literature on children in adversity certainly points to the importance of physical well being as part of holistic psychosocial well-being.\(^8\)

3. The third source was the CCF child protection team, which included global specialists who had extensive experience in the Ugandan context. As Table 2 shows, the items generated by the child protection team overlapped with some of the items from both the SDQ and local caregivers. Moreover, three additional items generated by the child protection team -- “safe at home” “safe in community,” and “support for caregiver” -- were included in the Child Well-Being Questionnaire.
<table>
<thead>
<tr>
<th>Items on CWBQ</th>
<th>Source of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Locally Elicited Indicators</td>
</tr>
<tr>
<td>Many worries</td>
<td>X</td>
</tr>
<tr>
<td>Often unhappy, tearful sad</td>
<td>X</td>
</tr>
<tr>
<td>Nervous or clingy in new situations</td>
<td>X</td>
</tr>
<tr>
<td>Many fears, easily scared</td>
<td>X</td>
</tr>
<tr>
<td>Complains of headaches, stomach aches, illnesses</td>
<td>X</td>
</tr>
<tr>
<td>Often loses temper</td>
<td>X</td>
</tr>
<tr>
<td>Generally obedient</td>
<td>X</td>
</tr>
<tr>
<td>Often fights with other children</td>
<td>X</td>
</tr>
<tr>
<td>Often lies or cheats</td>
<td>X</td>
</tr>
<tr>
<td>Steals from home, school or elsewhere</td>
<td>X</td>
</tr>
<tr>
<td>Restless, overactive</td>
<td>X</td>
</tr>
<tr>
<td>Constantly fidgeting or squirming</td>
<td>X</td>
</tr>
<tr>
<td>Easily distracted</td>
<td>X</td>
</tr>
<tr>
<td>Thinks things out before acting</td>
<td>X</td>
</tr>
<tr>
<td>Good attention span</td>
<td>X</td>
</tr>
<tr>
<td>Solitary, plays alone</td>
<td>X</td>
</tr>
<tr>
<td>Has at least one good friend</td>
<td>X</td>
</tr>
<tr>
<td>Liked by other children</td>
<td>X</td>
</tr>
<tr>
<td>Picked on or bullied by other children</td>
<td>X</td>
</tr>
<tr>
<td>Gets along better with adults than children</td>
<td>X</td>
</tr>
<tr>
<td>Considerate of other people’s feelings</td>
<td>X</td>
</tr>
<tr>
<td>Shares readily with other children</td>
<td>X</td>
</tr>
<tr>
<td>Helpful if someone is hurt or upset</td>
<td>X</td>
</tr>
<tr>
<td>Kind to younger children</td>
<td>X</td>
</tr>
<tr>
<td>Helps teachers, children, parents</td>
<td>X</td>
</tr>
<tr>
<td>Communicates needs</td>
<td>X</td>
</tr>
<tr>
<td>Shares with others (adults and children)</td>
<td>X</td>
</tr>
<tr>
<td>Plays with other children</td>
<td>X</td>
</tr>
<tr>
<td>Has a good appetite</td>
<td>X</td>
</tr>
<tr>
<td>Has a good memory, knows counting, alphabet</td>
<td>X</td>
</tr>
<tr>
<td>Is clean and has good hygiene</td>
<td>X</td>
</tr>
<tr>
<td>Uses the latrine correctly</td>
<td>X</td>
</tr>
<tr>
<td>Is confident, has self esteem</td>
<td>X</td>
</tr>
<tr>
<td>Helps other children</td>
<td>X</td>
</tr>
<tr>
<td>Safe at home</td>
<td>X</td>
</tr>
<tr>
<td>Safe in the community</td>
<td>X</td>
</tr>
<tr>
<td>Support for caregiver from community</td>
<td>X</td>
</tr>
</tbody>
</table>
Results

The research found that children in the intervention group – referred to as the CCS group -- showed significant improvements in their protection and psychosocial well-being relative to children in the comparison group. The improvements were significant not only statistically but also in terms of the children’s safety and quality of life, as detailed below.

