
An Evaluation of the Injaz Psychosocial Support Program in Northeast Syria: Formal and Informal IDP Camps

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Chemonics International

Injaz II Program

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Acronyms and Specific Terms

CBO	Community based organization
Comparison group	Group of formal IDP camp children who had not participated in the Injaz PSS program at the time of the evaluation data collection
EC	Education Committee
IDP	Internally displaced persons
Intervention group	Group of formal and informal IDP camp children in the different research populations (formal camp or informal camps) that participated in the Injaz PSS program prior to the evaluation data collection
ISIS	Islamic State of Iraq and Syria
KII	Key informant interview
M	Median
N	Number
NES	Northeast Syria
PSS	Psychosocial Support
P-value	The statistical probability of an event or outcome in a statistical experiment
Research groups	In this research, this refers to the following three groups: formal camp comparison group, formal camp intervention group, and the informal camps intervention group
SCARED	Screen for Child Anxiety Related Disorders
SD	Standard deviation
SEL	Social and Emotional Learning
SLP	Self-learning Program, the standard curriculum used in formal schools in northeast Syria
Starting points	The psychosocial wellbeing score or positive response rates that are measured in a group prior to their participation in the Injaz PSS program
Statistical significance	In this report, statistical significance has been determined using a t-test, by which a p-value of 0.05 or less indicates statistical significance and a value above 0.05 indicates no statistical significance
UNHCR	United Nations High Commission for Refugees

Executive Summary

The conflict in Syria has brought great physical and psychological devastation to its people over the last nine years. This prolonged exposure to conflict and insecurity can leave children with trauma and toxic stress. Injaz has been working since 2018 to support children and families in northeast Syria, by providing a psychosocial support (PSS) program implemented through local partners.

The program is grounded in the five core components of Social and Emotional Learning (SEL): self-awareness, self-management, responsible decision-making, relationships skills, and social awareness. It utilizes sports, music, dancing, theatre, drawing, and storytelling, among other activities, to help children improve their psychosocial wellbeing. Over the life of the project, the program has reached 64,087 children aged 6 to 17 (31,955 female and 32,132 male) in Governorate A and Governorate B.

This midline evaluation was undertaken to provide Injaz with a better understanding of the psychosocial needs of the children in northeast Syria and to provide insights into how the program might be influencing children's psychosocial wellbeing.

We utilized child and caregiver surveys that integrated three established and validated wellbeing measurement tools for children — the Rosenberg Self-Esteem Scale, the SCARED-5, and the Children's Hope Scale — to look at self-esteem, anxiety, and children's hope for the future. The surveys were conducted with a total of 345 children (aged 10-17) and their caregivers (n=345) in formal and informal camps in Governorate A and Governorate B in Northeast Syria in December 2019 and January 2020.

In the formal IDP camp, we interviewed 115 children (49% female) living in the camp who had participated in the Injaz PSS program (beneficiaries) and 178 children (59% female) who had not (future beneficiaries). In the informal camps, only children who had participated in the Injaz PSS program (beneficiaries) and their caregivers participated in the evaluation, as the program had reached almost all the children in the camp already. There, we interviewed a total of 52 children (58% female) and 52 caregivers. We also interviewed one caregiver per child, for a total of 690 interviews.

This midline evaluation is a stand-alone research, as unfortunately no baseline data is available due to the rapid start-up requirements of the program. Therefore, the results can only provide us with insights into what possible effects the program may be having, as we were only able to compare the results at one point in time between children who while living in the formal IDP camp had participated in the program and children who had not, requiring us to assume similar "starting points," an assumption that limits what we are able to extract from this research. We also compare the results in the two formal camp groups with those from the informal camps. Additionally, we collected child and caregiver reflections of change for children who participated in the PSS program, which provide us with insights into how children and their caregivers believe the children's psychosocial wellbeing has changed since they first started in the Injaz PSS program.

The scores across the different aspects of psychosocial wellbeing measured – self-esteem, anxiety and children's hope – show that children who participated in the Injaz PSS program were doing better than children who had not participated in the program in the formal camp, even if some of the differences were small and not found to be statistically significant. The difference in scores for self-esteem and children's hope provided by caregivers were found to be statistically significant, while those for anxiety were not proven to be statistically significant. This means that we have some evidence that children who have participated in

the PSS program have more self-esteem and more hope for the future than children that have not. This is encouraging for the Injaz program as it seems as though children are doing better when they have participated in the PSS program, which is its ultimate objective: to help increase children's psychosocial wellbeing.

It is interesting to note that children in the informal camp group had scores that indicated a lower level of self-esteem, a higher level of anxiety, and a lower level of hope for the future than both the formal camp groups (comparison and intervention). There was only one exception, and that was for self-esteem when reported by children. Here, the formal camp comparison group had an equal score to the informal camp group. This indicates to us that children in the informal camps are generally not doing as well as children in the formal camps overall (with and without PSS). One reason for this could be related to their relatively less secure living situation.

When the psychosocial wellbeing scores on the three measurements were disaggregated by gender, we found that male children were reported as having lower levels of anxiety than female children, with the differences in scores found to be statistically significant across almost all research groups and respondents. No trends were found for self-esteem and children's hope when the scores were disaggregated by gender. We were unable to find strong trends in the scores across the three psychosocial aspects by the age of the children. There are some hints that older children might have greater hope for the future than younger children, but more research would need to be conducted to confirm this. No trends were identified in the scores when we disaggregated them by children's primary exposure to ISIS or the length of their exposure to the PSS programming.

We also found that when we looked at the data by who reported it, children or caregivers, children reported having less anxiety than their caregivers. However, we found no clear trends for self-esteem and children's hope.

The positive response rates on each of the 21 items of psychosocial wellbeing included in the three measurements were used to classify the items into different categories of concern: higher, medium, and lower. Six of the items are items of higher concern, where the majority of the children appear to need more support. An additional seven items fell into the medium concern category, where some children need support, but not the majority. Finally, eight items were categorized as lower concern items, where less than a quarter of the children need support, and the vast majority were reported to be doing well.

Ranking the three psychosocial wellbeing aspects measured from the least problematic to the most, we see that self-esteem had the most positive reports, followed by anxiety, and lastly children's hope. This leads us to suggest that the current Injaz PSS curriculum should be reviewed to determine if and how it can be used to better support children's hope for the future, followed by anxiety, and then self-esteem.

The positive response rates for the different items of psychosocial wellbeing also provide encouraging evidence that children in the formal camp with PSS are doing better than children without PSS. Children with PSS reported a higher positive response rate on 15 of the 21 items covered in this research. While we are unable to draw lines of causality due to research limitations, it does encourage us to believe that the influence of participating in the program could be playing a role in these differences. For example, when comparing respondents in the formal camp, 23% more of the respondents that are receiving PSS said that the child feels they have much to be proud of, 14% more said that the child does not feel useless at times, and 10% more said that the child believes they are doing just as well as other kids their age.

Adding to these findings, the reflections provided by children who participated in the Injaz PSS program (beneficiaries) and their caregivers indicate that many feel that the children have made positive strides towards better psychosocial wellbeing since they started the program. On 14 of the 21 psychosocial wellbeing items, 75% or more of respondents in the formal and informal camps intervention groups reported seeing improvements since the child started their participation, with some items seeing at least 90% of respondents noting improvements. Combining this with the 5 items where at least 50% of the respondents noted improvement, we can say that the majority of respondents noted improvements on 90% of the psychosocial items (19 of 21) reviewed. This is a strong indicator that these children and their caregivers have seen positive changes in the children's psychosocial wellbeing since they started the Injaz PSS program. Though this research does not allow us to attribute that change to the program, it does encourage us to think that this might be the case.

In the end, we see every step towards greater psychosocial wellbeing for children living in northeast Syria as something to be celebrated as a success, and we believe that the findings of this evaluation provide us with encouragement that the program could be contributing positively to children's psychosocial wellbeing. The children in these IDP camps and their families have faced grave violence, danger, and insecurity. They, and many other people living in conflict and crisis areas, require psychosocial support. We believe that this evaluation will help Injaz further modify its PSS programming to meet the needs of the beneficiary population, and we hope it will persuade other education providers to supply children with the psychosocial support they need to lead healthier lives, so they can contribute positively to their communities and the world at large.

Injaz PSS Program Background

The conflict in Syria has brought great physical and psychological devastation to the people of Syria, especially the younger generation. Ongoing conflict, shelling and airstrikes, and ISIS control have exposed children in Syria to war, stress, extremist ideologies, and high levels of uncertainty. Over 11 million Syrians have fled their homes seeking safety in the last nine years. An estimated 6.6 million Syrians have been internally displaced and 5.6 million have fled the country,¹ accounting for over half of the Syrian population. An additional 500,000 Syrians are reported as killed or missing since 2011.² This prolonged exposure to conflict and insecurity can leave children with trauma and toxic stress.

Seeking to support children³ and their families, Injaz II implemented a structured psychosocial support (PSS) program as a piece of its multi-component stabilization program in northeast Syria (NES).

The Injaz PSS program seeks to support these traumatized children to process their experiences and develop greater resilience. The program is grounded in the five core components of Social and Emotional Learning (SEL): i) self-awareness, ii) self-management, iii) responsible decision-making, iv) relationships skills, and v) social awareness (see sidebar).⁴

These competencies are the means to help “children and adults understand and manage their own emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions.”⁵

The SEL approach has produced demonstrable positive impacts on social and emotional skills, attitudes, behavior, and academic performance in children from kindergarten through

Social and Emotional Learning Components:

Self-awareness: The ability to accurately recognize one’s emotions and thoughts and their influence on behavior

Self-management: The ability to regulate one’s emotions, thoughts, and behaviors effectively in different situations

Social awareness: The ability to take the perspective of, and empathize with, others from diverse backgrounds and cultures, to understand social and ethical norms for behavior, and to recognise family, school, and community resources and support

Relationship skills: The ability to establish and maintain healthy and rewarding relationships with diverse individuals and groups

Responsible decision-making: The ability to make constructive and respectful choices about personal behavior and social interactions based on consideration of ethical standards, safety concerns, social norms, the realistic evaluation of consequences of various actions, and the well-being of self and others

Source: www.casel.org

¹ UNHCR (April 2018). “Syria Emergency.” Last accessed 10 March 2020: <https://www.unhcr.org/syria-emergency.html>.

² Specia, Megan (2018). “How Syria’s Death Toll is Lost in the Fog of War.” *New York Times online*. Last accessed 10 March 2020: <https://www.nytimes.com/2018/04/13/world/middleeast/syria-death-toll.html>.

³ Please note that we use the term children in this report in alignment with the United Nations Convention on the Rights of Children, which defines children as those under 18 years of age, and USAID’s definition of children as those between the ages of 0 and 17. Accessed 24 June 2020: <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx> (Part I, Article 1); https://www.usaid.gov/sites/default/files/documents/1870/Youth_in_Development_Policy_0.pdf, (footnote, p. 18).

⁴ More about SEL can be learned on their website. The Collaborative to Advance Social Emotional Learning (Casel) (2017). “What is SEL?” Last accessed 27 April 2020: <https://casel.org/what-is-sel/>.

⁵ Ibid.

high school.⁶ The theory of change behind SEL is that in the short-term it will increase positive attitudes towards one's self and others, and in the long-term it will produce positive behavior, academic success, and mental health.⁷

The Injaz structured PSS program utilizes sports, music, dancing, theatre, drawing, and storytelling to help children gain a better sense of their personal identity, to identify their emotions and how they feel in their physical body, to understand their role in the group setting, to imagine the future that they want, and more. At the time of research, 17 structured PSS activities had been established, along with six types of recreational activities and seven different relaxation techniques, such as breathwork.

The program also seeks to give the children a sense of control of their environment. It helps them be a part of creating a safe learning environment by providing them the opportunity to establish their own code of conduct in their group setting. The children determine the rules and the consequences for breaking those rules in collaboration with the group leader and their peers.

⁶ Durlak, Joseph, Roger Weissberg, Allison Dymnicki, Rebecca Taylor, and Kriston B. Schellinger (2011). "The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interactions," *Child Development* vol. 82(1); 405-432; Taylor, Rebecca, Eva Oberle, Joseph Durlak, and Roger Weissberg (2017). "Promoting Positive Youth Development through School-Based Social and Emotional Learning Interventions: A Meta-Analysis of Follow-Up Effects." *Child Development* vol. 88(4), 1156-1171.

⁷ Mahoney, Joseph, Josepha Durlak, and Roger Weissberg (2018). "An Update on Social and Emotional Learning Outcome Research." Phi Delta Kappan. Last accessed 26 Nov. 2019: <https://www.kappanonline.org/>.



Figure 1 Children participating in Injaz PSS program activities in formal and informal IDP camps in northeast Syria.

The structured Injaz PSS program is a three-month program, with children participating in at least two structured PSS activities and three recreational and/or relaxation activities per week, for a total of 3 to 3.5 hours of PSS programming weekly. The children, therefore, generally participate in one PSS activity per day of learning. Additionally, most of the children participate in remedial numeracy and literacy or the Self-Learning Program (SLP) in the camps, depending on their individual learning paths. When they have graduated out of the remedial numeracy and literacy, they are then taught from the official curriculum, which in Governorate B and Governorate A was the SLP at the time of this evaluation.⁸ Children continue to receive PSS if they proceed with the educational opportunities offered by Injaz. This means that some children have received structured PSS for up to 14 months and some children have had up to ten additional months of unstructured PSS, which was provided prior to the establishment of the structured PSS program and consisted of only recreational activities.

⁸ The Self-Learning Program is a curriculum that was developed in a collaboration between UNICEF and partner organizations. For more information, see: <https://www.unicef.org/syria/stories/unicefs-self-learning-programme-brings-hope-out-school-children-syria-0>. Last accessed 20 July 2020.

Program Implementation

Working with nine local community-based organization (CBO) partners and five local council education committees' assemblies, Injaz was providing PSS programming to 5,297 children (2,375 female and 2,922 male) between the ages of 6 and 17 in formal and informal camps at the time of this evaluation.⁹ These children were also provided with remedial numeracy and literacy or SLP, as was appropriate for the child's learning needs.

The CBOs were trained together and provided with the same teachers' guide and activities booklets, an attempt to standardize the program delivery as much as possible. The Injaz II program staff in Syria and Berlin did not observe any strong differences in the program implementation between CBOs.

Injaz first began implementing its structured PSS program in formal and informal camps for internally displaced peoples (IDP) in October 2018 and expanded into formal schools in January of 2020. Therefore, over the life of the project, Injaz has provided the PSS program to 64,087 children (31,955 female and 32,132 male).¹⁰ This includes 2,539 children (1,243 female and 1,296 male) in the two formal camps in northeast Syria; 4,510 children (2,169 female and 2,341 male) in 21 informal camps; and 57,038 children (28,543 female and 28,495 male) in the 33 formal schools where Injaz began implementation subsequent to the data collection or this evaluation.

⁹ Injaz internal document from March 2020, "Embedded teams CW46-2019 Excel spreadsheet."

¹⁰ Data stems directly from Injaz's program M&E team and is valid as of April 2020.

Injaz PSS Program Midline Evaluation

The overall objective of this midline evaluation is to gain a better understanding of the psychosocial needs of the children in northeast Syria and hints at how it looks like the Injaz PSS program has influenced different aspects of children's psychosocial wellbeing. This information will inform Injaz PSS programming as it continues forward and contribute to the evidence-base for PSS programming for children in camps in conflict and crisis locations.

Data Collection

Injaz hired an external research company, Proximity International, through a competitive procurement process to conduct data collection in three IDP camps in Governorates B and A of northeast Syria. The firm has experience in conducting quantitative data collection in northeast Syria and the ability to gain the required permissions to access and work in the different IDP camps (formal and informal) where the Injaz PSS program is implemented.

