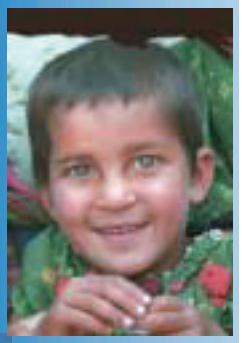

CHILDREN IN CRISIS:
GOOD PRACTICES IN EVALUATING PSYCHOSOCIAL PROGRAMMING

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The International Psychosocial Evaluation Committee and
Save the Children Federation, Inc.
With Support from the Andrew W. Mellon Foundation

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Preface

In recent years, the devastating consequences of long term and violent conflicts across the globe have generated tremendous interest in the psychosocial effects of complex emergencies on children, families and communities. At the same time, as relief organizations have developed projects to address these critical issues, there have been relatively few resources available to these implementing agencies on how to measure the effectiveness of their work. What concepts, methods and tools might be used to evaluate psychosocial projects implemented during crisis situations? How do we know if individuals and communities are benefiting over the short and long-term from projects designed to facilitate emotional healing, social reconciliation, and community building?

The development of outcome and impact measures for psychosocial projects in crisis situations presents a continual challenge for field practitioners. The various factors influencing child development and psychosocial well-being are difficult to isolate, define, and quantify. In addition, change takes time to evidence itself, a luxury in any emergency response project. As a result, too often project practitioners must take a leap of faith that their projects are having a measurable and positive effect on the lives of children, families, and communities. Without indicators, however, practitioners are left in the position of asserting that projects are "helpful" in broad and often unverified ways. There clearly exists a need to develop models of impact, share lessons learned, promote cross-fertilization of strategies, and to build effective intervention practices based on sound measures of project outcomes and impact.

To pursue this broad objective, Save the Children Federation, Inc. (Save the Children USA), with support from the Andrew W. Mellon Foundation, initiated a collaborative process among a number of academic institutions, donor organizations, and field-oriented non-governmental organizations that are operational in the broad area of psychosocial programming. Persons from these organizations with extensive experience in psychosocial programming participated in initial discussions regarding the focus of this document. A core committee of fifteen members was organized based on these initial discussions. The core committee has been responsible for the overall conceptualization and articulation of content area of this manual. In an effort to broaden the programmatic, cultural and geographic expertise of the core committee, several colleagues with extensive experience in psychosocial programming were asked to provide feedback at various points throughout the development of previous drafts of this document.

The manual should be considered a "working document." We anticipate that, through dissemination of this document, colleagues, field-based managers, and coordinators of psychosocial projects can continue to provide critical review and further input across a variety of disciplines, cultural settings, and regional perspectives.

Overview

This manual attempts to articulate major principles of psychosocial project design and evaluation practices in concise, user-friendly terms. It is intended for field-based managers and coordinators of psychosocial programming, as well as for managers of emergency relief programs who may want to integrate psychosocial programming methods into more traditional relief efforts, such as food distribution, construction projects, and medical assistance. The manual also seeks to heighten critical awareness of the cultural and ethical issues associated with psychosocial work. Since psychosocial projects vary considerably in emphasis, there is much to be learned from different experiences. Hence, the intention of this manual is to stimulate dialogue and the exchange of "lessons learned" across projects, organizations, theoretical perspectives, and field-based experiences. Through this dialogue, we hope to help project managers build concepts and methods for planning, implementing, and evaluating psychosocial projects using clear strategies.

Chapter One serves to orient the reader by briefly summarizing the concept of psychosocial development. This chapter focuses on the relationship between psychosocial development and culture, family and peer relationships, risk and resiliency. The importance of social and cultural factors in psychosocial development and in working effectively with children, families, and communities is emphasized. The chapter concludes with a discussion of the limitations of an individualized approach to psychosocial healing in complex emergencies and outlines the benefits of including community members, especially children and adolescents themselves, in developing psychosocial interventions.

Chapter Two focuses more specifically on psychosocial programming. It presents a definition of psychosocial programming and introduces major concepts and rationales underlying key principles of sound psychosocial interventions. It offers a conceptual tool for understanding that different groups within a community react differently to a crisis and discusses the relationship between target group, project content and project approaches. Finally, it encourages the integration of psychosocial programming principles into other types of relief interventions, such as health or food distribution, in an effort to address children's needs within the context of family, community and cultural resources.

Chapters Three through Six address the topic of evaluating psychosocial projects using case examples. Components essential to the development of a solid evaluation strategy are presented including: articulating a project logic model, developing objectives and indicators, and considering evaluation design options.

Chapter Seven uses a "worksheet" format to review key concepts and to guide the project planner in a step-wise fashion through the various stages of project conceptualization and evaluation.

Acknowledgements

The Committee would like to acknowledge the invaluable contributions of many colleagues and to express our appreciation to their organizations for supporting this effort.

We extend a special thank you to: Elizabeth Jareg and Mike Wessells whose work in writing the initial concept paper helped crystallize the committee's approach to evaluating psychosocial programs; Jan Williamson, Kirk Felsman, Gary Kose, Stan Phiri, and John Williamson who critically reviewed earlier drafts of this document; Jason Schwartzman, our consultant for his work with the subcommittee on redrafting the first draft of the document; and to Amy Wachtel, Marie de la Soudière, Alastair Ager, and Tamara Jachimowicz for their work in field testing the pilot document.

Finally, the Committee would like to thank members who also served on the Second Draft Subcommittee—Alastair Ager, Neil Boothby, Marie de la Soudière, Maryanne Loughry, Jason Schwartzman, and Mike Wessells—for their efforts in further orienting the document toward implementing organizations.

Our appreciation also goes to those who contributed in various ways, including Yakini Mack-Williams who identified various additional readings and resources, and many others who provided feedback during field-testing or upon reading drafts of the document.

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Chapter One

Chapter 1: Complex Emergencies and Psychosocial Development

This chapter presents a discussion of psychosocial development as it is influenced by culture, family and peer relationships, risk and resiliency. The importance of social and cultural factors in psychosocial development and in working effectively with children, families, and communities is emphasized. The chapter stresses that complex emergencies disrupt individual, family, and community functioning and discusses some of the limitations of an individualized approach to psychosocial programming. The need to ensure community participation in project planning, implementation, and evaluation is discussed.

I. Introduction

In many parts of the world, war, epidemics, natural disasters, and other humanitarian crises have resulted in complex emergencies[1] causing wide-ranging, multifaceted, sustained negative impact on children, families, and communities. Such emergencies impose heavy emotional, social, and spiritual burdens on children and their families that are associated with death, separation and loss of parents and caregivers, disruption of organized patterns of living and meaning, attack and victimization, destruction of homes, and economic ruin. In these situations, children's development is disrupted, security and trust in humankind threatened, and a sense of hope for the future undermined.

Governmental and nongovernmental organizations across the world have grown in their understanding of appropriate response to such circumstances. The United Nations Children's Fund (UNICEF), for example, was created in the aftermath of the Second World War. Reichenberg and Friedman[2] (1996), in their examination of the evolution of this organization's approach to working with war-affected children, families, and communities, create a historical framework that anchors current day psychosocial programming and strategies. While UNICEF originally and primarily focused on short-term material assistance through the distribution of food, clothing, and medicine, the organization increasingly realized that projects needed to be longer-term and to consider the whole child within the context of his or her community and culture if the desired benefits were to be obtained.

Adopted in 1989, the Convention on the Rights of the Child (CRC) established a legal and ethical framework to guide the international community in working with children during times of stability as well as during emergencies. Convention articles address, for example, family separation and reunification efforts and the protection and care of children affected by armed conflict (see Inset 1). Collectively, the articles establish an intervention standard that encompasses, as stated in Article 39, "measures to promote physical and psychological recovery and social re-integration of a child…" in the aftermath of complex emergencies.

[1] The United Nations High Commissioner for Refugees defines a complex emergency as a humanitarian crisis in a country, region, or society where there is a total or considerable breakdown of authority caused by international or external conflict, which requires an international response that goes beyond the mandate of any single agency and/or the ongoing United Nations country program.

[2] D. Reichenberg and S. Friedman, "Traumatized Children: Healing the invisible wounds of children in war: A rights approach." In International Responses to Traumatic Stress, edited by Yael Danieli, Nigel S. Rodley, & Lars Weisaeth (New York: Baywood Publishing Company, 1996), 307 – 326.

Inset 1: Convention on the Rights of the Child

The following are articles most relevant to complex emergencies. [3]

Article 9: Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.

Article 10: …Applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.

Article 19: Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

Article 20: A child temporarily or permanently deprived of his or her family environment… shall be entitled to special protection and assistance...

Article 22: Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or non-governmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason, as set forth in the present Convention.

Article 28: Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity...

Article 34: Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse...

Article 38: Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities...

In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflict, State Parties shall take all feasible measures to ensure protection and care of children who are affectedby an armed conflict.

Article 39: Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment that fosters the health, self-respect, and dignity of the child.

Consistent with the CRC, many international and national governmental and nongovernmental organizations now consider the psychological and social aspects of humanitarian assistance to children

[3] United Nations Office of the High Commissioner for Human Rights, Convention on the Rights of the Child, http://www.unhchr.ch/html/menu3/b/k2crc.htm.

and their families as necessary components in responding to the overall developmental needs of children in complex emergency situations. The fundamental aim of psychosocial programming is to improve children's well-being by:

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

As parents/caregivers, communities, governments, nongovernmental organizations, and donors have recognized the importance of addressing the psychological and social needs of children and their families, there has been an increased desire to make available the programming concepts and tools that support this work. Key questions include, "How do we conceptualize the psychosocial needs of children?" "How do we understand the impact of complex emergencies on families and communities?" "What are key components of psychosocial interventions?" and "How do we know if interventions are effectively addressing these needs?" There is little information available on the long-term consequences of the multiple and continuous effects of war and other complex emergencies on children, families, and communities - especially in the context of poverty and displacement. Given the lack of research in this area, this manual is an attempt to put forth one perspective of responding to children's needs in crisis situations based on the contributors' field and academic experience. This manual begins by providing a brief orientation to psychosocial development. Key project interventions are outlined, emphasizing ethical, cultural, and social issues associated with this kind of work. The main focus of this manual is on measuring the effectiveness of psychosocial projects and providing practitioners with tools and a framework for the monitoring and evaluation process.

II. The Need for Intervention

Inset 2: The Impact of Complex Emergencies on Individuals & Communities

In 1988 our team at Harvard University, with the support of the World Federation for Mental Health, sent a psychiatric team to Site 2, the largest Cambodian refugee camp on the Thai-Cambodian border. We interviewed 993 camp residents, who recounted a total of 15,000 distinct traumatic events, such as kidnapping, imprisonment, torture, and rape. Yet the international authorities charged with protecting and providing for the camp had made no provisions whatsoever for mental health services. Similar lapses affected other refugee operations the world over. Over time the reason became clear: the mental health effects of mass violence are invisible. Put simply, it is easier to count dead bodies and lost limbs than shattered minds. The bottom line is that although only a small percentage of survivors of mass violence suffer serious mental illness requiring acute psychiatric care, the vast majority experience low-grade but long-lasting mental health problems. For a society to recover effectively, this majority cannot be overlooked. Pervasive physical exhaustion, hatred, and lack of trust can persist long after the war ends. Like chronic diseases such as malaria, mental illness can weigh down the economic development of a country.[4]

The social fabric that binds individuals can and does unravel during times of conflict. While the degree of devastation wrought and its ultimate effect on individuals varies, children and families will always work to rebuild their lives to survive, endure, and flourish. The way people feel, the way they react to the world, and the way they relate to one another are tremendously influenced by the series of crises they have endured. As Inset 2 illustrates, mental health services are as critical and life-saving as other emergency interventions. When rebuilding communities, the effects of extreme horror, fear,

[4] R. Mollica, "Invisible Wounds," Scientific American 2000: 46.

mistrust, rage, and vengence experienced by most community members, including children, cannot be ignored any more than the effects of famine, epidemics, and homelessness.

Inset 3: The Context of Intervention

Following centuries of Western Colonial domination, East Timorese have lived the past 24 years in a climate of perpetual fear characterized by systematic oppression by the Indonesian Government. One of the century's worst genocides took place at the time of the Indonesian take-over of East Timor. An estimated 200,000 people were massacred or allowed to die of starvation. Violent repression, demonstrated by the repeated arrest, torture, and disappearance of people involved or thought to be involved in the liberation struggle, continued throughout the period.

These 24 years of repression culminated in the recent crisis following the August 30, 1999 referendum. On a large scale, people experienced the burning of homes and towns, attacks on themselves and their families, flight in the face of armed assaults by militias, forced displacement, destruction of businesses, and loss of agricultural means and production. As people fled or were forcibly displaced, large numbers were separated from each other, and many children were separated from their families. Many people fled to the mountains. Others were forced by militias into West Timor, where they lived in forced exile and constant fear, or were deported to more distant islands, their whereabouts unknown. Large numbers of people have disappeared and remain unaccounted for. Nearly every family lives with uncertainties about the location and safety of one or more family members.

The returning population found their land devastated, property looted, homes burned, livestock stolen or killed, and infrastructure, including schools, destroyed. Housing devastation has been particularly severe; nearly 80% of all homes were destroyed or damaged.

As people returned home, tensions and outbreaks of violence have increased in returnee communities. Returnees from West Timor include pro-integrationist adults and adolescents—a sub-set of whom had participated in militia-promoted violence. Thus there was an urgent need to address the immediate care and protection needs of children, families, and youth and to promote tolerance, restraint, and reconciliation efforts in returnee communities. [5]

A child's well-being and healthy development require strong and responsive social support systems, from the family to the societal levels. For example, the illness or death of a child's caretaker denies the child the many developmental benefits of parenting. Similarly, children who are driven into armed banditry and crime by circumstances of extreme poverty may contribute to political or ethnic turmoil in the wider society. In contexts where children's lives are already threatened by malnutrition and ill health, the eruption of war provokes generational cycles of poverty, violence, and insecurity.

The social consequences of violence can be found at the community level in terms of its relative cohesion or disintegration. Violence affects every aspect of social life; traditional community structures are broken down, authority figures are weakened, cultural norms and coping mechanisms are disintegrated, relationships and networks, which traditionally provide support during crises, are destroyed. As a result, traditional coping mechanisms may disappear. As violence increases, distrust and isolation out of fear may become the norm, making children more vulnerable to psychosocial harm. Psychosocial interventions may operate at the dual levels of focusing on individual health as well as community reconciliation and peace-building. In fact, breaking the cycle of violence is one fundamental aim of such projects.

In emergency situations, the rights of children are continually violated, ignored, and unfulfilled. The objectives of psychosocial interventions, whether in the context of a stand-alone project specifically aimed at improving the psychosocial well-being of children, or in the context of more traditional

[5] Child Protection and Psychosocial Programs Consortium, "Care and Protection of Children, Youth and Families in East Timor." Proposal submitted to the U.S. State Department, Bureau of Population, Refugees and Migration (2000).

health, education or other development project, should fit within a human rights framework as defined by the United Nations (UN) Convention on the Rights of the Child.

Field experience has shown that it is desirable to take a holistic approach to humanitarian efforts such that the psychological and social development and needs of children are an integrated part of programming from the outset of an emergency situation. As described in Inset 3, the context of emerency programming is complex and multi-layered. The concept of psychosocial recovery is an attempt to describe a process of coming to terms with the wide range of emotionally traumatic events, losses, isolation, destruction of social norms and codes of behavior most children will face in emergency situations. Each individual child goes through this process in his or her own unique way depending on multiple factors, including the nature of the child's family environment, peer relationships, age, experiences and family and peer group reactions. It is the position here that addressing these factors as part of a relief project enhances the overall effectiveness of the project and also promotes the psychosocial recovery process. For example, the identification of women-headed households and their registration for food rations can prevent women having to render sexual services to be able to feed their children. Consultations with women and children on their special needs for safety can influence the placing of water supplies, lighting in the camps, locks for doors, and many other issues.

Inset 4: Assessing Psychosocial Impacts and Responding Programmatically

The prolonged repression and terror, coupled with the recent outburst of violence and loss, have had profound effects on the East Timorese population, particularly children and adolescents. The damaging consequences are diverse and are both social and psychological. Socially prominent are changes in attitudes and beliefs, including entrenched hatred for "the other" and loss of trust. Psychologically, many children have experienced multiple losses, fear, hopelessness, and a diminished sense of self-worth and competence. Evidence from situation analyses indicates that significant numbers of children were experiencing problems such as nightmares, concentration loss, and social isolation. The overall impact is disruption of normal development.

To rebuild education and to enable healthy development, it is vital to promote healing, social integration, and recovery. An essential first step is to provide structured activities that normalize life, aid emotional and social integration, and reduce the current idleness of many children and youth. Properly designed, these activities enable the recovery of most children, although a small number of severely traumatized children will need special assistance. The activities take place in safe spaces where parents can participate, support each other, and engage in planning around meeting children's needs. Conducted communally, these activities can help to rebuild the social trust, protection, and tolerance that had been badly damaged by the recent events. In addition, structured activities can provide positive engagement of youth who have lived through disturbing and confusing events, seen families and communities torn apart by suspicion and violence, and missed important educational opportunities. Youth are significant actors who can contribute either to peace or to continued violence. Structured activities promote youth leadership and engage them in providing assistance to younger children.[6]

Since complex emergencies have multiple effects on children and communities, it is useful to draw from psychological and social theories that have linked the development of children to the wider social circles that surround them—their family, community, and culture. An understanding of the psychosocial development of children, and interventions that are designed to support this development, is intertwined with broader concepts of child development. We turn to these concepts next.

[6] *Ibid.*

III. Psychosocial Development

A. Social and Cultural Nature of Child Development

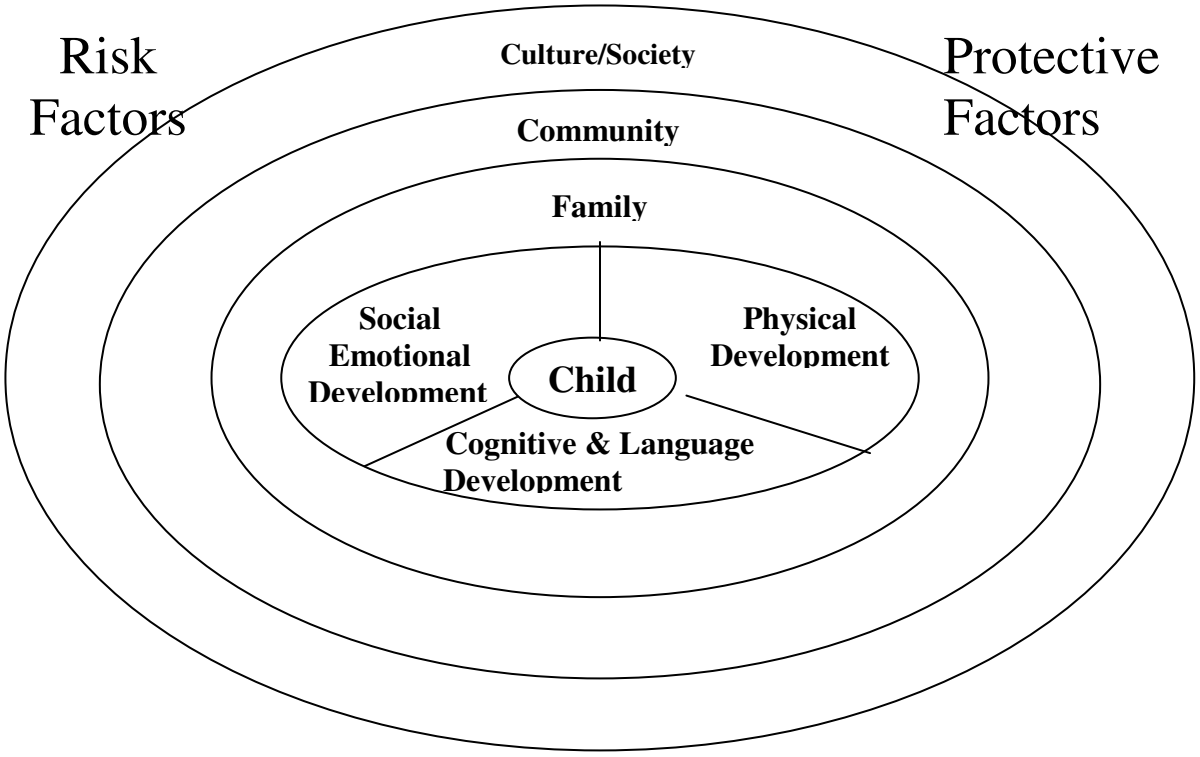
Children's development is inextricably connected to the social and cultural influences that surround them, particularly the families and communities that are children's "life-support systems." In all societies, families try to protect and meet the basic needs of children. Beyond the family, children's development is influenced by interaction with peers, teachers, community members, and, increasingly throughout the world, by mass media. Through social interaction, children acquire gender and ethnic identities and internalize culturally constructed norms, values, and beliefs, including modes of expressing emotion and acceptable social behavior. Children usually participate in formal or non-formal education and other social institutions, and learn to become functional members of their societies. Children's development must be considered holistically in order to include this process of social integration and of becoming connected within their wider social world.

Inset 5: The Social Ecology in Which Children Develop

A social and cultural approach to child development emphasizes the importance of the wider social context that surrounds us all. These social or "ecological" approaches focus not on the individual child but rather on the child interacting with the nested social systems of family (including clan and kinship group) and wider society (including community institutions, and potentially, religious and ethnic networks). A child's well-being and healthy development require strong and responsive social support systems, from the family to the societal levels.[7] This has been represented graphically in Diagram 1.

[7] Adapted from Bronfenbrenner, as cited in: Donahue-Colletta, Understanding Cross-Cultural Child Development and Designing Programs For Children (PACT, 1992).

Diagram 1. Social Ecology of the Child



B. Psychosocial Development Defined

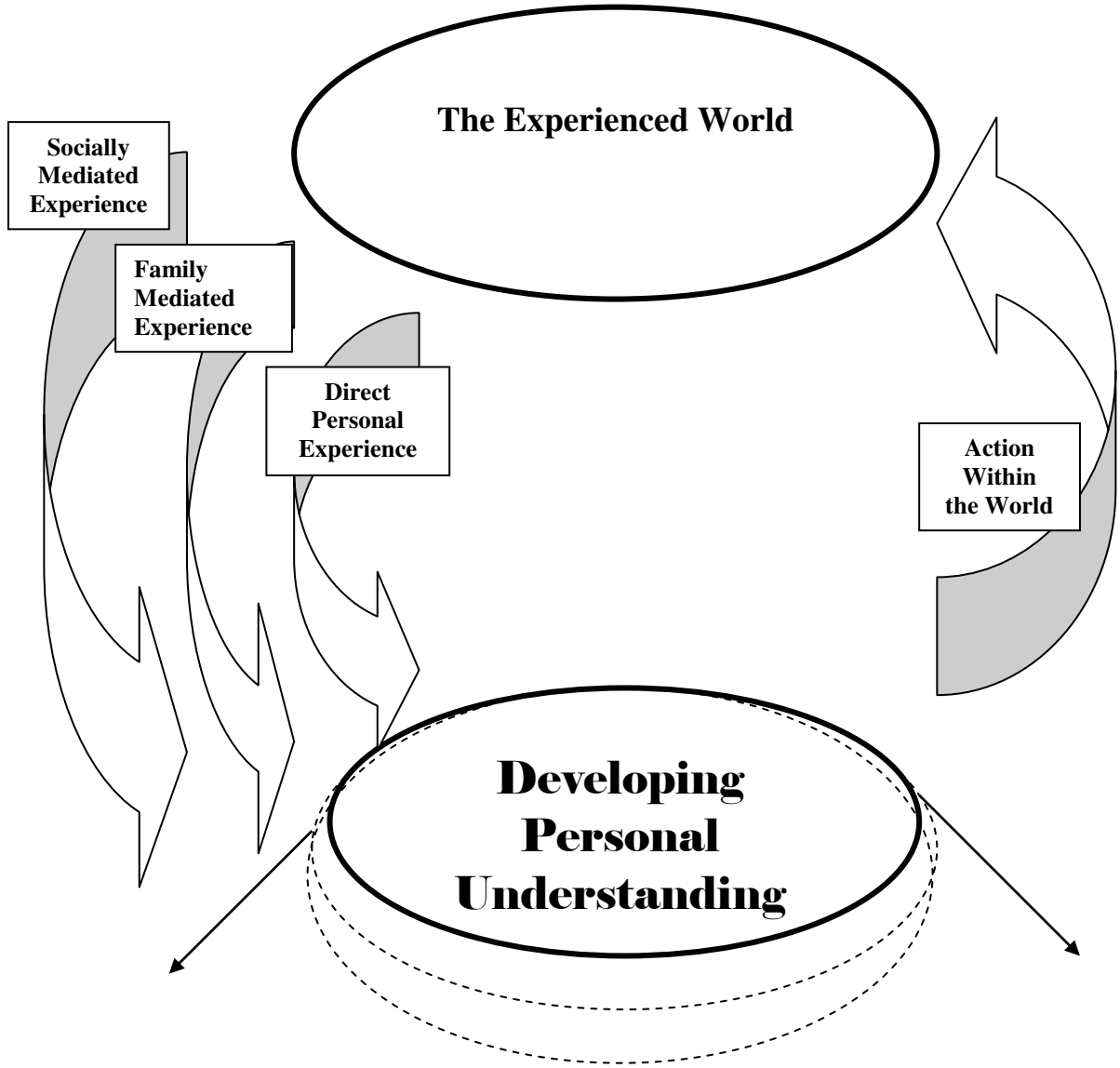
Most broadly, psychosocial development of children is defined as the gradual psychological and social changes that children make as they mature. Psychosocial development consists of the *psychological* aspects of human development – the capacity to perceive, analyze and learn from experiences, understand oneself and others, and experience emotion and *social development* – the ability to form attachments, especially to caregivers and peers, maintain satisfying reciprocal social relationships, and to learn and follow the social codes of behavior of one's own culture.

The term "psychosocial" implies a very close relationship between psychological and social factors. When applied to child development, the term underlines the *close, ongoing connections* between a child's feelings, thoughts, perceptions and understanding, and the development of that child as a *social* being in interaction with his or her social environment. Put slightly differently, psychosocial development is influenced throughout childhood by the dynamic interplay of the child's personality, genetic make-up, and environmental factors.

Inset 6: The Role of the Social World in Individual Development

The child's developing understanding of the world is shaped by his or her own individual experience, as well as by experience that is shaped and interpreted (or "mediated") by the family and broader social and community institutions. When interacting with the world, much of what one learns as a child is not simply "trial and error." Parents, uncles, grandmothers, siblings, friends, neighbors, school, church, mosque, or temple all likely play a part in "making sense" of the world —offering rules, ideas, explanations, and principles to guide behavior. In this sense the process of "growing up" is very much a social process because we assimilate the understandings shared and interpreted to us by these varied influential figures and institutions. The role of the social world in individual development can also be represented graphically, as portrayed in Diagram 2 (below).

Diagram 2. The Social World in Individual Development [8]



[8] Alistair Ager, "Children, war, and psychological intervention." In Psychology and the Developing World edited by S. Carr and J. Schumaker (New York: Praeger, 1996).

C. Cross-Cultural Commonality and Diversity

While we seek what is common to human development across cultures so that we might better design projects, we also recognize that cultures differ. The variation among cultures is found in the form, timing, content, and meaning of social actions and behaviors. As discussed above, a child's development as a social being varies according to the beliefs, practices, and values embedded in a child's culture. Primary agents of socialization, such as the "family," vary in definition across cultures. For example, in one cultural system, "family" may mean only the immediate or nuclear family; while in a different culture, it may mean the clan or extended family. Likewise, in some cultures the role of peer groups can be as important as the family for socialization. In secularized, Western contexts, spiritual development is peripheral and variable, but in some other cultures, spiritual development constitutes the core of individual and group life.

To design culturally appropriate interventions, one must understand and truly respect relevant beliefs and practices in a given local setting. This is no easy task since donors and staff in leadership positions are often not members of the culture in which assistance is provided. Of necessity, outsiders must start from what they know, that is, their own cultural assumptions and practices. However, it is important to realize that these assumptions and practices may not apply to other cultures. A value or belief from one culture—for example, the importance of building a strong sense of individuality—should not be imposed on another culture as truth. Rather, it should be a basis for discussion and seeking cross-cultural understanding. Further, in emergencies, chaos, suffering, and time pressures all act against learning about local beliefs and practices. This tension has often resulted in the view that culture and local communities are problems to be solved or obstacles to project development and implementation. Such attitudes encourage the marginalization of local people.

Inevitably, when designing psychosocial projects cross-culturally, a mixture of opportunities and potential problems arise. If the setting is viewed as an occasion for mutual learning and using the insights from different cultures, there will likely be a rich exchange, a sense of partnership, and joint construction of comprehensive assistance to children. On the other hand, when humanitarian agencies disregard or minimize local beliefs and practices, important and informative opportunities for intercultural exchange and enrichment are lost and the likelihood of imposing culturally discordant programming is significantly increased. An important guiding principle is that, within each culture are valuable insights toward providing comprehensive assistance to its children.

The participation of the people, including children, in the planning, implementing, monitoring, and evaluation of the activities that make up a psychosocial project is essential to generate ownership—of both problems and successes—and to ensure cultural appropriateness and sustainability. Above all, empowering people to take their lives into their own hands and to develop confidence and the will to do so is central to overcoming the deep pain and humiliation of traumatic experiences. This means that time must be taken to ensure real participation. The participatory process of developing psychosocial projects itself can have a profound effect on the well-being of the participants. A participatory process will always reveal that in every community there are local people who have a special interest in and an understanding of children's needs and experiences.

D. Resiliency and Protective Factors

Resilient children are those who have endured and flourished despite extremely challenging and stressful family and social circumstances including, for example, emotionally incapacitated parents and extreme poverty.

Inset 7: Some Characteristics of Resilient Children[9]

- Strong attachment to caring adults and/or peer groups
- Encouraging role models
- Socially competent at interacting with adults and children
- Independent and requests help when necessary
- Curious and explores the environment
- Plays actively
- Adapts to change
- Likely to think before acting
- Confident he or she can control some parts of his or her life
- Involved in hobbies, activities, and has multiple talents

As discussed previously, children's responses to extreme events vary as a function of individual characteristics and environmental factors. Children's development and resiliency will proceed as a result of the interplay between their needs and capacities, and the risk and protective factors within their environment. Resiliency can be enhanced by age-appropriate interventions that promote some of the characteristics outlined in Inset 7. This interplay will always reflect and be shaped by the culture and local circumstances. As discussed above, some elements of psychosocial development are specific to a particular culture, meaning that there is not a "one size fits all" approach to psychosocial programming. A key challenge facing project designers is how cultural factors minimize or increase risk, and promote or impede resiliency.

However, child development theory and research does point to a set of concepts that are useful building blocks for psychosocial projects regardless of where they are established. These include understanding what makes children resilient and the role that protective factors play throughout development. Identifying the ways these concepts are expressed within a particular culture should guide psychosocial project development and implementation. Through the study of children who have grown up under difficult circumstances, we have learned that some have certain characteristics and social supports that have enabled them to overcome adversity. Similarly, features of the social world have been identified that buffer the consequences of negative experiences on children. These features are often referred to as protective factors.[10]

Inset 8: Protective Factors

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

[9] Adapted from Donahue-Colletta, Understanding Cross-Cultural Child Development and Designing Programs For Children, (PACT, 1992).
[10] *Ibid.*

The concept of resiliency is extremely powerful for at least two reasons. First, it directs our attention to the fact that all children have assets and strengths. We are challenged to fully appreciate the depth of these assets and to design interventions that tap into, build on, and further augment them. Second, the concept of resiliency provides us with a hopeful perspective from which to work with children and youth. Many times we are so focused on the problems, deficits, and trauma that people have endured that it overshadows the fact that children, families, and communities have strengths and competencies. After all, being "free" of "problems" is not the same as being capable and healthy.