Protection

Protection issues were analyzed using two items pertaining to children’s safety from the Child Well-Being Interview – safe at home and safe in the camp -- as well as by analyzing the main themes that emerged from focus group discussions.

Increased Safety at Home and in the Camp

Caregivers from the CCS group were significantly more likely to report that their children were safe at home than were caregivers from the comparison group (p<.01; see Figure 1). Moreover, while 13.6% of caregivers from the comparison community reported that their children were never safe at home, less than 1% of caregivers in the
CCS community reported that their children were never safe.

Caregivers from the CCS community were also more likely to report that their children were safe in the camp than were caregivers from the comparison community -- 52.8% of children in the CCS community were reported to be safe always, compared to only 22.9% of children in the comparison community (Figure 1). Furthermore, 49.2% of children in the comparison community were reported to never be safe, compared to only 15.3% of children from the CCS community.

**Figure 1**

**Safety from Protection Risks at Home and in the Camp**

![Bar chart showing safety from protection risks at home and in the camp](chart.png)

In the focus group discussions in the CCS group, caregivers, camp leaders, child activity leaders, and child well-being committee members said that the CCSs had increased children’s safety because the CCSs were supervised and offered safe activities to keep children occupied.

*Before [the CCS had been established] “children used to move from morning to sunset. Parents would not know where their children were. The children would go into anybody’s home and take food. They would run to the road. Children used to get lost every day. Now the children are safe because they are at the center and not wandering aimlessly.”* (Elderly caregivers, Unyama Camp).

By contrast, children in the comparison group were described as being unsupervised and frequently exposed to dangerous activities.
“Children are just running around. They move anywhere. They are on the road alone. They go to the dumping pits and take dangerous items. They play with used condoms, using them as balloons.” (Camp leaders, Paicho Camp).

“The older ones stay home from school to care for the young ones. But they start playing and leave the young ones. Many of the young children are not found until night.” (Elderly caregivers, Paicho Camp).

While the overall perceptions of safety owing to the establishment of CCSs, could reflect biases such as the tendency to try to please the interviewers, they become more convincing in light of the participants’ identification of specific risks that had decreased following the establishment of CCSs. Both communities identified specific risks to children such as sexual exploitation, road accidents, house fires, injuries, and diseases. As outlined below, only the CCS group reported reductions in the frequency of children’s exposure to these risks, and they attributed the reductions to the establishment of the CCSs.

**Decreased Sexual Exploitation**

The types of sexual exploitation reported included rape, attempted rape, using children to procure customers for sex workers, exposing children to sexual behavior, and children watching sexually explicit videos.

**Decrease in Rapes**

In the year prior to the establishment of CCSs, there had been 3 reported rapes of young girls under 6 years of age in the CCS community. Following the establishment of the CCSs, there had been no reported rapes of children under 6 years.

“The parents would go digging in their gardens and leave their children behind. The men would come and try to rape children. They would tell them to come and get sweets. The child would come and then they would defile the girl.” (Child activity leaders, Unyama Camp).

In the comparison community, the rape of young children is still a major problem reported by caregivers and camp leaders. Camp leaders reported that there were at least 10 cases of children being raped in the past year.

“It (rape) happens a lot. My 3-year-old granddaughter was defiled last week by a 17-year old. We took the girl to the police. The police took her to hospital... The boy is now in jail.” (Elderly caregivers, Paicho Camp)

“Every month there is at least one case of a child being raped. It happens when the parents can’t be in the home to protect the child.” (Single and widowed caregivers, Paicho Camp).
“It is one of the main problems. The drunk men abuse children. They try to rape young girls. They show bad things to them... do bad things to them.” (Camp leaders, Paicho Camp).

Fewer young girls used by and exposed to sex workers

In the comparison group, it was reported that young girls were used to procure customers for sex workers. These girls were also exposed to watching sexual acts between sex workers and customers. This was not reported as a risk for young girls in Unyama camp.

