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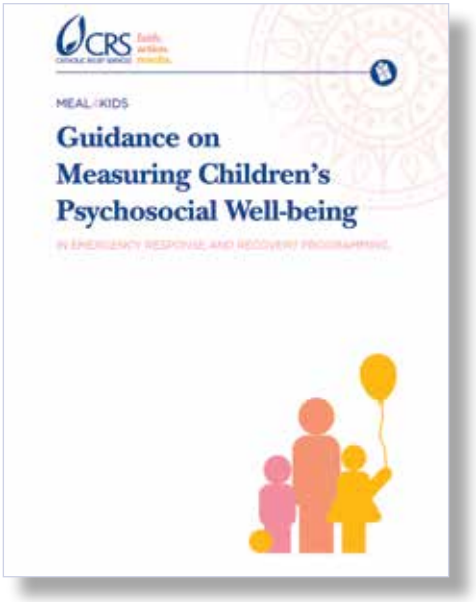
MEAL4KIDS

Guidance on Measuring Children's Psychosocial Well-being

IN EMERGENCY RESPONSE AND RECOVERY PROGRAMMING



This guidance aims to help country programs develop a locally and programmatically appropriate definition of psychosocial well-being, and indicators responsive to that definition. It will aid the selection of appropriate data collection methods and the development of corresponding data collection tools.

More guidance from the MEAL4KIDS series:

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Acronyms

CFS	child friendly space
CP	country program
CYRM	Child and Youth Resilience Measure
EMECA	Europe, Middle East and Central Asia (regional office)
FGD	focus group discussion
HRQOL	health-related quality of life
IDP	internally displaced person
INEE	Inter-Agency Network for Education in Emergencies
KII	key informant interview
M&E	monitoring and evaluation
MEAL	monitoring, evaluation, accountability and learning
MSLSS	Multidimensional Students Life Satisfaction Scale
NEF	New Economics Forum
NPC	New Philanthropy Capital
OFDA	Office of U.S. Foreign Disaster Assistance
PIRS	Performance Indicator Reference Sheets
PSS	psychosocial support
RSEA	Resilience Scale for Early Adolescents
SDQ	Strengths and Difficulties Questionnaire
UK	United Kingdom
Unicef	United Nations Children's Fund
WEMWBS	Warwick-Edinburgh Mental Well-Being Scale

Contents

Introduction

Catholic Relief Services' (CRS) child psychosocial support projects often have a strategic objective of improving *children's psychosocial well-being*.[1] This guide aims to help country programs (CPs) develop a locally and programmatically appropriate definition of psychosocial well-being and develop indicators responsive to that definition. The guidance also aims to help with the selection of appropriate data collection methods and the development of corresponding data collection tools to measure those indicators, and with performing quantitative data analysis at baseline, midterm[2] and endline.

The guidance places a strong emphasis on the use of quantitative methods and tools, as these are reportedly more challenging than qualitative methods and yet essential to reporting on quantitative indicators measuring well-being. Qualitative methods are also strongly recommended to complement quantitative methods whenever feasible, to learn the "why" behind quantitative data and to better understand the perceptions and opinions of children, parents, and staff working with children.[3] They are also often the most appropriate way to collect information from children of a certain age and developmental stage or to report on qualitative indicators. However, qualitative methods cannot be used to report on quantitative indicators.

The step-by-step approach presented here—from developing a contextually and programmatically relevant definition of psychosocial well-being, through selection of appropriate data sources, data collection methods and the development of corresponding data collection tools, to performing data analysis—aims to assist program teams in making informed decisions on pivotal points of developing a quality and locally appropriate monitoring, evaluation, accountability and learning (MEAL) system for child psychosocial support (PSS) projects. The guidance provides considerations for how these critical aspects can be contextualized for use in an emergency and/or recovery setting. The guidance is also useful for projects focusing on a particular component or combination of components of a child's psychosocial well-being (e.g. social well-being and/or improvement of a sense of belonging to a host community.)

This guidance should be used together with the CRS *MEAL4Kids: Standards for child participation* to ensure the meaningful, appropriate, safe and ethical participation of children in data collection activities.

1. Many donors require such an indicator. OFDA's guidelines for child protection interventions require at least one indicator that measures "Percentage of targeted children reporting an improvement in their sense of safety and well-being at the close of the program."
2. In short-term emergency programs, there may not be midterm data collection.
3. For more guidance about qualitative data collection, please refer to *Guidance on monitoring and evaluation* (Hagens et al. 2012). For more guidance on adjusting focus group discussions to children, please refer to *Practical guide: Focus group discussions* (Dzino-Silajdzic 2018).

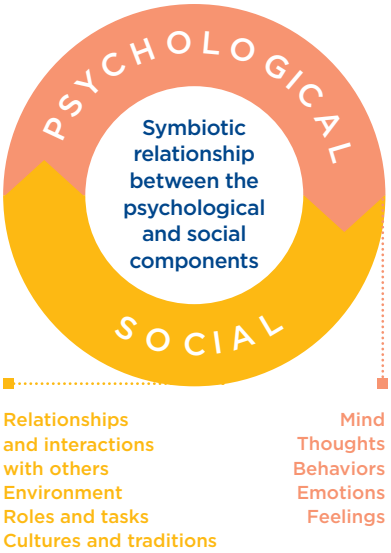
I. What is psychosocial well-being?

Considering a child's age and developmental stage[4] is essential in the measurement of psychosocial well-being. What constitutes and affects well-being in early childhood, middle childhood and adolescence varies considerably, so a one-size-fits-all approach fails to consider this spectrum.[5] Given this complexity and the dynamic nature of a child's psychosocial well-being, this document offers a menu of options for CPs to consider, depending on the project focus, and the age and developmental stage of the children. Such an approach supports staff as they contextualize psychosocial well-being measurement to the circumstances and cultural setting of each project, taking into account the evolving nature of programming and its progression over a child's psychosocial well-being continuum.

Well-being[6] can be described as a condition of holistic health in all its dimensions: physical, cognitive, emotional, social, psychological and spiritual. Well-being is comprised of the full range of what is good for a person: taking a meaningful social role; feeling happy and hopeful; living according to good values, as defined locally; having positive social relations and a supportive environment; coping with challenges through the use of appropriate life skills; and having security, protection, and access to quality services.

The term "psychosocial" in **psychosocial well-being** denotes the inter-connection between psychological sub-components—such as emotions, thoughts and behaviors, including coping strategies—and social sub-components, such as interpersonal relationships, social roles, norms, values, traditions and community life, that contribute to the overall well-being of a person. Psychological sub-components continually interact with and influence social sub-components. In crisis situations, the psychosocial well-being of children is affected, as they may suffer not only from losses and exposure to extreme events, but also from daily sources of distress such as crowded living conditions, family disputes, discrimination, community violence, an inability to attend school, and a lack of access to medical services and food.[7]

Figure 1: Symbiotic relationship between the psychological and social components of the term "psychosocial"



*ARC Resource Pack. Foundation Module 7: Psychosocial Support (Unicef 2009).

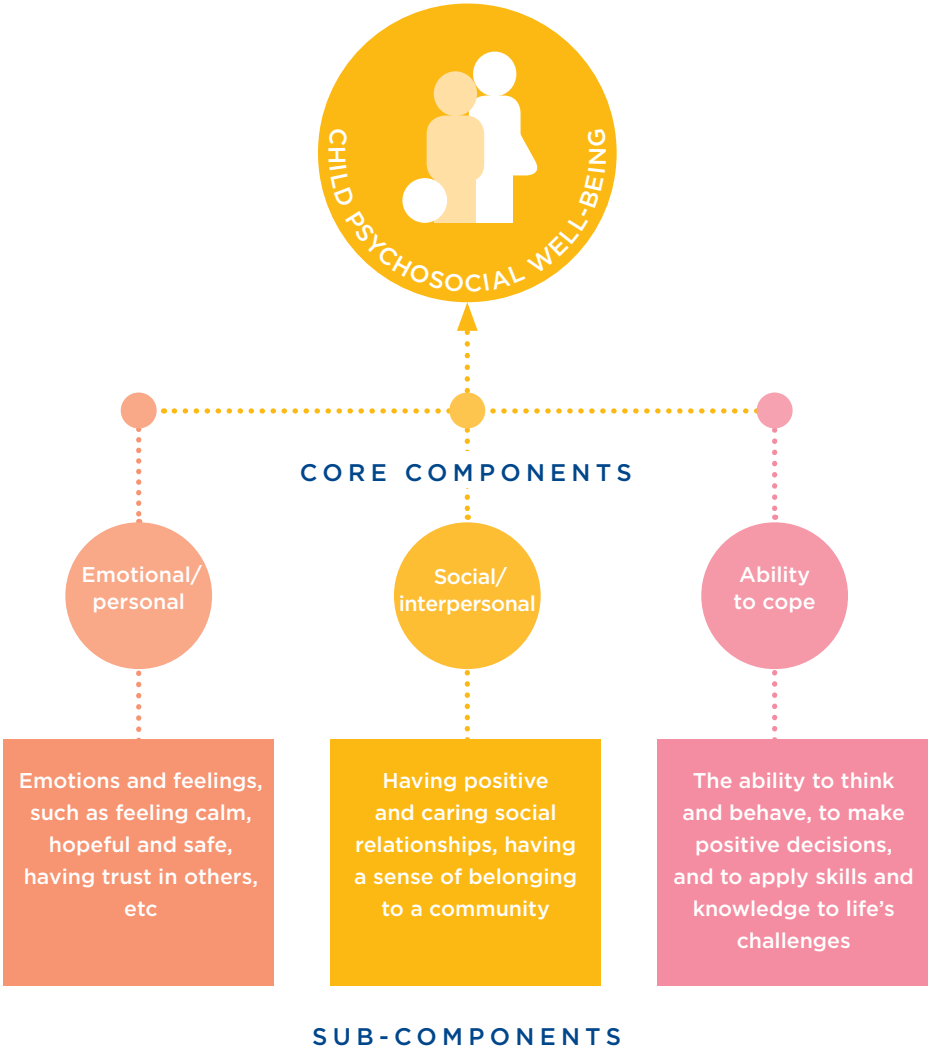
4. According to the United Nations Convention on the Rights of the Child, a child is anyone under the age of 18.
5. Assessing child and youth wellbeing: Implications for child welfare practice (Lou et al. 2008).
6. Although there is not one agreed definition of *psychosocial well-being*, and agencies may use different words to describe the term, the same underlying concepts and principles are used to describe the term industrywide.
7. INEE Thematic Issue Brief: Psychosocial Wellbeing.

II. Exploring *psychosocial well-being* for MEAL purposes

To ensure relevant and locally appropriate measurement of the progress and impact of projects aimed at improving children's psychosocial well-being, it is important to explore the term and clearly identify the components and related sub-components that the programming activities aim to influence. **This process takes place when selecting and defining indicators and should involve both programming and MEAL staff.**

Clearly identify the components and related sub-components of child psychosocial well-being that the programming activities aim to influence.

Figure 2. Child psychosocial well-being for MEAL purposes
Three core components and multiple sub-components. A full list of sub-components is outlined in Annex 1).



Psychosocial well-being is a dynamic experience that is influenced by a person's own capacity, their social connections and support systems (including access to basic services), and cultural norms and value systems as demonstrated by the child psychosocial well-being conceptual framework.[8] According to the leading agencies implementing psychosocial programs in humanitarian emergencies, the components that define psychosocial well-being and can be measured are as follows:

Psychosocial well-being is a dynamic experience that is influenced by a person's own capacity, their social connections and support systems, and cultural norms and value systems.

- **Emotional/personal well-being** includes emotions and feelings, such as feeling calm, hopeful, safe, having trust in others, etc.
- **Social/interpersonal well-being** relates to social life and includes having positive and caring social relationships (with peers, siblings, caregivers, teachers, neighbors, community members and other trusted, supportive adults); having a sense of belonging to a community; and being able to resume and participate in cultural traditions. This can also include willing participation in appropriate household responsibilities and livelihoods activities, and relates to having the ability and opportunity to perform and fulfill social roles that are customary in the context.
- **Ability to cope** in an uncertain or changing environment. It includes a person's sense of agency and their ability to think and behave, to make positive decisions, and to apply skills and knowledge to life challenges.

Depending on the stage of an emergency, the project may focus on specific components of well-being and their associated sub-components. As time moves on, the focus may change, with the project evolving into a more comprehensive intervention that tackles additional or different sub-components. The changing nature of emergencies requires continuous assessment and subsequent adjustments to ensure relevance to the context.

In the first phase of an emergency (e.g. first 3 months after displacement), PSS projects such as child friendly spaces (CFS) aim to provide children with a protective environment in which they can participate in organized activities to play, socialize, learn and express themselves as they rebuild their lives.

Beyond the first phase of the emergency, projects often transition to have a stronger and more explicit focus on building or improving children's resilience and their ability to better cope with current and future adversities in their lives through building, and learning to apply, specific knowledge and skills relevant to the context (e.g. life skills programs, etc.).

Therefore, during the first phase of emergencies, project and well-being measurement may focus on Components 1 (emotional) and 2 (social) of psychosocial well-being. In protracted emergency and recovery settings, there may be a stronger emphasis on Component 3 (ability to cope), in addition to continual work on Components 1 and 2.