The evaluation data collection tools were developed by a contracted M&E Specialist and uploaded by the research company into an electronic data collection application called CommCare.¹¹ Field researchers entered the data directly into the application and submitted it from the field electronically. It was checked daily by the Field Coordinator, Project Manager, and Data Management & Quality Specialist of the research team. Proximity worked with 25 field researchers who were trained in the research and the data collection tools in a multi-day training. They most often operated in pairs to conduct the surveys in the different research locations. Monitoring of the evaluation data collection process was conducted by Proximity's field managers and evidenced by the provision of photographs of the data collection process.

In December 2019 and January 2020, the evaluation data collection took place in one formal camp in Governorate A and two informal camps in Governorate B. In total, 690 surveys were conducted, 345 with children and 345 with caregivers, accounting for a total of 230 children participating in the Injaz PSS program at the time of this evaluation (formal and informal camps intervention groups). Further breakdown of these numbers is provided in Figure 4.

Evaluation Surveys Conducted by Research Group and Respondent		
	Child Surveys	Caregiver Surveys
Formal Camp – Comparison	115	115
Formal Camp – Intervention	178	178
Informal Camps – Intervention	52	52
TOTAL	345	345

Figure 2 Breakdown of the evaluation surveys conducted in December 2019 and January 2020 in the formal and informal IDP camps for the Injaz PSS Evaluation.

The field researchers informed and consulted with the local councils' education committees (ECs) and their assemblies and local Injaz CBO partners. Field researchers held caregiver gatherings to provide information about the learning exercise. In these meetings, the caregivers had the opportunity to pose questions and decide if they were interested in participating in the research. They were asked to provide their consent for themselves and their child to participate in the learning exercise, making it clear that there would be no repercussions should they choose not to participate. Most caregivers were interested in

¹¹ Last accessed 20 Jan 2020: <https://www.dimagi.com/commcare/>.

participating, with some showing great enthusiasm for the research topic. For those caregivers who provided consent, the researchers conducted a survey with them and their child in separate interviews. At the start of each interview, the researchers took time to explain the research and obtain individual consent to participate (see the evaluation tools in the Appendix), following international best practices for conducting research, in particular with minors (see Figure 5).



Figure 3 Field researcher conducting data collection with a child in formal and informal IDP camps.

Methodology

The methodology of the evaluation of Injaz’s psychosocial support program is complicated due to the complexities associated with measuring children’s psychosocial wellbeing, particularly in an unstable context where the situation on the ground is subject to unexpected change. The ongoing military and political dynamics in northern Syria affect access to program implementation sites and can even threaten the existence of such sites.¹² This resulted in the need to implement an experimental and highly localized approach to the evaluation methodology and sampling.

The implementation of Injaz’s structured psychosocial program has occurred at different times in the various implementation locations, depending upon access to the locations, permissions to work there, and the flows of people arriving and leaving camps. Therefore, we used multiple research methodologies to accommodate the various program stages in the formal and informal camps (see Figure 6).

¹² While the original plan had been to conduct the evaluation in two formal IDP camps, this became unfeasible.

Injaz PSS Evaluation Research Matrix: Formal and Informal Camps		
	Formal Camp: Governorate A	Informal Camps: Governorate B
Design	Post-test only, comparison group of those not yet participating	Post-test only, no comparison group
Methods	Surveyed beneficiaries Surveyed future beneficiaries Surveyed beneficiary and future beneficiary's caregivers	Surveyed beneficiaries Surveyed beneficiary's caregivers
Subject Research Population Frame	1,042 beneficiaries (ages 6-18) in the camp 151 non-beneficiaries (ages 6-18) in the camp	265 beneficiaries (ages 6-18) in the camps
Sample	178 beneficiaries (ages 10-17) ¹³ and 178 caregivers (intervention) 115 future beneficiaries (ages 10-17) ¹⁴ and 115 caregivers (comparison) Total: 586 surveys	52 beneficiaries (ages 10-17) ¹⁵ and 52 caregivers Total: 104 surveys
Future evaluation plans	Planned to survey the "future beneficiaries" after they have completed the 3-month program, but this has been postponed because of COVID-19 and has not yet been rescheduled.	No future evaluation plans

Figure 4 Injaz PSS evaluation research matrix.

We focused on conducting the evaluation with children (beneficiaries and future beneficiaries) to obtain a primary first-person perspective, and their caregivers to obtain a secondary perspective. The first-person perspective is vital in that it provides us with the internal perspective the child has of their attitudes and behaviors. The secondary perspective then tells us the external story of the children's attitudes and behaviors. We assumed that the caregivers were the most appropriate resource for understanding the children's attitudes and behaviors, as they have regular and continuous contact and interaction with the child and knew the child prior to their participation in the Injaz PSS program, which is vital when obtaining reflections on change.

In the formal IDP camp in Governorate A, it was possible to conduct surveys with beneficiaries who had participated in the Injaz PSS program previously, and future beneficiaries who had not yet participated in the PSS program. We were unable to control for external influences and there was no baseline, limitations that are discussed below. Additionally, beneficiaries (intervention children) and their caregivers were asked to reflect on how things had changed for the child since the start of the program.

¹³ Having a sample size of 178 children from a population frame of 1042, results in a margin of error of +/-6.69% at a confidence level of 95%.

¹⁴ Having a sample size of 115 children from a population frame of 151, results in a margin of error of +/-4.48% at a confidence level of 95%.

¹⁵ Having a sample size of 52 children from a population frame of 255, results in a margin of error of +/-12.15% at a confidence level of 95%.

In the sampled informal IDP camps in Governorate B,¹⁶ most children had already participated in the Injaz PSS program prior to the data collection for this evaluation, therefore, there was no comparison group to collect data from who had not participated in the program. The beneficiaries and their caregivers were asked to provide feedback on their current psychosocial wellbeing and to reflect on how this had changed, if it had changed, since they began the PSS program. The data from the two informal camps was clustered together for analysis. Their psychosocial wellbeing status and reflections have been compared to those of the beneficiaries and future beneficiaries in the formal camp.

If the context on the ground allows for another round of surveys to be conducted, the researchers will return and survey the children from the formal camp comparison group and their caregivers, who will by then have participated in the PSS programming. The data gathered in December 2019 and 2020 will then be used as a baseline (pre-intervention) that will be compared to the endline data (post-intervention) to identify trends or shifts in the psychosocial wellbeing of these children. Additionally, at the endline the comparison group children and caregivers will be asked to reflect on how things have changed for the children since they began their participation in the PSS program. This will give us a better understanding of how the children and their caregivers think the program has influenced the children's attitudes, behaviors, and psychosocial wellbeing.

Data Collection Tools

The research tools for the evaluation of the Injaz PSS program were identified in consultation with a child psychosocial wellbeing measurement expert from Columbia University and developed in consultation with a contracted evaluation specialist. We chose to integrate child psychosocial wellbeing assessments that have been validated in the field into the tool, with most having been used in conflict and crisis locations. To measure children's self-esteem we used the Rosenberg Self-Esteem Scale,¹⁷ anxiety was measured with the five question version of the Screen for Child Anxiety Related Disorders (SCARED),¹⁸ and hope for the future was measured with the Children's Hope Scale.¹⁹ When Arabic versions of these tools were available they were used, otherwise the questions/items were translated from English

¹⁶ These two informal camps were sampled from the eleven informal camps where Injaz was operating at the time of the evaluation planning, as they were the camps that had the largest number of children between the targeted ages of the evaluation.

¹⁷ Rosenberg Self-Esteem Scale. Last accessed 10 March 2020: <https://www.yorku.ca/rokada/psyctest/rosenbrg.pdf>. This scale has been used in multiple crisis/conflict contexts: Rousseau, C., A. Drapeau, and S. Rahimi (2003). "The Complexity of Trauma Response: A 4-Year Follow-Up of Adolescent Cambodian Refugees." *Child Abuse & Neglect*, 27(11), 1277-1290; Amone-P'Olak, K., P. B. Jones, R. Abbott, R. Meiser-Stedman, E. Ovuga, and T. J. Croudace (2013). "Cohort Profile: Mental Health Following Extreme Trauma in Northern Ugandan Cohort of War-Affected Youth Study (The WAYS Study)." *SpringerPlus*, 2(300). <http://www.springerplus.com/content/pdf/2193-1801-2-300.pdf>; Behrendt, A. (2008). "Associated with the Fighting Forces in Liberia: a Cross Section Study in Lofa Country." Last accessed 24 June 2020: <http://www.healthnettpo.org/files/706/study-report-liberia.pdf>.

¹⁸ SCARED-5. Last accessed 10 March 2020: <https://www.ementalhealth.ca/index.php?m=survey&ID=54>. This assessment has also been used in crisis/conflict areas, see Kohrt, B. A., M. J. Jordans, W. A. Tol, R. A. Speckman, S. M. Maharjan, C. M. Worthman, and I. H. Komproe (2008). "Comparison of Mental Health between Former Child Soldiers and Children Never Conscripted by Armed Groups in Nepal." *JAMA*, 300(6), 691-702; Jordans, M. J. D., I. H. Komproe, W. A. Tol, J. Nsereko, and J. T. de Jong (2013). "Treatment Processes of Counseling for Children in South Sudan: A Multiple n= 1 Design." *Community Mental Health Journal*, 1-14.

¹⁹ Children's Hope Scale. Last accessed 10 March 2020: <https://www.co.marion.or.us/CS/CFC/Documents/Camp%20Hope%20Child%20Survey.pdf>. The Children's Hope Scale has been used in crisis/conflict contexts, see Tol, W. A., I. H. Komproe, D. Susanty, M. J. Jordans, R. D. Macy, and J. T. De Jong (2008). "School-Based Mental Health Intervention for Children Affected by Political Violence in Indonesia." *JAMA*, 300(6), 655-662; Khamis, V. (2013). "The Mediating Effects of Child Strengths and Hopes on Academic Achievement for Palestinian Children Exposed to Armed Conflict." *International Journal of School & Educational Psychology*, 1(2), 112-121.

into Arabic and then back-translated into English to ensure that the essence and meaning of the items were not altered by the translation process.

Two different evaluation tools were developed and used in the formal and informal IDP camps: a Child Survey (A and B) and a Caregiver Survey (A and B). Versions A and B of both surveys have all the same questions or items; however, version B includes a reflection question for each item to obtain respondent perspectives on how the child has changed since they began their participation in the Injaz PSS program. Version A was used with future beneficiaries who had not participated in the Injaz PSS program and their caregivers, while version B was used with beneficiaries who had participated in the program and their caregivers.

The Child Survey was used to interview children aged 10-17. It consists of 47 questions that cover demographic information, exposure to ISIS ideology, self-esteem, anxiety, and children's goals (hopes for the future). The Caregiver Survey aligns with the Child Survey, with matching questions for consistency and triangulation. It consists of 49 questions that cover the same topics as those covered in the Child Survey. A copy of the tools can be found in the [Appendix](#).

Data Analysis

Primary data checking and cleaning was conducted by external research company's technical team. The data was provided to Injaz in Excel, with disaggregation by the child's gender and age. Further analysis was conducted internally, as explored below.

The data provided by the different research groups – formal camp comparison and intervention groups and informal camps intervention group – were analyzed separately by the type of respondent who provided the data: children (primary feedback) and their caregivers (secondary feedback). The data provided by children and caregivers was compared within each research group and then compared across research groups.

Scores were calculated for the psychosocial wellbeing measurements, in alignment with the scoring guidelines for each of the measurements, by research group and respondent (children vs. caregiver). Additionally, analysis of the data was done item by item, looking at positive response rates across all respondents in a research group, e.g. the percentage of respondents whose answer aligned with a higher psychosocial wellbeing. This allowed us to delve deeper into the data to see where commonalities and differences could be found. We recognize that this is using the tools in a way that goes beyond their validated use, which is addressed in the limitations section below.

The data was additionally looked at through the disaggregation lenses of the child's gender, age, exposure to ISIS ideology, and exposure to the Injaz PSS program, along with comparing results across respondents (children vs. caregivers). Differences that emerged are noted in the analysis below.

Reflections from the children who had participated in PSS, and their caregivers, were also analyzed item by item and compared across research groups.

Limitations of the Research

This evaluation research has some limitations that are important to lay before the reader so they can better interpret the findings and the conclusions reached.

Research Methodology

While we selected the best possible methodologies for the different situations in the formal and informal camps, they are methodologies that limit our ability to establish definitive correlations and causality. No baselines were conducted in the camps prior to the children participating in the Injaz PSS programming, therefore, we are unable to measure and calculate the extent to which children's psychosocial wellbeing has been impacted by the program as we do not know the intervention children's "starting points."

In the formal camp, we use the comparison group as a proxy for these baseline results, as a second-best option. This requires us to assume that the intervention group (beneficiaries) would have had similar "starting points" across the different aspects of psychosocial wellbeing measured in this evaluation to the comparison group (future beneficiaries). There are many reasons why this might not be the case, including external influences, such as the children in the comparison group more frequently having an urban background than the intervention group (comparison: 10% (N=11), intervention: 24% (N=43)). Additionally, according to the caregivers, comparison children have spent fewer months displaced (comparison: M=36.38, SD=20.37; intervention: M=44.53, SD=28.13, a difference that is statistically significant),²⁰ and have spent less time in the camp on average (comparison: M=6.82 months, SD=5.73; intervention: M=21.59 months, SD=12.02), which was also found to be statistically significant.²¹ There are additional factors that could also impact children's psychosocial wellbeing that we think are important to mention in this context, for example, the children's exposure to the conflict and whether they have lost a family member in the conflict.

However, we can still say that the groups also appear to have much in common. In both groups we had an almost equal gender balance among the children,²² the age range of the children and the mean age were similar,²³ and who the children live with²⁴ and the education level of their parents were also similar (see Figure 7).

²⁰ The p-value here is 0.0043, which is below the 0.05 threshold above which differences are no longer considered to be statistically significant when conducting a t-test.

²¹ P-value = 4.2E-34.

²² Comparison: 50% (N=57) female, 50% (N=58) male, Intervention: 49% (N=88) female, 51% (N=90) male

²³ Comparison group children: age range 10-17, M=11.83. Intervention group children: age range 10-17, M=11.91. Utilizing a t-test, the age differences between the two groups was found to be statistically not significant, with a p-value above 0.05.

²⁴ Comparison: 90% (N=113) of children live with a parent, 8% (N=10) live with another family members, and 2% (N=2) live with a non-family member. Intervention: 98% live with a parent and 21 (12%) live with another family member.

Highest Level of Education Achieved by Children's Caregivers								
	Illiterate		Primary school		Secondary School		University or higher	
	N	%	N	%	N	%	N	%
Comparison Mothers	51	44%	56	49%	4	3%	4	3%
Intervention Mothers	86	48%	77	43%	6	3%	9	5%
Comparison Fathers	22	19%	74	64%	10	9%	9	8%
Intervention Fathers	32	18%	109	61%	19	11%	18	10%

Figure 5 Table of education level achieved by the caregivers of the formal camp children sampled for this evaluation by research group.

We have sought to address this limitation through the inclusion of the reflection questions for children who have participated in the program (beneficiaries) and their caregivers. In this way, we have tried to capture first-hand reflections on if, and how, the children's psychosocial wellbeing has changed over time.

In the informal camp, almost all children had participated in the Injaz PSS program, leaving us with no comparison group, meaning we rely mostly on the reflections of change provided by the beneficiaries and their caregivers to gain insights into the changes in the children's psychosocial wellbeing.

While we would have preferred an experimental approach with baseline and endline data collection from a randomly selected group of beneficiaries (intervention) and non-beneficiaries (control), the fact that the program was already running in the camps meant that we had to meet the program where it was. This meant trying to find research methodologies that would provide us with the most reliable insights possible.

