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MEASURING IMPACT
THROUGH A CHILD PROTECTION INDEX

FINAL REPORT

Time 1 & Time 2 Studies
Kiziba Camp, Rwanda

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CPC LEARNING NETWORK

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PLAN INTERNATIONAL

LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
AHA	Africa Humanitarian Action
ARC	American Refugee Committee
AVSI	Associazione Volontari per il Servizio Internazionale
BIA	Best Interest Assessment
BID	Best Interest Determination
CBCPM	Community-Based Child Protection Mechanism
CFS	Child Friendly Space
CPI	Child Protection Index
DRC	Democratic Republic of the Congo
ECD	Early Childhood Development
FSDS	Foundation Saint Dominique Savio
GHH	Global Help to Heal
ICRC	International Committee of the Red Cross
LAF	Legal Aid Forum
MAJ	Maison d'Accès à la Justice
MIDIMAR	Ministry of Disaster Management and Refugee Affairs.
NGO	Non-Government Organization
RCT	Randomized Controlled Trial
SGBV	Sexual and Gender Based Violence
T2	Time 2
UASC	Unaccompanied and Separated Children
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Program

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EXECUTIVE SUMMARY

The CPC Learning Network and United Nations High Commissioner for Refugees [UNHCR] have been working together since 2013 to develop, pilot and implement a new methodology to assess child protection system strength, and its impact on child protection outcomes, in displacement settings.

Child protection policy and programming is based on the assumption that strengthening the child protection system will reduce risks and improve outcomes for children in displacement settings. Yet, the evidence base for this proposition is extremely limited. This project, "Measuring Impact Through a Child Protection Index," [henceforth referred to as "the CPI Study"], seeks to test this assumption, assessing whether a strong child protection system can better protect children and prevent harm. The CPI Study seeks to assess changes in child protection system strength, and related changes in child protection outcomes, seeking to develop assessment tools and a test a methodological approach to strengthen the evidence-base for child protection interventions in humanitarian settings.

The evidence-base for child protection in humanitarian settings is extremely limited, despite a clear need to prevent and respond to harms present for children in such contexts. Methodologies generally used to explore efficacy, effectiveness, and impact of child protection initiatives are insufficient and tend to lack standardization and rigor (see for example, Wessells, 2009; Ager et al., 2013). The development and testing of new methodologies to capture the impacts of child protection activities in humanitarian settings are a priority for the child protection sector. Moreover, the value of a systems-strengthening approach is now widely accepted and underpins recent policy and programming efforts in the field (Child Frontiers on behalf of the Systems Strengthening and Disaster Risk Reduction Task Force, 2016). Therefore, there is also a need for concerted effort to develop and test approaches to measure systems, rather than single interventions. The CPI Study responds to this need, establishing a methodological approach that combines rigorous qualitative and quantitative methods with a systems-level approach.

A system is defined as "a collection of components or parts that are organized around a common purpose or goal" UNICEF, 2010). Systems thinking, and systems strengthening, has been identified as an approach that enables more holistic approaches to children's protection issues in humanitarian settings. As a recent analysis notes,

> *"Systems thinking looks at an entire situation, taking into account all the different elements and factors and how they interrelate to one another. Rather than looking at protection issues in isolation, or a specific service available to children, systems thinking brings together the range of problems facing the child, the root causes, and the solutions provided at all levels. It promotes flexible programming with integrated learning and adaptation as implementation takes place."*
>
> Child Frontiers, 2016

UNHCR's 2012 *Framework for the Protection of Children* takes a child protection systems approach; the CPI Study uses the *Framework* as the starting point for measuring what interventions – services, policies and procedures – considered to be central to preventing and responding to violence, abuse, neglect and exploitation of refugee children. Further definition of a systems-level approach, the shift towards systems-strengthening in the field of child protection, and rationale for the present research on child protection systems in displacement settings is presented in Textbox 3.

This report describes the research conducted in 2015 in Kiziba camp, presenting a comparison of child protection system strength between 2013 and 2015, and child protection outcomes over the same time period, and key lessons, both in terms of methodology and the child protection situation for adolescent refugees in Kiziba camp.

Methodology

The CPI Study utilized a mixed methods approach to assess child protection system strength, child protection outcomes, and perceptions of reasons for change in and associations between system strength and outcomes. Three different data collection methods were employed – key informant interviews, adolescent and caregiver surveys, and focus group discussions – at three different time points – Time 1 [T1, December 2013], Time 2 [T2, October-November 2015] and follow-up [April 2016].

The CPI Study seeks to operationalize UNHCR's *Framework*, and its objectives using the Child Protection Index, an instrument developed for this study to assess overall child protection system strength. At T1 and T2, data was collected for the CPI, primarily via key informant interviews with child protection practitioners in Rwanda. At T1 and T2, adolescent and caregiver surveys were conducted to collect data assessing child protection outcomes. At T2, focus group discussions were conducted with adolescents to identify opportunities and barriers for adolescents' utilization of child protection activities and interventions and perceptions of quality of interventions. At follow-up, key informant interviews and focus group discussions with adolescents and caregivers were conducted, to explore reasons for observed change in child protection system strength and child protection outcomes across the study period.

Several key elements of the methodology are notable: firstly, the CPI Study focuses on child protection *systems*, rather than specific interventions, as operationalized through the CPI instrument, reflecting shifts in policy and thinking about how to effectively address child protection in humanitarian contexts (Child Frontiers on behalf of the Systems Strengthening and Disaster Risk Reduction Task Force, 2016). Secondly, the longitudinal aspect of the study allows for assessment of change over time, and conclusions regarding potential influences on those changes, rather than simply providing a snapshot of system strength, or prevalence of risks at one point in time. Thirdly, the inclusion of a qualitative follow-up phase of research expands understanding of the associations and changes identified in the quantitative comparative analysis. Future iterations of the study methodology can build on these strengths, and address questions of adaptation of the instruments for implementation by practitioners in field settings.

Findings

Comparison of child protection system strength between 2013 and 2015 indicates that the total score for Kiziba Camp increased 18.5 points (out of a potential 100 points) from the 2013 level, while the strength of the child protection system remained at a moderate level. Some areas of the system showed stability, including a range of policies and procedures designed to prevent child protection risks, and provision of services including adolescent clubs and committees, sports and recreational activities, and technical and vocational activities. Some areas, however, showed lack of improvement or decrease in strength, including gender parity in teaching staff, accessibility of education for children with disabilities, reporting of violent experiences, and utilization of services following sexual violence victimization. Improvements in system strength were also noted; particularly, improvement was documented with respect to procedures (including percentage of children born and registered and unique ID card for adolescents), services (adolescent age-appropriate complaint mechanisms), and utilization (adolescents who have used a community-based child protection mechanism [CBCPM] in past year and who participated in clubs and committees).

To move from 'moderate' to 'high', the child protection system must maintain the current levels of programming and services while increasing the focus on service utilization, the weakest performing domain here. Moreover, while there are some promising improvements in child protection outcomes – for example, reduction in caregivers' perceptions of appropriateness of beating in response to children's behavior and increased participation in adolescent-focused activities – these improvements do not yet appear to have had significant effects on exposure to violence, well-being and feelings of safety.

At T2, adolescents continued to report high levels of exposure to violence and abuse in the home and community. 28.3% of adolescents reported ever experiencing any psychological abuse, 27.5% reporting that this had occurred at least once in the past year. 25.9% reported ever experiencing physical abuse, 24.3% reporting that this had occurred at least once in the past year. In 2015 4.8% of adolescents reported experiencing some type of sexual abuse within the past year. Comparison of T1 and T2 data indicates increases of some forms of violence and


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some limited evidence of reduction of violence. For example, adolescents were nearly six times as likely in 2015 as in 2013 to report having been threatened or injured with a weapon on school property. Adolescents generally reported experiencing less sexual violence in 2015 than in 2013 (aOR = 0.34, 95% CI: 0.14-0.83, after adjusting for age and gender), however girls were still 2.6 times (95% CI: 1.0-6.8) as likely to report having experienced sexual violence as compared to boys (after adjusting for age and time). Adolescents were less likely to report violence on school premises in 2015 compared to 2013. Through qualitative focus groups, adolescents emphasized that physical and sexual abuse constitute major risks for adolescents in Kiziba Camp, along with parental neglect and child labor. Adolescents attributed these experiences to drug and alcohol abuse, and key informants further described the interrelationship between violence against adolescents in the home and difficulties in livelihoods and socio-economic standards. Lack of access to livelihood opportunities, the length of displacement, and lack of apparent future opportunities for both adolescents and adults in Kiziba Camp contributes to levels of violence in this context. There was a significant reduction in caregiver reported acceptability of child maltreatment, specifically physical abuse, from 2013 to 2015. This is a promising outcome, with potential impacts on caregiver use of violence against children in the home.

Surveys with adolescents indicated an overall worsening of psychosocial well-being. In the analysis of the full sample, there is an increase in mean levels of symptoms of anxiety and emotional problems, and a decrease in mean level of resilience. Moreover, when conducting the matched analysis (comparing only respondents who were interviewed both at T1 and T2), worsening of psychosocial well-being is seen across all indicators: an increase in levels of symptoms of anxiety and emotional problems, and reduction in levels of hope and resilience. Both sets of analysis provide strong evidence for a reduction in psychosocial well-being across a number of measures. This degradation could be related to the sustained high levels of violence in the camp, and that over time have left adolescents feeling less and less optimistic about their current life and future.

Findings from qualitative work suggest that financial constraints, insecurity, teenage pregnancy, and drug and alcohol abuse are potential sources of adolescent stress and hopelessness. Increases in participation in adolescent-focused activities, which are hypothesized to improve adolescent well-being in the camp, have not improved adolescent psychosocial well-being.[1] It appears that services and activities are not sufficient to address the hopelessness many adolescents reported feeling. Lack of access to secondary education had been reported as a factor influencing psychosocial well-being, and leading to drug and alcohol use; expansion of educational opportunities in Kiziba was welcomed by adolescents and caregivers. The impact of these increased educational opportunities on psychosocial well-being is not yet evident, as these changes in educational opportunities are recent and occurred shortly before or during the follow-up research for this CPI Study.

[1] Decreased psychosocial well-being is assessed across the whole sample and is not restricted to adolescents who participated in adolescent-focused activities.

Comparative analysis indicates that adolescents are more likely to report feeling unsafe in public spaces – on the way to and from school, or on the way to and from the market – in 2015 compared to 2013. Significantly fewer adolescents reported having a safe space to be with friends in 2015 (33.1%) than in 2013 (48.8%). Follow-up research reveals a complex picture related to safety: adolescents continue to report various threats to safety in Kiziba, particularly at night, however caregivers and key informants note several improvements in this area – reintroduction of police in the camp, and changes in the camp security committee – have ensured that reporting of security threats has improved. This disagreement also brought to light the issue that caregivers often perceive adolescents' feelings of safety to be related to their poor behavior in the camp, including moving around at night in groups and girls visiting boys in their homes. This disjuncture between adolescent and caregiver perceptions of safety – that adolescents perceive real risks to their safety moving around the camp, whereas caregivers often perceive adolescents to be behaving irresponsibly and putting themselves at risk – was reported to be a reason why adolescents may not disclose problems, including abuse, to caregivers. Adolescents' concerns for safety are correlated with increased symptoms of anxiety and emotional problems, and decreased levels of resilience, indicating the need to address perceptions of safety in order to improve overall well-being.

The findings indicate a mixed picture in terms of knowledge and utilization of services and activities. Adolescents reported a high level of knowledge of child protection activities and services in 2015, for example, 85.6% knew where to go if they experienced violence or abuse and 74.3% if they had a problem at home. Adolescent reporting of general utilization ("have you ever asked for help from a Child Protection Committee") has increased from 2013, however, reported utilization of the specific named community-based child protection mechanisms – Nkundabana, **Ijwi ry'abana or Abarengerabana** ("have you ever asked for help from Nkundabana, for example) is low. This may reflect that there are other organizations and structures that adolescents perceive as Child Protection Committees that they are reporting utilizing, or that they are utilizing the named CBCPMs without knowing their specific titles.

Knowledge of where to go to report sexual violence or a problem at school has decreased since 2013.

TEXTBOX 1:

SIGNIFICANT CHANGES AND STABILITY IN CHILD PROTECTION OUTCOMES – KEY FINDINGS

One of the objectives of the CPI Study was to identify changes in child protection outcomes – exposure to child protection risks, and levels of adolescent well-being – over the course of the study. Therefore, the CPI Study implemented the same survey to adolescents and caregivers at T1 and T2, and tested whether the level of a specific outcome – for example, exposure to verbal abuse in the past year – had changed.

The CPI Study in Kiziba Camp, Rwanda, identified the following significant changes.

Violence:

- Reduction in unwanted sexual touching (from 7.8% in 2013 to 2.8% in 2015; p-value=.030)
- Reduction in reporting of ever having been threatened by a knife or gun in the home (1.6% in 2013, 0.0% in 2015; p-value=.050)
- Increase in prevalence of past-year exposure to adults arguing in the home in a way that frightened (91.4% in 2013; 98.3% in 2015; p-value=.010)
- Reduction in any type of violence experienced at school (physical, psychological or sexual) in 2015 compared to 2013 (aOR=0.34, 95% CI: 0.14-0.83)
- Caregiver attitude towards physical abuse: significant decrease in acceptability of physical abuse if a child does not want to go to work (32.8% in 2013 to 22.2% in 2015; p-value=.027) or if a child does not care for his/her siblings (21.6% in 2013 to 13.5% in 2015; p-value=.044).

Psychosocial well-being and feelings of safety:

- Increase in mean level of symptoms of anxiety (1.7 in 2013 to 2.2 in 2015; p-value=.046)
- Increase in mean levels of symptoms of emotional problems (3.1 in 2013 to 3.8 in 2015; p-value=.03)
- Decrease in mean levels of resilience (55.3 in 2013 to 51.5 in 2015; p-value=<.001)

- Increase in reporting of feeling unsafe on the way to or from school in the past week in 2015 compared to 2013 (aOR=3.7, 95% CI: 1.95, 7.01)
- Increase in reporting of feeling unsafe on the way to or from the market in 2015 compared to 2013 (aOR 2.0, 95% CI: 1.01, 3.79).

Services – knowledge and utilization

- Reduction in adolescents reporting they have a safe space to be with friends (48.8% in 2013 to 33.1% in 2015, p-value=.003)
- Reduction in proportion of adolescents who know of a place to go if they experience violence or abuse (93.7% in 2013 to 86.5% in 2015, p-value=.034) or if they have a problem at school (91.9% in 2013 to 83.3% in 2015, p-value=.026).
- Increase in proportion of adolescents reporting they know where to go for a health problem (90.7% in 2013 to 97.6% in 2015, p-value=.003)
- Increase in participation in adolescent-focused activities: organized group or committee for adolescents (45.7% in 2013 to 81.4% in 2015, p-value=<.001), non-formal education (46.9% in 2013 to 59.2% in 2015, p=.047) and life skills training (57.0% in 2013 to 69.6% in 2015, p=.044).

The study did not document significant reduction in prevalence of past-year exposure to any type of verbal abuse, physical abuse or sexual assault apart from any type of violence at school. The study documented no change in the majority of specific violence-related exposures (i.e. "Has anyone ever pushed, grabbed or kicked you?"). This lack of change in prevalence of several specific types of exposure, and cumulative exposure, is not surprising given the relatively short time-period between the T1 and T2 studies.

Low utilization of CBCPMs (such as Abaregerabana, a committee of community volunteers responsible for monitoring children's right and abuses against children) may indicate that adolescents go elsewhere for help, or that these specific community-based child protection mechanisms are not meeting the needs of adolescents in Kiziba, while there are other similar structures that are (as noted above, with higher overall reporting of utilizing of a Child Protection Committee). Participation in adolescent-focused activities increased between 2013 and 2015, with higher levels of past year participation in organized groups specifically designed for children or adolescents (45.7% in 2013 and 81.4% in 2015), non-formal educational activities (46.9% in 2013 and 59.2% in 2015), and camp-based life skills training (57.0% in 2013 and 69.6% in 2015).

The hypothesis tested in this study is that *"a good child protection environment is associated with lower levels of child protection concerns (violence, abuse, neglect and exploitation), and higher levels of psychosocial well-being."* Conclusions regarding whether this hypothesis is proven in the context of Kiziba camp are not yet definitive, as cross-context comparisons and further longitudinal data would help identify patterns in associations between system strength and child protection outcomes. However, tentative conclusions can be drawn: improvements in child protection system strength do not appear to have had significant impacts on reduction of violence or resulted in higher levels of psychosocial well-being in this time period. The CPI Study's theory of change and research model hypothesized several intermediary outcomes that may link to reduced child protection risks and improved well-being. The T2 findings indicate improvements in some of these intermediary measures – registration and documentation, caregivers' attitudes towards appropriateness of beating in response to children's behavior and increased participation in adolescent-focused activities – which may have eventual downstream impacts on prevalence of violence and levels of psychosocial well-being.

1.
INTRODUCTION AND BACKGROUND

1.1 Background and rationale for the study

Children who are displaced and affected by conflict are vulnerable to threats to their health and well-being in humanitarian settings globally. These risks, as noted by UNHCR, include "abuse, neglect, violence, exploitation, trafficking or forced recruitment into armed groups", which can "have a profound effect on children – from infancy and childhood through to adolescence."1

In recognition of the need for policy and programming to support refugee children globally, UNHCR, which leads development and implementation of child protection standards for refugee children, released the *Framework for the Protection of Children* in 2012. The Framework sets out six primary goals for protection of refugee children, which are:

1. Girls and boys are safe where they live, learn and play;
2. Children's participation and capacity are integral to their protection;
3. Girls and boys have access to child-friendly procedures;
4. Girls and boys obtain legal documentation;
5. Girls and boys with specific needs receive targeted support; and
6. Girls and boys achieve durable solutions in their best interests

These six goals are designed to prevent violence, abuse, neglect and exploitation of children, and promote well-being of children in contexts which may pose overwhelming risks to health, safety and well-being.

Evidence base for child protection in humanitarian settings

The evidence base for the impact of humanitarian child protection activities and systems is limited. Structured reviews of commonly implemented interventions – community-based child protection mechanisms (Wessells, 2009) and child friendly spaces [CFSs] (Ager et al., 2013)– have found a very weak evidence base, and a lack of proven effectiveness, scalability and impact of these interventions.
The evidence-base for community-based child protection mechanisms was described in 2009 as "largely anecdotal, impressionistic, unsystematic, and underdeveloped" (Wessells, 2009). Subsequent efforts to identify impacts of these interventions through rigorous methodologies have identified some promising methodologies, and documented impacts of these interventions (see Textbox 2)

However, there remains a relative dearth of rigorous published work identifying the impacts of interventions in the child protection sector. Methodologies utilized to explore efficacy, effectiveness, and impact of child protection interventions are insufficiently developed and lack standardization and rigor. Given the limitations in the evidence-base in the child protection sector, programmatic decisions are often based on organizational experience in the field, anecdotal reports of efficacy, expert opinion, and the adoption and application of programs designed and tested with different populations, under different conditions. This can have significant impacts on quality and impact of these interventions, for example, implementation of interventions that are effective in a specific context being implemented in ways that may be inappropriate or ineffective for a different context. The review of evidence for CBCPMs noted, "the collection of rigorous evidence about the effectiveness, cost, scalability, and sustainability of interventions is

TEXTBOX 2:

RECENT DEVELOPMENTS IN THE EVIDENCE-BASE FOR CHILD PROTECTION INTERVENTIONS

Child-friendly spaces: Several recent evaluations of CFSs in varied contexts have used robust study design and sampling methods to understand the impact of CFSs on protection and psychosocial outcomes. Use of a comparison group (CFS-attenders vs. non-CFS attenders) allowed researchers to attribute impact to CFS attendance. Researchers used locally validated quantitative measures to ensure reliability and validity of outcomes measures. Moreover, use of baseline and endline assessments allowed for measurement of change over time (Metzler et al., 2013a; Metzler et al., 2013b). Findings show that CFSs studied had a positive impact on psychosocial well-being, although results varied according to CFS quality, and sex and age of participants, and a small positive impact on protection outcomes, with variation according to setting and sex of participants (Metzler et al., 2015). The necessity of baseline (pre-intervention) measurement and use of a comparison group to assess impact became evident from the results of this work; for example, without a comparison group, the assessment of CFSs in Ethiopia and Uganda would have indicated that CFS attendance did not impact protection concerns in the case of Ethiopia, and psychosocial well-being in the case of Uganda, without a comparison group. With the comparison group, it was evident that CFS attendance was protective against *increased* protection concerns and decline in psychosocial well-being, which was seen in the comparison group of non-CFS attenders (Metzler et al., 2015).

Community-based child protection mechanisms: Efforts to improve the evidence-base for CBCPMs have shown the centrality of community ownership for sustainability and efficacy of community-based mechanisms (Wessells, 2015). A structured review of evidence supporting the impact of community-based child protection mechanisms identified several key factors of successful interventions in this field, including community ownership, building on existing resources and capacities, and child participation (Wessells, 2009). Findings from the review were used to guide intervention and measurement efforts in a teenage pregnancy prevention intervention in Sierra Leone (Wessells et al., 2014a). The quasi-experimental research design found several impacts of the intervention between baseline [T1] and midline evaluation [T2], including increase of adolescents aged 15-17 in intervention areas being willing to ask their partner to use a condom, increase in girls under 15 in intervention areas expressing intentions to use a condom, and adolescents in intervention areas being more likely that adolescents in non-intervention areas to feel that they could refuse sex (Stark et al., 2014). Participatory community review of the intervention emphasized reduced teenage pregnancy in intervention villages, increased linkages to health centres, improved access to contraceptives, and improved communication between parents and children (Wessells et al., 2014b). Research guidance, based on research conducted on CBCPMs in Uganda, Liberia and Sierra Leone, has been developed, noting key elements of effective ethnographic research on CBCPMs (Child Protection in Crisis [CPC] Learning Network, 2014).

essential if the field of child protection is to develop and attract the resources needed to address child protection issues" (Wessells, 2009). The development and testing of new methodologies to capture the impacts of child protection activities in humanitarian settings are a priority for the sector.

The baseline report for the CPI Study in Rwanda1 [henceforth known as the Baseline Report] outlined the existing literature on child protection measurement in greater depth. As noted in the Baseline Report, two key issues emerge from the limited evidence base. The first key issue is that existing evidence is focused on specific, individual interventions, rather than taking a systems-approach. The United Nations Children's Fund's [UNICEF] 2010 publication succinctly synthesized current systems thinking with respect to child protection sector in that it provides a more "holistic view of children and child protection that necessarily engages the full range of actors involved in protecting children's rights" (Wulczyn et al., 2010). UNHCR's 2012 Framework

encapsulates a systems-approach, marking an "an institutional shift from mainly targeting categories of children at risk towards a systems approach to protecting children." The value of a systems-level approach that takes into account formal and informal actors at multiple levels is widely accepted and underpins recent policy and programming efforts in the field (Wessells, 2015). Given the recognition at a policy level of the need for a systems-approach, there is also a need for concerted effort to develop and test approaches to measure systems, rather than single interventions. However, to date, the CPI Study is the only research program working to develop an analytic methodology to accurately assess system-level outcomes, changes, and the impact on individual adolescents and their caregivers.

The second key issue identified in the Baseline Report is that the vast majority of the literature on interventions to improve child protection outcomes – to reduce violence, abuse, neglect and exploitation, and to improve well-being – is disconnected from interventions aiming to improve child protection systems. As the Baseline Report concluded, "There is a substantial gap in the literature and evidence-base around the impact of child protection activities on a combination of child protection outcomes, indicating a need to explore, develop and pilot methodologies that combine rigor and feasibility, assessing a package of key child protection interventions and a range of outcomes in a single, holistic and integrated approach" (Meyer et al., 2014). Previous research efforts have primarily focused on individual-level outcomes. While these studies have been instrumental in documenting prevalence of key concerns regarding well-being of children in humanitarian settings, they are insufficient with respect to exploring the connection between systems strength, child protection programming effects and impact on child protection outcomes. Child protection systems measurement approaches that do exist are not paired with population-level data on child protection outcomes; that is, measurements of system strength do not also measure improvements in child protection outcomes, the ultimate goal of a strong child protection system. This current research is unique, and garners its strength and validity, from exploring the multiple child protection domains of procedures, services, and utilization of child protection services and their impact on child protection outcomes through triangulated data drawn from mixed methods approach.

TEXTBOX 3:

CHILD PROTECTION SYSTEMS – DEFINITION AND MEASUREMENT OF A SYSTEMS-APPROACH

Definitions:

There are several terms that are utilized in child protection systems work. The following definitions are primarily drawn from the recent overview document, *"Adapting to learn, learning to adapt: Overview and considerations for child protection systems strengthening in emergencies"*(Child Frontiers, 2016):

Systems thinking "takes into account the interaction between different parts of any system to better understand how together the system works rather than simply trying to understand specific system components in isolation." Systems thinking is used in many fields, and is increasingly utilized in child protection policy and programming in humanitarian settings;

A **system** is "[a] set of things that interconnect in such a way that they produce their own pattern of behaviour over time. All systems consist of three broad categories of 'things': elements, interconnections, and a function or purpose";

A **child protection system** is a "collection of components – structures, functions, capacities – that are organized and connected to each other around a common goal, where the goal is to address child protection concerns";

Child protection systems-strengthening "refers to actions taken to improve the functioning, coordination, integration and, ultimately, effectiveness of these components and their interaction… A system is deemed to have been strengthened if there is evidence of, for example: additional capacity; improvement in the quality of processes and services; expanded reach; integration or coordination of mechanisms that were previously separate, and improvement in the functioning of processes and mechanisms" (Save the Children, 2010).

A systems-strengthening approach has become widely accepted in the field of child protection, and several major humanitarian agencies, including UNHCR, have key policy documents outlining their approach to child protection using a systems-strengthening framework.

Why utilize "systems-thinking" in child protection in humanitarian settings?

In the field of child protection, systems-thinking is increasingly supported, as it can promote "a holistic view of children and child protection that necessarily engages the full range of actors involved in protecting children's rights" (Wulczyn et al., 2010). Systems thinking in child protection "provides a powerful language, way of thinking and tools that may help child protection actors investigate and address inefficiencies in meeting the protection needs of children" (Child Frontiers, 2016). UNHCR's approach within the *Framework*, specifically, notes that a systems-approach is a shift from "mainly targeted categories of children at risk," and provides a more holistic approach to "prevent, respond and mitigate to the risks faced by children."

How have child protection systems and systems-strengthening been measured previously?

There are challenges in capturing the multiple components of a child protection system, and in assessing changes within the system, particularly in humanitarian contexts. Some measurement and assessment efforts are described here:

Assessing perceptions of systems-strengthening: Recent work has used qualitative methods to assess perceptions of systems-strengthening efforts in South Sudan. This research engaged multiple stakeholders within the child protection system, from Government officials to community members, to identify key processes in systems strengthening from a range of perspectives (Canavera et al., 2016).