Inset 9: Resiliency and Protective Factors: Lessons Learned

What has been learned about resiliency and protective factors that might be of value in working with children and families in complex emergencies? The following are nine lessons learned.[11]

- *Promoting* healthy development and competence, *not just treating problems*, is an important strategy for protecting child development and preventing psychosocial problems from appearing in the first place.
- There are potential risks, vulnerabilities, assets, and protective factors in *all* people, families, communities, and societies.
- The *greatest threats* to human development are those that damage or compromise key resources and protective systems. The corollary is also true: *If key resources and protective systems are preserved or restored, children are capable of remarkable resilience.*
- Resilience is typically made of ordinary processes and not extraordinary "magic"—*it is a reachable goal.*
- Children who make it through adversity or recover will *have more* human and social capital in the future, that is they will be in a better position to address future problems. However, *no child is invulnerable.* As risk and threat levels rise, the relative proportion of resilience among children will fall. There are conditions under which no child can thrive.
- *Adult behavior plays a central role* in the development of all protective systems for children.
- As children grow up, they become more able to influence their own level of risk and degree of resiliency.
- Assessments of children need to include *competence, assets, strengths, and protective factors* along with symptoms, problems, risks, deficiencies, and vulnerabilities.
- Interventions can focus on *decreasing* an individual's exposure to risk or adversity, *increasing* the individual's internal resources, and *mobilizing* protective processes in the social world that surrounds individuals.

In addition to some individuals exhibiting resilient qualities, communities can also be resilient. By addressing community resilience, a more holistic approach is promoted and local resources are valued. Inset 10 points out characteristics of resilient communities.

[11] A. Masten, "Resilience in Children Exposed to Severe Adversity: Models for Research and Action." Paper presented at Children in Adversity Consultation, Oxford, 2000.

Inset 10: Some Characteristics of Resilient Communities[12]

- There is a strong sense of community characterized by open relationships between people and good communication.
- Leadership is shared, or leaders genuinely represent the people and both men and women are able to exercise leadership functions.
- Supportive structures exist such as schools and pre-schools, health services, community groups, and religious organizations.
- There is a commitment to community development. Community members take responsibility and action to enhance community life.
- Problems such as the effects of conflict and displacement are widely acknowledged and shared rather than individual problems; psychological understandings are diffused broadly in the community, and there is a commitment to developing collective responses.
- People see themselves as resourceful, and their communities as having potential to meet the needs of their people in a culturally appropriate manner, relying on external resources only when necessary.

E. Children's Reactions to Violence

If there is a powerful connection between the social world and individual development, what happens to children when their social world is disrupted? By definition, complex emergencies are high-risk environments, but certain features are especially important because of their potential impact on the psychosocial development of children.

Inset 11: Risk Factors in Violent Circumstances

Features of the social environment that may place children in violent circumstances at particular risk.

- Lack of adequate food, shelter, and medical care
- Injury or death of a family member
- Separation from caregivers
- Injury to self
- Degree of persecution and exposure to violence
- Forced displacement from home
- Separation from friends and community
- Inadequate substitute care
- Lack of economic security
- Denial of educational opportunities
- Exploitation, physical or sexual abuse

The cumulative affect of these risk factors is to disrupt normal patterns of living and traditional practices that provide a powerful sense of continuity and meaning to daily life.[13]

Research and anecdotal evidence suggest that children all over the world manifest emotional distress after exposure to overwhelming, life-threatening events through some form of behavioral change, developmental delay or disturbance, or, at times, dramatic "symptoms." Reactions to extreme emergencies vary because individuals draw on their own internal resources (resiliencies), as well as resources in the environment (protective factors). Children exhibit a wide range of reactions to violence. Children's reactions to traumatic events depend on a range of risk and protective factors, in the child's family, community, and culture. A child's reaction also depends on the depth and strength

[12] D. Tolfree, Restoring Playfulness: Different approaches to assisting children who are psychologically affected by war or displacemen (Stockholm: Radda Barnen, 1996), 87.
[13] Adapted from Donahue-Colletta (1992) *op cit.*

of his or her own experiences and ability to cope with them. It is difficult therefore to state how any single child will respond over the short-term or long-term to complex emergencies. While on the one hand we need to be sensitive to the unique reactions of each child, family, and community, we also want to help build insights into what are children's likely reactions to violence.

Inset 12: Children's Reactions to Violence

Based on experience, the following are examples of reactions children may typically have to violence.[14]

Examples of Children's Short-Term Reactions to Violence:

- Fear
- Clinging to parents
- Mistrust and suspicion
- Nightmares and night terrors
- Physical complaints
- Regression to developmentally younger forms of behavior
- Sadness or depression
- Restlessness, defiance, disobedience
- Aggression
- Disturbed relations with adults and peers

Examples of Children's Longer-Term Reactions to Violence

- Preoccupation with traumatic memories
- Nightmares related to the trauma and disturbances in sleep
- Re-enacting trauma in play behavior
- Trouble concentrating
- Lack of interest in activities
- Showing of few emotions
- Withdrawal from others, social isolation
- Constant alertness to possible danger
- Guilt about surviving
- Poorly developed moral sense of right and wrong
- Loss of optimistic viewpoint toward life

The actual form of expression of reactions to violence again relates to cultural norms and beliefs, as well as to the age and maturity of a child. A useful approach to these "distress signals" is to understand them as a "language" whereby the child is struggling to communicate feelings and experiences for which she or he has no adequate words, or which are connected with extreme shame and fear and, hence, are "unspeakable." The challenge for those trying to support children is to "interpret" and understand this "language" or behavioral expression of feelings – keeping the focus on establishing communication and fostering the child's own understanding of what he or she is experiencing. Caution needs to be taken in treating characteristic reactions as if they were all symptoms of severe mental illness instead of normal reactions to extraordinarily negative events, however, the potential for children to have major mental health needs should not be ignored.

[14] Donahue-Colletta (1992) *op cit.*

IV. Conceptual Advances in Psychosocial Development & Complex Emergencies

A. Limitations of Individualized Approaches

Much of the first generation of psychosocial projects assisting children in crisis situations focused on stress, trauma, and emotional development. Although potentially useful, this emphasis ultimately proved too narrow. As recognized in the May 1997 UNICEF workshop in Nairobi, psychosocial projects should affect "emotions, behavior, thoughts, memory, learning ability, perceptions, and understanding." Emotional development is important, but it occurs in a wider context in interaction with cognitive, social, and spiritual development. Further, disproportionate emphasis on emotional development has often contributed to the adoption of individualized approaches that fail to take into account the powerful role of the social and cultural context of children's development. The use of the "trauma paradigm" to express and assess the degree of human suffering caused by complex emergencies may be limited in its ability to capture the diversity and magnitude of the effects of gross human rights violations.

A focus on trauma is usually discussed in terms of post-traumatic stress reactions (sometimes referred to as PTSS or PTSD—Post Traumatic Stress Syndrome or Disorder). This is defined as a delayed or protracted response to an exceptionally stressful event. Key symptoms include, intrusive flashbacks of the stress event, vivid memories and dreams, and the re-experience of the original distress when the person is exposed to similar situations.[15] Although important in some contexts, it is generally not an effective point of departure for psychosocial programming in situations where multiple on-going traumatic events are influencing psychosocial well-being. For example, such an approach may not take into account concurrent distress caused by multiple losses such as loss of community, loss of educational opportunities, uncertainty, poverty, and destruction of hope. In an emergency situation, life threatening or traumatic events may change a child's life pathway dramatically, and this change may have more damaging consequences for the individual's well-being than the traumatic event itself. For example, a study by Basoglu et al. (1994)[16] looked at Turkish activists with a history of torture and found that the secondary consequences on family, social, and economic life were more important predictors of outcome than the torture per se. Also, a study on Iraqi asylum-seekers in London showed that poor social support had a closer relationship to depression than did a history of torture.[17]

Additionally, a trauma orientation potentially leads to a focus on an individual's problematic reactions, and directs attention away from the person's strengths, resources and the current context of his or her life, an essential perspective in achieving the broader goal of enhancing psychosocial well-being. Too often such a focus obscures sources of resilience and coping, traditional beliefs that color interpretations of one's war experiences, and local resources for healing and providing assistance to children. As such, taken out of context, a "Western" approach can be potentially damaging.

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

[16] M. Basoglu,, M. Parker, E. Ozmen, O. Tasdemir, and D. Sahin, "Factors related to long-term traumatic stress in survivors of torture in Turkey," Journal of the American Medical Association 272 (1994): 357-63.

[17] C. Gorst-Unsworth and E. Goldenberg, "Psychological sequelae of torture and organized violence suffered by refugees from Iraq; Trauma-related factors compared to social factors in exile," British Journal of Psychiatry 172 (1998): 90-4.

While recognizing that there is a dearth of research on the relationship between experienced trauma and mental illness, especially for children, caution should be used when using a Western "trauma paradigm" that potentially leads to an individualized approach. Such an approach can be stigmatizing. There may be a role for more "intensive" interventions for those most affected; however, they should be culturally appropriate and based on individual's strengths and resources. Perhaps the most evident drawback of an individual approach is that the model may not explore the most pernicious and long-lasting effects of bitter civil wars—the destruction of relationships between and among people of the kind necessary to sustain survival, meaning, values, and hope.

B. Moving from Individuals to Communities

Complex emergencies disrupt both individual and community functioning in that the weakening of either will likely have a negative impact on the other. At the community level, psychosocial effects of complex emergencies are often seen when neighbors no longer trust each other, no longer relate to one another, and in some instances are hostile to each other. The breakdown of cohesion can be found in the disruption of normal patterns of living and traditional practices that provide a sense of continuity and meaning. The rupture of trust and friendship has serious generational consequences for the functioning of community life and the viability of societies as a whole. It is with these combined effects that children and their families struggle to cope.

It is thus vital to connect work on psychosocial healing with efforts to build tolerance and reconciliation. Psychosocial projects with a Western model of mental health often strongly encourage emotional expression as a means of aiding emotional healing. But in an ethnically divided context, such emotional expression and venting typically occurs among members of one's own group. In such circumstances there is risk that expressions of suffering can be a way to inappropriately valorize suffering. When traumatic memories become badges of honor, they can serve as warrants for revenge that can contribute to ongoing cycles of violence and beliefs that violence is justified. In Kosova, for example, the strengthening of one's cultural identity can become a justification for mistreating the other groups. Groups that feel assaulted on cultural grounds, whether Albanian or Serbian, have a powerful need to advance, express, and reclaim their own culture. To prevent additional violence, however, this reclamation must be integrated with wider efforts of building tolerance and peace. These experiences underscore the fact that healing must be social as well as individual, and it needs to occur across the lines of conflict. In a war zone, healing cannot be approached effectively as a singular endeavor; it must be holistic and include activities that build tolerance and reconciliation.

Chapter One Summary

There is a need to broaden the definition of psychosocial to recognize the holistic, integrated nature of child development and to situate it within an ecological perspective.

At its core, psychosocial programming is about emotional healing, social reconciliation, and community building. To do this, efforts must move beyond individual well-being and seek to foster community rebuilding and reconciliation.

A positive developmental environment is one that consistently provides children with opportunities and challenges to develop as competent social beings. Many factors such as adequate nutrition, good health, and freedom from disability will play a role in the rate and quality of a child's psychosocial development and well-being.

When designing psychosocial projects, the participation of communities is important so that protective factors and resiliencies may be recognized and harnessed in culturally appropriate and sustainable ways. The capacity to respond in an integrated way to the full range of children's and community's needs is a continuing challenge to practitioners, especially under emergency conditions.

Chapter Two

Chapter 2: What Is Psychosocial Programming?

This chapter offers a definition of psychosocial programming and provides a discussion of the dimensions of psychosocial programming, including fundamental goals, target population, project content, and project approach. The chapter concludes with a brief outline of major project areas and their importance for promoting the psychosocial well-being of children, families, and communities.

I. Definition

Child-focused psychosocial projects are those that promote the psychological and social well-being and development of children. The orientation here is that child development is promoted most effectively in the context of the family, community, and culture. At its most fundamental level, psychosocial programming consists of activities designed to advance children's psychological and social development, to strengthen protective and preventive factors that can limit the negative consequences of complex emergencies, and to promote peace-building processes and reduce tensions between groups. Inset 13 identifies fundamental goals of psychosocial programming.

Inset 13: Fundamental Goals of Psychosocial Programming

- Secure attachments with caregivers
- Meaningful peer relationships, friendships, and social ties; social competence
- A sense of belonging
- A sense of self-worth and value, self-esteem and well-being
- Trust in others
- Access to opportunities for cognitive and spiritual development
- Physical and economic security
- Hope, optimism, and belief in the future

Many different types of projects may be implemented to support these fundamental goals. The diversity is illustrated by the following sample interventions:

- Tracing and reunification of unaccompanied children with their families
- Food aid and distribution projects
- Projects to address the psychosocial effects of armed conflict
- Projects for the social reintegration of former child soldiers
- Violence prevention and peace education projects
- Early stimulation projects for infants
- Early child development projects
- Health projects for children and parents
- Positive parenting projects
- Vocational training projects for adolescents and adult caregivers
- Educational and cultural projects
- Awareness training on children's needs and rights
- Advocacy for greater protection and implementation of children's rights

The promotion of psychosocial well-being may be accomplished through a variety of approaches. It may be the main focus of a discrete or stand-alone project, or it can be integrated with other projects, such as food security, health, or shelter. As stated in Chapter One, the value of integrating psychosocial dimensions into other emergency interventions should not be underestimated. For example, a child health project will have limited success if caregivers are overwhelmed and unable to make effective decisions about family health management. A holistic approach, which addresses immediate health concerns while acknowledging the importance of the family system, is more likely to result in desired project impact because it addresses caregivers' needs as well.

II. Dimensions of Psychosocial Programming

To better understand the host of project strategies that can be designed, it is useful to organize them along three dimensions, according to the *population being targeted, the content of the project* itself, and the *project approach* being implemented. These three dimensions are described below.

A. Target Population

Children and families who are part of the same community and have endured the same sequence of events will nevertheless have different experiences and responses. We distinguish between three groups, according to the degree of risk:

1. Severely Affected Group
The psychological and social functioning of some children and adults may be severely compromised. While generally a small percentage of the overall population[18] (represented in the diagram below as 10%), this group requires intensive psychological attention because they are unable to manage on their own. Children forced to view and/or commit violent acts, such as child soldiers, are likely to fall into this group. More time-intensive, individualized approaches are likely to be the most appropriate responses, where social and cultural resources permit. Even if bolstered by project support, most community-based attempts are inadequate to rebuild psychological functioning unless coupled with an effective identification and referral system for more individualized support. This group is in need of one-on-one attention in order to address the more severe traumatic and/or depression disorders, for example. For the small percentage of children who require special assistance, one-on-one attention can be provided in the form of traditional rituals or other local cultural practices, and should not be limited to Western-derived responses such as psychological counseling. There is little research available on how to best address these more severe needs in emergencies, and, because of the high cost per beneficiary required to address the needs of this proportionally smaller group, most international relief organizations must by necessity focus on reaching larger numbers of children affected—the at-risk and more generally affected groups—through community-based interventions.

2. At-Risk Group
A second segment of the community (represented at 20% in the diagram below) consists of those who have experienced severe losses and disruption, are significantly distressed, and may be experiencing despair and hopelessness, but whose social and psychological capacity to function has not yet been overwhelmed. Children and adults in this category may be suffering from acute stress disorder (the most extreme, or exaggerated normal reaction to violence and trauma). They may have lost family members in the violence, they may have witnessed deaths, or they may be victims of violence. This group is at particular risk for psychological and social deterioration if their

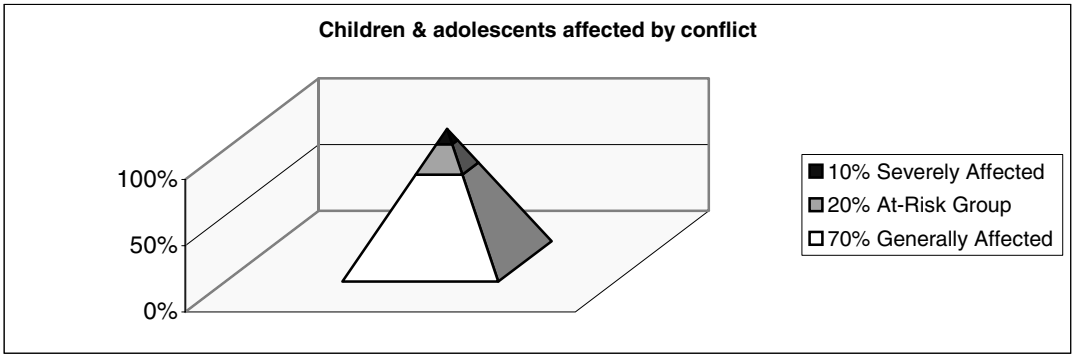
[18] E. Cairns, Children and Political Violence (Oxford: Blackwell, 1996).

psychological, social, cognitive, and development needs are not addressed through timely community and social support mechanisms.

3. Generally Affected Group

The third and broadest segment of the population consists of individuals who may not have been directly affected by crisis events and whose families may be largely intact. Children and adults in this group may be suffering from physical and mental exhaustion, for example, but are not experiencing the level of distress felt by those in the severely affected or at-risk groups. It is estimated that the physiological arousal that represents normal survival and stress responses to violence and/or trauma will abate over time for 60% to 80% of this group without direct intervention. Community-based interventions that include not only normalization activities but also theme- and body-based activities can preserve and augment positive coping strategies among this population in a shorter time-frame and contribute effectively and more immediately to children's and youths' social, cognitive, and emotional development.

Diagram 3: Groups within a Community Differentiated According to Psychosocial Impact



B. Project Content

Since children and adults experience and react to complex emergencies in unique ways, the types of projects designed to address their needs will also differ. Projects range and include those that are *curative*, *preventive*, and those that *promote* psychosocial well-being. Curative projects address the diagnosed psychological effects of complex emergencies on children and families, such as treatment of trauma. Preventive projects seek to prevent further psychosocial deterioration and may focus on a particular group or social environment. An example includes protecting women and children from physical assault in a refugee camp by integrating their safety concerns into camp management and facilitating the organization of a women's support group.

Inset 14: Strengthening Individuals and Social Environments to Support Psychosocial Development

One of the most basic psychosocial interventions is to support and foster the connection that exists between the well-being of caregivers and that of their children. Toward this end, in a guide to establishing projects for unaccompanied children, Williamson and Moser (1988) suggested the following interventions:[19]

- If parents or primary caregivers are not available, secure a caretaker who will have ongoing responsibility for the child. This individual needs to be able to provide emotional warmth, stability, and consistent care
- Use a consistent daily schedule to begin to reestablish a sense of order and security.
- Return the child to familiar activities: play, school, participation in household chores.
- Make sure children know what changes will happen in their daily lives and what is planned for them. A child as young as two years old needs to know that he or she will be moved, cared for by a new person, or returned to his or her family.

Lastly, projects may seek to ***promote*** healthy psychosocial development through, for example, opportunities to engage in educational, social, and spiritual activities that support the development of children.

Inset 15: Community Integration and the Restoration of Trust

The effects of the 1994 Rwandan genocide and the continued insurgent attacks have left deep social scars among the Rwandan population. According to a USCR report, "The existence of ethnic grievances and the sense of mutual victimization keep Rwandan society on edge, even in regions that are largely free of violence. Although Hutu and Tutsi live among each other again, a huge gap exists in their perceptions. Physical reintegration has occurred far more readily than psychological integration." One international NGO attempted to address the issue of basic trust in its projects targeting vulnerable children and their families by encouraging the creation of community associations to function as community resources. In addition to the associations' work with children, the positive impact that associations had on the quality of life for caretakers was substantial. The timeliness of the project filled an emotional, social and moral need at a time when most international aid was being directed towards material assistance. By bringing individuals together, hope was restored through group solidarity. As one participant stated, "Following the war, we did not have a peaceful heart. By working as a group, we were able to provide each other moral support at a time where we were all affected by the war."[20]

C. Project Approach

There are different approaches to psychosocial programming, depending on the population being targeted and the project to be implemented. It is possible to identify three major groupings:

1. Psychological: Some projects focus more on psychological factors than on social factors. For example, some projects may provide individual counseling to children who have had traumatic experiences or provide training to key community members to identify, refer, or counsel children. These projects will most likely target children and caregivers who have been most severely impacted by crisis events and require a higher level of individualized attention than community-based interventions can provide.

2. Predominately Psychosocial: Some psychosocial projects are predominately or exclusively psychosocial in focus. The project is self-contained and not integrated into other projects with different foci (e.g.,

[19] Donahue-Colletta (1992) *op. cit.*

[20] The US Committee for Refugees, Life After Death: Suspicion and Reintegration in Post Genocide Rwanda (Washington DC: Immigration and Refugee Services of America, 1998).

health, food security, shelter) that may co-exist and are co-located. Examples include stand-alone recreation projects, art therapy, or various community-based interventions that promote positive cognitive, emotional, and educational development and functioning. Staff working in these psychosocial projects may have only minimal contact with staff working on other projects. Predominately psychosocial projects are likely to target their activities toward generally affected and at-risk populations, and provide screening and referral (to individualized mental health services or counseling programs) for those more severely affected by conflict or violence.

3. Integrated/Holistic: In some cases psychosocial interventions are integrated into a holistic and total response to the needs of a community. In this case, the "psychosocial" elements may not be as visible. For example, income generation or vocational training projects are not typically thought to be psychosocial. Yet, addressing the economic livelihood of families is fundamental to psychosocial health both in terms of reducing the daily stress of how a family will feed itself, and in terms of providing a pathway to stability and hope for the future. Similarily, such an intervention may have an educational component that supports cognitive development and at the same time fosters good peer relationships and social skills. An income generation project or vocational training project may be a conduit for improved self-esteem and self-worth and the establishment of peer friendships. The position here is that projects that are based on such a holistic approach are to be preferred since they maximize a mutually reinforcing effect when responding to different aspects of child development simultaneously. These projects are most likely to focus on those in the at-risk or generally affected group.

The design of psychosocial project interventions—including content, beneficiary reach, and implementation—can draw on various principles that have been identified, as in Inset 16.

Inset 16: Recommended Principles for Targeting Psychosocial Projects

In their evaluation of a group of psychosocial projects funded by the Norwegian Ministry of Foreign Affairs, Agger and team recommended a number of principles for future project design.[21] These include:

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

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

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

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

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

III. Psychosocial Programming: Major Project Areas

Psychosocial projects can provide activities that foster social connection and reintegration, address educational needs, build economic survival skills, teach life skills and coping mechanisms, advocate for justice, and address recovery from traumatic experiences. In these projects, the emphasis is on strengthening social environments that nurture children's healthy development as a whole through close cooperation with the caretakers, peers, community members, and, very importantly, the children themselves. Children, particularly adolescents, are often overlooked as spokespersons for themselves. It is useful to organize projects into six broad areas that encompass the diverse social and psychological needs of children during and after a crisis: The Primacy of Family, Education, Engaging Activities, Economic Security, Community Connections, and Reconciliation and Restoration of Justice.

A. The Primacy of Family

As discussed in Chapter One, children's well-being is inextricably interconnected with family and community. The most basic level is that of families where there is a clear connection between the well-being of children and that of their primary caregivers. If caregivers can maintain a strong attachment to their children and have access to the basic needs of shelter, food, and medical care,

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

then children will cope better with difficult environments.[22] It is for this reason that family tracing and reunification is a priority in emergency situations. As primary caretakers become overwhelmed by the demands of the emergency, their capacity to provide care and nurturance to their children decreases. Thus, it is important to mobilize the resources of the community to provide consistent social support to caretakers.

When children are separated from their family, interventions may be designed that build on protective factors to enhance the child's internal resources as they cope with this separation. One common response has been to create residential centers where unaccompanied children may live, and which may evolve into orphanages over time. Unfortunately, these institutions are often overwhelmed and lack sufficient human or financial resources. They are, therefore, unable to provide an attentive, stimulating, and nurturing environment, which is so important in promoting healthy development. Practitioners have pointed out that frequently the long-term negative consequence to a child is not the experience of living through an actual emergency, but rather the fact that the child's life path has been permanently thwarted when he/she is placed in inadequate institutional care.

Inset 17: Institutional Care – Not an Appropriate or Long-Term Solution

Children fare best when they are an integral part of a family unit. Therefore, institutionalization is not a desirable solution, even as a last resort. Following the Rwandan genocide, the creation of unaccompanied children centers was a short-term response that was not intended to be a long-term solution. Many NGOs and international organizations opened new unaccompanied children centers and orphanages without sufficient attention to long-term planning and coordination. In general the quality of childcare in these centers was inadequate. Children were commonly crammed into overcrowded buildings and often supervised by inexperienced caretakers. Unfortunately, the establishment of centers also provided a livelihood to many people and could not be easily discontinued. According to UNICEF, between December 1994 and March 1995, 2,324 new children were placed in institutions. The continued trend towards institutionalizing children is in direct contradiction to government policy to close existing centers and integrate care into the community and to the CRC.

B. Education

Of particular psychosocial importance is the re-establishment or maintenance of formal and non-formal education opportunities. School is a major source of intellectual and psychosocial development. Children not only expand their cognitive capacities, but they also learn about sharing, following rules, controlling impulses, and becoming social beings. School offers structure and predictability, which contribute to a child's feeling of safety and emotional security. Establishing educational projects for children should take into account the fact that many children may have difficulty concentrating and learning due to the psychological consequences of war experiences.[23] Therefore, curricula, as well as teaching methodologies, may need to be adjusted or created to suit the special needs of children who have often witnessed and experienced extraordinarily negative events and who may be physically wounded or grieving the loss of family members.

The benefits of educational projects can extend to the wider community. In addition to addressing children's developmental and psychosocial needs, educational activities can be a forum for adolescents and adult community members to come together in a variety of ways to protect children and rebuild their community. For example, some community members may participate in training opportunities,

[22] Y.A. Al-Eissa, "The impact of the Gulf armed conflict on the health and behavior of Kuwaiti children," Social Science and Medicine 41 (1995): 1033-1037.
[23] J.D. Osofsky, "The effects of exposure to violence on young children," American Psychologist 50 (1995): 782-788.

while others may mobilize local resources for construction or material support. Participation of community members in educational programming can foster a sense of self-efficacy and provide opportunities for community support.

C. Economic Security

Economic security contributes greatly to feelings of safety and well-being for both adults and children. In addition to being a necessity for survival, being able to provide economically for the family increases a caregiver's sense of worth and in turn, positively influences the caregiver's ability to support their own child's development. Adults who feel they are not instrumental or have no control over life events become emotionally overwhelmed and gradually less responsive to the needs of their children.

Older children and adolescents often want to make genuine contributions to their families. They recognize when caretakers fear for the family's economic survival, and often are emotionally upset about their own limitations in relieving this economic stress. Project strategies that enable older children and adolescents to become active and meaningful participants in addressing economic vulnerabilities, support their healthy psychosocial development, and promote a sense of self-worth and value. Projects may prioritize families that may be particularly vulnerable to economic stresses, including households headed by single-mothers or by children and adolescents.

D. Engaging Activities

Play is the *work* of childhood and is a cornerstone of healthy psychosocial development. Play is an active learning method that provides manipulation and facilitates mastery, self-worth, and the development of basic competencies – including social competencies. Children are curious, and play provides a safe way to explore and learn about the environment. Individual and cooperative play facilitates neurological growth, fosters the development of physical strength and coordination, provides relaxation, encourages planning, facilitates processing symbols, allows practice of life skills, unites body, mind, and spirit, and allows a child to learn about learning.[24]

Traditional games, dances, songs, and stories provide a sense of stability during crises, and also help to strengthen youths' sense of cultural identity. Forced displacement may scatter communities and make it difficult for children to learn songs, proverbs, dances, and art forms that link generations and provide continuity. Participation in these types of group activities can rebuild a sense of solidarity and community, while also enabling pro-social behaviors such as cooperation, communication, and skills in settling conflict non-violently. It is important to note that during times of conflict, activities that promote cultural identity may play into political tensions. Project planners should build in ways to address these issues and seek ways to foster tolerance and reconciliation among groups.

E. Community and Cultural Connections

Friendships with peers and relationships with adults outside of the family play a vital part in social and emotional development throughout childhood. The ability to form social relationships and to maintain ongoing contact and support of close friends are central to resiliency in children and youth. Conversely, children and adolescents who are isolated or marginalized, especially through rejection

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

and stigmatization, are at risk of developing psychosocial problems that tend to push them even further into isolation.

If one's cultural group has been assaulted, oppressed, or made to feel inferior, the reassertion of cultural values and identity is part of the healing process and essential for the development of positive self-esteem. Since, increasingly, youth are actors who can contribute positively or negatively to make or break a peace accord, it is vital to engage them in activities that strengthen their cultural identity in ways that are positive and supportive of efforts toward building tolerance, peace, and reconciliation.

Recognizing the centrality of culture is key in developing culturally grounded and sustainable interventions that are in tune with local socialization practices. To develop meaningful, sustainable projects, international organizations must seek ways of recognizing and fully integrating relevant cultural beliefs, values, and practices. Local communities contain a wealth of indigenous psychosocial resources that embody local culture. Communities have constructed these cultural resources over centuries in response not only to daily challenges such as parenting, but also to the exceptional challenges posed by wars, and the cyclical challenges of famines, droughts, and other natural disasters. These cultural resources may include traditional patterns of child rearing, rites of mourning, rituals for healing, norms of caring for children in extended families and by community members outside of the extended family, and "cleansing or forgiveness" ceremonies for soldiers returning to society, among many others. Human resources, too, are of great importance. Every community contains people who care about children, know the local culture and situation, and have a culturally grounded understanding of children's needs and experiences. Effective psychosocial programming should identify and support appropriate local leaders, resources, and traditions, which disasters and wars frequently disrupt. Significant psychosocial benefits may occur through the strengthening of traditions, which provide social support, a sense of continuity, and positive social identify.[25]

At the same time, all cultures, communities, and local resources should be viewed critically. For example, local communities may have established patterns of hierarchy that tend to become more pronounced during crisis. As occurred in the aftermath of the 1994 Rwandan genocide, particular groups in a refugee camp may distribute aid resources unequally and use aid to augment their own power. In many communities, women and children ordinarily have less access to resources, and their access may decrease during crises. Effective psychosocial work requires respect for local cultures and communities tempered by ethical sensitivity, and a programmatic commitment to the principles of the Convention on the Rights of the Child.

F. Reconciliation and Restoration of Justice

Forgiveness, if feasible, is key in reconciliation processes and often takes the form of a cleansing ceremony, which provides a child with a chance for a new beginning. Where individual and community forgiveness are not attainable, tolerance may be a more realistic goal. This may be particularly relevant for children who have been engaged in particularly horrific events, such as rape or murder. Projects focusing specifically on forgiveness may facilitate reconciliation and peace among warring parties. Advocacy addressing issues of justice are important to promote reconciliation and peace. In addition to human rights violations and war criminals, other issues such as land tenure and

[25] See, for example: Mike Wessells and Carlinda Monteiro, "Psychosocial interventions and post-war reconstruction in Angola: Interweaving Western and traditional approaches." In Peace, Conflict, and Violence: Peace Psychology for the 21st Century, edited by D. Christie, R.V. Wagner, and D. Winter (Upper Saddle River, NJ: Prentice-Hall, 2001), 262-75; and Alcinda Honwana, Okusiakala Ondalo Yokalye, Let Us Light a New Fire (Luanda: Christian Children's Fund/Angola, 1998).

property rights may be a very important piece of the healing process. Projects can also include awareness on the special needs of certain populations such as child-headed households, unaccompanied minors, widows, disabled children and adults, etc.

Chapter Two Summary

Complex emergencies disrupt both individual and community functioning. To address children's psychosocial risk and protective factors, it is desirable for projects to be designed in holistic and integrated ways that take children's family, community, and cultural resources into consideration.

Major psychosocial project areas include those that promote family unity, education and economic opportunities, provide opportunities for children and youth to engage in activities that promote cognitive, emotional, and spiritual growth, and foster connections that create or re-create a sense of community.

These projects may be free-standing, but they may also be designed as part of an overarching emergency response. In order to be effective, projects must reflect – but on occasion take a critical stance towards - local cultural beliefs systems and resources.

Community-based projects that are respectful and supportive of local capacities to assist children are more likely to be accepted and have positive impact. The best orientation in programming is one of partnership, that is, truly shared decision-making with children in age appropriate ways, families and communities, along with flexibility and openness in learning how to strengthen family and community supports for children.

Ultimately, psychosocial interventions should advance and protect human rights, particularly children's rights.