Research Population

The research population was determined by several factors, including the age of the children and which children continued to live in the camps. Injaz provides the structured PSS program to children ranging from 6 to 17 years old, while the sample of children asked to participate in this evaluation ranged only from 10-17, as the measurement tools integrated into the Child and Caregiver Surveys were recommended only for children around this age range. This means that we are unable to say anything about the effect of the Injaz PSS program on younger children. This does not mean that there are no impacts, but rather that they are out of the scope of this research. The research also was conducted only with children who were living in a formal or informal IDP camp in northeastern Syria at the time of the research and not with children who might have left the camp environment.

Additionally, the research was conducted only with caregivers and children who provided informed consent to participate and, in the case of the intervention groups, caregivers and children who had agreed to participate in the Injaz PSS program. Both factors could introduce a bias into the research. Researchers did not report having any caregivers or children refuse to participate in the evaluation and most children who were not enrolled in the PSS program were not participating due to administrative challenges, such as the need to expand the child learning center to accommodate the influx of children after the Turkish incursion of October 2019. Therefore, we do not believe that this is a strong limitation that should influence how we view the findings.

Response Biases and the Cultural Context

As with all research, the possibility of response biases is present. People providing responses because they want to please the researchers or because they think it will bring them or their children more programming are strong possibilities. It is also possible that cultural gender norms influence the way both children and their caregivers responded to specific questions. We also recognize that responses might be provided that seek to protect the child or the family. For example, more children reported having primary exposure to ISIS ideology than their caregivers. It is possible that caregivers were more hesitant to discuss their children attending educational opportunities that could be associated with ISIS out of concern for their children and any possible stigma that might be attached to them if they are seen as having had exposure to ISIS ideology.

Another response bias could stem from the normalization of different attitudes and behaviors over time. For example, it is unclear if children would say they worry too much or if they accept worry as part of their normal experience, or, what one person might define as “a little of the time” another person might define as “a lot of the time.”

Finally, the data in the formal and informal camps was self-reported by the children and by the caregivers, which poses its own challenges, as people are generally less willing to discuss problems or challenges they face, especially with a stranger. This is especially true in societies where social norms do not create space to openly discuss challenges. This could lead to a bias towards more positive responses, which we believe could be a factor in this research based upon our team’s understanding of the socio-cultural norms in northeast Syria, anecdotal evidence of children suffering from extreme trauma, and the relatively positive responses provided by respondents.

To try to mitigate against some of these biases, the research team was trained in the purpose of the research and asked to share that purpose with the caregivers and children, with the hope that our desire to understand how the Injaz PSS program influenced them or their child would encourage them to open up to the researchers they spoke with. The researchers additionally emphasized the respondents’ anonymity to create a space in which they might feel they could share their truth.

PSS Program Implementation

Another limitation to be considered is that there were three different CBOs providing the Injaz PSS program to children, one in each of the three camps sampled. While efforts were made to ensure that the CBOs delivered the program in a similar manner, including conducting joint trainings and providing them with the same guidebooks and activity books, it is always possible that implementation varied from location to location, contributing to differences in the children’s scores across locations. Such differences have not been noted by the Injaz Technical team, nor by the Injaz field staff working with the different CBOs, and the different operating environments in each of the camps made comparing scores across the camps futile for identifying if and how this might have impacted on the results.

The Measurement Tools, Data Collection, and Analysis

While outside the scope of this research, we also believe it is important to note that while the different measurements integrated into this research have been used in different contexts, they were not created specifically for working with children in northeastern Syria. It is possible that they are not sensitive enough to capture the full picture of children’s psychosocial wellbeing in northeastern Syria and that they are not attuned to the cultural context. For example, the research team indicated that the differences between the possible

responses were not always clear to the respondents and that this sometimes meant that they chose an answer that they could easily understand. One example of this was that some respondents were unsure of how to differentiate between “a little of the time” and “some of the time” when answering the Children’s Hope Scale questions, and therefore, they chose one of the answers at the extreme ends of the spectrum: “all of the time” or “none of the time.”

The data collection in the field was conducted by an external research team with a great deal of data collection experience in northeastern Syria. Even so, differences between enumerators can produce different results due to their questioning style, how they might rephrase a question that was not understood, etc.. Efforts were made to mitigate against this as much as possible through enumerators participating in the same training and being provided with standard alternative wordings for questions that the team suspected might be harder for children and caregivers to respond to. Additionally, most interviews were conducted by a team of two enumerators. However, inter-rater reliability testing was not conducted, which means we are unable to determine the variance in recorded responses that might be attributable to inter-rater variability. This is somewhat mitigated by the fact that most questions were multiple choice, leaving less room for interpretation than open-ended questions.

In the data analysis, in addition to calculating and analyzing the data according to the scoring of the psychosocial wellbeing measurement tools we utilized, we also conducted analysis of the individual questions, for which validation is not available. We believe that the insights that could be gained from conducting an item-by-item analysis were important for informing the further development of our PSS programming. We calculated positive response rates to each item to gain insights into which attitudes and behaviors were responded to positively by the respondents. Based upon this data, we then grouped the questions into areas of low, medium, and high concern. As the tools have been validated based upon scales and not individual questions, we acknowledge that our positive response rate analysis is outside the bounds of the validation of the individual tools.

Finally, the questionnaire was quite long and while we were told by the research team that the interviews generally took 20-40 minutes, we do have concerns that respondents might have experienced some interview fatigue. For the child and caregiver surveys, the Children’s Hope Scale data, which was the final set of items asked about in the surveys, was possibly impacted by such fatigue.

Despite these limitations, the evaluation data collected does provide us insights into the psychosocial wellbeing of a sample of children living in formal and informal IDP camps in northeastern Syria and helps us see that the Injaz PSS program appears to be positively influencing children’s psychosocial wellbeing.

Evaluation Study Findings

Demographics

The mean age of the children in the formal camp was 11.88 years old, ranging from 10 to 17 years of age, with a standard deviation (SD) of 1.53.²⁵ In the informal camps, the mean age was 11.67 years old, ranging from 10 to 15 years of age, with a SD of 1.32. When the data was disaggregated by age, we grouped the children into two groups: children aged 10-12 and children aged 13-17, with 242 children (70%) in the 10-12 age group and 103 children in the 13-17 age group (30%). For a further breakdown of the children in the evaluation by age, see Figure 8).

Ages of Children Surveyed																	
	10		11		12		13		14		15		16		17		Total
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Formal Camp – Comparison	24	21%	32	28%	24	21%	23	20%	5	4%	3	3%	1	1%	3	3%	115
Formal Camp – Intervention	27	15%	59	33%	37	21%	28	16%	15	8%	10	6%	0	0%	2	1%	178
Informal Camps – Intervention	7	13%	24	46%	8	15%	8	15%	2	4%	3	6%	0	0%	0	0%	52
TOTAL	58	17%	115	33%	69	20%	59	17%	22	6%	16	5%	1	0%	5	1%	345

Figure 6 Age breakdown of the children surveyed for the Injaz PSS evaluation by research group. Data source: caregiver surveys.

Of the 345 children surveyed in the formal and informal camps, 175 were female (51%) and 170 were male (49%) (see Figure 9). In the formal camp comparison group, this was 57 female children (50%) and 58 male children (50%). In the formal camp intervention group, this was 88 female children (49%) and 90 male children (51%). In the informal camps, this was 30 female children (58%) and 22 male children (42%).

Gender of Children Surveyed					
	Female		Male		Total
	N	%	N	%	N
Formal Camp – Comparison	57	50%	58	50%	115
Formal Camp – Intervention	88	49%	90	51%	178
Informal Camps – Intervention	30	58%	22	42%	52
TOTAL	175	51%	170	49%	345

Figure 7 Gender breakdown of the children surveyed for the Injaz PSS evaluation by research group. Data source: caregiver surveys.

The number of months of displacement from one's home ranged across the research groups. Children in the formal camp were displaced for an average of only 41.33 months – 36.38 months for the comparison children (SD=20.37) and 44.53 months for the intervention

²⁵ Originally, the plan was to conduct the evaluation with children only between the ages of 11 and 17 in alignment with the different measurement tools integrated into the Injaz PSS evaluation tools. In the formal camp and informal camps, however, the age group was extended to include 10-year-old children to increase the number of respondents able to participate.

children (SD=28.13), with the difference between these two means measuring as statistically significant.²⁶ In the informal camp, the mean length of displacement was 49.65 months (SD=40.45). When compared to the means in the formal camp groups, we see statistical differences between the informal camp and formal camp comparison scores but not with the formal camp intervention scores.²⁷ These differences possibly play an influential role in children’s psychosocial wellbeing, as the context and, in particular, the relative safety and security of where one lives can strongly influence a child’s psychosocial wellbeing.

Reported primary exposure to ISIS ideology, gauged by whether the child attended ideological education after ISIS had closed the schools in the area, was relatively low in the formal and informal IDP camps.²⁸ Fourteen of the 345 children (4%) were reported by their caregivers to have had primary exposure to ISIS ideology (see Figure 10). When reported on by the children, however, this was 28 children (8%). Breaking these numbers down by research group, we can see that in the formal camp comparison group, caregivers reported six children (5%) as having primary exposure and children reported eleven children (10%). In the formal camp intervention group, caregivers reported seven children (4%) as having primary exposure and the children reported 17 (10%). In the informal camp, caregivers reported one child (2%) as having primary ISIS exposure and zero children self-reported as having had primary ISIS exposure.

Primary ISIS Exposure of Children Surveyed					
	Yes		No		Total
	N	%	N	%	N
Formal Camp – Comparison					
Children	11	10%	104	90%	115
Caregivers	6	5%	109	95%	115
Formal Camp – Intervention					
Children	17	10%	161	90%	178
Caregivers	7	4%	171	96%	178
Informal Camps – Intervention					
Children	0	0%	52	100%	52
Caregivers	1	2%	51	98%	52
TOTAL	14	4%	331	96%	345

Figure 8 Primary ISIS breakdown of children included in the evaluation research in the formal and informal camps by points of disaggregation.

While the number of children with primary exposure to ISIS is still quite low and, therefore, cannot be taken as being representative, we have looked to see if we can identify differences between the psychosocial wellbeing of those children in the formal camp groups with and without this exposure. When notable differences have been identified in the formal camp, they have been mentioned in the analysis below. As only one child was reported to have

²⁶ P-value = 0.0044 when comparing length of displacement by research group (formal comparison vs. intervention group).

²⁷ The p-value 0.029 when comparing length of displacement by research group (formal camp comparison group vs. informal camp group). The p-value = 0.40 when comparing the length of displacement by research group (formal camp intervention group and the informal camp group).

²⁸ It was strongly believed by Injaz staff and local partners that directly asking about exposure to ISIS ideology could cause problems for the researchers and/or the participants, and would likely be rejected by the local councils and their education committees. Based upon this, we attempted to capture primary and secondary exposure to ISIS ideology via inquiring as to whether the child had participated in educational opportunities after the formal schools in their area were closed by ISIS. We asked about the type of education, where it was held, and who managed it. Children who participated in ideological education during this time, which was referred to as religious in the questionnaire, have been categorized as having primary exposure; the only ideological education allowed at the time was controlled by ISIS. Additionally, anyone who mentioned ISIS or Daesh as playing a role in their education was also labeled as having primary exposure. Please note that we use ideological in this report instead of religious in recognition that many Muslims would take offense at having ISIS ideology categorized as religious.

primary exposure in the informal camp, no such analysis was conducted for this research group.

Finally, for those children who had participated in the Injaz PSS program, we also disaggregated the psychosocial wellbeing scores by the number of months the children were exposed to the structured PSS program, dividing the children into those who had participated in PSS program from 1-6 months and a second group of children who had participated in Injaz’s structured PSS program for seven months or more. The majority of children in the formal camp intervention group had 7 months or more of PSS exposure, while the majority of children in the informal camps had only 1-6 months of PSS exposure (see Figure 10). This difference could be a contributing factor that can help us understand some of the differences we will see between the results in the formal camp intervention and informal camps intervention groups.

Primary ISIS Exposure of Children Surveyed					
	1-6 months		7 months or more		Total
	N	%	N	%	N
Formal Camp – Comparison					
Children	0	0%	0	0%	0
Caregivers	0	0%	0	0%	0
Formal Camp – Intervention					
Children	58	33%	120	67%	178
Caregivers	21	12%	157	88%	178
Informal Camps – Intervention					
Children	43	83%	9	17%	52
Caregivers	42	81%	10	19%	52
TOTAL	14	4%	331	96%	345

Figure 9 Primary ISIS breakdown of children included in the evaluation research in the formal and informal camps by points of disaggregation.

In the following sections, we provide a detailed analysis of the evaluation data by psychosocial wellbeing measurement tool and by research group.

For the formal camp research population we look at and compare the mean scores of the comparison and intervention groups on the different psychosocial wellbeing measurement tools, review and compare the percentage of positive responses item by item across both groups, and explore the reflections on change provided by the formal camp intervention group respondents, item by item. This provides us with insights into how the Injaz PSS program could be affecting the children who have partaken in it from their perspective, their caregiver’s perspective, and by comparing scores between those with and without PSS living in one setting.

In the informal camp, the surveys were conducted only with children who had already participated in the Injaz PSS program, as most children resident in the informal camp had done. Therefore, there is no informal camps comparison group against which these results can be analyzed, though we do compare informal camp scores with those of the formal camp groups. Below, we look at the scores of the informal camp intervention children on the psychosocial wellbeing measures, at the positive responses item by item, and at the caregiver and child reflections on how things have changed for the children since they began the Injaz structured PSS program.

Children’s Self-Esteem

Self-Esteem was measured using the Rosenberg Self-Esteem Scale, which consists of ten items in total (both positive and negative). On it, the children and caregivers are asked to say whether they: i) “strongly agree,” ii) “agree,” iii) “disagree,” or iv) “strongly disagree” with each

item.²⁹ Each of the answers corresponds to an established score that ranges from zero to three, with the higher score corresponding to the response that indicates a higher level of psychosocial wellbeing. The scores from the ten statements for each child are added together to provide a final self-esteem score. The higher the final score, the higher the measured self-esteem. The lowest score possible on the Rosenberg Self-Esteem Scale is zero and the highest is 30.

Rosenberg Self-Esteem Scores

In the formal IDP camp in Governate A, we compared children who participated in the Injaz PSS program (intervention) with children living in the same camp who did not participate in the program (comparison). Overall, the intervention children were reported to have a higher level of self-esteem than the comparison children by both children and caregivers (see Figure 12), with the higher score indicating higher self-esteem. The mean score provided by the caregivers in the intervention group was 21.08 (SD=3.70), compared to 19.56 (SD=3.58) for the comparison caregivers. The differences between these scores was found to be statistically significant when utilizing a t-test.³⁰ The formal camp intervention children reported a mean score of 20.24 (SD=3.24) and the comparison children of 19.60 (SD=3.35), however the difference between the scores in the two groups was not found to be statistically significant.³¹

The mean self-esteem score provided by the caregivers in the informal camps is lower than that seen in both groups (comparison and intervention) in the formal camp, differences that were found to be statistically significant.³² The mean score provided by caregivers was 18.63 (SD=2.28) and by children was 19.60 (SD=2.18) (see Figure 12). When it comes to the scores provided by the children, the informal camps mean is lower than the formal camp intervention group, but equal to that of the formal camp comparison group, though these differences were not found to be statistically significant.³³

²⁹ A copy of all of the data collection tools can be found in the Appendix. The Rosenberg Self-Esteem questions correspond to questions 27- 36 of the Caregiver Survey and questions 25-34 of the Child Survey. For more information about the Rosenberg Self-Esteem Scale, see <https://www.yorku.ca/rokada/psyctest/rosenbrg.pdf>. Last accessed 10 March 2020.