8. In emergency child PSS programs, CRS uses a child-in-environment conceptual framework rooted in Bronfenbrenner's Ecological Systems Theory.

Industry approaches to defining well-being

Some organizations may define or group the psychosocial well-being components differently. For example, a study that measured well-being among children and teenagers in the United Kingdom for many years, used the following categories: **positive feelings, negative feelings, life satisfaction, optimism, resilience, autonomy, meaning and purpose, social relationships and vitality**.[9] Another organization[10] measured well-being using the following categories: 1) **Self**: self-esteem, resilience and emotional well-being; 2) **Relationships**: with peers and with family; 3) **Environment**: satisfaction with school environment and community environment (e.g. does the child feel safe in the community?).

While these organizations used different categories and groupings, most of these fit under the three components (emotional/personal well-being, social well-being and ability to cope) mentioned above.

Some organizations define or group the components of psychosocial well-being differently but most categories fit under the three components mentioned above.

9. European Social Survey.
10. *Feelings count: Measuring children's subjective well-being for charities and funders* (Nevill 2009).

III. Choosing data sources for measuring child psychosocial well-being

There are many factors to consider when identifying the most appropriate data source to report on how a child's well-being is affected by a child psychosocial support program. Key areas for consideration are:

- The age-group of children targeted by the program.
- The developmental stage and abilities of children targeted by the program. Note that this may or may not be related to the actual age of the child.
- The type of indicator being measured (e.g. qualitative versus quantitative).
- Staff competencies (e.g. if trained staff are available to collect data directly from children).

These factors in combination influence the choice of the most appropriate data source as well as the data collection method and tool. For example, if a project targeting children under 7 years of age has a quantitative indicator measuring improved well-being, most likely the data will be collected through a structured interview or self-administered survey. Given the age-group, and developmental stage of the children at this age, it is most appropriate to select parents as the main data source as surveys collecting quantitative data on abstract concepts such as well-being are not appropriate for children under 7 years of age. Even when parents are selected as the main data source, data coming from the children is tremendously useful for understanding their perspectives, and for triangulation and accountability purposes.[11]

Even when parents are selected as the main data source, data coming from the children is tremendously useful for understanding their perspectives, and for triangulation and accountability purposes.

11. *MEAL4Kids: Guidance on accountability to children* (CRS 2018).

Lesson learned from the field

When designing programs before submitting a proposal to the donor, if possible, it is best to keep indicator language undefined in terms of the data source (e.g. do not include a data source such as "children self-report" in the indicator language.) This will give you more flexibility to determine the most appropriate data source, decide on most appropriate method depending on the age range of the children (i.e. self-assessments or interviews with children) and ensure adequate staff competencies.

Even when the donor requires specific phrasing of the indicator that includes "children self-report," check this requirement in more detail e.g. review their guidelines and/or Performance Indicator Reference Sheets (PIRS) if available, or ask the donor directly if it is acceptable to use alternative data sources. For example, OFDA[12] guidelines ask for an indicator: *percentage of targeted children reporting an improvement in their sense of safety and well-being at the close of the program*. However, the PIRS sheet for this indicator lists data collection methods such as psychometric scales, observations (by adults) and/or children's narratives. Additional correspondence with the donor confirmed that child protection indicator reporting can come from adults and caregivers as long as the organization clearly outlines the chosen method in the corresponding monitoring and evaluation plan.

When designing programs before submitting a proposal, keep indicator language undefined in terms of the data source as this will give you more flexibility.

Children's level and type of participation is influenced by their age, development and education capacity, including both reading and writing abilities. It is critical that trained staff are available to collect data from children and that the necessary safeguarding measures are in place.

As a rule of thumb, assume we always want to hear from children about their well-being whenever and wherever possible.[13] Research has shown that asking children directly about what contributes to their well-being can lead to findings that might otherwise not have been discovered, in part because some sub-components of well-being (feelings) are subjective and cannot readily be observed by outsiders. At the same time, it is vital to recognize that subjective self-assessments will always be connected to individual frames of reference, circumstances and experiences.[14] Parents of children in CFS or child PSS programs are a reliable data source, as are project animators, facilitators or teachers, as they often have a valuable perspective on the demonstrated and changed attitudes and behaviors of the children in the program. In emergency contexts, time and resources may be limited, but, when possible, more than one data source is recommended when measuring child psychosocial well-being. To ensure adequate resources are available for collecting data from multiple sources, it may be necessary to reduce the sample size.

Asking children directly about what contributes to their well-being can lead to findings that might otherwise not have been discovered because some sub-components of well-being are subjective and cannot readily be observed by outsiders.

12. USAID/OFDA Proposal Guidelines Protection PIRS (May 2018).
13. Refer to *MEAL4Kids: Standards for child participation* (CRS 2018).
14. *A guide to measuring children's wellbeing* (NEF 2009).

Ethical considerations

1) Verbal and/or written consent before the data collection process starts is designed to empower a potential respondent to decide whether or not to participate. This means subjects must have the capacity to make their own decision. Therefore, in PSS programming, special considerations need to be given to cases where children are the respondents. The parents or legal guardians of the children who will participate in the survey, interview or focus group discussion (FGD) must be informed of the objectives of the data collection effort and provide their formal consent beforehand. No child* can participate in any data collection activities without CRS having received consent from their guardian. Also, the children themselves should understand the objective of the discussion, how the data will be used, and that their participation is voluntary. Even if a guardian has given their consent, a child should never be pressured into participating if they do not feel comfortable doing so.

2) Maintaining the confidentiality of participants' identity and responses ***after*** the data collection is completed is vital. Collect only the minimum "need to know" demographic data, especially when it comes to information that can identify an individual. These requirements typically correspond to the initially identified information necessary for adequate comparisons at the analysis stage. The survey forms or other records with children's responses need to be securely stored, managed and, later, disposed of. The documents need to be kept in a secure location and be accessible only to the team members who are engaged in collecting, analyzing or using the data. Remember that many countries may have specific laws and regulations related to responsible data collection and management; be sure to check.

3) Protection measures Be aware of and avoid potential risks you may inadvertently cause to children by selecting them to participate (e.g. children feeling singled out) or not (e.g. children feeling left out) in the data collection effort. Your primary concern is to Do No Harm and ensure the protection of the respondents, and that takes precedence over any other objectives you may have.

For a full list of standards on child participation in MEAL, see *MEAL4Kids: Standards for child participation* (CRS 2018).

*According to the United Nations Convention on the Rights of the Child, a child is anyone under the age of 18.

IV. Choosing methods and tools for measuring child psychosocial well-being

There are many qualitative and quantitative methods that can be used to measure changes in the well-being of children.

Qualitative methods focus on exploring meanings, contexts, processes, reasons and explanations. These are then captured in text or diagrams, but generally not in numbers. Examples of qualitative methods include focus group discussions, key informant interviews (KIIs), etc. They generate words and textual data, not numbers.[15] Qualitative methods call for non-random, purposeful sampling with respondents selected based on their knowledge, perspective or other characteristics of interest (e.g., girls or boys, younger children or adolescents, very poor or better off).[16]

Qualitative methods generate words and textual data, not numbers. They require strong facilitation skills, especially if used with children.

Qualitative methods that can be used to measure child psychosocial well-being include:

- Focus group discussions with parents, animators,[17] teachers, and/or children (older than 10 years)[18]
- Individual semi-structured interviews with parents, animators, teachers and/or children (older than 10 years)
- Creative group or individual exercises with children that involve drawings, pictures, role-plays, puppets and other visual aids
- Creative activities with adolescents using photography (Photovoice)[19]
- Observations of children's behavior made by animators, teachers or other adults

Qualitative methods require strong facilitation skills, especially if used with children. Even observation that may appear simple typically requires a trained eye to take note of specific behaviors children may exhibit. Qualitative methods cannot be used to generate data for an indicator with a percentage target; however, they may provide invaluable insights into participants' motivations and practices, and how they view or perceive experiences and specific aspects of life. Qualitative methods empower children, their parents and others to describe in their own words the changes the children are experiencing or exhibiting, and the positive and negative impacts of the project.

15. *Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA): A manual for CRS fieldworkers and partners* (Schoonmaker Freudenberge).
16. *Guidance on Monitoring and Evaluation* (Hagens et al. 2012). Please refer to the Purposeful Sampling section for specific strategies.
17. Animators are typically adults (often youth) selected from local communities targeted by the intervention, who are trained to work with children.
18. For more information on how to conduct FGDs, please refer to the CRS *Practical guide: Focus group discussions* (Dzino-Silajdzic 2018).
19. For more examples of qualitative research methods and tools with children, please consult: *A kit of tools for participatory research and evaluation with children, young people and adults* (Save the Children Norway 2008).

Quantitative methods generate information that can be captured numerically.[20] The selection of respondents is done using random sampling—also known as probability sampling—which is statistically representative of a surveyed population.[21] As with all quantitative methods, data collected can be generalized to the population from which the sample was drawn. The results are used to report on specific quantitative indicators that measure improvement in child psychosocial well-being in PSS programs.

Quantitative methods generate information that can be captured numerically.

The main quantitative methods used for measuring child psychosocial well-being are:

- **Structured observation**, using a tool such as a checklist
- **Structured interviews**, using a survey questionnaire

The survey may be administered through a face-to-face interview or as a self-assessment process. The interview is conducted by an enumerator who asks the questions in a predetermined order and records responses, while the self-assessment entails individual self-administration of the questionnaire. As with qualitative methods, in the face-to-face interviews, the enumerators have to be trained on participatory methods and child-friendly approaches.

Qualitative versus quantitative methods Each has advantages and disadvantages, and therefore require careful consideration. When deciding on a data collection method, it is advisable to consider the primary purpose of the data collection effort. If the primary purpose is **reporting on indicators** (e.g., percentage of children demonstrating improved well-being), qualitative methods alone cannot be the option, since they cannot be used to generate numerical (i.e. number or percentage) data.

Qualitative and quantitative methods each have advantages and disadvantages, and therefore require careful consideration.

If the project team is interested in the **reasons behind a certain situation or behavior**, or a narrative description of changes—intended or unintended, expected or unexpected—then qualitative methods are the best choice. As well-being is such a dynamic and personal concept, choosing qualitative methods is often the best way to elicit such personal information.

20. *Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA): A manual for CRS fieldworkers and partners* (Schoonmaker Freudenberge).
21. *Guidance on Monitoring and Evaluation* (Hagens et al. 2012). Please refer to the Random Sampling section for specific strategies.

More on selection of methods

Best practice is to use a mixed-method approach that involves both quantitative and qualitative data collection methods, although this may not always be possible, especially in emergency contexts where time and resources are scarce.

As a rule of thumb, quantitative methods result in establishing "what" is happening while qualitative methods offer insights into "how" and "why". For example, through quantitative methods we can learn that a certain percentage of children do not treat newcomers well in CFS, while qualitative methods would help us understand *how* it happens, and *why* it is the case (e.g. children are scared to talk to children from a different background or nationality, they simply don't know how to do it, or there are language barriers to communicating, etc.).

Both quantitative and qualitative methods require significant preliminary work, including the development of tools that correspond to a project's strategic objectives indicator(s), its definitions (i.e. of appropriate well-being components and associated sub-components), tool testing and training of enumerators to build their skills and knowledge for participatory data collection and, if needed, child-friendly approaches. Quantitative methods may require less time per respondent, but, given the need to apply a random sampling approach, usually involve a larger sample of respondents.

Data collection tools Each method, whether quantitative or qualitative, requires a data collection tool. The tool contains a list of questions that the enumerator needs to ask a specific data source. The process for developing a tool differs for different methods i.e. quantitative vs qualitative. For example, quantitative tool development is primarily led by an indicator definition developed based on an initial decision on the selected well-being components and associated sub-components planned to be influenced by the program (as described in Section III above). For a qualitative tool, the process of tool development is typically led by the overarching question(s) you are seeking to answer, as well as the psychosocial well-being sub-components to be addressed by the program.[22]

The process for developing a tool differs for different data collection methods.

Qualitative tools such as focus group discussion guides, parent interview guides, animator observation guides, etc., contain qualitative or open-ended questions, intended to guide an interview, FGD or specific activity. The questions are used as guidance for discussion rather than being a script that needs to be followed to the letter, although an enumerator still needs to ensure ***all*** questions are responded to. The responses can be used to create data in a narrative or text format.

22. For more guidance on developing quantitative and qualitative data collection tools, please refer to *Guidance on Monitoring and Evaluation* (Hagens et al. 2012) and *Practical guide: Focus group discussions* (Dzino-Silajdzic 2018).

Quantitative tools such as parent self-assessment questionnaires, teacher observation checklists, etc., contain quantitative or closed-ended questions, whose responses can be transformed into data in a numeric format, e.g. yes/no questions, agree/disagree, one-response or multiple-choice questions, scale-based questions, etc. The questions are asked in a specific order as laid out in the form/data collection tool. Quantitative tools may also contain a limited number of open-ended questions, which, during the analysis, often get grouped according to theme, are coded and then transformed into quantitative/numeric data.

Quantitative tools contain closed-ended questions—whose responses can be transformed into data in a numeric format—but may also contain a limited number of open-ended questions.