Mapping of child protection systems: There has been considerable work on mapping child protection systems, including Maestral International's work with UNICEF on mapping national child protection systems in Eastern and Southern Africa (Maestral International, 2011), and work by Child Frontiers in West Africa (Child Frontiers, 2010). The Child Frontiers work mapped both the formal child

protection system – often institutions and laws – and informal systems – the ways families, communities and children seek to achieve child protection and improve children's well-being. Findings showed discrepancies between the goals of the formal child protection system, and priorities and needs at the community-level (Krueger et al., 2014). The Child Frontiers methodology provides a national-level overview of what activities exist, how they operate and how various actors interact, and secondly, how the system actually functions on the ground, in terms of the actual and perceived functioning of the system from the perspective of children and caregivers.

Measurement efforts beyond mapping are needed, however, to identify dynamic changes within the system over time. The CPI Study seeks to assess both the formal child protection system – as conceptualized in UNHCR's *Framework* and operationalized in the CPI instrument – and its actual and perceived impacts through adolescent and caregiver surveys, key informant interviews and focus groups. In addition, the CPI Study seeks to assess the interaction between child protection system strength and child protection outcomes over time, seeking to assess the assumption underlying systems-strengthening approaches: that a stronger child protection system will improve child protection outcomes.

Rationale for the project, "Measuring Impact through a Child Protection Index"

The CPI Study is designed to respond to gaps in the evidence, which currently leave policy-makers, donors and programmers without adequate guidance as to how to best support refugee children by preventing child protection risks and improving child protection outcomes. The CPI Study specifically builds from previous efforts of mapping of child protection systems (for example, Maestral International's work with UNICEF on mapping national child protection systems in Eastern and Southern Africa) (Maestral International, 2011) to combine mapping of system strength with an understanding of how system strength impacts child protection outcomes (Meyer et al., 2015).

The hypothesis driving the project is one that is often taken as self-evident in the field of child protection, that *a good child protection environment is associated with lower levels of child protection concerns (violence, abuse, neglect and exploitation), and higher levels of psychosocial well-being*. The rationale for this project, and the motivation for the study design implemented, was to test this hypothesis through rigorous and appropriate methods.

The project's methodology also adds several unique aspects to existing approaches. Through measuring at T1 and T2, the research is able to identify changes in system strength, rather than only presenting a snapshot of system strength at one time point. Secondly, through measuring child protection outcomes at both timepoints, the study seeks to shed light on the actual relationships between system strength and changes in system strength, and child protection outcomes.

Children registered in education, Kiziba Camp, April 2016

Level	Male	Female	Total	Location
Nursery school	387	435	822	Kiziba Camp
Primary school	1,897	1,991	3,888	Kiziba Camp
Secondary school (Senior 1 to 4)	854	861	1,715	Kiziba Camp
Upper secondary school (Senior 6) scholarships*	83	51	134	Outside the camp
Total	**2,463**	**3,141**	**6,127**	

** Supported by ADRA through a donation from Howard Buffett and Impact Hope, the private donors*
Source: ADRA, April 2016 (Nursery, Primary and Secondary Education)

The study design measures the strength of the child protection system through the CPI, and assesses child protection outcomes through a household survey of adolescents and caregivers. The specific data collection methods utilized were associated with the key objectives of assessing *changes* in system strength by measuring system strength at two time points, and assessing how or if these changes are related to child protection outcomes of these objectives:

- Key informant interviews to collect data for the measure of system strength, the CPI;
- Household surveys of adolescents and caregivers to assess child protection outcomes; and
- Focus group discussions at two time points: first, during T2 data collection (to improve understanding of child protection risks, utilization and perceptions of services) and second, as part of the qualitative follow-up research, to shed light on key findings and examine underlying mechanisms for associations identified (*see Methodology for further detail*).

Rationale for the present study, Rwanda – Kiziba Camp, T2 study

The present study is a T2 assessment of the strength of the child protection system in Kiziba Camp, Rwanda. Specifically, the research questions of the T2 study in Rwanda were:

- What changes in system strength can be identified between T1 and T2;
- What changes in key child protection outcomes can be identified between T1 and T2; and
- How are changes in system strength related to changes in violence, exploitation, abuse, neglect and psychosocial well-being of adolescents?

The T2 study was a follow-up study to the T1 baseline study conducted in 2013. The research partner for the T1 study was Associazione Volontari per il Servizio Internazionale [AVSI] Rwanda and for the T2 study the research partner was Plan International Rwanda.

2.2 Kiziba camp, Rwanda

Rwanda's Kiziba Camp opened in December 1996 in response to the Democratic Republic of the Congo's [DRC] civil war. Since its founding, some refugees have returned to their homes in the DRC; however, at least 17,329 individuals remain in Kiziba, of which 4,193 are girls under 18 and 4,000 are boys under 18 (UNHCR, 2015). The majority of Kiziba refugees do not wish to return to DRC due to fear of violence and lack of safety (UNHCR, 2013).

Kiziba Camp is located approximately 15 kilometers from Karongi town, in Karongi District, in Rwanda's Western Province. The Camp is organized into 10 *quartiers* with 52 villages containing approximately 70 families per village. Family semi-permanent shelters are constructed out of poles and mud exteriors 45% covered with plastic sheeting with insufficient privacy. Some families, with assistance from non-governmental organizations [NGOs], have been able to cultivate gardens and raise small livestock, like rabbits, in the space directly outside their residence.

Education

Educational opportunities available in Kiziba Camp changed over the course of this study. In 2014, supported by the main education-implementing partner, Adventist Development and Relief Agency [ADRA], there was one nursery school, three primary schools, and one secondary (secondary level 1-3) school. In 2016 ADRA opened Senior 4 in the secondary school of Kiziba. In the same year, 136 adolescent refugees participated in the Community Access Technology center, funded by Microsoft Corporation in 2009. In December 2015, Kepler University launched its Kiziba Refugee Camp campus, enrolling 25 refugee students in the first year of its blended learning program. Four refugee-led Early Childhood Development [ECD] centers existed in 2013, with the support of AVSI. From 2014, Global Help to Heal [GHH] took over responsibility for ECD and now in 2016 there are 7 ECD centers with 694 children attending. Children within the camp also attend public and private secondary schools outside the camp in Rwanda through informal networks.

Economic Activities

Refugees at Kiziba Camp are able to buy and sell goods in the Mubuga, Bwishyura and Rubengera markets in Karongi District. In 2014, *Mawenderewo*, an association within the camp, started which provided a resale market for refugees' rations and outside goods. *Mawenderewo* also ran transportation services (taxi bus service) from Kiziba Camp to Karongi town. This association is no longer active in Kiziba camp as the leaders have since been resettled. In 2013, 2015, and 2016, micro-savings groups, or *tontine*, provide refugees an opportunity to pool their savings and members take turns receiving distributions. Additionally, there are several income-generating activities at the camp, such as: shoe repairs, carpentry, tailoring, teachers, gardeners, and community work/ facilitation for implementing partners.

To supplement diets possible from the above sources, Africa Humanitarian Action [AHA] provides vegetables and livestock. In 2014, 330 households had vegetable kitchen gardens and 153 households raised small livestock (rabbits). Families with children under 5 years old are the principal beneficiaries of these programs. ARC is the current implementing partner for Livelihood and Economic Recovery programs in Kiziba.

Structure and Organization

The Rwandan government's refugee authority, the Ministry of Disaster Management and Refugee Affairs [MIDIMAR], in coordination with UNHCR, manage Kiziba Camp. They coordinate implementing partner activities related to refugee protection. Camp committees are the principal administrative bodies at the community level (at the village level, *quartier* level, and Camp level). Members are elected by their peers and serve as the primary representative of refugee concerns responsible for liaising with national and international partners.

In additional to MIDIMAR and camp committees, other key organizations and structures at Kiziba include:

UNITED NATIONS AGENCIES

- **UNHCR:** Protection and assistance to refugees
- **World Food Program (WFP):** Provides food rations

INTERNATIONAL NGOS

- **ADRA:** Formal primary and secondary education for all Kiziba Camp children, distribution of food and non-food items and UNHCR logistics
- **American Refugee Committee (ARC):** Supports shelter and construction, water and sanitation, livelihoods and economic recovery in Kiziba Camp
- **AHA:** supports health and nutrition at Kiziba Camp
- **Plan International Rwanda:** supports child protection and SGBV
- **Handicap International:** works with populations with special needs, in particular persons with disabilities and elderly
- **International teams Rwanda:** Provides education support for youth in upper secondary school and in vocational training programs.

UNIVERSITIES

- **Kepler University:** university studies (blended program)

RWANDAN NGOS

- **Foundation Saint Dominique Savio (FSDS):** supports the overall camp environment and energy needs
- **Legal Aid Forum (LAF):** Provides legal support

FAITH BASED ORGANIZATION

- **GHH:** ECD programming

RWANDA GOVERNMENT INSTITUTIONS

- **Police:** over the course of the study period police officers have been located outside, inside, removed from, and are now currently operating with the Kiziba Camp. The police are officially in charge of security within the camp, in collaboration with MIDIMAR, who has overall responsibility for security in the camp.
- **Directorate General of Immigration and Emigration:** the provision of local travel and other documents (including refugee ID cards)
- **Rwankuba Sector**: provision of civil status documents
- **Courts:** judgment of crimes and supplementary judgements
- **Maison d'Accès à la Justice (MAJ), including Chambre de mineurs (children's courts):** advising refugees who bring civil cases on their rights and due process of complaints filed with the courts

Child protection in Kiziba Camp

Kiziba Camp has several child protection committees run by international and national NGOs and local groups, established by Save the Children, the previous child protection-implementing partner. Until 2013, these committees were managed by AVSI; as of May 2014, PLAN International Rwanda took over the responsibilities for protection in Kiziba refugee camp. There are four types of child protection structures, each with their own unique mandate. The existing structures are:

- **Nkundabana (I like children):** Volunteer members, selected by children and foster families, support children who lack appropriate parental care in Kiziba camp, through direct mentoring and facilitating access to available services.
- **Ijwi ry'abana (Voice of Children):** A forum, composed of six children (with a focus on representatives from marginalized populations) facilitates child participation in camp decision-making, with a specific focus on: raising awareness of children's rights', individual roles and responsibilities, active and meaningful child participation in abuse reporting process, and general advocacy. Forums exist at village, *quartier* and camp levels.
- **Abarengerabana (Protectors of Children):** Community volunteers (three or more per *quartier*), responsible for monitoring children's rights enforcement, abuses, active vulnerable children case finding, and reporting (including to AVSI previously, now to Plan International Rwanda and the Child Protection Forum).

- **Child Protection community mobilizers:** they are recruited by Plan International Rwanda and receive monthly stipends. They facilitate the implementation of community engagement activities, and coordinate and provide leadership to different community volunteers and groups.

Child Protection coordination mechanisms in Kiziba refugee camp:

Child protection forum: this meeting meets once in two months and is led by child protection implementing partner. The participants are UNHCR, MIDIMAR and other partners working directly on child protection.

Refugee coordination meeting: This meeting takes place once a month and is led by UNHCR. The participants are MIDIMAR and all implementing partners in the camp. Each implementing present updates about its activities.

Camp coordination meeting: This meeting meets once a month and is convened by MIDIMAR. UNHCR, MIDIMAR and all implementing partners meet with the executive camp committee to discuss the updated situation, different issues and together, they take the decisions regarding those issues.

Case management meeting: which is a forum to coordinate case management responses among relevant stakeholders. The case management meetings are held on a monthly basis unless needed more frequently. Clients are discussed in a confidential manner – i.e., names of children, family members, or others involved should not be used and identifying information should not be discussed.

Previous studies have explored and sought to document different components of the child protection environment in Kiziba, Rwanda. Community knowledge of main child protection concerns, including the reporting structures through which INGOs and child protection committees function, is high in Kiziba Camp (AVSI and InfoAid, 2013). Specific areas of concern for child protection include: violence and excessive physical work as a form of punishment; lack of access to adequate, quality education (leading to delinquency); food insecurity; lack of access to basic needs ; inability to trust camp-based volunteer security team; and teenage pregnancy, transactional sex and prostitution (AVSI and InfoAid, 2013; CPC Learning Network and AVSI Rwanda, 2013). The child protection environment is further complicated by a multi-sectoral response that at times serves as a barrier to abuse reporting, especially among the most vulnerable; and inappropriate child abuse perpetrator criminal justice proceedings (AVSI and InfoAid, 2013).

The Baseline Report for the CPI Study, based on data collected in 2013, noted several key challenges to child protection in Kiziba Camp (Meyer et al., 2014). The findings indicated high levels of exposure to violence, including witnessing violence and abuse in the home (72% of adolescents reported having witnessed shouting and yelling in the home; 18% reported witnessing physical violence in the home), direct experience of violence (being pushed, grabbed or kicked (11%), being hit, beaten or spanked (19%) and being beaten with a belt, paddle, a stick or other object (11%)). 4% of adolescents reported forced intercourse in the past year, 2% reported being pressured or persuaded to have sex in the past year, and 8% reported unwanted sexual touching in the past year. Psychosocial outcomes indicated some concerns about levels of well-being amongst adolescents. 17% of adolescents showed low levels of hope and 16% showed low levels of resilience. 27% of adolescents had a high score on the anxiety measure, and 12% of adolescent report high levels of emotional difficulties.

2.
METHODOLOGY

The CPI Study aims to describe, assess, and explore change in the child protection system in Kiziba Camp. In order to do so, researchers developed a study design that utilized three unique data collection methods:

- **Household surveys** (adolescents aged 13-17 and parents/caregivers) – conducted at T1 (2013) and again two years later at T2 (2015);
- **Focus group discussions** (adolescents aged 13-19 and parents/caregivers) – conducted at T2 and qualitative follow-up; and
- **Key informant interviews** (implementing partners, refugee leaders, UNHCR staff, government officials, and education and shelter sector leaders) – at T1, T2 and qualitative follow-up;

The CPI Study also included a qualitative consultation and member checking of findings with key informants, adolescents, and parents/caregiver, conducted four months after T2 data collection, in April 2016. Each method is introduced below, with detailed descriptions in Appendix 5. Ethical considerations and procedures are detailed in Appendix 2.

Figure 1: Data collection methods and utilization

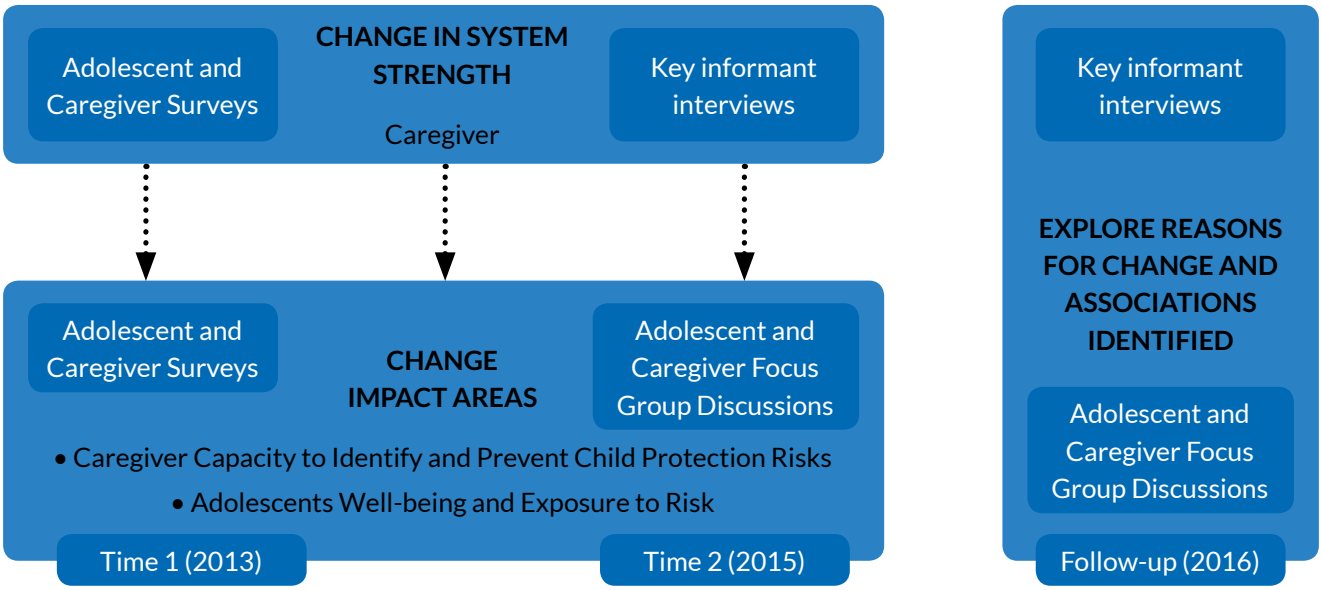

Table 1: Brief overview of CPI Study design

Terminology	Definition	Methodology	Data Sources	Data Collection
T1	Baseline – Time 1 study	Adolescent quantitative surveys Parent/caregiver quantitative surveys Key informant interviews	• Adolescents • Parent/caregivers • Key informants	December 2013
T2	Time 2 study	Adolescent quantitative surveys Parent/caregiver quantitative surveys Key informant interviews Focus group discussions with adolescents	• Adolescents • Parent/caregivers • Key informants	October- November 2015
Follow-up	Qualitative follow-up study	Focus group discussions with adolescents and parents/ caregivers Key informant qualitative in-depth interviews	• Adolescents • Parent/caregivers • Key informants	April 2016

2.1 Data collection and analysis methods

T2 research

2.1.1 CHILD PROTECTION INDEX (CPI)

Researchers used the previously developed CPI (Meyer et al., 2014; Meyer et al., 2015) to assess child protection system strength across several domains central to the UNHCR Framework for the Protection of Children. The CPI is a 32-item index, with a total possible score of 100, assessing three core components:

- **PROCEDURES:** Includes items focused on existence and operationalization of policies and procedures to prevent and address child protection risks, including laws and policies to address statelessness, allow access to national education systems, prevent corporal punishment and provide birth registration. In addition, existence of policies and procedures for identifying 'at risk' children, an information management systems and information-sharing protocol, and coordinating mechanisms, including a Child Protection Working Group, are included in this component.
- **SERVICES:** Includes items focused on role and functioning of community-based child protection mechanisms, availability of communal space for adolescents, safe learning environments and complaints mechanisms for adolescents, as well as availability of services and activities including technical and vocational activities
- **UTILIZATION (as a proxy for quality of services):** Includes items measuring adolescent participation in a range of activities designed for adolescents, including clubs and committees and sports and recreation activities, reporting of experiences of SGBV, reported feelings of safety and school attendance. This section contains the key activities and interventions identified by UNHCR as components of implementation of the Framework.

Data for the CPI were collected and evaluated at both T1 (2013) and T2 (2015). The overall CPI score was generated in 2013 and 2015 from data collected in the key informant interviews and adolescent surveys based on respondent expertise (responses evaluated based on expertise of respondent and apparent coherence with other respondents). CPI scores were then compared based on items asked in 2013 and 2015, across domains: procedures, services, and utilization. Changes in CPI item-level and domain-level responses guided follow-up qualitative data collection (2016).

2.1.2 KEY INFORMANT INTERVIEWS

Data for the CPI came from key informant interviews at T1 and T2. The key informant interview guide consists of two main components: the first contains questions to feed into the CPI assessment; the second component asks key informants their views on the strengths and weaknesses of the child protection system. Across the study period, key informant interviews were conducted in Kigali (with UNICEF, International Committee of the Red Cross [ICRC], Kigali-based UNHCR child protection officer, resettlement manager, legal protection officer staff), Plan International Rwanda (CP and SGBV project Manager and CP Program Manager) in Kiziba Camp and Karongi (with MIDIMAR, Plan International Rwanda, ARC, ADRA, AHA, AVSI, and UNHCR (child protection focal point, resettlement expert) staff).

A research manager from Plan International Rwanda and CPC Learning Network researchers conducted all interviews, took hand-written detailed notes, and transcribed notes to be analyzed. The same procedure was followed for the follow-up interviews conducted in 2016.

Thematic analysis of key informant interview data was performed. First, researchers independently read over transcripts highlighting key themes. Second, researchers checked key themes with each other, and connected these themes to the findings from both previous qualitative data and quantitative data. Third, direct quotes and summaries of themes were compiled and reported.

2.1.3 ADOLESCENT AND CAREGIVER SURVEYS

Adolescent and caregiver surveys were conducted in 2013 and 2015 (see Appendix 1 for detailed description of survey instruments). All surveys were developed in English, translated into Kinyarwanda, and then back translated by a different individual into English for review. The adolescent survey included the following sections: demographics; psychosocial well-being (scales measuring symptoms of anxiety, emotional difficulties, hope, and resilience); exposure to violence and abuse; feelings of safety; child labor; knowledge and use of services; attitudes towards violence against children and social support.

The parent/caregiver survey included the following sections: demographics; knowledge and attitudes towards violence against children and child protection issues; household socio-economic status and Humanitarian Emergency Settings Perceived Needs Scale; child safety environment; and parent/caregiver well-being.

269 parents/caregivers (129 in 2013 and 252 in 2015) and 274 adolescents (129 in 2013 and 252 in 2015) completed the questionnaires in Kiziba Camp, Rwanda (see Appendix 2 for more details on ethics and Appendix 3 on sampling). The follow-up rate was 84.4%: 109 of the 129 baseline respondents were re-interviewed in the T2 data collection.

All quantitative surveys were administered in Kinyarwanda on a mobile phone-based survey program, facilitating accurate data entry and minimizing common data entry inaccuracies. Each question was displayed, individually, in a multiple-choice format, with optional text entry for items requiring broader answer categories. The data collector read the question and answer choices out loud to respondents, and selected the respond given.

All quantitative surveys were conducted by trained Rwandan data collectors.[2] Data collectors were recruited, hired, and trained by Plan International Rwanda and CPC Learning Network research staff.

Female data collectors conducted all interviews with female adolescents and focus group discussions with female only groups. All data collectors participated in multiple days training before each phase of data collection (2013, 2015, 2016) that covered: background to the aims and objectives of the study, ethical procedures for human subjects research, special skills for interviewing children, use of mobile phones for data collection, and qualitative research methodologies (special focus in 2016, follow-up training). The training provided opportunities for data collectors to gain practice and role-play

[2] Data collectors were Rwandan nationals, as previous experience conducting research in refugee camps in Rwanda indicated that hiring refugee data collectors could cause tensions within the camp due to lack of employment opportunities and disagreements concerning payment policies for refugees.

conducting adolescent and caregiver surveys and engaging (facilitation and/or note-taking) in focus group discussions and key informant interviews. Data collectors pilot tested the survey instruments before data collection began to identify any remaining issues. All data collectors were also trained on UNHCR code of conduct and PLAN child protection policy and they signed a child protection policy prior to starting data collection.

Quantitative data analysis for this study was conducted in three stages: baseline (T1, 2013) data were analyzed; T2 (2015) data were analyzed; and comparisons between baseline and follow-up (T1-T2, 2013-2015) were explored. The process for cross-sectional data analysis has been discussed elsewhere (Meyer et al., 2014). The description of analysis below focuses on the quantitative comparisons between baseline and follow-up (T1-T2, 2013-2015) data collection.

Changes over time were calculated using appropriate statistical tests.[3] Significant changes were then further explored through modeling outcome-specific, simple and multiple linear and logistic regressions. In each model, the following confounders – variables that could be responsible for alternate explanations of our findings – were included: age, gender, and parental status (both living, one living, neither living). Sub-analyses of oversampled groups (unaccompanied or separated children, children with disabilities) and a matched analysis restricted to only individuals interviewed at T1 and T2, were also conducted as above.

TEXTBOX 4:

MATCHED VS. UNMATCHED ANALYSES

The statistical analysis conducted for this study was two fold: one form of analysis (matched) compared only those respondents who participated in both T1 and T2 studies, and the second form (unmatched) compares all T1 respondents and all T2 respondents. For these different analyses, different types of analysis approaches could be utilized. For the matched analysis, we utilized linear and logistic regression models, exploring the T2 outcome controlling for T1 outcomes levels (for example, level of symptoms of anxiety at T2 given a specific individual's level of symptoms of anxiety at T1. For the unmatched analysis, we utilized linear and logistic regression models, exploring the unique contribution of time (comparing T1 and T2) on the main outcome of interest. This unmatched analysis approach produces associations that are valid at the group level, but not at the individual level as they do not take into account individual variation over time.

Overall, all tables in the main text show the unmatched analysis of the full sample, and findings reporting on the matched analysis are included where they differed from the unmatched analysis and are indicated as such.

[3] p-values for statistically significant differences were calculated using unpaired t-tests for continuous variables (accounting for unequal variance, when necessary), two-sample Wilcoxon rank-sum (Mann-Whitney) tests for ordinal variables and chi-squared tests or Fisher's exact tests for categorical variables (depending on expected cell values).

TEXTBOX 5:

STATISTICAL TERMS UTILIZED IN THIS REPORT

p value: Statistical analysis uses hypothesis testing. For example, in comparing the mean level of symptoms of depression at T1 to mean level of symptoms of depression at T2, we test the null hypothesis. The null hypothesis is that there is *no difference in means* between T1 and T2. In this study, we used p-values of less that .05 to indicate statistical significance. For results with a p value of less than .05, the finding indicates that we can reject the null hypothesis of no difference between T1 and T2.

Odds ratio and adjusted odds ratio [OR and aOR]: An odds ratio is a measure that calculates the association between an exposure and an outcome. In the context of this study, an exposure may be a socio-demographic variable (i.e. sex) and an outcome may be experience of violence or level of psychosocial well-being. An odds ratio of 2.6 in the context of sex and reporting of sexual violence, for example, indicates that girls are 2.6 times more likely that boys to report sexual violence. The odds ratio is the odds of an outcome (reporting sexual violence) occurring in the presence of an exposure (being a female) vs. in the absence of the exposure (being a male). An adjusted odds ratio indicates that the analysis has taken into account confounders – non-causal variables that could be responsible for the outcome. For example, we reported that adolescents were less likely to report experiencing violence (physical, psychological, or sexual) on school premises in 2015 as they were in 2013, with the odds ratio of .34 adjusting for age and gender, ensuring that the difference identified does not reflect the influence of age or gender on experience of violence.

Confidence intervals [CI]: We report 95% confidence intervals, which indicate that if this research were conducted multiple times using the same sampling method, and calculated confidence intervals for each sample, we would expect the true population parameter (i.e. X% of girls experienced physical violence) to lie within these intervals 95% of the time.

Significant: A significant finding, in the context of the present statistical analysis, is one where the result indicates a p-value of less than .05.

2.1.4 FOCUS GROUP DISCUSSIONS WITH ADOLESCENTS

Focus group discussions were conducted as part of the T2 data collection. Discussions focused on opportunities and barriers for adolescents' utilization of child protection activities and interventions, perceptions of quality of interventions, and adolescents' approaches to addressing child protection risks in the camp.

The Research Manager and trained data collectors facilitated adolescent focus group discussions in 2015 and 2016 and parent/caregiver focus group discussions in 2016 (all in Kinyarwanda). Specially trained note-takers accompanied facilitators to take hand-written notes, subsequently transcribing and translating notes into English for analysis. Research staff reviewed English notes to assure data clarity and quality.

As with the key informant interviews, researchers independently conducted a thematic analysis of focus group transcripts. First, researchers independently read over the transcripts, highlighting key themes. Second, the researchers checked the key themes with each other, and connected these themes to the findings from the quantitative data. Direct quotes and thematic summaries were then generated and reported.