³⁰ P-value = 0.00054 when formal camp comparison and intervention mean caregivers' self-esteem scores were compared. Statistical significance has been determined in this research utilizing a t-test, which provides a p-value. When the p-value is 0.05 or less, the difference between two sets of data is considered to be statistically significant. When the p-value is greater than 0.05, the difference between two sets of data is considered to be not statistically significant.

³¹ P-value = 0.11 when formal camp comparison and intervention mean children's self-esteem scores were compared.

³² P-value = 4.066E-08 when formal camp intervention and informal camp caregiver self-esteem scores were compared. P-value = 0.047 when formal camp comparison and informal camp caregiver self-esteem scores were compared.

³³ P-value = 0.10 when formal camp intervention and informal camp children's self-esteem scores were compared. P-value = 0.99 when formal camp comparison and informal camp children's self-esteem scores were compared.

Rosenberg Self-Esteem Scale Scores by Research Group and Respondent			
	Formal Camp		Informal Camps
	Comparison	Intervention	Intervention
Caregivers	19.56	21.08	18.63
Children	19.60	20.24	19.60

Figure 10 Rosenberg Self-Esteem Scale mean scores by research group and respondent. The higher the score, the higher the reported self-esteem. The most positive score between the research groups overall has been highlighted in yellow.

Based upon the Rosenberg Self-Esteem scale cut-off points, all of these scores are within the “normal self-esteem” range of 15-25.³⁴ Seeing this from the opposite end of the spectrum, we can also look at the number of children who fell into the “low self-esteem” category in the research groups. In the formal camp comparison group, ten children (9%) were reported by caregivers to fall into the “low self-esteem” category, whereas children reported that 14 (12%) fell into this category. The situation was slightly more positive in the formal camp intervention schools, where caregivers reported 13 children (7%) as having “low self-esteem” and children reported seven (4%). The situation was similar in the informal camps to the formal camp intervention group, with four of the informal camp children (8%) reported by caregivers to have “low self-esteem,” and this was smaller still at only one child (2%), according to the children.

Disaggregating the Scores

By Type of Respondent

When we look at the self-esteem scores by who provided the data – caregivers or children – we see a mixed picture (see Figure 12), with caregivers in the formal camp comparison group being less positive about the children’s self-esteem than the children were, and the opposite being true in the intervention group. While the difference in the comparison group was not found to be statistically significant based upon a t-test,³⁵ the difference in the intervention group was found to be statistically significant with a p-value of 0.02. In the informal camps, children were more positive about their self-esteem than their caregivers were, and here the difference was also found to be statistically significant.³⁶ The data, therefore, draws a mixed picture, with caregivers in the formal camp intervention group more positive about the children’s self-esteem than the children themselves, while we see the opposite to be true in the informal camps comparison group.

By Gender of the Child

When the formal camp self-esteem scores are disaggregated by gender (see Figure 13), the comparison group caregivers and children report that male children have more self-esteem than female children. In the intervention group, the female children were reported by both the children and their caregivers as having higher self-esteem. However, these differences were not found to be statistically significant.³⁷ In the informal camps, we see no common trend.

³⁴ The Rosenberg Self-Esteem cutoff points found were on the Shirley Ryan Ability Lab website, and they are: 0-15 low self-esteem, 15-25 normal self-esteem, and 25-30 high self-esteem: Last accessed 20 April 2020: <https://www.sralab.org/rehabilitation-measures/rosenberg-self-esteem-scale>.

³⁵ P-value = 0.92 when comparing children’s and caregiver’s self-esteem scores in the formal camp comparison group.

³⁶ P-value = 0.03 when comparing children’s and caregiver’s self-esteem scores in the informal camp group.

³⁷ Formal camp comparison caregiver data had a p-value = 0.51 and children’s data a p-value = 0.94 when comparing self-esteem scores by gender. Formal camp intervention caregiver data had a p-value = 0.26 and children’s data a p-value = 0.57 when comparing self-esteem scores by gender.

The caregivers reported that the female children have more self-esteem, while the children reported that the male children have higher self-esteem. These differences have also not proven to be statistically significant.³⁸ Combined, these results mean that it is unclear if/how children's self-esteem is influenced by gender.

Rosenberg Self-Esteem Scale Scores by Research Group, Respondent, and Child's Gender						
	Formal Camp				Informal Camp	
	Comparison		Intervention		Intervention	
	Female	Male	Female	Male	Female	Male
Caregivers	19.33 (SD=3.29)	19.78 (SD=3.87)	21.40 (SD=3.81)	20.77 (SD=3.59)	18.93 (SD=2.10)	18.23 (SD=2.49)
Children	19.59 (SD=3.46)	19.61 (SD=3.26)	20.38 (SD=3.16)	20.10 (SD=3.34)	19.47 (SD=1.91)	19.77 (SD=2.54)

Figure 11 Rosenberg Self-Esteem Scale mean scores by research group, respondent, and child's gender. The higher the score, the higher the reported self-esteem. The most positive score between the genders (female vs. male) has been highlighted in pink in each research group by respondent (caregivers vs. children).

By Age of the Child

When the scores are disaggregated by age (see Figure 14), in the formal camp comparison group, children aged 13-17 were reported to have higher self-esteem than children aged 10-12 by both respondents. In the formal camp intervention group, however, it was children between the ages of 10-12 who were seen as having higher self-esteem, independent of respondent (children and caregivers). In informal camps, both correspondents report that younger children (10-12) have higher self-esteem than the older children (13-17). The differences between the age groups found in caregiver and child scores in formal and informal camps were not found to be statistically significant,³⁹ meaning that we are unable to say if/how age is affecting or connected to children's self-esteem.

Rosenberg Self-Esteem Scale Scores by Research Group, Respondent, and Child's Age						
	Formal Camp				Informal Camp	
	Comparison		Intervention		Intervention	
	10-12 years	13-17 years	10-12 years	13-17 years	10-12 years	13-17 years
Caregivers	19.33 (SD=3.29)	20.14 (SD=3.87)	21.13 (SD=3.75)	20.96 (SD=3.64)	18.87 (SD=2.46)	17.92 (SD=1.44)
Children	19.39 (SD=3.22)	20.12 (SD=3.65)	20.28 (SD=3.11)	20.14 (SD=3.54)	19.63 (SD=2.32)	19.50 (SD=1.83)

Figure 12 Rosenberg Self-Esteem Scale mean scores by research group, respondent, and child's age. The higher the score, the higher the reported self-esteem. The most positive score between age groups (10-12 vs. 13-17) has been highlighted in pink in each research group by respondent (caregivers vs. children).

³⁸ Informal camps caregiver data had a p-value = 0.29 and children's data a p-value = 0.64 when comparing self-esteem scores by gender.

³⁹ Formal camp comparison caregiver data had a p-value = 0.25 and children's data a p-value = 0.32 when comparing self-esteem scores by age. Formal camp intervention caregiver data had a p-value = 0.78 and children's data a p-value = 0.80 when comparing self-esteem scores by age. Informal camps caregiver data had a p-value = 0.10 and children's data a p-value = 0.83 when comparing self-esteem scores by age.

By Child's Exposure to ISIS

The same can be said for primary exposure to ISIS ideology in the formal camp (see Figure 15).⁴⁰ None of the differences shown below were not found to be statistically significant, with p-values above 0.05 for caregivers and children in both the comparison and intervention groups.⁴¹ Based upon the data collected, we are unable to say anything concrete about if/how primary exposure to ISIS ideology is affecting or connected to children's self-esteem.

Rosenberg Self-Esteem Scale Scores by Research Group, Respondent, and Child's ISIS Exposure Formal Camp				
	Comparison		Intervention	
	Primary exposure	No primary exposure	Primary exposure	No primary exposure
Caregivers	19.17 (SD=4.58)	19.58 (SD=3.45)	21.14 (SD=6.09)	21.08 (SD=3.60)
Children	20.27 (SD=2.83)	19.53 (SD=3.40)	19.76 (SD=2.70)	20.29 (SD=3.03)

Figure 13 Rosenberg Self-Esteem Scale mean scores by research group, respondent, and child's exposure to ISIS. The higher the score, the higher the reported self-esteem. The most positive score between the ISIS exposure groups (primary exposure vs. no primary exposure) has been highlighted in pink in each research group (formal camp comparison vs. intervention) by respondent (caregivers vs. children).

By Length of Child's Exposure to PSS

In the intervention groups (formal and informal camps), we also disaggregated the scores by how long the children had participated in the Injaz PSS program, looking at those who had 1-6 months of programming and those that had 7 months or more of Injaz's structured PSS program (see Figure 16). While three of the four groups of respondents found that children with 1-6 months of PSS exposure had more self-esteem, with only the formal camp intervention caregivers scoring children with 7 months of PSS exposure or more as having higher self-esteem, none of the differences between the scores within a group were found to be statistically significant.⁴² This means that we are unable to say anything definitive about how/if the length of exposure to the Injaz PSS program is influencing children's self-esteem.

Rosenberg Self-Esteem Scale Scores by Research Group, Respondent, and Child's PSS Exposure				
	Formal Camp		Informal Camp	
	Intervention		Intervention	
	1-6 mo.	7 mo. or more	1-6 mo.	7 mo. or more
Caregivers	20.95 (SD=4.48)	21.10 (SD=3.60)	18.71 (SD=1.90)	18.30 (SD=3.56)
Children	20.26 (SD=3.43)	20.23 (SD=3.16)	19.60 (SD=1.93)	19.56 (SD=3.28)

Figure 14 Rosenberg Self-Esteem Scale mean scores for PSS beneficiaries by research group, respondent, and child's exposure to PSS. The higher the score, the higher the reported self-esteem. The most positive score

⁴⁰ Please note that this analysis was not conducted in the informal camps as there were not enough children reported to have been exposed to ISIS ideology to draw meaningful conclusions.

⁴¹ Formal camp comparison caregiver data had a p-value = 0.84 and children's data a p-value = 0.43 when comparing self-esteem scores by exposure to ISIS. Formal camp intervention caregiver data had a p-value = 0.98 and children's data a p-value = 0.47 when comparing self-esteem scores by exposure to ISIS.

⁴² Formal camp intervention caregiver data had a p-value = 0.89 and children's data a p-value = 0.95 when comparing self-esteem scores by length of exposure to the structured Injaz PSS program. Informal camp intervention caregiver data had a p-value = 0.73 and children's data a p-value = 0.97 when comparing self-esteem scores by length of exposure to the structured Injaz PSS program.

between the PSS exposure groups (1-6 months vs. 7 months or more) has been highlighted in pink in each research group (formal vs. informal camps intervention group) by respondent (caregivers vs. children).

Item by Item Positive Responses

Looking at the different items of self-esteem measured individually, we see many positive responses in the formal and informal camps (see Figure 17 and Figure 18), meaning a response that aligns with a higher level of psychosocial wellbeing.⁴³ In the formal camp comparison group, 75% or more of all respondents (children and caregivers combined) responded positively to seven of the ten self-esteem items, and the intervention group responded positively to nine of ten items. In the informal camp group, 75% or more of the total respondents reported positively on nine of the ten different components of the Rosenberg Self-Esteem Scale. This means that for most of the self-esteem items, only 25% or less of respondents provided negative responses across all research group

⁴³ A positive response on the Rosenberg Self-Esteem Scale items is the one that aligns with a higher level of psychosocial wellbeing; for example when the statement “On the whole, I am satisfied with myself” was read to a child, they responded with “strongly agree” or “agree,” and for a statement such as “at times I think that I am no good,” the positive responses were seen as “disagree” or “strongly disagree.”

Positive Responses on the Rosenberg Self-Esteem Scale Items by Research Group Formal Camp							
Rosenberg Self-Esteem Items	Comparison			Intervention			% difference between intervention and comparison groups
	% of child respondents	% of caregiver respondents	% of all respondents	% of child respondents	% of caregiver respondents	% respondents Intervention	
Child takes a positive attitude towards them self	95%	96%	95%	97%	98%	97%	+2%
Child feels that they are a person of worth, at least on an equal plane with others	92%	89%	90%	99%	98%	99%	+9%
Child believes they have good qualities	92%	91%	92%	94%	99%	97%	+5%
Child is satisfied with their self	97%	80%	89%	97%	96%	96%	+7%
Child believes they are able to do as well as most other people	84%	90%	87%	93%	95%	94%	+7%
Child is not inclined to feel like they are a failure	94%	80%	87%	91%	93%	92%	+5%
Child does not sometimes think that they are no good	77%	77%	77%	80%	90%	85%	+8%
Child does not feel useless at times	73%	75%	74%	86%	89%	88%	+14%
Child feels they have much to be proud of	65%	59%	62%	85%	84%	85%	+23%
Child does not wish they could have more respect for them self	0%	2%	1%	0%	0%	0%	-1%

Figure 15 Percentage of formal camp children, caregivers, and all respondents who reported positively on the different items of self-esteem measured by the Rosenberg Self-Esteem Scale by research group (comparison vs. intervention). The right-hand column shows the percentage difference between the two research groups (formal camp intervention group minus comparison group), with those where the intervention group responded more positively highlighted in yellow.

Positive Responses on the Rosenberg Self-Esteem Scale Items Informal Camps			
Rosenberg Self-Esteem Items	Intervention		
	% of child respondents	% of caregiver respondents	% all respondents
Child takes a positive attitude towards them self	98%	98%	98%
Child feels that they are a person of worth, at least on an equal plane with others	100%	96%	98%
Child believes they have good qualities	100%	100%	100%
Child is satisfied with their self	98%	92%	95%
Child believes they are able to do as well as most other people	88%	96%	92%
Child is not inclined to feel like they are a failure	88%	81%	85%
Child does not sometimes think that they are no good	87%	71%	79%
Child does not feel useless at times	90%	73%	82%
Child feels they have much to be proud of	85%	73%	79%
Child does not wish they could have more respect for them self	0%	0%	0%

Figure 16 Percentage of informal camp children, caregivers, and all respondents who reported positively on the different items of self-esteem measured by the Rosenberg Self-Esteem Scale.

There was one item where we saw very low positive response rates across all respondents, this was for the child wishing they could have more self-respect for themselves. In the formal camp only 1% of the comparison and 0% of the intervention respondents said that the child wished they could have more respect for themselves, while this was 0% in the informal camp group. We believe that the ambiguity of this item has caused some confusion, as it is not clear whether one is doing better if one wishes for greater self-respect, as one can always hope for more self-respect, or if one believes they already have enough self-respect. What we can say, is that the results for this item of self-esteem are drastically different than those for the other self-esteem items. Therefore, we would suggest that research be conducted on self-respect in the formal schools to determine if this question was too ambivalent or if a lack of self-respect is a problem for these children and for children in northeast Syria in general.

Looking at the positive response rates for the self-esteem items for the formal camp comparison (without PSS) and intervention (with PSS) children (see final column of Figure 17), we see that the intervention children had more positive responses than their comparison counterparts on nine of the ten aspects of self-esteem measured, being 2%-23% higher, pointing towards a possibly higher psychosocial wellbeing for the intervention children who participated in the Injaz PSS. The most significant differences reported between formal camp intervention and comparison children were:

- The child does not have much to be proud of (a 23% higher positive response rate in the intervention group) and
- The child does not feel useless at times (a 14% higher positive response rate in the intervention group).

On only one of the statements did we see a higher positive response rate for the formal camp comparison group than for the intervention group; this was the statement about self-respect, discussed in more detail above.

When we compare the informal camp positive response rates to those of the formal camp groups, we find that the informal camp group had a higher rate than the other two groups on

eight of ten items. For the other two items, the informal camp positive response rate was either equal to or lower than the positive response rate in the formal camp groups.

These are encouraging findings. However, based upon this research, we cannot establish attribution to the children's participation in the Injaz PSS program, as we do not have baseline data against which we can compare these results. At the same time, we cannot rule out that these positive responses might be linked to the children's participation in the program.