Chapter Three

Chapter 3: Evaluating Psychosocial Projects: Overarching Principles and Project Logic Models

In this chapter we will discuss four basic principles of evaluating psychosocial interventions, cover the importance of having a rationale or logic model to guide the development of a project, and define key terms. Evaluation methods and tools will be illustrated using case examples from psychosocial projects.

I. Why Is Evaluation Important - Even in Complex Emergencies?

The primary purpose of project evaluation should be to help identify the strengths and weaknesses of an intervention in order to improve that intervention and, ultimately, others like it.

Psychosocial projects in the context of complex emergencies, whether in the midst of war or in the aftermath of environmental or other disasters, are designed to address compelling human problems and conditions. Therefore, getting a project up and running is urgent while the evaluation of that project is comparatively less urgent. Time pressures and the often chaotic setting of a complex emergency make evaluation difficult. Sometimes evaluation is viewed as a burdensome requirement of the donor or an unnecessary luxury that takes too much time and preparation and diverts resources that would be better spent on running the project. If not done efficiently, evaluation can cause delays in providing assistance and heighten expectations beyond the scope of the project.

However, without ongoing monitoring and evaluation, intervention activities can be misdirected. Indeed, experience has shown that efforts to launch emergency interventions have sometimes inadvertently or unintentionally resulted in the implementation of projects that actually undermine the individual and social benefits that the intervention is intended to accomplish. For example, sometimes this happens when "outsider" tools and concepts are brought in while local opinions and ideas are relegated to the sidelines. A good monitoring and evaluation plan alerts us to problems early in the course of the project and can also point to gaps in programming. These problems or gaps can then be addressed in a timely manner.

As illustrated in Inset 18 below, monitoring how a project is implemented as well as listening to feedback from project recipients can play an important role in meeting project goals or making mid-course changes in the project.

Inset 18: The Need for Cultural Sensitivity in Programming

In Albania following the exodus of hundreds of thousands of Kosovar in April 1999 into refugee camps, many organizations gave food to Kosovars. In one camp, the elders said they felt demeaned by being fed Albanian food and treated as if their own culture did not matter. The food handouts were unintentionally having a negative impact. They wanted to eat Kosovar food, not Albanian food. Accordingly, they gave nongovernmental organizations a list of the ingredients they wanted. Having taken over a building for a kitchen, they began cooking and serving their own meals and working 12 hours each day. Youth in the camp helped to organize people in shifts in order to avoid long lines. Both the cooks and the recipients reported that they felt much better about the food, felt more in control over their circumstances, and experienced pride in what they had accomplished. Through their demand for more control over their circumstances, what had been a straightforward food distribution project integrated a psychosocial component to address social and emotional well-being.

II. Four Overarching Principles of Evaluating Psychosocial Projects

- Culturally Grounded / Participatory
- Informed Consent and Feedback
- Confidentiality
- Sensitivity to Consequences

1. Culturally Grounded / Participatory

Project evaluation should be guided by sound overarching principles. The perspective offered here is that standard Western project evaluation practices can offer important guidance but are enhanced when integrated with local values, practices, and ways of understanding the effects of a project on a local culture and society. Just as project development must be in tune with culture, methods of monitoring and evaluating projects should also be culturally grounded and respectful of different ways of "knowing." The participation of communities helps to increase the likelihood that methodologies will be culturally grounded and appropriate to the specific setting. An evaluation methodology that capitalizes on both the strengths of Western approaches and local community insights and values will result in a more meaningful understanding of the intervention and its outcomes. The sustainability of programs also depends on the ability of communities to self-monitor, critically review, and refine their own initiatives. Just as local participation is necessary for the design of effective psychosocial interventions, working with communities and local cultures to design and carry out project evaluations builds local capacity and ownership of the intervention, and is necessary to the development of evaluation tools and strategies that adequately capture project results or outcomes.

Having said this, it is also clear that many communities do not yet possess some of the skills necessary to systematically evaluate and refine interventions. Communities need assistance. However, ***how*** help is provided is as important as ***what*** help is provided. For example, it is not appropriate to do an evaluation "on" a community; it is better practice to do an evaluation "with" a community. Target populations are not only a rich source of insights about problems and workable solutions, but also in finding sources of information on what an intervention is achieving. An evaluation should be inclusive of local partners and create a dialogue to capture local experience and insight, as opposed to a team composed solely of outside "experts" with little insider knowledge of the culture, who attempt to "objectively" evaluate the project using instruments that have originated and been standardized outside of that culture. Standard measures can be utilized in the process of developing culturally appropriate measures (i.e., measures such as survey questionnaires), but care must be taken with interpreting the results. Standard measures should be used in conjunction with qualitative studies as well as locally derived measures. Ideally, every measurement tool should itself be assessed for validity,

sensitivity, and reliability before making policy or programming decisions based on the results. In the process of working *with* a community, its traditional specialists, local healers, educators, and others, project implementers can strengthen the sense of local ownership and empowerment, and in so doing promote the success of the project, including its sustainability.

2. Informed Consent and Feedback

There are special consent issues that arise when interviewing and conducting evaluations with children. Children and minors have perhaps the least say in actions that affect them and routinely the rights of evaluation participants are violated. Evaluations that collect sensitive and personal information must be especially sensitive to this. Informed consent is fundamental to conducting an ethical evaluation. Clearly, in many instances, obtaining the informed consent of project participants is challenging. This is particularly the case with children whose parents or caregivers may not be available. Nonetheless, participants have an absolute right to know about the risks and benefits of an evaluation in which they are being asked to participate – even if they are children and require more effort or explanation. Real efforts must be made to obtain the consent of a child's parents, caregivers, or local authority. Participants should understand that whether they decide to participate or not has no impact on their continued receipt of project services. Participants should receive specific information on how the information will be used, what the process will entail, what level of confidentiality will exist, and what kind of reports will be written based on this data.

Another point to keep in mind in designing an evaluation methodology is if and how feedback will be provided to participants. Participants often have questions about the purpose of the evaluation, use of the data, and results of the evaluation. It is wise to consider beforehand the various mechanisms needed to provide feedback.

3. Sensitivity to Consequences

There can be negative consequences for the participant in being asked probing questions about emotionally sensitive events. The following questions act as guides in attempting to minimize stress that an interview may induce.

- Does the interviewer have experience in interviewing children?
- Is enough time allowed for the discussion of issues that may be raised during the interview?
- Is the interview going to occur in a place that is private?
- Will the identity of the child (or adult) be protected, particularly if the material is politically sensitive? Will anonymity be maintained throughout data collation?
- If deep wounds are brought to the surface during the evaluation process, how will this be handled? Is an appropriate resource available to help the participant?

Since the questions asked may make participants uncomfortable and/or may cause distress, advance planning as to how such situations will be handled in a culturally appropriate manner is necessary. For example, you may want to arrange a referral service with a trusted community member or "professional" so that participants are not abandoned with their distress following the interview. The point is not to leave children and others even more emotionally vulnerable. It is better not to ask questions than to ask them irresponsibly. Even though informed consent carries with it the option to discontinue an interview at any time, children and vulnerable adults may not feel empowered to stop an interview when distressed, so interviewers must be sensitized in order to recognize the signs and needs of children as well as adults. In addition, in emergency situations communities are vulnerable to inquiry from journalists, political delegations, and others who are seeking information that is often very sensitive and evocative of painful memories and feelings. The process of collecting such

information is often intrusive, fact-finding in tone, and done in a short time frame. Mechanisms and policies that can address these kinds of issues need to be put in place to protect children before a situation presents itself.

4. Confidentiality
Data of a confidential nature should be safeguarded and accessible only to designated staff. This means that files should be locked and access limited to authorized persons only. This procedure will also prevent the loss of data. It is good practice to use identification numbers on data collection forms rather than the actual names of participants. A confidential list of names and identification numbers can be kept by a senior staff person at some off site location. Once the data are grouped or summarized it may not be necessary to keep data that can be associated with an individual. If it is not necessary to keep such records, they should be destroyed. It is advisable to treat the data as if it were information collected about yourself and to consider how you personally would want it to be safeguarded.

In evaluations and other information gathering activities, issues such as these must be fully considered in developing ethical policies aimed at protecting children as well as adult participants.

III. Project "Logic Models"

The strategy for monitoring and evaluating any project is based on the building blocks of project rationale or concept, planning and implementation. In this section we begin by focusing on the reasoning behind project planning and the project "logic model."

Inset 19: A Project Logic Model

A project logic model is a graphic representation of the assumptions behind the design of a project. The aim is to illustrate the relationships between all the different steps in the project. We need to be explicit about all the links between activities (and other inputs) and their outputs, between outputs and intermediate results, and between intermediate results and the ultimate project outcomes, which are stated as project objectives.

A logic model is essentially the implicit made explicit. The first step is to identify the key inputs and outputs and their relationships to desired outcomes or results. The next step is to use graphics, such as flowcharts or lines that connect interventions and outcomes (sometimes referred to as "spiders" because they can resemble a spider web of relationships) to illustrate these pathways and relationships. The process of creating the logic model will help to articulate the assumptions behind the model as well as the intended project results.[26]

The graphic representation of a logic model may vary, depending on the level of detail, emphasis, and its utilization. The examples that appear in this chapter reflect only two options. The first takes on a flow-chart style, while the Consolacão example resembles building blocks.

A logic model reflects an understanding or assumptions about how project activities or inputs affect internal and external factors that in turn, affect the psychological functioning of children and families. The design of any project, including psychosocial projects, is based on a logic model or assumptions,

[26] A very useful guide to developing Logic Models is available from the W.K. Kellogg Foundation; (Kellogg Foundation, 2001). Available in PDF format from: http://www.wkkf.org/Programming/Overview.aspx?CID=281

whether explicitly stated or implicitly held, of how project activities should affect a target population. A project's logic model can change as important new information comes to light. The important thing is to start with some explicit ideas about how a project is attempting to assist its beneficiaries. Again, the process of building a logic model should be participatory and culturally grounded.

To illustrate logic models, let us turn to two psychosocial projects that have been implemented in Angola and Mozambique, respectively. (We will come back to these case examples to illustrate concepts throughout the document.)

A. Province-Based War Trauma Team

The Angolan project, named the Province-Based War Trauma Team (PBWTT)[27] project, was designed to address the effects of civil war on children and families. In Angola, war has continued for nearly forty years, and both children, who comprise nearly half the population, and caregivers have been affected by poverty, hunger, displacement, homelessness, death of loved ones, landmines, and violence at multiple levels. From 1995-98 the project sought to support the Lusaka Peace Process through community-based healing aimed at alleviating suffering and breaking cycles of violence (including the intergenerational cycles associated with violence).

Initially, the PBWTT logic model was based on the concept of **trauma**. It assumed that the horrific experiences associated with attack, displacement, and related factors led to war trauma which increased caregivers' stress, reduced their ability to provide effective care for children, and left some feeling overwhelmed and hopeless. It also assumed that trauma led to social disorganization and made it difficult for adults to engage in effective planning and communal activities to support children's healthy development. The project sought to enable adults to come to terms with their own experiences of war and violence, to understand the impact of violence and trauma on children, to organize themselves to assist children emotionally, and to plan community activities to promote children's well-being.

The project strategy was to select community leaders for children through a participatory process, train them to understand how they and their children had been affected, help the adults to come to terms with their experiences, and support community-based activities involving expressive arts (drawing, dance, song, etc.) and activities such as team sports that would increase social integration. To build local capacities, the project used a training-of-trainers methodology in which a national team of Angolan trainers selected and trained three-person training teams in seven of the most severely war-affected provinces. In turn, the province-based teams trained influential local adults who then implemented activities on behalf of children in open, communal spaces, conducted wider community dialogues about children's needs, and worked through networks of local groups to support children. The trainers also trained teachers, workers in different NGOs, and policy leaders to understand how children had been affected and to organize activities and policies to support children's healthy development.

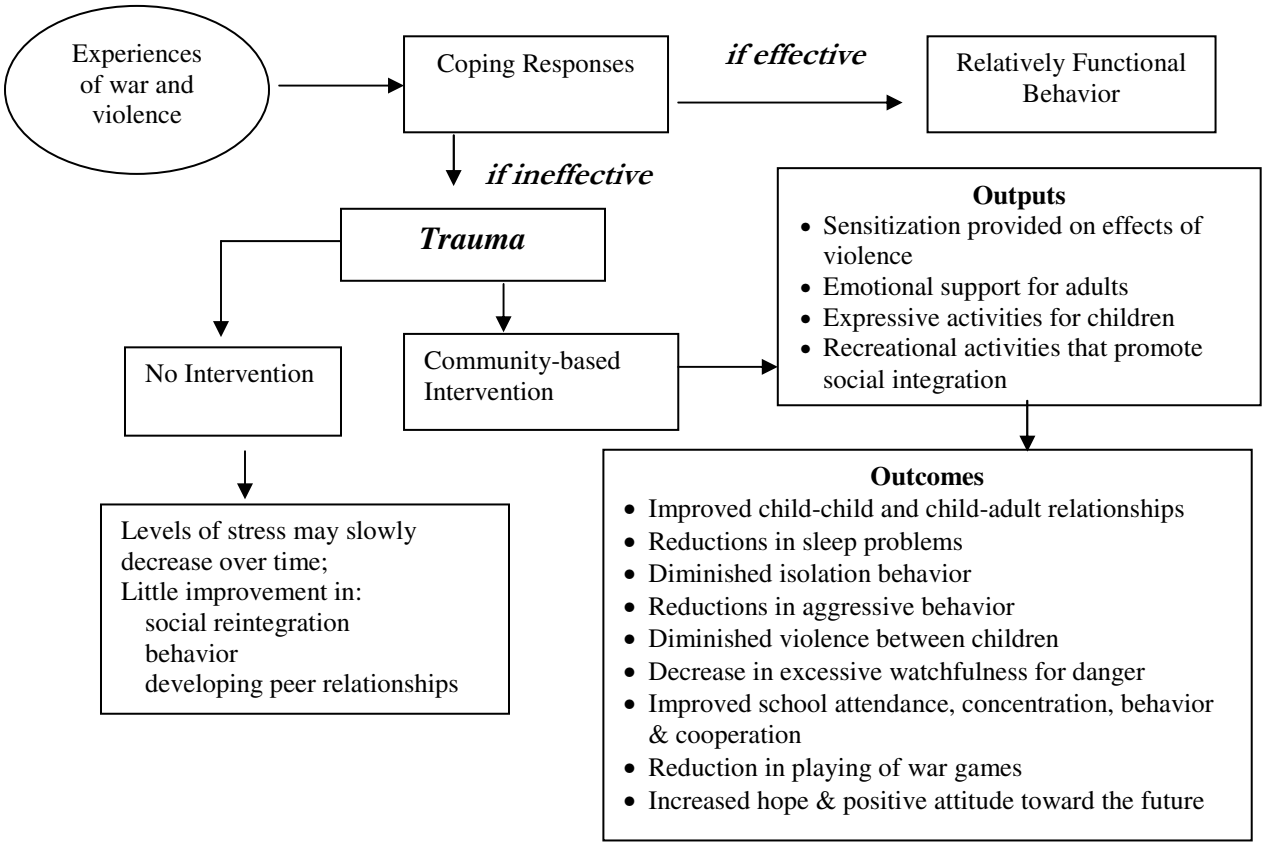
What are the assumptions behind the design of the project and how do the activities of the project relate to the desired outcomes and the impact for participants? That is, given certain inputs, (e.g.,

[27] Information on the Angola Province-Based War Trauma Team Project was provided by Dr. Carlinda Monteiro, Christian Children's Fund/Angola and Dr. Mike Wessells, Randolph-Macon College and Christian Children's Fund. See also: Mike G. Wessells and Carlinda Monteiro, "Healing wounds of war in Angola: A community-based approach," in Addressing Childhood Adversity, edited by D. Donald, A. Dawes, and J. Louw (Capetown: David Philip, 2000), 176-201.

training materials and training workshops), that result in certain outputs, (e.g., numbers of community volunteers and counselors trained, and number of children or families counseled), what kind of results or outcomes do we expect to see? In order to make explicit what is implicit in our project planning and implementation, we need to be clear about what we expect to see as a result of having trained volunteers and counselors, and having them counsel children and families. Thus, the outcome relates to the very purpose of the activity—what does counseling result in? Once we have clearly defined the project result, we then need to identify an "indicator" that will measure the achievement of that result. In the next chapter we will discuss the process of identifying indicators.

Returning to the multifaceted PBWTT project: What is the reasoning behind this project's logic model and how could we actually draw a "spider" representing the logic model? The logic behind the project might be represented as follows:

Diagram 4: Initial PBWTT Project Logic Model



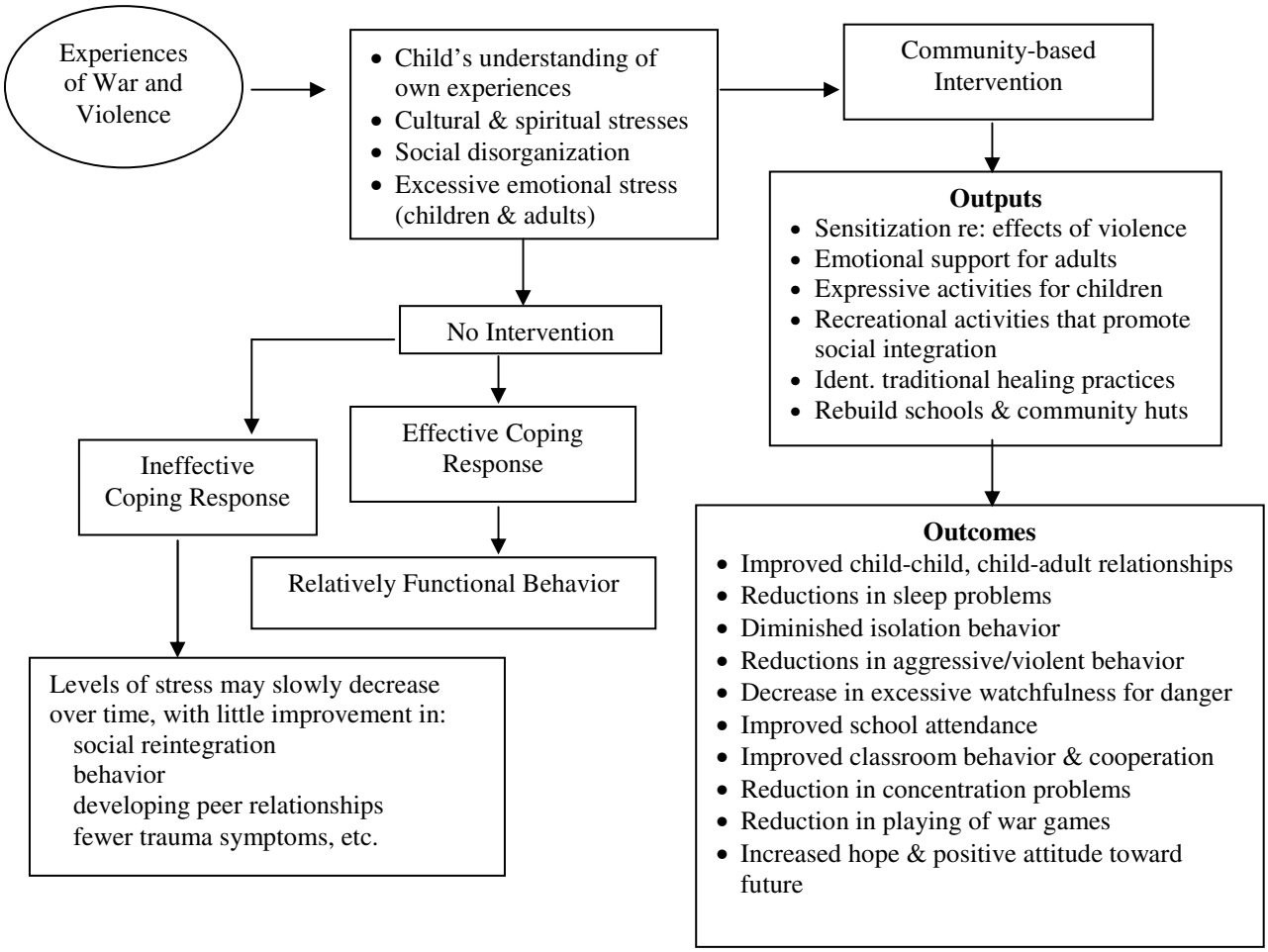
As the PBWTT was implemented, new learning led to a revision of the initial logic model. Constructed in Western cultures, the conceptualization of trauma was quite individualized, and it shed little light on spiritual issues that local people identified as the primary war-related sources of stress. For example, an 11-year-old girl reported that she fled after her home had been attacked and destroyed, and her parents had been killed. Her greatest self-reported stress, however, was not the attack or loss of her home and family but the fact that she had had to run away without having performed the appropriate burial ritual for her parents. According to local beliefs, her parents' spirits were unable to transit to the realm of the ancestors and the lingering spirits would cause community misfortune as well as individual problems. The problem was not viewed as an individual problem but as a rupture between the living and the ancestors. The way to repair the rupture and reduce the stress

would be through conducting an appropriate burial ritual that would restore spiritual harmony. The recognition of this led the team to move away from a trauma model and talk about violence-related sources of stress, including communal and spiritual sources of stress. Increasingly, the country team, which included highly educated Angolan, urban intellectuals, realized it had been imposing an "outsider" psychology, and thus marginalizing local voices and beliefs while not taking advantage of centuries-old practices that might benefit war-affected children.

To correct this problem, the country team changed its orientation and methodology, and made the interweaving of Western and local approaches to assisting war-affected children and adults a key objective. The team began to learn more systematically from local healers about local beliefs regarding illness, healing, life, and death. These topics were integrated into the training seminars, which increasingly became problem-solving spaces in which community members discussed how to combine Western and local methods for supporting children. Since the team knew relatively little about the local approaches, which have always been transmitted verbally or orally, they embarked on ethnographic research aimed at documenting traditional beliefs and local practices. The formerly colonized local people, who had internalized a sense of inferiority about their own cultural beliefs and practices, reported that the respect demonstrated for their local traditions had a powerful effect. In particular, they gained increased confidence in their own ability to plan and to shape their own future. Furthermore, the traditions increased emotional and spiritual support by providing a sense of continuity amidst difficult circumstances.

Another important insight was the relation between material improvements and healing. Since local people said they needed tangible improvements in their environments to feel better, the team adopted a schools reconstruction approach in which the agency supplied the materials, and the community donated the labor. In designing and building, planning processes that had been disrupted were restarted and people began reasserting control over circumstances in their lives. In addition, they reported feeling more hopeful toward the future and encouraged to initiate other activities to assist children. A revised logic model is as follows:

Diagram 5: Revised PBWTT Project Logic Model



B. Consolacão Enrichment Project

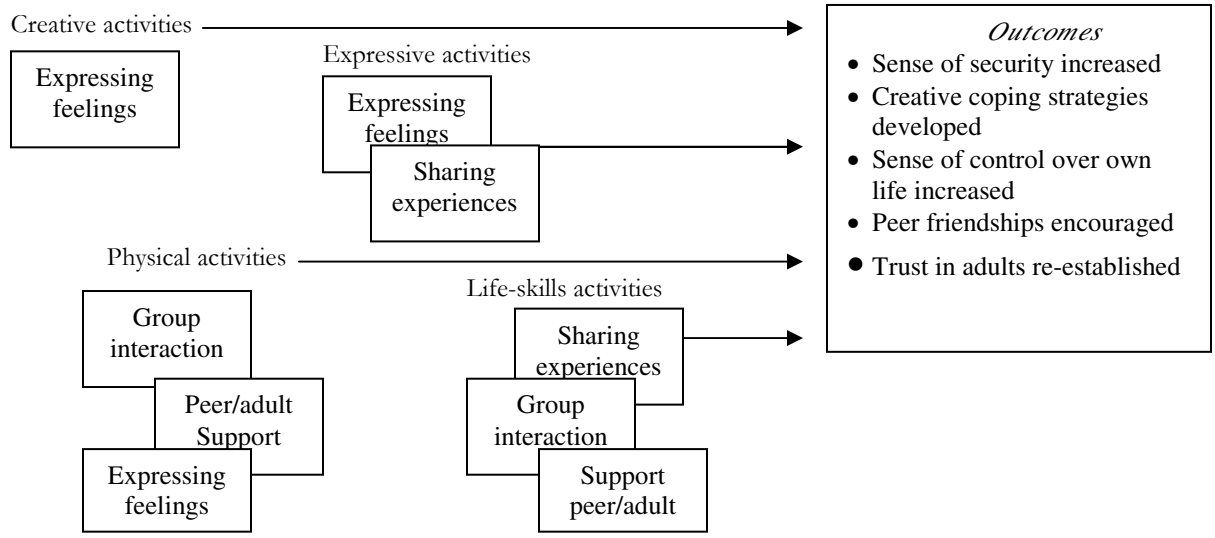
A second case study example comes from a project implemented in Mozambique. Approximately 1.1 million Mozambican refugees fled their country during Mozambique's 15-year internal war. In the neighboring country of Malawi, there were an estimated 950,000 refugees, of which about 50% were children. Recognizing the psychosocial risks that war poses for children and families, nongovernmental organization staff began discussions with refugee community leaders (teachers and health professionals, for example) to explore the need to help families address the emotional effects of the war on children living within refugee camps. The Consolacão Enrichment Project[28] developed out of these discussions. The goal of the project was to provide a creative, emotionally supportive, and culturally appropriate context in which the psychosocial development of children affected by war would be facilitated.

In the Consolacão Enrichment Project (CEP), activity groups were formed and staff was trained in conducting a fairly wide range of activities. Activities were chosen according to the logic model and with the participation of children. Project staff consisted of Mozambican adults from the refugee

[28] The case study of "Consolacão: A community-based enrichment project for war-affected Mozambican refugee children" was written by Joan Duncan, Ph.D., Consultant to Save the Children. Consolacão is a Portuguese word meaning to "comfort" or "console."

community – called Activistas. Activities engaged children in quiet creative activities (such as drawing or toy making), physical activities (e.g., drama, dance, song, sports) and life-skills building activities (e.g., knitting, gardening, carpentry). Throughout the project, activities were reviewed and refined to allow children to increase their participation and expression of thoughts and feelings, as desired. For example, as children became more comfortable and more engaged in the storytelling activity, Activistas encouraged children to tell their own stories about personally relevant issues. Themes that emerged were related to war experiences (e.g., separation and loss, overcoming adversity), camp experiences (e.g., divorce in the family, conflict resolution, sharing of resources), and general development issues (e.g., friendship, honesty, helping others). In the process, children were able to further develop their own strategies for coping with past traumatic experiences and adversity. One possible illustration of this logic model utilizes building blocks. Here, the assumption was that having children engage in various activities would lead to the desired outcomes. In other words, given the project inputs of opportunities for creative and personal expression and sharing, physical activities, and life-skills training, etc.; which resulted in outputs such as having creatively expressed their emotions, shared feeling, learned to employ alternative skills for coping, etc., children will have an increased sense of security, will develop creative coping strategies, and will achieve other anticipated outcomes. The building blocks were: 1) expressing thoughts and feelings through stories, drawing, dance, song, etc. 2) sharing experiences, 3) interacting in a group, and 4) finding adult and peer support.

Diagram 6: Consolacão Enrichment Project Logic Model



IV. Defining Key Terms

We have used a number of terms in our discussion already. It is useful to review these terms and go over their definitions before we move on to the next chapter.

A. Input

What the organization "puts into" the project includes resources and activities, such as financial support, materials, technical assistance, staff, and training. These inputs are what the organization brings to the intervention and might include things like materials for a temporary shelter, toys or games for children, training modules, or a person to provide technical assistance of some kind. When we ***monitor the implementation of the project***, we record the date of delivery and receipt or completion of materials, the number of locations that have received the materials, number of training sessions scheduled, etc. By monitoring the input we can answer the question whether or not the resources or activities have been implemented efficiently. When we monitor the implementation of our project, we are not asking whether or not the project was actually helpful to the target population because we cannot assess this until we know that we have implemented the project as planned. For example, our personnel records provide a data source for project *input* (i.e., number of staff we have hired). This does not tell us about the results of having hired and trained staff or the results of their having counseled traumatized children, but it does help us monitor our implementation of the project.

B. Output

Project Output refers to the immediate accomplishment of project input. When monitoring output, we are concerned with whether or not the inputs – activities or services the project is providing—are actually reaching the target group. For example, we would want to know whether the training materials designated for the project are being delivered to our trainers in a timely fashion, how many beneficiaries are receiving training, that the timeline for implementation is being followed, etc. Again, our ongoing documentation of each input and output, such as staff records of completed training sessions, is used to help us monitor and assess project outputs. In setting up our monitoring system, we will want to devise quick checklists and worksheets that document: the date and location of training sessions and the number of community volunteers trained by project staff, etc. With this information, the project manager or project documentation specialist can quickly extract the relevant information that shows if the project is being implemented.

C. Outcome

Project OUTCOME is what we are able to measure or observe with respect to our stated project objectives following implementation of the project.

In the next chapter we will provide an in-depth discussion of strategies for evaluating project outcome. For now, it is important to keep in mind that output and outcome are different. For example, activities such as drama, singing, dancing, or story-telling encourage emotional expression and group integration. The scheduling of such activities and children's attendance in them are *outputs*, while the *outcomes* would be results such as decreased feelings of isolation and/or other symptoms related to experiences of war-related violence.

D. Impact

Impact is a term used to refer both to *long term outcomes* (found at the Goal level or "Strategic Objective" level) and to *attributable outcome*; that is what we can *attribute* directly to our project and not to other interventions or environmental/contextual factors experienced by our project participants. Interventions of less than 4 or 5 years are less likely to show *impact* in the sense of high level, long-term goals such as reduced mortality or increased agricultural production, but we may speak of impact at the level of our project objectives where we have statistical confidence or reasonable assurance that we can attribute outcome directly to specific implementation activities. A demonstration of attributable outcome may be required if, for example, a project manager needs to justify the scaling up or replication of a project. In this sense, project impact is equivalent to a "treatment effect" directly brought about by our intervention.

Project IMPACT is the change in status or behavior related to our stated project objectives that we can say is a direct result of our project or intervention.

There are different evaluation designs that we can employ in order to carry out an evaluation of project impact. Some of these will be discussed in Chapter Six. But first we need to turn to the measurement of outcome and impact. In the next chapter, Chapter Four, we will discuss strategies for defining measurable objectives and identifying indicators to measure the achievement of those objectives.

Chapter Three Summary

The purpose of evaluation is to improve projects by identifying their strengths and weaknesses. Without ongoing monitoring and evaluation, well-intentioned projects can be misdirected and undermine cultural strengths and traditions.

Five important recommendations for conducting evaluations of psychosocial projects are that they be culturally grounded; obtain the informed consent of participants – even children; ensure confidentiality; be sensitive to the possible negative consequences of participants sharing painful memories; and provide feedback.

Logic models are a graphic representation of the implicit assumptions that guide the design of a project. By drawing a logic model, these implicit assumptions are made explicit, and the causal relationships or links between project activities, inputs, outputs, and desired outcomes can be clearly identified.

Chapter Four

Chapter 4: Fundamental Goals of Psychosocial Programming and Defining Objectives and Indicators

This chapter provides an overview of the fundamental goals of psychosocial programming and the criteria for defining sound objectives as well as the indicators or measures with which we can evaluate our success in meeting our project objectives. Project outcome evaluation is introduced. Guidelines for indicator development and data sources are provided.

I. Fundamental Goals of Psychosocial Programming

As stated in Chapter Two, fundamental goals of psychosocial programming include the establishment or re-establishment of:

- **Secure attachments with caregivers** - Child feels safe and cared for by supportive adult caregivers.

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

- **Sense of Belonging** - Child is socially connected to a community and feels he/she is part of a larger social whole. Child adopts the values, norms and traditions of his/her community.

- **Sense of self-worth and value, self-esteem, well-being** - Child thinks of him/herself as worthy and capable of achieving desired goals. Child has a sense of empowerment and a sense of being valued. Child participates in larger community and feels in harmony with norms of his/her society. Child has the capacity and/or possibility to participate in decisions affecting his/her own life and to form independent opinions.

- **Trust in others** – Child has a belief that he/she can rely on others for nurturance, help, and advice. Child feels that he/she will not be hurt by others.