“The young girls fear the bigger girls. They tell the little girls to go get men. They have intercourse and tell them to watch. They are teaching them how to get money. It spoils them.” (Elderly caregivers, Paicho Camp).

“They (older girls) use them (younger girls) to bring customers. They do it in front of them.” (Elderly caregivers, Paicho Camp).

“The young children are calling for men for the prostitutes.” (Single/widowed mothers, Paicho Camp)

“They are 4, 5, 6 years. They are used to call men. The man will give the young girl some money to buy biscuits and sweets. They want them to watch (them having sex). They are recruiting them.” (Elderly caregivers, Paicho Camp).

Less exposure to explicit sexual behavior and sexually explicit videos

In both camps, children left alone, particularly boys, sometimes went to “video halls” where sexually explicit videos would be shown. In the comparison group, the incidence of children going to watch sexually explicit videos was described as “a big problem.”

“The children are moving anywhere. They loiter near the bar and see drunk people doing bad things...having intercourse. It is very bad to see. They also go to watch the videos in the trading center when their parents are gone. The children imitate kissing.” (Camp leaders, Paicho Camp).

“The young children are not looked after because their parents go to dig. They sneak into the video hall and see bad things. Then they are playing intercourse.” (Single/widowed caregivers, Paicho Camp).

By contrast, caretakers in the CCS group reported that the incidence of children going to watch sexually explicit videos has decreased because the children are supervised in the CCS and not left on their own. In the afternoon, even though some parents were still away tending to their gardens, older siblings return from school in the early afternoon and are tasked with watching the younger children, so there was less likelihood that as many young children would be home alone or on their own for extended periods of time.
Decreased Injuries from Road Accidents

In Gulu District, vehicles often travel at high speeds on roads where children walk and play, creating a situation that is ripe for children getting hit. In the CCS group, focus group discussions revealed a decrease in children being hit and injured by cars on the road since the inception of CCSs.

“Every month some children get knocked (hit) by cars on the road. Now the number is much less than before. Because of the CCS, children stay in the camp. They don’t run to the road where they are knocked by cars.” (Camp leaders, Unyama camp).

By contrast, caregivers in the comparison group reported that children continued to be injured from road accidents at a high rate.

“Children are always getting knocked by the cars. They are on their own, and they run to the road. This has been a big problem for a long time.” (Camp leaders, Paicho camp).

“Parents sometimes come back and find children injured because children go to the road where they are knocked” (hit) by cars. (Elderly caretakers, Paicho camp).

CCSs offer a safe space where children can play without being exposed to the dangers of road traffic.

Decreased House Fires Started by Children

In the IDP camps in Gulu, it is not uncommon for young children to be left at home alone while the caregivers work in the fields or go to the market. Some children who are left home alone attempt to cook for themselves using kerosene, and start potentially lethal house fires in the process. In addition to their own house catching fire, because the houses are close together and have thatched roofs close to each other, neighbors’ houses also quickly catch fire.

In the CCS group, most of the children aged 3 to 6 years attend the CCSs instead of staying home and thus no longer cook while unsupervised.

“Last year there were many houses burned by cooking fires by children. They would be hungry and try to practice cooking by themselves. They would spill the kerosene and the house would burn. This year there are no burned houses as the children are in the CCS and not alone.” (Child Well-Being Committee, Unyama Camp).

“Before the CCSs there were more than 200 houses burned. Now there is no burning by children -- only one case where a drunkard man burned five houses.
Last week there were more than 100 houses burned in the camp nearby." (Camp leaders, Unyama Camp).

In contrast, house fires started by children was reported to be a major problem by all the focus groups in Paicho. In the focus group with elderly caretakers, more than half had house fires started by their children.

“Many houses are burned by children cooking in the home. This problem has been occurring for many years.” (Camp leaders, Paicho Camp).

“The children are left alone when the parents go to their gardens. The parents are away all morning and the children get hungry and try to cook something to eat. Because they do not know how to be careful, the fire spreads when they pour the kerosene trying to cook some things.” (Single/widowed mothers, Paicho Camp).