Industry experience with measuring well-being in emergency settings

There are many validated questionnaires to guide structured interviews or self-assessments of child well-being, but none of these has been developed for use in emergency contexts. In emergencies, children are typically in highly vulnerable and insecure situations. The type of information collected and how it is collected should not cause emotional distress to a child—who may have been exposed to overwhelming events—or violate any other child safeguarding measures. Also, some questions may not be relevant in an emergency context (e.g., questions about going to school when children no longer have access to school.)

Tips for contextualizing tools When developing tools, both quantitative and qualitative, it is good practice is to check approaches and examples from other CPs or organizations working in a similar context. Although having a ready-made tool may give the impression that field data collection can immediately be conducted, it is of utmost importance to first schedule time for a careful, detailed review of all the questions in the tool, and to adjust and contextualize it. A few tips for doing this:

- Look at the data sources and check whether the tool is appropriate to the age-groups and profile of the respondents.
- Look at the strategic objective and its corresponding indicator and check if the questions in the tool adequately correspond to the well-being definition (components and associated sub-components) or whether they need to be adjusted.
- Look at the specific focus of activities, i.e. curriculum or other activities targeted at a specific sub-component of well-being, and check if the questions are relevant to those activities.
- Always field-test the tools! This is your best strategy for ensuring tools are locally relevant and contextualized.

Contextualizing in practice

A CRS program decided to use another country program's parenting tool to measure changes in positive parenting practices. Due to time pressure, they did not carefully review all questions as the tool looked appropriate for their purposes. As a result, they included questions that were adolescent-oriented while the project focused on parents of children 6 to 10 years of age. Instead of saving time, they instead wasted time and effort. Careful review would have saved time and energy, and produced better results.

V. Quantitative methods and tools for measuring child psychosocial well-being

The table below summarizes quantitative methods and tools appropriate for measuring psychosocial well-being in children of different age-groups, and highlights some best practices:

Age	Quantitative methods and tools to measure well-being
5–6 years	• Individual one-on-one structured interview with parent to capture a parent's perception of their child's well-being, using a tool such as a parent interview questionnaire • Parent self-reporting to capture their perception of their child's well-being, using a tool such as a parent self-assessment questionnaire • Teacher or animator observation assessing an individual child's behavior, using a tool such as the individual observation checklist or form • Teacher or animator observation of a group of children, using, for example, a group observation checklist or form. (An observation tool could either be used to observe the behavior of randomly selected individual children or the behavior of the entire group.)
Best practice Practice has shown that children younger than 7 years of age cannot participate in an introspective assessment of their own experience; given their cognitive stage of development, the data would not be deemed reliable.	
7–9 years	• Individual one-on-one structured interview with a parent to capture their perception of their child's well-being, using a tool such as a parent interview questionnaire • Parent self-reporting to capture a parent's perception of their child's well-being, using a tool such as a parent self-assessment questionnaire • Teacher or animator observation to assess an individual child's behavior, using a tool such as an individual observation checklist or form • Teacher or animator observation of a group of children, using a tool such as a group observation checklist or form • Individual one-on-one structured interviews with children,[23] using a tool such as a child interview questionnaire
Best practice • For younger children, only a few questions should be included, and interviews should last a maximum of 15 minutes (inclusive of warm-up questions). • In a first-phase emergency response, it is suggested that parents and animators are used as data sources when using quantitative methods, as it may be sensitive or even inappropriate to collect baseline data from children who have just been displaced and/or have experienced distressing events.	
10–17 years	• Individual one-on-one interview with a parent, using a tool that mirrors the sub-components of well-being in a child tool • Parent self-reporting, using a tool that mirrors the sub-components of well-being in a child tool • Teacher or animator observation assessing an individual child's behavior, using a tool such as an individual observation checklist or form • Teacher or animator observation of a group of children, using a tool such as a group observation checklist or form • Individual one-on-one interview with a child/adolescent, using a tool such as a child questionnaire • Child/adolescent self-reporting, using a tool such as a child questionnaire if the children/adolescents are literate
Best practice Experience shows that : • Questionnaires for children aged 10–12 should include 10 to 15 questions on average, with the interview lasting no more than 20 minutes. • Questionnaires for children aged 13+ can be longer (up to 25 questions), with interviews lasting as long as 30 minutes • For a wide-ranging age-group (e.g. 10–17 years), you may need to develop slightly different versions of the tools to ensure that both the number and wording of the questions are age-appropriate.	

23. CYRM: Child and Youth Resilience Measure. Halifax: Resilience Research Centre

Additional considerations

- ✓ The principle of triangulation[24] advocates the use of several methods to measure the same phenomenon e.g. interviews with parents coupled with animator observation.
- ✓ Whenever and wherever possible it is strongly recommended that more than one data source is used to learn about changes in child well-being e.g. parents and children. Note that several well-known, validated tools include a parallel parent questionnaire that complements the questionnaire for children, easing comparison of responses across the different data sources. The statements for parents are adjusted from "I" to "my child."
- ✓ It is important to consider the context and the educational capacity of the children. In some countries where children attend school at an earlier age and are accustomed to giving formal feedback and/or participating in self-assessments in a school setting, children might be able to complete a simple self-assessment questionnaire at a younger age than in other contexts where this is not the case.
- ✓ Testing a well-being tool is critical. When testing any tool for use with children, always ask them for feedback: Did they like answering the questionnaire? How did it make them feel? Was it difficult answering the questions? Were there some questions that they did not understand or did not want to answer? Why? How would they recommend making the tool easier to use? Do they prefer using paper or an electronic device (if an option) to fill out a survey?

Whenever and wherever possible it is strongly recommended that more than one data source is used to learn about changes in child well-being.

All of the methods presented in the table above are recommended ways of measuring child psychosocial well-being. Based on experience, the child self-reporting using a self-assessment questionnaire is the method that poses the most challenges for field teams in emergency and recovery settings. The following section provides more explanation and guidance on this.

Self-assessment questionnaire for children Involving children directly to understand how they feel about their lives, and their perceptions of the impact of a PSS program on their well-being, is highly recommended. In fact, there has been a shift in recent years from assessing child well-being from an adult perspective to adding a child perspective. There is broad acceptance of the use of children's subjective perspectives of their own well-being, and using children as reporters is viewed as a reliable method of assessing their well-being.[25] Some organizations only measure the subjective well-being as reported by children, while others capture children's self-assessments alongside interviews with parents, teachers and animators and/or using observational tools. CRS strongly encourages the use of two data sources wherever possible.

Using children as reporters is viewed as a reliable method of assessing their well-being.

24. The term comes from "triangle". The aim of triangulation is to increase the validity of the study, and it applies to the selection of data sources (e.g. using two or more data sources), data collection methods (e.g. using two or more methods) and analysis (e.g. engaging different people to analyze the same data). The purpose of triangulation is not to arrive at consistent results across data sources, but to compare and validate, and if inconsistencies are revealed, to discover deeper meaning behind the data through additional data collection and/or participatory data interpretation (Dzino-Silajdzic 2018)
25. *Positive indicators of child wellbeing: A conceptual framework, measures and methodological issues* (Anderson et al. 2009)

Structure of the questionnaire This section discusses some of the most widely-used and well-known self-reporting and/or interview questionnaires that aim to measure well-being in children. It also includes CRS-specific experience and recommendations to support staff in making informed choices about questions and items to be included in their own tools.

As not all tools use the same definition of well-being, some self-assessment tools focus on more narrow sub-components of well-being, for example, the Children's Hope Scale[26] that measures optimism and resilience; the Resilience Scale[27] (Wagnild and Young); or the Strengths and Difficulties Questionnaire (SDQ)[28] that measures emotional well-being. A detailed matrix of these tools and what sub-components of well-being (within the corresponding well-being component) they measure is included in Annexes 1 and 2.

The structure of these questionnaires is the same: An opening section builds rapport, asks for consent, addresses ethical considerations and asks for demographic data. The heart of the questionnaire includes the item statements, presented with a response scale for the respondent to use. The statements typically allow only one response option, but there are exceptions. Some questions CRS has used were multiple choice, allowing the selection of several options as possible responses. The questionnaire ends with a section that allows children to share any additional information they wish and ask any questions, and then thanks the children for their time and participation.

A detailed matrix of self-assessment tools and what sub-components of well-being they measure is included in Annexes 1 and 2.

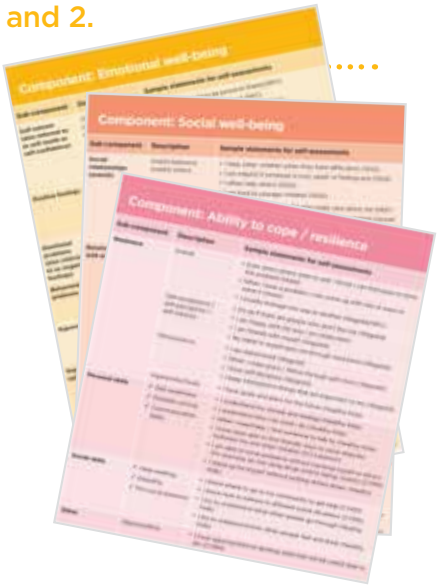


Figure 3: Questionnaire format

Opening section

- Builds rapport
- Seeks consent
- Addresses ethical considerations
- Requests demographic data

Main section

- Includes the item statements
- Includes response scale for respondent: Single response, multiple choice or multiple-response options

Closing section

- Includes a place for children to share additional information and ask questions
- Thanks the children for their time and participation

26. Children's Hope Scale, Page 21.
27. The Resilience Scale.
28. SDQ Information for researchers and professionals about the Strengths & Difficulties Questionnaires. Click on questionnaire download tab to access the tools in different languages.

Measuring behavior versus feelings Some statements in questionnaires **measure behaviors** and are **observable measures**. For example:

- I fight a lot
- I usually share with others
- I try to be nice to others
- I take things that are not mine

Other statements aim to **capture how children feel about something** and are therefore **subjective measures**. For example:

- I have been feeling good about myself
- I like spending time with my family
- I feel supported by my friends

Some tools specifically focus on only measuring behavior (e.g. SDQ) or only measuring subjective well-being sub-components (NPC), while others measure both. There are some advantages of having a combination. Questions focusing on subjective measures give children an opportunity to express how they feel about themselves, their relationships, environment, etc. Questions on objective measures can be triangulated with information coming through other data sources, e.g. questionnaires with caregivers or animators/teachers, thus serving as important cross checks if behaviors are confined to a specific environment or a situation (e.g. at home or at school or CFS).

Positive versus negative items (statements) The DeVellis guidelines state that having the same number of positive items (e.g. my friends are great) and negative items (e.g. I wish I had different friends) **to measure the same sub-component of well-being** increases the validity of the response.[29] However, certain tools use exclusively positive statements[30] as some researchers believe these make the questionnaire (a) more user-friendly[31] and (b) generate more reliable data as older children might not want to honestly answer negative statements, and younger children might find them confusing or even upsetting. Traditionally, there has been a focus on negative measures of child well-being. Nevertheless, recent critiques suggest that many tools have focused too much on negative items that merely measure the absence of mental health problems or a reduction in behavioral problems, but that do not capture positive sub-components of well-being such as having self-confidence or feeling supported by friends and family.

Some researchers believe positive statements make a questionnaire more user-friendly and generate more reliable data as older children might not want to honestly answer negative statements, and younger children might find them confusing or even upsetting.

In CRS projects in emergency and recovery settings, it is recommended that the majority of statements in child self-assessments and interviews are positive, and then the respondent answers how true/frequent a specific notion expressed in the statement is to them (e.g. agree/disagree spectrum or always/never options). The reason for this is that in emergency settings, too many negative questions may cause unintentional distress for children who are often already in volatile situations.

29. *Feelings count: Measuring children's subjective well-being for charities and funders* (Nevill 2009).
30. Children's Hope Scale.
31. Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) (Warwick Medical School 2006).

Scale-based questions These typically offer a statement and then a scale on which the respondent indicates their level of adherence to the notion in the statement:

- **"I worry a lot"** Not true | Somewhat true | True (SDQ)
- **"My friends treat me well"** Never | Sometimes | Often | Almost always (MLSS)[32]
- **"I feel supported by my friends"** Not at all | A little | Somewhat | Quite a bit | A lot (CYRM)

The validated tools referenced in this guidance use between three and seven answer categories on the scale. Some use an uneven number of answers to offer a neutral option, while a few provide an even number of answers and therefore do not offer a neutral answer.

