Defining and Measuring Child Well-Being in Humanitarian Action:

A Contextualization Guide

THE ALLIANCE
FOR CHILD PROTECTION
IN HUMANITARIAN ACTION

Daniele Volpe UNICEF 2017

The Alliance for Child Protection in Humanitarian Action (the Alliance) supports the efforts of humanitarian actors to achieve high-quality and effective child protection interventions in humanitarian settings. Through its technical Working Groups and Task Forces, the Alliance develops inter-agency operational standards and provides technical guidance to support protection of children in humanitarian settings.

For more information on the Alliance's work and joining the network, please visit *https://www.alliancecpha.org* or contact us directly: *info@alliancecpha.org.*

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For feedback or suggestions for the improvement of this publication, please contact the Alliance for Child Protection in Humanitarian Action AME Working Group at ame.wg@alliancecpha.org.

ACRONYMS

BHA	United States Bureau of Humanitarian Assistance
CP	Child Protection
CPHA	Child Protection in Humanitarian Action
CPMS	Child Protection Minimum Standards
CPCG	Child Protection Coordination Group
CWB	Child Well-Being
ECD	Early Childhood Development
FGD	Focus Group Discussion
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
IM	Information Management
IMO	Information Management Officer
KI	Key Informant
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organization
SMART	Specific, Measureable, Achievable, Relevant, and Time-bound
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

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INTRODUCTION

Humanitarian emergencies, such as natural disasters and conflicts, create adversity and often lead to the breakdown of family and community coping mechanisms. They also exacerbate existing child protection risks, such as child maltreatment, child labor, and family separation, and disrupt daily activities, such as school attendance and livelihood, as well as community life and community support. In addition, in many cultures stigma is attached to certain experiences, such as those related to sexual violence, which further impacts recovery and well-being. Long-term exposure to violence, neglect and other forms of adversity can have a long lasting impact on the optimal development and well-being of a child. Therefore, protecting children from harm, such as violence, abuse, and exploitation will allow them to thrive and develop to their full potential.

Ensuring children's well-being is generally recognized as the ultimate goal of child protection in humanitarian action (CPHA). A global definition of child well-being and a contextualized framework by which to measure it will improve efforts in program planning, coordination, and evaluation whether at the individual agency or inter-agency level.

Objectives of the Child Well-Being Measurement Framework Contextualization Guide

The Child Well-Being Measurement Framework Contextualization Guide highlights the key steps in the process of adapting the global inter-agency child well-being definition and measurement framework to context. It is based on the principle that the core factors that contribute to the well-being of children must first be understood in context to ensure cultural and contextual relevance to children, families, and communities. This Guide will:

1) Present the global definition of child well-being in humanitarian action and its key components;
2) Present the measurement framework;
3) Support child protection humanitarian practitioners and other relevant actors to a) contextualize the definition and measurement framework by outlining the key steps in the contextualization process, and b) to measure child well-being in a contextualized manner.

Measuring child well-being in accordance with community understanding of the term will result in data that can be used to inform:

- Strategic priorities;
- Programmatic design and priority interventions; and
- Baseline measures to be monitored over time.

Hasanthi Jayamaha World Vision 2020

Using a common language

The Child Well-Being Measurement Framework is not intended to replace existing or preferred measurement frameworks or approaches that individual agencies use to monitor and evaluate their programs. Rather it is organized in a simple manner that will allow child protection practitioners and agencies working in a specific humanitarian context to use a common definition of child well-being, domains, and indicators to complement their own measurement frameworks and project-specific designs.

A common definition and measurement framework for child well-being will enable the humanitarian child protection sector to be better equipped to work towards overarching, common objectives for humanitarian interventions, leading to a strengthened evidence base.

Why was this Guide developed?

Child protection programs work to promote and enhance child well-being and often seek to measure programmatic outcomes against well-being indicators. However, in 2017, in the backdrop of the revision of the Minimum Standards for Child Protection in Humanitarian Action, the lack of a common definition of child well-being and measurement framework was identified as a gap. The Alliance recognized that developing a common definition and measurement framework could help the sector strengthen its evidence base on interventions and practices that promote child well-being, while also increasing the cost effectiveness of child protection humanitarian work. With funding from USAID's Office of Foreign Disaster Assistance (now Bureau for Humanitarian Assistance) an initiative was developed under the Alliance's Assessment, Measurement and Evidence (AME) Working Group, to address this gap.

A Global Advisory group was established in 2019 in support of this initiative. The Global Advisory Group included a broad range of child protection and other sector representatives whose expertise and insights informed this work through a consultative process. In addition, a desk review of existing well-being definitions and domains was conducted to inform discussions. Lastly, pilot testing of the definition and measurement framework took place from September to October 2020 in two locations to further inform the finalization of this Guide. The pilot testing took place in the context of Nagorno Karabakh conflict, a disputed territory that is internationally recognized as part of Azerbaijan, but mostly governed by a de facto independent state with an Armenian ethnic majority, and in the Rwamwanja refugee settlement in Uganda.

What is included in the Child Well-Being Measurement Framework Contextualization Guide?

The Child Well-Being Measurement Framework Contextualization Guide provides guidance on how to define child well-being and the framework for measurement in context. The Guide is divided into three parts, and includes Annexes with key tools and materials to support in the contextualization and measurement processes.

Part 1: Child well-being definition provides an overview of the global definition of child well-being, and the categories of age and child developmental stages.

Part 2: Child well-being measurement framework presents the measurement framework, including the four common child well-being domains and a table of indicators.

Part 3: Contextualizing the child well-being definition and measurement framework provides guidance on the key steps of the contextualization process and guidance on measuring child well-being.

Annexes A-C: Sample tools and workshop materials; child well-being measurement questionnaires; and indicator guidance provide sample tools and workshop materials to support the process of contextualization, including a sample work plan and timeframe; and sample child well-being measurement questionnaires.

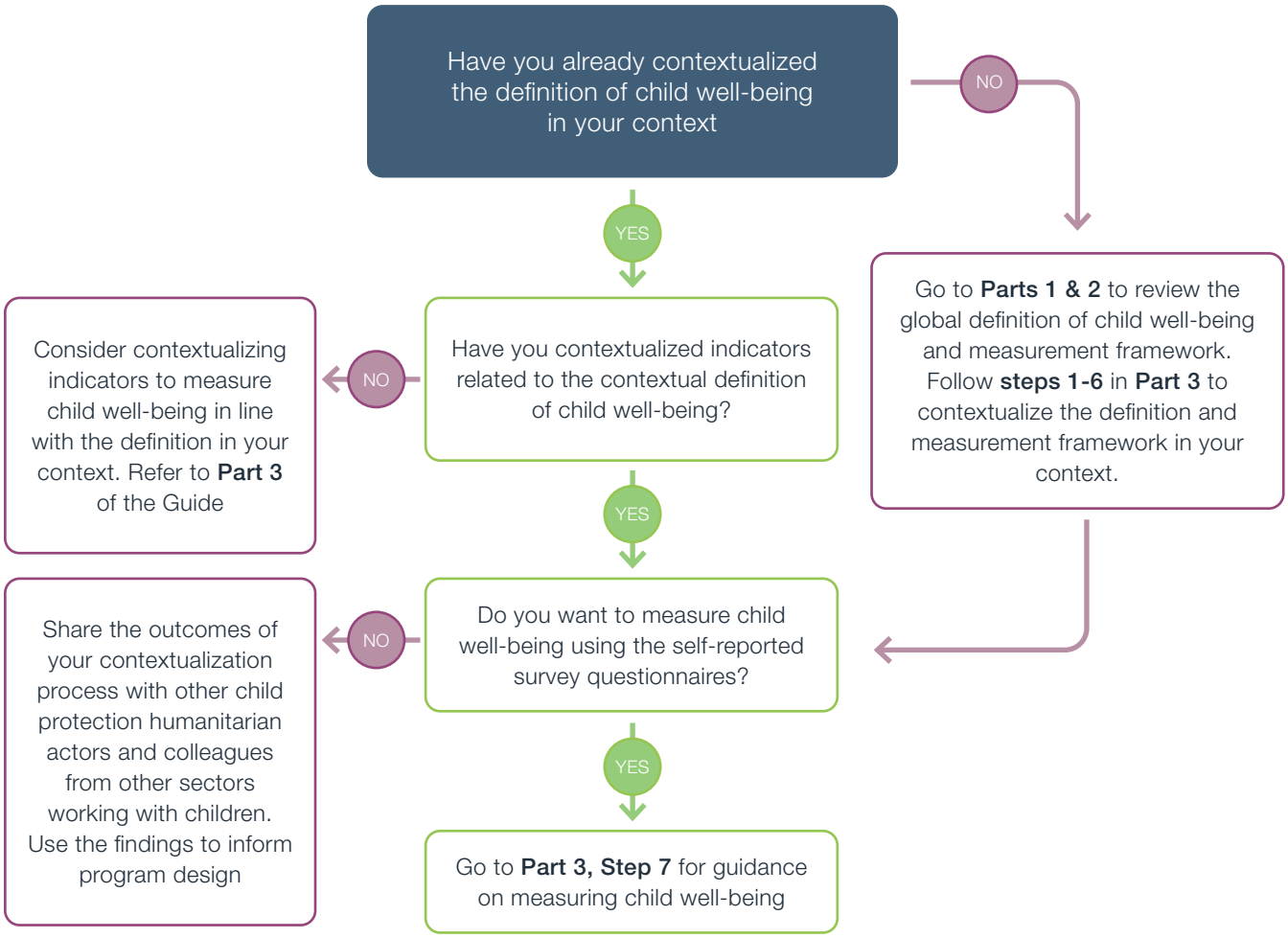
Who is this Guide for?

This Guide is important for all child protection humanitarian actors and other relevant stakeholders, such as government staff, mental health professionals, health providers, educators, faith communities, local community-level structures, and other relevant actors and service providers whose work directly or indirectly promotes the well-being of children.

It can be used by:

- Individual child protection agencies that want to measure the impact of their programs using the framework; and
- The inter-agency Child Protection Coordination Group (CPCG) at the national or sub-national level working in a specific humanitarian context that want to develop a contextual definition and measurement framework by which to identify common strategic objectives and outcomes for children that will ensure the measurability, relevance, and effectiveness of child protection programs across the response.

Child Well-Being Decision Tree: Navigating this Guide



PART 1:
Child well-being definition

Welcome to Part 1: Child well-being definition. In this section you will find:

- Global definition of child well-being in humanitarian action
- Ages and stages of child development, including Table 1: Ages and stages of child development with explanations

Srikanth Kolari UNICEF 2020

The global definition of child well-being in humanitarian action and the measurement framework were developed through a consultative process led by the Alliance for Child Protection in Humanitarian Action (the Alliance) that included representatives from various child protection agencies, donors, and colleagues working in MHPSS, health, and education.[1] The global definition, age groups, and measurement framework should be contextualized at the level of the humanitarian context to reflect community, cultural, and contextual understandings.

Global Definition of Child Well-Being in Humanitarian Action

Child well-being is a dynamic, subjective and objective state of physical, cognitive, emotional, spiritual and social health in which children's optimal development is achieved through:

- Safety from abuse, neglect, exploitation and violence;
- Basic needs met, including those promoting survival and development;
- Connection to and care provided by consistent, responsive caregivers;
- Supportive relationships with relatives, peers, teachers, community members and society at large; and
- Opportunity for children to exercise agency based on their evolving capacities.

The global definition of child well-being in humanitarian action highlights the multi-dimensional nature of health. Well-being is enhanced when all aspects of the child's health (physical, cognitive, emotional, spiritual and social) are nurtured and children can act on their intentions in developmentally appropriate ways.


Cesar Poveda UNICEF 2020

[1] Refer to ANNEX A for further background information on the consultative process.

Physical health encompasses basic survival as well as genetically and age-appropriate growth and development and freedom from disease, illness and injury, and is enhanced when a child's basic material needs are met (i.e. nutrition, shelter, material resources); when they have good hygiene; when their natural environment is healthy; when their political environment is stable; and when they are provided with positive measures such as physical activity, breastfeeding (babies), preventative health care, and the knowledge they and their caregivers need to make informed health decisions.

Cognitive health refers to how well a child acquires, organizes and uses information in increasingly complex ways. It requires that the child has developmentally appropriate informal and formal learning opportunities that enable them to develop their skills (including pro-social skills), talents, personality and character and become capable of more advanced cognitive functioning. Cultural norms and socialization shape what children learn and are expected to learn as they mature across the life course.

Emotional health can include feelings (such as safety, fear, happiness), relationships, varying psychological states, and the ability to act on one's intentions (i.e. agency). Emotional health is influenced by mental wellness, mental disorders, and trauma.

Spiritual health indicates a positive sense of meaning, purpose and belonging in life that is not limited to religious elements or experience. The basic characteristics of spiritual health include a sense of purpose and connection with others and the natural world. For many, this includes a sense of connection with God and the divine. Children's spirituality is evident in their feelings and thoughts about the divine and their relationships with others and the natural world.