Self-Esteem Reflections from those with PSS

The formal and informal camp children with PSS (beneficiaries) and their caregivers additionally provided their reflections on how the different items of self-esteem have been affected for the children since they started the Injaz PSS program. Across nine of the ten items related to self-esteem, 75% or more of the formal camp respondents indicated that the situation had improved and this was true for eight items in the informal camps, with a ninth coming in at 74% (see Figure 19). For example, 95% of formal and 92% informal camp respondents said they had seen an increase in the child taking a positive attitude towards themselves, 91% of formal and 95% of informal camp respondents said they had seen an increase in the child believing they have good qualities, and 92% of formal and 93% of informal camp groups said they had seen an increase in the child feeling they are a person of worth.

On four of the ten self-esteem items, the formal camp intervention group had a higher percentage of respondents noting improvements than the comparison group, while the opposite was true for another four; for two items the two groups had the same percentage.

When taken as a whole, the formal and informal camp intervention caregiver and child reflections on how the children's attitudes and behaviors related to self-esteem have changed appear to be very positive, which supports the idea that the program might be positively influencing children's self-esteem, though we must consider the research limitations. In particular for reflections, respondent bias could have played a role in these positive reflections, but it could also be that children and caregivers have seen positive changes in the children's behaviors and attitudes in relation to self-esteem.

Reflections on the Rosenberg Self-Esteem Scale Items by Research Group						
	Formal Camp Intervention			Informal Camp Intervention		
	% of child respondents	% of caregiver respondents	% all respondents	% of child respondents	% of caregiver respondents	% all respondents
Increase in the child taking a positive attitude towards them self	93%	96%	95%	96%	88%	92%
Increase in the child believing they have good qualities	89%	93%	91%	92%	96%	95%
Increase in the child feeling that they are a person of worth, at least on an equal plane with others	92%	93%	92%	96%	90%	93%
Increase in the child's satisfaction with their self	89%	96%	92%	85%	90%	88%
Increase in the child believing they can do as well as most other people	80%	89%	85%	85%	90%	88%
Decrease in the child sometimes thinking that they are no good	81%	80%	81%	75%	79%	77%
Decrease in the child feeling useless at times	70%	83%	76%	77%	85%	81%
Increase in the child feeling they have much to be proud of	75%	77%	76%	75%	77%	76%
Decrease in the child being inclined to feel like they are a failure	71%	80%	76%	75%	73%	74%
Decrease in the child wishing they could have more respect for them self	0%	0%	0%	0%	0%	0%

Figure 17 Percentage of formal and informal camp intervention caregivers, children, and all respondents who said that things had improved on the self-esteem items since the child started to participate in the structured Injaz PSS program.

Children's Anxiety

The five questions of the shortened Screen for Child Anxiety Related Disorders (SCARED), known as the SCARED-5, were used in this evaluation to measure children's anxiety.⁴⁴ It consists of five items. For each, the children and their caregivers are asked whether the item is: i) "not true or hardly true," ii) "somewhat true or sometimes true," or iii) "very true or often true." The answers are scored on a scale from zero to two, and the SCARED-5 score is the sum of the points for all five items. The lower the tallied score, the lower the measured anxiety. The lowest possible score for this assessment is zero, while the highest possible score possible is ten.

SCARED-5 Anxiety Scores

In the formal camp, the mean SCARED-5 scores show the intervention children (with PSS) having lower anxiety than the comparison children (without PSS), with the lower score representing lower anxiety (see Figure 20). Intervention caregivers gave a mean score of 2.79 (SD=1.97), while comparison caregivers gave a mean score of 3.05 (SD=2.20), with a p-value well above the 0.05 significant level, meaning this difference is not statistically significant.⁴⁵ Formal camp intervention children gave a mean SCARED-5 score of 2.01 (SD=1.90), while the comparison children gave a mean score of 2.22 (SD=1.94). This difference was also found to not be statistically significant.⁴⁶ This means that we do not have enough evidence to say whether comparison or intervention children are experiencing less anxiety.

Turning to the children in the informal IDP camps who have participated in the Injaz PSS program, we see that they report having more anxiety than either of the formal camp groups, though the differences were also not found to be statistically significant.⁴⁷ Caregivers gave a mean score of 3.40 (SD=2.01) and children a mean score of 2.56 (SD=1.90) (see Figure 20).

While the SCARED-5 does not have established ranges, we can say that all of these scores are at the lower end of the SCARED-5 range of zero to ten, with lower scores indicating lower levels of anxiety.⁴⁸

⁴⁴ A copy of all of the data collection tools can be found in the Appendix. The SCARED-5 questions correspond to questions 37- 41 of the Caregiver Survey and questions 35-39 of the Child Survey. There is also a longer SCARED screening tool with 41 questions. The SCARED and SCARED-5 are available for children and caregivers/parents. For further information on this screening tool, please see <https://www.midss.org/content/screen-child-anxiety-related-disorders-scared>. Last accessed 11 March 2020.

⁴⁵ P-value = 0.30 when comparing formal camp comparison and intervention caregiver scores for anxiety.

⁴⁶ P-value = 0.40 when comparing formal camp comparison and intervention children's scores for anxiety.

⁴⁷ P-value = 0.056 when formal camp intervention and informal camp caregiver anxiety scores were compared. P-value = 0.069 when formal camp comparison and informal camp caregiver anxiety scores were compared. P-value = 0.31 when formal camp intervention and informal camp children's anxiety scores were compared. P-value = 0.29 when formal camp comparison and informal camp children's anxiety scores were compared.

⁴⁸ No cutoff points have been found for the SCARED-5, which means that the scores are viewed along a spectrum that has not been divided into bands to indicate, for example, "lower than normal levels of anxiety," "normal levels of anxiety," or "higher than normal levels of anxiety." Such cutoff points do exist, however, for the longer version of the SCARED.

SCARED-5 Scores by Research Group and Respondent			
	Formal Camp		Informal Camp
	Comparison	Intervention	Intervention
	Mean Score	Mean Score	Mean Score
Caregivers	3.05	2.79	3.40
Children	2.22	2.01	2.56

Figure 18 SCARED-5 mean scores by research group and respondent. The lower the score, the lower the level of reported anxiety. The most positive score between research groups overall and by respondent has been highlighted in yellow.

Disaggregating the Scores

By Type of Respondent

Children reported more positively on their anxiety than their caregivers did across the board, with the children in each research group providing lower mean scores on the SCARED-5 than the caregivers did. These differences were found to be statistically significant,⁴⁹ meaning that we would expect children to report more positively on anxiety than their caregivers even if another sample of children and caregivers was selected.

By Child's Gender

When the scores are disaggregated by the child's gender (see Figure 21), we see that the male children are reported as having less anxiety than the female children in all research groups across respondents, with male children consistently having a lower mean SCARED-5 score than female children. While the difference between the anxiety scores by gender were found to not be statistically significant for the formal camp comparison group caregivers,⁵⁰ the difference in all of the other groups was found to significant.⁵¹ These findings seem to indicate that female children are having greater difficulties with anxiety than male children, and that we are likely to find this to be the case even if another sample were to be selected. We can also see that formal camp comparison male children reported having less anxiety than male intervention children reported. One possible reason for this could be that children who have participated in the PSS programming have more awareness of their emotions and a greater willingness to speak about their fears and anxieties.

This raises the question of whether it might be useful to adapt the ways in which the Injaz PSS program addresses anxiety based upon the children's gender. If this is to be pursued, it would be useful to conduct research on how female and male anxieties might differ and determining if there are ways to help address their anxiety that could be more targeted.

⁴⁹ Formal camp comparison group data had a p-value = 0.0026 when comparing caregiver and children's anxiety scores. The formal camp intervention group data had a p-value = 0.00015 when comparing caregiver and children's anxiety scores. Informal Camp data had a p-value = 0.030 when comparing caregiver and children's anxiety scores.

⁵⁰ Formal camp comparison caregiver data had a P-value = 0.11 when comparing anxiety scores by gender.

⁵¹ Formal camp comparison children's data had a P-value = 1.72E-10 when comparing anxiety scores by gender. Formal camp intervention group caregiver data had a p-value = 0.02 and children's data had a P-value = 0.0013 when comparing anxiety scores by gender. Informal camps caregiver data had a p-value = 0.011 and children's data had a p-value = 0.00024 when comparing anxiety scores by gender.

SCARED-5 Scores by Research Group, Respondent, and Child's Gender						
	Formal Camp				Informal Camps	
	Comparison		Intervention		Intervention	
	Female	Male	Female	Male	Female	Male
Caregivers	3.39 (SD=2.39)	2.72 (SD=1.96)	3.14 (SD=2.10)	2.46 (SD=1.78)	4.00 (SD=1.91)	2.59 (SD=1.89)
Children	3.32 (SD=1.80)	1.17 (SD=1.43)	2.47 (SD=1.96)	1.56 (SD=1.74)	3.33 (SD=1.79)	1.50 (SD=1.54)

Figure 19 SCARED-5 mean scores by research group, respondent, and child's gender. The lower the score, the lower the reported anxiety. The most positive score between the genders (female vs. male) has been highlighted in pink in each research group by respondent (caregivers vs. children).

By Child's Age

When we disaggregate the formal camp SCARED-5 scores by age, we might be tempted to say that younger children have less anxiety, as the 10-12 year old age group has scored better in both the formal camp comparison and intervention groups according to both respondents (children and caregivers) (see pink highlighting in Figure 22). However, when t-tests were conducted, the differences between the age groups were not found to be statistically significant.⁵² Additionally, the disaggregated scores from the informal camp stand in contrast to those of the formal camp; they indicate that the older children have less anxiety than the younger children. However, the differences in these scores was also not found to be statistically significant.⁵³ Taken altogether, this means that we do not have the data to tell us if/how age might affect children's anxiety.

SCARED-5 Scores by Research Group, Respondent and Child's Age						
	Formal Camp				Informal Camps	
	Comparison		Intervention		Intervention	
	10-12 years	13-17 years	10-12 years	13-17 years	10-12 years	13-17 years
Caregivers	2.97 (SD=2.39)	3.23 (SD=1.96)	2.67 (SD=2.07)	2.85 (SD=1.92)	3.44 (SD=2.10)	3.31 (SD=1.80)
Children	2.13 (SD=1.83)	2.42 (SD=2.21)	1.95 (SD=1.82)	2.03 (SD=1.95)	2.68 (SD=2.01)	2.21 (SD=1.58)

Figure 20 SCARED-5 mean scores by research group, respondent, and child's age. The lower the score, the lower the reported anxiety. The most positive score between age groups (10-12 vs. 13-17) has been highlighted in pink in each research group by respondent (caregivers vs. children).

⁵² Formal camp comparison group caregiver data had a p-value = 0.56 and children's data had a p-value = 0.51 when comparing anxiety scores by age. Formal camp intervention group caregiver data had a p-value = 0.60 and children's data had a p-value = 0.77 when comparing anxiety scores by age.

⁵³ Informal Camp caregiver data had a p-value = 0.83 and children's data had a p-value = 0.39 when comparing anxiety scores by age.

By Child’s Exposure to ISIS

When the formal camp data was disaggregated by the children’s primary exposure to ISIS (those with such exposure and those without), we found the comparison children indicated that children with primary exposure to ISIS had less anxiety than children without this exposure, and all of the other children and caregivers indicated the opposite (see the pink highlighting in Figure 23). However, we cannot confirm if there is a trend or a connection between children’s anxiety and their exposure to ISIS, as none of the differences in the table below were found to be statistically significant.⁵⁴ This analysis was not conducted in the informal camps as the number of children with exposure to ISIS was too small to make useful comparisons.

SCARED-5 Scores by Research Group, Respondent, and Child’s ISIS Exposure Formal Camp				
	Comparison		Intervention	
	Primary exposure	No primary exposure	Primary exposure	No primary exposure
Caregivers	3.50 (SD=2.59)	3.03 (SD=2.19)	2.86 (SD=2.04)	2.79 (SD=1.97)
Children	1.91 (SD=1.70)	2.25 (SD=1.97)	2.76 (SD=2.02)	1.92 (SD=1.88)

Figure 21 SCARED-5 mean scores by research group, respondent, and child’s exposure to ISIS. The lower the score, the lower the reported anxiety. The most positive score between the ISIS exposure groups (primary exposure vs. no primary exposure) has been highlighted in pink in each research group (formal camp comparison vs. intervention) by respondent (caregivers vs. children).

By Length of Child’s PSS Exposure

When we disaggregate the scores of the beneficiaries (intervention group children) in the formal and informal camps by the length of exposure to the structured Injaz PSS program, we see that both respondents in the informal camps and the formal camp caregivers indicated that children with 7 months of PSS exposure or more had less anxiety than those with less exposure. These differences were not found to be statistically significant.⁵⁵

SCARED-5 Scores by Research Group, Respondent, and Child’s PSS Exposure				
	Formal Camp		Informal Camps	
	Intervention		Intervention	
	1-6 mo.	7 mo. or more	1-6 mo.	7 mo. or more
Caregivers	3.19 (SD=1.99)	2.74 (SD=1.96)	3.50 (SD=2.13)	3.00 (SD=1.41)
Children	1.78 (SD=1.98)	2.12 (SD=1.86)	2.58 (SD=1.87)	2.44 (SD=2.19)

Figure 22 SCARED-5 mean scores by research group, respondent, and child’s exposure to PSS. The lower the score, the lower the reported anxiety. The most positive score between the PSS exposure groups (1-6 months vs. 7 months or more) has been highlighted in pink in each research group (formal vs. informal camps intervention) by respondent (caregivers vs. children).

⁵⁴ Formal camp comparison group caregiver data had a p-value = 0.68 and children’s data had a p-value = 0.54 when comparing anxiety scores by exposure to ISIS. Formal camp intervention group caregiver data had a p-value = 0.93 and children’s data had a p-value = 0.12 when comparing anxiety scores by exposure to ISIS.

⁵⁵ Formal camp intervention caregiver data had a p-value = 0.34 and children’s data had a p-value = 0.28 when comparing anxiety scores by PSS exposure. Informal camp intervention caregiver data had a p-value = 0.38 and children’s data a p-value = 0.86 when comparing anxiety scores by PSS exposure.

Item by Item Positive Responses

We now turn to the individual items of anxiety and the percentage of formal camp respondents who responded positively to each.⁵⁶ On only one of the five items of anxiety measured did 75% or more of all formal camp respondents responded positively across all three research groups (see Figure 25 and Figure 26). In the formal camp comparison and intervention groups, 50% or more of respondents reported positively on four of the five anxiety items, while this was true for only three of the five items in the informal camps intervention group.

Encouragingly, 97% of all comparison and 95% of all intervention respondents in the formal camp, and 91% in the informal camps reported that the child is not scared to go to the child learning center. This is important for Injaz as PSS programming is delivered in camps. The data shows that fear of the programming location is not likely to prevent children from participating in the program.

In the formal camp 36% of comparison and 34% of intervention respondents reported that the child is not shy, as well as 27% of respondents in the informal camp, indicating that the majority of children in the formal camps are shy. This is something that should be considered when planning future PSS program curriculum, in particular, ensuring that the PSS activities are suitable for these children and finding ways to encourage them to be less shy and more engaged.

Additionally, in the formal camps we found that only 55% of comparison and 58% of intervention respondents indicated that the children are not afraid to be alone in their home or tent; this was even lower at 39% in the informal camps. In other words, 45% of comparison and 48% of intervention, and 61% of informal camp respondents said children are afraid to be alone in their home/tent in the camps. This was concerning for us and instigated an in-house qualitative research study to determine where these fears stem from, and if Injaz might be able to contribute to addressing them. While some of the concerns raised in this research were seen as relatively easy to address, such as passing along requests to have the garbage areas moved away from tents to prevent animals coming into nearby tents, others were more long-term in perspective, such as working with caregivers to provide them with alternative means for positive discipline that do not include raising fears or threats.