When developing or selecting your own scales, it is recommended that you have an odd-numbered scale with a neutral option. Some data collection efforts seek data that will clearly side with either a positive or negative option (e.g. preference for location of a CFS or favorite snacks). When measuring child psychosocial well-being, collecting data that sides with an exclusively positive or negative option on the continuum is not the primary intention. Therefore, having a neutral midpoint is considered more appropriate.[33]

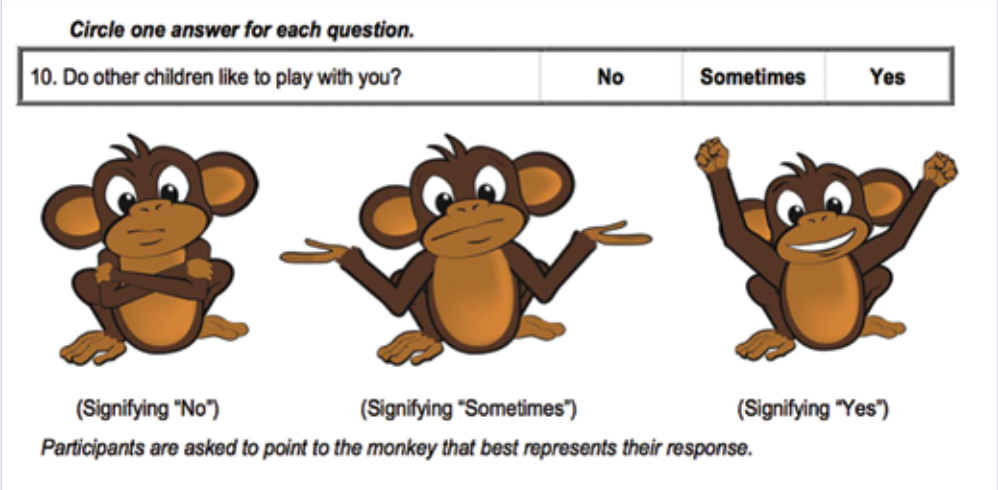
When developing or selecting your own scales, it is recommended that you have an odd-numbered scale with a neutral option.

On the respondent side, having a neutral or midpoint option reduces stress related to deciding whether to go with either a positive or a negative option. Experience has shown that in self-administered surveys, such pressure may result in questions not being answered. Several studies point to potential bias associated with an even scale as respondents who may be genuinely neutral are forced to choose either a positive or negative answer.[34] Finally, even if the majority of responses center around the neutral option, this information is still considered insightful and useful for project management.

In terms of the number of response options used in a scale, there is no right or wrong approach. The relevant literature suggests that more options help ensure more nuanced opinions and enable better distinguishing of extreme opinions.[35] In CRS' experience and for the purpose of generating data for evidence-based project management, for parent self-reporting, a scale of five may be most appropriate as it offers sufficiently nuanced ratings. For children, experience shows that scales with three answers are easier to understand, especially if—in the case of younger children—the scale is accompanied by a visual representation of possible options.

32. Multidimensional Students Life Satisfaction Scale (MSLSS) (Huebner).
33. FluidSurveys University 2014.
34. Bradburn et al 2004.
35. Ibid.

Here is an example of a child-friendly scale for younger children.[36]



It is recommended that descriptive scale options are used rather than numbers, as ratings from 1 to 5 may have different meanings for different respondents (e.g. 2 may be considered as "failing" or nearly "passing" in different contexts). Furthermore, when providing descriptive categories, make sure there is a clear difference between options. For example, "slightly agree" and "somewhat agree" may offer very little difference among possible responses. Finally, avoid using too nuanced response options if your analysis plan indicates that you would lump all these ratings together (e.g. somewhat agree, agree and strongly agree will be combined under the "agree" category).

Use descriptive scale options rather than numbers, as ratings from 1 to 5 may have different meanings for different respondents.

Scales in mirrored parent and child questionnaires

It is always recommended that you use two data sources to measure child well-being. If you decide to use parents and children, best practice is to use the same, or mirrored, statements in both questionnaires, to ensure comparison across the same sub-components. But what about scales? In some cases, when children are of an appropriate age and development stage, it is possible to use the same scale. However, in cases where the targeted children are of a younger age, use of a different scale for the two questionnaires is more appropriate (with the child tool having a less nuanced scale). The comparison is a little more challenging in this case, especially if more nuanced response calculations are retained in the results of the parent questionnaire. The recommended approach is to combine nuanced responses to simplify the comparisons. For example, two positive options on a scale of 1 to 5 from the parent questionnaire should be categorized as a bulk "positive" to better correspond to responses learned through the child questionnaire that has only one "positive" option in a 3-point scale.

36. Child and Youth Resilience Measure

Modified multiple-choice questions Some quantitative tools include questions that offer multiple answers. These typically involve the description of a scenario followed by the question. According to testing results in several country programs in EMECA, these resonate well with children. The question is asked in an open way, and the enumerator has a pre-determined list of response options that were identified during the tool testing phase. But there is also an "other" option, giving children the opportunity to respond as they like. The benefit of this approach is that it is less leading. However, there is a higher risk of enumerators incorrectly categorizing the response. An example of such a question is:

What do you do when you face a problem?
Suggested scenario:

- For younger children (6–10): "*Imagine a friend or sibling takes your favorite toy.*"
- For older children (11+): "*Imagine you have a fight with one of your friends.*"

(Enumerator: Please circle all responses mentioned by child)

- Ask someone for help
- Talk to them
- Try to solve the problem myself
- Do nothing
- Get upset (cry)
- Get violent (hit, kick)
- Apologize
- Other (please describe)

When deciding on possible response categories, follow similar principles as with choosing a scale, namely:

- Be sure to have an equal number of positive/desirable and negative/undesirable response categories.
- Be sure to have neutral options to avoid exerting pressure on the respondent to side with either positive or negative opinions.
- Add "other" so that new responses are not forced into a category.
- Avoid having too many choices. Remember, field-testing is the best way to ensure you have the appropriate number of choices in your final questionnaire.

Abstract concepts

Children may have difficulty conceptualizing and responding to abstract concepts. The more concrete the question is, the better. Using scenarios can be an effective way of measuring more abstract elements of psychosocial well-being. A promising practice is to use scenarios that put children in the first person with a real example (e.g. "When you are in X situation, what do you do?") rather than using a third person and/or overly hypothetical situations. These questions are easier for children to comprehend and respond to in a consistent and reliable way.

VI. Additional lessons learned and tips from the field

When designing the tool

Recall For time-bound/recall questions, it is better to use specific events as time markers such as "before coming to X location or CFS program" rather than asking questions based on a period of time such as "in the last month." Also, it is recommended that you use a shorter recall time as children often have difficulties looking back too far in the past.

Use a shorter recall time as children often have difficulties looking back too far in the past.

Additionally, many questionnaires targeting children specifically ask them to think about how they have felt in the previous 2 weeks or during the previous week, to provide an understanding of their current state of well-being. The assumption here is that such an approach will reduce potential bias and result in more reliable data, e.g. if you ask children about today, their perception might be heavily influenced by events that occurred on this particular day and may not give an accurate picture of their overall status.

Social desirability Response bias due to social desirability among children may affect responses. CRS experience has found that using emotion symbols such as sad and happy faces for children to select as their responses may unintentionally lead to them choosing the happy face regardless of how they actually feel about the question, in order to provide a socially desirable response (or because they just like the happy face better). Using responses, such as "yes" or "no", that are unlikely to trigger this type of bias, as well as conducting interviews in a less structured environment outside of the CFS venue or project location, may help alleviate some of this natural bias among children.

Using sad and happy faces in responses may unintentionally lead to children choosing the happy face regardless of how they actually feel.

Role-plays Field testing questionnaires first is a best MEAL practice for all programming, but is even more critical with children, given the greater potential for misunderstanding or different comprehension of the wording of questions. Staff can first test questions out loud on each other (especially those who work with children) to catch pitfalls before the field-testing stage. Do a role-play where one person is a child and puts themselves in the child's shoes to think about how they would respond or react.

Translation Many of the words and terms used in measuring changes in the psychosocial well-being of children may be difficult to translate into the local language; there may not be an exact word in the local language equivalent to the English word. A promising practice is to write questions in the local language first (not translate directly from English) and have a local technical advisor review the questions or statements before field testing the tools. For existing tools, always check to see if a local language version is available.

When administering surveys

Rapport Establishing a positive and friendly rapport with children is essential when conducting interviews. It may be helpful to start the survey with simple, friendly questions as a warm-up.

Drawing Giving children paper and crayons to draw freely while you administer the survey can also help them feel more comfortable.

Non-verbal communication The more at ease the child is, the more accurate and truthful their responses will be. Those collecting data should sit at eye level with the child and try to make them feel that they are having a natural conversation. They should convey a genuine interest in the child and their responses, rather than making them feel they are being interrogated.

Overcoming bias In order to minimize bias when program animators or teachers are collecting the data, consider having them work among children who they do not regularly support.

Convey a genuine interest in the child and their responses, rather than making them feel they are being interrogated.

Data analysis

This section presents some promising practices and tips for preparing for and doing quantitative data analysis based on experience of measuring child psychosocial well-being, particularly when creating new tools or adapting existing ones.[37] These tips apply to emergency rather than recovery projects.

Analysis helps transform data and other forms of evidence into usable information that supports interpretation.[38] Qualitative and quantitative data should be analyzed separately and then brought together during data interpretation. For more guidance on qualitative data analysis, please refer to CRS *Practical guide: Focus group discussions*.

It is good practice to prepare for data analysis before or as soon as the data collection commences in the field. Note that some preparatory work needs to be done even earlier. For example, scoring and weighting (see sections below) should be done at the time of the detailed development of the indicator(s) in the MEAL plan. Preparing for data analysis may include the following:

- Preparing databases for quantitative data
- Training staff on the data entry process
- Deciding on quality control measures, etc.[39]

37. If you are using an existing, validated tool, please follow the analysis guidance provided with that tool.
38. Data Interpretation should be done in a participatory manner, involving project and MEAL staff, as well as enumerators (or at least a few of them). Data interpretation is done in a workshop, usually referred to as a reflection event.
39. Light quality data check e.g. take every 10th form and check it against entered data. For more information on preparing a quantitative database, and data entry and cleaning, please refer to *Guidance on Monitoring and Evaluation*.

Quantitative data analysis is the process of turning raw numbers into meaningful data through the application of critical thinking.[40] In some cases—when questions entail descriptive rather than numerical data—the analysis also involves techniques for transforming data into numerical values. These are then subjected to statistical analysis which, for the purpose of emergency PSS programs, involves **summing up numbers** (i.e. *a total of 350 children regularly attended CFS*), **calculating percentages** (e.g. *75 percent of children reported making a new friend in a CFS*), **calculating averages** (e.g. *average rating of overall feeling of safety in the CFS was 3.8 out of 5*) and **calculating composite measures** (e.g. *average well-being score on the index measuring social and emotional components of psychosocial well-being was 3.5 out of 5*).

Scoring of statements with rating scale A critical preparatory activity is deciding how to treat responses that come through quantitative questions. This often entails deciding on a scoring process, i.e. assigning a specific value (e.g. 0, 1, 2, 3…) to each of the answer categories in statements in the data collection tool. The approach to scoring depends on the type of question. "Yes or no" questions are usually easy as each response is assigned either a one or a zero; however, statements with a rating scale or multiple choice questions may be more challenging.

For scale-based questions, assigning a value (e.g. 0, 1, 2, 3…) to each of the answer categories means that each scale option has a specific value or score that is summed up to a total maximum score. For example, for the statement:

- **"I try to be nice to others"** Not true | Somewhat true | True

We could assign the following values:

- **"Not true"** – assigned value "0"
- **"Somewhat true"** – assigned value "1"
- **"True"** – assigned value "2"

The maximum score for this question is 2. If your questionnaire has 5 questions with the same answer categories, the maximum score per child is 10. Also, it is important not to go through the scoring process in an "automatic" way as the phrasing of some statements may require that they are reverse coded e.g.:

- **"I worry a lot"** Not true | Somewhat true | True

For this statement, the coding would have to be reversed, with "true" being assigned the lowest value of 0, "somewhat true" as 1, and "not true" as 2, as the most positive option per project objective.

Scoring process: When and who?

It is best practice to decide on a scoring process at the time of MEAL plan development. Note that sometimes, once the actual tool is developed and questions/statements with corresponding options are clearly defined, the scoring process may be further refined. It is strongly recommended that you involve programming and MEAL staff in determining the scoring and calculation formulas.

40. Research Methodology. Quantitative Data Analysis.

Scoring of multiple-choice response options The scoring process for multiple-choice questions entails a similar value-assigning process, although the positive "desirable" options per project objective may be assigned the same value i.e. 2; neutral options, 0; and undesirable options, 1. For example:

Question from the tool:

- **"What do you do when you face a problem?"**

Suggested scenario:

- For younger children (6–10): "*Imagine a friend or sibling took your favorite toy.*"
- For older children (11 +): "*Imagine you had a fight with one of your friends.*"

(Enumerator: Please circle all responses mentioned by child.)

Assigned value	Response option
2	Ask someone for help
2	Talk to them
2	Try to solve the problem myself
1	Do nothing
0	Get upset
0	Get violent (hit, kick)
0	Apologize
Needs to be categorized and scored	Other (please describe)

It is up to you to decide on the choice of values and scoring.

Note: It is recommended that you use positive, absolute, progressive values (instead of negative and decimal values) as experience has shown that using values such as -1, 0 and 1 results in a very low overall score that makes it hard to spot substantial differences between different data collection periods (e.g., the differences become very minor e.g., 0.05).

Weighting It is possible to assign a specific weighting to each question so that one carries more importance than another. For example, the statement "*I try to be nice to other children*" may be assigned a higher value than "*I feel supported by my friends*". This may also simply happen through having more or different answer categories that result in some questions having a higher total value than others. In essence, this means that the first statement has a higher influence or weight in the total score. Try to avoid this, as weighting is not recommended in an emergency context.