Follow-up research

For the follow-up research phase, researchers employed the following process to develop key informant and focus group discussion guides. First, preliminary findings from quantitative and qualitative components of 2013 and 2015 waves of data collection were analyzed. Second, key findings, both expected and unexpected, in line with our hypothesis and potentially contradictory to it, were identified and discussed by the research team. Third, key informant interview guides and qualitative focus group discussion guides for adolescents and caregivers were developed to explore the main themes and issues discussed in the initial review of findings.

2.1.5 KEY INFORMANT INTERVIEWS

Key informant interviews conducted during the follow-up phase of research explored reasons for observed change in child protection system strength and child protection outcomes across the study period.

2.1.6 FOCUS GROUP DISCUSSIONS WITH ADOLESCENTS AND CAREGIVERS

Focus group discussions with adolescents and caregivers were conducted in the follow-up phase of research, and focused on changes in the child protection system and child protection outcomes identified in comparison of T1 and T2 data.

2.2 Limitations

There are several key limitations to our methods. The CPI is still a new instrument and the scoring evolved over the course of this study; future iterations of this methodology will further develop this instrument, changing specific items and/ or scoring of items, and may challenge the comparability of these findings to future work. Detailed scoring is provided in the findings section to allow for re-analyses to address the impact of this limitation. While researchers sought to inquire only on domains within the purview of the key informant's responsibilities, it is unclear at this point if differences across CPI items can be attributed to a genuine difference of opinion, or if the divergence was due to respondents answering items outside their direct expertise. A sensitivity analysis on the CPI results was conducted from the 2015 data to explore the potential effect of this divergence. Results reported here are based on respondent expertise, not average, high, or low, response options, which were all explored. Given limitations in time for data collection and resources, a validity study was not conducted for use of the psychosocial scales with this population, therefore appropriate cut-off scores cannot be determined. As such, analysis of the psychosocial scales assessed levels of symptoms using continuous measures. Ideally, the validity of psychosocial scales should be tested in new contexts and study populations prior to conducting research (Ager et al., 2014).

TEXTBOX 6:

THE PROCESS OF TRANSLATING PRELIMINARY QUANTITATIVE FINDINGS TO QUALITATIVE INSTRUMENTS

One example of how the follow up qualitative data collection illuminated some of the T1-T2 findings is as follows: From preliminary quantitative analyses, we found that significantly more adolescents in 2015 reported feeling unsafe in the past week on the way to or from school as compared to those in 2013, regardless of their gender. We brought this and other key findings from the adolescent and caregiver quantitative analyses into a working summary findings document. Here, it became apparent that the degradation in security reported by the adolescents was not reported by their caregivers. We decided to investigate both the increase in reported feelings of lack of safety by adolescents, and the discrepant adolescent-caregiver report in the follow-up qualitative assessments in 2016. Open-ended qualitative focus group discussion items were created for both adolescents and caregivers on this topic to try and understand a) if refugees – adolescents and caregivers – agreed with the quantitative finding; b) what might be underlying the adolescents' increase report of insecurity; c) what suggestions they have for addressing this issue; and d) why adolescents and caregivers apparently they disagreed on this issue. While the items for caregivers and adolescents focused on the same theme, the questions were asked and framed slightly differently to be age appropriate.

The current research sought to explore and attribute changes in child protection environment with adolescent and parent/caregiver reported outcomes. In many domains we were unable to document statistically significant changes during this study. It is possible that changes existed but this study was either underpowered, conducted too soon after the T1 study, or requires additional longitudinal data points to reach statistical significance. Future studies seeking to triangulate and explore system-level changes over time on such long-term outcomes as past year violence exposure should be conducted for at least five years.

Some biases may be present in the data. For example, recall bias – a systematic error introduced by differential patterns of recall, for example, that girls are more likely to recall verbal abuse than boys, or that adolescents are more likely to recall physical violence than verbal abuse – may influence the prevalence of certain child protection risks that are reported. These biases are limitations in research on sensitive topics in multiple settings, for example, a study of gender-based violence amongst refugees in Kampala indicated that recall bias may affect reporting of SGBV as more severe types of incidents may be more easily recalled (Morof et al., 2014). Researchers on the CPI Study aimed to reduce these forms of bias by utilizing questions that have been piloted and adapted to address this issue in other settings, as well as intensive training of data collectors to ensure sensitive and systematic interviewing. Nonetheless, under- and over-reporting of key child protection risks and outcomes explored in the CPI Study cannot be discounted.

TEXTBOX 7:

EXPERIMENTAL AND NON-EXPERIMENTAL STUDY DESIGNS

The CPI Study is a non-experimental study design. Experimental study designs are studies in which an intervention – an activity, service or treatment – is intentionally introduced to individuals or groups (i.e. villages), and the outcomes of the intervention are observed. Examples of experimental study design include randomized controlled trials [RCTs] (also known as impact evaluations), where individuals or groups are randomly selected to take part in a specific intervention, and outcome measures are measured prior to and after intervention, comparing individuals or groups who received the intervention to those who did not. An RCT can allow researchers to understand the impact of a specific intervention, controlling for a range of differences between intervention and control groups that could arise if individuals or groups are non-randomly selected for the intervention, i.e. socio-demographic factors that may influence intervention impact. Importantly, an RCT allows researchers to disentangle the impact of the intervention from broader changes that may have occurred without the intervention. Without the randomly selected comparison groups, researchers would be unable to determine if improvements in educational outcomes seen from before the intervention are due to the intervention or also due to other external factors.

Similarly, other quasi-experimental designs may allow inference regarding causality or impact of a specific intervention, with comparisons between a non-randomly selected intervention and comparison group allowing for conclusions regarding the impact of interventions on outcomes. In a summary of the work on measuring child friendly spaces, researchers concluded that use of a comparison group is central to determining impact of the CFSs, stating "without a comparison group, it is difficult to ascertain if the effects are resulting from the programme or from other factors in the broader community." For example, findings showed that without a comparison group, conclusions on CFS impact in Ethiopia would have shown little impact on protection concerns, whereas with the

comparison group, it was clear that while the CFS had not reduced protection concerns amongst the intervention group, amongst those in the comparison group who had not attended the CFS, protection concerns had increased (Metzler et al., 2015).

An experimental or quasi-experimental study design may be able to identify impacts of the program, i.e. "Respondents who received X intervention had lower exposure to violence after receiving the intervention," compare these outcomes to those who did not participate, i.e. "Respondents in the control group had the same/ higher levels of violence at follow-up compared to those who received the intervention," and infer from these impacts a causal mechanism between the intervention and the selected outcomes, i.e. "Intervention X is effective at reducing exposure to violence."

The CPI Study differs from experimental and quasi-experimental approaches by design, for a number of reasons:

i. **Measuring a system vs. measuring an intervention:** The child protection system cannot be considered as a single intervention: when researchers were designing this study in collaboration with UNHCR, it was clear that UNHCR sought to understand the influence of the 2012 Framework for the Protection of Children, which includes a wide range of activities which could be considered interventions, as well as policies, procedures and approaches. The system comprises of complex, highly inter-related and overlapping components, and cannot be assessed in the same way as a single policy, program or service. As such, experimental study design was not available to the researchers as a viable approach.

ii. **Use of baseline and post-intervention assessment:** In experimental, and often in quasi-experimental study design, measurement of outcomes is done at two time points: prior to implementation of the intervention (baseline) and following completion of the intervention (endline). In both Rwanda and Uganda, some services and activities measured within the CPI were continuations of previous programs implemented prior to baseline, some were new or renewed efforts to achieve specific outcomes, i.e. birth registration efforts in Rwanda, and some aspects of the Framework were expected to be implemented within the time frame between T1 and T2 studies. As such, the design of the CPI Study seeks to measure and capture system strength *change over time*, and changes to child protection outcomes over that same time period, without being able to claim that the changes are wholly due to implementation of the Framework.

iii. **Use of a comparison group:** In planning for the CPI Study, it was evident that implementation of the Framework does not allow for a comparison group. Within a single camp, it is not possible to identify individuals or groups who were not "exposed" to the child protection system. Some individuals or groups may have come into *more* contact with services and activities within the child protection system, but selecting this group as an intervention group risks selecting a group with higher need than other individuals or households, i.e. individuals or households in this group may have more contact with the child protection system because they have higher needs and have experienced greater child protection issues. As such, the CPI Study is not able to determine what would happen in the absence of the UNHCR Framework, or other systems-strengthening efforts.

The objectives of the CPI Study – specifically, measurement of change in terms of a system, rather than a single intervention – necessitated the study design selected. Limitations embedded within this study design are acknowledged and addressed to the extent possible. For example, lack of an experimental approach entails that linkages between change in system strength and outcomes may not be clear, and this is addressed using qualitative methods in the follow-up study. Moreover, these specific limitations could be further addressed by conducting a T3 study, measuring the subsequent changes and patterns of associations between changes in system strength and child protection outcomes.

3. FINDINGS

3.1 Changes in child protection system strength

Table 2: Changes in Child Protection Index (CPI), Kiziba Camp, Rwanda, 2013-2015

Source	Area	Scoring System	T1 Kiziba Score (n=10)	T2 Kiziba Score (n=14)	Kiziba Score Change
PROCEDURES			**23**	**30.5**	**+ 7.5**
1. Is violence against children and adolescents addressed in a Standard Operating Procedure (either a separate SOP or within SGBV SOP)?					
Key informant interview	Procedures	Yes = 3 No = 0	3	3	–
11. Did the most recent participatory assessment include a focus on adolescents?					
Key informant interview	Procedures	Yes = 1 No = 0	1	1	–
18. Is there a child protection focal point at UNHCR in this location?					
Key informant interview	Procedures	Yes = 4 No = 0	4	4	–
19. What % of children born in this location are registered?					
Key informant interview	Procedures	90% or more = 3 80-90% = 2 Less than 80% = 0	0	3	3
20. Do adolescents have their own individual ID card?					
Key informant interview	Procedures	Yes = 2 No = 0	0	2	2
21. Does every child at risk (vulnerable children and children who have experienced violence/abuse/neglect) receive a BIA?					
Key informant interview	Procedures	Yes = 2 No = 0	2	2	–
22. Is there a functioning BID panel?					
Key informant interview	Procedures	Yes = 2 No = 0	2	2	–
23. Are family tracing and reunification services available/ operational in this location?					
Key informant interview	Procedures	Yes = 3 No = 0 Not available but not needed = 1.5	3	1.5	-1.5

Source	Area	Scoring System	T1 Kiziba Score (n=10)	T2 Kiziba Score (n=14)	Kiziba Score Change
24. What is the % of UASC for whom tracing has reached an outcome (positive or negative)?					
Key informant interview	Procedures	More than 80% = 1 Less than 80% = 0	0	1	1
25. Are there alternative care options in place for UASC?					
Key informant interview	Procedures	Yes = 1 No = 0	0	1	1
27. Is there a backlog of resettlement cases because BIDs are pending?					
Key informant interview	Procedures	No = 1 Yes = 0	0	1	1
28. For UASC, what durable solutions are currently available: resettlement, local integration, voluntary repatriation, none					
Key informant interview	Procedures	More than one durable solution available = 4 One durable solution available = 2 No durable solutions available = 0	2	2	–
29. Is statelessness an issue that affects children in this location?					
Key informant interview	Procedures	No = 2 Yes = 0	2	2	–
30. Is this country a signatory of the 1951 Convention or does it have national asylum procedures in place?					
Key informant interview	Procedures	Yes = 2 No = 0	2	2	–
31. Do refugee children have access to free primary education?					
Key informant interview	Procedures	Yes = 2 No = 0	2	2	–
32. Do refugee children have access to free secondary education?					
Key informant interview	Procedures	Yes = 2 Some levels are free = 1 No = 0	1	1	0
SERVICES			**20**	**26**	**6**
10. Are there age-appropriate complaints mechanisms for adolescents?					
Key informant interview	Services	Yes = 4 No = 0	0	4	4
12. Are there clubs and committees that adolescents participate in?					
Key informant interview	Services	Yes = 3 No = 0	3	3	–
14. Are there technical and vocational activities (life skills training) for adolescents in the camp?					
Key informant interview	Services	Yes = 3 No = 0	3	3	–
16. Are there sports and recreation activities organized by UNHCR or partners for children and adolescents?					
Key informant interview	Services	Yes = 3 No = 0	3	3	–
26.i. Health services/ support					
Key informant interview	Services	Yes = 2 No = 0	0	2	2

Source	Area	Scoring System	T1 Kiziba Score (n=10)	T2 Kiziba Score (n=14)	Kiziba Score Change
26.ii. Psychosocial services/ support					
Key informant interview	Services	Yes = 2 No = 0	2	2	–
4. Are there community-based child protection mechanisms in this camp?					
Key informant interview	Services	Yes = 4 No = 0	4	4	–
6. Are there communal spaces for adolescents to meet?					
Key informant interview	Services	Yes = 3 No = 0	3	3	–
8.i. Do schools/informal learning areas have separate latrines?					
Key informant interview	Services	Yes = 2 No = 0	2	2	–
8.ii. Are there more than 50% female teachers?					
Key informant interview	Services	Yes = 2 No = 0	0	0	–
8.iii. Are schools/informal learning environments accessible for children with different types of disabilities?					
Key informant interview	Services	Yes = 2 No = 0	0	0	-
UTILIZATION			**18**	**22**	**4**
2. % of adolescents who indicated in their response in the survey that they had experienced sexual violence who formally reported their experience (in the past 12 months)*					
Adolescent survey	Utilization	> 80% = 5 60-80% = 2 < 60% = 0	0	0	–
3. % of adolescents who received services following an experience of sexual violence or abuse**					
Adolescent survey	Utilization	> 80% = 5 60-80% = 2 < 60% = 0	0	0	–
5. % of adolescents who have used a community- based child protection mechanism for some form of support (in the past 12 months)					
Adolescent survey	Utilization	≥ 60% = 2 < 60% = 0	0	2	2
7. % of adolescents who have attended school in the past year					
Adolescent survey	Utilization	> 80% attended school in past year = 5 60-80% attended school in past year = 2 < 60% attended school in past year = 0	5	5	–
9. % of adolescents reporting they feel safe at school all or most of the time					
Adolescent survey	Utilization	> 70% reporting safety all or most of the time = 5 50-70% reporting safety all or most of the time = 2 < 50% = 0	5	5	–
13. % of adolescents participating in clubs or committees in the past year					
Adolescent survey	Utilization	> 70% = 4 50-70% = 2 < 50% = 0	2	4	2

Source	Area	Scoring System	T1 Kiziba Score (n=10)	T2 Kiziba Score (n=14)	Kiziba Score Change
15. % of adolescents participating in life skills training in the past year					
Adolescent survey	Utilization	> 70% = 4 50-70% = 2 < 50% = 0	2	2	–
17. % of adolescents participating in structured recreation activities in the past year					
Adolescent survey	Utilization	> 70% = 4 50-70% = 2 < 50% = 0	4	4	–
Maximum available score			100	100	
TOTAL			**60**	**78.5**	

*Notes. Orange squares indicate improvement from 2013 to 2015 and blue squares indicate a worsening from 2013 to 2015. * This figure likely underestimates the number of adolescents who experience sexual violence and do not report, as it relies on an adolescent respondent having indicated in the course of the survey that they were a victim of violence. ** This item indicates services that the respondent reports having received, regardless of whether they formally reported the incident or not.*

Points – Total possible 100

- 81-100 indicates **HIGHLY FUNCTIONAL** child protection system
- 51-80 indicates **MODERATE LEVEL** child protection system
- 50 and below indicates comparatively **WEAK** child protection system

Scoring:

Domain (possible points)	2013	2015	Change
Utilization (35)	18	22	+4
Procedures and processes (35)	22	30.5	+8.5
Services (30)	20	26	+6
Total	60	78.5	+18.5

Total score for Kiziba camp change from 2013 to 2015 was + 18.5 points. The strength of the child protection system in Kiziba Camp was maintained at a moderate level.

The following discusses three aspects of system strength between T1 and T2: stability, lack of improvement or decrease in strength, and improvement:

STABILITY

The majority of the CPI was stable across time periods. There are several components of the CPI that child protection actors would hope to see hold stable over time, and which indicate maintained system strength. Evidence of maintained system strength is reported in a range of procedures: existence of SOP for violence against children and adolescents; adolescent inclusion in participatory assessments; presence of a local UNHCR child protection focal point; BIAs for vulnerable and victimized children; functioning BID panel; measures to address statelessness; Rwanda as a signatory status of 1951 Convention with requisite asylum procedures; and access to no-fee, free primary and secondary education.[4]

[4] Free access to part of secondary school was available in 2013 and 2015. In December 2015, after the final T2 data collection had completed, but before follow-up qualitative interviews were conducted, it appears that agreements for free complete secondary education were reached between UNHCR and Rwandan government. The lack of 'complete' free secondary

TEXTBOX 8:

HAS THE CHILD PROTECTION SYSTEM IN KIZIBA CAMP BEEN STRENGTHENED?

One of the key objectives of the CPI Study is to ascertain i) level of system strength at two time-points, ii) change in system strength over time by comparing change in system strength between the two time points, and iii) the impact of that change. Therefore, determining whether a change in system strength has indeed occurred is a key element of the overall study.

Has the child protection system in Kiziba Camp been strengthened, from 2013 to 2015? A discussion paper on child protection systems in emergencies noted that systems-strengthening "refers to actions taken to improve the functioning, coordination, integration and, ultimately, effectiveness of these components and their interaction… A system is deemed to have been strengthened if there is evidence of, for example: additional capacity; improvement in the quality of processes and services; expanded reach; integration or coordination of mechanisms that were previously separate, and improvement in the functioning of processes and mechanisms" (Save the Children UK on behalf of the Child Protection Working Group, 2010). The CPI ultimately measures outputs, not inputs: that is, whether significant efforts have gone towards elements of systems strengthening is not captured, but the ultimate impact of these efforts is assessed within the items included in the CPI. The CPI indicates that there have been some modest improvements in child protection system strength in Kiziba Camp. However, as discussed in the remainder of this report, while there are some promising improvements in child protection outcomes, for example, reduction in caregivers' perceptions of appropriateness of beating in response to children's behavior, these improvements do not appear to have had significant effects on well-being and safety. Some perceptions of reasons for this are highlighted throughout the report in Textboxes drawing on follow-up research conducted in March 2016, and further discussion of the relationship between systems strengthening and child protection outcomes, as identified in the CPI Study in Rwanda, is presented in *Synthesis*.

In addition, the following areas of services were maintained over time: adolescent clubs, committees, sports and recreational activities; communal space; technical and vocational activities; community-based child protection mechanisms; and separate latrines for school and educational areas.

Finally, the following areas of utilization were maintained: percentage of adolescents attending school; feeling safe at school most of the time; participating in life skills training; and structured recreational activities

LACK OF IMPROVEMENT

Other specific areas were stable overtime, however, this stability indicates a lack of improvement in key child protection domains. These are domains in which system strengthening would entail improvement in achievements in these areas. In the services domain, less than half of teaching staff is currently female. Gender parity in teaching staff is important for achieving gender parity in educational attainment and can facilitate abuse disclosure. Schools are still inaccessible and inadequate learning environments for children with disabilities, which serves as an impediment to children's meaningful access to education and potential preventive effect of educational attainment. In the utilization domain, it is clear that adolescents are still under-reporting violence, and adolescents are still receiving inadequate services after sexual violence victimization.

There was also some evidence of system-slippage from 2013 to 2015. Specifically it appears that family tracing and reunification services are no longer available or operational in Kiziba. Through qualitative interviews it appears that the services are available but that they are not currently being used, thus not operational. Therefore, it is unclear whether lack of family tracing and reunification services is due to a function of community need versus a system failure.

education was often listed in focus group discussions with adolescents as a source of both psychosocial stress and delinquency on the part of those students who could not afford to pay school fees to complete their secondary education.

TEXTBOX 9:

UTILIZATION OF SERVICES IN KIZIBA CAMP

Utilization was also the weakest area in the T1 study, with the conclusion in that study noting "Kiziba Camp received no points on some important components of utilization, most notably, reporting of violence or abuse, receipt of services after violence or abuse, and use of community-based child protection mechanisms. While data collected using the adolescent survey indicates that knowledge and awareness of these systems is high, it is unclear whether this knowledge translates to adequate utilization of these systems, resulting in improvements of child protection." This is again an area of concern. Data collected at T2 indicates that utilization of key services is still weak. While procedures and services are essential to a strong child protection environment, if children and adolescents are not accessing these services the impact of these services will not be fully realized.

The utilization component of the CPI is a proxy for quality of services. Services in this context may be low-quality for a range of reasons, including:

- Services are perceived by community members as inappropriate – for example, the way in which a service is designed or delivered is a mismatch with community or individual priorities or perceptions of priority risks;
- Services are difficult to access or reach – services have direct or indirect costs, or are located in areas that are difficult to reach;
- Knowledge or understanding of the purpose and availability of services is low

Focus group discussions with adolescents indicated that while there are services available for survivors of sexual violence, these services are perceived as inadequate and often ineffective. For example, in one focus group discussion, adolescents discussed services for adolescent girls who had given birth after sexual violence, noting, *"when the survivor has a baby, she receives not enough material support, they just give her few clothes for children."* In another example, an adolescent explained, *"when there is a case of sexual violence, the alleged perpetrators are arrested but there are some who came back in the camp and the parents got anxious when seeing the perpetrator back."* In particular, services provided to address sexual violence may not adequately take into account the significant stigma associated with sexual violence in this context. As one adolescent girl in a focus group discussion explained, *"[t]he girls of our age like keeping quiet [about sexual violence] because of being afraid that people may think we are responsible and that we did by our will."* In addition, low service utilization may be due to factors related to community norms and practices. As one adolescent reported in a focus group discussion, *"when chief of quartier is a friend of one who did the abuse, the leader doesn't follow-up and no action taken."* Community structures and norms may present powerful obstacles to improved utilization of services, particularly in the area of sexual violence.

Given this, it may be understandable that refugees would be unwilling to utilize existing services for survivors of sexual violence. Qualitative data from the CPI Study indicates some possibilities as to why service quality appears to be low. However, a more systematic investigation of these factors is warranted in order to identify approaches to service improvement.

IMPROVEMENT

There were many areas of marked improvement reported. Specifically, improvement was documented with respect to procedures (percentage of children born and registered; unique ID card for adolescents; UASC family tracing outcomes and alternative care options; lack of resettlement case backlog because of pending BIDs; Rwandan non-discrimination educational policies), services (adolescent age-appropriate complaint mechanism), and utilization (adolescents who have reported using a Child Protection Committee in past year and who participated in clubs and committees).

Based on the overall analysis of the CPI, the child protection environment in Kiziba is still ranked as moderate, although there was some slight overall improvement from 2013 to 2015, mostly related to strong procedural work. To move from moderate to high, the child protection system must maintain the current levels of programming and services while increasing the focus on service utilization, the weakest performing domain here.

3.2 Violence and abuse

3.2.1 EXPOSURE TO VIOLENCE AND ABUSE

Adolescents continue to experience high levels of exposure to violence and abuse in their homes in Kiziba. In 2015, 46.6% reported ever experiencing any type of physical, sexual, or psychological abuse, and that number drops to only 45.4% (only three less adolescents) when asked about any violence in the past year. A significant number of adolescents reported witnessing abuse in the home, with 18.0% reporting being scared of someone at home because they had used drugs or alcohol; 70.1% had been frightened by adults arguing; 20.7% had witnessed adults physically abuse each other; and 3.6% had seen someone hurt or intimidated with a weapon of some sort in the home.

28.3% of adolescents reported ever experiencing any psychological abuse (27.5% of whom reporting in the past year). Specifically, 24.4% reported having been screamed or yelled at loudly; 6.4% were called names; 8.8% were wished dead; 6.0% were threatened with abandonment; and 2.8% were directly threatened with harm or death. Similarly, 25.9% reported ever experiencing physical abuse (24.3% of whom experienced in the past year). Reported abuses included: 8.8% were pushed, grabbed, or kicked; 16.3% were hit with a hand; 9.6% were hit with a foreign object (belt, paddle, stick, etc.); 6.8% had their hair pulled, pinched, or ear twisted; and none reported being threatened with a knife or a gun.

With respect to sexual violence, in 2015 4.8% of adolescents reported experiencing some type of sexual abuse within the past year. Specifically, 1.2% of adolescents reported being physically forced to have sexual intercourse; 2.4% were persuaded to have sexual intercourse against their will; and 2.8% were sexually touched against their will. Table 3 below provides details of life-time adolescent exposure to violence, for past year output see Appendix 4. Table 13 in the appendix also includes comparison of gender exposures between boys and girls.

Table 3: Change in exposure to verbal and physical violence between T1 and T2

Question	T1	T2	Change
	N (%)	N (%)	p-value
Exposure to violence in the home			
Has anyone in your home ever used drugs and/or alcohol and then behaved in a way that frightened you?			
Yes	16 (12.4)	45 (18.0)	0.160
No	113 (87.6)	205 (82.0)	
Have you ever seen adults in your home shouting and yelling at each other (arguing) in a way that frightened you?			
Yes	93 (72.1)	176 (70.1)	0.120
No	34 (26.4)	75 (29.9)	
Missing	2 (1.6)	0 (0.0)	
Have you seen adults in your home hit, kick, slap, punch each other or hurt each other physically in other ways?			
Yes	23 (17.8)	52 (20.7)	0.500
No	106 (82.2)	199 (79.3)	
Have you ever seen anyone in your home use knives, guns, sticks, rocks or other things to hurt or scare someone else inside the home?			
Yes	4 (3.1)	9 (3.6)	0.800
No	125 (96.9)	241 (96.4)	
Verbal, physical, and emotional abuse in the home			
Has anyone in your family or living in your home ever screamed at you very loudly and aggressively?			
Yes	32 (24.8)	61 (24.4)	0.930
No	97 (75.2)	189 (75.6)	
Has anyone in your family or living in your home ever called you names, said mean things or cursed you?			
Yes	12 (9.3)	16 (6.4)	0.300
No	117 (90.7)	235 (93.6)	
Has anyone in your family or living in your home ever said that they wished you were dead/ had never been born?			
Yes	6 (4.7)	22 (8.8)	0.150
No	123 (95.3)	229 (91.2)	
Has anyone in your family or living in your home ever threatened to leave you forever or abandon you?			
Yes	8 (6.2)	15 (6.0)	0.930
No	121 (93.8)	236 (94.0)	
Has anyone in your family or living in your home ever threatened to hurt or kill you, including invoking evil spirits against you?			
Yes	2 (1.6)	7 (2.8)	0.450
No	127 (98.4)	244 (97.2)	

Question	T1	T2	Change
	N (%)	N (%)	p-value
Has anyone ever pushed, grabbed or kicked you?			
Yes	14 (10.9)	22 (8.8)	0.510
No	115 (89.1)	229 (91.2)	
Has anyone in your family or living in your home ever hit, beat or spanked you with a hand?			
Yes	24 (18.6)	41 (16.3)	0.580
No	105 (81.4)	210 (83.7)	
Has anyone in your family or living in your home ever hit, beat or spanked you with a belt, paddle, a stick or other object?			
Yes	14 (10.9)	24 (9.6)	0.720
No	115 (89.1)	226 (90.0)	
Don't know	0 (0.0)	1 (0.4)	
Has anyone in your family or living in your home ever pulled your hair, pinched you, or twisted your ear?			
Yes	14 (10.9)	17 (6.8)	0.170
No	115 (89.1)	234 (93.2)	
Has anyone in your family or living in your home ever made you stay in one position holding a heavy load or another burden or making you do exercise as punishment?			
Yes	13 (10.1)	19 (7.6)	0.410
No	116 (89.9)	232 (92.4)	
Has anyone in your family or living in your home ever threatened you with a knife or a gun?			
Yes	2 (1.6)	0 (0.0)	**0.050**
No	127 (98.4)	251 (100.0)	
Sexual violence in the past year			
Was there a time when you were physically forced to have sexual intercourse against your will?			
Yes	5 (4.2)	3 (1.2)	0.070
No	115 (95.8)	248 (98.8)	
Was there a time when you were persuaded or pressured to have sexual intercourse against your will?			
Yes	2 (1.6)	6 (2.4)	0.590
No	127 (98.4)	245 (97.6)	
Was there a time when you were touched against your will in a sexual way, such as unwanted touching, kissing, grabbing, or fondling, but the person did not try to force you to have sex?			
Yes	10 (7.8)	7 (2.8)	**0.030**
No	119 (92.2)	244 (97.2)	

T2 findings indicate that adolescents' experience and witnessing of violence continues to be an issue and has worsened in some areas for some adolescents. Adolescents were nearly six times as likely in 2015 as in 2013 to report having been threatened or injured with a weapon on school property. Adolescents generally reported experiencing less sexual violence in 2015 than in 2013 (aOR= 0.34, 95% CI: 0.14-0.83, after adjusting for age and gender), however girls are still 2.6 times (95% CI: 1.0-6.8) as likely to report having experienced sexual violence as compared to boys (after adjusting for age and time).