Social health reflects the quality of a child's interpersonal, family and community relationships as well as their relationship with the state and global institutions. Social health is strengthened when children experience relationships of care and support and when they develop context-specific, pro-social skills, norms, values and roles that equip them to build strong relationships and social connections that enable them to participate in peer, family and community life.

Child Development: Ages and Stages

The recommended age groups are harmonized with those identified by the IASC Guidelines for mental health and psychosocial support in emergency settings.[2] This uniformity will allow for harmonizing age-disaggregated data across different disciplines and technical areas. At the same time, the age groups employed to obtain indicators of child well-being should be reflective of key developmental markers, especially brain development, puberty, and learning in accordance with the cultural context. All cultures have ways of addressing these issues and may attribute specific development markers to different age groups of children. For example, in many cultures, children's roles and responsibilities change once they show physical signs of puberty. In such contexts age groups should be modified, as necessary.

Recommendations

- *Ensure any modifications to the age groups are in line with the cultural context and understanding.*
- *While the age groups are subdivided to include the standard psychosocial and Early Childhood Development (ECD) categories, you may decide not to include the subdivided categories.*

Table 1: Ages and stages of child development with explanations

CHILD DEVELOPMENT: AGES AND STAGES		
0-5[3]	0-18 months	Infancy
	18 months - 3 years	Toddlerhood
	3-5 years	Early childhood
6-11	6-8 years	Middle childhood
	9-11 years	Middle childhood – Age range when many girls start to menstruate
12-17	12-14 years	Early Adolescence – Age range when most boys and the remaining girls begin puberty
	15-17 years	Adolescence – Beginning development of pre-frontal cortex

Vinay Panjwani UNICEF 2020

[2] Inter-Agency Standing Committee, 2007

[3] Erikson, E.H. (1950). Childhood and Society. New York: Norton; Piaget Piaget, J. (2003). Part I: Cognitive Development in Children -Piaget Development and Learning. Journal of research in science teaching, 40.

PART 2:
Child well-being measurement framework

Welcome to Part 2: Child well-being measurement framework. In this section you will find:

- Table 2: Child well-being measurement framework – Age group specific indicators
- Table 2.1: Child well-being measurement framework – Common indicators across age groups
- Common domains of child well-being, including Figure 1: Child well-being domains
- Indicators

Syed Mehdi Bukhari UNICEF 2020

The purpose of the Child Well-being Measurement Framework is to encourage the use of a select number of outcomes to build the evidence base on practices and programs that contribute to and promote the well-being of children. The measurement framework includes four common domains and indicators. Every child protection project, practice or program will require its own unique measurement framework that is appropriate and relevant to its design, and the context where it is being implemented. However, to build evidence for CPHA globally and to demonstrate its effectiveness in humanitarian settings, it is necessary for interventions that seek to promote and enhance the well-being of children to measure common indicators, categorized by domain and age.

The measurement framework can be used in a way that best fits within the intended outcomes and outputs of CPHA programs. It is not expected that every CPHA initiative implemented by every organization will report against each of the indicators in the measurement framework. Rather individual agencies can select indicators based on the objectives of their child protection program to evaluate whether interventions are contributing to child well-being. Inter-agency consensus on what to measure and what constitutes progress will also help to provide direction and intervention priorities in each humanitarian context.

The Child Well-being Measurement Framework presented in **Tables 2 and 2.1** aim to capture standards for children's well-being in a broad range of circumstances so that they are applicable and open to adaptation across different contexts. It is recommended that child protection humanitarian practitioners using this Guide maintain these domains and modify, remove or add indicators to reflect key objective and subjective factors identified in accordance to the age groups and developmental stages of a child in context. At the programmatic level, agencies are encouraged to use these indicators alongside those that are recommended in the Child Protection Minimum Standards Indicator Table and relevant to their programs.

Recommendations

- *Maintain the common domains to the extent possible.*
- *Modify indicators according to cultural and contextual understandings of child well-being in line with the common domains or modifications made to them.*
- *Individual agencies implementing programs aimed at promoting the well-being of children should include indicators set out in the measurement framework that are relevant to the expected outcomes of their programs in program-specific M&E frameworks.*

Table 2: Child Well-Being Measurement Framework - Age group specific indicators

Age Group		Safety and Security		Basic Needs		Relationships with family and others		Agency	
		Indicator	Notes	Indicator	Notes	Indicator	Notes	Indicator	Notes
0-5	0-18 months	% of caregivers who report that there are areas in their proximate environment free from hazards where the child can safely crawl, grasp/pull on objects, etc.	"Proximate environment" may refer to areas within the home or nearby, such as in the yard.	% of caregivers who report that the child has feeding and sleeping practices similar to their own.	Feeding and sleeping should be measured separately but can be reported on jointly. The purpose of this indicator is to measure whether or not the child has a similar feeding and sleeping routine to that of the caregiver.	% of caregivers who report daily positive interaction with their child.	This interaction should be defined as providing responsive care, such as making consistent making eye contact with the child while interacting or other ways caregivers show attention and involvement. Affection can be shown by physical, visual and verbal context with children; the way affection is expressed will vary by culture. Modify this indicator as appropriate.	% of caregivers who report that the child interacts with (explores and discovers) the environment around them on a daily basis.	Whether or not a child in this age group will interact with their proximate environment is cultural. In some cultures children may be carried by their mothers up until the time they are able to walk. Use this indicator only if culturally appropriate.
		% of caregivers who report ability to maintain feeding and sleeping practices since the start of the emergency.	Feeding and sleeping practices should be measured separately but can be reported on jointly.	% of caregivers who report breastfeeding or providing other sufficient, nutritious foods to the child.	If the child is breastfeeding, this indicator can refer to exclusive breastfeeding, a mix of breast and bottle feeding, or only bottle feeding. Children of 6 months or less should be exclusively breastfeeding. Where bottle feeding is reported, it is important to inquire whether the respondent has access to clean water. If the child is not breastfeeding, this indicator refers to other sources of nutritious foods that are available in context and locally prepared. If the mother is the respondent, it is recommended that a follow-up question be asked regarding whether or not she is receiving maternal dietary supplementation. Complementary foods should be relatively viscous and have high nutriend density (which children need from 6-12 months); by 12 months the child can eat the family diet with some adaptations.	% of caregivers who report talking and playing with child on a daily basis over the past four weeks. % of caregivers who report playing with their child and/or teaching their child new things on a daily basis.	Talking or playing includes laughing or cooing with the child. The timeframe of four weeks can be modified as appropriate. Its purpose is to indicate whether or not the caregiver is consistently interacting with the child on a regular basis.	% of children in target population with a valid birth certificate.	Refer to the Child Protection Minimum Standards Indicator Table for further indicators related to birth registration.
						% of caregivers who can state one positive affect of parent-child bonding.	This indicator is culturally specific and should be determined in context.		
						% of caregivers who report that the child was in their care prior to the start of the emergency.	The timeframe can be modified as appropriate. This indicator will establish whether or not the child has had the same caregivers as they did prior to the humanitarian situation; e.g. the child and family have remained together or the child is being cared for by others, e.g. kinship carers or nonbiological carers.	% of caregivers who report their child indicates when they need something (e.g. crying when hungry).	

Age Group		Safety and Security		Basic Needs		Relationships with family and others		Agency	
		Indicator	Notes	Indicator	Notes	Indicator	Notes	Indicator	Notes
0-5	18 months-3	Refer to the common indicator table 2.1.		% of caregivers who confirm the child has received immunization.	Immunization may include vaccinations against measles, mumps, and polio. Modify as appropriate in context.	% of caregivers who report regular ability to meet the developmental needs of the child.	"Regular" should be defined in country (e.g. daily, weekly etc.). This indicator should be further specified as appropriate to the cultural context. E.g. "meeting developmental needs" may mean providing daily praise to the child, establishing structure in rules, etc.	% of caregivers who report daily time dedicated for the child to play.	Playtime includes time alone or with other children. It should be further defined in accordance to the cultural context.
	3-5	% of caregivers who report safety from phyiscal and environmental hazards.	"Environmental hazards" should be defined in context (such as stray dogs, air pollution from fires for cooking, household chemical hazards, or household pests, including insects like mosquitos or pests like rats). For indicators related specifically to child maltreatment refer to Standard 8 of the CPMS.	Refer to the common indicator table 2.1.		% of caregivers who report engaging in meaningful interactions with the child (e.g. talking, guiding, storytelling, etc.).	These interactions should be culturally meaningful and modified in accordance to context.	% of caregivers who report the child's ability to express ideas and preferences.	The expression of ideas and preferences should be defined in context as appropriate for the age and culture.
						% of caregivers who confirm the child spends daily time engaged in play activities.	Either alone or with peers in the same age group.		

Age Group		Safety and Security		Basic Needs		Relationships with family and others		Agency	
		Indicator	Notes	Indicator	Notes	Indicator	Notes	Indicator	Notes
6-11	6-8	% of children who demonstrate an understanding of the physical and environmental dangers present in their communities.	Modify to specify what these dangers include in accordance to the context.	% of children who report eating nutritious food daily.	Replace “nutritious food” with the specific types of food in accordance to the context.	% of children who report that a caregiver cares for them when times are difficult.	E.g. when ill or sad.	% of children who report feeling listened to and understood by at least one other person.	This person can be an older child, including an older sibling, or adult.
		% of children who report a place where they feel safe.	E.g. living quarters, home, school, community centre, religious centre, etc.			% of children who report having meaningful relationships with others outside of their family (e.g. with friends or other children their own age, or other community members.	“Meaningful” should be defined in context. For instance, it may refer to relationships that make the child feel good.	% of caregivers who report the child’s ability to express ideas and preferences.	The expression of ideas and preferences should be defined in context as appropriate for the age and culture.
						% of children who report eating at least one meal per day with at least one of their caregivers.			
	9-11	% of children who report feeling safe in the community where they live.	“Safe” can be defined in context or replaced with a culturally appropriate term. This indicator can be combined with other indicators related to safety, reports on specific harmful child protection outcomes or negative coping strategies, such as early marriage or child labour. Refer to the CPMS indicator table for further details.	% of children who report having enough food to eat when they are hungry. % of children who demonstrate basic literacy skills.	This indicator can be further specified in context with the type of nutritious food eaten locally. A basic question to determine ability to read and write can be included in the survey questionnaire.	% of children who report that they have a caregiver present whom they can rely on. % of children who report that their peers are kind and supportive.	“Rely on” refers to feeling able to depend on the caregiver or that the caregiver acts in their best interest. “Kind and supportive” can be modified accordingly in context.	% of children who report feeling a sense of empowerment and independence.	
						% of children who report feeling a sense of belonging at school.	School can be modified to refer to any formal or informal educational setting.		

Age Group		Safety and Security		Basic Needs		Relationships with family and others		Agency	
		Indicator	Notes	Indicator	Notes	Indicator	Notes	Indicator	Notes
12-17	12-14	% of children who demonstrate knowledge about how to avoid risky behavior (such as drug or alcohol use, unsafe sex, etc.).		% of children who report that completing their education is important to them.	Education can be formal or informal.	% of children who report that their caregiver knows a lot about them (such as who their friends are, how they are doing in school, the things that are important to them, and what they enjoy doing).		% of children who report believing in their ability to make a difference in their community.	
		% of children who report that their social environment is free from bullying and discrimination.	This may include school or recreational centers, etc. Bullying and discrimination should be measured separately but can be reported on jointly.			% of children who report feeling that they are treated well by community members.	"Well" may include being treated kindly or fairly.	% of children who feel motivated or optimistic about school or future opportunities.	
	15-17	% of children who demonstrate knowledge about how to avoid risky behavior (such as drug or alcohol use, unsafe sex, etc.).		% of children who report a sense of hopefulness about the future/employment opportunities		% of children who report that others (peers, family, etc.) enjoy spending time with them.		% of children who feel a sense of responsibility to serve or contribute to the betterment of their community.	This indicator refers to the sense of community involvement and responsibility to support the wider community.
		% of children who report that their social environment is free from bullying and discrimination.	This may include school or recreational centers, etc. Bullying and discrimination should be measured separately but can be reported on jointly.			% of children who report that they enjoy helping/supporting others.	"Enjoy" refers to something that makes them feel good.	% of children who report participation in extracurricular activities or clubs.	