Weighting questions is not recommended in an emergency context.

The assumption is that each of the psychosocial well-being components, and then the sub-components you chose when defining your indicator/focus of your activities, carries the same weight or importance in the overall psychosocial well-being measure.

Threshold value For indicators that use scoring, the question of a threshold or "cut-off" point is often asked: What is the threshold value for someone to qualify as having a "satisfactory" level of well-being? Is it indicated by a score of 5 or 10? Is it if they respond positively to 4 out of 5 questions? This dilemma often comes through the experience of measuring other technically similar indicators, such as percentage of project participants demonstrating satisfactory knowledge of a given topic, where we often have a clear cut-off point for someone to qualify as having "satisfactory" or "passing grade" knowledge e.g. responding correctly to 60 percent of questions in a knowledge test.

Since psychosocial well-being is such a personal concept, and there is not much evidence of what constitutes a cut-off point in the emergency context, in this early phase, it is recommended that you take an approach focusing on relative values pertaining to one data collection effort or comparisons of values between data collection efforts.

For example, let's assume that the maximum score a child can get is 10 (e.g. 5 questions, each with a maximum score of 2, and thus 5 x 2 = 10). After baseline data collection, you may calculate the average score across all children. You may choose to calculate the percentage of children that fall into different categories, e.g. percentage of children that fall into a range of below average, above average, etc. In this particular case, for the indicator "percentage of respondents reporting improved psychosocial well-being", "improved" is defined as "above average". The other approach, often applied in CPs, is to calculate the average score and compare it with a baseline value to determine percentage of change.

Since psychosocial well-being is such a personal concept, and there is not much evidence of what constitutes a cut-off point in the emergency context, it is recommended that you take an approach focusing on relative values pertaining to one data collection effort or comparisons of values between data collection efforts.

Promising practices for calculations during data analysis

Deeper analysis from several perspectives tested so far, and proven to be helpful, include:

- Calculating the average score at baseline and endline and comparing the two to check if the average score increased, thus reflecting the desired direction of change (improvement)
- Calculating the percentage of children (and/or other data sources) who reported highest/middle/lowest overall score and comparing this percentage at baseline and endline; highest/middle/lowest point determined relative to the highest score in each separate data collection effort
- Breaking down the overall average score into average score per psychosocial well-being sub-component
- Comparing average sub-component scores among different data sources

In terms of reporting to a donor, projects have typically chosen percentage of children (or caregivers) reporting the highest score. It is up to you to define your indicator and calculations for reporting purposes that best suit your project objective and context. However, it is critical to determine this analysis approach in advance to avoid potential retrofitting of the results that may present data in a better or worse light.

It is critical to determine the analysis approach in advance to avoid potential retrofitting of the results that may present data in a better or worse light.

Overall score versus score per sub-component During the analysis process, it is advisable to calculate a score for each well-being sub-component included in your indicator definition. Note that a calculation of score per component (emotional, social, ability to cope) has not proved to be useful, since the components are too broad to offer significant input into project evidence-based decision making. You do not have to report this detailed analysis to the donor; however, it may greatly inform your project strategies and overall project management. Such an approach enables you to understand which of the well-being sub-components have the lowest/highest values, where the children experienced most/least improvement, etc. (e.g., we may see that children have increased their number of friends but have not improved at being nice to or accepting of others who are different.) The PSS activities are organized in such a way that they affect a specific sub-component of well-being within the broader component. Knowing at baseline which sub-component has the lowest score helps determine the focus or emphasis of future activities. Teasing out the total score at endline may help you understand which of the sub-components were most affected by your project and/or if additional qualitative data collection is needed to learn why this is the case.

Also, if some of the sub-components were not expected to be affected by your project, yet you listed them as assumptions during project design and therefore added them to the data collection tool, the calculation of the score per dimension allows you to monitor if your assumptions were correct. For example, you may assume that children displaced by conflict who have already found refuge in host countries do not experience great levels of fear for their safety, and therefore during the endline analysis you would expect no change in a total score for this sub-component.

VII. Frequently asked questions

1. When in the program cycle should we measure well-being, how often and with what recall interval?

If you choose a quantitative method, it is very important that the baseline is taken either ***before*** the child attends the CFS or child PSS project or within the first week of the child attending. Based on the psychosocial theory, as well as from our experience in the field, many children will start showing marked improvement in their well-being within the first few weeks of attending the CFS. Conducting the baseline later risks not being able to demonstrate the full impact of the project on the child's well-being and may give a false impression of the state of a child's well-being at the outset of the project.

The endline should be conducted once the children are no longer involved with the project. In an emergency context, the time span between baseline and endline may be as short as 3 months, hence no interim data collection is recommended for measuring changes in psychosocial well-being. Note that the end of their involvement in the PSS project may not necessarily coincide with the actual end of the project as a whole. If you have multiple cohorts of children, you should be sure to conduct the endline before the children leave the project and potentially move away from the location of the project. This is especially important for highly transient populations.

2. What do we do if we did not have time to do a baseline measurement because we were overwhelmed with responding to the emergency?

In this scenario, you could conduct a retroactive impact evaluation. It would focus on asking the parents, animators and children how the children's well-being had changed since they began participating in the CFS or other child PSS project; that is, you ask caregivers or animators to recall how the children behaved before they joined the project, and compare this to how they are today.

Note that retroactive, quantitative self-evaluations with children themselves do not generally give reliable results and should be avoided if possible. Field experience has shown that emergency-affected children may find it difficult to recall their social and emotional status within distinct timeframes. Also, adults may exhibit recall bias, causing them to report either a better or worse situation than it was in reality. In this case, qualitative methods such as FGDs or individual interviews with children and/or parents are more feasible.

3. Why can't we just measure happiness?

Well-being measures that focus mainly on happiness and satisfaction fail to capture the multifaceted nature of well-being. Well-being emerges as a result of a dynamic interaction of many different factors.[41] It is necessary, therefore, to ask questions that cover a range of subjective dimensions that go beyond just a feeling good to functioning well.[42] Measuring the more holistic construct of well-being allows us:

41. In child PSS programs, CRS EMECA uses a child-in-environment conceptual framework rooted in Bronfenbrenner's Ecological Systems Theory (The Psychology Notes HQ, 2013)
42. *A guide to measuring children's wellbeing* (NEF 2009).

- ✓ To understand how our projects impact different gender, nationality and age groups.
- ✓ To adjust our programming and make it more relevant to different groups of children (e.g. the evaluation might show that some sub-components are more important in some age-groups than others). Essentially, we need to understand what works and why, and we need evidence for that.
- ✓ To understand which sub-components of well-being our projects are able to influence and to what degree (e.g. one outcome may be that we were able to influence self-esteem to a high degree but were not able to improve problem-solving skills to the same degree).
- ✓ To understand how the different sub-components of well-being interact with each other and how an increase in one area might contribute to improvement in another (e.g. could strong and positive peer relationships have the greatest influence on high self-esteem? Or would this only be valid for some groups of children? Which groups?)

4. How can we use this guidance when developing PSS proposals for OFDA funding? How can it help with the OFDA required indicators?

OFDA recently updated its guidance for proposal design, specifying required indicators for each sector and associated sub-sectors.[43] PSS proposals typically fit into the Protection sector, potentially addressing sub-sectors of Psychosocial Services and/or Child Protection.

Psychosocial services There is only one OFDA-required indicator for the sub-sector Psychosocial Services: "*Number of individuals participating in psychosocial support services.*" This is measured by counting the number of participants in PSS activities. Be sure to specify what "participating" means in your indicator definition (e.g. does it mean that a child attending one PSS activity counts as a participant? Or does participation mean attending a certain number, or percentage, of activities?). There is no higher-level (e.g. outcome or impact) required indicator for this sub-sector. Therefore, CPs can use this guidance to determine their own strategic objective indicators, definitions, data sources and methodologies.

Child protection The guidelines specify the following indicators as required in this sub-sector:

- Number of individuals participating in child protection services
- Number of dollars allocated to child protection programming
- Percentage of targeted children reporting an improvement in their sense of safety and well-being at the close of the program

The first two indicators are straightforward, with a caveat that you will need to define the term "participating", as in the indicator for psychosocial services mentioned above. For the percentage indicator, this guidance can be used to help define well-being. OFDA PIRS for this specific indicator suggest a sense of well-being being defined as: "*a general sense of comfort, trust, health, mental/psychosocial stability and functionality, and freedom from abuse, neglect, exploitation, or violence*", which intersect with the well-being components presented in this guidance. As suggested by OFDA, the final definition needs to be validated with local communities. This guidance can help with deciding on appropriate—and, if needed, child-friendly—data collection methods for this local validation process, as well as designing a tool to be used in this process. Even though the local validation process would most likely include qualitative data collection methods and tools, the well-being dimensions and quantitative questions can inform this effort. Furthermore, the guidance may help put into practice the OFDA recommendations on data collection methods, which include tools with psychometric scales, observation and/or children narratives. *Note: For all OFDA indicators, age categories need to be adjusted according to OFDA desegregation requirements for children, namely: under 5; 5–9; 10–14; 15–19.*

43. OFDA Guidelines (May 2018)

5. Do we need to collect data from all the children that were enrolled in the CFS or school? Do we need to find the same children we interviewed at baseline to repeat the measurement at endline? If we don't use the same children, we will not be able to track individual progress.

As circumstances allow, it is advisable at baseline to take a representative random sample of children in your program, or of other respondents (e.g. caregivers), and then another representative random sample at endline. These do not have to be made up of the same respondents. The assumption here relates to a principle of random sampling: if a sample is truly random, then it will be representative of all population members with the same characteristics. Note that in emergencies, random sampling takes a much "lighter" form e.g. with a higher margin of error, a more relaxed approach to identifying individual respondents, etc. Remember, the primary purpose is to get information that is "good enough" for project management purposes.

Finally, the purpose of the MEAL system is not to track individual cases, but to gauge information about overall project progress or impact. The MEAL system should not be the primary way of identifying any potentially alarming individual issues among children, i.e. decrease in score, severely alarming responses to some of the questions. If such cases do exist, animators and caregivers should be able to pick up on them in a much more timely and appropriate manner.

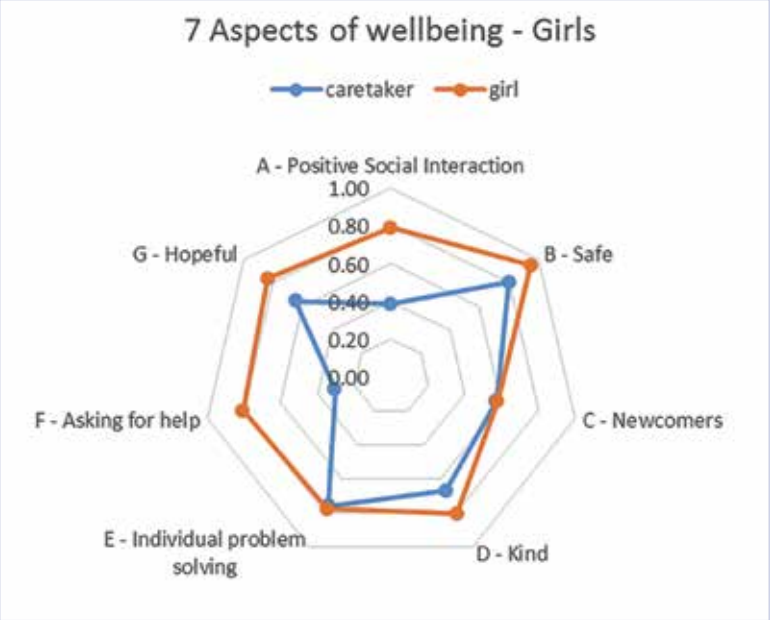
6. What do we do when we have missing responses in the questionnaires? Do we dismiss all data coming from these questionnaires?

In emergencies, dismissing any data is often an unaffordable luxury. Research principles and statistical significance take a back seat on account of the context and situation. Try to salvage and use as much information as possible. Ensure you use an appropriate total number of respondents when calculating percentages and averages, even if this means using a different number as denominator each time. Be sure to report these differences accurately. If there is missing data in self-assessment questionnaires, consider alternative data collection methods e.g. sending enumerators into the field and switching to face-to-face administration of the questionnaire. If responses were missing from one or two questions, discuss during the daily debrief other ways of asking the same question. It is important to identify these issues early in the data collection process, during daily debriefs. If however, you were unable to deploy any corrective procedures, and your self-assessment questionnaires are missing responses to some questions, calculate the indicators with data you were able to obtain and perform other analysis as defined in your analysis plan. Consider additional field work, e.g. perhaps qualitative methods to validate the findings. In general, if 30 percent[44] or more of the questionnaires did not have a response for one of the questions, this is considered a breaking point and the information for those questions may give you a false understanding of the situation.

7. How do we score responses if we collected data from several data sources? How do we triangulate? How do we calculate the indicator?

It is recommended that data is collected from several sources. This is mainly done for learning purposes, to ensure comparison across data sources and to validate your findings or, in other words, to conduct data triangulation. Perspectives from children, parents and/or animators may highlight different types of changes, both behavioral and emotional. To support a review of these different perspectives and data interpretation, the use of a "Spider Chart" (see below) is recommended.[45]

44. CRS Emergency Toolkit: Quantitative Data Analysis.
45. Taken from *Education and Protection for Displaced Children in Northern Iraq*. 2016. Funded by the Bureau of Population, Refugees, and Migration - US Department of State.