There are some differences in exposure to violence between boys and girls. Girls report statistically significantly higher levels of witnessing family arguments (1.6 times more likely than boys, for T1 and T2) and witnessing intra-adult physical abuse (2.5 times more likely than boys, for T1 and T2). Adolescents who witnessed family arguments in 2013 are 1.5 times as likely to have witnessed it in 2015, after adjusting for age (aOR1.51; 1.07-2.13), indicating continuity of negative household dynamics.

Through qualitative focus groups, adolescents emphasized that physical and sexual abuse constitutes major risks for adolescents in Kiziba Camp, along with parental neglect and child labor (explored further in subsequent sections). Adolescents interviewed during T2 data collection attributed these experiences to drug and alcohol abuse. For example, an adolescent noted, *"The children under 18 years are victims of alcohol and the drugs. They are the children who were physically abused by the drug users."* Another explained, "*Most of the violence is the consequence of taking alcohol or drugs."* Caregivers' alcohol-use was explained as related to physical abuse and neglect, for example, adolescents explained, *"The children are physically abused most by the father who is a drinker,"* and *"Children are neglected by their parents and you find this problem to the families where the parents drink."*

Key informants also noted various influences on family violence, for example, a key informant explained:

> *"In terms of abuse, we know that it relates to the parents, who are facing challenges regarding income generating activities. Women have managed to continue the same activities, such as caring for children, cooking, small market work. For men, it's much more*

TEXTBOX 10:

DIFFERENCES IN CHILD PROTECTION OUTCOMES BETWEEN BOYS AND GIRLS

UNHCR policy, including *Age, Gender and Diversity Mainstreaming*, recognizes the need to recognize different child protection risks for girls and boys, and based on this information, design and deliver prevention and response programs appropriate to boys and girls. Objectives within the Age, Gender and Diversity Mainstreaming Framework include integration of age, gender and diversity within programming, and that targeted services and services to address specific needs are age, gender and diversity sensitive; in the area of gender, this requires an understanding of the differential risks experienced by boys and girls (UNHCR, 2011).

Disaggregated findings by sex for all outcomes are presented in the Appendix. Some of the differences between girls and boys identified were:

- Girls are 1.6 times more likely than boys to report witnessing family arguments, at either time-point (95% CI: 1.02, 2.51);
- Girls are 2.5 times more likely to report witnessing intra-adult physical abuse in the household, at either time-point (95% CI: 1.44, 4.34);
- Girls (but not boys) reported a significant increase in being exposed to arguing in the home in a way that frightened them (92.9% in 2013 to 100.0% in 2015, p-value=.015);
- Girls (but not boys) reported feeling unsafe at school (16.0% in 2013 to 30.6% in 2015, p-value=.049);

Qualitative research also indicates that barriers to reporting experiences of violence are particularly significant for girls, who are afraid that the stigma of sexual violence may result in perceptions that they chose to be sexually active and/ or that they have brought shame to their family.

> *challenging, they used to be cattle keepers, that means that you need to have cattle, this is no longer possible in the camp…[this] leads them to start drinking more and abusing alcohol, which leads to domestic violence."*

Lack of access to livelihood opportunities, the length of displacement, and lack of apparent future opportunities for both adolescents and adults in Kiziba Camp contributes to levels of violence in this context.

Qualitative interviews with key informants indicated that interventions for prevention of violence and neglect and response (community sensitization, education, engagement, and response services, and targeted prevention), and advocacy and awareness raising are lacking. There are several interventions that are active and were identified in dissemination meetings with key informants as addressing some of the key child protection issues assessed in this study, for example, community sensitization and awareness-raising programs. However, key informants also indicated that there are some gaps in capacity and lack of interventions to address some issues, for example, psychosocial well-being.

There are no significant changes in CPI strength in areas related to violence or sexual abuse. Therefore, the relatively stable levels of experienced violence overall may be related to the lack of change in these areas in the child protection system. However, while this indicates stability of child protection system strength, this simultaneously reflects a failure of the child protection system to address some of most important child protection outcomes areas.

Qualitative research also indicated that areas beyond what is captured in the current CPI – for example, improving drug and alcohol prevention and treatment programming – could effectively address levels of violence, as adolescents repeatedly attribute violence to substance abuse both within and outside the home.

3.2.2 ATTITUDES TOWARDS CHILD MALTREATMENT

There was a significant reduction in caregiver reported acceptability of child maltreatment, specifically physical abuse, from 2013 to 2015 (See Table 18 in the Appendix for a detail output of change in caregiver attitudes). Caregivers reported


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a significant decrease in acceptability of physical abuse if a child does not want to go to work (32.8% endorsed beating in 2013 compared to 22.2% in 2015) or if a child does not care for his/her siblings (21.6% endorsed beating in 2013 compared to 13.5% in 2015). Other items on physical abuse acceptability have maintained at their 2013 levels, with stealing (55.6% endorsed beating for stealing in 2013 compared to 59.3% in 2015) being the most commonly endorsed condition where beating a child would be appropriate and child refusal to marry (4.2% endorsed in 2013 compared to 2.4% in 2015) being the least often endorsed and dropping.

From focus group discussions with adolescents, it is evident that that family conflict, physical abuse and violence are consistently identified as important, however adolescents generally rank sexual violence and early marriage as more pressing concerns compared to physical abuse (see Appendix 5 for detailed results of ranking of child protection risks from focus groups discussions with adolescents). This could reflect a number of things: the ubiquity and normalcy of physical abuse in this setting, the stigma associated with sexual violence compared to lack of stigma surrounding victimization by physical violence, or an indication that physical abuse is on the decline while sexual abuse is still a salient threat to adolescents. Key informants in the follow-up phase and in dissemination meetings identified a 'culture of silence' as a key factor influencing these risk factors; caregivers and adolescents often do not formally engage child protection organizations (implementing partners or community-based child protection mechanisms) to address cases of sexual violence or early marriage.

This apparent decline in acceptability of physical abuse could also be the result of improved recent awareness-raising activities designed by adolescents, as indicated in the CPI. Moreover, while the time period between 2013 and 2015 may be too short to see an impact of changes in attitude on behaviors of caregivers towards children, it is possible that these changes in attitude will result in a decrease of violence against children in the household.

3.3 Adolescent and caregiver psychosocial well-being

3.3.1 ADOLESCENT PSYCHOSOCIAL WELL-BEING

In 2015 adolescents indicated heightened levels of anxiety, as measured by the Screen for Child Anxiety Related Emotional Disorders (SCARED), with a mean score of 2.2 out of 10[5] (Birmaher et al., 1999). Adolescents reported mostly 'normal' levels of emotional symptoms; based on the Strengths and Difficulties Questionnaire adolescents mean score of 3.8 out of 10[6] (Goodman, 2001). The mean Children's Hope Scale, measuring levels of hope and optimism about the future was 11.0 out of 18[7] (Snyder et al., 1997). Adolescents also indicated high levels of resiliency as measured by the Children and Youth Resilience Measure, with a mean 51.5 out of a possible 66[8] (Resilience Research Centre, 2009).

There is evidence of adolescent psychosocial well-being degradation across all adolescent-reported psychosocial well-being measures from 2013 to 2015. The Screen for Child Anxiety Related Emotional Disorder (SCARED) suggests a statistically significant increase in anxiety symptoms from 2013-2015 (2013 mean score 1.7, 2015 mean score 2.2). Based on the emotional symptoms sub-scale of the SDQ, adolescents reported statistically significantly increase in emotional symptoms (2013 mean score 3.1, 2015 mean score 3.8). Adolescents' resilience also declined significantly overtime (mean 55.3 in 2013 reduced to mean 51.5 in 2015). Psychosocial well-being degradation appears most pronounced among those who were suffering in 2013. Adolescents who endorsed more anxiety symptoms on SCARED in 2013 had a statistically significant increase in anxiety symptoms in 2015 (β=0.27, 95% CI: 0.11-0.44). Adolescents with higher scores on the emotional symptoms sub-scale of the SDQ reported statistically significantly increase in emotional symptoms in 2015 (β= 0.25, 95% CI: 0.10-0.39). Adolescents' with lower resilience in 2013 also declined significantly by 2015 (β=0.31, 95% CI: 0.14-0.48).

Moreover, when conducting the matched analysis (comparing only respondents who were interviewed both at T1 and T2), the reduction in mean emotional symptoms score for males and females was also significant; levels of hope in the matched analysis for the whole sample and for males were significantly decreased. The matched analysis indicates that the comparison of respondents who participated in both T1 and T2 showed significant reductions in psychosocial well-being on all measures – anxiety, emotional symptoms, hope and resilience, whereas for the full comparison, the reduction in well-being is evident in anxiety, emotional symptoms and resilience outcomes. Both sets of analysis provide strong evidence for a reduction in psychosocial well-being across a number of measures. This degradation could be related to the sustained high levels of violence in the camp, and that over time have left adolescents feeling less and less optimistic about their current life and future.

Findings from qualitative work suggest that financial constraints, insecurity, teenage pregnancy, drug and alcohol abuse, and insufficient service improvement are potential sources of adolescent stress and hopelessness

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5 Clinical-cut offs for the complete SCARED instrument are available from Birmaher et al 1999, however the current instrument included only 5 items, and as such there are no available psychometric evaluations. There is insufficient evidence at this time to validate context specific cut-offs for this population, therefore, continuous scores are reported here. Categorical cut-off score data are presented in Appendix 4.

6 Clinical-cut offs for the complete SDQ emotional symptoms score subscale are available from Goodman 2001, however there are no available psychometric evaluations on adolescents in Rwanda or similar settings. There is insufficient evidence at this time to validate context specific cut-offs for this population, therefore, continuous scores are reported here. Categorical cut-off score data are presented in Appendix 4.

7 Clinical-cut offs for the complete Children's Hope Scale are available from Snyder et al 1997, however there are no available psychometric evaluations on adolescents in Rwanda or similar settings. There is insufficient evidence at this time to validate context specific cut-offs for this population, therefore, continuous scores are reported here. Categorical cut-off score data are presented in Appendix 4.

8 Clinical-cut offs for the complete Children's Hope Scale are available from Snyder et al 1997, however there are no available psychometric evaluations on adolescents in Rwanda or similar settings. There is insufficient evidence at this time to validate context specific cut-offs for this population, therefore, continuous scores are reported here. Categorical cut-off score data are presented in Appendix 4.

Table 4: Change in adolescent psychosocial well-being, mean and by gender

Scale	T1	T2	Change	Female			Male		
				T1 (N=77)	T2 (N=133)	Change	T1 (N=52)	T2 (N=118)	Change
	Mean [SD]	Mean [SD]	p value	Mean [SD]	Mean [SD]	p-value	Mean [SD]	Mean [SD]	p-value
SCARED	1.7 [2.3]	2.2 [2.5]	**0.046**	1.6 [2.4]	2.0 [2.5]	0.335	1.7 [2.2]	2.4 [2.5]	0.07
Emotional symptoms scores, SDQ	3.1 [2.5]	3.8 [2.9]	**0.03**	3.2 [2.6]	3.8 [2.9]	0.129	3.0 [2.3]	3.7 [2.8]	0.119
Children's Hope Scale	11.2 [2.8]	11.0 [3.1]	0.43	11.1 [3.0]	11.1 [3.2]	0.955	11.5 [2.5]	10.9 [3.0]	0.23
Children and Youth Resilience Measure	55.3 [8.1]	51.5 [9.2]	**<0.001**	55.7 [8.2]	52.8 [9.2]	**0.02**	54.6 [2.0]	50.2 [9.0]	**0.003**

Notes. **Bold** *indicates statistically significant finding, p<0.050. SCARED = Screen for Child Anxiety Related Emotional Disorder; SDwQ = Strengths and Difficulties Questionnaire*

3.3.2 CAREGIVER PSYCHOSOCIAL WELL-BEING

Caregivers in Kiziba Camp are also under considerable amounts of stress, which affects their psychosocial well-being. In 2013, 76.0% of caregivers met the Hopkins Symptom Checklist cut-off for emotionally distressed. In 2015, that percentage stayed high with 71.8% meeting the emotionally distressed level. In 2013, 71.3% of caregivers met the cut-off for major anxiety; that percentage in 2015 dropped slightly to 65.9%. The amount of caregivers meeting the threshold for depression increased, although not significantly, from 2013 to 2015 (72.0% met major depression level in 2013 and 79.4% met major depression level in 2015). Subsequent sections will explore potential sources of caregiver stress; here it is important to note the high burden of emotional stress and the toll this has on a caregiver's psychosocial well-being.

3.4 Feelings of safety

Adolescents report high levels of feelings of lack of safety in the past week in 2015. 25.3% reported feeling unsafe in their home; 30.3% at school; 29.2% en-route to school; 17.3% in public camp spaces, such as the market; 18.5% en route to a public camp space; 11.8% at work; and 7.1% (n=1) en route to work (see Table 25 in Appendix 4. iii for detailed output for adolescent change in feelings of safety).

After adjusting for sex, adolescents were 3.7 times more likely to report feeling unsafe on the way to or from school in the past week in 2015 as compared to 2013 and 2.0 times more likely to report feeling unsafe on the way to or from the market (see Tables 27-28, Appendix 4 for detailed output). Conversely, once at school, after adjusting for age and gender, adolescents were less likely (aOR=0.34, 95% CI: 0.14-0.83) to report experiencing violence (physical, psychological, or sexual) in 2015 as they were in 2013, thus implying improved safety within the school premise.

Vulnerable populations, such as those who have no living biological parents, reported feeling significantly less safe at home in 2015 than in 2013. Those who felt unsafe in 2013, adjusting for their biological parental status, were 3.9 times as likely to report feeling unsafe at home as compared to those who did not report feeling unsafe in 2013 (aOR: 3.9, 95% CI: 1.29-11.64)

Changes in levels of feelings of safety between 2013 and 2015 indicate that adolescents experience a deterioration of security in Kiziba Camp from 2013 to 2015. More adolescents in 2015 reported feeling unsafe at home, school, and generally the camp environment, though the difference reached statistical significance only when related to traveling to and from school (10.2% in 2013 and 29.2% in 2015) and the market (10.1% in 2013 and 18.5% in 2015). Girls feel significantly less safe at school in 2015 (30.6%) as compared to 2013 (16.0%) and

TEXTBOX 11:

FOLLOW-UP FINDINGS:

What might be some of the reasons for the decrease in adolescent psychosocial well-being between 2013 and 2015?

Follow-up research investigated perceptions of reasons for the decline in psychosocial well-being amongst adolescents. Adolescents, caregivers and key informants reported a number of reasons for a decrease in psychosocial well-being in Kiziba Camp.

In focus group discussions conducted at T2, adolescents highlighted living conditions in the camp and lack of hope for future opportunities as reasons behind this decline, stating for example:

> *"adolescents are in need of many things which are beyond the economic capacity of their parents."*

> *"thoughts are many because of the way of living is not easy."*

> *"As the adolescent are growing up, the needs also are increasing and there are no able to satisfy them, this makes them feel uncomfortable and sad and useless in the family."*

> *"…due to the problem of lack of school fees after senior 3 the girls become hopeless and the boys who also delinquents provide the small gifts and those girls sleep with them and as consequence the girls get pregnant or infected with HIV/AIDS"*

A caregiver also noted the influence of economic hardship on adolescents' well-being, reporting in a focus group discussion conducted in the follow-up research phase, *"In 2015, the children were worried and anxious because they had the no hope, their parents did not have the capacities to pay the school fees."* Lack of school attendance was linked by caregivers to psychosocial well-being. As discussed further in Textbox 7 below, adolescents being out of school was linked to delinquent behaviors, including drug and alcohol use, and lack of hope for the future. One caregiver explained, *"the adolescents were sad in 2015 compared to 2013, because they weren't school, and they were worried about their future."* Another noted, *"they were hopeless because of drugs, they had no activities for keeping them busy."* While access to education in Kiziba Camp appears to be improving, it is evident that adolescents and caregivers still note gaps in access, and perceive a strong linkage between access to education and psychosocial well-being. One caregiver described the limitations of education, despite expanding opportunities: *"before, the children have not the chance to continue the studies, and that has changed. But the problems remain in the family. We do not have the capacities to satisfy the basic needs of our children. Our children cannot feel well because the parents cannot afford what they need. Even those who finish the studies they cannot get job."*

Lack of future options was discussed as a primary reason for increased anxiety and worry. An adolescent in a focus group discussion noted: *"In 2013 many students were very poor but had hope that to study [things could get better]…. but in 2015 – the poverty continue to increase and there is no hope in our studying – studying is for nothing."* Maintenance or apparent deterioration of services, as well as the passage of time, have led adolescents to feel increasingly hopeless about their futures. One caregiver explained during follow-up research, *"I agree, because some services are decreasing, this makes adolescents get worried about the future."* Some adolescents and caregivers connected the decline in psychosocial well-being to experiences of violence. An adolescent noted: *"when you get abused, you lose hope and you don't have any plan of the future."*

Key informants noted that the protracted nature of displacement led to adolescents losing hope for the future. One explained that adolescents

> *are getting more bored, sad, in a way that no matter what implementing partners do, life is not enjoyable. In the past, they may have thought life might get better – either returning or getting resettled or being reintegrated – but the situation remains the same. So in general, people are bored and sad and angry…They say life is worse and they are upset with the living conditions. There is no improvement. They eat the same, live in the same small house…they feel hopeless."*

Another key informant agreed that psychosocial well-being was related to the prolonged displacement, explaining

"These people are bored. They've been here for a long time. They are bored...they're fed with being in a protracted camp. They see the solution to all their problems as resettlement or going back. Young people want resettlement. Old people want to go back. No one wants to be here."

As such, the decline in psychosocial well-being is perceived not as directly related to specific events, services or changes in the child protection environment, but rather the pervasive and increasing hopelessness related to prolonged displacement. As one key informant noted during follow-up research, *"They have no hope to return in their home country because the situation comes worse than before."*

TEXTBOX 12:

LACK OF ACCESS TO SECONDARY EDUCATION, PSYCHOSOCIAL WELL-BEING AND PROTECTION RISKS

At the time of T2 data collection, adolescents' lack of access to secondary education continued to be an issue, and was discussed by several key informants. For example, one key informant explained:

> *"Lack of education opportunities results in youth and adolescents being idle which leads to vices, the lack of something constructive to do, they are pulled into things like alcoholism, drug use"*

Another noted that,

> *"If they are not at school, they are idle in the camp…[we] did some assessments and confirmed that out of school children are at higher risk to be abused, recruited. They have no routine, no reason to structure life...lack of upper secondary education also contributes to lack of motivation in lower levels because they see their brothers and sisters don't have opportunity to go. So they end up joining other activities."*

In summary, several key informants interviewed for the T2 phase of the CPI Study indicated that lack of opportunity to continue secondary education significantly contributed to child protection risks, that *"after lower secondary, the children stay in the camp and have nothing to do which leads to child protection risks. Examples of risks include delinquency, drugs and alcohol use, and early pregnancy."*

During the follow-up phase of research, several caregivers in focus group discussions reported that education services had improved. One caregiver explained, *"during the day, you cannot find the children in street, almost all are at school and this reduce the cases of delinquency."* These improved services had resulted in children's improved commitment to education; as one caregiver reported, *"during the night my child revises his courses [does homework] because he knows that after Senior 3, he will be promoted to Senior 4."* Improved education services are evident overall, with the launch in August 2015 of a Kepler University branch, allowing a small number of refugees each year to earn credit towards a U.S. accredited degree. Key informants and caregivers agreed that the increased educational opportunities had made it more possible for adolescents to continue their education, and less likely for adolescents to drop out.

While school fees are now completely free (as of 2016 follow-up), there are still associated fees with school resources or for those in vocational education courses. Also, while key informant interviews conducted during the follow-up phase indicate that out-of-school adolescents are no longer an issue, adolescents themselves continue to report issues related to school with respect to limited future expectations and goals, and the deterioration of psychosocial well-being is perceived and understood as related to this lack of opportunities and hope. Moreover, the impact of these increased educational opportunities on psychosocial well-being is not yet evident, as these changes in educational opportunities are recent and occurred shortly before or during the follow-up research for this CPI Study.

orphans feel less safe significantly more unsafe at home in 2015 (50.0%) as compared to 2013 (0.0%).[9] Adolescents are 3.7 times as likely to say they feel unsafe on the way to school and 2.0 times as likely to feel unsafe on the way to the market in 2015 as compared to 2013 (after adjusting for gender). When asked specifically about having a safe space to be with friends, significantly fewer adolescents said they had one in 2015 (33.1%) than in 2013 (48.8%). Those who had no space in 2013 were 3.2 times more likely to report not having a place in 2015 (aOR=3.22, 95% CI: 1.32-7.83).

Qualitative focus group discussion results suggest adolescents believe that the insecurity in their daily lives can be attributed to familial violence. For example, in focus group discussions conducted during T2 data collection, adolescents reported that alcohol-use can lead to household insecurity and separation: *"when a father become a drinker and causes the insecurity in family, the case is reported and they give him his own house."* Lack of accountability for perpetrators was described as factor in feelings of safety; one adolescent explained that there is *"no punishment for the perpetrators,"* and "*There is corruption between those in charge of security in the camp and the perpetrators."* This impacts adolescents' willingness to report violence, as *"[w]e are afraid of being ashamed and we know that there is corruption between the in charge of security in the camp and the perpetrators."*

Key informants agree with the need to prosecute perpetrators and also suggest that local Rwandan police presence could improve camp security, with one key informant explaining during an interview at T2: *"Police should come to the camp, a station inside the camp would improve security in the camp."*

Caregivers generally report stable levels of security concerns overtime. Change in items related to child safety in school (53.1% strongly agreed that children were safe in 2013 compared to 30.1% in 2015), on the way to school (44.9% strongly agreed that children were safe in 2013 compared to 22.7% in 2015), and in the market (37.5% strongly agreed that children were safe in 2013 compared to 19.0% in 2015) suggest a trend towards a slightly less safe environment. However these changes dissipate and lose significance when four-response categories are collapsed into two agree/disagree options, the format that was used for adolescent reports. Thus, caregivers report is somewhat inconsistent with adolescent self-report of a deterioration of safety within the camp. The figures below show the change, by area, of safety.

Safety in the camps also has an effect on adolescent psychosocial well-being. Results indicate that increased safety concerns were significantly associated with worsening anxiety, emotional well-being, resilience, and feelings of hope and optimism. This was true for males and females, regardless of adolescent's age or if they were living with one, two, or no biological parents (See Appendix 4. iii, Table 31: "Factors associated with continuous safety composite score" for multivariate regression details)

Adolescents generally reported a decrease in feelings of safety, whereas caregivers generally report stable levels of security concerns over time. Some changes in CPI score indicate positive improvements in the security situation. The CPI results indicate that in 2013 there were no age-appropriate complaint mechanisms for adolescents in place, however in 2015 such mechanisms are in place. These mechanisms for reporting, investigating, prosecuting, and punishing perpetrators of violence may take time to change to have a noticeable security improvement in the community. One positive change documented since the T2 data collection was completed is that the Camp Committee has invited the Rwandan police back into the camp, which adolescents, caregivers, and key informants reported has been associated with a decline in violence. Further quantitative works is needed to validate this anecdotal evidence and see if the decrease in violence is evident. Qualitative results indicated that adolescents and caregivers thought a key way to improve security for adolescents would be to increase security presence, pay security personnel, and address some infrastructure issues related increased lighting of roads, limiting access to school to only students, and increasing firewood distribution. The impact of the police presence on levels of violence, reporting of violence, and punishment of perpetrators may be apparent in coming years in Kiziba Camp.

[9] This change appears very large given the denominator. The orphans in this analysis are all adolescents reporting that neither parent is alive (18 total at T2), not necessarily adolescents in the UASC sub-sample, as some UASC reported having a parent or both parents alive.

TEXTBOX 13:

FOLLOW-UP FINDINGS:

What are perceptions of feelings of safety and reasons for lack of security in Kiziba Camp?

During follow-up research, there was some disagreement as to the status of security for adolescents in Kiziba Camp, and whether security has improved since 2013. One adolescent explained that there can be considerable threats to adolescent security moving around the camp at night, reporting *"here in the camp there are so many jobless people who move around and may do bad things but during the day we are secure on the way."* Another explained, *"during the night you have difficulty on the way to go to school because you may meet thieves."* Key informants noted that reports of such risks and experiences are very low, indicating that reporting of security incidents is limited.

However, caregivers explained that there had been some recent improvements to security in Kiziba. One explained, *"there is security in our camp but in the previous years our children were hit by stones by other people on the way by others. Now the security is reinforced."* Caregivers reported that there was improved systems for punishing perpetrators of violence against adolescents, including presence of police and a new camp committee for security, noting *"currently there is strict follow up and punishment of aggressors."*

Caregivers generally believed that security for adolescents had improved, including improved reporting to organizations and camp committees; *"before you may have a problem with someone and on the way he/she may beat you or abuse but this time when she/he does bad thing [physical or verbal abuse] to you; you report the case to Plan staff."* Yet, as one key informant noted, many of the staff and volunteers associated with security mechanisms are men, and women and girls may not feel comfortable reporting to male security officials.