**Decreased Injuries from Dangerous Items**

In the CCS group, caregivers reported a decrease in exposure to, and injuries from, dangerous items for young children. This was due to children being in a safe place with supervision. Children not in CCSs had more injuries from stepping on and playing with dangerous objects, such as metal sheeting, nails, and broken glass found in the camp. Additionally, one of the activities of the CWBC was to organize camp cleanups where dangerous items for children were removed.

“Before (the CCSs) more children were hurt. Now they go to the CCS so they are not running around stepping on glass and nails.” (Single mothers/widows, Unyama Camp).

In contrast, caregivers and camp leaders from the comparison camp reported that many children were hurt by dangerous objects.

“Children run about. They cut their feet on glass and sharp objects. They find the warrage [local alcohol] containers that are thrown away and suck on them. They find condoms and blow them up as balloons.” (Single mothers/widows, Paicho Camp).

**Decrease in Seriously Ill Children Left Alone**

Children who become sick while at the CCS are now identified by the Community Activity leaders and taken to the local clinic. Prior to the establishment of the CCSs, children who became seriously ill while home alone sometimes died since they did not receive medical treatment in time.

“Children used to die from malaria. The parents would leave to dig (in their garden) thinking the child was healthy. But the child would get a high fever and
die. Now the CCS identifies children who are sick and take them to the clinic.”
(Camp leaders, Unyama Camp).

For caregivers in the comparison group, children becoming seriously ill while alone was still a concern.

“Some children become very sick when their parents are away. Some children have died because there was no one to care for them….they die from malaria and high fevers.” (Single/widowed mothers, Paicho Camp).

**Psychosocial Well-Being**

Psychosocial well-being was analyzed using both the items from the SDQ as well as the locally elicited indicators. The five subscales of the Strengths and Difficulties Questionnaire were: Emotional Distress, Behavioral Problems, Hyperactivity and Attention Difficulties, Peer Interaction Difficulties, and Pro-social Behavior, in addition to a Total Difficulties Scale. Local items included non well-being indicators of “sadness,” “not playing with other children,” and ‘misbehavior.’ Well-being indicators included ‘having a good appetite,’ ‘communicating needs,’ ‘helping other children,’ ‘playing with children,’ and ‘being well-behaved’. Data from focus group discussions provided additional information on young children’s emotional and social well-being in the CCS and comparison communities.
**Emotional Distress**

Participation in CCSs also led to discernible improvements in children’s emotional well-being. On the emotional distress subscale of the SDQ, children in the CCS group had significantly lower mean scores of emotional distress: 10.31 for the CCS group vs. 12.22 for the comparison group (p<.01). Significantly fewer children from the CCS group were reported to have many worries (19.3% vs. 52.5% from the comparison group); were often unhappy (16.5% vs. 46.6% from the comparison group); were nervous or clingy in new situations (49.4% vs. 70.3% from the comparison group), and had many fears (55.7% vs. 67.8% from the comparison group) (Figure 2). Children from both groups were reported to have extremely high levels of “complaints of headaches, stomach aches, and illnesses,” and the difference between groups was not statistically significant. Although the information was intended to assess psychosomatic complaints, in this context where rates of disease and illness are high, complaints are most likely indicative of actual physical illnesses.

**Figure 2**

*Psychosocial Well-Being: Emotional Distress*

Furthermore, children in the CCS group were less likely to be rated as “frequently unhappy” (16.5% vs. 46.6% for children in the comparison community). Being frequently sad and unhappy was identified in the local Ugandan context as one of the primary indicators that a child was not well.
Behavioral Problems

Behavioral problems were also assessed using the Strengths and Difficulties subscale and local indicators. Significant differences were found for mean scores on the SDQ behavioral subscale – 6.29 for the CCS group vs. 7.75 for the comparison group, indicating significantly less behavioral problems (p<.01). Three of the five items were especially salient: 26.2% of children from the CCS community vs. 48.3% of children from the comparison community were reported to frequently lose their temper; 4% CCS community vs. 22% comparison community were reported to be frequently disobedient; and 16.5% CCS community vs. 49.2% comparison community were reported to fight with other children. (See Figure 3).