Table 2.1: Child Well-Being Measurement Framework - Common indicators across age groups

Age Group	Safety and Security		Basic Needs		Relationships with family and others		Agency	
	Indicator	Notes	Indicator	Notes	Indicator	Notes	Indicator	Notes
0-5	% of caregivers who report consistent, caring oversight of child by designated adolescent(s) or adult(s).		% of caregivers who report hand washing with soap prior to feeding infant.				% of caregivers who report that one or more of child's behaviors or emotions have negatively changed since the start of the emergency.	
	% of caregivers who know where to go in the community to report a concern involving their child(ren) (e.g. if they are hurt or need a doctor)		% of caregivers who report washing hands with soap after disposing of infant's waste.					
			% of caregivers who report ability to provide child with these basic necessities on a daily basis: a) daily nutritious food; b) clean water; and c) shelter.	Each of these necessities should be measured separately but can be reported on jointly. "Nutritious food" should be defined in context.				
			% of caregivers who report bathing infant 2 or more times per week.	This is to be determine contextually.				
6-17	% of children who know where to report a concern (e.g. to a group activities worker or through a feedback and reporting mechanism in the community).		% of children who report that obtaining an education is important to them.	Refers to formal and non-formal education.	% of children who report a sense of belonging in their community.	From ages 6-8 onwards, the relationships the child has will expand to include members of the community, clergy, friends, etc. This sense of belonging refers to these other relationships in the wider community.		
	% of children who are able to state at least two actions they can take if they feel unsafe.	"Children" can be replaced with "girls" and "boys" to distinguish specific areas that may be unsafe for each. Actions may include going to a place where they feel safe, speaking to a trusted adult or going to an NGO-run safe space, etc.						
	% of children who report that there are separate toilet/ bathing facilities for girls/boys, men/women.	This indicator can be modified to also include separation of sleeping quarters (although in some contexts it may not be possible for families to sleep in separate rooms).						

Age Group	Safety and Security		Basic Needs		Relationships with family and others		Agency	
	Indicator	Notes	Indicator	Notes	Indicator	Notes	Indicator	Notes
9-17	% of children who report feeling safe at home.	“Safe” can be defined in context or replaced with a culturally appropriate term. This indicator can be combined with other indicators related to safety, reports on specific harmful child protection outcomes or negative coping strategies, such as early marriage or child labour. It may include basic needs being met or being free from violence and exploitation. Refer to the CPMS indicator table for further indicators.	% of children who demonstrate basic literacy skills.	A basic question to determine ability to read and write can be included in the survey questionnaire.	% of children who report a sense of value towards or connection with their culture.	This indicator includes spirituality or religion.	% of children who report that their views are listened to and valued by caregivers.	“Listened to” and “valued” should be measured separately and reported on jointly.
	% of children who report feeling safe in the community where they live.		% of girls who report access to menstrual hygiene materials.		% of children who report that their family has maintained traditional practices (such as celebration of milestones, holidays, special events, etc.) since the start of the emergency.		% of children who report that they are included in decision making processes in the household.	This indicator measures participation.
	% of children who report feeling safe at school.		% of children who report receiving sexual and reproductive health services in their community.	This indicator is relevant in communities where children have access to sexual and reproductive health services.	% of children who report a sense of belonging to a peer group of friends.			
	% of children who report feeling safe when they attend humanitarian program activities.		% of children who report having regular access to clean water for drinking and bathing.	“Regular” refers to having access on a daily basis.	% of children who report feeling able to speak openly to a caregiver(s) about matters that are important to them.			
					% of children who report having at least one caregiver who teaches, guides or mentors them.			

Using a measurement framework to assess cost-effectiveness and compare interventions across agencies

Currently, the field of child protection in humanitarian action is underfunded. Decision- makers increasingly seek information on cost-effectiveness as a key consideration when deciding how to invest scarce resources for CPHA. Cost-effectiveness refers to comparisons of (a) the financial costs of different programs with (b) the resulting impacts of the programs as measured by common indicators of child well-being. It provides information on value for money. Currently, there is limited evidence and comparative work on the cost-effectiveness of child protection practices or programs in humanitarian settings. A common definition and measurement framework allow child protection agencies to assess the cost-effectiveness of interventions using common indicators. It will also enable agencies to have a framework by which to evaluate and compare the outcomes of their initiatives, leading to a strengthened evidence base as well as better results for children over time.

Jose Luis Roca World Vision 2020

Common Domains of Child Well-Being

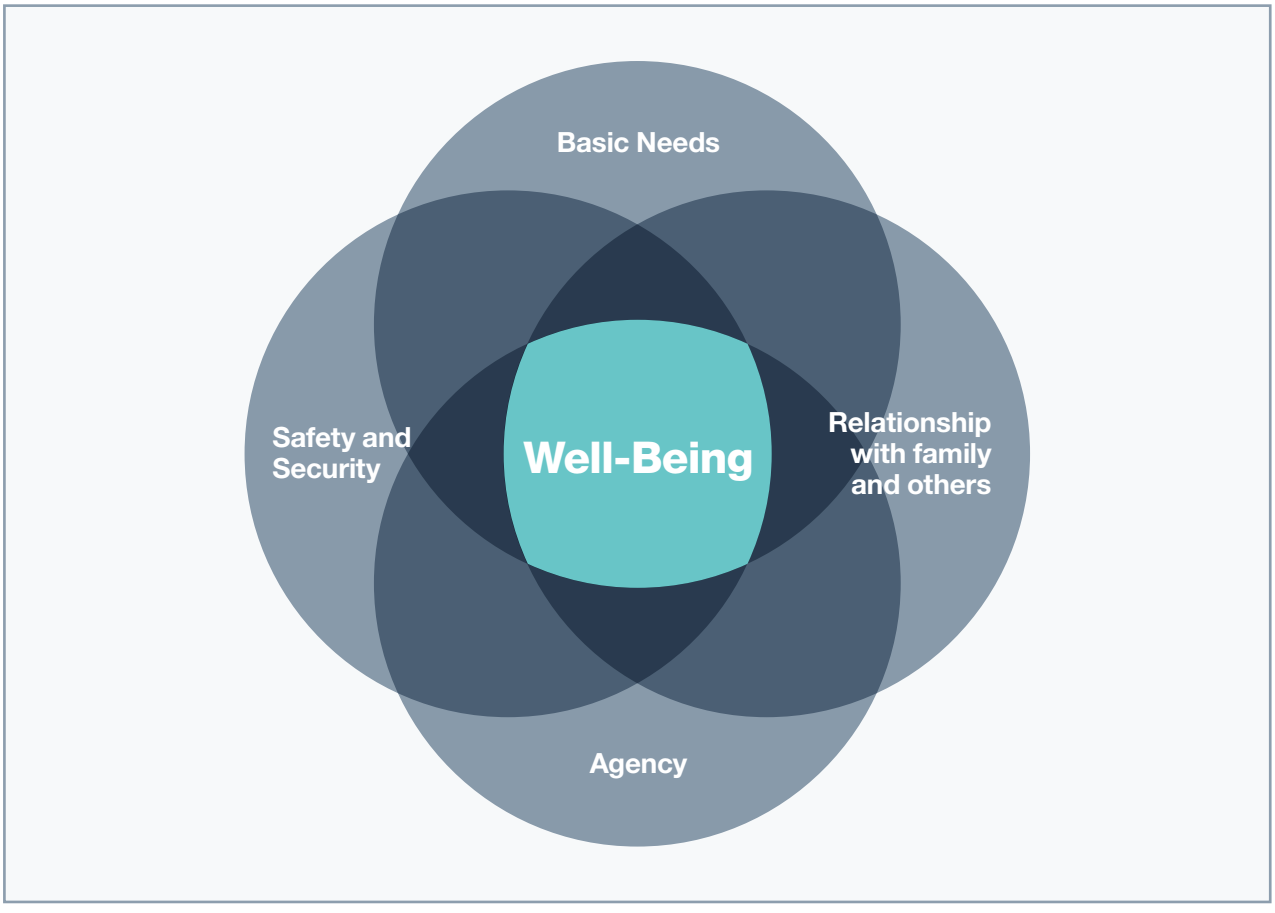
Since the concept of child well-being is dynamic and multi-dimensional, domains reflect the areas in life that are important to children and enable them to flourish. While indicators are intended to capture and define the underlying concept that should be measured, domains are often attributes that cannot be measured directly.

The four domains represented in the measurement framework were selected to build a holistic picture of child well-being in humanitarian action, ranging from safety and basic needs to children's sense of belonging and ability to participate:

- Safety and security
- Basic needs
- Relationships with family and others
- Agency

Each of these domains may vary according to the age and developmental stage of children, their gender, disability or other diversity factors, and it is likely that each of the domains will have a different meaning or level of importance depending on the age group.

Figure 1: Child Well-Being Domains



Safety and security

Physical and emotional safety and security is a significant domain for children's healthy development and well-being. Compared to adults, children are at higher risk of injury, disability, physical and sexual violence, psychosocial distress and mental disorders, morbidity, and death. They may become separated from their families; trafficked; recruited into armed forces; exposed to harmful traditional practices (e.g. early marriage); and economically, physically and/or sexually exploited. Children's safety and security is influenced by their gender and developmental stage. Attachment with a consistent, responsive caregiver and positive relationships with others, including community members play a significant role in keeping children safe and enhancing their sense of security.

Basic needs

Basic needs encompass material resources, nutrition, shelter, and learning and health facilities and services. They help ensure physical survival in the early years of life, and support the physical, mental, and social growth that determines children's capacities across the life course. Social norms and values influence how basic needs are distributed within households, for example, based on gender, birth order, and ability.

Protective factors that support children's well-being include access to nutritious food, clean water, adequate clothing, shelter, and hygiene. For infants, breast-feeding can enhance physical development and reduce the chance of disease. The provision of quality services, such as affordable healthcare and education also enhances child and adolescent well-being.

Relationships with family and others

Children's relationships with family and others (such as peers, teachers, and community members) are critical and influence all aspects of their well-being. From a child development perspective, family relationships, and especially the attachment bond with a consistent, responsive caregiver, are some of the most important and influential factors governing child well-being. The importance of relationships and the attachment figures may vary and change with gender and age.

Agency

Agency captures whether children are equipped and empowered to make informed decisions and to act on their intentions while being safeguarded from taking on responsibilities that are inappropriate for their age and developmental stage. It enables children to be active agents in their own lives, entitled to be listened to, respected and granted autonomy in the exercise of their rights, while also being entitled to protection.

Frank Dejongh UNICEF 2018

Indicators

Indicators of child well-being are informed by the definition of child well-being. They enable child protection humanitarian practitioners to measure the outcomes of interventions effectively, and to ensure that services and programs for children are cost-effective. Specific, Measurable, Achievable, Reliable and Time-bound (SMART) indicators are needed to set goals and design programs for children's well-being, as well as to evaluate the achievement of those goals.

The self-reported child well-being questionnaires pose questions that are designed to measure the indicators, which means that any amendments made to the global definition or domains should be accompanied with amendments to the indicators and subsequently to the questionnaires as necessary.

PART 3:
Contextualizing the child well-being definition and measurement framework

Welcome to Part 3: Contextualizing the child well-being definition and measurement framework. In this section you will find:

- Key 7 steps to the contextualization of the child well-being definition and measurement framework
- Sample work plan and timeline
- Table 3: Sample focus group discussion group composition
- Table 4: Overview of the measures

Vinay Panjwani UNICEF 2020

This section guides you through the step-by-step contextualization and measurement processes and explains how the tools in ANNEX A can be used. The **work plan and timeline** indicate the phasing of the steps over a five-week timeframe.

The contextualization and measurement processes serve to:

- Identify local terms and concepts of child well-being, capturing a full range of meanings, and how well-being is understood alongside other concepts, such as "happiness" or "resilience."
- Understand the local construct of child well-being (or similar local term) by identifying the key elements and protective factors that constitute or contribute to it in accordance with different gender, social, and age groups.
- Modify (where necessary) the global definition, child development ages and stages, domains, and indicators in accordance with the cultural context.
- Identify any additional indicators that are relevant to the cultural context.
- Measure child well-being using the self-reported questionnaires.

Key Steps to the Contextualization of the Child Well-Being Definition and Measurement Framework

Step 1: Coordination and planning

Step 2: Review, adapt and translate data collection tools

Step 3: Identify and train data collection team

Step 4: Qualitative data collection and data analysis

Step 5: Facilitate contextualization workshop

Step 6: Disseminate contextual definition and measurement framework to relevant stakeholders

Step 7: Data collection to measure child well-being

Remember! *These Steps are to be used to guide the contextualization of the child well-being definition and measurement framework, and can be modified in accordance with available resources. Ideally, key informant interviews and focus group discussions will be held to collect a broader range of input, followed by a contextualization workshop. However, in some contexts where resources are limited, it may be necessary to facilitate only the contextualization workshop. In this case, it is necessary to safely include in the workshop a broad range of actors, including children and local community members.*

Brian Sokol UNICEF 2019

Coordination and planning

1.1 Decide whether the contextualization process is an individual agency or inter-agency effort

Contextualization is a process, not just an activity. The contextualization of the child well-being definition and measurement framework can either be facilitated by individual agencies seeking to develop a common definition and measures for their child protection program or it can be an inter-agency collaborative effort that includes commitment from a range of agencies, led by the Child Protection Coordination Group (CPCG).