⁵⁶ A positive response on the SCARED-5 items is “not true or hardly ever true,” which aligns with a lower level of anxiety and, therefore, a higher level of psychosocial wellbeing.

Positive Responses on the Anxiety Items by Research Group Formal Camp							
SCARED-5 Item	Comparison			Intervention			% difference between intervention and comparison group
	% of child respondents	% of caregiver respondents	% of all respondents	% of child respondents	% of caregiver respondents	% of all respondents	
Child is not scared to go to the child learning center	97%	96%	97%	95%	96%	95%	-2%
Child does not get frightened for no reason at all	63%	65%	64%	74%	62%	68%	+4%
Child does not worry too much	85%	48%	67%	73%	56%	64%	-3%
Child is not afraid to be alone in the home/tent	58%	52%	55%	62%	53%	58%	+3%
Child is not shy	46%	25%	36%	43%	26%	34%	-2%

Figure 23 Percentage of formal camp children, caregivers, and all respondents who responded positively to the anxiety items measured by the SCARED-5 by research group (comparison vs. intervention). The right-hand column shows the percentage difference between the two research groups (formal camp intervention group minus comparison group), with those where the intervention group responded more positively highlighted in yellow.

Positive Responses on the Anxiety Items Informal Camps			
SCARED-5 Item	Intervention		
	% of child respondents	% of caregiver respondents	% all respondents
Child is not scared to go to the child learning center	92%	90%	91%
Child does not get frightened for no reason at all	67%	50%	59%
Child does not worry too much	44%	73%	59%
Child is not afraid to be alone in the home/tent	37%	42%	39%
Child is not shy	38%	15%	27%

Figure 24 Percentage of informal camp children, caregivers, and all respondents who reported positively on the anxiety items measured by the SCARED-5.

When we compare the formal camp responses across the comparison (without PSS) and intervention (with PSS) groups on children's anxiety, we can see that the children in the intervention group had higher positive response rates on two of the five anxiety items, which means that they chose responses that align with a higher level of psychosocial wellbeing (highlighted in yellow in Figure 25):

- The child is not afraid to be alone in the home or tent (a 3% higher positive response rate in the intervention group) and
- The child does not get frightened for no reason at all (a 4% higher positive response rate in the intervention group).

On the other three items of anxiety, the comparison children had a higher positive response rate:

- The child is not scared to go to the child learning center (a 2% higher positive response rate in the comparison group);
- The child does not worry too much (a 3% higher positive response rate in the group children); and
- The child is not shy (a 2% higher positive response rate in the comparison group).

This presents us with a mixed picture and could indicate that more efforts to address anxiety in the PSS programming could be appropriate if we presume that the intervention children would have had similar "starting points" as the comparison children. It could also indicate that some of the areas of anxiety or fear are beyond the ability of the PSS program to address.

When we compare the positive response rates between the formal camp groups and the informal camp group for anxiety, we see that the informal camp group consistently had a lower positive response rate, i.e. lower psychosocial wellbeing, than both formal camp groups across all anxiety items. This leads us to believe that children in informal camps (even with PSS) have greater anxiety than children living in a formal camp environment (without or without PSS).

Anxiety Reflections from Those with PSS

Analyzing the formal camp intervention caregiver and child reflections on the anxiety items, the evaluation results are overall positive (see Figure 27), though less so than for self-esteem. In the formal camp, none of the hope items were seen to have improved by 75% or more of respondents, while in the informal camp group, one item reached this benchmark. Across four of the five statements, the majority of formal camp caregivers and children noted that they saw a positive change since the child began participation in the Injaz PSS program, and in the informal camps this was seen across all five items.

It is interesting to note that across all five anxiety items, a higher percentage of informal camp respondents noted improvements than formal camp respondents.

These reflections on change are positive, as they seem to indicate that children and caregivers believe that the items of anxiety measured have improved for many of the children since they participated in the PSS program. Whether this is because of the program, however, is not something we can definitively say based upon this research.

Reflections on the Anxiety Items						
	Formal Camp Intervention			Informal camps Intervention		
SCARED-5 Item	% of child respondents	% of caregiver respondents	% all respondents	% of child respondents	% of caregiver respondents	% all respondents
Decrease in the child getting frightened for no reason at all	61%	70%	65%	73%	73%	73%
Decrease in the child being shy	65%	67%	66%	67%	71%	69%
Decrease in the child worrying too much	54%	63%	59%	63%	75%	69%
Decrease in the child being scared to go to the child learning center	41%	54%	47%	73%	77%	75%
Decrease in the child being afraid to be alone in the home/tent	51%	52%	52%	69%	67%	68%

Figure 25 Percentage of formal camp intervention caregivers, children, and all respondents who said that things had improved on the anxiety items since they started to participate in the Injaz PSS programming.

Children’s Hope for the Future

Children’s hope for the future was measured in this evaluation using a version of the Children’s Hope Scale,⁵⁷ which consists of six items that children and their caregivers were asked to respond to. For each item they could respond with: i) “none of the time,” ii) “a little of the time,” iii) “some of the time,” iv) “a lot of the time,” v) “most of the time,” and vi) “all of the time.” Each item is then scored on a scale from one to six. This means that the lowest possible score on the scale is a six and the highest is 36. In this scale, the higher the score, the higher the hope of the child for the future and the higher their psychosocial wellbeing.

Children’s Hope Scale Scores

As can be seen in Figure 28, the mean scores of the formal camp intervention children on the Children’s Hope Scale was higher than that for the comparison children, meaning that the intervention children sampled are reported to have more hope for the future than the comparison children. The intervention caregivers gave a mean score of 20.20 (SD=3.63), while the comparison caregivers gave a mean score of 19.22 (SD=4.42). This difference was found to be statistically significant.⁵⁸ The intervention children gave a mean score of 20.35 (SD=3.48) and the comparison children gave a mean score of 20.33 (SD=4.03); a difference that was not found to be statistically significant.⁵⁹ These findings indicate that there could be

⁵⁷ A copy of all the data collection tools can be found in the Appendix. The Children’s Hope Scale questions correspond to questions 42-47 of the Caregiver Survey and questions 40-45 of the Child Survey. For more information about the Children’s Hope Scale, see <https://www.co.marion.or.us/CS/CFC/Documents/Camp%20Hope%20Child%20Survey.pdf>. Last accessed: 10 March 2020.

⁵⁸ P-value = 0.048 when comparing formal camp comparison and intervention caregiver scores for Children’s hope.

⁵⁹ P-value = 0.96 when comparing formal camp comparison and intervention children’s scores for Children’s hope.

meaningful differences in children’s hope for the future between those with and without the PSS program, though only within the limitations of the research stated earlier.

In the informal camps, children’s hope for the future was not as high as seen in both of the formal camp groups (see Figure 28); the differences between the informal camps caregiver and children’s scores and those of the formal camp groups were found to be statistically significant.⁶⁰ The mean children’s hope score from the caregivers was 17.54 (SD=3.16) and from the children was 19.08 (SD=3.59).

The scores in all three groups are towards the mid-high end of the six to 36 range for the Children’s Hope Scale, however, without cut-off points, it is difficult to say more than this.⁶¹

Children’s Hope Scale Scores by Research Group and Respondent			
	Formal Camp		Informal Camp
	Comparison	Intervention	Intervention
	Mean Score	Mean Score	Mean Score
Caregivers	19.22	20.20	17.54
Children	20.33	20.35	19.08

Figure 26 Detailed Children’s Hope Scale mean scores by research group and respondent. The higher the score, the higher the children’s hope for the future. The most positive score between the research groups overall has been highlighted in yellow.

Disaggregating the Scores

By the Type of Respondent

It is interesting to note that the children in all three groups were more positive about their level of hope for the future than their caregivers (see Figure 28). The differences in the formal camp comparison group and the informal camps between caregiver and children’s scores were found to be statistically significant, but not in the formal camp intervention group.⁶² This seems to indicate that it is possible that children have more hope than their caregivers expect of them, but further data would need to be collected to be able to say this with greater confidence.

By the Child’s Gender

When the scores are disaggregated by gender (see Figure 29), we see a mixed picture. While most of the respondents indicated that male children had more hope for the future than female children, children in the intervention group of the formal camp indicated that female children had more hope. Despite this seeming alignment towards male children doing better,

⁶⁰ P-value = 1.34E-06 when formal camp intervention and informal camp caregiver hope scores were compared. P-value = 0.026 when formal camp comparison and informal camp caregiver hope scores were compared. P-value = 0.006 when formal camp intervention and informal camp children’s hope scores were compared. P-value = 0.047 when formal camp comparison and informal camp children’s hope scores were compared.

⁶¹ No cutoff points have been established that we are aware of to assist with interpretation for the Children’s Hope Scale. Last accessed 24 April 2020: <https://www.rand.org/education-and-labor/projects/assessments/tool/1997/childrens-hope-scale-chs.html>.

⁶² Formal camp intervention group data had a p-value = 0.69 when comparing children’s hope scores by respondent (caregivers vs. children), i.e. not statistically significant. Informal camps’ data had a p-value = 0.022 when comparing children’s hope scores by respondent (caregiver vs. children). Formal camp comparison group data had a p-value = 0.047 when comparing children’s hope scores by respondent (caregiver vs. children).

the differences were most often not found to be statistically significant,⁶³ meaning that we are unable to say if/how children’s hope might be affected by their gender based upon the research conducted.

We can also see that in the formal camp, the male comparison children reported having greater hope for the future than male intervention children. It is possible that this could relate to the male children who had already participated in the program answering the questions from a different frame or perspective because of their participation in the PSS program. Perhaps they feel more comfortable admitting their fears or concerns about the future than male children who have not participated in the program.

Children’s Hope Scale Scores by Research Group, Respondent, and Child’s Gender						
	Formal Camp				Informal Camp	
	Comparison		Intervention		Intervention	
	Female	Male	Female	Male	Female	Male
Caregivers	18.81 (SD=4.57)	19.62 (SD=4.27)	20.09 (SD=3.21)	20.31 (SD=4.02)	17.53 (SD=2.34)	17.55 (SD=4.08)
Children	20.18 (SD=3.87)	20.47 (SD=4.20)	20.83 (SD=3.73)	19.89 (SD=3.17)	18.80 (SD=3.28)	20.27 (SD=3.44)

Figure 27 Children’s Hope Scale mean scores by research group, respondent, and child’s gender. The higher the score, the higher the reported hope for the future. The most positive score between the genders (female vs. male) has been highlighted in pink in each research group by respondent (caregivers vs. children).

By the Child’s Age

When the hope scores are disaggregated by age, it appears at first as though children in the older category of 13-17 have more hope for the future, as the older group had higher scores across all respondents in all research groups, with the exception of informal camp caregivers (see Figure 30). However, the difference in scores by age were found to only be statistically significant for the formal camp comparison children.⁶⁴ For all other groups, the differences were not found to be statistically significant.⁶⁵ Therefore, it seems possible that older children have more hope for the future than the younger children. Our data hints at this, but does not provide solid enough evidence for to say this with full confidence.

Children’s Hope Scale Scores by Research Group, Respondent, and Child’s Age						
	Formal Camp				Informal Camp	
	Comparison		Intervention		Intervention	
	10-12 years	13-17 years	10-12 years	13-17 years	10-12 years	13-17 years
Caregivers	18.94 (SD=4.57)	19.86 (SD=4.27)	20.15 (SD=3.83)	20.31 (SD=3.16)	17.97 (SD=3.06)	16.23 (SD=3.19)
Children	19.87 (SD=4.58)	21.48 (SD=3.78)	20.29 (SD=3.39)	20.49 (SD=3.71)	18.63 (SD=3.51)	20.29 (SD=3.67)

⁶³ Formal camp comparison caregiver data had a p-value = 0.18 and children’s data had a p-value = 0.69 when comparing children’s hope scores by gender. Formal camp intervention caregiver data had a p-value = 0.69 and caregiver’s data a p-value = 0.99 when comparing children’s hope scores by gender. Formal camp intervention children’s data had a p-value = 0.072 when comparing children’s hope scores by gender. All of these scores are above the 0.05 and are, therefore, not statistically significant. The differences in the scores by gender stemming from informal camp children, however, were found to be significant. Informal camp children’s data had a p-value = 0.038 when comparing children’s hope scores by gender.

⁶⁴ Formal camp comparison children’s data had a p-value = 0.046 when comparing children’s hope scores by age.

⁶⁵ Formal camp comparison caregiver data had a p-value = 0.31 when comparing children’s hope scores by age. Formal camp intervention caregiver data had a p-value = 0.78 and children’s data a p-value = 0.73 when comparing children’s hope scores by age. Informal Camp caregiver data had a p-value = 0.10 and children’s data a p-value = 0.16 when comparing children’s hope scales by age.

Figure 28 Children’s Hope Scale mean scores by research group, respondent, and child’s age. The higher the score, the higher the reported hope for the future. The most positive score between age groups (10-12 vs. 13-17) has been highlighted in pink in each research group by respondent (caregivers vs. children).

By the Child’s Exposure to ISIS

When we disaggregate the hope scores by a child’s primary exposure to ISIS (those with and without such exposure) the findings are inconsistent, with caregivers in the comparison group indicating that those without primary exposure to ISIS have more hope for the future and the children reporting the opposite (see Figure 31). In the intervention group, the caregivers reported that those with primary exposure had more hope than those without, while the children reported the opposite. None of the differences reported were found to be statistically significant,⁶⁶ meaning that we are unable to determine if/how exposure to ISIS affects children’s hope for the future based upon the data collected.

Children’s Hope Scale Scores by Research Group, Respondent, and Child’s ISIS Exposure Formal Camp				
	Comparison		Intervention	
	Primary exposure	No primary exposure	Primary exposure	No primary exposure
Caregivers	18.67 (SD=2.73)	19.25 (SD=4.50)	20.86 (SD=3.18)	20.18 (SD=3.65)
Children	21.55 (SD=2.46)	20.20 (SD=4.13)	19.06 (SD=3.60)	20.49 (SD=3.46)

Figure 29 Children’s Hope Scale mean scores by research group, respondent, and child’s exposure to ISIS. The higher the score, the higher the reported hope for the future. The most positive score between the ISIS exposure groups (primary exposure vs. no primary exposure) has been highlighted in pink in each research group (formal camp comparison vs. intervention) by respondent (caregivers vs. children).

By the Length of the Child’s Exposure to PSS

When the hope scores are disaggregated by the number of months a child participated in the Injaz PSS program (formal and informal intervention groups) (see Figure 32), the picture is not entirely clear, though it does appear that children with 1-6 months of programming have the most hope for the future of all PSS exposure groups, as both respondents in the informal camp group and the children in the formal camp indicated that children with 1-6 months of PSS exposure had higher scores than the children with 7 months or more of exposure. However, none of the differences visible in the table below between the two PSS exposure groups were found to be statistically significant.⁶⁷

Children’s Hope Scale Scores by Research Group, Respondent, and Child’s PSS Exposure				
	Formal Camp		Informal Camp	
	Intervention		Intervention	
	1-6 mo.	7 mo. and more	1-6 mo.	7 mo. and more
Caregivers	19.57 (SD=3.20)	20.29 (SD=3.68)	18.00 (SD=2.73)	15.60 (SD=4.17)
Children	20.66 (SD=3.55)	20.21 (SD=3.46)	19.23 (SD=3.45)	18.33 (SD=4.36)

⁶⁶ Formal camp comparison caregiver data had a p-value = 0.64 and children’s data had a p-value = 0.13 when comparing children’s hope scores by exposure to ISIS. Formal camp intervention caregiver data had a p-value = 0.60 and children’s data a p-value = 0.13 when comparing children’s hope scores by exposure to ISIS.