**Figure 3**

**Psychosocial Well-Being: Behavior Problems**

The two items from the locally generated indicators that overlapped with the SDQ were being disobedient and fighting with other children. As reported above, differences on these items were especially strong: 4% of children from CCS community vs. 22% from comparison community were reported frequently disobedient, and 16.5% from CCS community vs. 49.2% from comparison community were reported to fight with other children. Focus group data support these findings.

*Children used to fight with other children. Now they know each other. They are friends.* (Single/Widowed Caregivers, Unyama Camp).

*Children in groups used to beat children from other zones (in the camp). Since*
the CCS, they no longer beat other children. They know how to get along. (Camp Leaders, Unyama Camp).

In contrast, much fighting still occurred in the comparison group.

Children fight with each other...they provoke each other and then much fighting occurs. (Single/Widowed Caregivers, Paicho Camp).

Hyperactivity and Attention Problems

A trend for less problems emerged for the CCS group on the Strengths and Difficulties Hyperactivity and Attention Problems subscale, although this difference was not statistically significant (mean of 8.80 for the CCS group vs. 9.31 for the comparison group). However, two of the five items (easily distracted and acting impulsively) were statistically significant when analyzed separately: 48.9% of children from the CCS group were reported to be easily distracted vs. 60.2% from the comparison group. Additionally, 27.3% of children from the CCS group were reported to act impulsively vs. 36.4% from the comparison group (see Figure 4). Children from the CCS group also were reported to have fewer problems such as restlessness, fidgeting, and short attention span, although these differences were not statistically significant. Of note, however, is that none of the hyperactivity or attention items were identified in the local context as being important for children’s well-being.

Figure 4
Hyperactivity and Attention Problems
**Peer Interaction Difficulties**

Significant differences on interactions with peers were found for the Strengths and Difficulties Peer Problems subscale (mean score of 7.80 for the CCS group vs. 8.46 for the comparison group) \( (p<.01) \). Children from the CCS community exhibited less solitary behavior (7.4% vs. 19.5% of children from the comparison community), which was also a locally identified marker of non-well-being. Additionally, children from the CCS group were less likely to be bullied by other children (38.6% from CCS group vs. 58.5% of children from the comparison group) or not have any friends (1.7% from CCS group vs. 5.9% from comparison group) (Figure 5).

![Figure 5: Psychosocial Well-Being: Peer Problems](image)

Furthermore, on the Strengths and Difficulties Total Difficulties Scale, which is a composite of the Emotional Distress, Behavior Problems, Hyperactivity and Attention Problems, and Peer Interaction Difficulties subscales, a significant difference between the CCS and comparison group were found. The CCS group had significantly lower mean scores – 33.27 vs. 37.88 for the comparison group, indicating significantly fewer psychosocial problems overall.

**Pro-social Behavior**

Significant differences between the two groups also occurred in regard to pro-social behavior. Children in the CCS group had higher prosocial scores on the SDQ subscale:
13.07 for the CCS group vs. 12.49 for the comparison group (p<.01). On individual items, 86.9% of children from the CCS community were reported to be considerate of others’ feelings vs. 71.2% of children from the comparison community. In addition, 97.7% of children from the CCS community vs. 85.3% of children from the comparison community were reported to readily share with other children, while 52.8% of children from the CCS community vs. 33.1% of children from the comparison community were reported to be helpful if someone was hurt or ill (Figure 6).

![Figure 6](image)

**Psychosocial Well-Being: Pro-social Behavior**

Local Subscale of Psychosocial Components

Significant differences between the intervention group and the comparison group occurred for each of the locally elicited indicators of children’s distress. In particular, the children who participated in the CCSs exhibited less sadness, less fighting, less misbehavior, and were more likely to play with other children, share, and behave well.