Focus group discussions with caregivers also indicated that caregivers often perceive adolescents' feelings of safety to be related to their poor behavior in the camp, including moving around at night in groups and girls visiting boys in their homes. One caregiver explained, *"they behave like independent children. When they come late during the night and when you try to show him/her that it is not good for her/his security, in that case they think that you are harassing them and might have different opinions."* This disjuncture between adolescent and caregiver perceptions of safety – that adolescents perceive real risks to their safety moving around the camp, whereas caregivers often perceive adolescents to be behaving irresponsibly and putting themselves at risk – was reported to be a reason why adolescents may not disclose problems, including abuse, to caregivers.

TEXTBOX 14:

FOLLOW-UP FINDINGS:

Measures to improve security for adolescents

Adolescents, caregivers, and child protection staff at follow-up agree that security for adolescents could be improved through increased security salaries, perpetrator punishment, and structural changes to the camp.

> *increase the salary of security men"*

> *... to punish those who did bad things to others"*

> *We need the light on the road during the night for self-protection."*

> *We need new lamps at night"*

> *Put a fence around the school."*

> *Provide enough firewood which will let children to not go out of the camp because they are sexually and physically abused [when they go to collect firewood]."*

3.5 Knowledge and utilization of child protection activities and services

3.5.1 KNOWLEDGE OF CHILD PROTECTION ACTIVITIES AND SERVICES

Adolescents reported a high level of knowledge of child protection activities and services in 2015. 86.5% know where to go if they experience violence or abuse; 97.6% if they have a health problem; 83.3% if they have a problem at school; 74.3% if they have one at home; and about 50% know where to go if they have a problem at work, the weakest area.

Comparing levels of knowledge in 2013 to 2015, significantly fewer adolescents know of a place to go if they experience violence or abuse (93.7% in 2013 and 86.5% in 2015) or if they have a problem at school (91.9% in 2013 and 83.3% in 2015). Female adolescents appear to drive the decline, with a change from 94.7% reporting that they know of a place to go after experiencing violence or abuse in 2013, and 83.5% in 2015, and a change from 83.1% knowing of a place to go after experiencing a problem at home in 2013, compared to 70.0% in 2015. However, this difference is no longer significant when conducting the matched analysis and only comparing the respondents who participated in both waves of data collection.

After adjusting for age, sex, and biological parental status (both living; either single or double orphan) adolescents were less likely (aOR = 0.4; 95% CI 0.2-0.9) to report knowing where to go if they have a problem at school in 2015 as they were in 2013, an indication of a serious deterioration in the adolescent knowledge of school grievance reporting systems. As with other safety and reporting concerns, adolescents who did not know where to report abuse in 2013 more likely not to know where to report abuse in 2015.

The opposite trend is seen with respect to health-related problems with 90.7% reporting they knew where to go in 2013 and 97.6% in 2015. This is driven by male adolescents, in stratified analyses, moving from 86.5% knowing where to go if they have a health problem in 2013 to 98.3% in 2015. After adjusting for gender and biological parental status (both living; either single or double orphan), adolescents were 3.9 times (95% CI 1.4-10.9) more likely to know where to go with health-related problems in 2015 as compared to 2013, an indication of a success in the health promotion messaging programs and services.

Table 5. Change in knowledge of services

Question	T1	T2	Change
	N (%)	N (%)	p-value
Do you know of a place to go to if you have experienced violence or abuse?			
Yes	119 (93.7)	217 (86.5)	**0.034**
No	8 (6.3)	34 (13.5)	
Do you know where to go if you have a health problem?			
Yes	117 (90.7)	245 (97.6)	**0.003**
No	12 (9.3)	6 (2.4)	
Do you know where to go if you have a problem at school?			
Yes	113 (91.9)	195 (83.3)	**0.026**
No	10 (8.1)	39 (16.7)	
Do you know where to go if you have a problem at home?			
Yes	104 (81.9)	182 (74.3)	0.099
No	23 (18.1)	63 (25.7)	
Do you know where to go if you have a problem at work?			
Yes	2 (20.0)	8 (50.0)	0.218*
No	8 (80.0)	8 (50.0)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Adolescents suggested that additional services for non-victim health-related issues and improved teacher training, specifically focusing on special education, medical, social support services, are needed. Key informants additionally suggested the need for: services related to child protection knowledge and data management (community sensitization, data management, research, and case documentation), coordination of child protection activities (conducting regular meetings, monitoring, calling child protection panels, and facilitating collaborations), and human and financial capacity (working with community mobilizers to fill funding-created staffing gaps, human resource capacity building, and livelihood programing). As one key informant explained, *"in this camp we don't have enough activities for adolescents. As you've seen, we have one football ground, one basket ground and there are many,*

many children in the camp. If children or adolescent have no activities to occupy them, they are easily influenced to take drugs and do risky behavior. If he or she has a lack of activities, this may be allow children to do things that are not good."

Adolescents have a high level of name recognition of key providers in child protection. 96.4% had heard of Nkundabana, 88.4% of Abarengerabana, and only 58.0% of Ijwi ry'Aban. Parents and/or caregivers report similar levels of name recognition with 96.4% recognizing Nkundabana, 96.4% for Abarengerabana, and only 54.4% for Ijwi ry'Aban. See Table 35 – Table 38 in Appendix 4. iv for detailed output on adolescent and parent/caregiver change in service provider name recognition.

3.5.2 UTILIZATION OF CHILD PROTECTION ACTIVITIES AND SERVICES

The CPI Study investigated utilization of child protection services – specifically, services for response for survivors of SGBV, and CBCPMs, as well as adolescent-focused activities, participation in an organized group (club or committee), non-formal education or lifeskills training activities. Overall adolescents report low organization-specific program utilization but higher general activity utilization. For CBCPMs, 2.9% had asked for help from Nkundabana, 2.7% from Abarengerabana, and 1.4% from Ijwi ry'Aban.

Adolescents reported a decrease of almost 17 percentage points (19.4% in 2013 and 2.9% in 2015) for asking for help from Nkundabana, 8 percentage points (10.9% in 2013 and 2.7% in 2015) from Abarengerabana, and 4 percentage points (5.4% in 2013 and 1.4% in 2015) from Ijwi ry'Aban, the only organizations with data at both T1 and T2. This decline appears consistent across both genders. However, there was an overall increase in general utilization of child protection committees in general, so it may be that overall, adolescents are participating in structures that they perceive to be child protection committees, while they do not turn to these specifically-named entities for help. Adolescent reporting of general utilization ("have you ever asked for help from a Child Protection Committee") has increased from 2013, however, reported utilization of the specific named community-based child protection mechanisms – Nkundabana, Ijwi ry'abana or Abarengerabana ("have you ever asked for help from

TEXTBOX 15:

KNOWLEDGE OF HEALTH AND CHILD-PROTECTION SERVICES

Qualitative findings from adolescent focus group discussions in 2015 support the overall high level of service and reporting knowledge. Adolescents reported services existed in their community or camp environment dealing with health, communication, conflict mediation, and indemnification.

Adolescents specifically reported knowledge of health and child-protection related services in focus group discussions conducted at T2:

"To carry her [abuse victim] when, she is in a very bad conditions the community help to carry her to the hospital"

> *"Community mobilizers move around in every quartiers to sensitize the children about child protection"*

> *"...the Churches also intervene in terms of providing the advices. The CBPMs members also pray a role to help the victims."*

Key informants in 2015 also discussed health, social, and legal services.

> *"...vaccinations, supplemental nutrition, medical treatment for SGBV"*

> *"...extra housing if required due to conflict / victimization"*

> *"...provides and maintains space for adolescents to play"*

> *"...indemnification [legal financial compensation] assistance"*

Nkundabana, for example) is low. This may reflect that there are other organizations and structures that adolescents perceive as Child Protection Committees that they are reporting utilizing, or that they are utilizing the named CBCPMs without knowing their specific titles.

Table 6. Change in child protection services and activity use, adolescent report

Question	T1	T2	Change
	N (%)	N (%)	p-value
Have you asked for help from Nkundabana?			
Yes	25 (19.4)	7 (2.9)	**<0.001**
No	104 (80.6)	235 (97.1)	
Have you asked for help from Abarengerabana?			
Yes	14 (10.9)	6 (2.7)	**0.001**
No	115 (89.1)	216 (97.3)	
Have you asked for help from Ijwi ry'Aban?			
Yes	7 (5.4)	2 (1.4)	0.089*
No	122 (94.6)	143 (98.6)	
In the past year, have you ever participated in an organized group, or committee specifically for children or adolescents?			
Yes	59 (45.7)	105 (81.4)	**<0.001**
No	70 (54.3)	24 (18.6)	
In the past year, have you ever participated in non-formal education, for example, after-school activities?			
Yes	60 (46.9)	77 (59.2)	**0.047**
No	68 (53.1)	53 (40.8)	
In the past year, have you ever participated in any life skills training in the camp?			
Yes	73 (57.0)	78 (69.6)	**0.044**
No	55 (43.0)	34 (30.4)	

*Notes. Time-period of all items is past year. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Adolescents report higher levels of past year participation in several types of activities: organized groups specifically designed for children or adolescents (45.7% in 2013 and 81.4% in 2015), non-formal educational activities (46.9% in 2013 and 59.2% in 2015), and camp-based life skills training (57.0% in 2013 and 69.6% in 2015). In stratified analyses by gender, both male and female adolescents are reporting higher percentages of participation, however females are driving the statistical change observed in camp-based life skills training (58.4% participated in 2013, 76.5% participated in 2015). In follow-up research, caregivers noted that adolescent participation in these groups is positive for their well-being and behavior. For example, one caregiver noted, *"a child who attend those clubs is different of other children who do not attend. That child respects the parents and the parents are happy."* Another caregiver explained, *"the child who attends the dialogue sessions of adolescents, he becomes flexible [willing to help parents and not resistant] – s/he is more willing to help their parents and is not resistant."* Another reported, *"the child who attends those clubs has discipline, when you ask him to help in some work at home, he helps."* Adolescent participation in activities has increased, and caregivers note positive benefits of participation for adolescent behavior.

Interestingly, adolescents reported some barriers to attendance of these programs, most often due to cost. For example, an adolescent in a focus group discussion during T2 data collection explained, *"it is very expensive, each month is 1000 RWF. The parents have to afford all requirements to their children and few parents are able to find the amount needed."* Follow-up qualitative analyses found that between 2013 and 2015 community mobilizers started taking a more active role in recruiting adolescents to participate in community activities. Thus, adolescents report that they are reminded of activities, encouraged to participate, and thus have increased their participation due to these extra efforts by their local community mobilizers. Additional suggestions from adolescents on how to improve participation include improving the quality of the programming (ensuring that adolescent voices are heard) and to start programming at a younger age and in age-specific groups.

The increased utilization of activities – organized groups, non-formal education and life skills training – is a positive indication that adolescents view these activities as appropriate and useful by adolescents, and that they are accessible to adolescents. Participation in these activities may have downstream impacts on prevalence of violence and adolescent psychosocial well-being. However, the positive impacts of participation in these activities on these outcomes is not yet indicated in the T2 data. As such, it may be that increased participation in these activities will take more time to influence these

outcomes, or that these activities are in fact not sufficient to influence violence and well-being, in the presence of lack of livelihoods, stress on caregivers, and prolonged displacement of refugees in Kiziba Camp.

3.5.3 REPORTING EXPERIENCES OF VIOLENCE AND SEXUAL ABUSE

Adolescents who had experienced forced sexual intercourse within the past year did not always report the abuse. In 2013 40% reported the most recent physically forced sexual intercourse and that percentage decreased to 33% in 2015. However these percentages and numbers should be reviewed with care as that difference represents the change in just one individual reporting and the number of adolescents reporting is too small to find a statistically meaningful change over the course of the study period. When analyzing reporting of any form of sexual abuse (combining all three forms into a single binary variable), results show that girls were slightly more likely to report an event than boys, after taking into consideration age, data collection wave, and parental status. There is a slight decrease in reporting overall in 2015, however this does not meet statistical significance.

Table 7. Change in adolescent reporting most recent sexual abuse, within past year

Question	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
Did you tell anyone about most recent physically forced sexual intercourse?			
Yes	2 (40)	1 (33.3)	1.000*
No	3 (60)	2 (66.7)	
Did you tell anyone about most recent psychologically forced sexual intercourse?			
Yes	1 (33.3)	3 (50)	0.429*
No	2 (66.6)	3 (50)	
Did you tell anyone about most recent unwanted sexual touching?			
Yes	3 (30)	2 (28.6)	1.000*
No	7 (70)	5 (71.4)	

*Notes. Time-period of all items is past year. * Fischer's exact test run due to small cell values.*

Table 8: Adolescents less likely to report a violent event in 2015 than in 2013, adjusted analysis Kiziba Camp, 2013-2015

Factors		Coefficient	95% CI	p value
Parent status (ref. orphan)	Single parent	0.03	(-0.04, 0.10)	0.388
	Both parents	0.04	(-0.03, 0.10)	0.264
Data collection wave		-0.03	(-0.07, 0.00)	0.076
Age		0.01	(-0.00, 0.02)	0.054
Gender (ref. male)		0.01	(0.00, 0.02)	**0.004**

Notes. **Bold** *indicates significant association at p<0.05.*

Caregivers, however, state that they often report child abuse, either in the home or community. In both 2013 and 2015, 91% of caregivers said that if they saw abuse take place they reported it. Most often, those caregivers report the abuse to an NGO or a community elder. Table 9 shows where caregivers reported witnessed abuse. In both waves of data collection, caregivers reported child abuse cases to NGO staff, the Child Protection Committee, community leaders and close friends and family. Caregivers rarely reported to religious leaders and security personal.

Table 9: Caregiver report child abuse

Relation	T1	T2
	N (%)	N (%)
Family member/close friend	18 (14.0)	33 (18.4)
Community leader	27 (20.9)	29 (16.2)
Religious leader	3 (2.3)	2 (1.1)
Counselor	14 (10.9)	10 (5.6)
NGO / Plan staff social worker	47 (36.4)	69 (38.6)
Child Protection Committee	56 (43.4)	25 (14.0)
Police/someone from security sector	7 (5.4)	8 (4.5)
Another person	0 (0)	2 (1.1)

Adolescents were asked to report to whom they would feel comfortable reporting to if a friend or acquaintance experienced a sexual assault. Results show that 42.2% would hypothetically report sexual abuse to their mother; 17.9% to their father; 16.7% to

TEXTBOX 16:

REASONS FOR LACK OF REPORTING OF VIOLENCE

Adolescents discussed reasons for lack of reporting in focus groups conducted for T2, noting that they are hesitant to report abuse for fear of victim-blaming and perceived perpetrator impunity.

> *"The girls of our age like keeping quiet because of being afraid that people may think we are responsible and that we did by our will"*

> *"We are afraid of being ashamed and we know that there is corruption between the in charge of security in the camp and the perpetrators"*

> *"No one we may trust to tell, even our friends"*

> *"… Many girls keep quiet and do not report the cases of sexual violence. If you find someone who give you money for buying the requirement such as the lotion body, soaps, cloths, etc. the girls get pregnant not due that they are prostitutes, only because of poverty."*

In dissemination meetings, child protection practitioners in Kiziba and Kigali noted that a 'culture of silence' is prevalent amongst caregivers and adolescents. They noted that community response to incidents of violence often includes encouraging the victims to not report, and to try and resolve the incident within the community. This perception is counter to caregivers' responses in the survey as to whether they report abuse. Moreover, this response from community members may also indicate perceptions of the quality of services available to victims of abuse and concerns surrounding stigma if other community members find out about abuse, particularly sexual abuse.

another relative; 11.2% to a friend; 10.0% to a health care provider (doctor, nurse, etc.); and less than 10% felt comfortable reporting a hypothetical sexual abuse to a teacher or principal, policy or security individual, counselor, or community leaders. No adolescents said they would feel comfortable reporting sexual assault to religious leaders, traditional healers, or Plan staff.

Table 10: Change in who adolescents would feel comfortable seeking help from if friend or acquaintance were sexually victimized[10]

Relation	T1	T2	Change
	N (%)	N (%)	p-value
Mother	58 (45.0)	106 (42.2)	0.611
Father	26 (20.2)	45 (17.9)	0.598
Other relative	20 (15.5)	42 (16.7)	0.759
Friend	8 (6.2)	28 (11.2)	0.118
Teacher/Principal	7 (5.4)	5 (2.0)	0.070
Religious leader	0 (0.0)	0 (0.0)	n/a
Health care provider / doctor / nurse	20 (15.5)	25 (10.0)	0.113
Traditional healer	0 (0.0)	0 (0.0)	n/a
Police/someone from security sector	15 (11.6)	20 (8.0)	0.243
Counselor	12 (9.3)	17 (6.8)	0.379
Community leader	16 (12.4)	24 (9.6)	0.393
Plan staff	2 (1.6)	0 (0.0)	0.178*

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

With respect to the continued lack of reporting by adolescents who experienced sexual abuse, even though almost half of adolescents state they would report abuse of a friend or acquaintance to their parents if it happened, the quantitative evidence suggests they do not *personally* report experiences of

[10] Note. In 2013, caregivers were able to select multiple individuals to whom they reported an event, thus the sum of the percentages in column T1 is greater than 100%. In 2015, caregivers were guided to only select one individual, thus the sum of the percentages in column T2 is closer to 100% (slightly off due to rounding). As the items were slightly different no additional statistical comparisons were made.

TEXTBOX 17:

FOLLOW-UP FINDINGS:

What are some of the reasons why adolescents may not report violence, including sexual violence?

Follow-up research indicated several reasons why adolescents may not report violence, including sexual violence, to family members, camp leadership, or child protection organizations. In focus group discussions, adolescents mentioned shame, fear of repercussions from perpetrators and fear of being blamed, for example *"[They do not report as] they are afraid of their parents and they are ashamed"*; *"There are some who don't tell to any one because she/he may feel ashamed"*; *"The perpetrator may know that you report them and they may do worse things to you"*; and *"When adolescent have a bad habit to go back home late in the night when like girls got pregnant the parents may think that it was by your will."* When the violence experienced is at the hands of caregivers, reporting is even more difficult, as one adolescent explained *"the home violence, for example if it's your parent [perpetrating the violence], you can't tell to anybody because you live every day with them you may have many problems so to avoid all those you keep quiet."*

Key informants working in areas of service provision for SGBV in Kiziba noted a range of reasons for low levels of reporting and use of services after experiences of violence, including a culture of silence, fear of being blamed for being a victim of violence, knowing the perpetrator, and lack of support from caregivers for reporting. As one key informant explained, *"the adolescent may choose not to talk about it [at home]. Maybe they think they won't be listen to by family members or it's not a big deal as compared to other problems their face."* Key informants described a culture of silence, encouraging adolescents to stay quiet about experiences of violence, in particular, sexual violence, and discouraging adolescents reporting to organizations.

However, caregivers largely disagreed that adolescents did not report violence, including sexual violence, with one stating *"In 2016, the children report the cases and the person in charge of security will go and punish the aggressors."* Caregivers described a changed camp leadership resulting in more reporting, explaining *"the reason which caused them to not report, before there were so much corruption but these days there are good leaders."* Caregivers reported some of the same barriers to reporting as adolescents (fear of perpetrator, stigma, fear of telling caregivers) but also reported counter perceptions, including lower levels of stigma regarding sexual violence (*"the mindset of people has changed, they don't feel ashamed anymore. They think it's a normal case and will report it"*), and perceptions of high levels of reporting of violence by adolescents.

violence, and qualitative evidence suggests they do not report because they are afraid of victim blaming and apparent perpetrator impunity.

There is a potential disconnect between adolescents and the child protection community when it comes to the understanding, reporting, and documenting of sexual relations between adolescents. Per Rwandan law, any individual under the age of 18 who engages in sexual intercourse is in violation of child protection legislation, and thus liable to prosecution. Adolescents and key informants report that this is a large issue for adolescents who are engaged in consensual sexual intercourse with other adolescents. For fear of legal repercussions, adolescents do not report apparent consensual sexual intercourse to doctors or teachers, potentially increasing their risk of sexually transmitted infections and pregnancy.

Both quantitative and qualitative interviews with adolescents support the CPI finding that there is a serious weakness in the service utilization domain. This highlights a central challenge for Kiziba Camp whereby an improvement in child protection procedures and service availability is insufficient if the adolescents do not use the services provided. Key informants suggested that weaknesses in child protection environment could be attributed to *"… limited funds. Lack of appropriate way of training people. Focus is on numbers, not quality, especially for reproductive health."* In the CPI, utilization of services is a proxy for quality of services. Low service utilization may be indicative of poor quality, inappropriate, or inaccessible services.

3.6. Socio-economic well-being

3.6.1 SOCIO-ECONOMIC STATUS

Adolescents reported mixed levels of past year child labor. 84.9% reported having to log for firewood however only 11.2% reported gathering water that was too heavy for them. There were no significant changes in these domains across years or when separated by gender.

Table 11: Change in child labor, past year

Question	T1	T2	Change
	N (%)	N (%)	p-value
Have you had to log for firewood?			
Yes	112 (86.8)	213 (84.9)	0.607
No	17 (13.2)	38 (15.1)	
Have you had to fetch water too heavy for your body?			
Yes	16 (12.4)	28 (11.2)	0.719
No	113 (87.6)	223 (88.8)	

Caregivers report modest levels of economic activity. In the past seven days before being interviewed, 44.8% of caregivers reported working and for those who had not worked, 14.4% have a job or business of some type. The majority of those who work (54.1%) have regular employment throughout the year with only 9.5% reporting intermittent employment. For income, caregivers most often either sell food received from the World Food Program (WFP) (25.8%) or have business activities (18.3%). 38.1% of caregivers report having no source of income. 80.7% receive their main source of water from an improved water source (46.8% from pipes and 34.9% from public taps or standpipes).

Caregivers report both a decrease in business activities (28.1% in 2013 compared to 18.3% in 2015) and conversely, a significant increase in recent work (from 33.3% in past week in 2013 to 44.8% in past week in 2015). This increase is driven by a large increase in female participation in the workforce (29.5% in 2013 to 45.4% in 2015). Similarly the amount of work caregivers report, on an annual basis significantly shifted from only 39.7% reporting regular work in 2013 to 54.1% reporting it in 2015. Again this change is driven by increased female participation in the workforce (36% reported working once in a while in 2013 and only 10.8% reported the same in 2015).

3.6.2 HUNGER

Caregivers are still reporting high levels of hunger within the past four weeks. In 2015, 87.7% reported having no food to eat at some point in the past four weeks; 77.0% reported members going to sleep hungry; and 48.8% reported household members going an entire day and night without food.

Table 12: Change in hunger scale

Question	T1	T2	Change
	N (%)	N (%)	p-value
In the past 4 weeks, was there ever no food to eat of any kind in your house because of lack of resources to get food?			
Yes	103 (79.8)	221 (87.7)	**0.042**
No	26 (20.2)	31 (12.3)	
In the past 4 weeks, did you or any household member go to sleep at night hungry because there was not enough food?			
Yes	107 (82.9)	194 (77.0)	0.176
No	22 (17.1)	58 (23.0)	
In the past 4 weeks, did you or any household member go a whole day and night without eating anything at all because there was not enough food?			
Yes	51 (39.8)	123 (48.8)	0.097
No	77 (60.2)	129 (51.2)	

Notes. **Bold** *indicates statistically significant finding, p<0.050.*

Unfortunately the situation has significantly deteriorated with respect to hunger. A significantly larger percentage of caregivers (79.8% in 2013 and 87.7% in 2015) reported having someone in the household go hungry in the past month. This difference was more pronounced among female caregivers.

To understand why greater strides against hunger have not been achieved, it is helpful to review the quantitative economic data and some qualitative interviews. Roughly one quarter of the caregivers in 2013 (26.6%) and 2015 (25.8%) reported their primary source of income as "selling food from World Food Program," higher than any other reported income generating activity. Key informants verified this finding, often attributing the sale as not only to

assist in family necessities (for example, selling the food to buy school books for children), but also to fuel personal addictions.

The issue of food distribution and sale for economic gain is not explicitly addressed in the CPI, however one could extrapolate that in an environment where adolescents feel perpetrators of sexual and physical abuse at treated with impunity, one could imagine less severe grievances, such as food distribution within a family, are not adequately reported and addressed. Additionally, in an environment where hunger is increasing and socio-economic concerns impact individual and household well-being, decreased psychosocial well-being amongst adolescents may be associated with these concerns. To try and combat this issue schools have started distributing additional supplemental feeding programs, however these changes occurred too close in time with our 2015 data collection to see a quantifiable impact on hunger.

3.6.3 HUMANITARIAN EMERGENCY SETTINGS PERCEIVED NEEDS SCALE (HESPER)

In addition to hunger, caregivers overall reported significant needs in 2015. The HESPER was only utilized in 2015. In 2015, over half of the caregivers interviewed reported being separated from family members, inadequate education for their children, feeling distressed, a physical illness, insufficient financial resources, clothing (shoes and bedding), inaccessibility to a safe toilet and insufficient food quantity or quality. While we are unable to compare these to 2013, it is clear that caregivers in 2015 are under a great amount of stress and pressure.

Over fifty percent of caregivers reported serious problems in their community due to insufficient support to separated children and adults and drug and alcohol abuse. Around thirty percent indicated that mental illness, women's security, and the legal system caused serious problems for people in their community.

4.
KEY LESSONS – METHODOLOGY

This report details findings from the first completed CPI Study, conducted in Kiziba Camp, Rwanda. The report provides comparative data, both for child protection system strength, and for child protection outcomes, with assessments from 2013 and 2015 compared using various analytic methods. One of the primary overarching objectives of the CPI Study was to pilot, refine and implement measurement methods to assess changes in child protection system strength in a humanitarian setting, and assess how system strength is related to child protection outcomes. At this juncture, there are several key lessons from a methodological perspective.

i. **Use of the CPI in field settings:** Implementation of the methodology at two time points indicates that it is possible to collect the majority of the data for the CPI (the short version, developed through piloting and refinement of a significantly longer version of the CPI) rapidly, through key informant interviews with practitioners. Some components of the CPI rely on survey data, which is more time and resource intensive to implement. A modified version of the CPI that relies only on key informant data can be developed from the current CPI version, resulting in a tool that is parsimonious, and can rapidly be implemented in field settings without significant additional external research expertise, providing a snapshot of current child protection system strength which could inform programming, policy and funding decisions.

ii. **Measurement of quality of services:** One key component of the CPI is measurement of quality of services. This was operationalized throughout the CPI Study as utilization of services. Given the length of the CPI, and the various activities and services included within its purview, individual assessment of the quality of each service and intervention (for example, via a checklist assessment of presence or absence of key aspects of each service) is not possible within the constraints of seeking to develop and implement a parsimonious tool encompassing overall system strength. However, service utilization was found to be an area of concern in both the 2013 and 2015 assessments, and in-depth investigation of reasons for low service utilization, or perceptions of service quality, for each and every service included in the CPI was not possible. The qualitative data collected as part of the T2 data collection and the follow-up phase did shed some light on the reasons for this, but the use of utilization as a proxy for quality means that the primary drivers of poor utilization – whether accessibility, appropriateness of services, or external factors, such as cultural norms – may not be fully understood. In the first iteration of the CPI, which included 141 items, efforts were made to capture quality of services – for example, 5 items were included to determine whether interview rooms for best interest determinations were child-friendly – but this proved to result in an instrument, and database, that was unwieldy, unfocused and far too broad. Yet the current methodology may not provide adequate insight into quality of services. As such, a key lesson from the completion of the first CPI Study in Rwanda is that future iterations of the research may need methodology that can provide more granular understanding of quality of services delivered as part of the child protection system

iii. **Triangulation:** The CPI Study is a mixed methods study, utilizing quantitative (adolescent and caregiver surveys) and qualitative (focus group discussions [at T2 and follow-up] and key informant interviews (at T1, T2 and follow-up). These varied approaches allow rich insights into varied components of the child protection system, ensuring a multi-dimensional assessment of child protection system strength and child protection outcomes. Data collected at different time points and using different methods allowed a deeper understanding of a range of issues.