- **Access to opportunities** – Child has a sense of being in a supportive environment. Child has access to opportunities for cognitive, emotional, and spiritual development and economic security.

- **Physical and economic security** – Child's physical health, livelihood/economic security and environment are supportive and do not pose threats to the child's emotional or physical well-being.

- **Hopefulness or optimism about the future** – Childs feels confident that the world offers positive outcomes and a hopeful future.

As a project is conceptualized, these major goals give rise to specific project responses and activities. Psychosocial projects can be geared toward meeting any number of project objectives that build

protection and support mechanisms with these overarching goals in mind. Strategies for building psychosocial support for children in crisis situations should strengthen appropriate traditional protection and support mechanisms as well as draw on local norms, values, and worldviews. Community participation and mobilization strategies should be at the core of our response to psychosocial needs and support.

One way to engage and mobilize communities is to bring them into the process of defining project objectives and identifying measures (indicators) of achievement of those objectives. The very process of community engagement and mobilization may be a psychosocial intervention in itself. It is important to work through a logic model or a model of project impact, as discussed in Chapter Three, with input from the target community.

II. Defining Project Objectives

Project objectives may be conceptualized as a chain of results, from intermediate or proximal results (also called benchmarks) to anticipated end outcomes, as identified in the impact or logic model. In order to be able to evaluate project success and the achievement of objectives, these objectives need to be defined in such a way that they can be "measured," either quantitatively (i.e., with numbers) or qualitatively (i.e., through rich, non-numeric description).

A. "SMART" Objectives

In the process of articulating a project logic model, project objectives should be clearly defined. Well-defined objectives strive to meet five criteria that can be easily remembered by their acronym, "**SMART**."

Strive to Make Objectives **SMART:**

Specific
Measurable
Appropriate
Realistic
Time-bound

SMART Objectives are:

- **S**pecific: They are particular to a given project and guide as precisely as possible the content and activities of the project. Objectives that are too vague or general do not help guide project planning and evaluation.

- **M**easurable: They can be measured using quantitative (numeric or categorical) or qualitative (non-numeric or descriptive) data, and the method and source of measurement can be identified.

- **A**ppropriate: They fit the goal, logic model, and time frame of the project, needs of the affected population, and politico-cultural context.

- **R**ealistic: They are attainable under the prevailing situation. They are not idealistic, impractical, or out of the project's reach given the context.

- **T**ime-bound: They are limited to a specified timeframe. Time periods for reaching objectives should be specified.

Consider the following project's initial objective and how it might be made smarter.

B. Making Objectives SMARTer

We can start with an example of a psychosocial project objective:

1. Provide access to community-based educational and recreational projects and facilities for IDP (internally displaced persons) and host community children, and foster self-reliance.

This objective can be made SMARTer:

1.a. Provide 1200 IDP and host community children of preschool age access to Early Childhood Education projects through community-based efforts during the course of the project year.

1.b. Decrease the drop-out rate of youth aged 8 to17 by:
- Promoting integration of IDP youth with host community youth through structured after-school recreational activities
- Promoting informal interactions between teachers and students outside the classroom through structured after-school recreational activities
- Providing safe and productive environments for social interaction among IDP and host community youth

The components of the initial objective have been separated and clarified. By refining the initial statement, we are able to identify realistic, desirable results that we can measure. A time frame has also been determined. In this way, we have a much clearer idea of what it is the project intends to accomplish within the means at the project's disposal. With greater refinement, it becomes clearer that access to the education interventions will not involve providing transportation, since the project's budget in this case did not include transportation. The objective has been linked to the project activities or outputs. The rationale behind recreational activities led to articulating the objective as "decreasing the drop out rate." This objective was made more precise and measurable and is more clearly linked to project activities. If the timeframe of a project is too short to be able to measure change in the drop-out rate, we can back up to one of the intermediate steps in the pathway toward achieving a lower drop-out rate, such as identifying a target proportion of IDP youth and host community youth who participate in structured after-school recreational activities. This can be measured with accurate monitoring records of attendance or participation.

By bringing more specificity to the objectives and linking project outputs to appropriate and realistic anticipated outcomes, the resulting objectives become easier to evaluate and can better guide activities and the monitoring of those activities. Examine Inset 20; although the changes made to the objectives appear minor, they prove key to articulating the objectives in such a way that they inform an evaluation strategy. They suggest particular behaviors or manifestations of behavior to be improved and measured. As we will cover later in the chapter, the indicators developed as a result will likely include both *qualitative* and *quantitative* indicators.

Inset 20: Objectives of the Consolacão Enrichment Project

The initial objectives of the *Consolacão Project* were:

- Reduce children's feelings of isolation through the formation of attachments and friendships with peers
- Rebuild children's trust by forming supportive attachments with adult role models within the community
- Assist children in understanding and in learning adaptive ways of coping with past traumatic experiences and the feelings resulting from such experiences
- Assist children in developing a sense of mastery and control over their lives through creative and recreational activities

These objectives could be made **"SMARTer"** with the following changes:

- Reduce children's feelings of isolation by **increasing the number and quality** of peer friendships and attachments to supportive adults
- **Increase** children's trust and thus the **number and quality of attachments** with supportive adult role models from the community
- **Increase children's use and recognition of the value** of creative and adaptive coping strategies (that is, strategies to cope with past traumatic experiences and feelings resulting from such experiences)
- **Increase children's sense of mastery and control** over their own lives through active involvement in creative, expressive, and physical (recreational) activities.

Ideally, the identification of **SMART** objectives takes place during the initial phase of project conceptualization and in conjunction with the development of a monitoring and evaluation strategy. Even when this does not happen initially, objectives can still be refined to approach the **SMART** criteria.

The objectives of a project shape measurement processes and indicators, and vice versa. Therefore, a consideration of what can and should be measured ought to be included early on in the process of determining a project's objectives. As we will see in the following section, having clear objectives fosters the identification of clear indicators.

III. Identifying Indicators

All too frequently, an undue amount of anxiety surrounds the development of indicators. This is understandable because the identification of adequate and reliable indicators is a difficult process and demands focused attention. However, they are only measures to assist us in our monitoring of project implementation and in our evaluations of achievement of project objectives. Indicators should not drive project planning. Just because we may be able to more easily measure something does not mean this should determine the focus of the project. Rather, project planning should be driven by an interest in measuring achievement of objectives and project benchmarks and in documenting the progress of project implementation by tracking project inputs and outputs.

An INDICATOR is a measure of a project input, output, results, or outcomes of interest. For example, an indicator measures the presence, absence, level, or degree of a status, or social or behavioral condition within our target population.

We use indicators during each phase of a project and throughout its life cycle. Although our discussion will touch on the use of indicators in monitoring a project, our main focus will be on their use in measuring project outcomes. By identifying indicators, we are defining the evidence that we will

use to determine whether or not the objectives and goals are being accomplished according to the original plan and time frame of the project.

The identification and selection of indicators is a very important process in the design and implementation of a monitoring and evaluation strategy. Although there are some indicators that are appropriate for comparison globally across various projects (these are relatively few and they are used to evaluate long-term impact related to global initiatives such as reduced child malnutrition, decreased rates of HIV infection, increased literacy rates, and better physical and social survival of children affected by war, for example), in general, indicators must be developed for a specific project because they are a tool to evaluate a specific outcome.

Indicators should be: **V**alid
Reliable
Sensitive

Indicators should be valid, reliable, and sensitive to the output, status, or outcome of interest:

- **Validity** implies that our indicator is a valid or true measure of the behavior, status, knowledge, attitude or other feature it is supposed to measure.

- **Reliability** means that if we measure the same thing more than once using the same indicator, we will get the same response; it is reliable and does not change according to unpredictable factors.

- **Sensitivity** implies that the measure is responsive to *change* in our outcome, status or behavior of interest.

In order to further illustrate the process of developing indicators, we will again draw on the case study examples. In the Province-Based War Trauma Team (PBWTT) project, Exposure and Impact Scales were initially used to measure a child's psychosocial distress. In order to identify valid, reliable, and sensitive **indicators**, we need to understand the various **measurement tools** we will utilize in order to derive the information on the indicators. The PBWTT project used the Exposure scale as a tool to measure the kind, frequency and severity of traumatic experiences encountered. This was identified as degree of exposure to death and violence according to the number of times a child experienced such things as: aerial bombardment, mine explosions, mortar bombardment, death of family, neighbors, or others, personal injury, kidnapping, maltreatment, hunger, flight and homelessness, etc. The Impact scale was used as a tool to measure the frequency and severity of trauma or violence-related symptoms. Use of these scales assumed that the greater the exposure, the greater the risk of displaying symptoms commonly assumed to be manifestations of war trauma (such as frequent nightmares, wetting the bed, fear, excessive alertness for possible danger, frequent headaches, palpitations, etc.). Thus, the primary **indicator** for measuring success in the PBWTT project was a quantitative measure that came from having combined the results of questions about the frequency of nightmares, bed-wetting, fear, headaches, etc., as correlated with or understood in relation to exposure to death and violence.

Was this a valid indicator of the project outcomes as identified above:

- Improved child-child, child-adult relationships
- Reductions in sleep problems
- Diminished isolation behavior
- Reductions in aggressive/violent behavior
- Decrease in excessive watchfulness for danger
- Improved school attendance
- Improved classroom behavior & cooperation
- Reduction in concentration problems
- Reduction in playing of war games
- Increased hope & positive attitude toward future

If we had evidence that linked manifestations of war trauma (the bedwetting, nightmares, etc.) so strongly to improved concentration and classroom behavior; diminished isolation; improved relationships; positive behaviors; an increased sense of hope; and so on, we might choose this as an indicator to represent these other outcomes. In the absence of clear evidence that this one indicator is valid enough to stand in for the other outcomes, reliable enough in that it measures functioning accurately and consistently, and sensitive enough to pick up a wide range of behaviors and attitudes that we hope to influence through psychosocial programming, we might conclude that the two measurement tools (the Exposure and Impact Scales) and the indicator they inform are not a sufficient measure of program success or failure.

Indicators need to be used for what they can actually tell us. As discussed earlier in conjunction with the development of a logic model, the reliance on the Impact and Exposure scales has failed to uncover other sources of stress (such as the inability to conduct burial rites for parents) and were therefore not *sensitive* enough to pick up all sources of stress. As the entire approach of the project evolved, information collected as part of the on-going monitoring process highlighted the realization that the trauma scales were no longer relevant. By the end of the PBWTT project, a reliance on these measures had faded into the background.

A more valid, reliable, and sensitive indicator would be the degree of social functioning as defined by local people and program beneficiaries. There are additional quantitative measures of social functioning that could be utilized. However, they still need to be validated for utilization across cultures, since the development of many such instruments[29] originates in a western European and American context. An even better starting point would have been to carry out an ethnographic exercise to identify local understandings of stress, coping, and functioning resources and to use these as a platform for project design. Beneficiaries had self-imposed a silence on spiritual issues because they were willing to have the "experts" define what their problems were. A better attempt at understanding local perceptions could have yielded additional markers or measures of functioning to those measured by the Impact Scale that looked at bed-wetting, nightmares, etc.

The development of good indicators involves a clear understanding of: 1) what it is you want to measure; and 2) how you will measure it—that is, what kind of tools, scales, or quantitative or

[29] Examples include the following: Achenbach's "Child Behavior Checklist"; Robert Goodman's "Strengths and Difficulties Questionnaire," © 2000; Rosenberg's "Self Esteem Scale"; "Children's Attributions and Perceptions Scale (CAPS)" by Maccarino, et al; "Youth Coping Index" by Hamilton McCubbin, Anne Thompson, and Kelly Elver, ©1995; "State Hope Scale" and the "Trait Hope Scale" by C. R. Snyder, et al. Additional examples are referenced in the ***Selected Resources*** section at the end of this document.

qualitative instruments you will use in order to measure it. We need to assess whether or not our indicators are reliable and valid, whether we can realistically collect the data given a particular situation, and whether the data collection efforts represent a reasonable amount of cost and effort.

Where some implementers can run into problems using scales such as these, is in a lack of *specificity*. For example, when the goal is to identify different needs of community members (those who need extra support and attention in order to cope, for instance), an indicator that is not *specific* enough might not be able to distinguish between the different degrees of need; it may in fact show that 90%-100% of a population is suffering from post-traumatic stress disorder, for example. Indicators need to be *specific* enough to measure needs and changes in those needs.

A. Quantitative and Qualitative Indicators

1. *Quantitative* data are represented in the form of numerical or categorical (yes/no) responses, or other scales or ratings that lend themselves to numerical values (e.g., "frequently/ sometimes/ never"). Quantitative indicators are often gathered through surveys, tests of knowledge and skill retention, records, existing population data, direct observation, or other sources. A frequently used type of quantitative measure is the survey questionnaire. Participants are asked to respond to questions by indicating the strength of their feeling or attitude on a scale (e.g., when asked, "How frightened do you feel?" an adolescent indicates "almost never," "somewhat," or "almost always"). Questionnaires are a convenient and clear way to measure a variable. However, they sacrifice the range of personal and subjective responses that are best captured by qualitative measures.

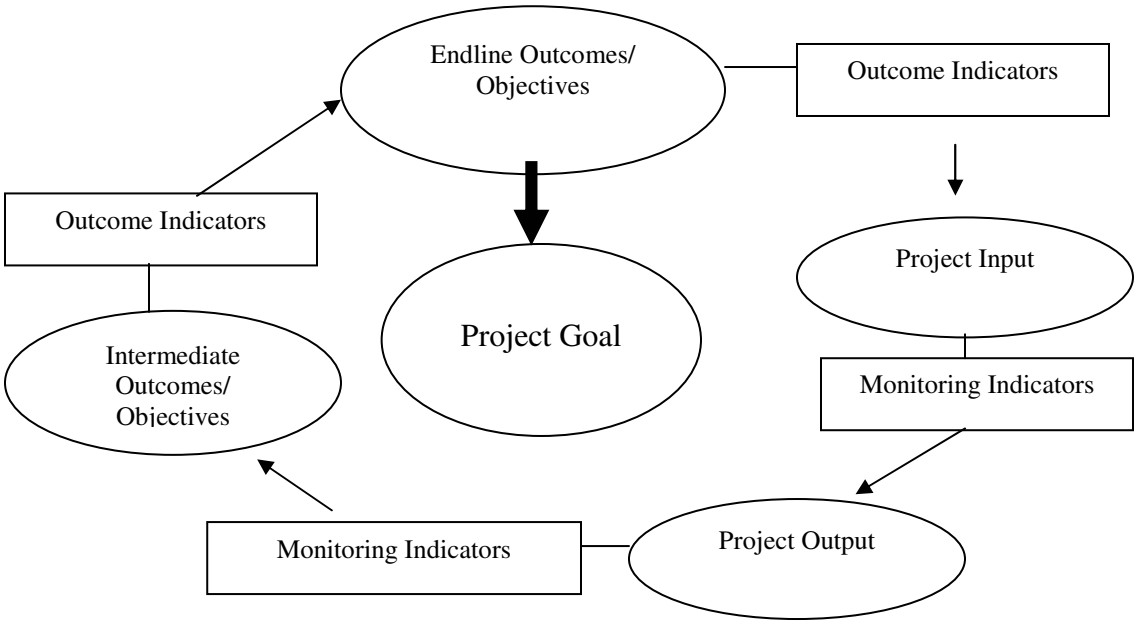
2. *Qualitative* data's greatest value lies in the ability to represent the depth of the subjective experience of participants or beneficiaries in a given population. Qualitative measures are thought provoking and enlightening, and attempt to get at the richness of human experience by tapping into the participants' own ways of expressing their perceptions, reactions, feelings, attitudes, and interpretations. Because individuals respond differently to crisis, measures that can accommodate personal representations of experience are more likely to bring valuable but hidden information to the surface. As illustrated in the PBWTT project, qualitative data can highlight problems with project activities specific to a cultural context early in the life cycle of a project. Qualitative measures often depend on verbal self-reports of these feelings, descriptions, and interpretations of events. Although qualitative measures can be quantified, they are not numerical in their raw form. A greater amount of time in collecting data and a greater degree of analytical skill must be applied to qualitative data. The variety of qualitative methods will be discussed in the next chapter.

IV. Linking Objectives and Indicators

Project planners need to have a clear idea of their objectives before they can discuss indicators of "success." Indicator development and the spelling out of project objectives and intermediate results go hand in hand. It is an iterative process; that is, the articulation of the pathway to desired results develops out of a series of adjustments and refinements as project activities and inputs, their outputs, intermediate results, and final outcomes (i.e., the higher-level outcomes that are essentially the project objectives), and relevant indicators for each step are considered in turn. The process of developing indicators is therefore best thought of as resulting from a cyclical consideration of information. From a consideration of the overarching or broader project objectives and the kinds of activities to achieve them (with their various inputs and outputs), the focus shifts to specific activity objectives, the anticipated output, and indicators to monitor their implementation. From there, consideration moves to the outcomes related to larger objectives and indicators to evaluate and measure them, based on the

project logic model. The cycle can be reiterated during the course of project implementation in order to adjust the selection or determination of objectives, indicators, and means of measurement as necessary. At the heart of the process is always the project goal.

Diagram 7: Linking Project Inputs, Outputs, Objectives, and their Indicators



Ideally, this sequence as captured in Diagram 7 will be made explicit during project planning. However, many projects, particularly in emergency situations, may assume an outcome without explicitly stating the relationship between a project activity and the result or outcome. Although not desirable, many project coordinators may face this situation at one time or another. The task then is to work in the other direction, seeking to clarify the project objectives the activities are actually working to achieve, and to articulate the outcome that is tacitly anticipated. Indicators at the level of activity, output, and outcome are then considered in turn, again often leading to adjustments of the objectives themselves. Thinking about ***how*** to measure makes one more aware of ***what*** to measure.

Another approach to designing a monitoring and evaluation strategy is to think of objectives at different levels of project implementation. A project may in fact have a range of objectives with different timeframes. Such an approach may take as its starting point very simple activity statements and end up with more complex outcomes—outcomes we hope will be achieved by our activities. A project that has multiple levels of objectives can distinguish between objectives that are achieved during the course of a project (e.g., parents have increased their knowledge and skills in recognizing and handling violent or anti-social behavior in children) and objectives that will be achieved by the end of a project (e.g., children exhibit fewer violent or anti-social behaviors). This can also be thought of as a "chain of results" in which intermediate results lead to other results that in turn lead to the end results or outcomes. These will have been articulated during the development of the logic model, or the reasoning behind the project. It is important to understand that all projects have objectives at different levels and that indicators may be used to assess progress on objectives at each of these different levels.

Insets 21 and 22 illustrate the process of developing objectives and indicators linked to two examples of difficult-to-measure concepts that are characteristic of psychosocial programming. Our examples focus on building or restoring a child's *sense of value*, also referred to as self-esteem or self-worth, and

the concept of *hopefulness*. There are numerous pathways toward these objectives as they are shaped by a particular socio-cultural context and by the events or circumstances that have led to a child's loss of self-worth and hope (such as traumatic events experienced during war).

Project design would best begin with a participatory assessment involving various members of the community that will benefit from project implementation. By learning from different members of a community (not only from those whose voices are most accessible, such as community leaders, but also from more vulnerable groups and from children and youth themselves) what self-worth and hope look like, project planners can, with the assistance of the community, begin to identify appropriate intervention strategies, appropriate objectives, and valid, reliable, and sensitive indicators to observe and measure change in self-worth and hope.

Through a culturally grounded process, an important pathway toward an increased sense of self-worth was found to include:

- An increased sense of self-worth or value as a function of being a member of a larger community in society; and
- An increased capacity to make personal views, opinions, or observations heard, where culturally appropriate.

In order to develop indicators to measure achievement of these objectives, project planners would need to work with local communities to learn what roles children and youth can take in particular events, what expressive channels of communication are available, and how to recognize cries for help, expressions of need or opinions, etc., given a particular socio-cultural context.

Project planners will also need to work with local community members and use participatory methodologies in order to learn from children, their caregivers, extended family members, community leaders, local healers, teachers, and others, what restored hope looks like in order to develop culturally appropriate objectives and indicators for *restored hope*.

Again, through a culturally grounded process, we might determine that a "hopeful" child is one who is:

- More engaged in social and recreational activities
- More engaged in future planning
- More willing to share dreams about the future with peers
- Expressing optimism about the future
- Trusting others in community

Inset 21: Objectives and Indicators for Hopefulness

Possible Objectives:

- Increase children's and youth's involvement in planning for the future (near-term and long-term) and conviction that they have some control over the direction of that future
- Increase the capacity for sharing and working together toward future goals
- Increase the sense of trust in members of a community
- Strengthen the social support mechanisms of a community
- Increased level of hope among generally affected and at-risk children

Some Possible Indicators:

- Degree of children's and youth's perceptions of their own ability to plan for the future (skills development, education, saving resources, or other)
- Number of children and youth involved in cooperative endeavors (such as planting community gardens, contributing toward the building or decoration of a more permanent community structure, etc.) and their perceived value of such endeavors
- Children's perceptions of the value of teamwork
- Number and quality of social support mechanisms in a community
- The level of trust children have in other members of a community and/or social network (this would very likely require proxy indicators)
- Proportion of children or youth who respond positively to a majority of questions designed to measure their level of hope (e.g., a score between 31 and 42 points on the Children's State Hope Scale).

V. Using Indicators to Monitor Project Input and Output

The implementation of a project is monitored to ensure that necessary *inputs* are provided and that activities are actually carried out as planned. For example, we need to know whether or not personnel, financing, facilities, and supplies were received on time since these facilitate or hinder the progress of an intervention. A good monitoring system will also keep track of project *output*, such as: the number of training sessions scheduled; the number of trauma counselors trained; and the number of children counseled. A reporting mechanism should be in place so the project manager can make decisions about implementation in a timely fashion. Project outputs or activities are monitored to make sure that each step in an overall plan is completed. For example, we need to know that training curricula have been developed, that trainers have been trained, and that caregivers were given the training. On the one hand, we need to know that inputs—newly hired but untrained trainers, funds for salaries, space for trainings, and training materials—are in place. On the other hand, we need to know that trainers have been trained, and that caregivers have received training from these trainers; these are examples of different levels of project outputs.

Indicators can be defined for each step

For example, if teams will be trained:

- Have the teams been identified?
- Have the training modules been developed and translated, if necessary?
- Is the quality of the modules up to standard?
- How many training sessions have been scheduled?
- How many training sessions were actually carried out?

It is a good idea to identify the actual source of information or data for each indicator during the initial project planning stages. This can help eliminate any duplication of effort and ensure that data

required for monitoring are collected in a timely fashion. Sometimes the information an indicator might have provided is lost because too much time has passed and it is no longer possible to collect the data. In designing a monitoring strategy, it is important to list the inputs and outputs, identify indicators, *and* identify data sources for each.

If it is sensitive enough, the monitoring strategy will also point out areas where more attention is needed. However, it cannot always alert project managers to a need for programmatic changes outside of the activities already anticipated. In the case of projects designed to address the psychosocial needs of children and families, a monitoring and evaluation strategy must be designed to determine not only whether or not project activities are adequately carried out, but very importantly, whether or not they are indeed reaching those they are intended to help. This is particularly important when marginalized groups are the intended project recipients. We want to know that, given the project input, we are seeing the anticipated output (from scheduled activities and other input) among intended project participants.

Although written project proposals and descriptions often give the impression that indicators and evaluation methodologies are static and never change, indicators may evolve as a project evolves. The ability to adjust our measures of input, output, and outcome based on lessons learned is one of the keys to developing a useful monitoring and evaluation system. Among the factors that may necessitate adjustments are changes in the external situation, workload increases for staff, or a realization that the initially defined indicators are less relevant than had been envisioned. In fact, as a project unfolds and implementers gain new insights, it may become clear that the measures are focusing on the wrong things or not monitoring the most relevant indicators. For example, one may learn that that the logic model or reasoning behind the project was only partially correct. In such circumstances, rigid adherence to predetermined indicators blocks learning and movement beyond one's preconceptions.

A. Consolacão Enrichment Project

To illustrate how indicators are developed in the context of a project, let us turn to the example of the Consolacão Enrichment Project. In this project, a total of ten staff members were selected from among the Mozambican refugees and three staff from the host country of Malawi. Additional consultants and technical assistants were attached to the project at various intervals during the five years that the project ran. The personnel involved in the project are part of a project's input. The staff received training that emphasized:

1. Principles of child development and psychosocial development;
2. Understanding and recognizing children's reactions to war experiences;
3. The centrality of cultural traditions and the importance of supportive adult role models in building or restoring children's sense of security and belonging to a community; and
4. Principles and strategies of working with children through recreational and creative activities.

Project output, then, would include trained staff. An indicator to monitor this output would be the number of staff who successfully completed this series of trainings. An additional indicator that should also be considered is the number of staff who could successfully recall key messages in the training upon completion of the training workshop, and again, at an interval of six months after the training (this could provide an indication of the quality of the training and monitor project output as a step toward achieving project objectives). Monitoring project input and output may be primarily a matter of maintaining accurate financial and personnel record-keeping and maintaining a schedule of

activities that also record, in this case, attendance at training sessions, completion of training, and results of the training exercise (e.g., retention of messages and methods).

B. Sample Input/Output Matrix

A matrix of project inputs and outputs can prove useful in designing a monitoring strategy. By linking output directly to project activities and objectives, we can assess project implementation. Ideally, both quantitative and qualitative indicators should be used because of the variety of data accessible through these different means.

Table 1 represents a sample of what a partial matrix of input and output indicators for the PBWTT project might look like. Activities are linked to input and output indicators, and data sources are identified. We also note whether indicators are primarily qualitative or quantitative.

Table 1: Monitoring Implementation: Linking Input, Output, Indicators, and Data Sources

Sample Project Activities	*A Sample of Possible Indicators*	*Examples of Data Sources*
INPUT 3-person teams identified for training	*Quantitative* ▪ Team members identified	▪ Project manager's records
OUTPUT In each province, 3-person teams will be trained in child development, impact of war on children, training and mobilization processes, and community-based, expressive activities	*Quantitative* ▪ Number (#) of teams trained ▪ # and % of teams with adequate knowledge and skills following training and at 6 months *Qualitative* ▪ Local perceptions of the knowledge and skills that trained team members bring to the community	▪ Supervisor's records ▪ Knowledge/skills assessment following training and at 6 months ▪ Focus group or key individual interviews
INPUT Select and train community adults on: The impact of violence on children; Children's healthy development; Local modes of healing; Organizing structured activities to support children's psychosocial development	*Quantitative* ▪ # of community adults selected for training ▪ # of training sessions scheduled ▪ # of training sessions scheduled that are completed *Qualitative* ▪ Adult's assessment of their own emotional well-being	▪ Training team and/or project manager's records
OUTPUT Community members are better able to recognize children's needs, understand the impact of violence on children, and know how to assist children	*Quantitative* ▪ Number of community members who recognize certain symptoms as manifestations of the way violence affects children; recorded as a score on a knowledge scale administered at the end of training *Qualitative* ▪ Community adults' perceptions of the value of children's psychosocial development, local modes of healing, and structured activities	▪ Survey of community members who attended dialogue sessions ▪ Focus group interviews

Sample Project Activities	*A Sample of Possible Indicators*	*Examples of Data Sources*
Next Level OUTPUT Trained community adults will organize structured activities to promote children's psychosocial development	*Quantitative* ▪ % of violence-affected children involved in activities *Qualitative* ▪ Children's enthusiasm for and self-reported and/or observed quality of participation	▪ Activity attendance records (*denominator:* existing data or population estimates) ▪ Semi-structured interviews with children, innovative qualitative methods with groups, and observations

An *output* indicator can sometimes be misconstrued as an *outcome* indicator. This can happen when the outcome of a certain activity is not made explicit, or when an activity is viewed as an end in itself. To expand on a previous example, if activities such as drama, singing, dancing, or story-telling, which encourage emotional expression and group integration, are understood to decrease feelings of isolation and other symptoms related to experiences of war-related violence, we might be tempted to think that, if a child simply participates in these activities, we have achieved an *outcome*. However, participation is only a project *output*. What we really need to measure as an outcome is the prevalence or degree of feelings of isolation and other symptoms related to experiences of war-related violence as reported by the children or their care-givers. The monitoring of *output* only assesses whether or not a project is being implemented as designed. It is not a measure of the actual *outcome* or the results of the project as implemented. The "next level output" in Table 1 above could also be viewed as an intermediate result or outcome; however, it too is an *output* that serves to monitor project implementation. An example of an *outcome* that would follow the input and output described in the table would be the *result* of community adults' application of the training. A quantitative *outcome* measure might be the number of children who exhibit fewer anti-social behaviors and show greater integration, trust, and specific measures of psychosocial development (as defined specifically for the context of the project intervention). A qualitative indicator might be community adults' self-reported value of their capacity to assist children in coping with violence-related stress and in improving in psychosocial development.

VI. Evaluating Project Outcome

The simple outcome of our intervention is what we are able to measure or observe following implementation of our project. But how do we interpret the outcome we observe and how do we learn if our project has been successful or not? The most obvious answer is to compare the status of interest (e.g., children's sense of security or utilization of creative coping mechanisms) in our project beneficiaries before and after project implementation (that is, pre- and post-intervention). This will tell us if the change has been positive or negative, but it will not tell us if the change was caused by our project, because there may have been other NGO activities or environmental factors that occurred at the same time as our intervention. If we do not have data on pre-intervention status, we can still collect information following completion of the project and compare status between those who participated in our project and those who did not, even though this will not tell us about preexisting differences between participants and non-participants that could have influenced the outcome we observe.

In the absence of more data, we can report on simple outcome measures and this may be sufficient for our project reporting needs. Reporting on outcome can demonstrate to an extent whether or not our project objectives have been met. In order to decide if a report on outcome measures is sufficient, we need to define the purpose of the evaluation clearly. Is it to document results and lessons learned? Is it to empower a community? What do we want to learn from the evaluation?

What are the donor's expectations? Given the nature of responses to humanitarian crises, NGO coordination, and multi-sectoral interventions, it is becoming increasingly difficult to isolate changes in status that have resulted from one particular project. Also, because of the complexity of factors that influence psychosocial well-being in individuals and communities, we cannot always be sure that we fully understand a particular intervention effect as distinct from another. However, we can still report on outcome and the apparent achievement of project objectives. We can make informed assumptions about our particular project impact based on previous interventions, although it is important to note that we are reporting on general or "net" outcome and not "attributable" outcome—that is, outcome that we can say is directly attributable to our intervention and not other activities or environmental factors.

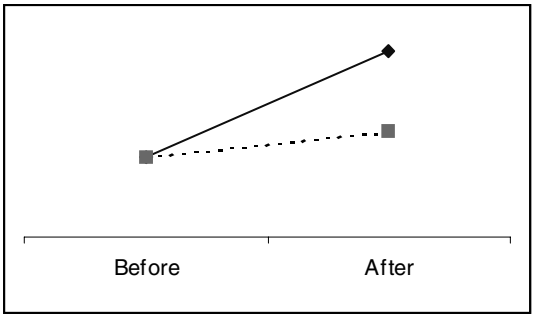
A. The Difference between Project Outcome and Impact

Some evaluations demand that we evaluate causal links between our project activities and outcome rather than simply observe the general outcome, especially if the field is new enough that not much documentation on the causal chain between activities and input, output, intermediate results, and end outcomes exists. For example, it is well documented that during times of war and forced separations, reuniting children with their primary caregivers who are supportive and coping emotionally and socially is highly beneficial to children. If we know (through monitoring activities) that our project has been successful in reuniting families it is likely that we would not need to establish a causal link between reunification and psychosocial benefit through conducting an impact evaluation. However, given that the field of psychosocial programming is relatively new and includes a wide range of potentially helpful interventions, it is important to conduct more *action research* (usually smaller-scale, pilot studies in which an impact evaluation is planned ahead of time and circumstances make it feasible) in order to document causal links between project interventions and outcomes. We may also be asked to report on the outcome that we can *attribute* directly to our project in order to justify the scaling up or replication of a project.

If, for example, it might be argued that the reason children in an IDP camp are interacting better with their peers is simply a result of time having passed since the children experienced trauma or separation from their homes, and not because we introduced recreational and educational activities. In order to rule this out, we would want to show that the outcome we observe can be attributed to our project activities. We also want to know that our project activities have helped and not hindered the psychosocial recovery of our participants. But how do we know if the change we see pre- and post-intervention is a result of our project and not due to other factors? In order to talk about project *impact*, we need to be able to measure or estimate the difference between the outcome of a project intervention and what the outcome would have been *in the absence of* the project. In other words, we need to have a realistic idea of what the change in status of our project participants would have been if our project had never been implemented.