If this is an individual agency effort, proceed to 1.2 Determining the approach

Inter-agency level

If it is an inter-agency effort, the process can be initiated at the national or sub-national level, depending on the context. In mixed settings with refugees and internally displaced persons (IDP), it may be necessary to carry out this process with both the CPCG responsible for the refugee population as well as the CPCG at the OCHA cluster level as local understandings of child well-being amongst the refugee and IDP populations may differ.

Build consensus on the need for a definition of child well-being and the contextualization process as well as buy-in from child protection member agencies of the CPCG to support the process. While the Child Protection Coordinator or CPCG co-lead may initiate this process, it is important that one or two child protection agency members lead it. To ensure adequate resources and time commitment it is recommended that the CPCG set up a Child Well-Being Task Force composed of member agencies that can dedicate time and resources to leading the process. Members of the Child Well-Being Task Force should provide skilled human resources (focal points) to manage logistics, coordinate with partners, carry out data collection, and facilitate the contextualization process. Given the nature of this exercise, it is important that the agency leads of the Task Force be composed of at least one local partner or the government.

Remember! *Ensure that none of the members or any other actors have already carried out a similar activity. If there is a contextualized definition of child well-being that exists in context, identify how it can be used to inform the measurement framework and ensure that it is shared amongst the CPCG members.*

The terms of reference of the Child Well-Being Task Force or CPCG may include:

- Costing the process and identifying financial resources
- Developing a time-bound work plan for the contextualization process
- Determining logistical and human resource needs
- Deciding on the scope, sample size, and geographic coverage (for instance, in both urban and rural locations, number of FGDs with children, number of FGDs with adults, number of KIIs with adult key stakeholders)
- Agreeing on how the data collection process will be supervised and supported
- Determining how the contextualized definition and measurement framework will be shared with other stakeholders following the contextualization workshop

Identify child protection staff employed by agency members to conduct the data collection or incorporate focus group discussions or key informant interviews in on-going agency activities, for instance, at child safe spaces or with youth animators already supporting specific child protection projects instead of hiring external data collectors.

1.2 Determining the approach

While it is recommended to conduct KIIs and FGDs prior to the contextualization process to gain a wider overview of the cultural and contextual understandings of well-being this ideal may not always be possible due to limited time, resources, or access constraints.

Identify existing resources and decide on the contextualization process that is feasible within the budget. It can be facilitated in two ways:

1) Conduct KIIs and FGDs, summarize and present results, AND hold a contextualization workshop; or
2) Hold **ONLY** a workshop with key stakeholders, including children.

Lastly, identify staff that will lead the process and facilitate the contextualization workshop. It is recommended that there be two workshop facilitators, as well as 2-3 other child protection staff that can act as back-up facilitators that are able to support facilitating small group work. (For further details refer to **Step 5: Facilitate contextualization workshop).**

Sample work plan and timeline

WORK PLAN AND TIMELINE FOR IMPLEMENTING CHILD WELL-BEING CONTEXTUALIZATION AND MEASUREMENT																										
#	Steps	Recommended tasks	APPROXIMATE TIMELINE																							
			Week 1					Week 2					Week 3					Week 4					Week 5				
			1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1	Coordination and planning	Cost the process and identify financial resources																								
		Develop a time-bound work plan (including which agency will lead each activity if inter-agency initiative)																								
		Determine logistical and human resource needs																								
		Decide on the scope, sample size and geographic location																								
		Agree on the data collection process																								
		If resources allow, determine if KIIs and FGDs will be conducted and how many																								
		Define criteria for key informant and focus group selection																								
		Determine how to disseminate results																								
		Identify and invite contextualization workshop participants																								
		Identify KII and FGD participants and organize discussions																								

WORK PLAN AND TIMELINE FOR IMPLEMENTING CHILD WELL-BEING CONTEXTUALIZATION AND MEASUREMENT

#	Steps	Recommended tasks	APPROXIMATE TIMELINE																						
			Week 1					Week 2					Week 3					Week 4					Week 5				
			1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
2	**Review, adapt and translate tools**	Make any necessary modifications to the sample tools																									
		Identify which participatory activities will be included																									
		Translate the sample tools into the local language and back translate to ensure clarity																									
3	**Recruit and train data collection team**	Identify data collectors																									
		Provide a 1-1.5 day training																									
4	**Qualitative data collection and thematic analysis**	Conduct KIIs and FGDs																									
		Analyze data																									
		Write 2-page report with key themes																									
5	**Facilitate contextualization workshop**	Hold 2-day workshop to define child well-being and its measurement framework in context																									
		Write summary workshop report																									
6	**Disseminate the contextual definition and measurement framework**	Disseminate summary workshop report with key child protection actors, and other key stakeholders																									
7	**Data collection**	Conduct short survey using self-assessment tools and summarize results with key implications for programming																									

Karin Bridger UNICEF 2019

Review, adapt and translate data collection tools

Review the process and tools in this Guide. It is important to thoroughly read the contents of this Guide prior to engaging in this exercise.

Adapt and modify the contextualization process and tools as necessary, including any questionnaires or activities. There may be other participatory activities that have been used or are relevant to context that have not been suggested in this Guide. You are encouraged to adapt activities as suitable to context.

Ensure any modifications made to the KII and FGD questionnaires revolve around identifying activities that indicate a child is doing well, as well as on community coping mechanisms in times of adversity.

Translate all materials into the local language. As these sample tools are in English, qualified, bi-lingual translators must conduct the translation.

Remember! *It is always a good idea to back translate the translated materials and have them reviewed by at least two bi-lingual people to ensure that certain terms and meanings are conveyed accurately in the local language.*


Khudr Al-Issa UNICEF 2018

Giacomo Pirozzi UNICEF 2009

Train the data collection team

KIIs and FGDs require a high level of expertise and a dedicated amount of time for analysis and interpretation. Ensure experienced staff is available. It is essential that staff strictly follow guidance of this methodology. It is recommended that national child protection staff working for the response facilitate the data collection process. If this exercise is an inter-agency effort, agency members of the Child Well-Being Task Force or CPCG should contribute national staff to facilitate data collection.

Essential requirements for data collectors include:

- Knowledge of the local language
- Ability to express oneself clearly
- A track record of working or interacting responsibly with communities and children in the context
- Knowledge of child protection.

Determine the structure of the data collection team (or teams if this exercise is being carried out in more than one location). Since this is a short exercise, it is recommended that the team be composed of a minimum of 3-4 people.

Gender, age, ethnicity, religion, other socio-cultural identity or affiliations could have a direct impact on the information received from key informants and focus group participants. Balance the team in all these aspects as best as possible.

Train the data collection team on:

- Contents of this Guide
- An orientation of the objectives of this exercise and the tools
- Logistics of data collection
- Ethical considerations.

The training will be carried out over the duration of two days. A sample training agenda and training package is included with this Guide.

Jordi Matas UNICEF 2018

Qualitative data collection and thematic analysis

If there is limited budget and time, consider skipping this step and focusing on the Step 5 Contextualization Workshop

During the Step 1 Planning phase you will have determined the number of key informants to interview and focus group discussions to hold. In this section, you will learn how to:

A. Define criteria for key informant selection
B. Conduct key informant interviews
C. Define criteria for focus group participant selection
D. Facilitate focus group discussions
E. Analyze data using thematic analysis and write summary of findings

The purpose of the key informant interviews and focus group discussions is to gather information from key stakeholders, including children to better understand:

1) Cultural and contextual understandings of child well-being and related terms; and
2) Characteristics of a child who is doing well by age categories.

The questionnaires included in this guide are samples and the questions can be amended as necessary according to your context.

The following actions should be completed:

- ✓ Arrange the interviews and focus group discussions
- ✓ Provide participants with an orientation on this exercise and how their participation and input will be used
- ✓ Obtain informed consent and informed assent from all participants

A. Define criteria for key informant selection

A **key informant** (KI) is a person who can provide information or opinions on a specific subject based on their experience and knowledge. It is recommended that for the contextualization exercise, key informants be contacted during the planning phase. At this stage, you may choose whether to share the global definition of child well-being in humanitarian action and the measurement framework with the key informants so that they are familiar with both prior to the interview.

Key informants will be government staff, local child protection experts or experts from other sectors, service providers, or other relevant local authorities on how child well-being is defined in context. It is recommended that **4 to 12** key informants be interviewed per location.

Key informants may include:

- 1 to 2 government officials working for the child protection governing authority (such as the Ministry of Social Affairs)
- 2 to 3 local child protection actors working for international, national, or local

organizations or civil society organizations

- 1 to 2 national/local MHPSS actors
- 1 to 2 national/local healthcare actors
- 1 to 2 national/local education actors
- 1 to 2 national social workers/caseworkers

B. Conduct key informant interviews

The key informant interview is structured in a simple manner to gain an initial indication of cultural and contextual understandings of child well-being.

See Tool 1: Key Informant Interview Questionnaire

The questionnaire is structured in a way to:

1) **Define** child well-being, happiness, resilience, and quality of life in meaningful and relevant local terms.
2) **Identify** the criteria by which well-being is understood in a particular culture or community by using the method of free listing.

Free listing is a method used to identify what key informants perceive to be the characteristics of a "child who is doing well". The interviewer will ask a primary, open-ended, general question: "What are the characteristics of a child who is doing well?" to create a list, probing to make the list as long as possible. The respondent is then asked to make descriptions of each of the terms in the list, and to identify other local people, including local government members who are knowledgeable about each of the items listed, which will support identifying participants for the contextualization workshop.

The resulting list can be used to help guide discussions during the contextualization workshop.

For key informant interviews, it is important that:

- ✓ The global definition of child well-being and the measurement framework are shared with the key informants prior to the interview
- ✓ There is a balanced number of women and men
- ✓ Informed consent and informed assent is collected (See ANNEX A for **Sample: Informed consent/assent form**)

C. Define criteria for focus group participant selection

In selecting focus group participants, consider:

- ✓ A broad range of actors that directly or indirectly work to promote the well-being of children
- ✓ Children from different age groups
- ✓ Caregivers of children and community members, including community leaders and religious leaders

Remember! *Ensure diversity in the selection to gain a broad overview of how child well-being is understood by different individuals.*

It is important that there are:

- At least two focus group discussions with community members, including religious leaders (one with men and one with women)
- At least one focus group discussion with local actors working in other sectors (education, health, nutrition, etc.)
- At least four focus group discussions with children (see Table 3 for details)
- A balanced number of women and men and girls and boys.

Table 3: Sample Focus Group Discussion group composition

# of FGDs	Focus Groups	# Male Participants	# Female Participants
1-2	Children (aged 6-11)	7-10	7-10
1-2	Children (aged 12-17)	7-10	7-10
1-2	Other sector actors	7-10	7-10
1-2	Caregivers and community members	7-10	7-10

Each focus group should be composed of 7 to 10 participants. Determine in context whether it is necessary to have separate male and female FGDs with children and caregivers or community members.

D. Facilitate focus group discussions

Two qualified facilitators should facilitate focus group discussions. One facilitator can lead the discussion while the other can provide back-up support and act as the note taker. The tips below can help you make focus groups as effective as possible.


Aggrey Nyondwa World Vision 2020

Prepare the room

- Arrive an hour early to set up the room. This allows time to deal with unexpected room scheduling, and to set up materials and refreshments.
- Post plenty of signs so participants can find their way to the space. This helps participants feel welcome when they arrive.

Open the session

- Introduce yourself and explain the purpose of the focus group. Explain to participants that they have been invited to share their opinions and feedback and that you will guide the discussion by asking the group to reflect on specific questions.
- Explain the expected duration of the focus group.
- Obtain informed consent (for children, also obtain informed assent prior to the focus group during the preparation phase).
- Explain the ground rules for the focus group discussion. These will set the tone and expectations for behavior to enable everyone to feel safe, encouraging their participation.
- Allow time for questions, and ask participants to introduce themselves.

Conduct the focus group discussions

Refer to Tool 2: Focus Group Discussion Questionnaire for questions for adults and older children. This tool can be modified as necessary during Step 2: Review, adapt and translate data collection tools. The focus group discussion questionnaire is designed to pose similar questions to those posed in the key informant interview questionnaire related to what terms are used in the local context to describe when a child is doing well. It builds on the key informant questionnaire by asking about specific age groups and activities, such as cultural practices, to identify key factors that contribute to a child's well-being. The responses can be used to modify the domains or indicators. Note that this is a sample questionnaire, and the questions can be amended as necessary according to your context.

Younger children from age 6-11 should be engaged in a participatory activity as opposed to using a guided discussion. Examples of participatory activities can be found in Tool 4: Examples of Participatory Exercises for Younger Children during FGDs.

Remember! *Always obtain informed consent and informed assent from child participants and informed consent from adult participants. For children's participation, the informed consent is sought from their adult caregiver and informed assent should also be sought from the children themselves. Alternative informed consent/assent methods should be available for children or caregivers who cannot read or write and all relevant information should be presented in simple, age-appropriate language or pictures (if necessary). Support the right of children with disabilities to make their own informed choices. Remind participants that they can refuse or withdraw permission at any time.*

If a child discloses a protection concern during the focus group discussion, follow your agency's safeguarding policy accordingly.