Statistically significant differences were found on all locally constructed items of child well-being, with a higher percentage of children from the CCS communities being reported to have the following indicators of well being: plays with other children: 95.4%
vs. 80.5%; has a good appetite: 78.2% vs. 58.5%; communicates needs: 54.8% vs. 26.9%; shares with others: 89.2% vs. 61.9%; helpful to other children: 86.9% vs. 62.7%; and obedient and good mannered: 68.6% vs. 41.9% (Figure 7). These data are important because they reflect local understandings of children’s well-being, which are likely to have the greatest validity in the Ugandan context. They also corroborate findings of the SDQ and offer a more holistic view of children’s well-being.

Focus group interviews with caregivers, CWBC members, and camp leaders complemented these findings.

“Children used to run around and move from here to there aimlessly. Now they play together in groups.” (Elderly caregivers, Unyama Camp).

“Children know how to be in a group. Before they didn’t know how to sit still. They used to fight among themselves and throw stones. Now they have friendships with each other.” (Child Well-Being Committee, Unyama Camp).

In contrast, children in the comparison group were reported to exhibit less prosocial behavior.
“Many children are not well behaved and have bad manners. They practice how to fight and have rough behavior.” (Elderly caregivers, Paicho Camp).

“Some children have bad behavior. They have no respect for adults.” (Camp leaders, Paicho camp).

**Increase in Knowledge and Life Skills**

**Hygiene Knowledge and Skills**

Significant differences were found for two locally constructed items that pertained to hygiene knowledge and skills: “Knows how to use the latrine properly” and “washes hands after using the latrine.” 93.7% of children from the CCS community were reported by caregivers to know how to use the latrine properly vs. only 57.6% from the comparison community. In addition, 78.3% of children from the CCS community vs. 37.3% of children from the comparison community washed their hands after using the latrine or defecating (Figure 8).

Focus group discussions revealed that a consequence of children from the CCS community knowing how to use the latrine was that the children were exposed to less excrement and therefore to disease and sickness.

“Children used to defecate anywhere. Cholera was common before the CCS. Now it is not so common. Children at the CCS are taught how to use the latrine. They are not exposed to so much feces and there is less disease.” (Child Activity Leaders, Unyama Camp).

In the comparison community, the exposure of children to excrement was a major problem.

“Children are exposed to feces in the garden, in the house. Children don’t know how to use the latrine.” (Elderly caretakers, Paicho Camp).
Cognitive Skills

In addition to hygiene skills, caregivers from the CCS community reported in focus group discussions that their children had better communication skills, and had increased cognitive skills as demonstrated in counting and knowing the alphabet since attending the CCS. Moreover, CCS children were reported to be better acclimated when they enter primary school. Cognitive skills are important because they can elevate self-esteem and also strong cognitive skills are an important determinant of resilience.

"Before the CCS, it was difficult when sending children to the market. They didn’t know the vegetables. Now, you can send them to the market to help the parents. They know this is tomato, this is potato." (Child Well-Being Committee, Unyama Camp).

"Children know counting, not just 1-10, but 1-20. They know their alphabet in English and Luo. When other children enter P1 (Primary School, Class 1), they still can’t count. The CCS children know all these things when they enter P1. The parents are very happy and the teachers are very happy." (Elderly caretakers, Unyama Camp).

“Before my twins did not talk well. Now they know many words. They can count and know the alphabet. They know many things.” (Single/widowed caretakers, Unyama Camp).
“My child comes home and tells me what he learned. He even teaches me. He says, now mama, you repeat!” (Single/widowed caretakers, Unyama Camp).

“In the afternoon when I come back from the garden my granddaughter tells me all the stories and things she learned at the center. She says, grandmother this is “Hello. Goodbye. One! Two! Three! She wants to teach me all the English words she learned.” (Elderly caretakers, Unyama Camp).

Social Skills

Community members identify having confidence when interacting with adults as an indicator of child well-being by community members. Adults reported that participation in CCSs had given children more confidence and social skills when dealing with adults, especially shaking hands and greeting people.