If we knew exactly what the status of participants would be in the absence of a project, all we would need to measure would be their status following our project intervention. But we cannot know this because we do not control all the internal and external influences on our project participants. An alternative is to measure where our participants and non-participants started and where they are following the project implementation. Diagram 8 below illustrates this graphically. The "treatment effect" or project impact is the difference in outcome between project participants (in which the change is illustrated by a solid line) and equivalent non-participants (degree of change illustrated by a dotted line), or where the participants would have been had they not participated in the project or treatment.

Diagram 8



It is not enough to simply know how status has changed for participants, however. We also need to know if there are some factors that could have influenced change differently between project participants and non-participants. How can we know that non-participants would have reacted or changed in the same way as participants? If we take the status of non-participants to represent what the status of participants would have been had they not received the project intervention, we need to know that the two groups are equivalent.

There are different evaluation designs we can employ in order to accomplish a valid comparison. Some of these will be discussed in Chapter Six. Impact evaluations require considerably more resources than an outcome evaluation. Such resources as staffing (do we have the staff or can we hire sufficient staff, and does the staff have the adequate technical skill or is additional training needed?), time, and adequate funding to carry out the evaluation are required. Seeking technical assistance specifically for this effort may help you and your staff identify measures that have either been used previously or that may be a good fit with your project objectives in order to design an effective methodology. As stated previously, the input of community members is very valuable in designing a culturally grounded evaluation effort. Impact evaluations are especially helpful when assessing intervention strategies that have untested assumptions, or when it is necessary to prove with a higher degree of certainty that a particular project or the implemented activities can be credited with specific results. They also focus on longer-term and often broader objectives or goals rather than on intermediate results. As previously emphasized, not every project must necessarily undergo an impact evaluation.

B. Indicators as Measures of Status or Outcome

Whether we undertake an outcome evaluation or an impact evaluation, we need to measure (or be able to model statistically) what existed prior to the intervention. Data regarding the state of things before an intervention are referred to as *baseline data*. Data on outcome following an intervention can be referred to as "endline" data. The data may include both quantitative and qualitative information.

BASELINE data provide a view of the behavior, attitude, knowledge, risk, status, etc. prior to project implementation.

The ability to identify valid, reliable, and sensitive indicators (the measures with which we will assess the status prior to and following an intervention) will guide the content and methods used in collecting baseline data. By recording our outcome indicators both prior to and following an intervention (e.g., in a baseline and an endline survey), we have a way to measure change in behavior, attitude, knowledge, risk, status, etc.

It is also important to remember that some indicators may provide data for more than one outcome or desired result. For example, if a project objective is to reduce children's feelings of isolation by

increasing the number and quality of close attachments and friendships with peers, an indicator (a measure) of this outcome might be the number of close friendships a child has formed. This same indicator could provide a measure of a child's trust or ability to interact with peers. If a project objective is to increase ethnic tolerance in the community by sponsoring a number of ethnically diverse cultural events, one outcome indicator might be the ethnic diversity at one of the sponsored events (expressed as numbers of major ethnic groups as a proportion of total attendees). This same indicator might also measure the degree of access by diverse ethnic groups to the venue for cultural events.

As mentioned before, baseline and endline data can be both quantitative and qualitative. Inset 22 describes qualitative outcome indicators at both the individual and community level for an East Timor project.

Inset 22: East Timor: Qualitative Outcome Indicators

The psychosocial project promotes normal family and every day life in order to reinforce a child's natural resilience. The project focuses on primary care and prevention of further harm in healing children's psychological wounds through the provision of support and training to community members. The objective is to create a sustainable, community-based response to mitigate the impact of violence and displacement of children, youth, and families. Project outcome indicators have been identified to gauge progress and results during the project's first year. These indicators focus on outcomes for the community, for children, for youth, and in the policy arena. Monitoring has required the development of survey tools and a database that tracks project activities, individuals' progress, and aggregate data. The following are the qualitative indicators that were identified to measure project outcomes:

- Perceptions of tolerance by sub-groups within communities;
- Children's level of hope and positive future orientation (this could also be quantified on a scale);
- Teachers' perceptions of children and youth's adjustment in school;
- Parental perception of children and youth's emotional and social well-being; and
- Community leaders' perceptions of the role and functioning of youth.

Qualitative methods for gathering information include individual structured interviews and focus groups. In addition, individuals use field journals to report insights and reflections, while documentary photography and video are being used to record the changes the project and the participants go through.

C. An Evaluation Matrix: Objectives, Outcomes, Indicators, and Data Sources

The use of a matrix can facilitate the process of linking indicators to outcome measures. Table 2 offers examples of both quantitative and qualitative indicators and their data sources and links them to anticipated outcomes (i.e., project objectives). In Chapter Five we will return to discuss advantages and disadvantages of several of these data sources.

Table 2: Evaluation Matrix: Objectives, Outcomes, Indicators, and Data Sources

Objectives/Outcomes	*Examples of Indicators*	*Examples of Data Sources*
Increased capacity of local organizations and community adults to help children affected by war-related violence readjust ▪ Is there an indication that communities have a better understanding of the psychosocial needs of children?	*Quantitative* ▪ % of community adults and local organizations involved in activities to promote children's well-being ▪ # of communities and % of community leaders/adults who recognize the value of expressive activities for meeting the psychosocial needs of children *Qualitative* ▪ Community members' perceptions of their capacity to assist children ▪ Perception of ability to function better as a community in assisting children.	▪ Records of activities designed to support psychosocial well-being and development ▪ Survey questionnaire of community leaders and adults ▪ Semi-structured interviews (with focus groups) and observations
▪ Have adult caregivers experienced a reduction in war-related stress?	*Quantitative* ▪ % of adults reporting fewer symptoms of war-related stress *Qualitative* ▪ Adults' reported sense of hope, self-efficacy, confidence, ability to plan	▪ Survey questionnaire ▪ Semi-structured interviews with community adults
Children will experience a reduction in war-related stress ▪ Do children experience fewer and less severe symptoms related to experiences of violence?	*Quantitative* ▪ Frequency & severity of war-related stress symptoms among children (including nightmares) ▪ Frequency & severity of violence-related symptoms in relation to experiences of violence	▪ Impact of Events Scale ▪ Brief Symptom Inventory
▪ Are children and youth coping better with stress?	*Quantitative* ▪ Degree of children's ability to concentrate in school ▪ % of children able to express difficult emotions (verbally, other) ▪ % of youth who score at the optimal level on a scale that measures coping	▪ Teachers' records on children's behaviors ▪ Strengths & Difficulties Questionnaire ▪ Youth Coping Index
Improved psychosocial well-being, social integration, and return to "normalcy" ▪ Are children integrating socially and better able to express and deal with difficult emotions and violence-related symptoms? ▪ Do children have an increased sense of security?	*Quantitative* ▪ # of positive social interactions counted within a specified period of time ▪ A scale of children's relationships with peers and adults ▪ % of children exhibiting <2 negative emotional responses *Qualitative* ▪ Degree of social functioning according to families ▪ Children's perceptions of what it is to integrate socially (what does it mean to get along well with others, etc.)	▪ Screening data ▪ Ethnographic observations ▪ Survey interview ▪ Focus group interviews with children and family members
▪ Are children able to form peer friendships?	*Quantitative* ▪ % of children who have more and stronger friendships with peers *Qualitative* ▪ Problems with peers voiced by children	▪ Progress notes ▪ Focus group interviews with children
▪ Are children rebuilding their trust in adults?	*Quantitative* ▪ % of children contributing more at home *Qualitative* ▪ Caregivers' perceptions of children's cooperation with adults in home and community	▪ Home visit records and notes on observations and interactions with caregivers

Objectives/Outcomes	*Examples of Indicators*	*Examples of Data Sources*
▪ Are children resolving conflicts peacefully?	*Quantitative* ▪ # of aggressive or negative behaviors observed in a time period ▪ # of conflicts observed in a given setting within a specified period of time and % of those resolved peacefully ▪ # of incidences of violence in the family *Qualitative* ▪ Children's perceptions of social integration (what does it mean to get along well with others, etc.)	▪ Ethnographic observations ▪ Interviews with community adults, teachers, and children

D. Proxy Indicators

In identifying indicators to evaluate project outcome, we often need to turn to information that indirectly provides a measurement or reading on our outcome of interest. We are able to gather data that can serve as a "proxy" for information that is not directly observable, essentially unobtainable, or ethically inappropriate to collect. For example, health projects frequently use proxy indicators to measure sexual practices. Since health workers cannot directly observe whether safe sex practices are actually being practiced, they often must rely on other evidence, such as whether or not a person knows how to practice safe sex or whether a person purchases condoms. While knowledge certainly does not predict behavior, and having a condom is not the same as using one, these might serve as "next best" indicators. Various qualitative research methods can be utilized in order to draw out data for indicators and proxy indicators. Encouraging a child to draw pictures descriptive of home life or of particular situations, for example, can provide insight into a child's perception of experiences and ability to cope. Drawing may be a more appropriate communicative or expressive channel for young children than direct verbal communication. Telling a story or play-acting is another avenue that may be easier for a child as well.

Chapter Four Summary

Certain fundamental goals are at the center of psychosocial programming.

In developing project responses, we should always strive for project objectives that are SMART: **S**pecific, **M**easurable, **A**ppropriate, **R**ealistic and **T**ime-bound. In order to measure our achievement of these objectives as well as our project implementation and progress, we should identify indicators that are: **V**alid, **R**eliable, and **S**ensitive.

Quantitative data are represented in the form of numerical or categorical (yes/no) responses, or other scales or ratings that lend themselves to numerical values. Qualitative data represent the subjective experience of the participant. Qualitative measures attempt to get at the richness of human experience by tapping into the participants' reactions, feelings, attitudes, and interpretations.

The objectives of a project direct its process of measurement. As such, objectives drive indicators, and not the other way around. It is good practice to link indicators to intended data sources early on in the process of designing a monitoring and evaluation strategy. Sometimes we need to use indicators that indirectly measure an outcome of interest. These are called proxy indicators and provide the "next best" measure when a direct measure of the outcome is not feasible.

In the absence of more data, we can report on simple outcome measures, and this may be sufficient for project reporting needs. In order to talk about project *impact*, however, we need to be able to measure or estimate the difference between the outcome of a project and what the outcome would have been *in the absence of* the project. This requires a more rigorous research design.

Chapter Five

Chapter 5: Identifying Data Sources and Methods of Data Collection

This chapter will provide an introduction to issues surrounding different sources and methods of collecting data.

I. Data Sources

As indicators are identified, their data sources should also be determined. You will recall that in Chapter Four we discussed the process of developing specific objectives for fundamental goals of psychosocial programming. In Table 3 we expand on this discussion by identifying different kinds of data sources used in evaluating the achievement of these fundamental goals.

Table 3: Example Data Sources for Fundamental Goals of Psychosocial Projects

Goals	***Sample of Data Sources***
Secure attachment with caregiver – Child feels safe and cared for by an adult caregiver	▪ Adapted standardized scale that asks child to rate pictures depicting behaviors indicative of secure attachment ▪ Unstructured interview with child and caregiver ▪ Observation of caregiver child interaction
Peer relations or social competence – Child has the capacity to create and maintain meaningful relationships with peers and adults. Feels he/she is able to navigate the social world.	▪ Standardized scale such as the Achenbach Child Behavior Checklist or other widely used child behavior checklist (CBC) adapted to current context, which asks different informants to rate a child's competencies and problems in a wide range of domains ▪ Unstructured interview with child and peers ▪ Peer nomination rating obtained from friends ▪ Observation of child in social situations
Sense of belonging – Child is socially connected to a community and feels he /she is part of a larger social whole.	▪ Unstructured interview with child ▪ Observation in social situations ▪ Records of participation in organizations and clubs
Well-being, Self worth, Self-esteem - Child thinks of him or herself as worthy and capable of achieving desired goals. Child has sense of being valued. Has the capacity to participate in decisions affecting his/her well-being.	▪ Semi-structured scale that asks child to speak about any interesting or dramatic experience they wish to discuss ▪ Adapted standardized self-esteem scale ▪ Unstructured interview with child ▪ Observation of child in decision making situations ▪ Ratings by peers
Trust in others – Child has belief that he/she can rely on others for help, nurturance, and advice. Child feels that he/she will not be hurt by others.	▪ CBC ▪ Unstructured interview with child ▪ Unstructured interview with caregiver or other key informant, such as a teacher
Hopefulness or optimism about the future – Child feels confident that the world offers positive outcomes and a hopeful future. Shows willingness to make future plans.	▪ Semi-structured scale that asks child to speak about any interesting or dramatic experience he/she wishes to discuss ▪ "State Hope Scale" and "Trait Hope Scale" ▪ CBC ▪ Unstructured interview with child and/or caregiver and/or teacher
Access to opportunities - Child has access to opportunities for cognitive, physical, & spiritual development and economic security.	▪ School attendance and performance records ▪ Caregiver/teacher/religious leaders interviews ▪ Marketing of vocational training opportunities and attendance/completion records

As shown there can be a range of data sources including:

- **Standardized instruments**. Such instruments should be culturally adapted for use and may include: self-reporting by responding to a survey questionnaire; qualitative narratives produced by the participant on some variable of interest; or pictorial ratings of a construct, idea, or perception;
- **Structured or unstructured one-on-one interviews** with project participants;
- **Interviews, judgments, ratings, or nominations** made by persons who have contact with project participants, such as caregivers, teachers, friends and other key informants;
- **Focused discussions with groups** who are effected by the project or who interact with project participants in some way;
- **Systematic behavioral observations** made by staff or others who have received some training as observers; and
- **Written records** routinely collected on a particular behavior, such as school attendance.

Most quantitative indicators are fairly straightforward to collect. For example, the number and frequency of children's activities scheduled can be easily obtained if a record-keeping system is maintained by community adults directing children's activities, and with periodic checks by project staff. Other, qualitative, indicators require individual and/or small group interviews, and ethnographic observations. Sometimes a group of individuals (a focus group) is chosen for what its participants can contribute to a discussion on a particular topic or issue. By conducting focus group discussions, an evaluation can obtain responses not always available in one-on-one interviews. In addition, very useful data can emerge out of facilitated community group discussions. Individual interviews may be more appropriate than group methods for other questions—particularly for sensitive topics.

In order to derive children's opinions or reactions to activities, various other techniques in addition to semi-structured interviews may be required. It may not be enough to simply ask a child whether or not an activity such as storytelling is enjoyable or what other activities he/she would like to be involved in. Asking a child to play-act or to draw a picture of activities that he/she imagines children in "normal" situations engage in, for example, might solicit insight into the value particular activities hold for the child and a child's perception of his/her role in those activities. While an expressive activity such as drawing might be considered an activity toward an objective, since it is assumed to increase a personal sense of security through the very activity itself, it may also provide a source for outcome indicators. This may be so because, through drawing, children are often able to express their thoughts, concerns, and feelings, which in turn contributes to a sense of security and possibly control over one's life, in which case we would add more lines of interaction. We could possibly discover information both in the content of the drawing itself (either through assessment of the visual artifact and/or through a child's explanation of the drawing) and in a child's demeanor while drawing. This could provide an indicator to measure the presence or degree of a sense of security in that child at a particular point in time. The field of art therapy, for instance, has uncovered particular symbolism in children's drawings that can point to a greater or lesser sense of security in a child. For example, recall that over time, children in the Consolacão Enrichment Project (CEP) began to talk about their drawings – what the characters were doing and why, and then created their own full-length stories based on their drawings, which they then shared with each other as a group. The drawings, stories, and sharing the stories before the group, were all sources of data.

A. Qualitative Data Sources of Consolacão Enrichment Project (CEP)

The CEP collected both quantitative and qualitative data. The screening data used as part of the selection criteria for participants was quantitative. School-age children were initially screened according to a list of seven emotional and behavioral responses common of children exposed to war and related crisis situations. The list of characteristic responses was derived from a review of published literature on children's responses and from discussions with community members about troublesome and recent changes in children's behavior linked to war exposures. Given cultural differences in the definition and expression of emotional experiences, CEP staff felt it was also important to assess the actual experiences of children. It assumed that certain experiences – such as the death of a caregiver or being chased by bandits – would cause psychological distress in most cultures, (regardless of whether or not the term describing that experience was the same across cultures). Children given highest priority for participation in the project were those who scored highest on this list (the greatest number of symptoms and/or experiences) and who had other additional risk factors, for example, poverty, separation from family or siblings, lack of school enrollment. Inset 23 shows an abbreviated version of the CEP screening measure.

Inset 23: Consolacão Enrichment Project: Abbreviated Screening Measure

Child shows signs of:

- Sadness, crying
- Being withdrawn, alone, or not playing with friends
- Appearing afraid or worried
- Unable to concentrate, having trouble at school
- Experiencing intrusive war-related imagery
- Being physically aggressive, uncooperative, or being hard to discipline

Child has had the following experience:

- Witnessing a killing
- Parent/caregiver killed in war
- Family member injured or killed in war
- Family or child pursued by bandits
- Capture by bandits

One strategy for determining whether or not the project was having the desired outcome was to measure the persistence or alleviation of emotional and behavioral responses of individual children over time. CEP's strategy was to compare the seven emotional and behavioral responses of a child before entering the project and again after that child had been in the project for a period of time. (The five criteria relating to a child's history were not appropriate for this purpose since they could not change over time.)

Results at the project level were reflected primarily in weekly work summaries and weekly activity reports. These were designed to record the number of activities, participants, and overall ability of the project to meet its timeline for input and output. Project records and other data sources provide key indicators that can also tell us about specific outcome at the community level and population level (i.e., an aggregation of community-level data).

Qualitative indicators may require creative methods to capture changes over time. In CEP, a set of qualitative methods provided useful data with which to measure project outcomes. Inset 24 describes some of these qualitative methods.

Inset 24: Qualitative Methods of the Consolacão Enrichment Project

The Consolacão Enrichment Project utilized a set of qualitative tools to capture outcome data. The tools included: family interview data; progress notes (a qualitative measure used to monitor a child's psychosocial adjustment); home visit data (primarily qualitative information provided by a child's caregiver); and weekly project activity summaries (quantitative and qualitative data regarding the outcome of project activities, gathered initially for project monitoring).

Family interviews provided in-depth qualitative information on the experiences, social functioning, strengths, and interests of a child from the perspective of the child's caregiver, as well as aspects of the functioning of a child's family and the stress a family might be experiencing. When gathered at multiple points in time, a project may document whether or not, from the family's point of view, a child's functioning is becoming better.

Progress Notes described a child's behavior during activities, his or her interactions with other children, and noted problems voiced by the child as well as any special accomplishments or interests. Each local staff trainee (Activistas, as they were called) was given responsibility for the observation and monitoring of four to six specific children. The assignment of a child to an Activista was random. Notes were conceptualized as a dynamic form of monitoring and evaluation, since they allowed staff to understand a child more fully, monitor a child's progress or lack of progress, and continue formulating project goals for the psychosocial development of each child. By utilizing a group format of project review, staff skill development was enhanced, theory was linked to practice, and the activity functioned as a team-building exercise for the staff.

Home Visits were made in an attempt to gather additional information about a child's overall functioning. The home visit served as an additional tool in assessing the child's behavior from the caregiver's perspective.

In retrospect, CEP could have better utilized available data by having a staff member specifically assigned to the evaluation effort. Too often, the task of evaluating a project suffers when it is tacked on to existing staff workloads. In CEP, the staff had primary responsibility for running the project. This, as in many children in crisis initiatives, required considerable time and emotional energy and meant that a significant amount of data were not collected in as timely a fashion as hoped. It would have been better to assign specific CEP staff to the evaluation, and to provide them with training, supervision, and support. Without clearly designated staff, the day to day activities required to collect data are likely to give way to the more pressing concerns of the project. Once certain critical time periods passed it was not possible for CEP to "catch" up in collecting time-sensitive data.

II. Methods of Data Collection

In this section we will focus on major methods of data collection that are frequently used in the context of psychosocial projects: interviews, observations, and self-report methods. Often these methods are used in combination with each other. When considering any of these, one should be aware of the advantages and disadvantages of each, and decide which one alone, or in combination with others, best meets the unique goals of the project evaluation. An important consideration in choosing a methodology is the depth of information sought, its ease of administration, and level of skill required to administer.

A. Interviews

Different interview methods are valuable for different topics and circumstances. They can also be used in combination with one another in order to gather different perspectives on the same topic or to probe for more reflective and descriptive responses. Some examples of various interview styles or methods include:

- Open-ended or focus group
- Key informant
- Unstructured or semi-structured
- Structured
- Self-reporting

1. *Open-ended Interviews and Focus Group Interviews* can be efficient sources of information while being minimally intrusive. They allow the interviewer to explore a variety of topics in a systematic way while giving the interviewer the possibility of discovering new or indigenous concepts. Additionally, they allow the interviewer to understand the personal meaning of discussed concepts and ways concepts may overlap in meaning. While these techniques can provide valuable and rich data, there is a need to be careful to design interviews to ensure that the opinions gathered are representative of the variety of views held by the targeted population. You may want to identify several different focus groups for the same interview questions and carry them out in different settings to encourage those members of a population that are not used to speaking out to air their opinions as well. Staff will require training in conducting focus group interviews. Traditions surrounding privacy, open discussion, and the expression of opinions—particularly with regard to groups composed of females and males—need to be taken into consideration when opting for a focus group methodology.

2. *Key Informants* are people in the community who are in a position to have greater depth of knowledge on a particular aspect of the culture you are interested in learning about. They can prove to be invaluable sources of information in assessing a situation, developing a project, and evaluating a project. They can provide "quick" access to information that might take someone from outside the community longer to learn or understand the importance of fully. However, key informants may not always be representative of the community as a whole; the information shared with you may represent mainly an individual key informant's own experience of a situation. Key informants may also have a particular agenda, such as an interest in helping their own ethnic or clan groups, and must be carefully selected and their views weighted accordingly.

To take an example, suppose the focus of your project were on the recovery process following a war. A ritual healer would be a valuable key informant for local perspectives on healing after the effects of war. Recall the PBWTT project included information from traditional healers in its inquiry. Not only would he have his own perspective drawn from his many interactions with those who sought his help, he is likely to also be able to tell the stories of those whom he has helped to heal.

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

4. *Structured interviews* often follow a questionnaire. For various reasons, the primary purpose of an interview may be to record responses to very specific questions. In order to guarantee that particular questions are answered, it may be necessary to structure an interview, with either qualitative (open-ended) questions or quantitative (closed or quantifiable) questions.

5. *Self-report methods* are efficient and systematic for both implementation and data analysis. While self-report measures are easily administered and provide systematic data, it is important to be aware of the disadvantages. The data collected from a self-report questionnaire is indicative of a person's *own perception* of what they are doing or how they feel, and may not be factual or consistent with behavioral manifestations of self-reported feelings or attitudes. A self-report methodology may be less effective with young children who are unable to recognize, characterize, or explain clearly their own patterns of behavior, especially over time.

Additionally, there may be factors that influence the responses, such as social desirability, self-selection of participants (not everyone who receives a questionnaire responds to it), or an unwillingness to answer candidly if the person is embarrassed by the question or his/her answer to it. Also sometimes responses become exaggerated when the person believes he will get something if he answers the questions in a way that indicates he is more in need than he really is. For example, a child who knows that he will get in trouble for fighting in school may not report it on the questionnaire out of fear of getting in trouble. Likewise a parent may not report seeing her child fight because she is aware of its undesirable social implications. A caregiver may exaggerate economic need believing that this will increase resource allocation. It is recommended that other techniques such as those mentioned above be used in conjunction with a self-report questionnaire to ensure the accuracy of the data and correctly interpret the meaning behind the obtained responses.

If you decide to use a standardized questionnaire or scale that has already been developed and validated on another cultural group, it is especially important to consider its appropriateness and adaptability to the cultural group. While it may be quicker to use an existing instrument like a scale, structured interview schedule, or some other paper and pencil instrument, it is important to assess how embedded this instrument is in Western tradition and if it is culturally appropriate for the context within which one is working. However, many instruments, while originally developed in the US or Europe, have been translated into other languages and, more importantly, validated on similar populations. In addition, some measures, because of their close reliance on observable behavior are more cross-culturally appropriate than others or can be adapted more easily. These measures may be an efficient way to gather the necessary data.

Keep in mind that even if a measure is standardized on the population with whom you are working, it does not necessarily mean that it will provide all of the information needed in order to assess the project's specific goals. For example, a standardized measure for assessing post-traumatic stress may be able to provide data on trauma experienced, as it is defined within the instrument, but it may miss some of the context-specific social meanings of trauma as well as culturally embedded coping skills and resources. You may want to develop your own measure or use a combination of measures to ensure that the data you are collecting are addressing the appropriate variables with which to measure the project goals.[30] As you make this decision, keep in mind the emotional discomfort of the participant and time and emotional cost of the evaluation for staff. Thus, every question should count. You should have a clear idea of the questions you want to ask and assess how each question, whether in interview, observation or self-report format, assesses those questions. Extraneous data, while tempting to collect since you are there and are interested in the participants' experience, can be insensitive, a waste of valuable project time and ultimately more of a burden than an asset to the data analysis process.

[30] A discussion of principles of developing questionnaires and structured interviews will not be covered in this document. The reader is referred to several resources within the bibliography.

B. Ethnographic Techniques

Ethnographic techniques, most often used by anthropologists, describe a culture or some aspect of a culture in detail by "building an ethnographic record" through observations, listening, and asking questions.[31] In this method, the observer keeps a careful and detailed record of what was seen and heard. This can be time-consuming and requires fieldwork over time. However, there is great value in ethnographic approaches because they provide extremely rich data on how people see their own experience and communicate that experience through various expressive channels.

Common ethnographic methods include:

- Participant observation
- Systematic observation
- Participatory appraisal

1. In *Participant Observation*, the observer establishes a relationship or rapport with the persons or community he/she is observing, and learns about the culture and society by observing *while interacting,* usually over a period of time. Although this method can yield valuable information, being a participant observer requires maintaining a difficult balance of objectivity and involvement with a community. Sometimes it is just too difficult to "join" a community or there is not enough time – particularly a community in the midst of a crisis.

2. In *Systematic Observation*, the observation process is more planned or organized according to what kind of information is of interest. There may be checklists, a scoring system, or prearranged categories that are used to record the data of interest. The observer has some rapport with the community but maintains his/her status as observer rather than becoming a participant.

When making observations of behaviors, careful planning is needed. The observer should attempt to observe or measure each participant under similar conditions. For example, when observing social interactions of children, it would be good to observe all of the children at approximately the same time of day and under similar conditions (e.g., during an afternoon free play session). It would not be a good method to observe some children during free play and others while they worked in the classroom. This is because although you are likely to observe different amounts of social play among the children, it would not be clear if the differences were due to the children or the locations.

3. A *Participatory Appraisal* method familiar to many NGOs is commonly called Participatory Rural Appraisal (PRA). This is a culturally sensitive survey methodology that builds on the teachings of Paulo Freire,[32] A PRA method of inquiry values experience and context over scientific experimental research designs that analyze data collected by an outside "expert." PRA emphasizes using local knowledge and empowering local people to make their own assessment, analysis, and future plans. Chambers[33] defines PRA as "an empowering process of appraisal, analysis, planning, action, monitoring and evaluation." The survey teams strive to be multi-disciplinary and gender balanced. They use group animation and exercises to facilitate information sharing, analysis, and action among stakeholders. The key tenets of PRA are participation, teamwork, flexibility, optimal ignorance, and

[31] H. Russell Bernard, Research Methods in Anthropology; Qualitative and Quantitative Approaches, 2nd Edition (Walnut Creek, California and London: Sage Publications, Inc., 1995).
[32] Paolo Freire, Pedagogy of the Oppressed (Harmondsworth: Penguin, 1972).
[33] R. Chambers, Rural Appraisal: Rapid, Relaxed, and Participatory (Sussex: HELP, Institute of Development Studies Discussion Paper 311, 1992).

triangulation. The PRA methodology uses semi-structured interviewing; focus group discussions; preference ranking; mapping and modeling; timelines; wealth ranking; and seasonal and historical diagramming to gather data.[34] While PRA was originally developed for rural agriculture situations, its use has expanded to other sectors including education, conflict resolution, and health and is widely used in urban settings by international and local NGOs, academic institutions, and donors. Similarly, many of the PRA tools and guidelines can be adapted to assess and evaluate psychosocial projects.

C. Direct Observation Techniques

Direct observation techniques are a valuable data collection method. Observation is considered to be more direct than other methods because it detects the behavior of interest at a particular time and place as it occurs naturally. Observation can be done by project staff, or by caregivers, teachers, and peers. This would provide a wide range of information about the child in different settings (e.g., home, school, play) and offer a broader assessment than if the data were just collected from one source. When multiple sources of data are used and they offer consistent findings – referred to as triangulation - conclusions based on them are more validated. We will discuss triangulation in more detail later in the chapter.

Commonly used forms of recording observed behavior are:

- Narratives
- Event records
- Interval recording.

1. Narratives are written or spoken observations of everything an observer sees, and these provide a rich array of observations of events and activities. The drawback is that the quality of the data may be marginal, since it is difficult to assess the objectivity of narratives and one observer of one child may focus on particular behaviors while another observer of another child may notice something completely different.

2. *Event Records* provide a record of how often a particular behavior occurs within a specified time frame and may track duration or magnitude, depending on the type of behavior. Event recording may be difficult when one observer is observing multiple participants. In this case, interval recording may be a good option.

3. *Interval recording* breaks time periods such as a day into smaller segments (15 minutes to 1 hour) and observes one person (e.g., child playing with a toy) or an interaction between two people (e.g., two children playing together), or behavior in a small group (e.g., group of children playing a game) for that amount of time. The observation can also take place within randomly selected intervals—instead of observing for fifteen continuous minutes, an observer may randomly select three five-minute intervals during a particular hour. If a person exhibits the behavior of interest within that timeframe, it is noted. It is important to consider how countable a behavior is, and whether just the act of counting may have an affect on the behavior and participants (e.g., a child becomes shy and stops the

[34] See: M. Brydon-Miller and D. Tolman, editors, "Transforming psychology: Interpretive and participatory research methods," Journal of Social Issues 54/4 (1997); and World Bank Participation Sourcebook. http://www.worldbank.org/wbi/sourcebook/sba104.htm.

behavior).[35] These are important variables to consider in designing a direct observation coding system.

Field notes are key in recording field observations. Examples include:

- Jottings (brief notes on key details in order to jog your memory for fuller descriptions later);
- A diary (this is a valuable record of personal observations that may highlight details that prove important later, even if they seem marginal at the time);
- A running field log of how you plan to spend your time and then how you actually spend your time[36]; and
- Full notes that can detail methodology or be descriptive or analytical, or all three.

D. Back-Translation of Scales

There are several issues to address when selecting and adapting a scale: translation or language equivalence; cultural and socioeconomic equivalence; and conceptual equivalence. Language equivalence implies that the descriptors and measures of psychological concepts can be translated well across languages. A good way to address this issue is to use a back translation technique,[37] which entails four steps:

- Developing the questionnaire in the researcher's language
- Translating the questionnaire into the language in which the interview will be conducted
- Doing an independent back-translation into the language in which the questionnaire was originally developed by the researcher
- Field-testing the questionnaire for reliability and validity

This is best done by bilingual speakers, with the back-translation carried out by someone who has not seen the original questionnaire developed by the researcher. It should be noted, however, that even though the language may be equivalent, this does not necessarily mean that the concepts themselves are equivalent.