Informed consent is the voluntary agreement of an individual who has the capacity to take a decision, who understands what they are being asked to agree to, and who exercises free choice. When obtaining informed consent, practitioners must disclose, in a child-friendly manner, what information will be collected, how it will be used, and any details regarding confidentiality and its limitations. Informed consent should only be sought from children above the age of consent, as determined by the local laws and mandates.

Informed assent is the expressed willingness to participate in a service or activity. Informed assent is sought from children who are by nature or law too young to give consent, but who are old enough to understand and agree to participate in services or activities. Informed consent from an adult caregiver is necessary in addition to informed assent.

Ethical Considerations for Children's Participation[4]

Children are creative, resourceful and insightful, and the ethical involvement of children in the focus group discussions, contextualization workshop, and the child well-being survey will inform the design of appropriate program interventions that seek to enhance and support their well-being and protection. Meaningful participation recognizes that girls and boys have agency to analyze their situation, express their views, influence decisions that affect them, and achieve change. This includes the informed and willing involvement of all children, including the most marginalized and those of different ages and abilities, in any matter concerning them directly or indirectly. Children's participation in the contextualization and measurement processes can improve the appropriateness and quality of child protection programs and practices that seek to improve their well-being. However, children's participation must be safe, ethical and meaningful and should only take place with the full and informed consent/assent of the child and their caregivers.

In humanitarian contexts, ethical concerns may arise regarding the potential harm of involving children in data collection activities. It is crucial that the principles of "best interests" and "do no harm" are applied when determining how and when to support children's participation. Every humanitarian setting is unique and requires an understanding of the cultural context.

It is critical that a risk assessment be facilitated to inform decision making about whether the participation of children is appropriate. Key considerations should include identifying:

- Whether there are potential risks involved in engaging with children, and how severe the risks are (such as potential repercussions against children for engaging with outsiders or recalling distressing events);
- The likelihood that the risks will occur, and how to prevent or mitigate against them; and
- Further action that can be taken to ensure the principles of do no harm and best interests are upheld.

When planning to engage children, ensure:

- Participation is voluntary and with the informed consent/assent of both the children and their caregivers;
- Child friendly approaches are used;
- Participation is inclusive (girls, boys, children with disabilities, etc. are included);
- A plan to mitigate harm is developed, including preparing in advance who or where it would be most important to refer a child who is distressed or needs support otherwise (urgent action procedure);
- Data collectors are trained on child rights, safeguarding, participation, and urgent action procedures.

With regards to the child well-being measures, if you are administering the measure as part of a longer assessment survey, be mindful of how long the total survey will take to complete as some participants may experience fatigue when completing lengthy surveys. This can lead to premature termination, lack of focus when answering questions, and other issues such as participants tending to select the same response option to proceed faster.

If potential harm cannot be mitigated it is recommended that only caregivers take part in the child well-being survey using questionnaire 1 and 2b, and that questionnaire 3 for children aged 9-17 be adapted for adult respondents (refer to Step 7 for further guidance).

[4]Refer to the following documents for further guidance on child participation and ethical considerations:
https://data.unicef.org/wp-content/uploads/2015/12/EPDRCLitReview_193.pdf
https://www.unicef.org/media/54796/file
http://www.cpcnetwork.org/resource/ethics-of-childrens-participation/

E. Analyze data using thematic analysis and write summary of findings

Once data has been collected from KIIs and FGDs, analyze the data, pulling out common themes to present at the contextualization workshop. Consolidate the responses into common themes and write a 1-2 page summary of the findings.

Remember! *Stay as close as possible to the exact terms local respondents use to capture local values and understandings. When interpreting data and identifying key themes, pay close attention to the data to ensure that you are not characterizing points that are not there – or obscuring things that are.*

Thematic analysis is a useful approach to research when you are trying to find out something about people's views, opinions, knowledge, experiences or values from a set of qualitative data, for example, interview transcripts or focus group discussions. Thematic analysis allows flexibility in interpreting the data by sorting data into broad themes.

It also involves the risk of missing nuances in the data. Thematic analysis is often subjective and relies on the researcher's judgment, which means that child protection staff interpreting the data must reflect carefully on their own subjectivities and interpretations. As a result, it is essential that staff from the local humanitarian population lead this process to ensure that local understandings are reliably interpreted.


Harandane Dicko UNICEF 2017

Brian Sokol UNICEF 2018

Facilitate contextualization workshop

The steps outlined in this section will support child protection humanitarian practitioners to identify the subjective and objective factors that contribute to children's well-being in accordance with community, cultural, and contextual understandings of the term. In this section, you will learn:

A. How to select workshop participants
B. Key elements required for facilitating a workshop
C. How to structure the workshop
D. How to modify, add or remove indicators by domain

The contextualization workshop outcomes:

- Final contextual definition. Agreement on any necessary amendments to the global CPHA definition of child well-being through identification of key elements of child well-being in context.
- Agreement on the developmental and social age groups: understand how the local community perceives different social and developmental age groups and agree on the ages for infancy, early childhood, middle childhood, early adolescence and late adolescence.
- Final domains in accordance with key elements contributing to well-being in context.
- Key indicators by age group to include in the measurement framework. The indicators can also be finalized at a later stage if time is limited, however, the key factors that will be measured must be decided upon during the workshop. Ask for the support of an M&E Officer or Advisor or an Information Management Officer (IMO) to ensure SMART indicators are developed (see ANNEX C for further guidance).

A. How to select workshop participants

Selection of participants

Participation is central to the success of this workshop. You will have identified child protection agency staff to lead the workshop and key stakeholders to participate in the workshop during the Step 1 Planning phase. Carefully consider whom to invite. Organizers should articulate to relevant stakeholders why contextualization is needed, what purposes it serves, and what is the final goal, i.e. what the plans are for its ultimate use.

Members of the local population affected by or responding to the humanitarian situation should be participants in the workshop. Participants may include:

- Government representatives; community members, including community leaders, religious leaders, and others working directly or indirectly to promote the well-being of children
- Professionals working in other sectors, such as health, nutrition, and education, camp management

- Mental health and psychosocial support actors
- Caregivers of children, and
- Children.

It is important that children from different age groups are included in the workshop. A diverse and inclusive range of stakeholders working on child protection should be invited to participate in the contextualization process.

To ensure that the workshop is constructive and interactive, it is important to limit the total number of participants to a maximum total of **25-30** people.

Remember! *Include children in the workshop. Any adaptions to the definition, domains, or indicators must be informed by what children consider as important in the present context as well as in the future.*

B. Key elements required for facilitating a workshop

Facilitation team

The facilitation should be composed of 2 lead facilitators. An additional 2-3 child protection staff should also be present to support group activities. All facilitators should be from the local community or nationals of where the humanitarian situation is taking place.

Skills of the facilitation team

The team should be child protection practitioners. They should be well versed in leading workshops, and in conducting participatory activities with children and adults. They should also possess excellent group facilitation skills and have active listening skills.

Remember! *Participants may hold strong beliefs about the key elements that contribute to child well-being. Thus, it is important to develop ground rules with the group, describing the definition and measurement framework as a living document to be utilized and amended or added to, as necessary. Posting a flip chart or using a chalkboard are all effective ways of keeping these "ground rules" visible throughout the workshop.*

Language of facilitation

While there may be multiple languages spoken in the country where the humanitarian situation is occurring, it is essential that the workshop be held in the local language of those affected by the humanitarian situation to convey accurate understandings of child well-being.

Guest speaker

It is wise to invite a government representative or a senior national child protection actor to introduce the topic and provide background.

C. How to structure the workshop

Note: The exercises, session topics, and sample agenda in ANNEX A: Sample Tools, Workshop Materials and Child Well-Being Measurement Questionnaires are to be used as a general guide and adapted as necessary in context. Substitute any of the suggested exercises for any others that are relevant to the workshop outcomes.

Workshop Content Overview (example)

Day 1

- Provide background and orientation to the workshop and its objectives, including presentation of the global definition and measurement framework of child well-being in humanitarian action.
- Present summary of findings of key themes that were provided by key informants and focus group discussions.
- Small group work and plenary on **Defining the term**. Participants should define what child well-being, happiness, resilience, quality of life and any other related terms mean locally, and the factors that contribute to each. They can also discuss whether they agree with the findings from the KIIs and FGDs.
- Small group work and plenary on **Who is doing well** to identify key developmental milestones and factors that signal when a child is doing well per each age group.
- Summarize the common themes of the day.

Day 2

- Overview of key themes from Day 1.
- Small group exercise work and plenary on **The Life Map**.
- Small Group work and plenary: **Visioning Tree** of a child's care and protection in the community, including services.
- Presenting common themes and any modifications to the global child well-being definition and measurement framework.
- Final contextual definition, age groups, and domains agreed upon.

Please refer to Tool 4 for further guidance on the activities. Refer to the Sample Workshop Agenda for an example of how to structure the workshop.

During the group exercises and plenary, the facilitation team will identify key themes to discuss with the participants to determine whether there are any necessary modifications to be made to the child well-being definition, age categories, domains or indicators. **Note** that the global definition may capture cultural and contextual understandings already in which case no modifications will be necessary.

Key Contextualization Tips!

Child Well-Being Definition and Domains

- Modify the global definition, if necessary, to reflect cultural and contextual understandings of a child's development and interactions with their environment.
- Balance local views with those of international child rights standards.
- Ensure the diversity of participating children. Children's experiences are situated in cultural and social contexts, and what they value in terms of their well-being may differ as a result.

D. Modifying, adding, or removing indicators by domain

Key consideration: Amending or developing indicators can be a lengthy process. The key factors to be included under each domain and age group should be discussed and agreed upon during the workshop. In some contexts, no amendments will be necessary, but in others it may be necessary to make minor adjustments to the indicators, adding, removing, or modifying them to context.

Guiding questions when modifying, updating, or developing new indicators to context

- What is critical to measure?
- What needs to be measured to determine if the intervention is working?
- What do you need to know (not just what you would like to know)?
- What data is needed to measure the indicator? (If the answer is not clear, think twice about adding it).
- Does the indicator measure one specific variable, such as knowledge AND attitude or children AND caregivers? If so, break it down into separate indicators to ensure that the different variables are measured separately.
- Will the change measured by the indicator represent progress?

Do's and don'ts when modifying indicators to context or to program interventions

DO:

- ✓ Contextualize key indicators based on local and cultural understandings of child well-being.
- ✓ Ensure indicators are culturally appropriate and relevant to the humanitarian context.
- ✓ Ground any new or modified indicators in the experiences of children to ensure relevance to well-being domains.
- ✓ Ensure that any indicator modified to context remains focused, precise, and specific, describing exactly what is being measured in clear and reliable terms – consistently measurable over time in the same way by different observers.
- ✓ Check that any indicator targets, when applied to context, are accompanied by evidence backing up why that target was chosen.
- ✓ Confirm that the indicator is measurable and quantifiable using tools and methods available and accessible in the humanitarian context.

DON'T

- ✗ Make the indicator so complex that it will be impossible to measure.
- ✗ Confuse indicators with targets. Remember that an indicator is a neutral variable that operationalizes an activity. A target sets the specific goal for that indicator.
- ✗ Create a long list of indicators; rather consider what must be measured in relation to child well-being and in accordance with the specific age groups and developmental stages.
- ✗ Try to measure more than one thing within each indicator (it is useful to watch out for the word "and" in an indicator).

Remember! *Always consider the changes that children experience over time because of their age and developmental stage when identifying new or modifying existing indicators in the child well-being measurement framework. Certain indicators may be relevant to certain developmental stages, but it should not be assumed that these stages are attributed to specific ages. For instance, the need for autonomy and security will be universal throughout a life course but may be experienced in different ways by different children at different developmental stages during their lives. They should be comprehensive in their coverage and relate to significant outcomes for children's well-being.*

The selection of the indicators in each domain must be guided by principles that address the purpose and scope of the measuring and monitoring process as well as accuracy of measurements.

See ANNEX C for further information on indicators.


Syed Mehdi Bukhari UNICEF 2021

Disseminate and apply the contextual definition and measurement framework

It is essential that the contextualized definition and measurement framework be widely disseminated and shared with all relevant stakeholders in the form of a short report.

If this is an inter-agency exercise, the CPCG and government (where appropriate) have the responsibility of sharing and disseminating the definition and measurement. The CPCG Coordinator should also share the report with Coordinators representing other relevant sectors, such as Education and Health, as well as the Coordinator of the MHPSS Working Group in country.

The contents of the report will include the following sections:

- Background information
- Methodology
- Results of the contextualization process
- Contextualized definition and measurement framework.

The report will be approximately 2-3 pages in length, not including the modified measurement framework. It should be drafted in the local language.

Informing strategic prevention and response priorities

While the aim of the workshop and contextualization process is to inform a contextually relevant definition of child well-being and measurement framework, it is important to note input from participants as it may bring to light specific risk or protective factors, important gaps that international humanitarian actors have not considered or false assumptions about the context. This information can be used to inform strategic prevention and response activities.