In these cases, it is not advisable to come up with a calculation of the overall score across all data sources but rather to choose one source for calculation of the indicator for reporting purposes. Note that whatever data source you chose for the baseline will also have to be used for the endline.

8. What should we do if our emergency child PSS program is extended into a new phase and we need to conduct a new baseline, but some of the same children are participating again? Do we have to create a new well-being tool?

You will definitely need to adjust your well-being tool and align it with the new objectives and curriculum. If the new program, for example, specifically works on life skills or has a strong community engagement/social cohesion element, you will need to ensure that these new elements are added to the tool.

- If many but not all children are continuing, disaggregate by time spent in the program or target only new children for the baseline. Be sure to include a question on when a child started participating as this is critical for accurate disaggregation.
- If the program has changed (is no longer a CFS but now has a social integration or life skills focus), then it is not technically a continuation and a new baseline would focus on the new components of the project.

9. What should we do if we do not have staff with the competence to collect information directly from children?

In addition to complying with and understanding all child safeguarding and ethical requirements, any staff responsible for collecting data directly from children should have the background/experience to work with children, or have been trained to do so. If for any reason this is not feasible in your context, you should not collect data from children. In this case, you should consider using alternative data sources such as parents/caregivers or animators/teachers and/or others who may be privy to a child's progress. The well-being and safety of the child overrides anything else, including commitments to donors. No donor would want you to collect data from children if this could potentially harm their well-being.

10. What kind of disaggregation (or comparison groups) should we have in the data analysis?

At a minimum, the comparison groups need to include gender, age, location and, in the case of a CFS project, the name of the CFS. The project may have additional comparison groups depending on its purpose (e.g. nationality; vulnerability categories, such as unaccompanied minors, working children and children with disabilities; parents' status (IDP or host); etc.). A decision on the comparison groups needs to be made at the time of MEAL plan development, planning for analysis or, at the latest, at the time of tool development. This information becomes part of the demographics section of the data collection tool. Also note that comparison of data across different disaggregation categories should always be done and, even though it may not carry statistical significance, it may signal a problem that we might wish to further explore through additional data collection.

11. Who should be involved in data analysis and interpretation?

Data analysis including calculations is done by one or several selected staff, usually MEAL staff in CPs. However, data interpretation and the process of attaching meaning to the data has to be done in a participatory manner at the reflection event, engaging all key programming staff.

12. How do we treat "red flags" discovered during data collection or analysis?

Previous experience has shown that some of the responses to well-being questionnaires can show alarmingly low levels of well-being, with responses to open questions indicating severe mental distress (e.g. suicidal thoughts or suicide attempts, self-harm, etc.). Such cases, according to the CRS Protection Policy, need to be identified and addressed immediately during data collection, rather than flagged during data analysis. This is a critical element to include in enumerator training.

13. What should we do if our baseline seems unusually high?

There are several reasons why this could be a case. In many cases, the baseline was taken too late, when children had already spent some time in the child friendly spaces. If your baseline is appropriately timed and baseline values remain high, it is recommended that you tease out the analysis and review the average scores per sub-component of well-being. It is of utmost importance to have clear links between project activities and the sub-components we are measuring. The only exceptions are critical assumptions, which we may want to monitor (e.g. child's fear for their safety outside the CFS) and therefore include in the tool, even though we have no project activities that influence those assumptions. This work ought to be done at the time of tool development as no sub-component should be included in the tool unless there is a clear reason for doing so. Finally, be sure to set realistic targets; given the type of work we do, the duration of projects and the context, these may not include significant increases in the numbers. Remember, any positive change is a good change!

Annex 1: How validated tools measure the sub-components of child psychosocial well-being

There are many existing, validated tools that measure children's well-being. Each tool measures certain sub-components of psychosocial well-being and these can be categorized according to the three overarching components (emotional well-being, social well-being and ability to cope) discussed in Chapter II. The table below provides a more comprehensive list of well-being sub-components within each component as well as sample statements from existing tools categorized according to sub-components.

The table provides a comprehensive list of well-being sub-components as well as sample statements from existing tools.

Please note that in some tools one statement may cut across two different sub-components. The table does not account for these nuances; rather it aims to provide a general overview of the type of statements and what they intend to measure. Additionally, be aware that the statements may target different age-groups. Some tools are applicable only for adolescents. Please refer to Annex 2, where all the tools are explained in detail, including the targeted age-group.

Component: Emotional well-being

Sub-component	Description	Sample statements for self-assessments
Self-esteem (also referred to as self-worth or self-confidence)	Child has confidence in their own worth or abilities	• Overall, I have a lot to be proud of (Marsh/NPC) • When I do something, I do it well (NPC) • I do things as well as most people (Marsh/NPC) • I have been feeling confident (WEMWBS) • I have been feeling good about myself (WEMWBS/NEF) • I am aware of my own strength (CYRM) • I can't do anything right (NPC)
Positive feelings	Feelings are defined as the state of a person's emotions	• I felt happy / I have been in a good mood (NEF/Kidscreen) • I had fun (Kidscreen) • I have been feeling relaxed (WEMWBS/NEF) • I have been interested in new things (WEMWBS) • I have been dealing with problems well (WEMWBS/NEF)
Emotional problems (also referred to as negative feelings)	Child is worried, nervous, unhappy, etc.	• I feel under pressure (Kidscreen) • I felt so bad I didn't want to do anything (Kidscreen) • I worry a lot (SDQ/NPC/Marsh) • I kept waking up at night / My sleep was restless (NEF)
Behavioral problems	Child has behavioral issues such as throwing tantrums, disobedience, etc.	• I get angry and lose my temper (SDQ) • I fight with other children (SDQ adjusted) • I usually do as I am told (SDQ) • I keep waking up at night
Hyperactivity	Child is restless, distracted, cannot think before taking a decision, is fidgeting often	• I have been thinking clearly (e.g., at school) (NEF) • I am easily distracted and find it difficult to concentrate (SDQ) • I am constantly fidgeting or squirming (SDQ) • I think before I do things (SDQ)
Hopefulness/ optimism	Child is hopeful and optimistic when thinking about achieving their goals and about life in general. Child has ability to remain positive.	• I think I am doing pretty well (Hope Scale) • I am doing just as well as other kids my age (Hope Scale) • I have been feeling optimistic about the future (WEMWBS) • I think the things I have done in the past will help me in the future (Wagnild) • I usually find something to laugh about (Wagnild)
Vitality	Child feels energetic, not lethargic	• I had lots of energy / I felt energized (NEF/Kidscreen) • I felt tired (NEF) • I felt everything I did was/took an effort (NEF) • I have been physically active (Kidscreen)
Autonomy	Child feels able to control certain aspects of their life	• I am free to decide / I am involved in decisions that affect my life • I am allowed to make up my own mind about things • I've had enough time for myself (Kidscreen) • I've been able to choose what to do in my free time (Kidscreen)

Component: Social well-being

Sub-component	Description	Sample statements for self-assessments
Social relationships (overall)	Child's behavior toward others	• I help other children when they have difficulties (SDQ) • I am helpful if someone is hurt, upset or feeling sick (SDQ) • I often help others (SDQ) • I am kind to younger children (SDQ)
	Child feels supported by people in their life	• There are people in my life who really care about me (NEF) • I have people in my life who help me solve problems (Unicef 2009)* • I have had someone help me when I needed it (SCI Lebanon) • I have been feeling loved (WEMWBS)
Relationships with peers	Number of friends	• I have one good friend or more (SDQ) • I have enough friends (MSLSS) • I have friends to play with (NEF)
	Child's ability to make friends	• It is difficult to make friends (Marsh) • I make friends easily (Marsh) • I have made new friends in the community
	Peer problems: children being bullied or excluded	• Other children bully me / make of fun of me / are mean to me (SDQ/Kidscreen/MSLSS) • I am afraid of other children • I do not get along very well with boys/girls my age (Marsh)
	Positive peer relationship / Peer support	• My friends are nice to me (MSLSS) • My friends will help me if I need it (MSLSS/NPC) • My friends stand by me during difficult times (CYRM) • I am able to talk with my friends about everything (Kidscreen) • Me and my friend help each other out (Kidscreen)
Family relationships	Child's satisfaction with family relationships	• I like spending time with my family (MSLSS/NPC) • My parents and I do fun things together (MSLSS/NPC) • My family gets along well together (MSLS/NPC) • Members of my family talk nicely to one another (MSLSS)
	Psychological caregiving: Child feels understood and supported by their parents	• My parents understand me (Marsh) • My parents know a lot about me (CYRM) • My parents help me to solve problems • I talk to my family about how I feel (CYRM) • I share my problems with my family (RSEA) • We overcome difficulties in the family together (RSEA)
	Physical caregiving	• My parents watch me closely / My parents know where I am and what I am doing all of the time (CYRM) • My family gives me responsibilities that I can handle (RSEA)

* Adjusted from a Unicef indicator: Increase in the number of people that go for help to solve their problem as reported by children.

Sub-component	Description	Sample statements for self-assessments
Availability of trusted adults to provide support to the child (e.g. animators, teachers)	Child has trusted adults available to support them, that they look up to and can go to for help if needed. These adults can provide support and guidance, and have high expectations for the child.	• I have people I look up to / want to be like (CYRM) • My teacher appreciates me (RSEA) • The CFS facilitator listens to me and respects my opinion (SCD) • I get along with my teachers (Kidscreen) • Outside of my home and school, there is an adult who really cares about me / whom I trust. • Outside of my home and school, there is an adult who tells me when I do a good job / who always wants me to do my best (Healthy Kids)
School environment **(Could be adapted to child friendly space)**	School environment: Child feels safe and has a sense of belonging	• I feel I belong at my school (CYRM) • I fit in with other children at school (CYRM) • I like being in school / I am happy at school (MSLSS/NPC) • I feel safe at school (NPC) • I feel bad at school (MSLSS) • There are many things about school I don't like* (MSLSS) • I have been picked on/bullied at the CFS (SC Denmark)
	Learning	• I enjoy school activities (MSLSS/NPC) • I learn a lot at school (MSLSS/) • School is interesting (MSLSS/NPC)
Community environment	General environment and satisfaction	• I like my neighborhood (MSLSS) • I like my neighbors (MSLSS) • I feel positive about the community I live in (SCI Lebanon) • My community is filled with mean (good) people (MSLSS)
	Participation in community activities	• I enjoy my community's traditions/activities (CYRM) • I attend activities organized in my community (NEF) • I have participated in community activities that made me happy (SCI Lebanon)
	Perception of social cohesion and sense of belonging	• People in my community help one another (NEF) • I like how people in my community treat each other • I feel like I belong to my community/neighborhood (NEF) • I am treated fairly in my community (CYRM) • Adults in my area treat young people fairly (NPC) • I think it's important to serve my community (CYRM)

Component: Ability to cope / resilience

Sub-component	Description	Sample statements for self-assessments
Resilience	Overall	• Even when others want to quit, I know I can find ways to solve the problem (Hope) • When I have a problem, I can come up with lots of ways to solve it (Hope) • I usually manage one way or another (Wagnild/NPC)
	Self-acceptance / self-perception / self-reliance	• It's ok if there are people who don't like me (Wagnild) • I am happy with the way I am (Kidscreen) • I am friends with myself (Wagnild) • My belief in myself gets me through hard times (Wagnild)
	Perseverance	• I am determined (Wagnild) • When I make plans, I follow through with them (Wagnild) • I have self-discipline (Wagnild) • I keep interested in things that are important to me (Wagnild)
	Aspirations/Goals	• I have goals and plans for the future (Healthy Kids)
Personal skills	✓ Self-awareness ✓ Problem solving ✓ Communication Skills	• I understand my moods and feelings (Healthy Kids) • I understand why I do what I do (Healthy Kids) • When I need help, I find someone to talk to (Healthy Kids) • I have been able to find friendly ways to solve disputes between me and other children (SCI Lebanon) • I am able to solve problems without harming myself or others (for example, by not using drugs and/or being violent) (CYRM) • I stand up for myself without putting others down. (Healthy Kids)
Social skills	✓ Help-seeking ✓ Empathy ✓ Pro-social behavior	• I know where to go in my community to get help (CYRM) • I know how to behave in different social situations (CYRM) • I try to understand what other people go through (Healthy Kids) • I try to understand how other people feel and think (Healthy Kids)
Other	Opportunities	• I have opportunities to develop skills that will be useful later in life (CYRM)

This table represents only a few examples of the type of statements included in existing tools for resilience-focused and life skills programs for children and youth.