E. Triangulation

Each method of collecting data has its biases and weaknesses. Therefore, it is best to not use just one method of data collection, or methods that have similar weaknesses. It is much better to use different methods of data collection that represent a range of methods that do not share the same weaknesses. This is called "triangulation." By utilizing three (or more) methods to get at the same information, we can uncover more information about the true measure and the potential weaknesses of any given method. For example, psychosocial competence could be measured by interviewing children about their friends and play activities (a qualitative measure) as well as asking a teacher to fill out a questionnaire about the social interactions of those same children in her class (yes/no categorical responses or responses that rate interaction on a scale from 1 to 3 or 1 to 5, for example, would be quantitative measures). We could also observe children playing and characterize the quality of the play (e.g., interactive/solitary, aggressive/ cooperative, etc.). We might also discover alternative and

[35] J. Cone, "Observational assessment: Measure development and research issues." In Handbook of Research Methods in Clinical Psychology edited by Kendall, Bucher and Holmbeck (New York: John Wiley & Sons, Inc., 1999), 191.
[36] *Ibid*., page 184.
[37] H. Russell Bernard (1995) *op. cit*.: 275.

unobtrusive measures[38] that illustrate natural erosion or natural accretion, for example, such as the wear that particular areas of a playground or particular sports equipment and games show, potentially as an indication of a certain quality of play. Multi-modal methods of measurement increase the confidence one can have when positive results are obtained. Examples include self-report diaries, behavioral observations, peer nominations, questionnaires, and surveys.

Chapter Five Summary

Typical data sources include:

- Standardized instruments
- Structured or unstructured one-on-one interviews
- Interviews, judgments, ratings, or nominations made by persons who have contact with project participants (caregivers, teachers, friends and other key informants)
- Focus Group discussions with persons impacted by the project or who interact with project participants in some way
- Systematic behavioral observations made by staff or others who have received some training as observers
- Written records ideally those that are routinely collected on a particular behavior

Interviews, observations, and self-report methods are frequently used methods of data collection. Interviewing, ethnographic techniques, and observation methods were discussed, including:

- Unstructured or semi-structured interviewing
- Focus group interviews
- Key informant interviews
- Quantification of selected observations from field notes
- Participant observation techniques
- Systematic observation techniques
- Personal narratives
- Event records
- Self-report methods
- Unobtrusive measures

Triangulation describes a data collection approach that utilizes several modes of measuring a status, behavior, outcome, event, or phenomena. When several ways of measuring an event show consistent results, the confidence in that result is increased.

[38] For a valuable discussion on unobtrusive, alternative and complementary measures, see: Unobtrusive Measures (revised edition) by Eugene Webb, Donald Campbell, Richard Schwartz, and Lee Sechrest (Thousand Oaks, California: Sage Publications, Inc., 2000).

Chapter Six

Chapter 6: Project Impact Evaluation

Although a full discussion of impact evaluation is beyond the scope of this manual, an introduction to some key methodological issues and challenges faced in conducting an impact evaluation will be presented.

I. Impact Evaluation

An IMPACT evaluation is done in order to determine whether or not longer-range outcome is directly attributable to a project.

In order to determine impact or attributable outcome, there must be a causal pathway between the project's activities and the changes reported or observed. An impact evaluation may be required in order to test the logic behind the project or to decide whether or not a pilot (i.e., experimental) project should be scaled up or replicated elsewhere.

As mentioned in our discussion on project outcome evaluation in Chapter Four, we need to be able to measure the difference, pre- and post-intervention, between outcomes where we implemented the project and outcomes *in the absence of* the intervention. In other words, in order to identify the outcome attributable to our project intervention (that is, the actual project effect), we need to have a realistic idea of where our project participants would have been if they had never received our intervention. To reconstruct where participants would have been had they not received our intervention, it is easiest to compare our beneficiaries with an equivalent group. For a reliable comparison, our comparison group (also called "control group") must be the same as our beneficiaries, or we should at least be able to calculate how differences between beneficiaries and non-beneficiaries might influence the outcome differently.

One of the strongest evaluation designs is one in which beneficiaries are selected at random for participation in the project (and in which beneficiaries and non-beneficiaries are compared both pre- and post-intervention). Random selection (whether simple or systematic random selection) assures us that the individuals or households we choose at random from a population will be representative of the entire population, since everyone has an equal opportunity to be included. In other words, if we are able to randomly assign individuals from a population to an intervention, then probability tells us that the group that receives the intervention and the group that does not receive the intervention are equivalent. We will be able to compare participants with non-participants and be confident that the outcomes for the two groups are not differentially affected by factors that we cannot control.

In full coverage projects and in most emergency response projects, however, we often cannot randomly assign participants to an intervention because either everyone is included in the intervention, or it would be unethical to withhold project activities from all those in need. We must therefore find or devise a comparison group or statistically model pre- and post-intervention measures in order to say with confidence that the observed outcomes can be attributed directly to our project.

Impact evaluations are very valuable for project learning and in preparation for project replication and/or scaling up. From an impact evaluation, we can learn if our project logic is sound in spite of poor implementation or, conversely, if our implementation was carried out well but the project logic behind it was inaccurate. That is, failure to produce anticipated project results could be due to either logic failure or poor implementation. If the logic is sound and if we have implemented our project activities and other inputs correctly, we would expect to see the outcome we anticipated. It is possible to implement project activities very effectively and reach the expected output (e.g., community counselors trained, children enrolled in psychosocial activities, etc.) and at the same time fail to see anticipated outcome. Project activities and input can be successfully completed, but if there is no causal link between them and anticipated results, we will not see the outcome we expect.

A. Attributing Outcome

Key indicators used to measure project outcome can also be used to measure project impact. However, because the actual impact of a project will most often be limited to fewer, more long-term objectives, not all outcome indicators will necessarily be used. There may also be a need to develop additional impact indicators because of the interest in the longer-term or ultimate project objectives. An impact assessment can be thought of as an evaluation of the sum total of a chain of causal relationships between project input, output, intermediate results, and achieved outcomes or objectives that contribute to a long-term project goal. In order to establish a causal relationship, certain criteria must be met.

Inset 25: Attributing Outcome to a Specific Intervention

To demonstrate that an outcome is attributable to a specific intervention, the evaluation must show that:

- There is a statistical relationship between the intervention and outcome (that is, by using principles of statistics, the relationship can be mathematically represented)
- The intervention either preceded or was concurrent with the outcome
- The change in the outcome observed is <u>not</u> attributable to changes in other factors that happen to occur at the same time

Extraneous factors that can confound the interpretation of attributable outcome may include:

- The presence of other intervention activities in a region
- "Uncontrolled selection" (e.g., some participants of the project might be more likely than others to participate in the intervention activities or there may be other differences between participants and non-participants influencing the outcome)
- "Endogenous change" or some kind of change outside of the control of project, such as general trends that affect the population, interfering events (political events, economic shifts, personnel changes), or maturational trends (change that occurs because of the passage of time)

The extent to which impact evaluation can measure and clearly show that the results achieved can be attributed to a project's activities depends on the nature of the intervention and its setting.

The effectiveness of an impact evaluation also relies on available resources (time, money, personnel, etc.). Budgets must reflect the additional funds required to conduct an impact evaluation. It is not wise to attempt an impact evaluation unless the cost for this evaluation is carefully itemized. These costs include materials, equipment, technical assistance, the time of other staff in supporting the evaluation effort, and costs associated with the documentation and dissemination of the results and lessons learned through written materials and attendance at relevant conferences.

B. Reasonable Assurance of Project Impact

The inability to carry out an impact evaluation, due to limited resources or the inability to find an adequate evaluation design within a difficult emergency context, does not mean that a project was not effective. It means only that resources or data were not available in order to demonstrate with statistical confidence that anticipated changes were due to the project's efforts. An alternative approach is to carry out a rigorous outcome evaluation and support your assumptions about impact with alternative and complementary measures. A "mixed methods" approach (one that utilizes both quantitative and qualitative data) is often the most desirable method because it can address a broad range of outcomes and influencing factors.

If budget and other resource limitations restrict data collection to fewer sites or households than would be ideal, and if the sample size or other design characteristics rule out statistical power or confidence, we can still find methods that will provide us with reasonable assurance that the outcomes we are seeing are in fact attributable, at least in part, to our intervention. The most important thing to remember is to *be transparent* about the selection criteria used for sampling and *be honest* about what the study's limitations are. Do not try to make claims beyond what the data provide.

II. Research Design Options

In order to evaluate project impact, an appropriate research design must first be selected.

> ***A RESEARCH DESIGN is a methodological strategy for avoiding or controlling for bias and interfering events.***

A strategy for avoiding or controlling bias requires the establishment of a measurement scheme and comparison groups. The particular research design will vary depending on coverage, available data or constraints on data collection, and issues such as budget and time allowance. Some designs result in greater statistical power than others. Having more statistical power means that we are able to say with more confidence (represented and measured mathematically) that the observed results are attributable to the project.

Having defined our indicators (i.e., the items or the status we will measure to tell us about project results), we need to define how we will use them. Measurement schemes involve a comparison of results or observations at different times; before and after project implementation, for example. Some of the standard measurement schemes, followed by options for comparison groups are outlined

below.[39] Observations are indicated by O, and project intervention is indicated with an X. The order from left to right represents the time sequence.

Measurement Schemes

1. Post-test only; measurements or observations (i.e., the measurement of indicators) take place after project implementation.

   X …….. O
   Intervention *Observation*

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

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

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

   O_{1a} .... X …. O_{2a} (a = participants exposed to the project)
   O_{1b} .... O_{2b} (b = control group; not exposed to project activities)

4. Panel design; multiple measurements are taken throughout the project implementation and include an observation before intervention and observations after intervention.

   O_1 X O_2 O_3 O_4

5. Continuous measures pre- and post-intervention (also called a time series design); multiple measurements are taken both before and after intervention.

   O_1 O_2 O_3 X O_4 O_5 O_6

A. Major Types of Comparison Groups

1. Randomized Controls. As mentioned previously, one of the strongest designs for maintaining internal validity involves random selection of project participants to an intervention. By random, we mean that selection is carried out with no predetermined criteria or biases guiding the selection. This can be accomplished through simple random selection, such as pulling names "out of a hat" or through systematic random selection. Systematic random selection entails the systematic selection of, for example, an individual or a household from a complete listing of all individuals or households according to a sampling interval. The sampling interval is determined by dividing the total population (such as the number of individuals or households) by our sample size (80, for instance). If the sampling interval is 34, we would start at a randomly selected number between 1 and 34, and from there select every 34th individual or a household from the list. If we started at the 17th individual or household on the complete list, our second selection (on our way to selecting 80 individuals or households) would be the 51st on the list (17 + 34 = 51), our third selection would be the 85th on the list, etc.

Randomized control design involves at least two groups that have been randomly assigned to either the intervention group (i.e., participants) or to a group that does not receive the intervention (the non-

[39] Earl Babbie, "Chapter 4, Types of Study Design," Survey Research Methods, 2nd edition (Belmont, California: Wadsworth Publishing Company, 1997), 51-64; and Peter H. Rossi and Howard E. Freedman, Evaluation: A Systematic Approach (Newbury Park, California and London: Sage Publications, Inc., 1993).

intervention group). Withholding participation in an intervention can be very difficult, if not impossible, in emergency situations where a project is most often full coverage; however, there may be opportunities for introducing randomized control designs. Interventions where there are different phases or timelines for implementing the project, or other cases in which there is a natural delay in implementation may lend themselves to a randomized control design.

2. Reflexive Comparison Group. This involves one group in a simple before and after project intervention comparison. In full coverage projects (i.e., projects where all children and youth are potential beneficiaries, such as in a refugee or IDP camp), this may be the only option available. However, attempts should be made to identify possible comparison groups from among those who will receive the intervention at different levels of intensity or at different times during the course of the project's implementation. In the case of the PBWTT project, for example, the project was phased in at different villages over time. There was a natural delay between the institution of the project in the first community and the second, third, etc. Baseline measures were taken in the first and second communities, for example, but only the first community initially received the project. Thus, the second community served initially as a comparison group with the first. At a later date, measures were again applied to the two communities in an effort to determine whether or not there were any differences that could be attributed to the project. It was only later that the second community received the project.

3. Constructed Controls. In this design, two or more groups are compared; one group made up of those who participated in the project (exposure group), the other made up of those not exposed to the project. We should be confident that the control group is similar in all respects, or that we can anticipate factors that might influence differential outcome (that is, factors that might have resulted in different outcomes for the control group, had they been exposed to the project). Another option is to define the control group ourselves so that we can model where their status *had they been exposed to the program*. An example of this is the "Discontinuity Regression" or "Cut-point" design discussed below (in the discussion on "Quasi-experimental Designs").

4. Shadow Control. This is the least strong design and is used when other options are simply not feasible. In this design, the outcome of the exposure group is compared to external standards or to expert opinion regarding assumed impact.

III. Evaluation Designs

When we put together measurement schemes and comparison groups in various combinations, we come up with particular evaluation design options as shown in Inset 26.

Inset 26: Design Options for Impact Evaluation

Partial Coverage Projects:

- Randomized or "True" Experimental Design
- Quasi-Experimental Design

Full Coverage Projects:

- Non-Equivalent Control Group Design
- Repeated Measures Design (Panel Studies or Time Series Designs)
- Simple Before and After Studies
- Cross-Sectional ("Non-Uniform") Studies

The questions that need to be asked when deciding which research design can and should be utilized include:

1. What baseline data are available?
2. Is the project partial or full coverage?
3. What resources (time, budget, personnel, etc.) have been made available?

Whether we are conducting an *impact* evaluation or an outcome evaluation, we want to know whether or not a change has occurred. As discussed previously, baseline data provide us with information on the status, behavior, knowledge, etc. that exist prior to the intervention. Time pressures of emergency response programming often make the collection of baseline data appear to be an unnecessary luxury; however, these data are very important if we want to be sure that our project is resulting in the anticipated outcome and that our intervention activities are helpful rather than harmful or a hindrance to our goals. When baseline data are available, research design options are improved immensely.

We also need to construct a valid comparison. Since emergencies tend to affect large areas or else result in displaced populations temporarily settled among host populations, it is difficult to find a comparable group (e.g., similar in socio-economic and ethnic-political-cultural background, with a similar experience of trauma and displacement). One option is to utilize a modified time-series design in which *stages of change* resulting from on-going intervention activities are compared. This can be done by drawing a comparison group from within the intervention group itself.

A. Partial Coverage Projects

The preferred research designs for an impact assessment of partial coverage projects include randomized experiments and quasi-experimental design. Partial coverage projects are those in which not all the potential beneficiaries are reached, such as a project that is implemented in only three of five refugee camps, for example. Partial coverage projects afford the opportunity to conduct pre- and post-intervention surveys in affected communities among those who will receive the intervention and those who will not receive the intervention, thus providing a comparison of the "before" and "after" pictures in communities "exposed" and "not exposed" to the intervention.

1. Randomized experiments involve the random assignment to exposure or non-exposure groups. In all the other designs, exposure to a project is not random but purposeful. In randomized experiments, measures typically involve observations before, during, and after intervention, of both exposure (intervention) group and control groups, who have both been randomly assigned by the researcher.

2. Quasi-experimental designs include:

- *Regression-discontinuity studies*. This design lends itself well to interventions that entail a cut-off point for inclusion in an intervention. For example, if only children above a defined level of war trauma experiences are included in a particular type of intervention, we can statistically model (given strong measures of the outcomes we are interested in) where this group would have been *in the absence of* the intervention. This can be done by fitting two lines on a graph of pre- and post-intervention "scores" for children *above* the cut-off point and for children *below* the cut-off point, and extending each for comparison. This design introduces an amount of

control over the differences between the two groups that would have resulted in differential outcomes.[40]

- *Matched controls*. Exposure groups are matched with control groups (i.e., groups, communities, or regions) not affected by the project by the researcher or evaluator. These typically consist of before- and after-intervention observations.

- *Statistically equated controls*. Exposure groups and non-exposed groups are compared by means of statistical controls. The measurement scheme may be before- and after- or after-intervention only, but relies heavily on statistics and uses control variables.

- *Generic controls*. Exposure groups are compared to outcome measures available in the general population. After-intervention outcomes are compared to "normal" levels or expected indicators within a general population. This assumes that there is a "general population" comparable and accessible.

B. Full Coverage Projects

1. *Nonequivalent Control Group Designs* measure two or more groups both before and after a project intervention. Nonequivalent implies that the two groups of participants differ from one another at the outset, before the intervention occurs. If refugee and non-refugee children had different experiences of war, for example, these would represent nonequivalent groups, yet they might be matched according to approximate characteristics, such as age, sex, educational background, make up of family, language spoken, etc. Because they are nonequivalent, it is more difficult to measure the effect of the project (its *impact*) because chances are, the fact that the control group is not equivalent to the intervention participants means that there are factors that influence the potential outcome differently. That is, we cannot assume that the nonequivalent control group reflects where the participant group would have been *in the absence of* the intervention.

2. *Repeated Measures Designs* (either panel studies or time series designs) involve taking multiple measures of the same indicators for the same participants over time. For example, in order to examine the effects of the PBWTT project, the impact measures could have been applied at intervals prior to and after the project was introduced. Here the relevant comparison is between the measurements from the first week, which provides a baseline measure, and the measurements made after the completion of the training. In a sense, the participants in a time series design serve as their own control group, in that they are being compared to themselves at a previous time. The PBWTT project chose a non-equivalent control group design; children and families who participated in activities were compared to similar communities that did not participate. By comparing changes in symptoms for the communities that received the intervention with those that occurred in matched communities that had not received the intervention, the project hoped to determine whether the reductions stemmed from the psychosocial intervention rather than improvements in the wider economic or political conditions.

3. In *Simple Before and After Designs*, the project intervention group (also called the "exposure group") is compared to itself before and after project implementation. This is often the most do-able research design option for projects implemented in emergency situations because time and resources may be

[40] For a complete explanation of this design, see Trochim, William, M. K., Research Design for Program Evaluation: The Regression-Discontinuity Approach (Thousand Oaks, California: Sage Publications, 1984).

limited, and it may be difficult if not impossible to find a comparison group. In this design, outcome (and impact) indicators are compared before and after the project. In order to establish attributable outcome, we must use more sophisticated statistical models and carry out a thorough accounting of other possible confounding factors. A simple before and after design can be effectively used for an *outcome* evaluation, but will not indicate *attributable outcome* unless other factors influencing net outcome have been identified. *Net outcome* refers to all observable outcome, without differentiation between what may have occurred due to political, economic, or other shifts, and what outcome is attributable to the intervention itself.

4. Cross-Sectional ("Non-Uniform") Design Studies rely heavily on statistical models also, by utilizing after-intervention outcome measures and control variables. Differentially exposed groups are compared with statistical controls in order to disentangle attributable outcome from net outcome.

IV. Sampling

A SAMPLE is only a sub-set of a population, but when done correctly, it is representative of the entire population.

An important consideration when carrying out a population-based evaluation (whether before or after project implementation) or conducting a baseline survey, is the issue of sampling. Because it would be a prohibitive use of resources or logistically impossible to gather baseline data as well as outcome and impact indicators on every single project beneficiary, we need to collect data from a portion or sub-set of the larger population. In order to be valid, our sample must be a true representation of the larger population. In order to say with statistical confidence that the results of our sample are representative of a population and not due merely to chance, the sample must be of sufficient size. That is, the number of individuals, families, or households interviewed in a survey or included in an evaluation must be large enough to give us statistical power to say that the results we come up with in our sample are equivalent to the results had we interviewed everyone in the population. In order to illustrate a statistical correlation that implies a causal relationship between our intervention and an outcome (i.e., an evaluation of attributable outcome, or impact), we need to have derived our results from a sample that truly is representative of our population of interest.

What constitutes a "large enough" *sample size*? Mathematical formulas developed out of probability statistics are used in order to determine appropriate sample size. In the most general sense, the rule is "the more the better;" that is, the larger the sample size, the greater the confidence in the results and the smaller the margin or error.[41] Guidelines for sample size requirements are available elsewhere and will not be discussed in depth here except to say that sample size is derived primarily by a formula that divides the product of the confidence level (a z-score) and product of the population proportion and its inverse (and in cluster sampling, the design effect also) by the square of the maximum tolerable error. The resulting sample size "n" is the number of respondents needed.

Additional households or individuals should be included in the sample to account for non-response and to reflect the population proportion if not every household or individual contacted represents part of the specific respondent population desired. A simple random sample, with 95% confidence

[41] For an accessible guide to sampling, see Magnani, Robert, the Food and Nutrition Technical Assistance (FANTA) Sampling Guide (1997) available at the FANTA website: www.fantaproject.org.

that the results did not occur by chance, and with a maximum tolerable error of 10%, might require a sample size of 75, for example. A 2-stage cluster sample with the same level of confidence and margin for error might require a sample size of 220 (or 10 clusters of 22 respondents each), for example. However, sample size alone is not enough to give us statistical power; we also need to define a strategy to interview households, individuals, or otherwise collect data on a representative subset. This is called our *sampling design*. Some of the more common sampling designs are briefly described below.

A. Probability Sampling

For a design to be a probability sample, two criteria must be met:

- Each participant must have an equal chance of being selected.
- The probability of selection of each element can be calculated. Without the ability to calculate what the chance is that any given element will be selected, we lose the ability to say that a sample is representative of the whole population.

Four kinds of sampling strategies are described below (other, equally powerful strategies exist but are not described here).

1. Simple Random Sampling

This is the most common type of sampling (a fuller discussion can be found in various texts devoted to sampling[42]). With simple random sampling, every individual in the population has an equal chance of being selected for the study. For example, if there are two hundred children in a project, each child's name can be put on a slip of paper and a sample of 60 or 70 children can be randomly drawn for participation in the study (this is simple random sampling without replacement). This method is not always convenient or possible.

2. Systematic Random Sampling

If the goal is to identify a sample of 120 households from a complete list of 1440 households, for example, in an IDP camp in order to interview mothers regarding particular aspects of children's behavior (such as aggressive behaviors, acting withdrawn, etc.), we systematically select the required number of households from the list. First we define the sampling interval by dividing the total number of households (1440) by the number of households we want to visit. Our sampling interval equals 12; therefore we will select every twelfth household from the complete list of households after beginning with a randomly selected start between 1 and 12. As long as our sampling interval does not coincide with a regularly recurring feature of the population, this will result in a probability sample of the population of the IDP camp under investigation.

3. Stratified or Block Sampling

A stratified sample is used when the precise proportions of important subgroups of a population are known. For example, if there are 150 females and only 50 males in a group, and the goal is to reflect this inequality in the sample, a random selection of 20% of each of these two groups would result in 30 girls and 10 boys ending up in the sample.

4. Cluster Sampling

This type of sampling is valuable in cases where the actual population count within clusters is unknown (there is no complete list of households, for example). If we do not have an accurate list of

[42] See Leslie Kish, Survey Sampling (New York: John Wiley & Sons, Inc., 1965); and Steven K. Thompson, Sampling (New York: John Wiley & Sons, Inc., 2002).

all first-grade students in an area, for example, but we do have a list of all first-grade classrooms of roughly comparable size in an area, we can use a 2-stage cluster design. Since we cannot randomly choose respondents according to a random selection by student's name (because this list does not exist), we can first randomly select a specified number of first-grade classrooms from the list, and then interview (through random selection) the same number of students from each "cluster," or in this case, from each first-grade classroom. For instance, in the first stage, we could randomly select four first-grade classrooms from a complete list of all first-grade classrooms in the sample frame, and then in the second stage, 20 children in each classroom selected in the first stage would be selected at random and interviewed in each classroom selected.

B. Nonprobability Sampling

A weakness of all nonprobability sampling methods is that they can be assessed only by using subjective evaluation. The likelihood of a participant being selected is not known to the evaluator. Because we cannot mathematically determine the probability of selection for each person interviewed in a sample, we cannot say with statistical confidence that the results we end up with are truly objective and not influenced by subjective factors. In the end, the results may in fact be close enough that, given limited resources, nonprobability sampling provides an indication of project impact. In nonprobability sampling, participants are purposefully chosen, usually due to cost restraints and/or convenience (e.g., it may be far easier to select families or households to interview when they live close to a project office). While non-random sampling is quite common, it is necessary to be cautious when generalizing findings to the larger population. Examples of nonprobability sampling include: convenience sampling, quota sampling, and matched sampling. Again, the key thing to remember is to *transparent* and *honest* about the criteria for selection and the limitations of the data obtained through non-probability sampling.

1. Convenience Sampling

In a convenience sample the evaluator selects participants according to their availability or accessibility for a survey, interview, etc.

2. Quota Sampling

In sampling strategy, the evaluator also selects participants but there is some attempt to highlight certain characteristics of the population. For example, individuals or households from among a number of different villages, communities, or sections of a camp, are identified by particular features or characteristics. A "quota" from among the different characteristic groups of villages, communities, or sections, then serves as the basis for a sample.

3. Matched Sampling

Matched sampling is another technique that is used when, due to cost or convenience sake, purposeful selection is chosen over random selection. This technique involves creating comparable groups of participants based on matching the individuals in each group on some factor or variable that is believed to be important. For example, when comparing the effects of the PBWTT project on children, the sample of children who completed the project could be compared with another sample of children who have not gone through the project. In forming these two groups, each child in one group is matched with another in the second group. The criteria for matching might include such variables as age, gender, nature of war experiences, etc.

V. More on Qualitative Data Collection and Analysis

The research designs outlined above apply primarily to quantitative data. They can also be used with qualitative data that have been quantified (i.e., where qualitative responses have been assigned a numerical value following analysis or categorization). For example, in a survey where an open-ended question has been asked and responses tabulated, these same responses may be sorted or grouped according to degree of creativity, degree of "hope" expressed, or some other scale constructed only after the data have been gathered and with the input of local perceptions of creativity, hope, or other markers of attitude, perceptions, knowledge, etc. Much of qualitative research does not follow a strict probability design. This is not to devalue it, however. On the contrary, it provides important insight into other data collected. It also offers another method of *triangulating* data. Recall that in triangulation, we collect the same information (e.g., a particular set of indicators of status of interest) from different sources or using different methods. We might ask a question that results in quantitative data on the one hand, while we also ask an open-ended question within a focus group that provides another view of the same data. Or we might use a different method, such as observation or unobtrusive measures (such as physical accretion or physical erosion measures).

Chapter Six Summary

An IMPACT evaluation is done in order to determine whether or not anticipated final results or the realization of longer-term outcomes are attributable to an intervention. It can be thought of as the sum of a chain of *causal relationships* between project input/output, *intermediate* outcomes, and *ultimate project outcome*.

A true impact evaluation requires resources such as time, money, technical assistance, personnel, etc. Project budgets must reflect the additional funds necessary to carry out an impact evaluation.

Four types of comparison groups were defined: reflexive, constructed, randomized and shadow control groups.

A research design is a methodological strategy for avoiding or controlling bias or interfering events. The following research designs were discussed:

- Randomized experimentation
- Quasi-experimental design
- Nonequivalent control group design
- Repeated measures
- Simple before and after studies
- Cross-sectional non-uniform designs

Baseline data provide a view of the behavior, attitude, knowledge, risk, status, etc. prior to project implementation.

A valid sample is representative of the larger population. Probability and nonprobability sampling were defined and descriptions provided for: simple random sampling, systematic random sampling, stratified sampling, and cluster sampling, as well as nonprobability designs such as convenience sampling, quota sampling, and matched sampling.

Chapter Seven

Chapter 7: Designing a Psychosocial Project and Building an Evaluation Strategy

In this chapter we will review the content presented throughout this document using a worksheet format. Questions useful in building an evaluation strategy will be presented. This presentation is somewhat artificial in that the development of an evaluation strategy is not a linear process. Rather it is a dynamic back and forth process with many adjustments and refinements based on experience and feedback from project monitoring systems and other sources. With this in mind we will begin the discussion with some very basic questions aimed at getting off to a good start in formulating a psychosocial project.[43]

I. Key Questions in Formulating a Psychosocial Project

1. What segment of the affected community is your project seeking to assist and ***why***? □ Population generally affected by events and circumstances—the 70% or so of the population that is not experiencing the same level of distress as those at higher risk or more severely affected, but yet would benefit psychosocially from community-based interventions. □ The "At-Risk" segment of the population that may have witnessed or been directly involved in violence, and are significantly distressed and at risk of not functioning well psychologically and socially unless needs are addressed in an appropriate and timely fashion. □ Severely affected group, including children and adults who need intensive psychological attention.
2. Describe what situational analysis and needs assessments have been done, and their findings or recommendations.
3. Match findings and recommendations from the situational analysis and needs assessments to your answers in Box 1.

[43] This is not meant to provide a comprehensive discussion of steps in formulating a project; resources identified in the bibliography can provide a more thorough discussion of relevant issues.

What gaps are there in your information about the situation and needs of your program target group(s)?

How will you fill these gaps? Who will you go to for information? How will you gather more information?

4. How much ***community participation*** was there in the situational analysis and needs assessment(s)?

□ A lot; community was involved in strategy development, data collection, situation analysis
□ Some; community was involved in collection of data for situation analysis only
□ Not much; community had little or no involvement

5. List the appropriate community members, groups, gatekeepers, and others (if any) who were included in discussions about the need, purpose, design, and implementation strategy of the project.

6. List additional groups that could provide valuable information, insight, and guidance.

7. What community resources have you identified for project implementation (trainers, community centers, advisors, monitors, other)?

8. Brainstorm and ask different people in the community to learn if there is anyone else you could consult while planning project objectives, activities, and implementation, regarding traditional practices, appropriate roles and activities, cultural beliefs, local resources, etc. (list possible sources here).

9. List your project objectives (that is, outcomes you expect to see as a result of your project intervention), intermediate results (i.e., steps or benchmarks along the path toward achieving those objectives), and the different activities that will help achieve those objectives, given your target group, the needs assessment, and community input you have received.

(*NOTE:* As you receive additional input from community members and others, you will probably revise some of your initial assumptions about which activities will lead you to certain outcomes, and that's okay because this is a learning process between your project staff and the community.)

10. How will the project foster sustainable solutions to community identified needs?

How might you improve the chances that it will?

In what ways will the project promote community ownership?

11. Conduct a cost-effective analysis; how many people will the project assist and what is the estimated cost per person?

How can you increase the scale (that is, reach more people across a larger area) without jeopardizing the effectiveness of the project?

12. Consider if your project poses any risks to participants. If so, what are they and what steps will you take to minimize these risks?

13. Name any other groups (e.g., local NGOs, governmental departments, international NGOs, community-based organizations etc.) that are addressing similar needs or working with the same group or community.

How does your project differ from these other project(s)/interventions?

How does your project complement the other project(s)/interventions?

What are possible linkages between your project and others that would be beneficial?

II. Develop a "Logic Model"

1. What do you want your project to accomplish? What are the **objectives** or the changes you would hope to see as a result of your project intervention?

1) At the individual level?

2) At the family level?

3) At the community level?

4) At the population level?

Next to each **objective**, list all the **intermediate results** you can think of that will help achieve these objectives or end results.

At the individual level.

At the family level.

At the community level.

At the population level.

EXAMPLE:

At the individual level.

OBJECTIVE: Improved psychosocial well-being among children affected by war.

What would this look like?

- Children display a desired level of pro-social behavior
- Children display a desired level of cognitive/emotional functioning
- Children maintain a desired level of performance in school
- Children report a positive degree of coping
- Children report a positive degree of self-esteem and agency

Intermediate Results & Outputs:

What are the steps to get there?

- Children **learn** what appropriate pro-social behavior means
- Children **practice** pro-social behavior (*example of an activity:* non-competitive group games that rely on and build teamwork)
- *Output:* Teachers, counselors, and other community members are **trained** to provide a safe environment for children to begin to explore their feelings and perceptions about their experiences of violence
- *Output:* Trained adults **plan and carry out** the psychosocial support activities in which they have been trained *(example of activities:* activities offered in a supportive environment, in an appropriate and systematic way provide children with alternative ways of expressing their feelings and perceptions about their experiences)
- Etc.

Now link all the intermediate steps and outputs.
What leads to what? What does your project need to accomplish before accomplishing the next step?

Think about identifying "spiders," a "chain or results," or other types of linkages or pathways. Are there any gaps? Identify additional intermediate results if necessary to fill in any gaps.

You should make every effort to include different groups from the community (a mothers group, a group of youth, and a group of community leaders, for example) in your discussions.

Draw a diagram of your logic model.

(*NOTE: You may want to write each outcome and each intermediate result on a separate slip of paper or note card. This will make it easier to move these around in relation to each other.)*

Identify all the activities to achieve each intermediate result or step along your pathway. Again, community participation is crucial to the design and success of the project.

Objective 1……..
Intermediate Result 1.1…….
Activities……
……
……

(NOTE: Fr your program proposal or implementation plan for reporting to the donor, you may want to highlight only KEY activities. You will still want to identify ALL activities for your time & budget calculations and for project staff planning needs.)