For instance, there may be fewer adolescent girls in the education system than boys. Humanitarian actors may assume that this is a result of traditional gender norms. However, it may come to light that community members value education for adolescent girls, but that parents are not able to afford it and as a result it is de-prioritized, which could lead to joint efforts by child protection, education, and livelihood actors to identify modalities to better support livelihoods and income generating activities for adult caregivers.

Alternatively, it may become apparent that adults place value on skills children develop from working, some forms of which may be hazardous. This information could lead to prioritizing efforts to raise awareness about protecting children from the risks and harms associated with child labor or hazardous forms of labor, as well as to ensure safe work places for children of legal working age.

If this is an inter-agency exercise: Do Not Forget!

- Use the newly adapted definition to inform the sector's humanitarian response planning and funding strategy.
- Encourage all CPCG members, including the local government where possible to use the definition and measurement framework in the programming interventions.

Karin Schermbrucker UNICEF 2017

Data collection: measure child well-being

Data Collection – Child Well-Being Measures

Objectives – What can these tools be used for?

The child well-being measures are self- or caregiver-reported measures of well-being depending on the age of children. The tools can be used to gain a snapshot of how well children are doing in the communities where you are working or plan to implement activities. They are easy-to-use tools that can be employed to:

- Understand broadly how well children are doing in a specific location
- Determine important characteristics and needs of children
- Identify priority areas of concern to inform program planning and interventions or areas in which to build on strengths
- Monitor improvements in the dimensions of child well-being over time, and
- Support advocacy for resources or improvements in the quality of service provision.

Audience – Who can use these tools?

These tools can be used by all actors working to enhance and promote the well-being of children. These actors include:

- Child protection actors from local, national, or international NGOs
- Government representatives
- Other relevant stakeholders that work with children, such as MHPSS, education or health actors

Timing – When to use these tools?

When to use these tools will depend on how the information gathered will be used, the capacity of the organization(s) conducting the measures, resources available, and the timeframe in which children may be expected to experience change in the domains contributing to well-being. The frequency of use should be programmatically useful. For instance, the tools may be used to obtain baseline information following a humanitarian emergency and at the response transition phase, or at the baseline, mid-term or end-line of a specific project.

Introduction to the measures

The measures include four tools suitable for children aged 6-8 and 9-17, and adult caregivers who can report on children aged 0-5 and 6-8 in their care. They consist of between 20-31 items (i.e. statements used in the measure) that can be scored on a 3- or 5-point Likert scale. The items in the questionnaires are all formulated in the positive and therefore scoring involves simply summing up the responses. The measures targeting younger children aged 6-8 and their caregivers use a 3-point Likert scale. The questionnaire for child respondents in this age group uses simplified language to make sure the child respondents can easily understand the questions and that they are child-friendly.

The measure for caregivers of children aged 6-8 can be used on its own, for instance, in contexts where there are ethical or safety concerns related to children's involvement in the child well-being survey, or alongside the measure for children aged 6-8. Since the questions are similar and since both use a 3-point Likert scale, a comparative analysis can be carried out to explain differences and similarities between child and caregiver responses in relation to the contextual conditions. Children and their caregivers may perceive their circumstances differently, which may provide more information on the main issues affecting the well-being of children.

Table 4: Overview of the measures

Measure	Recommended age of target individuals	Completed by	Scoring system (Likert scale)	Language
Infancy, toddlerhood and early childhood	0-5	Caregiver	5-point	Standard
Middle childhood	6-8	Child	3-point	Simplified
Middle childhood	6-8	Caregiver	3-point	Standard
Middle childhood and adolescence	9-17	Child / adolescent	5-point	Standard

Contextualizing the measures

The items included in the measures, age groups, and language may need to be modified depending on the outcomes of the contextualization process. If there are modifications to the child well-being definition, age groups, domains or indicators, amend the measures accordingly to ensure alignment and determine whether or not new statements need to be added or existing ones removed. The measures for infancy, toddlerhood, and early childhood and for middle childhood and adolescence can be amended from a 5-point Likert scale to a more simplified 3-point scale if necessary.

While modifications to the measures should be in line with any changes to the global child well-being definition and measurement framework, the following questions will help guide the process:

- What do children in each age group need to be healthy (mentally, physically, emotionally, spiritually and socially)?
- What do children in each age group need to grow up well?
- What does being healthy mean for children in your family and community?

Administering the measures

The measures can be administered on their own or used alongside wider population-based assessment tools using convenience, snowball, or purposive sampling. They can be administered to participants in groups or individually (e.g. when conducting a household survey). Each measure takes approximately 15-20 minutes to complete, depending on the age of the participant, their level of comprehension, and the addition of any new items.

The measures are designed to be self-reported and anonymous. When administering the measures:

- Review and explain the measure to participants, allowing time for questions.
- Decide whether to read the items out loud to participants or allow them to complete the measure at their own pace. If you are unsure about the participants' level of literacy or comprehension (most notably the child respondents in the 6-8 age group), reading aloud may be a better option. If participants have the measure read to them, their responses should still be self-completed to encourage truthfulness.

- Consider turning the Likert responses to represent visual cues appropriate to the cultural context (such as smiley faces or cups filled with different amounts of water). Visual aids can help participants understand which response to choose.
- Work individually with children aged 6-8 to make sure they understand each item in the measure.
- Pilot each measure with 2 or 3 respondents and make any necessary adjustments prior to administering them to a larger sample.

Sampling

The sampling method you choose for the child well-being survey will depend on whether the survey questionnaires are administered alongside a wider child protection, multi-sector or joint assessment survey, or as a standalone survey. If you are using it alongside a wider assessment, follow the sampling procedure that is being used for the purpose of that assessment.

If you are completing the child well-being survey to inform the design of questions for a wider assessment or to derive data that can be triangulated with wider assessment findings, or simply as a standalone exercise, it is recommended that non-probability sampling be used, which means that the sample will not be representative to a broader population. Non-probability sampling is a sampling technique in which samples are selected based on the subjective judgment of the child protection actors involved in measuring child well-being rather than on random selection. Non-probability sampling is often used when there are time or resource considerations. Despite the results from surveys administered using non-probability sampling not being representative to a wider population, the results can nonetheless be useful in identifying key themes in an area as well as the respondents' prioritization of various issues.

Types of non-probability sampling methods that can be used for the purpose of the child well-being survey are purposive sampling, convenience sampling, or snowball sampling, or a combination of these methods.

Purposive sampling, also known as judgmental, selective, or subjective sampling, is when the data collection team relies on their own judgment when choosing locations or members of the population to participate. In this method units of measurement are purposefully selected based on a set of defined criteria, such as children in a specific age group who are affected by the humanitarian situation.

Convenience sampling is when samples are selected from the population because they are conveniently available to the data collection team. An example may be children who are in school or who are already participating in specific program activities that your agency is facilitating. This is convenient because you can reach groups of children in the specific age groups quickly and in a time and cost-efficient manner.

Snowball sampling is useful if you are trying to locate a specific sample or when the sample size is small, not easily available or difficult to locate. This sampling technique works like a referral system and may be useful if you aim to target a specific group of children, particularly children who may be hard to reach, such as children with disabilities.

All of these methods will give a measure and sense of the scale and priorities of the most pressing issues impacting the well-being of children as perceived by the individuals whom you select to interview, which can be used to inform program design and planning. The sampling method you choose will depend on your context, the purpose of the child well-being survey in your context, and what you intend to use the results for. Since the results are likely to depend heavily on the sample of children and adults whom you choose to speak with, you should consider what general categories of children and adults to consult with to learn about the priorities in the community. Whichever method you decide on, it is recommended that the sample size be no less than 30 participants per each of the measures in each target location.

It is important to consider the following when deciding on the sampling approach:

- Objectives of sampling—whose voices do you need to hear, and why?
- Access constraints—if you cannot access certain populations, are there ways you could connect with people who come from or who have information about those populations? For example, convenience sampling can often lead humanitarian workers to speak with those people who have the most access to humanitarian support. Be intentional in trying to reach out to children and adults who may benefit from humanitarian action but have less access to you.
- Available resources (financial and human) and length of time to administer the measures.
- If populations with distinct characteristics (such as language, ethnicity, place of origin, status, etc.) live together in one site, and you believe that these characteristics are likely to have an impact on how each group understands child well-being, these locations should be divided into multiple sites along the lines of those distinct characteristics regardless of their size. Likewise, be intentional about sampling children and adults whom you understand from preliminary research or data collection activities to be more vulnerable to child protection violations. These may include gender differences, disability status, ethnic or racial affiliation, sexual orientation or gender identity/expression, or other locally salience considerations.

Scoring and interpretation

Scoring

The items within the measures can be directly summed to gain a total score of the child's well-being. All the items in the measures are weighted equally. In addition, a sub-score will be provided for each of the domains. These sub-scores will show whether there are certain aspects of well-being that are lacking and can be used to inform appropriate interventions.

If a respondent skips or misses an item, their scores cannot be computed, as their overall score will be artificially lower than others who complete the measure. If this happens, the incomplete result should be discarded. To avoid errors when entering data it is recommended that drop down options be added to the data analysis tool you are using, and that the settings are arranged to show error alerts if an invalid number is added. In Excel this can be achieved under the data validation tab for instance. See the Excel sample template that is included in the Child Well-Being Resource package on the webpage of the AME Working Group for an example.

Note: The questionnaires should reflect the domains and indicator table. If any changes are made to the domains or indicator table, make sure they are accompanied with changes to the questions and domains in the measurement tools.

Each of the measures is rated on a numerical scale from 1-3 or 1-5, depending on the measure.

In measures with a scale of 1-5, the numbers indicate the following:

5	4	3	2	1
Very well	**Well**	**Fair**	**Not doing well**	**Very bad**
The child is doing very well and there are no concerns or apparent risks for the child.	The child is doing well; there are no concerns and no apparent risk for the child.	The child or their situation is generally acceptable, but there is room for improvement. Additional resources, services or support will be helpful.	There is concern that the child or situation they are in will lead to harm. Additional resources, services or support are needed.	The child is at serious risk of harm or is already experiencing harm. Urgent attention to the child or the situation is needed.

'In measures with a scale of 1-3 add , the numbers indicate the following:

3	2	1
Doing Well	**Fair**	**Not doing well**
The child is doing well; there are no concerns and no apparent risk for the child.	The child or their situation is generally acceptable, but there is room for improvement. Additional resources, services or support will be helpful.	There is concern that the child or situation they are in will lead to harm. Additional resources, services or support are needed.

Scores that increase or decrease over time will require further assessment of the influences that may have led to the change(s), such as program quality, changes in the humanitarian situation, or changes in the family situation. With this information, decision-makers can plan, implement, and modify child protection activities based on information about child well-being over time.

You may also consider disaggregating the data further to determine if there are differences between the specific age, location, gender or disability of respondents, which will provide further insight into whether the humanitarian context is specifically impacting children in certain locations, age groups or of a specific gender.

Patricia Willocq UNICEF 2019

Understanding and interpreting scores

In general, higher scores indicate characteristics associated with well-being. In any given context, there will be respondents with higher and lower levels of reported well-being. For this reason, it is recommended to compare high scores to low scores across respondents (including between girls and boys) and locations, and to investigate potential reasons for these differences. Refer to the sample data analysis tool included in the wider child well-being package.

However, it is especially important that the sub-scores for each domain also be analyzed. While aggregating the total scores can provide an overall picture of how well children are doing at a given time and in a specific location, aggregated scores across all of the domains do not reflect the possible variation underlying those total scores, which may result in serious issues affecting children being underestimated.

For instance, the total average scores across the different age groups may be similar; however, it may be that the basic needs domain in the infancy, toddlerhood and early childhood measure scores much lower than the other domains, while in the middle childhood and adolescence measure the agency domain scores much lower relative to the others. These sub-scores will help tell us what interventions need to be prioritized for which groups of children. In this example, child protection agencies will want to coordinate with other sectoral actors to make sure that assets are delivered to support caregivers to meet the basic needs of children aged 0-5. For children in the 9-17 age group, child protection agencies may want to prioritize life skills interventions that aim to empower children in this age group.

ANNEX A:
Contextualizing the definition of child well-being: sample tools and workshop materials

Welcome to Annex A: Contextualizing the definition of child well-being: Sample tools and workshop materials.

This section includes sample tools and questionnaires that can be amended in context. Only 2-3 of the suggested participatory activities should be selected and used during the FGDs and/or workshop. The sample tools and workshop materials are:

Sample Informed Consent Form

Tool 1: Key Informant Interview questionnaire

Tool 2: Focus Group Discussion questionnaire (adults and older children)

Tool 3: Focus Group participatory activity for younger children (aged 6-11)

Tool 4: Contextualization Workshop description of activities

Sample Contextualization Workshop Agenda

Tanya Bindra UNICEF 2019

Sample Participant Consent/Assent Form

You are invited to participate in an X [insert whether it is the key informant interview or focus group discussion] being conducted by X [insert agency name or the Child Protection Coordination Group/ Child Well-Being Task Force]. We are conducting several key informant interviews and focus group discussions to identify local and cultural understandings of the concept "child well-being" and other related terms. The purpose of these discussions is to inform the development of a contextual definition and framework for measuring child well-being. This work is important because it will enable organizations and the government (where applicable) to strengthen our interventions to promote the well-being of children in your communities.