5.
SYNTHESIS

The combination of changes in CPI scores, changes in child protection outcomes, and qualitative findings – both T2 and follow-up data – brings to light a number of key issues related to the child protection system in Kiziba Camp. The following discussion highlights some of these findings, elaborating on the key themes as they relate to the objectives of the CPI Study.

CPI score and changes in child protection system strength

Comparison of T1 and T2 CPI scores in Kiziba Camp indicates some limited improvement of child protection system strength. Assessment of some indicators reflects stability between the two time points for various procedures, services and service utilization. Conversely, lack of change for some indicators points towards continued weaknesses in system strength; for example, access to education for children with disabilities, reporting of SGBV experience, utilization of services by SGBV survivors and gender parity in teaching staff. Some improvements in system strength were noted, particularly, improvement was documented with respect to procedures (including percentage of children born and registered; unique ID card for adolescents; and UASC family tracing outcomes and alternative care options), services (adolescent age-appropriate complaint mechanism), and utilization (adolescents who have used a community-based child protection mechanism in past year and who participated in clubs and committees). Based on the overall analysis of the CPI, the child protection environment in Kiziba is still ranked as moderate (78.5 out of a possible 100 points, with the moderate range encompassing 60-80), although there was some slight overall improvement from 2013 to 2015, mostly related to strong procedural work.

There are some areas of the CPI where no improvements were seen from 2013 to 2015, but where improvements are essential for the creation of a highly functioning child protection system. For example, the funding gap in child protection has been consistently reported to be 51% or higher than the overall operational level gap for all sectors, indicating that the funding gap for child protection is worse than other sectors. This funding gap can manifest as insufficient or low-quality programming. This may result in low levels of utilization of services, as evidenced, for example, in the case of utilization of services by adolescent victims of sexual violence.

The CPI Study's theory of change and research model hypothesized several intermediary outcomes that may link to reduced child protection risks and improved well-being. The T2 findings indicate improvements in some of these intermediary measures – registration and documentation, caregivers' attitudes towards appropriateness of beating in response to children's behavior and participation in adolescent-focused activities – which may have eventual downstream impacts on prevalence of violence and levels of psychosocial well-being. Moreover, the lack of resulting decrease in child protection risks and increase in adolescent psychosocial well-being, despite some improvements in system strength, can be further understood in light of the multiplicity of influences on child protection outcomes in Kiziba camp, many of which were investigated in greater depth in the follow-up research phase.

Child protection systems-strengthening approaches in humanitarian settings, and UNHCR's *Framework* more specifically, are based on the assumption that strengthening of the child protection system will ultimately have positive impacts on child protection outcomes. Therefore, the lack of strong association between positive changes in child protection system strength in Kiziba Camp, and positive changes

in child protection outcomes, in the CPI Study in Kiziba Camp raises important questions and considerations regarding methodology and policy. As noted previously, some significant positive changes may not be able to be identified in the time period between T1 and T2, and a T3 study may in fact identify reduction in violence against children in Kiziba Camp, and therefore support the assumption behind systems-strengthening. Another consideration is whether the CPI includes all the relevant and appropriate benchmarks related to child protection outcomes. Given the CPI is a direct reflection of the benchmarks included in UNHCR's *Framework*, this is a policy consideration – does the *Framework* include the relevant benchmarks to impact child protection outcomes? There may be discrepancies between UNHCR's priority interventions, and community needs. Consideration of the need to add additional benchmarks to the CPI raises the larger question of whether or how a child protection systems approach in displacement settings, as conceptualized in UNHCR's *Framework*, operates to impact individual-level changes for adolescent refugees. Findings from child protection systems-strengthening research has identified that the disconnect between child protection systems and community perceptions of priority needs is a significant problem (for example, Krueger et al., 2014; Canavera et al., 2016). As noted below, quantitative and qualitative findings in the CPI study indicate multiple influences on child protection outcomes, and some of these influences may not currently be adequately addressed within UNHCR's *Framework*, or measured within the CPI.

Safety, security and adolescents and caregivers

Findings in the T2 and follow-up research indicate some divergence in perception of child protection concerns between adolescents and caregivers, particularly level of safety for adolescents and influences on security issues. While adolescents reported increased feelings of lack of safety in 2015, caregivers generally report stable levels of security concerns over time. Follow-up research indicated that while adolescent note multiple sources of insecurity and risk, including violence in the household, caregivers describe an improved security environment, with opportunities for adolescents to report violence and have their concerns addressed due to reduction in stigma against sexual violence and improved camp leadership.

These differences in perceptions may be explained by the fact that while adolescents experience threat and risk daily, caregivers are more likely to perceive changes, such as introduction of police, as significantly improving the security environment. However, follow-up research also indicated that caregivers perceive some child protection risks to be the fault of adolescents, and due to their poor behavior in the camp. This disjuncture between adolescent and caregiver perceptions of safety – that adolescents perceive real risks to their safety moving around the camp, whereas caregivers often perceive adolescents to be behaving irresponsibly and putting themselves at risk – may be related to adolescents not feeling comfortable or safe disclosing abuse to caregivers, given they may feel that they will be blamed for experiences or threats of violence.

Feelings of lack of safety were quantitatively associated with adolescent psychosocial well-being, and represent an important area of concern: feelings of safety are subjective, and may not be associated with an actual increase in violence, abuse or exploitation of adolescents. However, given the association with psychosocial well-being, and the qualitative findings that this divergence of understanding of adolescent safety and security can impact communication and disclosure between adolescents and caregivers, it is an important area for further investigation and, potentially, programming. Moreover, a key theme that emerged in dissemination meetings with national and Kiziba-level stakeholders is that of a 'culture of silence,' whereby low reporting of incidents of violence and low utilization of formal reporting mechanisms was identified as reflective of community norms surrounding how to address violence against children. This perception diverges with caregiver reports of their responses to witnessing abuse, and further research is needed to explore whether and how a 'culture of silence' influences levels of utilization of reporting mechanisms. Key informants reported the existence of community sensitization programs on violence against children; the design and implementation of these programs, and their impact, could be further examined.

Multiple influences on child protection outcomes

The CPI Study focuses on the association between child protection system strength and child protection outcomes. However, while linkages can be made between, for example, levels of funding for child protection activities and adolescent psychosocial well-being, it is also crucial to account for other influences on child protection outcomes, in particular those noted as important by refugee adolescents and their caregivers.

Firstly, adolescents continue to experience high levels of exposure to violence, both as direct victims of various forms of violence, and as witnesses to violence in the household. Improved prevention and response services delivered by international organizations may act to reduce this exposure. Yet, it is also evident that adolescents and caregivers attribute some forms of this violence to lack of livelihoods, socio-economic hardships and stress on caregivers. Socio-economic data collected for this study indicates that households experience food insecurity and hunger, and that the situation has deteriorated since 2013, when 79.8% of caregivers reported having someone in the household go hungry in the past month, compared to 87.7% reporting this in 2015. In particular, drug and alcohol abuse was cited by adolescents and caregivers as a result of these stressors, and perceived as causally related to use of violence in the household. This study did not measure alcohol or substance-use by caregivers or adolescents due to challenges in adapting and validating existing measures in this context (Meyer et al., 2014), therefore the correlation between alcohol-use and violence in households, or alcohol-use and adolescent psychosocial well-being, cannot be quantitatively assessed. However, existing assessments confirm the linkages between lack of livelihood opportunities, poverty-related stressors and alcohol-use, and alcohol-use and prevalence of violence (Catani et al., 2008; Ezard et al., 2011; Streel & Schilperoord, 2010). Qualitative data collected for this CPI Study indicates that a holistic view of household well-being and functioning, taking into account available income sources, household stressors, and alcohol and substance-use, is needed in order to effectively address levels of violence against adolescents.

Secondly, findings in the CPI Study indicate a number of interrelated influences on adolescent psychosocial well-being. Lack of hope for the future, the prolonged nature of displacement, and worry about the future, which is intensifying with the increased length of displacement, were all cited as reasons for the decline in adolescent psychosocial well-being. The documented decline in psychosocial well-being is perceived not as directly related to specific events, services or changes in the child protection environment, but rather the pervasive and increasing hopelessness related to prolonged displacement. Participation in adolescent-focused activities – which did increase from 2013 to 2015 – is posited within UNHCR's Framework (Goal 2: Children's participation and capacity are integral to their protection) as a way to increase children's contribution to their own protection, build skills and capacities, and enhance positive coping strategies. In follow-up research, it was evident that caregivers saw the value of these activities for adolescents, and in general, that key informants and caregivers saw adolescents being occupied, whether through formal education or adolescent-focused activities, as important to keep adolescents safe and to prevent risk behaviors. However, overall level of participation in these activities does not appear to have maintained or increased overall psychosocial well-being amongst adolescents. The increase in educational opportunities – which was perceived by adolescents, caregivers and key informants alike as instrumental in improving adolescents' well-being – may have subsequent impacts on psychosocial well-being.

Levels of well-being may be directly related to experiences of violence in the household, community and school, and are also interrelated with feelings of safety and security. Adolescents reported increased feelings of lack of safety from 2013 to 2015, indicating that adolescents experience a deterioration of security in Kiziba Camp, despite positive changes in security measures reported by caregivers and key informants. More adolescents in 2015 reported feeling unsafe at home, school, and generally within the camp environment. Analysis indicates that adolescent report of feeling unsafe was correlated with increased symptoms of anxiety and emotional problems, and decreased resilience. Moreover, findings show continued barriers to reporting violence, including sexual violence, and accessing services after experiencing violence. Qualitative data indicates that adolescents report several factors influence willingness to report, including adolescents' fears of repercussions from perpetrators, fear of being blamed, and stigma associated with sexual violence. Key informants echoed several of these issues, noting a 'culture of silence' in Kiziba camp, and lack of support from caregivers to report these issues.

Overall, the findings in the CPI Study indicate multiple and overlapping influences on child protection outcomes. Household-level factors emerge in the CPI Study in Kiziba Camp as important influences on child protection risks and well-being. Family and community-level contribution to child protection is recognized within the *Framework*, which notes that "[f]amilies and communities are central to the care and protection that children need." However, family-level interventions or activities to support caregivers are not included within the *Framework*, and results from the CPI Study indicate that holistic, household-based interventions to improve child protection outcomes may be lacking. Child protection systems strengthening is an increasingly powerful paradigm in the child protection sector, however there is a need for critical reflection as to what can and should be considered part of a child protection system, and how systems-strengthening can interact with household-level influences on child protection outcomes.

The positive changes in system strength, as measured by the CPI, were not accompanied by significant reduction of child protection risks and improvement of adolescent well-being. As such, several questions emerge: Does the lack of positive changes in terms of child protection outcomes, in the presence of systems-strengthening, indicate that the strength of the child protection system is not a key influence on child protection outcomes? Does this finding indicate that the CPI instrument, which operationalizes the key components included in UNHCR's Framework , lacks key benchmarks that influence child protection outcomes? What additional benchmarks may need to be included in order to accurately capture the core influences on child protection outcomes? And, does a child protection systems approach in displacement settings, as conceptualized in UNHCR's Framework, operate in such a way as to impact individual-level changes for adolescent refugees? Recent research on child protection systems-strengthening in South Sudan indicates a disconnect between child protection systems-strengthening activities and community-based responses to protection, with lack of alignment between the focus of interventions

and the priorities of communities (Canavera et al., 2016). Consideration of these dynamics, and possible limitations to the systems-strengthening approach within UNHCR's Framework may be important in light of the findings of the CPI Study in Kiziba Camp.

Conclusions

The hypothesis tested in this study is that "a good child protection environment is associated with lower levels of child protection concerns (violence, abuse and neglect), and higher levels of psychosocial well-being." Conclusions regarding whether this hypothesis is proven in the context of Kiziba camp are not yet definitive, as cross-context comparisons are needed to identify patterns in associations between system strength and child protection outcomes. Results from the T2 study in refugee settlements in Uganda in 2016 will allow researchers to investigate associations between system strength and child protection outcomes comparatively. However, tentative conclusions can be drawn: improvements in child protection system strength in Kiziba camp do not appear to have had significant impacts on reduction of violence or resulted in higher levels of psychosocial well-being. The T2 study identified reduction in exposure to sexual violence, however, several other forms of violence maintained at high levels. Moreover, the significant increase in psychosocial problems and decrease in level of resilience indicates overall reduced levels of adolescent well-being between 2013 and 2015, regardless of improvements in system strength. Further assessment of the relationship between system strength and child protection outcomes, as part of the continued CPI Study in Uganda, will be concluded in 2017, and additional lessons learned regarding methodology, as well as comparative findings regarding associations between child protection system strength and child protection outcomes, can contribute to the developing policy and practice of child protection systems-strengthening for refugee children.

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APPENDICES

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APPENDIX 1:

DESCRIPTION OF MEASURES USED IN ADOLESCENT AND CAREGIVER SURVEYS

A1.1 Adolescent survey

The adolescent survey was slightly altered in 2015, from 2013, to remove poorly functioning domains and add new areas; the main consistent components are detailed below:

DEMOGRAPHICS

- This section included items on respondent's place of birth, time spent in Rwanda, household characteristics (including size of household, primary caregiver, and whether the adolescent lives with their biological mother and/ or father), school attendance and school attainment level.

PSYCHOSOCIAL WELL-BEING

- Three scales (for anxiety, hope and resilience) and one sub-scale (for emotional problems) were included in this section at both waves of data collection. Reliability of the scales were tested using a Cronbach's alpha:
  - **ANXIETY** – measured using the Screen for Child Anxiety Related Disorders (SCARED). The Cronbach's alpha for this scale was 0.73 in 2013 and 0.68 in 2015.
  - **HOPE** – defined as perceived pathways and agency to accomplish goals and measured with The Children's Hope Scale. The Cronbach's alpha for this scale was 0.63 in 2013 and 0.62 in 2015.
  - **EMOTIONAL SYMPTOMS** – emotional symptoms of distress were measured with the Strengths and Difficulties Questionnaire [SDQ], emotional symptoms subscale. The Cronbach's alpha for this sub-scale was 0.59 in 2013 and .70 in 2015.
  - **RESILIENCE** – psychosocial resilience was assessed through the Child and Youth Resilience Measure, with some items removed. The Cronbach's alpha for this scale was 0.79 in 2013 and .84 in 2015.

EXPOSURE TO VIOLENCE AND ABUSE

- This section assessed adolescents' exposure to violence and abuse in the home, verbal abuse, physical abuse, intimate partner violence, sexual violence, violence in school, violence in the community, transactional sex, and forced early marriage, adapting questions that have been used in previous studies of Violence against Children designed by the Centers for Diseases Control and the IPSCAN Child Abuse Screening Tool – Children's Version. All items, except sexual abuse experience, asked respondents to report whether an event had ever happened in their lifetime and how many times it had happened in the past year. Additional items related to reporting of violence, reasons for non-report, and relational information about the perpetrator of the violence were also included.

FEELINGS OF SAFETY

- These items explored the issue of safety in the Kiziba, and asked adolescents if they have ever felt unsafe in a number of locations, including home, school, at the market, and on the way to school within the past week. Researchers designed these questions specifically for this survey in 2013.

EXPLOITATION – CHILD LABOR

- This section asked about adolescents' experience of work, including hard physical labor, and work earning money for the household. Researchers designed these questions specifically for this survey in 2013.

KNOWLEDGE AND USE OF SERVICES AND INTERVENTIONS

- This section sought to assess adolescents' knowledge of different services in the settlement, including services for those who have experienced or are experiencing violence and abuse, problems at school, problems at home and health problems.

Adolescents were also asked to report if they knew of the various child protection committees in the settlement, and to report their perception of the role of the child protection committee. Finally, this section assessed participation in, and reasons for non-participation in, activities such as structured recreation activities, clubs and committees, non-formal education and life skills training. Researchers designed these questions specifically for this survey, based on the key interventions identified within the UNHCR Framework.

ATTITUDES TOWARDS VIOLENCE AGAINST CHILDREN

- This section presented a number of scenarios and asked adolescents to respond whether it is right for a caregiver to beat children in the given scenario. Scenarios included if the child is disobedient, if the child talks back to the parent, if the child steals and if the child refuses to get married. These questions were adapted from a Knowledge, Attitudes and Practices survey implemented by AVSI in Rwanda (AVSI and InfoAid, 2013).

A1.2 Parent/caregiver survey

The parent/caregiver survey was also slightly altered in 2015, from 2013, to remove poorly functioning domains and add new areas; the main consistent components are detailed below:

DEMOGRAPHICS

- This section included items on respondent's place of birth, time spent in Rwanda, household characteristics (including size of household), educational attainment level, marital status, and birth registration and documentation of children.

ATTITUDES TOWARDS VIOLENCE AGAINST CHILDREN

- This section assessed caregivers' attitudes towards adolescents, knowledge of child protection committees in the camp and the role of those committees, attitudes towards harsh punishment of children, and towards reporting of abuse and violence against children.

HOUSEHOLD SOCIO-ECONOMIC STATUS

- This section used items adapted from Demographic and Health Surveys, including questions focused on household income, employment and frequency of work, and source of drinking water. In order to develop a scale of ownership of household items, data collectors asked respondents to list all the items the household owned during the pilot test in 2013, in order to develop questions for the full study that would allow for indicators of household socio-economic status. This section also includes the Food and Nutrition Technical Assistance [FANTA] Household Hunger Scale, a measure that includes three questions and three measures of frequency in order to assess household hunger and allow for estimation of prevalence of households affected by 1) little to no household hunger, 2) moderate household hunger; and 3) severe household hunger. Finally, questions assessed use of health services and reasons for not utilizing health services for children who needed it in the past 12 months.
- To generate meaningful context specific categories of socio-economic status, researchers explored the data to identify appropriate cut-offs for low, medium and high relative socio-economic status. The socio-economic status scale developed includes employment status (past seven days), household food security, and ownership of household items.

CAREGIVER WELL-BEING

- Caregiver well-being was assessed using the Hopkins Symptoms Checklist 25, a measure of depression and anxiety previously used in a number of international settings. The measure asks respondents to report frequency of feelings and emotions over the past week, such as feeling "suddenly scared for no reason," "trembling," "faintness, dizziness or weakness," and "spells of terror or panic." In order to generate categorical variables (i.e. depressed or not depressed), the widely used cut-off of an average of 1.75 (out of 4) for depression, anxiety and total score was used for analysis. This cut-off has not been validated in this setting, so these findings should be read with some caution and further analysis is required to assess the appropriate cut-off for this population.

APPENDIX 2:

ETHICAL CONSIDERATIONS

This study employed a number of ethics procedures based on best practices for conducting research on sensitive topics with adolescents. Data collector training included a focus on all ethics procedures: explaining the study, obtaining permission from the caregiver, obtaining informed consent from the caregiver, obtaining informed consent from the adolescent, and checking in with the adolescent after the interview.

Data collectors were trained to be aware of the effects questions may have on respondents and how best to respond, based on the respondent's level of distress. They were instructed, however, not to provide any counseling, but instead to inform respondents of services available and how to access those services if needed.

Plan Rwanda and UNHCR Rwanda agreed to exempt researchers and data collectors from any existing mandatory reporting policies of abuse and violence. When a case was identified, the respondent was informed of services, and asked if s/he would like assistance in accessing those services.

Upon entering a selected household, data collectors identified the primary caregiver, in order to provide a short introduction to the study and obtain permission to interview an adolescent aged between 13-17 (up to age 19 for baseline respondents). Data collectors were trained to present the survey as an opportunity to learn more about the health and life experiences of male and female adolescents and youth in the camps, emphasizing that the survey is both confidential and voluntary. While this explanation did not fully present the content of the survey, which included questions about sexual violence and violence in the home, this approach was seen as justified, as a description of the study which included all components of the survey could potentially reduce caregiver permission and therefore exclude adolescents from the survey who are at-risk or in vulnerable situations.

The data collector then sought informed consent from the caregiver to participate in the caregiver survey, and then subsequently sought informed consent/ assent from the adolescent, to complete to adolescent survey. The adolescent survey was only conducted if a caregiver was present to give permission. In households where the caregiver was an adolescent, the adolescent and caregiver surveys (without the well-being measures) were both administered to the adolescent caregiver. All informed consent and permission was obtained through a written form that data collectors read to respondents. Informed consent forms explained to respondents that information they provided was confidential, and that their decision regarding participation was voluntary and would have no bearing on their access to health or relief services or to their family's access to these services.

Data collectors ensured that the interview took place in a private setting, to protect confidentiality and enable respondents to feel comfortable responding to sensitive questions. Data collectors found that the most private space to conduct the interview was in the respondents' home, with the caregiver leaving the house during the adolescent interview, and vice versa.

After completion of the interview with an adolescent respondent, data collectors asked respondents the following post-survey screening questions: "I know this discussion might have been difficult for you. How are you feeling right now? Would you like to discuss any of these issues further with someone else?" Respondents were offered information about services in the camp that they could access if they wished.

Adolescents and caregivers who agreed to participate in focus groups were administered one-on-one informed consent by a data collector. The focus group facilitator monitored the participants for distress, and reminded participants that they could choose not to answer a question, or to end their participation in the focus group at any time.

No identifying information was collected about respondents, and each survey was identified only by a survey ID number. All data was collected using mobile phone technology, and survey data was uploaded daily onto a secure server.

APPENDIX 3:

SURVEY SAMPLING

The sampling approach in the 2013 pilot study is described in the Baseline Report, and involved using systematic sampling approach to generate a random, population-based sample in Kiziba camp (10). The systematic sampling approach planned involved generating a sampling interval, by dividing the number of households in the camp by the number of planned interviews, and selecting households in each village and cluster throughout the camp based on that interval. Researchers modified the sampling plan to allow data collectors to select the neighboring household or household after that if the designated household did not contain an adolescent. The 2013 baseline study sample was 129 adolescent and caregiver pairs.

For the T2 study in 2015, researchers aimed to conduct follow-up interviews with baseline respondents, and add additional randomly selected respondents to the sample. The final sample in T2 consisted of 106 adolescents from the baseline study, 131 new (T2 only) adolescents, 11 UASC adolescents and 3 adolescents living with physical disabilities, a total of 274.

The total sample size of caregivers for T2 data collection of caregivers was 269. This was 112 caregivers from the baseline study, 129 new (T2 only) caregivers, 8 caregivers of UASC and 3 caregivers of adolescents living with physical disabilities.

At T2, there was purposive selection of a sample of UASC or children with physical disabilities. UNHCR Rwanda provided the research team with a list of registered UASC and children with physical disabilities, and eligible adolescents were selected from this list. All other procedures (i.e. informed consent) were the same for this sub-sample. A total of 11 UASC adolescents and 3 adolescents with physical disabilities were selected.

For the qualitative components of the study, key informants were purposively selected from the fields of child protection, health and education, and from positions in Government, UNHCR, other humanitarian organizations operating in Kiziba camp, community-based organizations and community structures. Adolescents and caregivers were purposively selected by Plan Rwanda to participate in focus group discussions. Potential participants were approached by the research assistants hired as part of the study, and asked if they would be willing to participate in a focus group discussion about topics of safety, services, and well-being in the camp.

APPENDIX 4:

RESULTS, ADOLESCENT AND CAREGIVER SURVEYS: DETAILED OUTPUT, MODEL DEVELOPMENT, PSYCHOMETRIC PROPERTIES

The following sections provide detailed output of items from quantitative adolescent and caregiver surveys. When significant changes resulted in significant linear or logistic regression models, those models are also included.