Now identify all the inputs and anticipated outputs for each activity in your project designed to achieve each intermediate result along the pathway toward achieving your project objectives.

EXAMPLE:
Objective 1……..
Intermediate Result 1.1…….
Activities…… *INPUT: (materials for training workshops;*
…… *time allocated for training workshops; local*
…… *expertise for conducting training; etc.)*
…… *OUTPUT: (10 teachers trained in CBI; etc.)*

Identify any underlying assumptions about why and how certain activities lead to desired outcomes, and why and how particular intermediate results are linked to or lead to other results. Do any of these assumptions need to be tested? Have they been proven elsewhere or do you need to evaluate the validity of an assumption that the logic behind your intervention will achieve the desired objective, if implemented according to plan?
Are there any other factors that could influence the project's ability or inability to achieve the desired outcomes? Write these down.
Now revisit your logic model to see if any linkages have been left out. Remember to think about **causal links** between activities and outcomes, and between the intermediate results and the end outcomes or project objectives.

III. "SMART" Objectives and Measurable Outcomes

The next step is to more clearly define your **objectives** in order to make them **SMARTer**; **S**pecific, **M**easurable, **A**ppropriate, **R**ealistic, and **T**ime-bound.

EXAMPLES:

Objective 1. Increased awareness by community leaders of key community-level issues affecting children
Is SMARTer as:
Objective 1. By the end of the project, community leaders in at least 10 of the 14 sub-districts will be have identified and produced a list of key issues affecting children in their community and will have designed strategy to mobilize resources and plan activities for children.

Objective 2. Children can express themselves
Is SMARTer as:
Objective 2. By the end of the project, 80% of children report that they are "always" or "almost always" able to talk to their parents and teachers about their feelings and concerns

Objective 3. Improved psychosocial well-being of children
Is SMARTer as:
Objective 3. Improved psychosocial well-being in 90% of children in the project area, as measured by pro-social behavior, school performance, and self-esteem

On the Program M&E Plan (PMEP) worksheets provided at the end of this chapter, write down your SMART Objectives and Key Intermediate Results where indicated.

Now **review** each of your objectives and intermediate results. Is each one **S**pecific, **M**easurable, **A**ppropriate, **R**ealistic, and **T**ime-bound? If not, go back and rework the ones that are not. You may find that you need to break one of your objectives into two objectives or add another level to the chain of results (i.e., your pathway of linked intermediate results on the way to achieving your end outcome).

Revisit your logic model again to see that there are no gaps in it. This is another opportunity to engage community members in the process. Review the logic, objectives, and outcome with key community members and make adjustments as necessary.

IV. Develop Indicators to Measure Achievement

For each objective and intermediate result, you will need to identify what it is you need to measure (quantitatively) or identify (qualitatively) in order to record progress toward achieving the desired result or a change in status, behavior, attitude, or knowledge. Review your objectives and intermediate results. Is it clear **what** you need to measure? If you cannot identify what it is you need to measure, you will need to re-think your objective or intermediate result in the context of your logic model.

For each objective and intermediate result, **identify what you need to measure**—either quantitatively or qualitatively—in order to record progress toward achieving the desired result or a change in status, behavior, attitude, or knowledge.

(NOTE: Circle the phrase or key word in each objective and intermediate result that helps prompt you as you identify the indicators for measuring achievement.)

EXAMPLE

Objective 1. By the end of the project, 80% of children report that they are "always" or "almost always" able to talk to their parents and teachers about their feelings and concerns

Intermediate Result 1.1: 80% of parents report taking more time and care to listen to their children

Intermediate Result 1.2: 100% of teachers in the project area incorporate non-verbal expressive activities for children into the curriculum

Objective 2. Improved psychosocial well-being in 90% of children in the project area, as measured by pro-social behavior, school performance, and self-esteem

Intermediate Result 2.1: 90% of children are able to correctly identify appropriate and inappropriate pro-social behavior

Intermediate Result 2.2: 80% of communities in the project area have trained adults implementing appropriate psychosocial support activities for children

Etc.

For the objectives and intermediate results you have identified above and listed in your PMEP worksheet, identify **indicators** that are **valid**, **reliable**, and **sensitive** to the outcome of interest. Write these down in the PMEP worksheet aligned with the objective or result they measure. Now is the time to be very specific so that you can clearly identify **what** you need to measure and, based on this, **how** you will collect/uncover the information. Try to avoid "number"—specify "proportion,"

where possible or appropriate, and include a definition of the numerator and denominator so that you know exactly what it is you need to measure.

EXAMPLES of quantitative indicators:

Objective: By the end of the project, community leaders in at least 10 of the 14 sub-districts will be have identified and produced a list of key issues affecting children in their community and will have designed strategy to mobilize resources and plan activities for children.

- Proportion of communities in which leaders have designed strategies to mobilize resources and plan activities that address key issues affecting children's well-being in their community.
  Numerator: Number of communities in which leaders have designed strategies to mobilize resources and plan activities that address key issues affecting children's well-being in their community.
  Denominator: Total number of communities within project implementation area.

Objective: By the end of the project at least 80% of children in the project area show improved psychosocial well-being, as measured by pro-social behavior, school performance, and self-esteem

- Proportion of children who display a desired level of pro-social behavior
  Numerator: Number of children whose score on a compound variable (derived from scales that measure pro-social behavior) is within the optimal range
  Denominator: Total number of children in the survey

- Proportion of children who maintain a desired level of performance in school
  Numerator: Number of children whose score on the *Perceived School Performance Scale* is within the optimal range
  Denominator: Total number of children in the survey

- Proportion of children who report a positive degree of self-esteem and agency
  Numerator: Number of children whose score on the *Children's Attributional Style Questionnaire, Rosenberg's Self-Esteem Scale*, and/or the *State Hope Scale* is within the optimal range
  Denominator: Total number of children in the survey

In your PMEP Worksheet are spaces to identify, next to each indicator:

- Target, where appropriate (e.g., 80%)
- Data source (i.e., the specific measurement tool and/or method of collecting data)
- Frequency of collection (e.g., pre- and post-intervention)
- Staff person responsible for collecting and reporting data

For each indicator, you will need to determine **how** you will collect or uncover the information you need. The first step is to identify your required data sources. Could you gather the information you need as part of routine monitoring of project input, activities, and output? If so, make sure that you identify someone to develop a monitoring sheet for collecting and periodically reporting the information. If the data cannot be gathered in the course of routine monitoring, you will need to identify specific measurement tools for quantitative indicators (e.g., question sets or scales developed specifically to measure degree of self-esteem, hope, coping, or pro-social behavior) and/or measurement strategies for qualitative indicators (e.g., semi-structured question guidelines for focus group discussions, a list of materials and activities necessary to conduct a participatory mapping exercise with children, etc.).

In the process of identifying **how** you will collect the data you need and **who** will be responsible for collecting and reporting the information, you should meet with key stakeholders and community

members. It is important to identify participatory mechanisms for monitoring progress toward those results that are appropriately tracked by community members, and you should be thinking of how information can be gathered in a sensitive manner. You should also consider how you will feedback information to community members and other key stakeholders.

Be sure that the **method** of collecting the information is clear. Review the various methods discussed in Chapter Five. Interviews, observations, and self-report methods are frequently used methods of data collection. These include:

- Unstructured or semi-structured interviewing
- Focus group interviews
- Key informant interviews
- Quantification of selected observations from field notes
- Participant observation techniques
- Systematic observation
- Personal narratives
- Event records
- Self-report methods
- Unobtrusive measures

Review your indicators and their data sources and methods. Try to identify additional ways to gather the **same information**. By collecting information toward your indicators from three different data sources or methods, you can be more confident in your data. This is referred to as triangulation. Where possible, you should attempt to collect your data through unobtrusive measures.

Revisit selected indicators and **data sources** with key community members. Are there particular measures, indicators, or data collection sources and methods that are politically or socio-culturally sensitive? With input from key community members, you can identify proxy indicators and/or alternative and unobtrusive measures, if necessary.

V. Design a Strategy to Monitor Project Input and Output

Revisit your logic model and the key activities you identified in order to reach the desired outcomes. You will need to develop a system to record and track your input and key output. You will also need to identify systems and mechanisms for reporting this information on a periodic basis. This will help the program manager determine if the project is being implemented adequately and if any adjustments or changes are required in order to ensure that the project is making progress toward its objectives.

Provide a detailed implementation plan by elaborating your project activities. **List all activities**, specify each step in realizing key activities, and list all supportive project activities also.

What **resources** will the project need in order to get set up and begin implementation of activities? Identify staff, financing, facilities, supplies, necessary policies in place, training curricula, educational support materials, recreational materials, training workshops scheduled, etc. This is your **project input**.

(NOTE: It is useful to speak with other NGO program managers who have implemented similar projects.)

Develop a **timeline** for each **input** and the implementation of each **activity** (identify key steps or components of each activity). (*You may want to use a computer graphic or spreadsheet application for this.)*

Have you specified the dates of completion for specific activities? □ Yes □ No
Is this timeline realistic and appropriate, given the climate/setting and resources? □ Yes □ No
If you answered no to either of these questions, write out your plan to address this.

For each project activity, identify all expected **outputs** (e.g., number of workshops, number of community members attending workshops out of the total number of community members invited or expected to attend, number of people trained, number of psychosocial support services operational by a specified date, etc.) and identify date of completion according to your timeline, if applicable.
What safeguards have you designed to protect project participants (e.g., data coding systems, limited access, locked files)?

VI. Outcome and Impact Evaluations

Planning for a project evaluation must commence at the very beginning of project implementation planning. The design you choose depends primarily on the questions you wish to answer with your evaluation. If your primary interest is in documenting achievement of your objectives with quantitative data, your focus will be primarily on specific, key indicators for reporting. If you are more interested in sustainability and community empowerment and project ownership, you will want to consider an *empowerment evaluation*. An empowerment evaluation focuses on community participation in the planning, monitoring, and evaluation process and is more likely to focus on indicators and measurement strategies defined by the community rather than on measurable outcome indicators as defined by a project's objectives, although in some instances these could be the same. If the purpose of your evaluation is to learn which intervention strategies are the most successful in achieving particular outcomes, you will want to consider a more rigorous *impact evaluation* because you will need to know which outcomes can be attributed to which activities and interventions.

State the **purpose(s) of your evaluation**.

What do you and/or the donor need to know?

Does this require an evaluation that can statistically account for attributable outcome? □ YES □ NO

If your answer is YES, skip to the Impact Evaluation Worksheet below.
If your answer is NO, continue with the Outcome Evaluation Worksheet.

Do you have the necessary resources to carry out an impact evaluation? □ YES □ NO

If your answer is YES, skip to the Impact Evaluation Worksheet below.
If your answer is NO, continue with the Outcome Evaluation Worksheet.

A. Outcome Evaluation

If your answer is NO, then you will want to consider an evaluation design that can measure specific outcomes of interest and provide a *reasonable assurance* that the outcomes you observe can be attributed, at least in part, to your project intervention.

OUTCOME EVALUATION WORKSHEET

First you need to decide which research design is feasible.

1) What baseline data are available?

2) What baseline data would you need to collect?

3) What resources (time, budget, personnel, logistical support, etc.) are available for data collection?

Identify an appropriate evaluation design.

Is your program full coverage?

If it is not full coverage, will you be able to identify and interview/observe/survey a "control" group comparable to your group of beneficiaries?

If the program is full coverage, will you be phasing in your project activities in different locations?

If your answer is yes, you will want to consider a panel design:

A **panel design** involves multiple measurements taken throughout the project implementation; observations are made before and after the intervention.

O_1 X O_2 O_3 O_4

If you will not be able to identify a control group and your resources or time limit you to only two large-scale data-gathering exercises, you should consider a simple pre-test/post-test design:

A **simple pre-test and post-test design** records indicators in the beneficiary population before and after project implementation.

O_1	X	O_2
Observation at Time 1 (pre-test)	*Intervention*	*Observation at Time 2 (post-test)*

If your project is not full coverage and/or you will be able to identify and interview, observe, or survey a "control" group comparable to your group of beneficiaries, you could consider a pre-/post-test comparison group design.

A **pre-test and post-test comparison group design** collects data on the same indicators (using the same measurement instruments) in both the beneficiary population and a control group, before and after project implementation.

O_{1a} .... X …. O_{2a} (a = participants exposed to the project)
O_{1b} .... O_{2b} (b = control group; not exposed to project activities)

If you will be phasing in your project activities in different areas over the life of the project, you may want to consider a panel design with a "wait-list" or other control group comparison.

A **panel design with control group comparison** involves multiple measurements taken throughout the project implementation; observations or surveys are conducted with the first group of beneficiaries before and after the intervention, and also with the second ("wait-listed" or delayed intervention) group of beneficiaries, before and after the intervention.

O_{1a} X O_{2a} O_{3a} (a = 1st group of participants)
O_{1b} X O_{2b} O_{3b} (b = 2nd group or wait-listed participants)

If you will be utilizing a comparison or control group design, you need to clarify how you will select a control group. Will you match families in the beneficiary group and control group by socio-economic status and educational attainment, by linguistic-ethnic and cultural factors, or other, for example? Will you select comparable classrooms out of the control population that match classrooms in the beneficiary population, for example? *(In your own words, describe how you will identify a control group.)*

For quantitative data collection, decide on a **sampling methodology** and identify a **sample size** that is appropriate, given your resources, the setting, and your needs.

Sampling methodology:

- □ simple or systematic random sampling
- □ stratified sampling
- □ cluster sampling
- □ convenience sampling
- □ quota sampling
- □ matched sampling
- □ sentinel survey sampling (key households or individuals selected for periodic observation)
- □ other

Sample size: _____

SAMPLE SIZE CALCULATIONS

Do you have a **sampling frame** (i.e., a complete list of names or household numbers from which you can randomly select individuals or households)? If YES, then you can conduct a simple random sample or a systematic random sample.

Simple or **Systematic Random Sample**

$n \geq [z^2 * P * (P-1)] \div D^2$

z = z-score at level of confidence (95%=1.96, 90%=1.645, 80%=1.282

P = proportion of the population (.50 if unknown) *(the proportion that is likely to answer "yes" or "no" to a particular question of interest in your survey questionnaire)*

D = maximum tolerable error

EXAMPLE:

$n \geq [(1.96)^2 (.25) (.75)] \div (.10)^2 = 73$

How many randomly-selected households would you need to visit? If you need to interview a child between 10 and 18 years, for example, and you estimate that 30% of all households will have a child in this age range, you can calculate the number of households you need to visit in order to reach your minimum required sample size by considering the percentage of the population and add in 10% non-response: (73 / 0.30) * 1.10 = 268

If you do not have a sampling frame, you will need to randomly select clusters, from which you will then randomly select individuals or households to interview. *(You should randomly select your clusters in proportion to population size.)* The first-stage cluster might be a village, a grouping of small villages that are close together, or a neighborhood of a city, for example. At the second stage, you randomly select households or individuals to interview.

2-stage Cluster Sampling requires an additional calculation for design effect:

$n \geq [dz^2 * P * (P-1)] \div D^2$ d = design effect (2.0 by default)

If you do not have a sampling frame or an existing map or listing of households prior to conducting a household sample, consider involving community members to quickly map out households and estimate population and household size.

No matter which design you've selected above, consider a mixed-method approach—that is, an approach that utilizes both quantitative and qualitative methods.

What kind of staffing, time, and budget (monetary) resources do you have? Could you conduct a pre- and post-test or baseline/endline quantitative survey ***and*** several qualitative studies?

Consider conducting at least two different qualitative studies, such as:

- Pre- and post-intervention focus group discussions with at least 3 different gender/age groups
- Participatory mapping exercises with children or youth—mapping such things as: where time is spent doing which activities during the day; how much time is spent in the company of family members or peers during the course of a day; perceived risks, threats, or fears mapped onto the body; etc.
- In-depth interviews and observations of individual children and families over the course of several weeks or months

Describe your **sampling design** for *quantitative* data collection:

Total number of villages, households, and/or individuals in project area (real or estimated):

Number of villages, households, and/or individuals that you can realistically sample/interview:

How will you select villages, households, and/or individuals for the sample?

Describe your **selection criteria** for *qualitative* data collection:

Number of families, households, or individuals in your sample:

What are your selection criteria? How will you select villages, households, and/or individuals for the sample?

What questions would you like to answer, given the data you will collect?

(You may want to identify various features (mix of ethnicity, caste, economic livelihoods, level of displacement, protection problems, security risks, more or less likely to respond to psychosocial program intervention, greater numbers of affected youth, etc.) that could serve to group certain regions or villages together, and then select individuals or families from there. Or you might want to identify individual children from among beneficiaries and non-participants, for what the different backgrounds or situations could tell you about the success of your program intervention.)

Interviewing

Have you obtained the informed consent of participants or does your survey questionnaire include a mechanism for obtaining informed consent? □ Yes □ No

If your project focuses on children, do you have a plan for asking the caregiver's consent to interview the child? □ Yes □ No

Required resources

- Identify all the resources your surveys or other data collection strategies, data analyses, and reporting will required.
- How many interviewers will you need?
- What kind of training will they need?
- How many days are necessary for training interviewers and how much will it cost to conduct the training (including a facilitator, materials, room, transportation to/from the training site, etc.)?
- What resources are required for conducting a translation, an independent back-translation, and a field-test of the survey questionnaire(s)?
- What resources are required for conducting the survey (transportation, salaries, per diems, supervision, etc. for enumerators)?
- What resources will qualitative data and participatory methods require?
- Etc.

Ensure community participation

Finally, having determined the scope and design of your program monitoring and evaluation strategy, revisit each step in order to discover additional opportunities to could include community/participant member participation.

B. Impact Evaluation

If your agency's program learning and/or donor reporting needs require an *impact evaluation*, you will want to identify a rigorous evaluation design that is appropriate to the resources available to your project. Because psychosocial interventions in the field are designed to meet the needs of a population under duress and not designed to be clinical trials, *quasi-experimental* evaluation designs are used in psychosocial program evaluation. Several quasi-experimental designs are discussed above in Chapter Six. In order to determine which is appropriate to your project evaluation and to plan your evaluation design *as you plan your project's detailed implementation*, the following worksheet will prove useful.

IMPACT EVALUATION WORKSHEET

Decide which research design is feasible.

1) What baseline data are available?

2) What baseline data would you need to collect?

3) What resources (time, budget, personnel, logistical support, etc.) are available for data collection?

Identify an appropriate evaluation design.

Is your program full coverage?

If it is not full coverage, how will you be able to identify and interview/observe/survey a "control" group comparable to your group of beneficiaries?

If the program is full coverage, will you be phasing in your project activities in different locations?

If your answer is yes, you will want to consider a panel design:

A **panel design** involves multiple measurements taken throughout the project implementation; observations are made before and after the intervention.

O_1 X O_2 O_3 O_4

Comparison or Control-Group Designs

If your project is not full coverage and/or you will be able to identify and interview, observe, or survey a "control" group comparable to your group of beneficiaries, you could consider a pre-/post-test comparison group design.

A **pre-test and post-test comparison group design** collects data on the same indicators (using the same measurement instruments) in both the beneficiary population and a control group, before and after project implementation.

O_{1a} .... X …. O_{2a} (a = participants exposed to the project)
O_{1b} .... O_{2b} (b = control group; not exposed to project activities)

If you will be phasing in your project activities in different areas over the life of the project, you may want to consider a panel design with a "wait-list" or other control group comparison.

A **panel design with control group comparison** involves multiple measurements taken throughout the project implementation; observations or surveys are conducted with the first group of beneficiaries before and after the intervention, and also with the second ("wait-listed" or delayed intervention) group of beneficiaries, before and after the intervention.

O_{1a} X O_{2a} O_{3a} (a = 1st group of participants)
O_{1b} X O_{2b} O_{3b} (b = 2nd group or wait-listed participants)

Defining Control Groups

There are a number of ways to define your control or comparison group. Some of these, as discussed in Chapter Six, are as follows:

Regression-discontinuity studies. This design lends itself well to interventions that entail a cut-off point for inclusion in an intervention. This design relies on statistically modeling to determine where the treatment (participant) group would have been *in the absence of* the intervention.

Matched controls. Exposure groups are matched with control groups according to specific criteria that are likely to influence outcomes.

Statistically equated controls. This measurement scheme relies heavily on statistics to make comparisons between participant and non-participant groups.

Generic controls. Exposure groups are compared to outcome measures available in the general population. This assumes that there is a "general population" comparable and accessible.

If you will be utilizing a comparison or control group design, you need to clarify how you will select a control group. Will you match families in the beneficiary group and control group by socio-economic status and educational attainment, by linguistic-ethnic and cultural factors, or other, for example? Will you select comparable classrooms out of the control population that match classrooms in the beneficiary population, for example? *(In your own words, describe how you will identify a control group.)*

For quantitative data collection, decide on a **sampling methodology** and identify a **sample size** that is appropriate, given your resources, the setting, and your needs.

Sampling methodology:
- □ simple or systematic random sampling
- □ stratified sampling
- □ cluster sampling
- □ convenience sampling
- □ quota sampling
- □ matched sampling
- □ sentinel survey sampling (key households or individuals selected for periodic observation)
- □ other

Sample size: _____

SAMPLE SIZE CALCULATIONS

Do you have a **sampling frame** (i.e., a complete list of names or household numbers from which you can randomly select individuals or households)? If YES, then you can conduct a simple random sample or a systematic random sample.

Simple or **Systematic Random Sample**

$n \geq [z^2 * P * (P-1)] \div D^2$

z = z-score at level of confidence (95%=1.96, 90%=1.645, 80%=1.282

P = proportion of the population (.50 if unknown) *(the proportion that is likely to answer "yes" or "no" to a particular question of interest in your survey questionnaire)*

D = maximum tolerable error

EXAMPLE:

$n \geq [(1.96)^2 (.25) (.75)] \div (.10)^2 = 73$

How many randomly-selected households would you need to visit? If you need to interview a child between 10 and 18 years, for example, and you estimate that 30% of all households will have a child in this age range, you can calculate the number of households you need to visit in order to reach your minimum required sample size by considering the percentage of the population and add in 10% non-response: (73 / 0.30) * 1.10 = 268

If you do not have a sampling frame, you will need to randomly select clusters, from which you will then randomly select individuals or households to interview. *(You should randomly select your clusters in proportion to population size.)* The first-stage cluster might be a village, a grouping of small villages that are close together, or a neighborhood of a city, for example. At the second stage, you randomly select households or individuals to interview.

2-stage Cluster Sampling requires an additional calculation for design effect:

$n \geq [dz^2 * P * (P-1)] \div D^2$ d = design effect (2.0 by default)

If you do not have a sampling frame or an existing map or listing of households prior to conducting a household sample, consider involving community members to quickly map out households and estimate population and household size.

No matter which design you've selected above, consider a mixed-method approach—that is, an approach that utilizes both quantitative and qualitative methods.

What kind of staffing, time, and budget (monetary) resources do you have? Could you conduct a pre- and post-test or baseline/endline quantitative survey ***and*** several qualitative studies?

Consider conducting at least two different qualitative studies, such as:

- Pre- and post-intervention focus group discussions with at least 3 different gender/age groups
- Participatory mapping exercises with children or youth—mapping such things as: where time is spent doing which activities during the day; how much time is spent in the company of family members or peers during the course of a day; perceived risks, threats, or fears mapped onto the body; etc.
- In-depth interviews and observations of individual children and families over the course of several weeks or months

Describe your **sampling design** for *quantitative* data collection:

Total number of villages, households, and/or individuals in project area (real or estimated):

Number of villages, households, and/or individuals that you can realistically sample/interview:

How will you select villages, households, and/or individuals for the sample?

Describe your **selection criteria** for *qualitative* data collection:

Number of families, households, or individuals in your sample:

What are your selection criteria?
How will you select villages, households, and/or individuals for the sample?

What questions would you like to answer, given the data you will collect?

(You may want to identify various features (ethnicity, caste, economic base, displacement, protection & security risks, more or less likely to respond to psychosocial program intervention, greater numbers of affected youth, etc.) that could serve to group certain regions or villages together, and then select individuals or families from there. Or you might want to identify individual children from among beneficiaries and non-participants, for what the different backgrounds or situations could tell you about the success of your program intervention.)

Interviewing

Have you obtained the informed consent of participants or does your survey questionnaire include a mechanism for obtaining informed consent? □ Yes □ No

If your project focuses on children, do you have a plan for asking the caregiver's consent to interview the child? □ Yes □ No

Required resources

Identify all the resources your surveys or other data collection strategies, data analyses, and reporting will required.

- How many interviewers will you need? and What kind of training will they need?
- How many days are necessary for training interviewers and how much will it cost to conduct the training (including a facilitator, materials, room, transportation to/from the training site, etc.)?
- What resources are required for conducting a translation, an independent back-translation, and a field-test of the survey questionnaire(s)?
- What resources are required for conducting the survey (transportation, salaries, per diems, supervision, etc. for enumerators)?
- What resources will qualitative data and participatory methods require?

Ensure community participation

Finally, having determined the scope and design of your program monitoring and evaluation strategy, revisit each step in order to discover additional opportunities to could include community/participant member participation.

C. Reporting

The real purpose of an evaluation goes far beyond satisfying a donor requirement. The value of an evaluation is in documenting a project's implementation, how success was or was not achieved, and in disseminating lessons learned for future or continued psychosocial intervention. Because psychosocial programming is still relatively new, we have much to learn about the nature of our interventions, what works well, and why. Knowledge gained in the process of implementing projects should be shared with local and international practitioners, academic colleagues, and donors. With the application of systematic and rigorous approaches to psychosocial program monitoring and evaluation, everyone benefits, including future recipients of our interventions and the societies they build after a crisis.

One of the most important lessons to remember when designing, conducting, and reporting on a project evaluation is to be transparent and honest in what you can claim, given the data you have and any restraints or challenges to data collection and analysis. Claims about project achievements or the activities that lead to such achievements can play a significant role in public policy, donor funding, and future interventions. Thus we should not make claims beyond what we can realistically say with the data we have. At the same time, however, we need to share our experiences, lessons learned in

the process of implementing and evaluation a project, and what we can learn about the outcomes we see as a result of our interventions.

Timely and appropriate feedback to stakeholders is also important. Sharing results can be crucial to building bridges between international organizations and local communities, for example, and it opens up avenues for continued learning on effective and appropriate psychosocial interventions. It is important to establish adequate reporting mechanisms, for both monitoring data as well as evaluation results, early in the planning and implementation process.

Numerous examples of reporting on results and documenting lessons learned are available in print and on the web. A recently released publication, How to Mobilize Communities for Health and Social Change[44] provides a *Worksheet for Reporting Results* and a *Matrix for Documenting Lessons Learned* that are very useful for organizing the information that goes into a report and a dissemination of lessons learned. The *Worksheet for Reporting Results* suggests articulating: desired results (objectives, indicators, and questions related to objectives); actual results (what was achieved?); analysis (why? What contributed to achieving these results?); lessons learned; and recommendations.[45]

Desired Results	Actual Results	Analysis	Lessons Learned	Recommendations

The *Matrix for Documenting Lessons Learned* prompts a consideration of key steps in realizing a documentation and dissemination plan.[46]

Stakeholders/ Audience	Learning Interest	Purpose of documentation/ dissemination	Material/Method of dissemination	Person/Team responsible	When?

D. Next Steps

This guide to good practices in evaluating psychosocial programming is a work-in-progress and as such represents an initial, coordinated step in the process of building stronger monitoring and evaluation designs and greater dissemination of lessons learned so that project practitioners will not have to "take a leap of faith" that their psychosocial projects are having a measurable and positive effect on the lives of children, families, and communities.

As mentioned in the Preface, this manual should be considered a "working document." Through dissemination, it is hope that more colleagues, field-based managers, and coordinators of

[44] Lisa Howard-Grabman and Gail Snetro, How to Mobilize Communities for Health and Social Change, A Field Guide (Baltimore: Johns Hopkins Population Information Program, Health Communication Partnership, Media/ Materials Clearinghouse, 2003).
[45] *Ibid.*, 209-210.
[46] *Ibid.*, 211.

psychosocial projects can continue to provide critical review and further input across a variety of disciplines, cultural settings, and regional perspectives. The next step, then, is to utilize this manual in developing psychosocial project training, planning, implementation monitoring, and evaluation, and to adapt and expand on it in order to meet the needs of practitioners in the field.

SELECTED RESOURCES

Psychosocial Programming

Ager, A.
1996 "Children, war, and psychological intervention." In Psychology and the Developing World edited by S. Carr and J. Schumaker (New York: Praeger).
1997 "Tensions in the psychosocial discourse: Implications for the planning of interventions with war-affected populations," Development in Practice 7(4): 402-7.
1999 "Psychosocial needs in complex emergencies," The Lancet 360, Supplement: 43-4.
2000 "Psychosocial programs: Principles and practice for research and evaluation." In Psychosocial Wellness of Refugees: Issues in Qualitative and Quantitative Research, edited by F.L. Ahearn (Oxford: Berghahn).

Berry, J.
1989 "Imposed etics-emics-derived etics: The operationalization of a compelling idea," International Journal of Psychology 24: 721-35.

Boothby, N.
1990 "Working in the war zone: a look at psychological theory and practice from the field," Mind and Interaction 2(2): 30-6.
1996 "Mobilizing communities to meet the psychosocial needs of children in war and refugee crises." In Minefields in their Hearts: the Mental Health of Children in War and Communal Violence, edited by R. Apfel and B. Simon (New Haven: Yale University Press).

Boyden, J.
1994 "Children's experience of conflict-related emergencies; some implications for relief policy and practice," Disasters 18(3): 254-67.

Dagnino, N.
1996 "Responding to the psychosocial needs of refugee children: A multi-faceted approach." In The Psychological Well-being of Refugee Children: Research, Practice and Policy Issues, edited by M. McCallin (Geneva: International Catholic Child Bureau).

Dawes, A. and D. Donald
2000 "Improving children's chances; Developmental theory and effective interventions in community contexts." In Addressing Childhood Adversity, edited by D. Donald, A. Dawes, and J. Louw (Capetown: New Africa Books and David Philip).

Edgerton, J.
1994 "Working with key players for psychological and mental health services," American Psychologist 49(4): 314-21.

Garbarino, J., K. Kostelny, et al
1991 No Place To Be a Child: Growing up in a War Zone. Toronto: Lexington Books.

International Save the Children Alliance
2000 Children's Rights: Reality or Rhetoric?: The UN Convention on the Rights of the Child: The First Ten Years. London: International Save the Children Alliance.

Kos, A.M. and S. Derviskadic-Jovanovic
1998 "What can we do to support children who have been through war?" Forced Migration Review 3: 4-7.

Loughry, Maryanne and Carola Eyber, editors
2003 Psychosocial Concepts in Humanitarian Work with Children: A Review of the Concepts and Related Literature. New York: National Academies Press. Roundtable on the Demography of Forced Migration, National Research Council, Program on Forced Migration and Health at the Mailman School of Public Health, Columbia University.

Mays, V., M. Bullock, M. Rosenzweig, and M. Wessells
1996 "Ethnic conflict: Global challenges and psychological perspectives," American Psychologist 53(7): 737-42.

Psychosocial Working Group
2003 A Conceptual Framework for Psychosocial Intervention. Edinburgh: Psychosocial Working Group. *Available at*: www.forcedmigration.org/psychosocial

Save the Children Alliance
1996 Promoting Psychosocial Well-being Among Children Affected by Armed Conflict and Displacement: Principles and Approaches. International Save the Children Alliance.
1997 Keeping Children with Families in Emergencies. London: Save the Children/U.K.
2001 Creative Force: Arts-based Exercises for Work with Young People around Issues of Violence. London: Save the Children/U.K.

UNICEF
2003 Working with Children in Unstable Situations: A Guiding Manual for Psychosocial Interventions. New York: UNICEF.

Uppard, S., C. Petty, et al
1998 Working with Separated Children. London: Save the Children Fund.

Wessells, Mike G. and Carlinda Monteiro
2003 "Healing, social integration, and community mobilization for war-affected children: A view from Angola." In The Impact of War Trauma on Civilian Populations: An International Perspective, edited by T. McIntyre and S. Krippner (Westport, CT: Praeger).