In this X [insert either interview/focus group discussion, we will ask you questions related to your understandings of key concepts, such as child well-being and other related terms. We also hope to understand how you define these terms locally, and the key factors that contribute to a child being well in your community.

Please note that **your participation is voluntary.** If you decide not to participate, you can do so at any time, and we will not be offended. If you do decide to participate, you can choose to stop at any time. If there ever is a question that you do not want to answer for any reason, you do not have to answer it. Please know that you can skip any question you are not comfortable answering, and you can decide to end your participation at any time.

If you have questions about the interview/focus group discussion, please contact X [insert name of child protection staff/interviewer] at X [insert contact information].

I understand that information regarding my participation will not be passed to others and that my views will be treated in confidence.

I understand that I am free to withdraw from the X [insert interview/focus group discussion] at any time.

I understand that by checking the following box and writing today's date below that I am indicating my consent to participate in this interview/focus group discussion.

☐ I AGREE TO PARTICIPATE IN THE ABOVE INTERVIEW/FOCUS GROUP DISCUSSION

Date: _____

Tool 1: Sample Key Informant Interview questionnaire

Note: You may choose to share the global CPHA definition of child well-being and the measurement framework with key informants prior to the interview to make them aware of the global definition, domains and indicators or you may decide not to share this information if you think it will influence their responses.

Introduction

The purpose of this interview is to gain your feedback and insights related to the concept of child well-being and what it means for a child to be well in your community, including the factors that contribute to well-being. We will also discuss other related terms. Your responses will help to contextualize a definition of child well-being and measurement framework, which will support the government (if relevant) and local/national and international actors working to promote the optimal development of children in your country. This interview will take approximately 45-60 minutes. It is comprised of X questions.

Questions

1) What is the term most commonly used in your language/culture to describe when a child is doing well?
   a) Are there other related terms? If yes, please tell me what they are. (Do not probe, simply allow the terms to be mentioned. They may include words like resilience, happiness, etc.)
2) Can you please describe the key factors/characteristics of a child who is doing well (or use whichever local term appropriate, e.g. resilient) at:
   a) 0-5 years of age
   b) 6-12 years of age
   c) 13-17 years of age

Instructions for interviewer: *Develop a list of the qualities the participant associates with children who are doing well at each age group. Next, discuss the factors/qualities listed and group them under the common domains. Qualities may include playful and sociable; intelligent; happy; respectful; responsible; and healthy, or other local 'indicators' of a child who is doing well. Note anything that does not appear to 'fit' under one of the common domains in a separate category.*

Summarize/review the factors/qualities mentioned as per each of the domains and confirm with the participant whether they agree with the categorization, and whether or not they would like to add anything additional.

Tool 2: Sample Focus Group Discussion Questionnaire

Instruction: *This questionnaire can be used for adults and older children aged 12-17.*

Participant Selection

Participating agencies should select individuals and groups from communities in which they work. If necessary in your context, organize separate focus group discussions for: men and women, and boys and girls. If relevant, groups can be further disaggregated by rural/urban. Do not separate disabled children or children living without parental care from other children, rather include them in the appropriate age and gender group, unless the objective is to have a measure of a specific group of children's well-being that is separate from the general population.

Time allocation

Children's groups take about 1 hour; adult groups take approximately 1½ hours.

Number of Participants per Focus Group

Limit the size of each group to 7-10 participants, if possible. Young children can participate in some exercises supported by an older child or adult.

Informed consent and informed assent

Always begin by informing members of each group the purpose of the focus group discussion and obtain informed consent and informed assent.

Establishing a supportive environment

- Explain that participation in the focus group is voluntary
- Make it clear that it is all right to abstain from discussing specific topics
- All responses are valid—there are no right or wrong answers
- Everyone must respect the opinions of others even if you do not agree
- Participants can speak as openly as they feel comfortable
- Help protect others' privacy by not discussing details outside the group.

Instruction: *If helpful, ask participants to think about a time before the humanitarian situation and the conditions that caused it, when life was "as it should be." This will help identify key domains that have been impacted as a result of the humanitarian situation and may support you in identifying key domains or indicators that should be prioritized. During this time…(proceed with questions):*

General Questions

- What term is used to describe when a child is doing well (e.g. well-being)? Are there related terms that could be used to describe the same? (Probe in local language terms such as 'resilience' or 'happiness' if something different was raised.
  a) How are these terms differentiated?
- You described many factors that indicate when a child/person is doing well (or similar term). Summarise here what the participants raised, doing so by the age groups below. Are there any other key elements or factors that indicate when a child is doing well?
  a) If yes, please describe what they are.

Early Childhood

- What is the first thing that happens when a new baby is born? This refers to breast feeding or not, prayer rituals surrounding birth or not, care by other than mother or not
  - Any special parties or celebrations at this time? (Note: this question is posed to gain an idea of key milestones in childhood)
- Describe how infants are cared for and by whom? What is the most important thing for a child to learn in the first months of life (e.g. 0-3 years)?
- What is a child like from 3 to 5 years old?

Middle Childhood

- At what age can a child begin to learn the important rules of the community?
- How are children taught these things and by whom?
- At what age can a child begin school or work? What makes this a good age?
- What is a child like from 6 to 12 years old?
- At what age can a child begin to help the parent(s)?
- Which parent(s)? With what chores?

Adolescence

- At what age can a person speak of their opinions to the family? In the community? Participate in community councils or meetings?
- At what age is a person considered to be a proper adult in this community (fully grown up person)?
- List the characteristics that make a respected man or woman in this community? How do they learn these things? Are there special ceremonies associated with the acquisition of this knowledge/these capacities? At what age is one expected to behave in this way?
- Are there any special danger signs that indicate that things are not going well in this regard? (For girls? For boys?) What do you do and with whom do you consult if things are not going well?
- At what age can a person get married? Who makes that decision?
- At what age can a person start working? Who makes the decision?

Tool 3: Focus Group participatory activity for younger children

Instruction: *Distribute paper and crayons or markers to participants.*

Who is doing well? Draw around the shape of a child in the community on a flipchart paper. Ask them to think about a child in their community who is doing well (they can also think about themselves). Do not prompt participants with the ideas or terminology. Simply allow them to identify what factors signal when a child is well (e.g. they may show a child smiling, or a child with food in their belly). They should reflect when a child is doing well both on the body of the child, but also in their surroundings. Ask them to think about whom in the community contributes to a child being well. What activities do they engage in to keep well? (e.g. they may draw a school or a religious structure).

When they have completed this exercise, ask each group to present.

Make sure to summarize what the children have identified following the presentations and ask if anyone has anything else they would like to add.

Thank the children for their participation.

Prashanth Vishwanathan UNICEF 2020

Tool 4: Contextualization Workshop: description of activities

Instruction: *Provide flipcharts, different colored crayons or markers, scissors, tape and index cards to all small groups during the workshop. Prior to facilitating this exercise, the key themes identified by key informants and focus group discussion participants should be shared with the workshop participants.*

Day 1 Activity Details

Define the term: Define child well-being, happiness, resilience, and quality of life in terms that are locally relevant, meaningful and understood, and the factors that contribute to each.

Who is Doing Well? Participants describe a typical child, in each of the age groups, in their community who they perceive to be 'doing well'. You may also want to inquire about a child who 'is not doing well' as doing so may bring forth different responses that you can use to determine what they need to live well in their community and why. The characteristics that emerge can be used as indicators of well-being. One option is to split the small groups into identifying when a child is doing well, and when a child is not doing well as additional factors may arise from the perception of a child not doing well. It is also possible to have all groups work only on identifying a child who is doing well if asking about a child who is not doing well may bring up difficult memories. Decide what is most appropriate in accordance with your context.

The participants will specify the characteristics of a child that is 'doing well'. Each characteristic will be recorded on a single index card, and the resulting cards can be sorted into piles of what are seen as related characteristics by a number of different participants/small groups. Categorizing the cards in such a way will lead to identifying a number of 'domains,' and a number of specific 'indicators' within each.

During the plenary discussion, facilitators will identify whether these are the same domains as specified in the global measurement framework or if new domains have arisen.

Day 2 Activity Details

The Life Map: This exercise can tell us which events are most important in children's lives from ages 0-18. Participants in each small group should draw a map from the place where they were born to this place where they are today (if many were born in other locations they can agree on one location or a fictional location).

Include all of the most important people, and all of the most important events, the best and the worst (that they want to and feel comfortable sharing)…. if the events were difficult, show the road going uphill, easy, show the road going down, if there was an event that changed everything for them, indicate it by a turn in the road. Tell them not to worry about how well they draw and that any picture will help us to understand. They can also think about a child (someone they know like a family member or neighbor). When the drawings are finished have each group present their drawing. This exercise will support you in exploring any trends in the factors that contribute to a child's well-being during 0-18 years.

Visioning tree: Draw the shape of a tree on a flipchart paper and explore a vision of children's care and protection in communities and strengths that can be built upon to promote child well-being, including identifying local resources (people, groups, institutions) or services (health, educational facilities, etc.) that support the well-being of children. This exercise will help to identify the community members, service providers, and resources, etc. that contribute to supporting the well-being of children in the community. It will also help to identify what resources or services may be lacking.

Sample Contextualization Workshop Agenda

Child Well-Being and Measurement Framework Contextualization Workshop Date/Location		
DAY 1		
Timing	**Session**	**Facilitator**
8.30 – 9.00	Registration and Coffee	
9.00 – 9.30	Welcome and Introductions	
9.30 – 9.50	Session 1.1 Security Briefing, Introduction to the Workshop, learning outcomes, ground rules, housekeeping	
9.50 –10.30	Session 1.2 Overview of the global CPHA definition of child well-being and measurement framework	
10.30 – 10.45	**Coffee Break**	
10.45 – 11.30	Session 1.3 Presenting summary of findings and common themes identified by KIIs and FGDs	
11.30 – 12.30	Session 1.4 Small Group work: Defining child well-being (and other related terms) in context	
12.30 - 13.30	**Lunch**	
13.30 – 14.30	Session 1.4 cont. Plenary discussion	
14.30 – 15.00	Session 1.5 Small Group work: Who is Doing Well?	
15.00 – 15.15	**Coffee Break**	
15.15 – 16.30	Session 1.5 continue small group work and plenary discussion, drawing out common themes	
16.30 – 17.00	Wrap up and Q&A	

DAY 2		
Timing	**Session**	**Facilitator**
9.00 – 9.20	Admin & Recap of Day 1: What struck you on Day One?	
9.20 – 9.30	Overview of Day 2	
9.30 – 10.45	Session 2.1 Small Group work: The Life Map	
10.45 – 11.00	**Coffee Break**	
11.00 – 12.00	Session 2.1 cont. Plenary discussion	
12.30 - 13.30	**Lunch**	
13.30 – 14.30	Session 2.2 Small Group work and plenary: Visioning Tree of a child's care and protection in the community, including services	
14.30 – 14.45	**Coffee Break**	
15.00 – 16.15	Session 2.3 Facilitators to present common themes and any suggestions to modifications of the global definition or domains.	
16.15 – 16.45	Session 2.4 Discuss in plenary any changes to indicators	
16.45 – 17.00	Q&A and Wrap up, explaining the next steps (e.g. the measurement survey and/or how the report and final definition and framework will be disseminated and shared)	

ANNEX B:
Measuring child well-being: child well-being measurement questionnaires

Welcome to Annex B: Measuring child well-being: Child well-being measurement questionnaires. In this section you will find:

- Questionnaire 1: Child Well-Being Scale for Infancy, Toddlerhood and Early Childhood (Children Aged 0-5)
- Questionnaire 2a: Child Well-Being Scale for Children Aged 6-8 (middle childhood)
- Questionnaire 2b: Child Well-Being Scale for Caregivers of Children Aged 6-8 (middle childhood)
- Questionnaire 3: Child Well-Being Scale for Children and Adolescents aged 9-17 (middle childhood and adolescence)

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Questionnaire 1: Child Well-Being Scale for Infancy, Toddlerhood and Early Childhood (Children Aged 0-5)

Instruction: This questionnaire is to be completed by the caregiver of the child, not by the child. The questions are all formulated in the positive. Any amendments to the questions must be formulated in the positive so that the highest score (5) indicates a positive and the lowest score (1) indicates a negative.