Annex 2: Child self-assessment tools that measure child psychosocial well-being

Name of tool	Description	Sub-components of well-being measured	Notes
Children's Hope Scale (Page 21) Author: Snyder	A six-item dispositional self-report index designed for **children aged 8–16 years** Underlying theory: The importance of goals in guiding the lives of children has gained attention in the last two decades. The model and accompanying measurement of hope are based on the premise that children are goal-directed, and that their goal-related thoughts can be understood according to two interrelated components: pathways and agency.	• Measures whether children are hopeful when thinking about achieving their goals. • Looks at two aspects based on the definition of hope that was used: Children's hope is defined as a cognitive set involving beliefs in one's capabilities to produce workable routes to goals (the pathways component), as well as the self-related beliefs about initiating and sustaining movement toward those goals (the agency component).	• Compared to the Hopelessness Scale for Children (Snyder 2003), that was developed and validated as a reflection of negative expectancies toward oneself and the future, the Children's Hope Scale was conceptualized in terms of positive expectancies (hence only positive statements are used in the questionnaire). • Takes, on average, 4 minutes to complete. There is also a modified parent-report version available for use. • This tool is not copyrighted and is free to use.
SDQ (Strengths and Difficulties Questionnaire) Author: Goodman	• The SDQ is a brief behavioral screening questionnaire. • Mental health clinics use the SDQ as part of an initial assessment. • "Before" and "after" SDQs can be used to evaluate specific interventions (e.g. parenting groups) by mental health services, and other specialist services for children with emotional and behavioral difficulties. • Includes questionnaires for parents and self-assessments for adolescents (11–17 years) • The self-assessment questionnaire for adolescents has 25 questions. **Questionnaires available** • SDQ for parents or educators of children aged 2–4 years • SDQ for parents or teachers of children aged 4–10 years • SDQ for parents or teachers of children/ youth aged 11–17 years • Self-rated SDQ for children/youth aged 11–17 years	• **Emotional symptoms/problems** (worries, headaches, unhappiness, nervousness, fear) • **Conduct problem scale** (tantrums, disobedience, fighting, lying, stealing) • **Hyperactivity** (restlessness, distraction, not thinking before acting, fidgeting) • **Peer problems** (is bullied, is liked by other children, plays alone, likes adults better than children) • **Pro-social scale** (shares with others, is helpful to others, is considerate of others, is kind to younger children, volunteers to help others)	• Only measures/analyzes children's behavior; it does not capture how they feel.* • Analyzes behavior and symptoms of children (e.g. questions focus on how the child behaves or the symptoms they have, not how they feel: e.g. I am restless, I fight a lot, I share with others, I take things that are not mine, etc.). • Does not measure the quality of peer relationships or whether the child is happy/ satisfied with those relationships. • Does not look into child's relationship with parents, adults or community. • The tool is available in more than 70 languages. • The tool is copyrighted and the documents that may not be modified in any way. Paper versions may be downloaded and subsequently photocopied without charge for non-commercial purposes.

* *Feelings count: Measuring children's subjective well-being for charities and funders* (Nevill 2009).

Name of tool	Description	Sub-components of well-being measured	Notes
Resilience Scale Authors: Wagnild and Young	• Resilience, as used in this tool, is defined as the capacity to successfully maintain or regain mental health and well-being in the face of significant adversity or risk. Resilience is an ability to adapt successfully to adversities in life. • The Resilience Scale was developed based on research results that identified five underlying characteristics of resilience: a purposeful life, perseverance, equanimity, self-reliance and existential aloneness. • The original version has 25 questions and the short version, 14 questions (RS 14). • **Suitable for adolescents 13 years +**	Overall, it measures the five underlying characteristics of resilience (according to Wagnild's theory): • **Purposeful/meaningful life**: Having a sense of one's own meaning or purpose in life • **Perseverance** • **Equanimity**: Ability to remain calm in stressful situations and remain positive/ optimistic. • **Self-reliance**: Reliance on one's personal strength and experiences. Ability to continuously learn from experiences and develop ***problem-solving skills*** • **Self-acceptance** (Self-love, referred to by Wagnild as "existential aloneness")	• The scale focuses on individual dispositional attitudes and does not include any of the other social categories of resilience (family support /cohesion and external support systems). • Has been used with a variety of individuals of different ages, and socioeconomic and educational backgrounds. • Has performed as a reliable and valid tool to measure resilience and has been used with a wide range of study populations. • A licence must be purchased for use.
CYRM (The Child and Youth Resilience Measure) Author: Resilience Research Centre (Michael Ungar)	• The CYRM is a measure of the factors (individual, relational, communal and cultural) available to individuals, which may increase their resilience. • Originally designed to be used with **youth aged 9–23 years**. Since its initial validation, the measure has also been adapted into a 26-item version for use with **children aged 5–9 years** • There are questionnaires for children, adolescents and parents. • The CYRM was established through a process of interviews with youth and adults in countries around the world. Reflection on what obstacles youth confront, as well as possible resources called upon to navigate through and/or around these obstacles, resulted in the original 58-item version. The instrument was piloted with 1,451 youth from 14 communities in 11 countries. This enabled it to be reduced to a 28-item version (26 items for the child version) and further to a 12-item version.	CYRM has three sub-scales: **1. Individual capacities/resources** • Personal skills • Peer support/relationships • Social skills **2. Relationships with primary caregivers** • Physical caregiving • Psychological caregiving **3. Contextual factors that facilitate a sense of belonging** • Spiritual • Education • Cultural/community Resilience is defined as: 1) The capacity of individuals to navigate their way to resources that sustain well-being; 2) The capacity of individuals' physical and social ecologies to provide those resources; and 3) The capacity of individuals, their families and their communities to negotiate culturally meaningful ways to share resources.	• Has acceptable psychometric properties and is one of the only measures to look at resilience across cultures. • Contains items that are both consistent across cultures and unique to specific cultures, allowing for the introduction of culturally specific items. • Available free for researchers, academics and frontline staff. CYRM requests that a short survey is filled out so they know how the tool is being used. Once you fill out the survey, you will gain access to the password-protected tool.

Name of tool	Description	Sub-components of well-being measured	Notes
Multidimensional Students Life Satisfaction Scale (MSLSS) Author: Huebner	• The MSLSS was designed to provide a multidimensional profile of children's life satisfaction judgments. Such differentiated assessments are expected to enable more focused diagnostic, prevention and intervention efforts. • Specifically, the MSLSS was designed to (a) provide a profile of children's satisfaction with important, specific domains (e.g., school, family, friends) in their lives; and (b) assess their general overall life satisfaction. • **For children aged 8-18 years**	• **Self-esteem and self-acceptance** • **Friends**: The child's satisfaction with the quality and quantity of friendships both in and out of school. • **Family**: The child's satisfaction with the quality and quantity of time spent with parents, and how well the family gets along. • **Schools**: The child's satisfaction with the school environment, including how enjoyable and interesting it is, and how safe it feels. • **Living environments:** The child's satisfaction with their local area and the people in the community, as well as feelings of safety and satisfaction with local activities.	• Has not been tested widely beyond the United States; further studies are necessary to determine the cross-cultural validity of the scale. • Focuses on the positive aspects of an individual's well-being. • Is in the public domain and may be used without permission.
Marsh Self-Description Questionnaire Authors: Marsh et al.	The Self-Description Questionnaires (SDQ I & II) have been used in various versions internationally for decades. The SDQ I is a 76-item self-report inventory that is designed to provide a multidimensional measure of self-concept for **children and preadolescents (aged 8–12 years)**. The SDQ II is a companion 102-item instrument designed for use with **adolescents (aged 13–17 years)**.	It measures a school child's evaluation of the following aspects of their own worth/well-being: • Relationships with peers • Relationships with parents • Emotional stability and well-being • Self-esteem and self-acceptance • Honesty/trustworthiness • Physical abilities and involvement in physical activities • Satisfaction with physical appearance • Academic skills and performance	• Has been used extensively in different international contexts and has been translated into many languages. • Comprehensive and solid measure of multi-dimensional (holistic) self-concept.
Well-being measure Author: New Philanthropy Capital UK	• NPC researched well-being, and supported schools, charities and other organizations in the UK to measure their soft outcomes—such as how they improve self-esteem. • Helps NGOs quantify the difference they make in the lives of the children they support. • Ideal age-group: **11–16 years (but based on context, 10–17 years might be possible)**. • 8,000 young people surveyed from over 100 schools and charities	The tool measures eight key aspects of well-being: • Self-esteem • Emotional well-being (worry, fear, etc.) • Resilience • Family relationships • Friend/peer relationships • Satisfaction with school environment (feeling safe at school, enjoying school and its activities) • Satisfaction with community environment • Overall well-being	• Well-rounded tools that looks at well-being holistically. • Developed after analyzing most of the abovementioned tools (you will see some questions/statements that were adjusted from other tools). • Has only been used in a UK context. • The measurement tool is available in paper form (and listed below), and anyone is free to use it within their work, use existing survey tools to deploy it online, and build on it.

Name of tool	Description	Sub-components of well-being measured	Notes
Kidscreen 52 Author: European Commission	• The Kidscreen instruments assess children's and adolescents' subjective health and well-being (health-related quality of life, HRQOL). It was developed as a self-report measure applicable to healthy and chronically ill children and adolescents aged 8–18 years. The Kidscreen project used a simultaneous approach to include 13 European countries in the cross-cultural harmonization and development of the measure. • **For children and adolescents aged 8–18 years** There are 3 questionnaires: • Kidscreen-52 (52 questions) • Kidscreen-27 (27 questions) • Kidscreen-10 (10 questions)	The Kidscreen-52 instrument measures 10 well-being dimensions: • **Physical well-being**: Explores the level of the child's/adolescent's physical activity, energy and fitness • **Psychological well-being**: Examines the psychological well-being of the child/adolescent, including positive emotions and satisfaction with life • **Moods and emotions**: Covers how much the child/adolescent experiences depressive moods and emotions, and stressful feelings • **Self-perception**: Explores whether respondents perceive their bodily appearance positively or negatively; body image is explored by questions concerning satisfaction with looks as well as with clothes and other personal accessories • **Autonomy**: Looks at the respondents' opportunities to create social and leisure time • **Parent relations and home life**: Examines relationships with parents and the atmosphere at home • **Social support and peers**: Examines the nature of the respondents' relationships with other children/adolescents • **School environment**: Explores the child's/adolescent's perceptions of their cognitive capacity, learning and concentration, and their feelings about school • **Social acceptance** (bullying): Covers feeling rejected by peers in school • **Financial resources**: Assesses the respondents' perceptions of their financial resources	• Was tested across 13 European countries in a participatory way. • Is free to use, but you must register and sign a collaboration form to access it.

Name of tool	Description	Sub-components of well-being measured	Notes
Warwick-Edinburgh Mental Well-being scale (WEMWBS) Author: Warwick Medical School (UK)	• Developed to enable the monitoring of mental well-being in the general population and the evaluation of projects, programs and policies that aim to improve mental well-being. • A 14-item scale with 5 response categories, summed to provide a single score ranging from 14 to 70. The items are all worded positively and cover both feeling and functioning aspects of mental well-being. • Not a clinical tool and was not designed as a screening instrument to detect mental illness and is not recommended for use in this context. However, very low scores may be indicative of the need for clinical support.	• Measures mental well-being among **adults, and children aged 13 years and older**. • Regards mental well-being as covering both hedonic (happiness, subjective) well-being and eudaimonic (positive functioning) well-being. It defines well-being as "the positive and sustainable mental state that allows individuals, groups and nations to thrive and flourish."	• Its strengths are that it is positively worded, represents positive attributes of well-being and covers both feeling and functioning. Evidence from a recent study suggests that users of mental health services and their caregivers prefer the WEMWBS to other mental health outcome measures. • Only validated for the UK. • Free to use but users need to register their use by completing a registration form. Copyright for the scales rests with the University of Warwick and the National Health Service Scotland.

**This table is not exhaustive of all available, validated child self-assessment tools to measure child well-being. There are many further tools, including the* CRS *Orphans and Vulnerable Children Wellbeing Tool that look at aspects beyond psychosocial well-being (e.g. nutrition, shelter/environment, economic opportunities, etc.)*

Annex 3: Examples of child self-assessment tools for validated measures

Children's Hope Scale

1. I think I am doing pretty well.
2. I can think of many ways to get the things in life that are most important to me.
3. I am doing just as well as other kids my age.
4. When I have a problem, I can come up with lots of ways to solve it.
5. I think the things I have done in the past will help me in the future.
6. Even when others want to quit, I know that I can find ways to solve the problem.

Answer options: None of the time | A little of the time | Some of the time | A lot of the time | Most of the time | All of the time

Wagnild's Resilience Scale (Long version, 25 questions)

1. When I make plans, I follow through with them.
2. I usually manage one way or another.
3. I am able to depend on myself more than anyone else.
4. I keep interested in things that are important to me.
5. I can be on my own if I have to.
6. I feel proud that I have accomplished things in life.
7. I usually take things in my stride.
8. I am friends with myself.
9. I feel that I can handle many things at a time.
10. I am determined.
11. I seldom wonder what the point of it all is.
12. I take things one day at a time.
13. I can get through difficult times because I've experienced difficulty before.
14. I have self-discipline.
15. I keep interested in things.
16. I can usually find something to laugh about.
17. My belief in myself gets me through hard times.
18. In an emergency, I'm someone people can generally rely on.
19. I can usually look at a situation in a number of ways.
20. Sometimes I make myself do things whether I want to or not.
21. My life has meaning.
22. I do not dwell on things that I can't do anything about.
23. When I'm in a difficult situation, I can usually find my way out of it.
24. I have enough energy to do what I have to do.
25. It's okay if there are people who don't like me.