⁶⁷ Formal camp intervention caregiver data had a p-value = 0.35 and children’s data a p-value = 0.43 when comparing children’s hope scores by exposure to PSS. Informal camp intervention caregiver data had a p-value = 0.11 and children’s data a p-value = 0.57 when comparing children’s hope scores by exposure to PSS.

Figure 30 Children's Hope Scale mean scores by research group, respondent, and child's exposure to PSS. The higher the score, the higher the reported hope for the future. The most positive score between the PSS exposure groups (1-6 months vs. 7 months or more) has been highlighted in pink in each research group (formal vs. informal camps intervention group) by respondent (caregivers vs. children).

Children's Hope Responses Item by Item

Overall, the positive response rates from the formal camp groups to the children's hope items were lower than their rates for some of the other measures of psychosocial wellbeing covered in this evaluation.⁶⁸ None of the six items had an overall positive response rate of 75% or higher in any of the research groups (see Figure 33 and Figure 34).

In the formal camp comparison group, 50% or more of respondents had a positive response on three of the six children's hope items. This was only two of six for the formal camp intervention group and zero of six for the informal camps intervention group.

Areas of particular concern include children not being adept at problem solving and finding ways to solve problems and children's perseverance.

These relatively poor positive response rates lead us to believe that children need greater support to help them have more hope for the future. The PSS program could possibly help provide that support by emphasizing the above-mentioned areas (problem-solving, perseverance).

⁶⁸ A response of "all of the time," "a lot of the time," or "most of the time" is considered to be a positive response on the Children's Hope Scale.

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Positive Responses on the Children's Hope Scale Items by Research Group							
Formal Camp							
Children's Hope Scale Item	Comparison			Intervention			% difference between intervention and comparison group
	% of child respondents	% of caregiver respondents	% all respondents	% of child respondents	% of caregiver respondents	% all respondents	
Child believes they are doing just as well as other kids their age	61%	51%	56%	66%	65%	66%	+10%
Child thinks they are doing well	58%	53%	56%	57%	56%	56%	0%
Child thinks the things they have done in the past will help them in the future	57%	44%	50%	54%	42%	48%	-2%
Child can think of many ways to get the things in life that are most important to them	43%	37%	40%	38%	44%	41%	+1%
Child can come up with lots of ways to solve problems	36%	38%	37%	43%	44%	44%	+7%
Child knows they can find ways to solve problems, even when others want to quit	45%	29%	37%	40%	44%	42%	+5%

Figure 31 Percentage of formal camp children, caregivers, and all respondents who reported positively on the Children's Hope Scale items by research group (comparison vs. intervention). The right-hand column shows the percentage difference between the two research groups (formal camp intervention group minus comparison group), with those where the intervention group responded more positively highlighted in yellow.

Positive Responses on the Children's Hope Scale Items			
Informal Camp			
Children's Hope Scale Item	Intervention		
	% of child respondents	% of caregiver respondents	% all respondents
Child believes they are doing just as well as other kids their age	50%	40%	45%
Child thinks they are doing well	50%	37%	43%
Child thinks the things they have done in the past will help them in the future	29%	35%	32%
Child can think of many ways to get the things in life that are most important to them	38%	37%	38%
Child can come up with lots of ways to solve problems	40%	31%	36%
Child knows they can find ways to solve problems, even when others want to quit	38%	12%	25%

Figure 32 Percentage of informal camp children, caregivers, and all respondents who reported positively on the different items of the Children's Hope Scale

Comparing the positive responses from the formal camp comparison and intervention groups to gain insights into how the PSS program might have influenced children's hope for the future, we see that intervention respondents (with PSS) had a higher positive response rate on four of the six items than the comparison group (without PSS) (highlighted in yellow in Figure 33). This suggests that children who participated in the Injaz PSS program are doing better in terms of their hope and optimism for the future, though we are unable with this research to establish a correlation between participating in the Injaz PSS program and higher hope for the future due to the limitations of the research. Below are two examples of intervention children doing better than comparison children:

- The child believes that they are doing just as well as other kids their age (a 10% higher positive response rate in the intervention group) and
- The child can come up with lots of ways to solve problems (a 7% higher positive response rate in the intervention group).

At the same time, it looks like the programming is having little to no effect on two aspects of children's hope looked at in this evaluation:

- The child thinks the things they have done in the past will help them in the future (a 2% higher positive response rate in the comparison group) and
- The child thinks they are doing well (zero difference between the groups).

When we compare the informal camp positive response rates with those from the formal camp groups, we see that the positive response rate is lower in the informal camp than in both formal camp groups across all children's hope items. This indicates that children in the informal camp, even after participating in a PSS program have less hope than the children in formal camps irrespective of whether the formal camp children had participated in a PSS program or not.

Overall, these are not inspiring results for children's hope, and they lead us to believe that greater attention needs to be paid to building children's hope and particularly in informal camps.

Children's Hope Reflections from Those with PSS

When reflecting on children's hope for the future, most intervention caregivers and children (beneficiaries) reported seeing an improvement. In both the formal and informal camps, 75% of intervention respondents reported that things had improved on all six children's hope items (see Figure 35).

The percentage of respondents who noted improvements in the formal camp ranged from 78% to 87% and in the informal camps from 80% to 96%. This is very positive in that it indicates that children and caregivers are seeing positive changes in the children's sense of hope for the future since they started participating in the PSS programming, though the extent to which the program helped bring about these changes cannot be fully determined based on this research alone.

We see this as particularly important because the positive response rates for children's hope items was relatively low, indicating that many children needed greater support on these items.

Reflections on the Children's Hope Scale Items						
	Formal Camp (Intervention Group)			Informal camps (Intervention Group)		
	Intervention			Intervention		
Children's Hope Scale Item	% of child respondents	% of caregiver respondents	% all respondents	% of child respondents	% of caregiver respondents	% all respondents
Increase in the child thinking they are doing well	89%	84%	87%	96%	96%	96%
Increase in the child being able to think of many ways to get the things in life that are most important to them	85%	84%	85%	85%	88%	87%
Increase in the child believing they are doing just as well as other kids their age	79%	77%	78%	98%	90%	94%
Increase in the child thinking the things they have done in the past will help them in the future	81%	80%	81%	87%	88%	88%
Increase in the child knowing they can find ways to solve problems, even when others want to quit	81%	85%	83%	85%	77%	81%
Increase in the child being able to come up with lots of ways to solve problems	82%	84%	83%	85%	75%	80%

Figure 33 Percentage of formal and informal camps intervention children, caregivers, and all respondents who said that things have improved on the items of the Children's Hope Scale since the child started their participation in the Injaz PSS program.

Midline Evaluation Conclusions

The data presented in this report provides us with a snapshot of the wellbeing of the children in the three research groups at the time of this research on different measures of psychosocial wellbeing: self-esteem from the Rosenberg Self-Esteem Scale, anxiety from the SCARED-5, and children's hope for the future from the Children's Hope Scale. Together it provides insight into how children with the program are faring as compared to children who had not yet participated in the Injaz PSS program when the research was conducted.

The following provides a summary of the key findings of the midline evaluation, first looking at what the psychosocial wellbeing measurement tool scores can tell us before turning to responses on the individual items included in the research tools, and finally extracting suggestions and recommendations for how the Injaz PSS program might want to consider moving forward to support the children in northeast Syria as best it can.

Putting the Scores into Perspective and Questioning the Reliability of that Perspective

Overall, the children's scores on the different aspects of psychosocial wellbeing in the formal and informal camps where this evaluation was conducted indicate that they are doing well. This is especially clear for the Rosenberg Self-Esteem Scale, where established cut-off points were provided to differentiate ranges: low self-esteem, normal self-esteem, and high self-esteem. The children in all research groups fell into the normal self-esteem category. This was a surprising finding for us, considering the nine years of conflict these children and their families have lived through. We were also surprised to see that children's anxiety was evaluated to be at the lower end of the SCARED-5 spectrum of 0-10 and that children's hope was towards the middle of the Children's Hope Scale spectrum of 0-36 (see Figure 36). These results have led us to question if the measures we used are sensitive enough to the social context and social norms related to what people are willing to talk about.

That being said, we do believe that the findings stemming from this research tell an interesting story that can help us with program decision-making and with obtaining a sense of how the Injaz PSS program might be impacting on the self-esteem, anxiety, and hope of children who participate.

What the Scores Can Tell Us

A Snapshot of the Psychosocial Wellbeing Status at the Time of Data Collection

The following table outlines the mean scores across the research groups, with the best scores (which sometimes means the highest and sometimes means the lowest score) between the groups highlighted in yellow. As a reminder, intervention children in the formal camp and informal camps had participated in the Injaz structured PSS program prior to the data collection for this evaluation, while the comparison group in the formal camp had not.

Psychosocial Wellbeing Aspect Scores by Research Group and Respondent			
	Formal Camp		Informal Camps
	Comparison (without PSS)	Intervention (with PSS)	Intervention (with PSS)
	Mean Score	Mean Score	Mean Score
Self-Esteem			
Caregivers	19.56	21.08	18.63
Children	19.60	20.24	19.60
Anxiety			
Caregivers	3.05	2.79	3.40
Children	2.22	2.01	2.56
Children's Hope			
Caregivers	19.22	20.20	17.54
Children	20.33	20.35	19.08

Figure 34 Mean scores by psychosocial wellbeing measurement by research group and respondent. For self-esteem and children's hope, a higher score indicates greater psychosocial wellbeing. For anxiety, a lower score indicates greater psychosocial wellbeing. The scores that indicate the highest level of psychosocial wellbeing across the research groups have been highlighted in yellow.

Looking at the scores across the research groups, we can see that the formal camp intervention group (with PSS) has the best score in all three areas of psychosocial wellbeing measured (see Figure 36). Children who participated in the Injaz PSS program are consistently reported to be doing better on the psychosocial wellbeing aspects measured than children that have not participated in the program, even if in some cases the differences are relatively small in nature and not always statistically significant.

The higher scores found in the formal camp comparison group as compared to the intervention group, as reported by the caregivers, for self-esteem and children's hope was found to be statistically significant, which we find very encouraging. It is possible that the program has contributed to the formal camp intervention children doing better in terms of self-esteem and children's hope, where we found statistical significance, and even on anxiety where our research showed no statistical significance between the scores in the formal camps. Without a baseline for the intervention group, we are unable say for certain.

These scores also reveal to us that the children in the informal camps are reported to be worse off than both the formal camp groups when it comes to self-esteem, anxiety, and children's hope, despite the children having participated in the Injaz PSS program. Specifically, the differences between the informal camp group and both formal camp groups were found to be significant for both self-esteem and children's hope to different degrees. We hypothesize that one reason for this could be the different living situations of the children. Children in informal camps face greater insecurity than children in the formal camp, as informal camps are by nature more transient and less stable and with fewer services provided.

Disaggregation of the Scores

When the psychosocial wellbeing scores are disaggregated by the gender of the child, we were able to identify only one trend that links the child's gender to their psychosocial wellbeing. Male children were seen by all respondents across research groups as having less anxiety than female children. These differences were found to be statistically significant across five of the six sets of data looked at, which seems to indicate a difference in anxiety connected to gender. Further research into this topic could help illuminate the reasons for these differences and help determine if it would be useful to develop bespoke activities for

male and female children for this issue. We also saw in the formal camp that male comparison children reported themselves to be doing better off in terms of anxiety and children's hope than the male intervention children, which seems curious as the overall scores were better in the formal camp intervention groups across all three aspects of psychosocial wellbeing. One possible explanation is that participating in the PSS program could be helping children connect more with their own inner state and to be more willing to talk about challenges they might be facing.

We were unable to identify any clear and statistically significant trends relating the three children's psychosocial wellbeing aspects to the child's age in the different research groups. This does not mean that such connections do not exist, but that we were unable to say if/how the self-esteem, anxiety, and hope of the children might be affected by the age of the child. There are some hints that older children (13-17) might have greater hope for the future than younger children (10-12), but as the difference in scores between these groups was only found to be statistically significant for formal camp comparison children's data, we believe that this would require further research to confirm before it could be put forward with confidence.

When the scores were disaggregated by primary ISIS exposure, we were unable to identify any trends that were supported through our statistical testing for self-esteem, anxiety, and children's hope. The same can be said when the scores were disaggregated by the length of time a child was exposed to the PSS program. The scores were often mixed, and the results were found to not be statistically significant. Therefore, we are unable to say if/how children's self-esteem, anxiety, and hope for the future are affected by a child's primary exposure to ISIS and the length of their exposure to PSS programming.

Finally, we also disaggregated the scores within a research group by respondent to see if we could identify differences between how children and their caregivers reported. When it comes to self-esteem, we found a mixed picture, which leads us to caution against making any general assumptions about whether children or caregivers tend to be more optimistic about the children's self-esteem. When we looked at the anxiety scores, however, we saw a clear trend, with children reporting more optimistically across all research groups than their caregivers did, with the differences found to be statistically significant. This seems to point towards a divide between the perspectives of the children and their caregivers when it comes to anxiety, which might be something the program wants to conduct further research on and perhaps address through its programming. When we look at children's hope, we found no clear patterns related to the type of respondent in the different research groups.

We note these trends by respondent because it helps us understand where perspectives differ between the children and their caregivers, and because it could be useful when considering which respondents to include in future research. It also leads us to suggest that PSS programming be provided to caregivers to ensure that they and the children are operating from similar frames of reference when it comes to psychosocial wellbeing.

What the Item-by-Item Responses Can Tell Us

Identifying Items of Higher, Medium, and Lower Concern

When we look at the positive response rates for the 21 items in the evaluation, we gain insights into the areas of weakness and strengths for children in the formal and informal camps. Positive response rates are the calculated percentage of child and caregiver respondents who provided a response to an item that correlates to a higher psychosocial wellbeing. For example, responding "disagree" or "strongly disagree" to the statement, "All in

all, I am inclined to feel that I am a failure,” would be positive responses. Positive response rates were calculated for each research group separately, so the results can be compared to one another.

Higher Concern Items

Turning to the psychosocial wellbeing items of higher concern, where 50% or less of the respondents in all research groups responded positively (see Figure 37), we find that there are six items of higher concern out of 21. These include one of ten self-esteem items, one of five anxiety items, and four of six children’s hope items.

Higher Concern Psychosocial Wellbeing Items					
		Formal Camp		Informal Camps	
		Comparison (without PSS)	Intervention (with PSS)	Intervention (with PSS)	
	Psychosocial Wellbeing Item	% respondents	% respondents	% respondents	Aspect of Psychosocial Wellbeing
1.	Child does not wish they could have more respect for them self	1%	0%	0%	Self-Esteem
2.	Child is not shy	36%	34%	27%	Anxiety
3.	Child knows they can find ways to solve problems, even when others want to quit	37%	42%	25%	Children’s Hope
4.	Child can come up with lots of ways to solve problems	37%	44%	36%	Children’s Hope
5.	Child can think of many ways to get the things in life that are most important to them	40%	41%	38%	Children’s Hope
6.	Child thinks the things they have done in the past will help them in the future	50%	48%	32%	Children’s Hope

Figure 35 Evaluation items on which only 50% of the respondents in all three research groups or less responded positively by research group and psychosocial wellbeing item.

The lowest positive response rate related to children wishing they had more self-respect (self-esteem). We are concerned that this item was confusing for the respondents, based upon the other self-esteem responses and the ambiguity of the statement, and recommend that further research be conducted to determine whether self-respect is a grave problem in northeast Syria.

Additionally, we see that a worrying majority of children are shy (anxiety), are not certain they can find ways to solve problems (hope for the future), are unable to come up with lots of ways to solve problems (hope for the future), are not able to think of ways to get the things in life that are most important to them (hope for the future), and do not think that things they had done in the past will help them in the future (hope for the future).