“Children know how to greet and welcome people. Before (the CCS) they would run away when you would ask them a question. Now they are not shy to answer a question.” (Child Activity Leaders, Unyama Camp).

“The children know how to shake hands. Before they would be shy and not answer if they were spoken to. Now they like to shake hands and greet people.” (Elderly caregivers, Unyama Camp).
Limitations of the Study

It is important to recognize the limitations of this study, which in many respects is a first step in a longer process of ongoing research and learning in regard to CCSs. A useful question to examine in the future would be to determine how well the results realized in this study in Northern Uganda can be generalized to other countries and contexts. The appeal of CCS interventions is that they have global applicability and can be tailored to different contexts. Yet additional research in other contexts is needed to establish a broad knowledge and understanding of the impacts of CCSs. It is an open question whether positive results such as those reported here would occur in regard to the use of CCSs in emergencies created by natural disasters or in situations of ongoing armed conflict. Similarly, it is important to analyze the outcomes of CCSs for different age groups and children at different levels of development. This research showed positive outcomes for young children, yet future research should explore the possible impacts on youth and on school-aged children, with results disaggregated according to gender.

In addition, this research did not address the issues of cost effectiveness and comparative advantage that warrant attention if the field of child protection and psychosocial support are to become more systematized and mature. Although this research reported positive outcomes for a CCS intervention, it is unknown whether even greater impact for children might have been achieved through other child-focused interventions. In future research, it would be very useful to compare different child-focused interventions in an effort to analyze the comparative advantage and cost effectiveness of CCS interventions.

A significant methodological limit of this study was its reliance on self-reports. The use of self-reports is helpful in generating participation, enabling insight into local understandings and perspectives, and encouraging community mobilization and learning through group discussions. Nevertheless, self-reports are subject to numerous limitations and biases, not least of which is the tendency of participants to try to please the interviewers. To some extent, these issues were managed through the triangulation of information from different sources. For example, the data collected by research assistants who were independent of CCF and the community converged with the data collected by a CCF consultant and CCF staff. However, it would be useful in future research to combine self-report with methods of direct observation of children’s behavior.

Conclusion:

This study offers encouragement for the use of Child Centered Spaces as an intervention to support children's well-being and protection in emergency situations. Using locally derived as well as Western indicators, the study showed tangible, meaningful benefits for children in a situation of long-term displacement and armed conflict. For young children in Northern Uganda, CCSs provided discernable protection from exposure to risks, such as sexual exploitation, road accidents, house fires, and dangerous objects. Children attending CCSs also evidenced fewer symptoms of emotional distress, including less unhappiness and less worries, fewer behavioral problems, including less fighting with
other children and less misbehavior. Also, children who participated in CCSs demonstrated fewer problems with peers, including less solitary behavior.

Children attending CCSs also displayed more pro-social behavior—considering others’ feelings, sharing with others, being helpful when someone was hurt or upset, and being helpful to other children. Furthermore, children participating in CCSs gained important life skills, such as learning to wash their hands and using a latrine, and cognitive skills. These positive elements serve as a poignant reminder of the importance of moving beyond the deficits emphasis that has been so prominent in studies of children in situations of armed conflict. Children’s assets, such as pro-social skills, as well as deficits, are both important components of children’s resiliency.

Although this research shows the value of CCSs in protecting children and promoting their well-being, it is important to recognize that the establishment of CCSs alone cannot ensure children’s care and protection. The establishment of CCSs in the IDP camps did little, for example, to address the wider protection issues of displacement and armed conflict. In the broader context of northern Uganda and most war zones, it is important to establish holistic, multi-level systems of child protection. CCSs are best regarded as only one element in the wider protection systems that are needed to protect children’s rights and well-being in zones of armed conflict.
References

1 Inter-Agency Network for Education in Emergencies (INEE) (2004). INEE Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction.


7 INEE op cit.

8 IASC op cit.