Answer options: Strongly disagree | Disagree | Neutral (Neither agree nor disagree) | Agree | Strongly disagree

Resilience Scale for Early Adolescents (RSEA) (developed for the Turkey context, 2014)

1. I keep up even under the most difficult circumstances.
2. I have self-confidence even in the most difficult conditions.
3. I use my creativity to solve the problems I face in my life.
4. I find different solutions to problems.
5. I control my life.
6. I find a solution even in the most difficult conditions.
7. I easily adapt to the changes in my life.
8. I have plans for the future.
9. My family supports me in every condition.
10. My family gives me responsibilities that I can handle.
11. I have good relationships with my family.
12. I feel safe with my family.
13. I share my problems with my family.
14. My family trusts me.
15. We overcome the difficulties in the family together.
16. My friends listen to me when I have a problem.
17. My friends trust me.
18. My friends appreciate me.
19. I communicate with people easily.
20. I attend a school I like.
21. My teachers appreciate me.

Answer options: Strongly disagree | Disagree | Neutral (Neither agree nor disagree) | Agree | Strongly disagree

SDQ: Self-assessment for 11–16 year olds (parents' questionnaire for younger children)

1. I try to be nice to other people. I care about their feelings.
2. I am restless, I cannot stay still for long.
3. I get a lot of headaches, stomach aches or sickness.
4. I usually share with others, for example, CDs, games, food.
5. I get very angry and often lose my temper.
6. I would rather be alone than with people of my age.
7. I usually do as I am told.
8. I worry a lot.
9. I am helpful if someone is hurt, upset or feeling ill.
10. I am constantly fidgeting or squirming.
11. I have one good friend or more.
12. I fight a lot.
13. I can make other people do what I want.
14. I am often unhappy, depressed or tearful.
15. Other people my age generally like me.
16. I am easily distracted; I find it difficult to concentrate.
17. I am nervous in new situations. I easily lose confidence.
18. I am kind to younger children.
19. I am often accused of lying or cheating.
20. Other children or young people pick on me or bully me.
21. I often offer to help others (parents, teachers, children).
22. I think before I do things.
23. I take things that are not mine from home, school or elsewhere.
24. I get along better with adults than with people my own age.
25. I have many fears, I am easily scared.
26. I finish the work I'm doing. My attention is good.

Answer options: Not true | Somewhat true | Certainly true

Marsh Self-Description Questionnaire for secondary school students (without academic skills and performance)

1. I have a nice looking face.
2. Overall, I have a lot to be proud of.
3. I am honest.
4. I worry more than I need to.
5. I get along well with my parents.
6. I am not very popular with my peers.
7. It is difficult to make friends.
8. I am good-looking.
9. Most things I do, I do well.
10. I often tell lies.
11. I am a nervous person.
12. My parents treat me fairly.
13. I make friends easily.
14. Other people think I am good-looking.
15. Overall, most things I do turn out well.
16. I sometimes cheat.
17. I often feel confused and mixed up.
18. My parents understand me.
19. I do things as well as most people.
20. I get upset easily.
21. I do not like my parents very much.
22. I do not get along very well with boys.
23. I do not get along very well with girls.
24. If I really try, I can do almost anything I want to do.
25. I sometimes take things that belong to other people.
26. I worry about a lot of things.
27. Overall, I am a failure.
27. I sometimes tell lies to stay out of trouble.

Answer options: Respondent selects 1–6 position on True–False continuum

See Measuring self-concept

Multidimensional Students Life Satisfaction Scale (MSLSS)

Self

1. I think I am good-looking.
2. I am fun to be around.
3. I am a nice person.
4. Most people like me.
5. There are lots of things I can do well.
6. I like to try new things.
7. I like myself.

Family

8. I enjoy being at home with my family.
9. My family gets along well together.
10. I like spending time with my parents.
11. My parents and I do fun things together.
12. My family is better than most.
13. Members of my family talk nicely to one another.
14. My parents treat me fairly.

Friends

15. My friends treat me well.
16. My friends are nice to me.
17. I wish I had different friends.*
18. My friends are mean to me.*
19. My friends are great.
20. I have a bad time with my friends.*
21. I have a lot of fun with my friends.
22. I have enough friends.
23. My friends will help me if I need it.

School

24. I look forward to going to school.
25. I like being in school.
26. School is interesting.
27. I wish I didn't have to go to school.*
28. There are many things about school I don't like.*
29. I enjoy school activities.
30. I learn a lot at school.
31. I feel bad at school.

Living environment

32. I like where I live.
33. I wish there were different people in my neighborhood.*
34. I wish I lived in a different house.*
35. I wish I lived somewhere else.*
36. I like my neighborhood.
37. I like my neighbors.
38. This town is filled with mean people.*
39. My family's house is nice.
40. There are lots of fun things to do where I live.

Answer options: Never | Sometimes | Often | Almost always (Only 4 options, does not offer a neutral answer as most questionnaires do)

CYRM
26 questions for adolescents 9/10 years or older or based on local context

A. Individual

- **Personal skills**
  - ✓ I cooperate with people around me.
  - ✓ I try to finish what I start.
  - ✓ People think that I am fun to be with.
  - ✓ I am able to solve problems without harming myself or others (for example, by not using drugs and/or being violent).
  - ✓ I am aware of my own strengths.
- **Peer support**
  - ✓ I feel supported by my friends.
  - ✓ My friends stand by me during difficult times.
- **Social skills**
  - ✓ I know how to behave in different social situations.
  - ✓ I know where to go in my community to get help.
  - ✓ I have opportunities to show others that I am becoming an adult and can act responsibly.
  - ✓ I have opportunities to develop skills that will be useful later in life (like job skills and skills to care for others).

B. Relationship with primary caregiver

- **Caregiver: Physical caregiving**
  - ✓ My parent(s)/caregiver(s) watch me closely.
  - ✓ If I am hungry, there is enough to eat.
- **Caregiver: Psychological caregiving**
  - ✓ My parent(s)/caregiver(s) know a lot about me.
  - ✓ I talk to my family/caregiver(s) about how I feel.
  - ✓ My family stands by me during difficult times.
  - ✓ I feel safe when I am with my family/caregiver(s).
  - ✓ I feel safe when I am with my family/caregiver(s).
  - ✓ I enjoy my family's/caregiver's cultural and family traditions.

C. Context

- **Spiritual**
  - ✓ Spiritual beliefs are a source of strength for me.
  - ✓ I participate in organized religious activities.
  - ✓ I think it is important to serve my community.
- **Education**
  - ✓ Getting an education is important to me.
  - ✓ I feel I belong at my school.
- **Cultural**
  - ✓ I have people I look up to.
  - ✓ I am proud of my ethnic background.
  - ✓ I am treated fairly in my community.
  - ✓ I enjoy my community's traditions.
  - ✓ I am proud to be a citizen of _____ (insert country).

Answer option 1: No | Sometimes | Yes
Answer option 2: Not at all | A little | Somewhat | Quite a bit | A lot

CYRM
26 questions for literate children 5–9 years (Interview – not self-assessment!)

A. Individual

- **Personal skills**
  - ✓ Do you share with people around you?
  - ✓ Do you try to finish activities that you start?
  - ✓ Do other children like to play with you?
  - ✓ When things don't go your way, can you fix it without hurting yourself or other people (for example, without hitting others or saying nasty things)?
  - ✓ Do you know what you are good at?
- **Peer support**
  - ✓ Do you have friends that care about you?
  - ✓ Do you think your friends care about you when times are hard (for example, if you are sick or have done something wrong)?
- **Social skills**
  - ✓ Do you know how to behave/act in different situations (such as school, home and church or mosque)?
  - ✓ Do you know where to go to get help?
  - ✓ Do you have chances to show others that you are growing up and can do things by yourself?
  - ✓ Do you have chances to learn things that will be useful when you are older (like cooking, working, and helping others)?

B. Relationship with primary caregiver

- **Caregiver: Physical caregiving**
  - ✓ Do you feel that your parent(s)/caregiver(s) know where you are and what you are doing all of the time?
  - ✓ Is there enough to eat in your home when you are hungry?
- **Caregiver: Psychological caregiving**
  - ✓ Do you feel that your parent(s)/ caregiver(s) know a lot about you (for example, what makes you happy, what makes you scared)?
  - ✓ Do you talk to your family about how you feel (for example, when you are hurt or feeling scared)?
  - ✓ Do you think your family cares about you when times are hard (for example, if you are sick or have done something wrong)?
  - ✓ Do you feel safe when you are with your family?
  - ✓ Do you like the way your family celebrates things (like holidays or learning about your culture)?

C. Context

- **Spiritual**
  - ✓ Do you participate in religious activities (such as church, mosque)?
  - ✓ Do you think it is important to help out in your community?
- **Education**
  - ✓ Is doing well in school important to you?
  - ✓ Do you feel you fit in with other children?
- **Cultural**
  - ✓ Do you have people you want to be like?
  - ✓ Do you know where your family comes from or know your family's history?
  - ✓ Are you treated fairly?
  - ✓ Do you like the way your community celebrates things (like holidays, festivals)?

Answer options: Yes | Sometimes | No

NPC well-being measure (UK context, children 11–16 years)

1. Self-esteem

- A lot of things about me are good.
- I can't do anything right.
- In general, I like being the way I am.
- I do a lot of important things.
- Overall, I have a lot to be proud of.
- I can do things as well as most other people.
- Overall, I am no good.
- Other people think I am a good person.
- I am as good as most other people.
- When I do something, I do it well.

2. Emotional well-being

- I cry a lot.
- I am too fearful or anxious.
- I am nervous or tense.
- I am unhappy, sad or depressed.
- I worry a lot.

3. Resilience

- I usually manage one way or another.
- I keep interested in things.
- My life has a sense of purpose.
- I find life really worth living.
- My life has meaning.

4. Family

- I enjoy being at home with my family.
- I like spending time with my parents/carers.
- My parents/carers and I do fun things together.
- My parents/carers treat me fairly.
- My family gets along well together.

5. Friends

- My friends treat me well.
- I have a lot of fun with my friends.
- My friends are great.
- My friends will help me if I need it.

6. School

- I like being in school.
- I wish I didn't have to go to school.
- I feel safe at school.
- I enjoy school activities.
- School is interesting.

7. Community

- Adults in my area treat young people fairly.
- I wish I lived somewhere else.
- I like where I live.
- There are lots of fun things to do where I live.

8. Overall well-being

The young person is asked to tick a rung on a ladder to represent where they stand at the moment, where the bottom rung "0" is "the worst possible life for you" and the top rung "10" is "the best possible life for you".

Warwick-Edinburgh Mental Well-Being scale (validated for children 13–16 years and adults)

Statements

1. I've been feeling optimistic about the future.
2. I've been feeling useful.
3. I've been feeling relaxed.
4. I've been feeling interested in other people.
5. I've had energy to spare.
6. I've been dealing with problems well.
7. I've been thinking clearly.
8. I've been feeling good about myself.
9. I've been feeling close to other people.
10. I've been feeling confident.
11. I've been able to make up my own mind about things.
12. I've been feeling loved.
13. I've been interested in new things.
14. I've been feeling cheerful.

Answer options: None of the time | Rarely | Some of the time | Often | All of the time
For example vist this link.

Kidscreen-52

1. Physical well-being / vitality

- In general, how would you say your health is?
- Have you felt fit and well?
- Have you been physically active?
- Have you been able to run well?
- Have you felt full of energy?

2. Psychological well-being

- Has your life been enjoyable?
- Have you felt pleased that you are alive?
- Have you felt satisfied with your life?
- Have you been in a good mood?
- Have you felt cheerful?
- Have you had fun?

3. Moods and emotions

- Have you felt that you do everything badly?
- Have you felt sad?
- Have you felt so bad that you didn't want to do anything?
- Have you felt that everything in life goes wrong?
- Have you felt fed up?
- Have you felt lonely?
- Have you felt under pressure?

4. Self-perception

- Have you been happy with the way you are?
- Have you been happy with your clothes?
- Have you been worried about the way you look?
- Have you felt jealous of the way other girls/boys look?
- Would you like to change something about your body?

5. Autonomy

- Have you had enough time for yourself?
- Have you been able to do things you want to do in your free time?
- Have you had enough opportunity to be outside?
- Have you had enough time to meet friends?
- Are you able to choose what to do in your free time?

6. Parent relations and home life

- Have your parent(s) understood you?
- Have you felt loved by your parent(s)?
- Have you been happy at home?
- Have your parent(s) had enough time for you?
- Have your parent(s) treated you fairly?
- Have you able to talk to your parent(s) when you wanted to?

7. Social support and peers

- Have you spent time with your friends?
- Have you done things with other girls and boys?
- Have you had fun with your friends?
- Have you and your friends helped each other?
- Are you able to talk about everything with your friends?
- Have you been able to rely on your friends?

8. Social acceptance and bullying

- Have you been afraid of other girls and boys?
- Have other girls and boys made fun of you?
- Have other girls and boys bullied you?

9. School environment

- Have you been happy at school?
- Have you got on well at school?
- Have you been satisfied with your teachers?
- Have you been able to pay attention?
- Have you enjoyed going to school?
- Have you got along well with your teachers?

10. Financial resources

- Have you had enough money to do things with your friends?
- Have you had enough money for your expenses?

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