Date:						
Location (district/village):						
Age of child in years:						
Gender of child (male/female):						
	Please choose one answer for each question to describe the child in your care. There are no right or wrong answers.	**Never** [1]	**Not much of the time** [2]	**Some of the time** [3]	**Quite a lot of the time** [4]	**All of the time** [5]
Safety and Security						
1	The child in my care can safely crawl, grasp, or pull on objects in the area where we live					
2	The area where we live is free from physical and environmental hazards					
3	The child in my care has an adult or older child look after him/her_____(select option)					
4	I know where to go in my community to report something bad that has happened to my child (e.g. if they are hurt or need a doctor)					
5	I have been able to maintain my child's feeding and sleeping practices since the start of the emergency					

	Please choose one answer for each question to describe the child in your care. There are no right or wrong answers.	Never [1]	Not much of the time [2]	Some of the time [3]	Quite a lot of the time [4]	All of the time [5]
Basic Needs						
1	The child in my care has enough nutritious food to eat on a daily basis[5]					
2	The child in my care has clean/uncontaminated water to drink[6]					
3	The child in my care has a safe place to sleep every night					
4	There is soap and other hygiene items available to clean the child in my care and the items/dishes he/she uses					
5	I wash my hands with soap before feeding my child and after disposing his/her waste					
6	My child and I have a similar feeding and sleeping practice/routine					
Relationships with family and others						
1	I interact positively with the child in my care each day (e.g. play, sing, laugh)					
2	I teach the child in my care new things every day (insert cultural appropriate activities)					
3	I am able to meet the developmental needs of my child (e.g. I provide daily praise to my child and establish structure in rules)[7]					
4	When I am not available another adult or adolescent positively interacts with the child[8]					
Agency						
1	The child in my care indicates when they need/want something (e.g. points to what he/she wants to take, cries, or pulls towards the direction he/she wants to go)[9]					
2	The child in my care enjoys exploring/engaging with the world around him/her					
3	The child in my care expresses different emotions/ behaviors (e.g. happiness, laughter, sadness, frustration)					
4	Since the start of the emergency the child in my care's behaviors and emotions have remained more or less the same as they were before the emergency[10]					
5	The child in my care expresses their ideas and preferences.[11]					

[5] If this question is included, specify the type of nutritious food according to your context. If the child is less than 6 months, rephrase to ask whether the caregiver is exclusively breastfeeding.
[6] For instance, the water is boiled before drinking to prevent against waterborne illnesses.
[7] The examples provided in this phrase are not culturally or contextually specific. Determine development needs in the context and provide an example that is culturally and contextually appropriate.
[8] This question is linked to the following indicator: % of caregivers who report consistent, caring oversight of child by designated adolescent(s) or adult(s).
[9] This question is directed at children aged 0-18 months. Modify accordingly in context.
[10] This question will determine if the behaviors and emotions have remained the same or if there has been a change, such as the child becoming withdrawn, having mood swings, nightmares, sleep issues, or acting out in negative ways.
[11] Include this question only if all of the caregivers have children aged 3-5 as infants will not be able to express ideas or preferences and this could impact the overall scoring.

Questionnaire 2a: Child Well-Being Scale for Children Aged 6-8 (middle childhood)

Instruction: This questionnaire is to be completed by the child. The questions are all formulated in the positive. Any amendments to the questions must be formulated in the positive so that the highest score (5) indicates a positive and the lowest score (1) indicates a negative.

If for any reason, whether ethical, safety, or cultural, it is not possible to conduct this survey with children themselves, questionnaire 2b can be administered to the caregivers of children in this age group.

Date:				
Location (district/village):				
Participant's age in years:				
Participant's gender (male/female):				
	Please choose one answer for each question. There are no right or wrong answers.	**No** [1]	**Sometimes** [2]	**Yes** [3]
Safety and Security				
1	I feel safe when I am with my family/caregiver(s)			
2	I feel safe in my community/with neighbors			
3	I feel safe at school (or center of learning[12])			
4	I know where I can ask for help when I need it			
5	I know where to go/who to talk with to report something bad that has happened to me or someone I know			
6	I know how to avoid places in my community that are unsafe (e.g. where there are dangers or hazards)			
Basic Needs				
1	I go to school/learning center			
2	I enjoy going to my school/learning center[13]			
3	When I am hungry, there is enough to eat in my home			
4	I eat_____ each day (insert locally prepared nutritious foods according to context)			
5	I always have access to clean water for drinking and bathing			
6	I have a comfortable place to sleep each night			

[12] Include this question only if all of the respondents are enrolled in formal or informal education. If they are not all attending, it will impact the scoring.
[13] This question relates to the indicator '% of children who report feeling a sense of belonging at school'. It can also be modified to directly ask if the child feels a sense of belonging at school.

Relationships with family and others				
1	My parent(s)/caregiver(s) take good care of me			
2	I have at least one adult in my family or community that I look up to and can rely on for guidance and support (such as a caregiver, community elder, neighbor or religious leader)			
3	My family/caregiver(s) makes me feel better when I am upset			
4	I have at least one good friend who I can talk to and who plays with me			
5	I eat at least one meal every day with my family/caregiver(s)			
6	I like being in my community			
Agency				
1	Adults in my family listen to my opinions and thoughts when I express my preferences or ideas			
2	I like celebrating_____ (insert a holiday or celebration that is celebrated in the culture)			

Questionnaire 2b: Child Well-Being Scale for Caregivers of Children Aged 6-8 (middle childhood)

Instruction: This questionnaire is to be completed by the caregiver in situations when for any reason, whether ethical, safety, or cultural, it is not possible to conduct this survey with children themselves. The questions are all formulated in the positive. Any amendments to the questions must be formulated in the positive so that the highest score (3) indicates a positive and the lowest score (1) indicates a negative.

Date:				
Location (district/village):				
Age of child in years:				
Participant's gender (male/female):				
	Please choose one answer for each question. There are no right or wrong answers.	**No** [1]	**Sometimes** [2]	**Yes** [3]
Safety and Security				
1	I think the child in my care always feels safe and comfortable with other members of our household			
2	I think the child in my care always feels safe and comfortable around members of the community/neighborhood			
3	I think the child in my care always feels safe and comfortable at school (or center of learning[14])			
4	I am confident that I can provide help to my child when they need or where I can ask for help when further assistance is needed (such as medical care)			
5	I know where to go in my community to report something bad that has happened to my child (e.g. if they are hurt or need a doctor)			
6	I know the places in my community that are unsafe for my child (e.g. where there are dangers or hazards)			
Basic Needs				
1	The child in my care attends school or a learning center			
2	The child in my care enjoys going to school/learning center[15]			
3	There is enough to eat in my home when my child is hungry			
4	The child in my care eats_____ each day (insert locally prepared nutritious foods according to context)			
5	The child in my care has clean/uncontaminated water to drink and for purposes of bathing			
6	The child in my care has a comfortable place to sleep each night			

[14] Include this question only if all of the respondents have children that are enrolled in formal or informal education. If the children are not all attending, it will impact the scoring.
[15] This question relates to the indicator '% of children who report feeling a sense of belonging at school'. It can also be modified to directly ask if the child feels a sense of belonging at school.

Relationships with family and others				
1	I interact positively with the child in my care each day (e.g. play, sing, laugh)			
2	The child in my care has at least one adult in our family or community that they look up to and can rely on for guidance and support (such as an aunt, uncle, community elder, neighbor or religious leader)			
3	I always spend time to comfort the child in my care when they are upset			
4	The child in my care has at least one good friend who they can talk to and who plays with them			
5	I eat at least one meal every day with the child in my care			
6	I believe that the children in my care likes being apart of our community			
Agency				
1	I always listen to the opinions and thoughts of the child in my care when they express their preferences or ideas			
2	The child in my care enjoys celebrating_____ (insert a holiday or celebration that is celebrated in the culture)			

Questionnaire 3: Child Well-Being Scale for Children and Adolescents aged 9-17 (middle childhood and adolescence)

Instruction: This questionnaire is to be completed by the caregiver in situations when for any reason, whether ethical, safety, or cultural, it is not possible to conduct this survey with children themselves. The questions are all formulated in the positive. Any amendments to the questions must be formulated in the positive so that the highest score (3) indicates a positive and the lowest score (1) indicates a negative.

Date:						
Location (district/village):						
Participant's age in years:						
Participant's gender (male/female):						
	To what extent do the sentences below describe you? Select one answer for each statement.	**Never** [1]	**Not much of the time** [2]	**Some of the time** [3]	**Quite a lot of the time** [4]	**All of the time** [5]
Safety and Security						
1	I feel safe when I am with my family/caregiver(s)					
2	I feel safe in my community					
3	I feel safe at school (or center of learning[16])					
4	I know where to go in my community to obtain help when I need it (e.g. when I am hurt, in danger or afraid of being harmed)					
5	I know where to go in my community to report something bad that has happened to me or someone I know					
6	I am able to solve problems without harming myself or others (for instance using drugs or violent behavior when I am upset)					
7	My social environment is free from bullying and discrimination.					

[16] Include this question only if all of the respondents are enrolled in formal or informal education. If they are not all attending, it will impact the scoring. This question is formulated in such a way as to determine whether the child feels safe at school. This could mean that the school environment is free of bullying and discrimination. Alternatively, a more direct question can be posed.

Basic Needs						
1	Getting an education (formal or informal) is important to me					
2	When I am hungry, there is enough to eat					
3	I eat_____ each day (insert locally prepared nutritious foods according to context)					
4	I have access to clean water for drinking and bathing					
5	I am hopeful and optimistic about the future					
6	I have a comfortable place to sleep each night					
7	I have access to the sanitary and hygienic products that I need, such as soap or menstrual hygiene products					
8	Sexual and reproductive health services are available in my community.					
Relationships with family and others						
1	My parent(s)/caregiver(s) take good care of me					
2	I have at least one adult in my family or community that I look up to and can rely on for guidance or support (such as a caregiver, community elder, neighbor or religious leader)					
3	My family/caregiver(s) stand by me and support me during difficult times					
4	I talk to my family/caregiver(s) about how I feel and they listen					
5	My caregiver knows a lot about me (such as who my friends are and what is most important to me)					
6	I have at least one good friend who supports me					
7	Other people (like my peers and family members) enjoy spending time with me					
8	I feel I belong in my community					
9	I am treated fairly by members of the community (e.g. adults and peers)					
Agency						
1	Adults in my family value and listen to my views and opinions					
2	I have opportunities to show others that I am maturing by taking responsibility for certain tasks					
3	I have opportunities to develop skills that will be useful later in life (like skills to care for others or job skills)					
4	I enjoy participating in cultural traditions and celebrations because I am proud of my culture					
5	I think it is important to be an active member of my community by supporting others					
6	I have the option to participate in extracurricular activities or clubs					
7	When I think about the future (when I am an adult) I see myself still living in this community[17]					

[17] This question and number 5 can be used to measure this indicator: % of children who feel a sense of responsibility to serve or contribute to the betterment of their community.

ANNEX C:
Child well-being indicators

Welcome to Annex C: Child well-being indicators. In this section you will find additional guidance on indicators.

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What do we mean by indicator?

An indicator is a number, proportion, percentage or rate that helps to measure – or to indicate – the extent to which planned activities have been conducted (output indicators) and program achievements have been made (outcome indicators). Indicators are also used for situational analysis, which is not necessarily linked to activities or programs.

What does an indicator do?

Indicators are 'signals' that show whether an objective has been attained. They can also be used to show the progress that is being made toward achieving a specific child protection outcome. They provide a way of measuring and communicating the processes and results of activities. All indicators must be measurable.

Types of indicators in the Child Well-Being Measurement Framework

I. Output indicators

Output indicators measure the direct, immediate-term results of an activity, or in other words, what the intervention has achieved in the short-term. They add more details in relation to the 'output' of the activity. Outputs generally include the number of support or service interactions received by a beneficiary of a particular program, as well as the products or goods that result from an intervention. Where output indicators are seen as critical steps for characterizing an intervention's contribution to achieving outcomes on child well-being, they can be included in the framework as complements to the outcome indicators.

II. Outcome indicators

An outcome indicator is a specific and measurable variable that will represent the achievement or failure of the outcome. It relates to the change that results from an intervention on child well-being in the short-, medium- or long-term. These indicators, therefore, allow us to know whether the desired outcome has been generated. An outcome indicator should indicate to what extent an intervention was reached or progress towards child well-being as a result of implementation of key activities or interventions; in other words whether progress against expected outcomes were achieved. For instance, indicators of change in behavior, attitude or knowledge among a program's target population are usually considered outcome indicators.

When to use a number or a percentage

Firstly, think about what is more useful to measure. Use a # in the indicator when you want, for instance, to provide a complete count of people reached or items disseminated, or to show the magnitude. A % in the indicator may be used when a) a sample of the target population will be sufficient to determine whether or not a desired change is occurring (and if proportion or ratio are not being used), or b) to show coverage or reach.

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Defining and Measuring Child Well-Being in Humanitarian Action:
A Contextualization Guide

THE ALLIANCE
FOR CHILD PROTECTION
IN HUMANITARIAN ACTION