A4.1 Exposure to violence and abuse

Table 13. Change in exposure to verbal and physical violence, by gender

Question	Female			Male		
	T1 (N=77)	T2 (N=133)	Change	T1 (N=52)	T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Exposure to violence in the home						
Has anyone in your home ever used drugs and/or alcohol and then behaved in a way that frightened you?						
Yes	8 (10.4)	26 (19.7)	0.080	8 (15.4)	19 (16.1)	0.906
No	69 (89.6)	106 (80.3)		44 (84.6)	99 (83.9)	
Have you ever seen adults in your home shouting and yelling at each other (arguing) in a way that frightened you?						
Yes	56 (72.7)	102 (76.7)	0.370	37 (71.2)	74 (62.7)	0.150
No	20 (26.0)	31 (23.3)		14 (26.9)	44 (37.3)	
Missing	1 (1.3)	0 (0.0)		1 (1.9)	0 (0.0)	
Have you seen adults in your home hit, kick, slap, punch each other or hurt each other physically in other ways?						
Yes	14 (18.2)	40 (30.1)	0.060	9 (17.3)	12 (10.2)	0.192
No	63 (81.8)	93 (69.9)		43 (82.7)	106 (89.8)	
Have you ever seen anyone in your home use knives, guns, sticks, rocks or other things to hurt or scare someone else inside the home?						
Yes	3 (3.9)	4 (3)	0.740	1 (1.9)	5 (4.2)	0.451
No	74 (96.1)	128 (97)		51 (98.1)	113 (95.8)	
Verbal, physical, and emotional abuse in the home						
Has anyone in your family or living in your home ever screamed at you very loudly and aggressively?						
Yes	16 (20.8)	30 (22.6)	0.760	16 (30.8)	31 (26.5)	0.567
No	61 (79.2)	103 (77.4)		36 (69.2)	86 (73.5)	
Has anyone in your family or living in your home ever called you names, said mean things or cursed you?						
Yes	6 (7.8)	8 (6.0)	0.620	6 (11.5)	8 (6.8)	0.298
No	71 (92.2)	125 (94.0)		46 (88.5)	110 (93.2)	
Has anyone in your family or living in your home ever said that they wished you were dead/ had never been born?						
Yes	4 (5.2)	12 (9.0)	0.310	2 (3.8)	10 (8.5)	0.278
No	73 (94.8)	121 (91.0)		50 (96.2)	108 (91.5)	

Question	Female			Male		
	T1 (N=77)	T2 (N=133)	Change	T1 (N=52)	T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Has anyone in your family or living in your home ever threatened to leave you forever or abandon you?						
Yes	5 (6.5)	5 (3.8)	0.370	3 (5.8)	10 (8.5)	0.541
No	72 (93.5)	128 (96.2)		49 (94.2)	108 (91.5)	
Has anyone in your family or living in your home ever threatened to hurt or kill you, including invoking evil spirits against you?						
Yes	0 (0.0)	4 (3.0)	0.120	2 (3.8)	3 (2.5)	0.643
No	77 (100.0)	129 (97.0)		50 (96.2)	115 (97.5)	
Has anyone ever pushed, grabbed or kicked you?						
Yes	8 (10.4)	10 (7.5)	0.470	6 (11.5)	12 (10.2)	0.789
No	69 (89.6)	123 (92.5)		46 (88.5)	106 (89.8)	
Has anyone in your family or living in your home ever hit, beat or spanked you with a hand?						
Yes	11 (14.3)	17 (12.8)	0.760	13 (25)	24 (20.3)	0.497
No	66 (85.7)	116 (87.2)		39 (75)	94 (79.7)	
Has anyone in your family or living in your home ever hit, beat or spanked you with a belt, paddle, a stick or other object?						
Yes	8 (10.4)	10 (7.5)	0.470	6 (11.5)	14 (11.9)	0.799
No	69 (89.6)	123 (92.5)		46 (88.5)	103 (87.3)	
Has anyone in your family or living in your home ever pulled your hair, pinched you, or twisted your ear?						
Yes	8 (10.4)	5 (3.8)	0.060	6 (11.5)	12 (10.2)	0.789
No	69 (89.6)	128 (96.2)		46 (88.5)	106 (89.8)	
Has anyone in your family or living in your home ever made you stay in one position holding a heavy load or another burden or making you do exercise as punishment?						
Yes	8 (10.4)	8 (6.0)	0.250	5 (9.6)	11 (9.3)	0.952
No	69 (89.6)	125 (94.0)		47 (90.4)	107 (90.7)	
Has anyone in your family or living in your home ever threatened you with a knife or a gun?						
Yes	0 (0.0)	0 (0.0)	n/a	2 (3.8)	0 (0.0)	0.092*
No	77 (100.0)	133 (100.0)		50 (96.2)	118 (100.0)	
Sexual violence in the past year						
Was there a time when you were physically forced to have sexual intercourse against your will?						
Yes	3 (4.2)	3 (2.3)	0.430	2 (4.1)	0 (0.0)	0.085*
No	68 (95.8)	130 (97.7)		47 (95.9)	118 (100.0)	
Was there a time when you were persuaded or pressured to have sexual intercourse against your will?						
Yes	0 (0.0)	6 (4.5)	0.060	2 (3.8)	0 (0.0)	0.092*
No	77 (100.0)	127 (95.5)		50 (96.2)	118 (100.0)	
Was there a time when you were touched against your will in a sexual way, such as unwanted touching, kissing, grabbing, or fondling, but the person did not try to force you to have sex?						
Yes	7 (9.1)	5 (3.8)	0.110	3 (5.8)	2 (1.7)	0.147
No	70 (90.9)	128 (96.2)		49 (94.2)	116 (98.3)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050*

Table 14. Past-year change in exposure to verbal and physical violence

Question	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
Exposure to violence in the home			
Has anyone in your home ever used drugs and/or alcohol and then behaved in a way that frightened you?			
Yes	14 (87.5)	43 (95.6)	0.279*
No	2 (12.5)	2 (4.4)	
Have you ever seen adults in your home shouting and yelling at each other (arguing) in a way that frightened you?			
Yes	85 (91.4)	173 (98.3)	**0.010***
No	8 (8.6)	3 (1.7)	
Have you seen adults in your home hit, kick, slap, punch each other or hurt each other physically in other ways?			
Yes	21 (91.3)	50 (96.2)	0.582*
No	2 (8.7)	2 (3.8)	
Have you ever seen anyone in your home use knives, guns, sticks, rocks or other things to hurt or scare someone else inside the home?			
Yes	4 (100)	9 (100)	n/a
No	0 (0)	0 (0)	
Verbal, physical, and emotional abuse in the home			
Has anyone in your family or living in your home ever screamed at you very loudly and aggressively?			
Yes	30 (93.8)	59 (96.7)	0.606*
No	2 (6.2)	2 (3.3)	
Has anyone in your family or living in your home ever called you names, said mean things or cursed you?			
Yes	12 (100)	16 (100)	n/a
No	0 (0)	0 (0)	
Has anyone in your family or living in your home ever said that they wished you were dead/ had never been born?			
Yes	6 (100)	19 (86.4)	1.000*
No	0 (0)	3 (13.6)	
Has anyone in your family or living in your home ever threatened to leave you forever or abandon you?			
Yes	7 (87.5)	14 (93.3)	1.000*
No	1 (12.5)	1 (6.7)	
Has anyone in your family or living in your home ever threatened to hurt or kill you, including invoking evil spirits against you?			
Yes	1 (50)	7 (100)	0.222*
No	1 (50)	0 (0)	
Has anyone ever pushed, grabbed or kicked you?			
Yes	13 (92.9)	22 (100)	0.389*
No	1 (7.1)	0 (0)	
Has anyone in your family or living in your home ever hit, beat or spanked you with a hand?			
Yes	24 (100)	39 (95.1)	0.527*
No	0 (0)	2 (4.9)	
Has anyone in your family or living in your home ever hit, beat or spanked you with a belt, paddle, a stick or other object?			
Yes	12 (85.7)	20 (87)	1.000*
No	2 (14.3)	3 (13)	
Has anyone in your family or living in your home ever pulled your hair, pinched you, or twisted your ear?			
Yes	14 (100)	17 (100)	n/a
No	0 (0)	0 (0)	
Has anyone in your family or living in your home ever made you stay in one position holding a heavy load or another burden or making you do exercise as punishment?			
Yes	13 (100)	17 (89.5)	0.502*
No	0 (0)	2 (10.5)	
Has anyone in your family or living in your home ever threatened you with a knife or a gun?			
Yes	2 (100)	2 (100)	n/a
No	0 (0)	0 (0)	
Sexual violence in the past year			
Was there a time when you were physically forced to have sexual intercourse against your will?			
Yes	5 (100)	3 (100)	n/a
No	0 (0)	0 (0)	
Was there a time when you were persuaded or pressured to have sexual intercourse against your will?			
Yes	2 (66.7)	6 (100)	0.333*
No	1 (33.3)	0 (0)	
Was there a time when you were touched against your will in a sexual way, such as unwanted touching, kissing, grabbing, or fondling, but the person did not try to force you to have sex?			
Yes	10 (100)	7 (100)	n/a
No	0 (0)	0 (0)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050*

Table 15. Past-year change in exposure to verbal and physical violence, by gender

Question	Female			Male		
	Baseline, T1 (N=77)	Follow-up, T2 (N=133)	Change	Baseline, T1 (N=52)	Follow-up, T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Exposure to violence in the home						
Has anyone in your home ever used drugs and/or alcohol and then behaved in a way that frightened you?						
Yes	7 (87.5)	26 (100)	0.235*	7 (87.5)	17 (89.5)	1.000*
No	1 (12.5)	0 (0)		1 (12.5)	2 (10.5)	
Have you ever seen adults in your home shouting and yelling at each other (arguing) in a way that frightened you?						
Yes	52 (92.9)	102 (100)	**< 0.015***	33 (89.2)	71 (95.9)	0.219*
No	4 (7.1)	0 (0)		4 (10.8)	3 (4.1)	
Have you seen adults in your home hit, kick, slap, punch each other or hurt each other physically in other ways?						
Yes	14 (100)	40 (100)	n/a	7 (77.8)	10 (83.3)	1.000*
No	0 (0)	0 (0)		2 (22.2)	2 (16.7)	
Have you ever seen anyone in your home use knives, guns, sticks, rocks or other things to hurt or scare someone else inside the home?						
Yes	3 (100)	4 (100)	n/a	1 (100)	5 (100)	n/a
No	0 (0)	0 (0)		0 (0)	0 (0)	
Verbal, physical, and emotional abuse in the home						
Has anyone in your family or living in your home ever screamed at you very loudly and aggressively?						
Yes	16 (100)	30 (100)	n/a	14 (87.5)	29 (93.5)	0.597*
No	0 (0)	0 (0)		2 (12.5)	2 (6.5)	
Has anyone in your family or living in your home ever called you names, said mean things or cursed you?						
Yes	6 (100)	8 (100)	n/a	6 (100)	8 (100)	n/a
No	0 (0)	0 (0)		0 (0)	0 (0)	
Has anyone in your family or living in your home ever said that they wished you were dead/ had never been born?						
Yes	4 (100)	11 (91.7)	1.000*	2 (100)	8 (80)	1.000*
No	0 (0)	1 (8.3)		0 (0)	2 (20)	
Has anyone in your family or living in your home ever threatened to leave you forever or abandon you?						
Yes	4 (80)	5 (100)	1.000*	3 (100)	9 (90)	1.000*
No	1 (20)	0 (0)		0 (0)	1 (10)	
Has anyone in your family or living in your home ever threatened to hurt or kill you, including invoking evil spirits against you?						
Yes	4 (100)	4 (100)	n/a	1 (50)	3 (100)	0.400*
No	0 (0)	0 (0)		1 (50)	0 (0)	
Has anyone ever pushed, grabbed or kicked you?						
Yes	8 (100)	10 (100)	n/a	5 (83.3)	12 (100)	0.333*
No	0 (0)	0 (0)		1 (16.7)	0 (0)	
Has anyone in your family or living in your home ever hit, beat or spanked you with a hand?						
Yes	11 (100)	17 (100)	n/a	13 (100)	22 (91.7)	0.532*
No	0 (0)	0 (0)		0 (0)	2 (8.3)	

Question	Female			Male		
	Baseline, T1 (N=77)	Follow-up, T2 (N=133)	Change	Baseline, T1 (N=52)	Follow-up, T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Has anyone in your family or living in your home ever hit, beat or spanked you with a belt, paddle, a stick or other object?						
Yes	8 (100)	9 (100)	n/a	4 (66.7)	11 (78.6)	0.613*
No	0 (0)	0 (0)		2 (33.3)	3 (21.4)	
Has anyone in your family or living in your home ever pulled your hair, pinched you, or twisted your ear?						
Yes	8 (100)	5 (100)	n/a	6 (100)	12 (100)	n/a
No	0 (0)	0 (0)		0 (0)	0 (0)	
Has anyone in your family or living in your home ever made you stay in one position holding a heavy load or another burden or making you do exercise as punishment?						
Yes	8 (100)	8 (100)	n/a	5 (100)	9 (81.8)	1.000*
No	0 (0)	0 (0)		0 (0)	2 (18.2)	
Has anyone in your family or living in your home ever threatened you with a knife or a gun?						
Yes	0 (0)	0 (0)	n/a	2 (100)	0 (0)	n/a
No	0 (0)	0 (0)		0 (0)	0 (0)	
Sexual violence in the past year						
Was there a time when you were physically forced to have sexual intercourse against your will?						
Yes	3 (100)	3 (100)	n/a	2 (100)	0 (0)	n/a
No	0 (0)	0 (0)		0 (0)	0 (0)	
Was there a time when you were persuaded or pressured to have sexual intercourse against your will?						
Yes	0 (0)	6 (100)	0.143	2 (100)	0 (0)	n/a
No	1 (100)	0 (0)		0 (0)	0 (0)	
Was there a time when you were touched against your will in a sexual way, such as unwanted touching, kissing, grabbing, or fondling, but the person did not try to force you to have sex?						
Yes	7 (100)	5 (100)	n/a	3 (100)	2 (100)	n/a
No	0 (0)	0 (0)		0 (0)	0 (0)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050*

Table 16. Female adolescents report higher levels of witnessing family arguments, adjusted analysis Kiziba Camp, 2013-2015

Factors	aOR	95% CI	p value
Data collection wave	0.87	(0.54, 1.40)	0.555
Gender (ref. male)	1.60	(1.02, 2.51)	**0.040**

Notes. **Bold** indicates significant association at p<0.05.

Table 17. Female adolescents report higher levels of kicking and slapping, adjusted analysis Kiziba Camp, 2013-2015

Factors	aOR	95% CI	p value
Data collection wave	1.28	(0.74, 2.23)	0.376
Gender (ref. male)	2.50	(1.44, 4.34)	**0.040**

Notes. **Bold** *indicates significant association at p<0.05.*

Table 18. Change in caregiver attitudes around beating children for different reasons

Conditions	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
If the child is disobedient			
Yes	52 (40.6)	111 (44.0)	0.524
No	76 (59.4)	141 (56.0)	
If the child disagrees with the parent			
Yes	27 (21.4)	54 (21.7)	0.954
No	99 (78.6)	195 (78.3)	
If the child runs away from home			
Yes	34 (26.8)	63 (25.2)	0.741
No	93 (73.2)	187 (74.8)	
If the child does not want to go to school			
Yes	55 (43.0)	95 (37.8)	0.335
No	73 (57.0)	156 (62.2)	
If the child steals			
Yes	70 (55.6)	147 (59.3)	0.491
No	56 (44.4)	101 (40.7)	
If the child does not want to go to work			
Yes	41 (32.8)	56 (22.2)	**0.027**
No	84 (67.2)	196 (77.8)	
If the child does not care for brothers and sisters			
Yes	27 (21.6)	34 (13.5)	**0.044**
No	98 (78.4)	218 (86.5)	
If the child is engaged by adult in prostitution			
Yes	52 (43.3)	105 (42.0)	0.808
No	68 (56.7)	145 (58.0)	
If the child wets bed			
Yes	35 (28)	68 (27.3)	0.888
No	90 (72)	181 (72.7)	
If the child takes drugs or alcohol			
Yes	47 (37.9)	107 (42.6)	0.381
No	77 (62.1)	144 (57.4)	
If the child refuses to get married			
Yes	5 (4.2)	6 (2.4)	0.341
No	113 (95.8)	242 (97.6)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 19. Change in caregiver attitudes around beating children for different reasons, by caregiver gender

Conditions	Female			Male		
	Baseline, T1 (N=112)	Follow-up, T2 (N=216)	Change	Baseline, T1 (N=16)	Follow-up, T2 (N=36)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
If the child is disobedient						
Yes	51 (45.9)	101 (46.8)	0.889	1 (6.2)	10 (27.8)	0.140*
No	60 (54.1)	115 (53.2)		15 (93.8)	26 (72.2)	
If the child disagrees with the parent						
Yes	27 (24.8)	50 (23.4)	0.779	0 (0.0)	4 (11.4)	0.295*
No	82 (75.2)	164 (76.6)		16 (100.0)	31 (88.6)	
If the child runs away from home						
Yes	31 (27.9)	59 (27.6)	0.945	3 (20.0)	4 (11.1)	0.406*
No	80 (72.1)	155 (72.4)		12 (80.0)	32 (88.9)	
If the child does not want to go to school						
Yes	49 (43.8)	83 (38.4)	0.351	6 (40.0)	12 (34.3)	0.700
No	63 (56.2)	133 (61.6)		9 (60.0)	23 (65.7)	
If the child steals						
Yes	64 (58.2)	126 (59.4)	0.828	6 (40.0)	21 (58.3)	0.232
No	46 (41.8)	86 (40.6)		9 (60.0)	15 (41.7)	
If the child does not want to go to work						
Yes	37 (33.9)	53 (24.5)	0.074	4 (26.7)	3 (8.3)	0.174*
No	72 (66.1)	163 (75.5)		11 (73.3)	33 (91.7)	
If the child does not care for brothers and sisters						
Yes	25 (22.9)	33 (15.3)	0.089	2 (13.3)	1 (2.8)	0.203*
No	84 (77.1)	183 (84.7)		13 (86.7)	35 (97.2)	
If the child is engaged by adult in prostitution						
Yes	48 (45.3)	92 (43)	0.697	4 (30.8)	13 (36.1)	0.729
No	58 (54.7)	122 (57)		9 (69.2)	23 (63.9)	
If the child wets bed						
Yes	33 (30.3)	62 (29.1)	0.828	2 (13.3)	6 (16.7)	0.766
No	76 (69.7)	151 (70.9)		13 (86.7)	30 (83.3)	
If the child takes drugs or alcohol						
Yes	42 (38.9)	95 (44.2)	0.363	5 (33.3)	12 (33.3)	1.000
No	66 (61.1)	120 (55.8)		10 (66.7)	24 (66.7)	
If the child refuses to get married						
Yes	5 (4.8)	5 (2.4)	0.243	0 (0.0)	1 (2.8)	0.544*
No	99 (95.2)	207 (97.6)		13 (100.0)	35 (97.2)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

A4.2 Adolescent psychosocial well-being

Table 20. Categorical change in adolescent psychosocial well-being, adolescent report

Scale	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
SCARED			
High	35 (27.1)	86 (34.3)	0.158
Low	94 (72.9)	165 (65.7)	
Emotional symptoms scores, SDQ			
Low	106 (82.2)	174 (69.3)	**0.015***
Medium	7 (5.4)	27 (10.8)	
High	16 (12.4)	50 (19.9)	
Children's Hope Scale			
Low	22 (17.1)	34 (13.5)	0.991*
Medium	88 (68.2)	189 (75.3)	
High	19 (14.7)	28 (11.2)	
Children and Youth Resilience Measure			
Low	21 (16.3)	37 (14.7)	0.148*
Medium	95 (73.6)	171 (68.1)	
High	13 (10.1)	43 (17.1)	

*Notes. * ANOVA test reported due to greater than two response options.* **Bold** *indicates statistically significant finding, p<0.050. SCARED= Screen for Child Anxiety Related Emotional Disorder; SDQ = Strengths and Difficulties Questionnaire*

Table 21. Categorical change in adolescent psychosocial well-being, adolescent report by gender

Scale	Female			Male		
	Baseline, T1 (N=77)	Follow-up, T2 (N=133)	Change	Baseline, T1 (N=52)	Follow-up, T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
SCARED						
Yes	22 (28.6)	41 (30.8)	0.731	13 (25)	45 (38.1)	0.096
No	55 (71.4)	92 (69.2)		39 (75)	73 (61.9)	
Emotional symptoms scores, SDQ						
Normal	62 (80.5)	93 (69.9)	0.138*	44 (84.6)	81 (68.6)	**0.041***
Borderline	4 (5.2)	13 (9.8)		3 (5.8)	14 (11.9)	
Abnormal	11 (14.3)	27 (20.3)		5 (9.6)	23 (19.5)	
Children's Hope Scale						
Low	16 (20.8)	18 (13.5)	0.909*	6 (11.5)	16 (13.6)	0.839*
Medium	48 (62.3)	101 (75.9)		40 (76.9)	88 (74.6)	
High	13 (16.9)	14 (10.5)		6 (11.5)	14 (11.9)	
Children and Youth Resilience Measure						
Low	11 (14.3)	16 (12)	0.118*	10 (19.2)	21 (17.8)	0.560*
Medium	58 (75.3)	90 (67.7)		37 (71.2)	81 (68.6)	
High	8 (10.4)	27 (20.3)		5 (9.6)	16 (13.6)	

*Notes. * ANOVA test reported due to greater than two response options.* **Bold** *indicates statistically significant finding, p<0.050. SCARED= Screen for Child Anxiety Related Emotional Disorder; SDQ = Strengths and Difficulties Questionnaire*

Table 22. Adjusted change in anxiety (SCARED), Kiziba Camp, 2013-2015

Factors	aOR	95% CI	p value
Age	1.16	(1.03, 1.31)	**0.013**
Data collection wave	1.30	(0.81, 2.10)	0.271

Notes. **Bold** *indicates significant association at p<0.05.*

Table 23. Adjusted change in emotional symptoms (SDQ), Kiziba Camp, 2013-2015

Factors		Coefficient	95% CI	p value
Parent status (ref. orphan)	Single parent	-2.44	(-3.57, -1.30)	**<0.001**
	Both parents	-2.17	(-3.21, -1.12)	**<0.001**
Age		0.32	(0.17, 0.47)	**<0.001**
Sex		0.27	(-0.45, 0.63)	0.743
Data collection wave		0.49	(-0.08, 1.06)	0.090

Notes. **Bold** *indicates significant association at p<0.05.*

Table 24. Matched, adjusted change in psychosocial wellbeing, Kiziba Camp, 2013-2015

Factors		SCARED			Emotional Symptoms, SDQ			Resilience		
		Coeffi-cient	95% CI	p value	Coeffi-cient	95% CI	p value	Coeffi-cient	95% CI	p value
Psychosocial wellbeing (T2)		0.25	(0.08, 0.42)	**0.004**	0.16	(0.02, 0.30)	**0.025**	0.31	(0.13-0.48)	**0.001**
Parent status (ref. orphan)	Single parent	-0.32	(-2.20, 1.55)	0.732	-3.31	(-5.18, -1/43)	**0.001**	3.51	(-2.74, 9.76)	0.268
	Both parents	0.28	(-1.42, 1.98)	0.743	-2.57	(-4.25, -0.89)	**0.003**	0.42	(-5.31, 6.15)	0.884
Age		0.07	(-0.21, 0.36)	0.590	0.40	(0.12, 0.67)	**0.005**	-0.41	(-1.34, 0.52)	0.379
Sex		-0.08	(-0.94, 0.77)	0.853	0.01	(-0.83, 0.85)	0.981	1.56	(-1.33, 4.44)	0.287

Notes. **Bold** *indicates significant association at p<0.05. Psychosocial wellbeing factor (T2) is SCARED in first model, Emotional symptoms, SDQ in second model, and Resilience in third model.*

A4.3 Feelings of safety

Table 25. Adolescent change in feelings of safety, in the past week

Question	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
Have you felt unsafe in your home?			
Yes	26 (20.2)	63 (25.3)	0.264
No	103 (79.8)	186 (74.7)	
Have you felt unsafe at school?			
Yes	15 (19.7)	71 (30.3)	0.073
No	61 (80.3)	163 (69.7)	
Have you felt unsafe on the way to or from school?			
Yes	13 (10.2)	68 (29.2)	**<0.001**
No	115 (89.8)	165 (70.8)	
Have you felt unsafe at the market, or other public spaces in the camp?			
Yes	9 (11.8)	43 (17.3)	0.259
No	67 (88.2)	206 (82.7)	
Have you felt unsafe on the way to or from market, or other public spaces in the camp?			
Yes	13 (10.1)	46 (18.5)	**0.033**
No	116 (89.9)	203 (81.5)	
Have you felt unsafe at work?			
Yes	1 (12.5)	2 (11.8)	1.000*
No	7 (87.5)	15 (88.2)	
Have you felt unsafe on the way to work?			
Yes	2 (25.0)	1 (7.1)	0.527*
No	6 (75.0)	13 (92.9)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 26. Adolescent change in feelings of safety, by gender

Question	Female			Male		
	Baseline, T1 (N=77)	Follow-up, T2 (N=133)	Change	Baseline, T1 (N=52)	Follow-up, T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Have you felt unsafe in your home?						
Yes	15 (19.5)	36 (27.3)	0.206	11 (21.2)	27 (23.1)	0.782
No	62 (80.5)	96 (72.7)		41 (78.8)	90 (76.9)	
Have you felt unsafe at school?						
Yes	8 (16.0)	37 (30.6)	**0.049**	7 (26.9)	34 (30.1)	0.75
No	42 (84.0)	84 (69.4)		19 (73.1)	79 (69.9)	
Have you felt unsafe on the way to or from school?						
Yes	9 (11.8)	36 (30.0)	**0.003**	4 (7.7)	32 (28.3)	**0.002***
No	67 (88.2)	84 (70.0)		48 (92.3)	81 (71.7)	
Have you felt unsafe at the market, or other public spaces in the camp?						
Yes	6 (12.0)	16 (12.0)	0.996	3 (11.5)	27 (23.3)	0.287*
No	44 (88.0)	117 (88.0)		23 (88.5)	89 (76.7)	
Have you felt unsafe on the way to or from market, or other public spaces in the camp?						
Yes	7 (9.1)	18 (13.5)	0.338	6 (11.5)	28 (24.1)	0.06
No	70 (90.9)	115 (86.5)		46 (88.5)	88 (75.9)	
Have you felt unsafe at work?						
Yes	0 (0.0)	2 (22.2)	1.000*	1 (25.0)	0 (0.0)	0.333*
No	4 (100.0)	7 (77.8)		3 (75.0)	8 (100.0)	
Have you felt unsafe on the way to work?						
Yes	0 (0.0)	1 (16.7)	1.000*	2 (40.0)	0 (0.0)	0.128*
No	3 (100.0)	5 (83.3)		3 (60.0)	8 (100.0)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 27. Adolescents felt more unsafe on the way to school in 2015 than in 2013, Kiziba Camp, 2013-2015

Factors	aOR	95% CI	p value
Data collection wave	3.70	(1.95, 7.01)	**<0.001**
Gender (ref. male)	1.17	(0.70, 1.94)	0.558

Notes. **Bold** *indicates significant association at p<0.05.*

Table 28. Adolescents felt more unsafe on the way to the market in 2015 than in 2013, Kiziba Camp, 2013-2015

Factors	aOR	95% CI	p value
Data collection wave	1.96	(1.01, 3.79)	**<0.046**
Gender (ref. male)	0.55	(0.31, 0.96)	0.037

Notes. **Bold** *indicates significant association at p<0.05.*

Table 29. Change in caregiver perceptions of child safety

Question	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
A child in this camp is safe in their school.			
Strongly agree	68 (53.1)	75 (30.1)	**<0.001****
Agree	47 (36.7)	131 (52.6)	
Disagree	8 (6.3)	24 (9.6)	
Strongly disagree	5 (3.9)	19 (7.6)	
A child in this camp is safe on their way to school.			
Strongly agree	57 (44.9)	57 (22.7)	**<0.001****
Agree	51 (40.2)	121 (48.2)	
Disagree	17 (13.4)	60 (23.9)	
Strongly disagree	2 (1.6)	13 (5.2)	
A child in this camp is safe at the market or other open places in the camp.			
Strongly agree	48 (37.5)	48 (19.0)	**0.017****
Agree	48 (37.5)	132 (52.4)	
Disagree	24 (18.8)	57 (22.6)	
Strongly disagree	8 (6.3)	15 (6.0)	
Are there any places in the camp where children are UNSAFE?			
Yes	39 (30.5)	70 (29.0)	0.775
No	89 (69.5)	171 (71.0)	
Has your child ever been injured while walking around the camp?			
Yes	47 (36.7)	79 (31.5)	0.305
No	81 (63.3)	172 (68.5)	
Are there police or security officials in the camp?			
Yes	124 (96.9)	240 (95.2)	0.593*
No	4 (3.1)	12 (4.8)	

*Notes. * Fischer's exact test run due to small cell values. ** ANOVA test reported due to greater than two response options.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 30. Change in caregiver perceptions of child safety, by caregiver gender