Resiliency, Coping, and Social Development

Bettner, B. L. and A. Lew
1989 Raising Kids Who Can: Use Good Judgment, Assume Responsibility, Communicate Effectively, Respect Self & Others, Cooperate, Develop Self-Esteem, and Enjoy Life. Newton Centre, MA: Connexions Press.

Boothby, N.
1996 "Mobilizing communities to meet the psychosocial needs of children in war and refugee crisis." In Minefields in Their Hearts: The Mental Health of Children in War and Communal Violence, edited by R. Apfel and B. Simon (New Haven, CT: Yale University Press).

Borba, M.
1989 Esteem Builders. California: Jalmar Press

Boyden, Jo
2003 "Children under Fire: Challenigng Assumptions about Children's Reslience," Children, Youth and Environments 13(1). Retrieved June 6, 2003 from on-line journal: http://cye.colorado.edu/

Cummins, J.
1986 "Empowering minority students: A framework for intervention," Harvard Educational Review 56: 18-36.

Donald, D., A. Dawes, and J. Louw, editors
2000 Addressing Childhood Adversity. Capetown: New Africa Book/David Philip.

Farwell, N.
2001 "'Onward through strength;' Coping and psychological support among refugee youth returning to Eritrea from Sudan," Journal of Refugee Studies 14(1): 43-69.

Garmezy, N. and R. Michael, editors
1983 Stress, Coping and Development in Children. New York: McGraw-Hill.

Hagerty, B. M., J. Lynch-Sauer., K.L. Patusky, M. Bouwsema, and P. Collier
1992 "Sense of belonging: A vital mental health concept," Archives of Psychiatric Nursing 6: 172-177.
Haggerty, R., L. Sharrod, et al
1996 Stress, Risk and Resilience in Children and Adolescents; Processes, mechanisms, and Interventions. Cambridge: Cambridge University Press.
Harrell-Bond, B.
2002 Are Refugee Camps Good for Children? Geneva: United Nations High Commissioner for Refugees.
Mann, D.
1996 "Serious play," Teachers College Record 97: 446-467.
Masten, A.
2000 "Resilience in Children Exposed to Severe Adversity: Models for Research and Action." Paper presented at Children in Adversity Consultation, Oxford.
Rutter, M.
1979 "Protective factors in children's response to stress and disadvantage." In Primary Prevention of Psychopathology, Volume 3: Social Competence in Children, edited by M.W. Kint and J.E. Rolf (Hanover, NH: University Press of New England).
1985 "Resilience in the face of adversity: Protective factors and resistance to psychological disorder," British Journal of Psychiatry, 147: 598-611.
1996 Restoring Playfulness: Different Approaches to Assisting Children Who Are Psychologically Affected by War or Displacement. Stockholm: Radda Barnen.
Salvin-Williams, R. C., and T.J. Berndt
1990 "Friendship and peer relations." In At the Threshold: The Developing Adolescent, edited by S. S. Feldman & G. R. Elliot (Cambridge: Harvard University Press).
UNICEF
1999 Children in Armed Conflict. New York: UNICEF.
Women's Commission for Refugee Women and Children
2000 Untapped Potential. Social Development: A Sullivan-Piaget Perspective. Chicago: University of Chicago Press.

Trauma

Ager, A.
1999 Refugees: Perspectives on the Experience of Forced Migration. New York: Continuum.
Ahearn, F.L., editor
2000 Psychosocial Wellness of Refugees. New York: Berghahn.
Ahearn, F.L., M. Loughry, and A. Ager
1999 "The experience of refugee children." In Refugees: Perspectives on the Experience of Forced Migration., edited by A. Ager (London and New York: Pinter).
Basoglu, M., M. Parker, E. Ozmen, O. Tasdemir, and D. Sahin
1994 "Factors related to long-term traumatic stress in survivors of torture in Turkey," Journal of the American Medical Association 272: 357-63.
Bracken, P.J. and C. Petty
1998 Rethinking the Trauma of War. London: Free Association Books.
Diaz, M.
1994 "Children uprooted by war: Angola and Sierra Leone," Refugee Participation Network 24: 9-11.

Friedman, M. and J. Jaranson
1994 "The applicability of the post-traumatic stress disorder concept to refugees." Chapter 12 in Amidst Peril and Pain: The Mental Health and Well-being of the World's Refugees, edited by A. Marsella, T. Bornemann, S. Ekblad, and J. Orley (Washington, DC: American Psychological Association).

Gorst-Unsworth, C. and E. Goldenberg
1998 "Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma-related factors compared to social factors in exile," British Journal of Psychiatry 172: 90-4.

McIntyre, T. and M. Ventura
2003 "Children of war: Psychosocial sequelae of war trauma in Angolan adolescents." In The Psychological Impact of War Trauma on Civilians, edited by S. Krippner and T. McIntyre (Westport, CT: Praeger).

Mollica, Richard
2000 "Invisible Wounds," Scientific American, 46.

Orley, John
1996 "Health Activities Across Traumatized Populations: WHO's Role Regarding Traumatic Stress." In International Responses to Traumatic Stress, edited by Yael Danieli, Nigel S. Rodley, & Lars Weisaeth (Amityville, NY: Baywood Publishing Company).

Osofsky, J.D.
1995 "The effects of exposure to violence on young children," American Psychologist, 50: 782-788.

Punamaki, R.-L.
2000 How to Help Children Experiencing Traumatic Stress? An Evaluation of Long-Term Effects of Psychosocial Assistance and International Solidarity Work. Saarijarvi, Finland: STAKES.

Reichenberg, D. and S. Friedman
1996 "Traumatized Children: Healing the invisible wounds of children in war: A rights approach." In International Responses to Traumatic Stress, edited by Yael Danieli, Nigel S. Rodley, & Lars Weisaeth (New York: Baywood Publishing Company), 307 – 326.

Summerfield, D.
2000 "Childhood, war, refugeedom, and 'trauma': Three core questions for mental health professionals," Transcultural Psychiatry 37(3): 417-33.

Cultural Issues in Programming and Assessment

American Alliance For Health Physical Education
1994 Cultural Awareness and Sensitivity. American Alliance for Health, Physical Education, Recreation.

Dawes, A. and E. Cairns
1998 "The Machel Report; Dilemmas of cultural sensitivity and universal rights of children," Peace and Conflict: Journal of Peace Psychology 4(4): 335-48.

Donahue-Colletta, N., editor
1992 Understanding Cross-Cultural Child Development and Designing Programs for Children. (Washington, D.C.: PACT).

Faden R and T. Beauchamp
1986 "The Concepts of Informed Consent and Competence," and "Understanding." Chapters 8 and 9 in A History and Theory of Informed Consent (New York: Oxford University Press).

Green, J.W.
1982 Cultural Awareness in the Human Services. (Englewood Cliffs: Prentice-Hall).

Honwana, Alcinda
1998 "Healing for Peace: Traditional Healers and Post-War Reconstruction in Southern Mozambique," Peace and Conflict: Journal of Peace Psychology 3: 293-305.
1999 "Non-Western Concepts of Mental Health." In The Refugee Experience, Volume 1, edited by Maryanne Loughry and Alistair Ager (Oxford: Oxford University, Refugee Studies Programme), 103-19.

Nader, K., N. Dubrow, and B. Stamm
1999 "Honoring differences: Cultural issues in the treatment of trauma and loss." In Trauma and Loss, edited by K. Nader, N. Dubrow, and B. Stamm (Philadelphia: Bruner/ Mazel).

Nylund, V. and J.-C. Legrand
1999 "The art of psychosocial care and protection for displaced children," Forced Migration Review 6: 16-19.

Porter J.P
1995 "Basic Considerations in Informed Consent in Research," Clinical Research and Regulatory Affairs 12 (2): 95-109.

Sheppard, R.
1987 "Cultural Sensitivity." In Enhancing Child Protective Service Competency: Selected Readings, edited by D. DePanfilis (Charlotte, NC: ACTION for Child Protection).

Soler, M. and M. Peters
1993 Who Should Know What? Confidentiality and Information Sharing in Service Integration. New York: National Center for Service Integration.

Swartz, L.
1998 Culture and Mental Health. Capetown: Oxford University Press.

Wessells, M.
1999 "Culture, power, and community; Intercultural approaches to psychosocial assistance and healing," In Honoring Differences: Cultural Issues in the Treatment of Trauma and Loss, edited by K. Nader, N. Dubrow, and B. Stamm (Philadelphia: Bruner/ Mazel).

Wessells, M. G. and Carlinda Monteiro
2001 "Psychosocial interventions and post-war reconstruction in Angola: Interweaving Western and traditional approaches." In Peace, Conflict, and Violence: Peace Psychology for the 21st Century, edited by D. Christie, R.V. Wagner, and D. Winter (Upper Saddle River, NJ: Prentice-Hall).

Program Evaluation Guidelines

Ager, A.
2000 "Psychosocial programs: principles and practice for research and evaluation." In Psychosocial Wellness of Refugees. Issues in Qualitative and Quantitative Research, edited by F. L. Ahearn (Oxford: Berghahn Books).

Connor, A.
1993 Monitoring and Evaluation Made Easy: A Handbook for Voluntary Organizations. Edinburgh: HMSO.

Fitz-Gibbon, C. and L. Morris
1988 How to Design a Program Evaluation (Program Evaluation Kit, Vol. 3). Newbury Park, CA: Sage Publications.

Gosling, L.
1994 Toolkits on Assessment, Monitoring, Review and Evaluation. London: Save the Children Fund, U.K.

Kellogg, W.K., Foundation
2001 Evaluation Handbook. Battle Creek, Michigan: W.K. Kellogg Foundation. Available in PDF format: http://www.wkkf.org/Programming/Overview.aspx?CID=281
Logan, T., D. Padgett, D. Royse, and B. Thyer
2000 Program Evaluation: An Introduction. Wadsworth Publishing Company.
Patton, Michael Quinn
1986 Utilization-Focused Evaluation. Newbury Park, CA: Sage Publications.
Rossi, P., H. Freedman, and M. Lipsey
1999 Evaluation: A Systematic Approach. Newbury Park, California and London: Sage Publications, Inc..
Stecher, Brian M.
1987 How to Focus an Evaluation. Newbury Park, CA; Sage Publication.
Thomas, A.
2000 Valuing Evaluation: A Practical Approach to Designing an Evaluation That Works for You. The Hague: Bernard van Leer Foundation.
United Ways of America
1999 Measuring Program Outcomes: A Practical Approach. Plenum Publishing Corporation.
Van der Eyken, W.
1992 Introducing Evaluation. The Hague: Bernard van Leer Foundation.
Weiss, Heather B. and Francine H. Jacobs, editors
1988 Evaluating Family Programs. New York: de Gruyter.
Worthen, B.
1996 Program Evaluation: Alternative Approaches and Practical Guidelines (2nd Edition). (Reading, MA: Addison-Wesley Publishing Company).

Logic Models

Cummings, H.F.
1997 "Logic Models, Logical Framework and Results-Based Management: Contrasts and Comparisons," Canadian Journal of Development Studies XVIII: 587-596.
Diana, D., D. Julian, and A. Jones
1995 "Open Systems Evaluation and the Logic Model: Program Planning and Evaluation Tools," Evaluation and Program Planning 18(4): 333-341.
Julian, D.
1997 "The Utilization of the Logic Model as a System Level Planning and Evaluation Device," Evaluation and Program Planning 20(3): 251-257.
Kellogg, W.K., Foundation
2001 Logic Model Development Guide. Battle Creek, Michigan: W.K. Kellogg Foundation. Available in PDF format: http://www.wkkf.org/Programming/Overview.aspx?CID=281

Research Design and Methods

Angrist, Joshua D., Guido W. Imbens, and Donald B. Rubin
1996 "Identification of Causal Effects Using Instrumental Variables," Journal of the American Statistical Association 91(434): 444-455.
Babbie, E.
1997 "Chapter 4, Types of Study Design." In Survey Research Methods, 2nd edition, edited by P. Rossi and H. Freedman (Belmont, California: Wadsworth Publishing Company).

Berk, R. A.
1989 "What your mother never told you about randomized field experiments." No. 44 in the UCLA Statistic Series. (Unpublished report available from the author, Department of Sociology and Program in Social Statistics, University of Southern California, Los Angeles, CA.)

Bernard, H. Russell
1995 Research Methods in Anthropology; Qualitative and Quantitative Approaches, 2nd Edition (Walnut Creek, California: Sage Publications, Inc.).

Blalock, H. M., editor
1974 Measurement in the Social Sciences: Theories and Strategies. Chicago: Aldine Publishing Company.

Boruch, R. F., A. J. McSweeny, and E. J. Soderstrom
1978 "Randomized field experiments for program planning, development, and evaluation," Evaluation Quarterly 2:655-95.

Boruch, R. F. and W. Wolhke, editors
1985 "Randomization and field experimentation," New Directions in Program Evaluation Series, 28. San Francisco: Jossey-Bass.

Christensen, L. B.
1988 Experimental Methodology. Boston: Allyn and Bacon.

Cone, J.
1999 "Observational assessment: Measure development and research issues." In Handbook Of Research Methods in Clinical Psychology, edited by Kendall, Bucher, and Holmbeck (John Wiley & Sons, Inc: New York), 191.

Cook, T. D., and D.T. Campbell
1979 Quasi-experimentation: Design and Analysis Issues. Boston, MA: Houghton Mifflin Company.

Heiman, G. A.
1999 Research Methods in Psychology. Boston. Houghton Mifflin.

Hulley S.B. and S.R. Cummings
1988 Designing Clinical Research. Baltimore: Williams & Wilkins.

Jacob, E.
1990 "Alternative approaches for studying naturally occurring human behavior and thought in special education research," The Journal of Special Education 24(2): 195-211.

McClelland, G.H.
1997 "Optimal design in psychological research," Psychological Methods 2: 3-19.

Mansfield, D.
1997 Evaluation: Tried and tested? A review of Save the Children evaluation reports. London: Save the Children/U.K.

Marsella, A., L. Levi, and S. Ekblad
1997 "The importance of including quality-of-life indices in international social and economic development activities," Applied & Preventive Psychology 6: 55-67.

Popham, James, W.
2001 "The Mystique of Standardized Measuring Instruments," Chapter 3 in The Truth About Testing: An Educator's Call to Action. (Alexandria, VA: Association for Supervision and Curriculum Development).

Rogler, Lloyd
1999 "Methodological sources of cultural insensitivity in mental health research," American Psychologist 54(4): 424-33.

Sattler, J.
2002 Assessment of Children: Behavioral and Clinical Applications. California: Jerome J. Sattler, Publisher, Inc.
Shaughnessy and Zechmeister
1994 "Quasi-Experimental Designs and Program Evaluation." In Research Methods in Psychology, 3rd Edition. (New York, NY: McGraw-Hill Publishing).
Trochim, W.M.K.
1984 Research Design for Program Evaluation: The Regression-Discontinuity Approach. Thousand Oaks, California: Sage Publications.
Trochim, W.M.K.
2000 The Research Methods Knowledge Base, 2nd Edition. Cincinnati: Atomic Dog Publishing.
Zhu, Shu-Hong
1999 "A Method to Obtain a Randomized Control Group where it seems Impossible," Evaluation Review 23(4): 363-77.

Interview and Survey Methods

Acquadro, C., B. Jambon, D. Ellis, and P. Marquis
1996 "Language and translation issues." In Quality of Life and Pharmacoeconomics in Clinical Trials, Second Edition, edited by B. Spilker (Philadelphia: Lippincott-Raven), 575-585.
Mangione, T.W.
1990 Standardised Survey Interviewing. Newbury Park, California: Sage Publications.
Merton, R.K., M. Fiske, and P.L. Kendall
1990 The Focused Interview: a Manual of Problems and Procedures, 2nd edition. (London: Collier MacMillan).
Rubin, H. and I. Rubin
1995 Qualitative Interviewing: The Art of Hearing Data. Newbury Park, California: Sage Publications.
Salant, P. and D. A. Dillman
1994 How to Conduct Your Own Survey. New York: John Wiley & Sons, Inc.

Qualitative Research Methods

Ahearn, F.L., editor
2000 Psychosocial Wellness of Refugees: Issues in Qualitative and Quantitative Research (Studies in Forced Migration, Vol. 7. London: Berghahn.
Camic, P., J. Rhodes, and L. Yardley, editors
2003 Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design. Washington, DC: American Psychological Association.
Flick, U.
2002 An Introduction to Qualitative Research. Newbury Park, California: Sage Publications
Kreuger, R.A.
1988 Focus Groups: A Practical Guide for Applied Research. Newbury Park, California: Sage Publications, Inc.
Marshall, Catherine and Gretchen B. Rossman
1995 Designing Qualitative Research. Thousand Oaks, California: Sage Publications, Inc.
Maxwell, J.
1996 Using Qualitative Research to Develop Causal Explanations. Harvard University: Harvard Project on Schooling and Children.

Patton, Michael Quinn
1990 Qualitative Evaluation and Research Methods. Newbury Park, California: Sage Publications.
Silverman, D.
2000 Doing Qualitative Research: A Practical Handbook. Newbury Park, California: Sage Publications.

Participatory Methods

Boyden, J.
1997 Children in Focus: A Manual for Participatory Research with Children. Stockholm: Rädda Barnen.
Brydon-Miller, M. and D. Tolman, editors
1997 "Transforming psychology: Interpretive and participatory research methods," Journal of Social Issues 54(4).
Chambers, R.
1992 Rural Appraisal: Rapid, Relaxed, and Participatory. Sussex: HELP and the Institute of Development Studies, Discussion Paper 311.
Christensen, P. and A. James, editors
2000 Research with Children. London: Falmer Press.
Fajerman, L., M. Jarrett, et al
2000 Children as Partners in Planning: A Training Resource to Support Consultation with Children. London: Save the Children Fund, U.K.
Feuerstein, M.-T.
1986 Partners in Evaluation: Evaluating Development and Community Programmes with Participants. London: MacMillan.
Freire, P.
1972 Pedagogy of the Oppressed. Harmondsworth, UK: Penguin.
Hart, R.
1997 Children's Participation: The Theory and Practice of Involving Young Children in Community Development and Environmental Care. New York: UNICEF.
Howard-Grabman, L. and G. Snetro
2003 How to Mobilize Communities for Health and Social Change; A Field Guide. Baltimore: Health Communication Partnership, Johns Hopkins Population Information Program.
Jareg, E. and P. Jareg
1994 Reaching Children through Dialogue. London: Save the Children Fund and MacMillan.
Johnson, V., E. Ivan-Smith, G. Gordon, P. Pridmore, and P. Scott, editors
1998 Stepping Forward: Children and Young People's Participation in the Development Process. London: Intermediate Technology Publications.
Kirby, P.
1999 Involving Young Researchers: How to Enable Young People to Design and Conduct Research. York, U.K.: Joseph Rowntree Foundation.
Lewis, A. and G. Lindsay, editors
2000 Researching Children's Perspectives. Buckingham: Open University Press.
McCracken, Jennifer A., Jules N. Pretty, and Gordon R. Conway
1988 An Introduction to Rapid Rural Appraisal for Agricultural Development. London: International Institute for Environment and Development.
PLA Notes
1998 "Participatory monitoring and evaluation," PLA Notes 31.

Pretty, J., I. Guijt, et al
1995 A Trainer's Guide for Participatory Learning and Action. London: International Institute for Environment and Development.
Refugee Participation Network
1997 "Children and Youth," Refugee Participation Network, 24.
Save the Children Fund, U.K.
2001 Children and Participation: Research, Monitoring, and Evaluation with Children and Young People. London: Save the Children Fund, U.K.
Theis, J. and H. Grady
1991 Participatory Rapid Appraisal for Community Development. London: Save the Children Fund.
White, S., editor
1999 The Art of Facilitating Participation: Releasing the Power of Grassroots Communication. New Delhi, India: Sage Publications.

Ethnographic Methods

Adler, Patricia and Peter Adler, Peter
1994 "Observational Techniques," In Handbook of Qualitative Research, edited by Norman Denzin and Yvonna S. Lincon (Newbury Park, California: Sage).
Atkinson, P.
1990 The Ethnographic Imagination: Textual Constructions of Reality. London: Routledge.
Bakeman, R.
2000 "Behavioral observations and coding." In Handbook of Research Methods in Social Psychology, edited by H. T. Reis & C. K. Judd (New York: Cambridge University Press).
Blomberg, J., J. Giacomi, A. Mosher, and P. Swenton-Hall
1993 "Ethnographic field methods and their relation to design." In Participatory Design: Principles & Practices, edited by D. Schuler and A. Namioka (New Jersey: Lawrence Erlbaum / Fowler).
Fetterman, D.M.
1998 Ethnography: Step by step. 2nd edition. Newbury Park, California: Sage Publications.
Johnson, J. C.
1990 Selecting Ethnographic Informants (Vol. 22). Thousand Oaks, CA: Sage.
Sampson, R.J. & Raudenbush, S.W.
(In press)"Systematic social observation of public spaces: A new look at disorder in urban neighborhoods," American Journal of Sociology.
Spradley, James P.
1980 Participant Observation. Orlando, FL: Harcourt Brace Jovanovich College Publishers.
Webb, E., D. Campbell, R. Schwartz, and L. Sechrest
2000 Unobtrusive Measures (revised edition). Thousand Oaks, California: Sage Publications, Inc.

Sampling

Kish, L.
1965 Survey Sampling. New York: John Wiley & Sons, Inc.
Magnani, R.
1997 The Food and Nutrition Technical Assistance (FANTA) Sampling Guide. *Available at* www.fantaproject.org.
Thompson, S.
2002 Sampling. New York: John Wiley & Sons, Inc.

Measurement Instruments and Scales

The following list is by no means exhaustive; nor does inclusion in this list necessarily imply an endorsement or recommendation by the International Psychosocial Measurement Committee. The measurement instruments included here are only examples and, with few exceptions, have not been validated cross-culturally. Reviews of these and other instruments and scales can be found in the Mental Measurement Yearbook (Lincoln, Nebraska: Buros Institute of Mental Measurement) and Test Critiques (Austin, Texas: Pro-Ed).

Adaptive Behavior Inventory for Children (ABIC). 1982. Mercer, J. R., & Lewis, J. F. The Psychological Corporation.

Beck Depression Inventory II. 1996. Beck, A.T. San Antonio: Harcourt, Brace & Co.

Beck Depression Inventory (2nd edition). 1996. Beck, A.T., R.A. Steer, and G.K. Brown. San Antonio, TX: The Psychological Corporation.

Beck Hopelessness Scale. 1993. Beck, A. T. San Antonio, TX: The Psychological Corporation.

Child Behavior Checklist, Revised/4-18 (Achenbach). 1991. Achenbach, T. M. University of Vermont Department of Psychiatry.

Child Behavior Checklist, Revised/2-3 (Achenbach). 1992. Achenbach, T. M. University of Vermont Department of Psychiatry.

*Children's Apperception Test***.** 1987. Bellak, L., M.D., & Bellak, S. CPS.

Children's Attributions and Perceptions Scale (CAPS). Maccarino, et al.

Coloured Progressive Matrices. 1962. Raven, J.C. Oxford: Oxford Psychologists Press.

K-ABC. 1983. Kaufman, A.S. and N.L. Kaufman. Kaufman Assessment Battery for children. Circle Pines, MN: American Guidance Service.

Measures of Psychosocial Development (MPD). 1988. Hawley, G. A. Psychological Assessment Resources.

Parenting Stress Index (PSI). 1990. Abidin, R.R. Pediatric Psychology Press.

Piers-Harris Children's Self Concept Scale, Second Edition (Piers-Harris 2). 2002. Piers, E.V. and Herzberg, D.S. WPS.

Profiles of Student Life: Attitudes and Behaviors (PSL-AB). 1990. Minneapolis: The Search Institute.

Revised Behavior Problem Checklist. 1987. Quay, H. C. and Peterson, D. R. Behavior checklist completed by parent/teacher with 89 items and scales for conduct disorder, socialization-aggression, attention problems, etc. Ages 6-18, 20 minutes to complete.

Revised Child Manifest Anxiety Scale (RCMAS). 1994. Reynolds, C. R. and Richmond, B. WPS.

Reynolds Adolescent Depression Scale - 2nd Edition (RADS-2). 2002. Reynolds, W. M. WPS.

Reynolds Child Depression Scale (RCDS). 1989. Reynolds, W. M. PAR.

Rosenberg Self Esteem Scale. 1989. Rosenberg, M. Princeton: Princeton University Press.

Standard Progressive Matrices. 1962. Raven, J.C., J.H. Court, and J. Raven. Oxford: Oxford Psychologists Press.

State Hope Scale. 2000. Snyder, C.R., et al. In: *Handbook of Psychological Change: Psychotherapy Processes and Practices for the 21st Century*, edited by C.R. Snyder & R. E. Ingram (New York: John Wiley & Sons), Chapter 7.

State-Trait Anger Expression Inventory - 2 (STAXI-2). 1999. Spielberger, C.D. WPS.

Strengths and Difficulties Questionnaire. 2000. Robert Goodman.

Stress Profile. 1999. Nowack, K. M. WPS.

Tennessee Self-Concept Scale. 1994. Roid, G. H., and Fitts, W. H. WPS.

TONI-3. 1997. Brown, L., R. Sherbenou, and S. Johnsen, Test of nonverbal intelligence, a language-free measure of cognitive ability, 3rd edition (Austin: Pro. Ed.).

Trait Hope Scale. 2000. Snyder, C.R., et al. In: Handbook of Psychological Change: Psychotherapy Processes and Practices for the 21st Century, edited by C.R. Snyder & R. E. Ingram (New York: John Wiley & Sons), Chapter 7.

Youth Coping Index. 1995. Hamilton McCubbin, Anne Thompson, and Kelly Elver.

Cross-Cultural Adaptation of Measurement Scales

Lonner, W.
1990 "An overview of cross-cultural testing and assessment," Applied Cross-Cultural Psychology 14: 56-76.

Van de Vijver, F. and Hambleton, R.
1996 "Translating Tests: Some practical guidelines," European Psychologist 1 (2):89-99.

Training Guides

ARC (Action for the Rights of Children)
2001 Action for the Rights of Children (ARC): A Rights-based Training and Capacity Building Initiative. Geneva: UNHCR/SCF/UNICEF.

Hope, A. and S. Timmel
1995 Training for Transformation. A Handbook for Community Workers. Gweru, Zimbabwe: Mambo Press.

Loughry, M. and A. Ager
2001 The Refugee Experience: A Training Module. Oxford: Refugee Studies Centre.

Macksoud, M.
1993 Helping Children Cope with the Stresses of War. A Manual for Parents and Teachers. New York: UNICEF.

Revell, B.
2000 Playing with Rainbows: A Manual. Toronto: YWCA Canada.

Richman, N.
1998 In the Midst of a Whirlwind: A Manual for Helping Refugee Children. Stoke-on-Trent, UK: Trentham Books.

Richman, N. and D. Pereira
1992 Helping Children in Difficult Circumstances. A Teacher's Manual. London: Save the Children Fund, U.K.

Save the Children Fund, U.K.
2001 In Safe Hands: A Resource and Training Pack to Support Work with Young Refugee Children. London: Save the Children Fund, U.K.

Segerstrom, E.
1995 Focus on Refugee Children: A Handbook for Training Field Refugee Workers in Social and Community Work. Stockholm: Rädda Barnen.

Tefferi, H.
1999 Psychosocial Needs of Children in Armed Conflict and Displacement. A Module for Training Teachers and Caregivers. Stockholm: Rädda Barnen.

Treseder, P.
1997 Empowering children and young people. Training Manual. Promoting involvement in decision-making. London: Save the Children Fund, U.K.

Victorian Foundation for Survivors of Torture
1996 Guide to Working with Young People Who Are Refugees. Parkville, Victoria: Victorian Foundation for Survivors of Torture.

Reports, Project Examples, and Case Studies

Adjukovic, M. and V. Busko
1997 School-based Health and Peace Initiative; Trauma Healing and Peaceful Problem-Solving Program for Primary Schools in Western and Eastern Slovenia. Zagreb: UNICEF, CARE, McMaster University Project, Croatian Ministry of Education and Sports.

Agger, I., E. Jareg, A. Herzberg, J. Mimica and C. Rebien
1999 Evaluation of Norwegian Support to Psycho-Social Projects in Bosnia-Herzegovina and the Caucasus. Norway: The Royal Ministry of Foreign Affairs.

Al-Eissa, Y.A.
1995 "The impact of the Gulf armed conflict on the health and behavior of Kuwaiti children," Social Science and Medicine 41: 1033-1037.

Blomqvist, U.
1995 Protection of Children in Refugee Emergencies: The Importance of Early Social Work Intervention—The Rwandan Experience. Stockholm: Radda Barnen.

Boyden, J.
1997 Children of War: Responses to Psycho-social Distress in Cambodia. Geneva: United Nations Research Institute for Social Development.

de Berry, Jo, A. Fazili, S. Farhad, F. Nasiry, S. Hashemi, M. Hakimi
2003 The Children of Kabul: Discussions with Afghan Families. Westport, CT: Save the Children Federation, Inc. and UNICEF. Available on-line at: http://s6.savechildren.org/publications/children_of_kabul.pdf

De Jong, J.T.V.M. and J.M.A. Hermanns
1999 "The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda; An exploratory study," Journal of Child Psychology and Psychiatry 40(4): 529-36.

Demusz, K
2000 Listening to the Displaced: Action Research in the Conflict Zones of Sri Lanka. Oxford: Oxfam.

Dybdahl, R.
2001 "Children and mothers in war: An outcome study of a psychosocial intervention program," Child Development 72(4): 1214-30.

Gibbs, S.
1994 "Post-war social reconstruction in Mozambique; re-framing children's experience of trauma and healing," Disasters 18(3): 268-76.

Honwana, A.
1997 "Healing for peace; Traditional healers and post-war reconstruction in Southern Mozambique," Peace and Conflict: Journal of Peace Psychology 3(3): 293-305.

Jareg, Elizabeth, Lenhart Falk, and GUSCO (Gulu Support the Children Organisation)
1999 Steps in the Development of a Monitoring and Evaluation System for Centre- and Community-based Psychosocial Work with War-Affected Children in Uganda. Redd Barna, Norway and Red Barnet, Denmark.

Save the Children Fund, U.K.
2001 Breaking through the Clouds: A Participatory Action Research (PRA) Project with Migrant Children and Youth along the Borders of China, Myanmar and Thailand. London: Save the Children Fund, U.K.

Schembri, G.
1997 Liberia's Ex-Child Fighters: A Narrative Account of the Work of Save the Children Fund, UK, in Liberia. London: Save the Children Fund, U.K.

Segerstrom, E.
1994 From Exposed to Involved: An Action-Oriented Study of Somali Refugee Mothers' Psychological Well-Being and Their Sense of Competence to Care for Their Children. Stockholm: Rädda Barnen.

Shaw, J. and J. Harris
1994 "Children of war and children at war; Child victims of terrorism in Mozambique." In Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos, edited by R. Ursano, B. McCaughey, and C. Fullerton (Cambridge: Cambridge University Press).

Smith, P., S. Perrin, et al
2002 "War exposure among children from Bosnia-Herzegovina: Psychological adjustment in a community sample," Journal of Traumatic Stress 15(2): 147-56.

Stubbs, P. and B. Soroya
1996 "War trauma, psycho-social projects and social development in Croatia," Medicine, Conflict and Survival 12: 303-14.

Summerfield, D.
1999 "A critique of seven assumptions behind psychological trauma programmes in war-affected areas," Social Science & Medicine 48: 1449-62.

Williams, G., C. Aloyo Obonyo, et al
2001 Resilience in Conflict: A Community-Based Approach to Psycho-Social Support in Northern Uganda. Kampala: AVSI, UNICEF.

PERFORMANCE MONITORING & EVALUATION PLAN

INDICATORS	**Baseline**	**Target**	**Data Source**	**Data Collection**	
				Frequency of collection	**Staff person responsible**
STRATEGIC OBJECTIVE 1:					
Intermediate Result 1.1:					
Intermediate Result 1.2:					
STRATEGIC OBJECTIVE 2:					
Intermediate Result 2.1:					

INDICATORS	**Baseline**	**Target**	**Data Source**	**Data Collection**	
				Frequency of collection	**Staff person responsible**
Intermediate Result 2.2:					
STRATEGIC OBJECTIVE 3:					
Intermediate Result 3.1:					
Intermediate Result 3.2:					