Question	Female			Male		
	Baseline, T1 (N=77)	Follow-up, T2 (N=133)	Change	Baseline, T1 (N=52)	Follow-up, T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
A child in this camp is safe in their school.						
Strongly agree	59 (52.7)	67 (31.5)	**<0.001****	9 (60.0)	8 (22.2)	0.142**
Agree	43 (38.4)	111 (52.1)		3 (20.0)	20 (55.6)	
Disagree	6 (5.4)	18 (8.5)		2 (13.3)	6 (16.7)	
Strongly disagree	4 (3.6)	17 (8)		1 (6.7)	2 (5.6)	
A child in this camp is safe on their way to school.						
Strongly agree	51 (45.5)	48 (22.3)	**<0.001****	6 (42.9)	9 (25.0)	0.132**
Agree	44 (39.3)	105 (48.8)		6 (42.9)	16 (44.4)	
Disagree	15 (13.4)	51 (23.7)		2 (14.3)	9 (25)	
Strongly disagree	2 (1.8)	11 (5.1)		0 (0.0)	2 (5.6)	
A child in this camp is safe at the market or other open places in the camp.						
Strongly agree	43 (38.4)	42 (19.4)	0.021**	5 (33.3)	6 (16.7)	0.564**
Agree	42 (37.5)	113 (52.3)		5 (33.3)	19 (52.8)	
Disagree	20 (17.9)	49 (22.7)		4 (26.7)	8 (22.2)	
Strongly disagree	7 (6.2)	12 (5.6)		1 (6.7)	3 (8.3)	
Are there any places in the camp where children are UNSAFE?						
Yes	35 (31.2)	53 (25.9)	0.305	4 (26.7)	17 (47.2)	0.221*
No	77 (68.8)	152 (74.1)		11 (73.3)	19 (52.8)	
Has your child ever been injured while walking around the camp?						
Yes	43 (38.4)	67 (31)	0.18	3 (20)	12 (34.3)	0.502*
No	69 (61.6)	149 (69)		12 (80)	23 (65.7)	
Are there police or security officials in the camp?						
Yes	108 (96.4)	206 (95.4)	0.779*	15 (100)	34 (94.4)	1.000*
No	4 (3.6)	10 (4.6)		0 (0)	2 (5.6)	

*Notes. * Fischer's exact test run due to small cell values. ** ANOVA test reported due to greater than two response options.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 31. Factors associated with continuous safety composite score

Factors		Coef.	95% CI	p value
SCARED, anxiety, higher worse, continuous		0.18	(0.11, 0.24)	**<0.001**
SDQ emotional, higher worse, continuous		0.12	(0.06, 0.18)	**<0.001**
Children and Youth Resilience Measure, higher better, continuous		-0.02	(-0.04, -0.01)	**0.002**
Children's Hope Scale, higher better continuous		0.01	(-0.03, 0.06)	0.622
Gender (ref. male)		-0.03	(-0.27, 0.20)	0.783
Age, continuous		0.05	(-0.01, 0.12)	0.124
Parent status (ref. orphan)	Single parent	-0.22	(-0.73, 0.29)	0.39
	Both parents	0.08	(-0.40, 0.55)	0.752
Data collection phase		0.26	(0.00, 0.51)	**0.049**

A4.4 Access to, knowledge of and utilization of child protection activities and services

Table 32. Change in adolescent reporting most recent sexual abuse, within past year by gender

Question	Female			Male		
	Baseline, T1 (N=)	Follow-up, T2 (N=)	Change	Baseline, T1 (N=)	Follow-up, T2 (N=)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Did you tell anyone about most recent physically forced sexual intercourse?						
Yes	1 (33.3)	1 (33.3)	0.800*	1 (50)	n/a	n/a
No	2 (66.7)	2 (66.7)		1 (50)	n/a	
Did you tell anyone about most recent psychologically forced sexual intercourse?						
Yes	0 (0)	3 (50)	1.000*	1 (50)	n/a	n/a
No	1 (100)	3 (50)		1 (50)	n/a	
Did you tell anyone about most recent unwanted sexual touching?						
Yes	2 (28.6)	1 (20)	0.636*	1 (33.3)	1 (50)	0.700*
No	5 (71.4)	4 (80)		2 (66.7)	1 (50)	

*Notes. Time-period of all items is past year. * Fischer's exact test run due to small cell values.*

Table 33. Change in child protection services and activity use, by adolescent gender

Question	Female			Male		
	T1 (N=77)	T2 (N=133)	Change	T1 (N=52)	T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Have you asked for help from Nkundabana?						
Yes	17 (22.1)	3 (2.3)	**<0.001***	8 (15.4)	4 (3.5)	**0.010***
No	60 (77.9)	126 (97.7)		44 (84.6)	109 (96.5)	
Have you asked for help from Abarengerabana?						
Yes	9 (11.7)	4 (3.5)	**0.039***	5 (9.6)	2 (1.9)	**0.037***
No	68 (88.3)	110 (96.5)		47 (90.4)	106 (98.1)	
Have you asked for help from Ijwi ry'Aban?						
Yes	4 (5.2)	2 (2.8)	0.682*	3 (5.8)	0 (0.0)	0.070*
No	73 (94.8)	70 (97.2)		49 (94.2)	73 (100.0)	
In the past year, have you ever participated in an organized group, or committee specifically for children or adolescents?						
Yes	32 (41.6)	54 (80.6)	**<0.001**	27 (51.9)	51 (82.3)	**<0.001**
No	45 (58.4)	13 (19.4)		25 (48.1)	11 (17.7)	
In the past year, have you ever participated in non-formal education, for example, after-school activities?						
Yes	37 (48.1)	40 (61.5)	0.108	23 (45.1)	37 (56.9)	0.206
No	40 (51.9)	25 (38.5)		28 (54.9)	28 (43.1)	
In the past year, have you ever participated in any life skills training in the camp?						
Yes	45 (58.4)	39 (76.5)	**0.036**	28 (54.9)	39 (63.9)	0.332
No	32 (41.6)	12 (23.5)		23 (45.1)	22 (36.1)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 34. Change in knowledge of services, by gender

Question	Female			Male		
	T1 (N=77)	T2 (N=133)	Change	T1 (N=52)	T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Do you know of a place to go to if you have experienced violence or abuse?						
Yes	72 (94.7)	111 (83.5)	**0.017***	47 (92.2)	106 (89.8)	0.779*
No	4 (5.3)	22 (16.5)		4 (7.8)	12 (10.2)	
Do you know where to go if you have a health problem?						
Yes	72 (93.5)	129 (97.0)	0.293*	45 (86.5)	116 (98.3)	**0.004***
No	5 (6.5)	4 (3.0)		7 (13.5)	2 (1.7)	
Do you know where to go if you have a problem at school?						
Yes	67 (91.8)	100 (83.3)	0.096	46 (92.0)	95 (83.3)	0.221*
No	6 (8.2)	20 (16.7)		4 (8.0)	19 (16.7)	
Do you know where to go if you have a problem at home?						
Yes	64 (83.1)	91 (70.0)	**0.035**	40 (80.0)	91 (79.1)	0.899
No	13 (16.9)	39 (30.0)		10 (20.0)	24 (20.9)	
Do you know where to go if you have a problem at work?						
Yes	1 (20.0)	4 (66.7)	0.242*	1 (20.0)	4 (40.0)	0.600*
No	4 (80.0)	2 (33.3)		4 (80.0)	6 (60.0)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 35. Change in service provider name recognition, adolescent report

Question	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
Have you ever heard of Nkundabana?			
Yes	126 (97.7)	242 (96.4)	0.758*
No	3 (2.3)	9 (3.6)	
Have you ever heard of Abarengerabana?			
Yes	113 (88.3)	222 (88.4)	0.962
No	15 (11.7)	29 (11.6)	
Have you ever heard of Ijwi ry'Aban?			
Yes	85 (65.9)	145 (58.0)	0.136
No	44 (34.1)	105 (42.0)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 36. Change in service provider name recognition, by adolescent gender

Question	Female			Male		
	Baseline, T1 (N=77)	Follow-up, T2 (N=133)	Change	Baseline, T1 (N=52)	Follow-up, T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Have you ever heard of Nkundabana?						
Yes	75 (97.4)	129 (97.0)	1.000*	51 (98.1)	113 (95.8)	0.668*
No	2 (2.6)	4 (3.0)		1 (1.9)	5 (4.2)	
Have you ever heard of Abarengerabana?						
Yes	68 (89.5)	114 (85.7)	0.436	45 (86.5)	108 (91.5)	0.318
No	8 (10.5)	19 (14.3)		7 (13.5)	10 (8.5)	
Have you ever heard of Ijwi ry'Aban?						
Yes	52 (67.5)	72 (54.1)	0.057	33 (63.5)	73 (62.4)	0.895
No	25 (32.5)	61 (45.9)		19 (36.5)	44 (37.6)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 37. Change in service provider name recognition, caregiver report

Question	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
Have you ever heard of Nkundabana?			
Yes	122 (97.6)	243 (96.4)	0.758*
No	3 (2.4)	9 (3.6)	
Have you ever heard of Abarengerabana?			
Yes	119 (93.0)	242 (96.4)	0.136
No	9 (7.0)	9 (3.6)	
Have you ever heard of Ijwi ry'Aban?			
Yes	78 (61.4)	115 (45.6)	**0.004**
No	49 (38.6)	137 (54.4)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 38. Change in service provider name recognition, by caregiver gender

Question	Female			Male		
	Baseline, T1 (N=77)	Follow-up, T2 (N=133)	Change	Baseline, T1 (N=52)	Follow-up, T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Have you ever heard of Nkundabana?						
Yes	3 (2.7)	7 (3.2)	1.000*	0 (0)	2 (5.6)	1.000*
No	107 (97.3)	209 (96.8)		14 (100)	34 (94.4)	
Have you ever heard of Abarengerabana?						
Yes	8 (7.2)	7 (3.3)	0.107	1 (6.2)	2 (5.6)	1.000*
No	103 (92.8)	208 (96.7)		15 (93.8)	34 (94.4)	
Have you ever heard of Ijwi ry'Aban?						
Yes	42 (38.2)	119 (55.1)	**0.004**	7 (43.8)	18 (50)	0.677
No	68 (61.8)	97 (44.9)		9 (56.2)	18 (50)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 39. Adjusted change in knowledge of where to go if experience violence or abuse, Kiziba Camp, 2013-2015

Factors		aOR	95% CI	p value
Parent status (ref. orphan)	Single parent	1.47	(0.41, 5.30)	0.560
	Both parents	1.96	(0.60, 6.36)	0.262
Age		1.49	(1.21, 1.83)	**<0.001**
Data collection wave		0.35	(0.15, 0.80)	**0.013**
Gender (ref. male)		0.72	(0.36, 1.42)	0.340

Notes. **Bold** *indicates significant association at p<0.05.*

Table 40. Adjusted change in knowledge of where to go if have a problem at school, Kiziba Camp, 2013-2015

Factors		aOR	95% CI	p value
Parent status (ref. orphan)	Single parent	1.39	(0.39, 4.94)	0.611
	Both parents	1.22	(0.39, 3.82)	0.739
Age		1.05	(0.89, 1.25)	0.561
Data collection wave		0.44	(0.21, 0.91)	**0.027**
Gender (ref. male)		1.02	(0.55, 1.87)	0.959

Notes. **Bold** *indicates significant association at p<0.05.*

Table 41. Adjusted change in knowledge of where to go if have a health problem, Kiziba Camp, 2013-2015

Factors		aOR	95% CI	p value
Parent status (ref. orphan)	Single parent	1.14	(0.11, 11.65)	0.914
	Both parents	0.71	(0.09, 5.80)	0.752
Data collection wave		3.93	(1.41, 10.93)	**0.009**
Gender (ref. male)		1.23	(0.46, 3.30)	0.684

Notes. **Bold** *indicates significant association at p<0.05.*

Table 42. Change in who adolescents would feel comfortable seeking help from if friend or acquaintance were sexually victimized, by gender

Relation	Female			Male		
	T1 (N=77)	T2 (N=133)	Change	T1 (N=52)	T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Mother	41 (53.2)	66 (49.6)	0.613	17 (32.7)	40 (33.9)	0.878
Father	17 (22.1)	17 (12.8)	0.078	9 (17.3)	28 (23.7)	0.350
Other relative	13 (16.9)	13 (9.8)	0.132	7 (13.5)	29 (24.6)	0.102
Friend	6 (7.8)	18 (13.5)	0.208	2 (3.8)	10 (8.5)	0.348*
Teacher/Principal	2 (2.6)	5 (3.8)	0.651	5 (9.6)	0 (0.0)	**0.002***
Religious leader	0 (0.0)	0 (0.0)	n/a	0 (0.0)	0 (0.0)	n/a
Health care provider / doctor / nurse	11 (14.3)	16 (12.0)	0.638	9 (17.3)	9 (7.6)	0.059
Traditional healer	0 (0.0)	0 (0.0)	n/a	0 (0.0)	0 (0.0)	n/a
Police/someone from security sector	6 (7.8)	7 (5.3)	0.464	9 (17.3)	13 (1.01)	0.260
Counselor	6 (7.8)	11 (8.3)	0.903	6 (11.5)	6 (5.1)	0.130
Community leader	7 (9.1)	8 (6.0)	0.404	9 (17.3)	16 (13.6)	0.525
Plan staff	2 (2.6)	0 (0.0)	0.211*	0 (0.0)	0 (0.0)	n/a

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 43. Change in report role of Child Protection Committee, adolescent report

Question	T1	T2	Change
	N (%)	N (%)	p-value
Raise awareness on child rights/ advocacy for children in the community			
Yes	14 (10.9)	25 (10.0)	0.796
No	115 (89.1)	225 (90.0)	
Monitor child protection in the community/identify vulnerable children			
Yes	55 (42.6)	95 (38.0)	0.382
No	74 (57.4)	155 (62.0)	
Give advice to children, parents, and other community members			
Yes	21 (16.3)	41 (16.4)	0.976
No	108 (83.7)	209 (83.6)	
Refer cases to social workers			
Yes	21 (16.3)	32 (12.8)	0.355
No	108 (83.7)	218 (87.2)	
Protect children from violence and abuse			
Yes	61 (47.3)	134 (53.6)	0.244
No	68 (52.7)	116 (46.4)	
Teach children good behavior and give them advice			
Yes	16 (12.4)	45 (18.0)	0.160
No	113 (87.6)	205 (82.0)	

Table 44. Change in report role of Child Protection Committee, adolescent report by gender

Question	Female			Male		
	T1 (N=112)	T2 (N=216)	Change	T1 (N=16)	T2 (N=36)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Raise awareness on child rights/ advocacy for children in the community						
Yes	7 (9.1)	19 (14.3)	0.271	7 (13.5)	6 (5.1)	0.061
No	70 (90.9)	114 (85.7)		45 (86.5)	111 (94.9)	
Monitor child protection in the community/identify vulnerable children						
Yes	30 (39.0)	50 (37.6)	0.844	25 (48.1)	45 (38.5)	0.242
No	47 (61.0)	83 (62.4)		27 (51.9)	72 (61.5)	
Give advice to children, parents, and other community members						
Yes	11 (14.3)	20 (15.0)	0.882	10 (19.2)	21 (17.9)	0.842
No	66 (85.7)	113 (85.0)		42 (80.8)	96 (82.1)	
Refer cases to social workers						
Yes	10 (13.0)	21 (15.8)	0.581	11 (21.2)	11 (9.4)	**0.036**
No	67 (87.0)	112 (84.2)		41 (78.8)	106 (90.6)	
Protect children from violence and abuse						
Yes	38 (49.4)	66 (49.6)	0.97	23 (44.2)	68 (58.1)	0.095
No	39 (50.6)	67 (50.4)		29 (55.8)	49 (41.9)	
Teach children good behavior and give them advice						
Yes	10 (13.0)	23 (17.3)	0.409	6 (11.5)	22 (18.8)	0.241
No	67 (87.0)	110 (82.7)		46 (88.5)	95 (81.2)	

Notes. **Bold** *indicates statistically significant finding, p<0.050.*

Table 45. Change in report role of Child Protection Committee, caregiver report

Question	T1	T2	Change
	N (%)	N (%)	p-value
Raise awareness on child rights/ advocacy for children in the community			
Yes	15 (11.6)	15 (6.0)	0.054
No	114 (88.4)	235 (94.0)	
Monitor child protection in the community/identify vulnerable children			
Yes	38 (29.5)	90 (36.0)	0.202
No	91 (70.5)	160 (64.0)	
Give advice to children, parents, and other community members			
Yes	25 (19.4)	45 (18.0)	0.743
No	104 (80.6)	205 (82.0)	
Refer cases to social workers			
Yes	15 (11.6)	26 (10.4)	0.715
No	114 (88.4)	224 (89.6)	

Question	T1	T2	Change
	N (%)	N (%)	p-value
Protect children from violence and abuse			
Yes	63 (48.8)	159 (63.6)	**0.006**
No	66 (51.2)	91 (36.4)	
Teach children good behavior and give them advice			
Yes	26 (20.2)	51 (20.4)	0.955
No	103 (79.8)	199 (79.6)	

Notes. **Bold** *indicates statistically significant finding, p<0.050.*

Table 46. Change in report role of Child Protection Committee, by caregiver gender

Question	Female			Male		
	T1 (N=112)	T2 (N=216)	Change	T1 (N=16)	T2 (N=36)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Raise awareness on child rights/ advocacy for children in the community						
Yes	11 (9.8)	14 (6.5)	0.291	4 (25)	1 (2.8)	**0.027***
No	101 (90.2)	200 (93.5)		12 (75)	35 (97.2)	
Monitor child protection in the community/identify vulnerable children						
Yes	32 (28.6)	74 (34.6)	0.271	5 (31.2)	16 (44.4)	0.371
No	80 (71.4)	140 (65.4)		11 (68.8)	20 (55.6)	
Give advice to children, parents, and other community members						
Yes	21 (18.8)	37 (17.3)	0.743	3 (18.8)	8 (22.2)	1.000*
No	91 (81.2)	177 (82.7)		13 (81.2)	28 (77.8)	
Refer cases to social workers						
Yes	14 (12.5)	19 (8.9)	0.303	0 (0.0)	7 (19.4)	0.085*
No	98 (87.5)	195 (91.1)		16 (100.0)	29 (80.6)	
Protect children from violence and abuse						
Yes	54 (48.2)	136 (63.6)	**0.008**	8 (50.0)	23 (63.9)	0.346
No	58 (51.8)	78 (36.4)		8 (50.0)	13 (36.1)	
Teach children good behavior and give them advice						
Yes	20 (17.9)	40 (18.7)	0.854	6 (37.5)	11 (30.6)	0.622
No	92 (82.1)	174 (81.3)		10 (62.5)	25 (69.4)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

A4.5 Socio-economic well-being

Table 47. Change in child labor, past year, by gender

Question	Female			Male		
	T1 (N=77)	T2 (N=133)	Change	T1 (N=52)	T2 (N=118)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Have you had to log for firewood?						
Yes	65 (84.4)	110 (82.7)	0.749	47 (90.4)	103 (87.3)	0.564
No	12 (15.6)	23 (17.3)		5 (9.6)	15 (12.7)	
Have you had to fetch water too heavy for your body?						
Yes	10 (13)	21 (15.8)	0.581	6 (11.5)	7 (5.9)	0.205
No	67 (87)	112 (84.2)		46 (88.5)	111 (94.1)	

*Notes. * Fischer's exact test run due to small cell values.*
***ANOVA test reported due to greater than two response options.*
****T-test for difference in means.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 48. Change in socio-economic status

Question	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
Have you worked in the past seven days?			
Yes	43 (33.3)	113 (44.8)	**0.031**
No	86 (66.7)	139 (55.2)	
For those who did not work in the last seven days, do you have any job or businesses?			
Yes	15 (17.9)	20 (14.4)	0.49
No	69 (82.1)	119 (85.6)	
Is there any work that you did in the 12 last months?			
Yes	20 (23.3)	21 (20)	0.586
No	66 (76.7)	84 (80)	
Do you work in the whole year, part of the year or just in sometimes?			
Regularly throughout year	25 (39.7)	40 (54.1)	**0.0029****
Seasonally/part of the year	16 (25.4)	27 (36.5)	
Once in a while	22 (34.9)	7 (9.5)	
What is your main source of income?			
Farming	1 (0.8)	9 (3.6)	0.0985**
Wages	10 (7.8)	16 (6.3)	
Business activities	36 (28.1)	46 (18.3)	
Selling food from WFP	34 (26.6)	65 (25.8)	
Cash from international org	0 (0)	4 (1.6)	
Money from family/friend	4 (3.1)	4 (1.6)	
No income	43 (33.6)	96 (38.1)	

Question	Baseline, T1	Follow-up, T2	Change
	N (%)	N (%)	p-value
What is the MAIN source of drinking water for members of your household?			
Piped water	28 (21.7)	118 (46.8)	0.0762**
Public tap/standpipe	99 (76.7)	88 (34.9)	
Tanker/ trunk	0 (0)	41 (16.3)	
Stream or river	2 (1.6)	5 (2)	
How long does it take to go to fetch water and coming back home? (in minutes)			
Mean [SD]	6.7 [10.8]	7.8 [10.9]	0.3627***
How many rooms are there in your living structure?			
Mean [SD]	2.5 [0.9]	2.5 [0.9]	0.6232***
How many of these rooms are used for sleeping?			
Mean [SD]	2.1 [0.7]	2.1 [0.7]	0.4553***

Table 49. Change in socio-economic status, by caregiver gender

Question	Female			Male		
	Baseline, T1 (N=112)	Follow-up, T2 (N=216)	Change	Baseline, T1 (N=16)	Follow-up, T2 (N=36)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
Have you worked in the past seven days?						
Yes	33 (29.5)	98 (45.4)	**0.005**	10 (62.5)	15 (41.7)	0.165
No	79 (70.5)	118 (54.6)		6 (37.5)	21 (58.3)	
For those who did not work in the last seven days, do you have any job or businesses?						
Yes	13 (16.9)	19 (16.1)	0.885	2 (33.3)	1 (4.8)	0.050
No	64 (83.1)	99 (83.9)		4 (66.7)	20 (95.2)	
Is there any work that you did in the 12 last months?						
Yes	17 (21.5)	18 (20.5)	0.866	2 (33.3)	3 (17.6)	0.423
No	62 (78.5)	70 (79.5)		4 (66.7)	14 (82.4)	
Do you work in the whole year, part of the year or just in sometimes?						
Regularly throughout year	18 (36)	36 (55.4)	**0.002****	6 (50)	4 (44.4)	0.436**
Seasonally/part of the year	14 (28)	22 (33.8)		2 (16.7)	5 (55.6)	
Once in a while	18 (36)	7 (10.8)		4 (33.3)	0 (0)	
What is your main source of income?						
Farming	1 (0.9)	8 (3.7)	0.169**	0 (0)	1 (2.8)	0.352**
Wages	4 (3.6)	9 (4.2)		6 (37.5)	7 (19.4)	
Business activities	31 (27.9)	39 (18.1)		4 (25)	7 (19.4)	
Selling food from WFP	33 (29.7)	59 (27.3)		1 (6.2)	6 (16.7)	
Cash from international organization	0 (0)	3 (1.4)		0 (0)	1 (2.8)	
Money from family/friend	4 (3.6)	4 (1.9)		5 (31.2)	13 (36.1)	
No income	38 (34.2)	83 (38.4)		0 (0)	1 (2.8)	

Question	Female			Male		
	Baseline, T1 (N=112)	Follow-up, T2 (N=216)	Change	Baseline, T1 (N=16)	Follow-up, T2 (N=36)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
What is the MAIN source of drinking water for members of your household?						
Piped water	22 (19.6)	99 (45.8)	0.115**	10 (62.5)	12 (33.3)	0.381**
Public tap/standpipe	88 (78.6)	76 (35.2)		0 (0)	3 (8.3)	
Tanker/ trunk	0 (0)	38 (17.6)		0 (0)	2 (5.6)	
Stream or river	2 (1.8)	3 (1.4)		16 (100)	36 (100)	
How long does it take to go to fetch water and coming back home? (in minutes)						
Mean [SD]	7.0 [11.5]	7.4 [10.7]	0.767***	4.8 [4.7]	10.1 [12.2]	0.094***
How many rooms are there in your living structure?						
Mean [SD]	2.4 [0.8]	2.5 [0.9]	0.445***	2.6 [1.2]	2.5 [0.9]	0.687***
How many of these rooms are used for sleeping?						
Mean [SD]	2.1 [0.7]	2.0 [0.7]	0.485***	2.1 [1.0]	2.1 [0.7]	0.955***

*Notes. * Fischer's exact test run due to small cell values. * *ANOVA test reported due to greater than two response options. ***T-test for difference in means.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 50. Change in hunger scale, by caregiver gender

Question	Female			Male		
	T1 (N=112)	T2 (N=216)	Change	T1 (N=16)	T2 (N=36)	Change
	N (%)	N (%)	p-value	N (%)	N (%)	p-value
In the past 4 weeks, was there ever no food to eat of any kind in your house because of lack of resources to get food?						
Yes	90 (80.4)	191 (88.4)	**0.048**	13 (81.2)	30 (83.3)	1.000*
No	22 (19.6)	25 (11.6)		3 (18.8)	6 (16.7)	
In the past 4 weeks, did you or any household member go to sleep at night hungry because there was not enough food?						
Yes	95 (84.8)	169 (78.2)	0.154	12 (75)	25 (69.4)	0.752*
No	17 (15.2)	47 (21.8)		4 (25)	11 (30.6)	
In the past 4 weeks, did you or any household member go a whole day and night without eating anything at all because there was not enough food?						
Yes	46 (41.1)	110 (50.9)	0.09	5 (33.3)	13 (36.1)	0.85
No	66 (58.9)	106 (49.1)		10 (66.7)	23 (63.9)	

*Notes. * Fischer's exact test run due to small cell values.* **Bold** *indicates statistically significant finding, p<0.050.*

Table 51. More caregivers have worked in past seven days, adjusted, Kiziba Camp, 2013-2015

Factors	aOR	95% CI	p value
Age	0.99	(0.97, 1.00)	0.107
Data collection wave	1.57	(1.00, 2.46)	**0.049**
Gender (ref. male)	0.70	(0.38, 1.29)	0.250

Notes. **Bold** *indicates significant association at p<0.05.*

Table 52. More caregivers had insufficient food in the past month, adjusted, Kiziba Camp, 2013-2015

Factors	aOR	95% CI	p value
Age	1.00	(0.98, 1.03)	0.717
Data collection wave	1.83	(1.03, 3.26)	**0.041**
Gender (ref. male)	1.34	(0.60, 2.99)	0.478

Notes. **Bold** *indicates significant association at p<0.05.*

APPENDIX 5:

RESULTS, FOCUS GROUP DISCUSSIONS

Commonly identified problems:

In focus group discussions during data collection at T2 (2015), adolescent boys and girls identified the following common problems in Kiziba camp:

- Physical abuse
- Parental neglect; family conflict; divorce – adolescents specifically attribute familial discordance with drug and alcohol abuse. Adolescent boys, more than girls, brought up the issue of divorce as a source of conflict and stress in their lives.
- Child labor, for example one respondent said "the children face the problem of child labor; some parents ask their children to carry more quantity of water which is beyond of their physical."

GIRLS SPECIFICALLY IDENTIFIED:

- Early marriage appears to continue to be a large problem in the camp and should be directly investigated further. Adolescents attribute early pregnancy to early marriage, however there is some indication that adolescents who become pregnant are forced to marriage, which has serious implications for child protection.
- Sexual abuse
- Access to feminine hygiene products
- Gender discrimination

Ranking of problems (by both boys and girls), 2015:

	FGD1	FGD2	FGD3	FGD4	FGD5
Most important	• Sexual violence • Divorce, parental separation	• Early marriage • Sexual violence • Child labor • Physical violence	• Sexual violence • Physical violence • Poor caretaker behavior, neglect • Early pregnancy	• Sexual violence • Divorce	• Early marriage, sexual violence
Least important	• Family conflict, early marriage, physical abuse	• Neglect	• Forced marriage	• Early marriage, physical violence, neglect, child labor	• Physical violence, caretaker separation


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