These areas of higher concern are areas where we see the lowest positive response rates and where we see that most children need greater support. As we will see later, some of these areas appear to have been positively influenced for beneficiaries since they began participation in the Injaz PSS program, but we still see them as areas to be strengthened. We would advise that these areas of relative weakness be taken into consideration for future PSS programming and that the curriculum of the current Injaz PSS program be reviewed to determine if additional activities to address these items could be added or if changes to the already existing activities could be made to help further support the children in these areas.

Medium Concern Items

There were also seven psychosocial wellbeing items that we categorized as of medium concern (see Figure 38). This category includes items with a positive response rate higher than 50% and less than 75% in all research groups. For these medium concern items, it appears as though many children still require support, though less than the majority.

We found that two of ten for self-esteem items fell into the medium concern category, while this was three of five anxiety and two of six for children's hope.

Medium Concern Psychosocial Wellbeing Items					
		Formal Camp		Informal Camps	
		Comparison (without PSS)	Intervention (with PSS)	Intervention (with PSS)	
	Psychosocial Wellbeing Item	% respondents	% respondents	% respondents	Aspect of Psychosocial Wellbeing
1.	Child is not afraid to be alone in the home/tent	55%	58%	39%	Anxiety
2.	Child thinks they are doing well	56%	56%	43%	Children's Hope
3.	Child believes they are doing just as well as other kids their age	56%	66%	45%	Children's Hope
4.	Child feels they have much to be proud of	62%	85%	79%	Self-Esteem
5.	Child does not get frightened for no reason at all	64%	68%	59%	Anxiety
6.	Child does not worry too much	67%	64%	59%	Anxiety
7.	Child does not feel useless at times	74%	88%	82%	Self-Esteem

Figure 36 Evaluation items on which more than 50% but less than 75% of the respondents in all research group responded positively by research group and psychosocial wellbeing item.

Many children were still seen as being afraid to be alone in their home/tent (anxiety), to not think they are doing well (children's hope), and to not believe that they are doing as well as other children their age (children's hope). This was not the majority in the formal camps groups; however, it was the majority in the informal camp group.

Most children across all groups felt that they do have much to be proud of (self-esteem). The same can be said for children not being frightened for no reason or worrying too much (both anxiety), though we should note that this does seem to be more of a concern for children in the informal camps than those in the formal camp. Finally, we see that most of the children do not feel useless at times (self-esteem), with those who participated in the Injaz PSS program having a higher positive response rate than those that did not.

These middle concern items are also important to take into consideration when planning future PSS programs.

Lower Concern Items

There were eight psychosocial wellbeing items where 75% or more of the respondents in all research groups responded positively, indicating that the vast majority of children are already reported to be doing well in those areas (see Figure 39).

When we break these lower concern items down by psychosocial wellbeing aspects, we see that seven of the ten self-esteem items fall into this category, one of five for anxiety items, and zero of six for children's hope.

Lower Concern Psychosocial Wellbeing Items					
		Formal Camp		Informal Camps	
		Comparison (without PSS)	Intervention (with PSS)	Intervention (with PSS)	
	Psychosocial Wellbeing Item	% respondents	% respondents	% respondents	Aspect of Psychosocial Wellbeing
1.	Child does not sometimes think that they are no good	77%	85%	79%	Self-Esteem
2.	Child is not inclined to feel like they are a failure	87%	92%	85%	Self-Esteem
3.	Child believes they are able to do as well as most other people	87%	94%	92%	Self-Esteem
4.	Child is satisfied with their self	89%	96%	95%	Self-Esteem
5.	Child feels that they are a person of worth, at least on an equal plane with others	90%	99%	98%	Self-Esteem
6.	Child believes they have good qualities	92%	97%	100%	Self-Esteem
7.	Child takes a positive attitude towards them self	95%	97%	98%	Self-Esteem
8.	Child is not scared to go to the child learning center	97%	95%	91%	Anxiety

Figure 37 Evaluation items on which 75% or more of the respondents in all research groups responded positively by research group and psychosocial wellbeing item.

Most children do not think they are “no good,” and more than 80% of children in all three research groups said that they are not inclined to feel like a failure and that they believe that they are able to do as well as most other people (all self-esteem).

Adding to these, we see that the vast majority of respondents said that they are satisfied with themselves, that they feel they are a person of worth, believe they have good qualities, and that they take a positive attitude towards themselves (all self-esteem). Additionally, nearly all respondents said that the child is not afraid to go to the child learning center (anxiety), which is particularly important as this is one of the locations where Injaz has implemented its PSS program.

While we see these as items of lower concern, this does not mean that they should be of no concern. They too should be considered for future PSS programming.

Ranking of Psychosocial Needs Measured

Based upon these positive response rates and the different psychosocial wellbeing aspects they are connected to, we have ranked the aspects of psychosocial wellbeing from the areas that appear to be the least problematic for the children of the formal and informal camps to the most problematic. Self-esteem was reported on the most positively, followed by anxiety, and finally by children’s hope, which leads us to suggest that the current curriculum be reviewed to determine if and how it can be used to further support children’s hope for the future, first and foremost, followed by anxiety, and then self-esteem.

Evidence of Possible Influence of the Injaz PSS Program on Children

We can also use the positive response rates for the individual psychosocial wellbeing items to obtain some clues as to how the Injaz PSS program might have influenced the beneficiary children’s attitudes and behaviors by comparing the response rates in the comparison group (without PSS) with those of the intervention group (with PSS) in the formal camp. When the positive response rates are higher in the intervention group, it suggests that the PSS program could have helped the children in the intervention group, assuming that the “starting

point” of the two groups would have been similar. Due to the limitation of the research outlined in this report, we cannot say for certain if the differences infer a causal relationship, but they provide encouragement that this could be the case.

The intervention group (with PSS) had a higher positive response rate than the comparison group (without PSS) in the formal camp on 15 of the 21 items looked at in this evaluation (see Figure 40). The difference between the two groups on these items ranged from 1% to 23% and was on average 6.19%. This seems to indicate that the Injaz PSS program positively influences the psychosocial wellbeing of the children who participate in it. When we break this down by psychosocial wellbeing aspect, we see that this includes nine of the ten self-esteem items, two of the five anxiety items, and four of the six children’s hope items.

Items Where the Formal Camp Intervention Group Had a Higher Positive Response Rate Than the Comparison Group					
		Formal Camp			
		Comparison	Intervention		
	Psychosocial Wellbeing Item	% respondents	% respondents	% difference intervention - comparison	Psychosocial Wellbeing Aspect
1.	Child feels they have much to be proud of	62%	85%	+23%	Self-Esteem
2.	Child does not feel useless at times	74%	88%	+14%	Self-Esteem
3.	Child believes they are doing just as well as other kids their age	56%	66%	+10%	Children's Hope
4.	Child feels that they are a person of worth, at least on an equal plane with others	90%	99%	+9%	Self-Esteem
5.	Child does not sometimes think that they are no good	77%	85%	+8%	Self-Esteem
6.	Child can come up with lots of ways to solve problems	37%	44%	+7%	Children's Hope
7.	Child is satisfied with their self	89%	96%	+7%	Self-Esteem
8.	Child believes they are able to do as well as most other people	87%	94%	+7%	Self-Esteem
9.	Child is not inclined to feel like they are a failure	87%	92%	+5%	Self-Esteem
10.	Child knows they can find ways to solve problems, even when others want to quit	37%	42%	+5%	Children's Hope
11.	Child believes they have good qualities	92%	97%	+5%	Self-Esteem
12.	Child does not get frightened for no reason at all	64%	68%	+4%	Anxiety
13.	Child is not afraid to be alone in the home/tent	55%	58%	+3%	Anxiety
14.	Child takes a positive attitude towards them self	95%	97%	+2%	Self-Esteem
15.	Child can think of many ways to get the things in life that are most important to them	40%	41%	+1%	Children's Hope

Figure 38 List of psychosocial wellbeing items where the intervention group (with PSS) had a higher positive response rate than the comparison group (without PSS).

For six of the 21 items of psychosocial wellbeing looked at in the evaluation, the positive response rates in the formal camp comparison (without PSS) group and the intervention group (with PSS) were either equal or the comparison group had a higher positive response rate (see Figure 41). The difference between the two groups remains relatively low at only 0% to 4% for all eight items, averaging only 1.67% per item, which is much smaller than seen above.

Items Where the Formal Camp Intervention Group Had a Positive Response Equal to or Lower than the Comparison Group					
		Formal Camp			
		Comparison	Intervention		
	Psychosocial Wellbeing Item	% respondents	% respondents	% difference intervention - comparison	Psychosocial Wellbeing Aspect
1.	Child thinks they are doing well	56%	56%	0%	Children's Hope
2.	Child does not wish they could have more respect for them self	1%	0%	-1%	Self-Esteem
3.	Child is not shy	36%	34%	-2%	Anxiety
4.	Child is not scared to go to the child learning center	97%	95%	-2%	Anxiety
5.	Child thinks the things they have done in the past will help them in the future	50%	48%	-2%	Children's Hope
6.	Child does not worry too much	67%	64%	-3%	Anxiety

Figure 39 List of psychosocial wellbeing items where the intervention group (with PSS) had the same positive response rate as, or lower than, the comparison group (without PSS).

This comparison of the positive response rates in the formal camp paints a generally positive picture, with the majority of the 21 items of psychosocial wellbeing having a positive response rate that is higher among children who have participated in the program compared to children who have not. We acknowledge that the psychosocial wellbeing measurement tools we used are not validated for item-by-item responses and believe that these findings should be looked at with caution. They seem to indicate that children with PSS are doing better than children without PSS, and it is possible that this is related to their participation in the program, though this research is unable to prove this.

What Can Caregiver and Child Reflections Tell Us?

The Possible Influence of Injaz PSS Program on Children

The reflections provided by children in the formal and the informal camp intervention groups (both with PSS) and their caregivers support the theory that participating in the Injaz PSS program might be contributing to the positive changes in the children's psychosocial wellbeing they have noticed. The children of both groups participated in the Injaz PSS program prior to the evaluation data collection and they and their caregivers were asked to provide us with their reflections on how things had changed for the child since they started the PSS program.

Overall, the reflections' feedback from these two groups was positive, with the majority of respondents noting improvements on many of the items. For the self-esteem items, we saw a range of 76%-95% in the formal camp group and 74%-95% in the informal camp group.⁶⁹ For the anxiety items, the formal camp saw a range of 47%-66% and the informal camp of 68%-75% of respondents indicating that they had seen improvements. For children's hope, this was 78%-85% for the formal camp and 80%-96% for the informal camp.

On 14 of the 21 items (67%), 75% or more of both sets of respondents in the formal and informal intervention groups noted an improvement (see Figure 42). These include eight of ten self-esteem items, zero anxiety items, and all six children's hope items.

⁶⁹ Please note that we have left the self-respect item out of this range based upon concerns about the reliability of the data associated with this item.

Having 75% or more of respondents report improvement on a specific item indicates that the majority of children and caregivers are seeing positive changes in the children's behaviors and attitudes since their involvement with the Injaz PSS program.

Items Where 75% or More of Respondents Noted Improvements				
		Formal Camp	Informal Camp	
		Intervention (with PSS)	Intervention (with PSS)	
	Psychosocial Wellbeing Item	% of all respondents	% of all respondents	Psychosocial Wellbeing Aspect
1.	Increase in the child taking a positive attitude towards them self	95%	92%	Self-Esteem
2.	Increase in the child believing they have good qualities	91%	95%	Self-Esteem
3.	Increase in the child feeling that they are a person of worth, at least on an equal plane with others	92%	93%	Self-Esteem
4.	Increase in the child thinking they are doing well	87%	96%	Children's Hope
5.	Increase in the child's satisfaction with their self	92%	88%	Self-Esteem
6.	Increase in the child believing they are able to do as well as most other people	85%	88%	Self-Esteem
7.	Increase in the child being able to think of many ways to get the things in life that are most important to them	85%	87%	Children's Hope
8.	Increase in the child believing they are doing just as well as other kids their age	78%	94%	Children's Hope
9.	Increase in the child thinking the things they have done in the past will help them in the future	81%	88%	Children's Hope
10.	Increase in the child knowing they can find ways to solve problems, even when others want to quit	83%	81%	Children's Hope
11.	Increase in the child being able to come up with lots of ways to solve problems	83%	80%	Children's Hope
12.	Decrease in the child sometimes thinking that they are no good	81%	77%	Self-Esteem
13.	Decrease in the child feeling useless at times	76%	81%	Self-Esteem
14.	Increase in the child feeling they have much to be proud of	76%	76%	Self-Esteem

Figure 40 Psychosocial wellbeing items for which at least 75% of both the formal and informal camps intervention group respondents reported an improvement for the child since their participation in the Injaz PSS program.

There are five more items for which 50% to 74% of both formal and informal camp intervention respondents noted an improvement (see Figure 43). By psychosocial wellbeing aspect, this accounts for one of ten self-esteem items and four of five anxiety items. We still find these items that fall into this middle range to be encouraging as they indicate that some children's psychosocial wellbeing is reported to have improved, though it does leave room for improvement.

Items Where 50% to 74% of Respondents Noted Improvements					
		Formal Camp	Informal Camp		
		Intervention (with PSS)	Intervention (with PSS)	Intervention (with PSS)	
Psychosocial Wellbeing Item		% of all respondents	% of all respondents	% of all respondents	
1.	Decrease in the child being inclined to feel like they are a failure	76%	74%	Self-Esteem	
2.	Decrease in the child getting frightened for no reason at all	65%	73%	Anxiety	
3.	Decrease in the child being shy	66%	69%	Anxiety	
4.	Decrease in the child being afraid to be alone in the home/tent	52%	68%	Anxiety	
5.	Decrease in the child worrying too much	59%	69%	Anxiety	

Figure 41 Psychosocial wellbeing items for which 50%-74% of both formal camp intervention and informal camps intervention group respondents reported an improvement for the child since their participation in the Injaz PSS program.

In total, this means that the majority of respondents reported improvements on 19 of the 21 psychosocial wellbeing items looked at in this research, accounting for 90% of the items. This is a positive sign, and we believe, but cannot yet prove, that participating in Injaz’s PSS program played a contributing role in bringing about these changes.

There were two items, however, where improvement was noted by only 50% or less of the respondents: one of ten self-esteem items and one of five anxiety items. The first is related to the child fearing going to the child learning center, with most respondents indicating that this had not changed, which might be related to a possible low number of respondents indicating that children feared going to the child learning center as a “starting point.” This possibility is hinted at by the formal camp comparison group’s positive response rate on this item, which was also quite high at 97%. The second item is the one related to self-respect, which we have noted in the report appears to have confused respondents due to its ambiguity.

Items Where less than 50% of Respondents Noted Improvements					
		Formal Camp	Informal Camp		
		Intervention (with PSS)	Intervention (with PSS)		
Psychosocial Wellbeing Item		% of all respondents	% of all respondents	Psychosocial Wellbeing Aspect	
1.	Decrease in the child being scared to go to the child learning center	47%	75%	Anxiety	
2.	Decrease in the child wishing they could have more respect for them self	0%	0%	Self-Esteem	

Figure 42 Psychosocial wellbeing items for which less than 50% of both the formal camp intervention and informal camps intervention group respondents reported an improvement for the child since their participation in the Injaz PSS program.

Another interesting thing to note as we look at the formal and informal camps reflections is that the informal camps reported seeing more positive change across the different items than the formal camp intervention group. In total, the informal camp group had a higher improvement response rate than the formal camp intervention group on 13 of the 21 items, while the formal camp intervention group only had higher rates on six items; they were equal on the other two items (see Figure 44). This hints at, but does not prove, that children in informal camps could be benefitting more from the PSS program than formal camp children.

We hypothesize that this could relate to the higher level of instability the children in the informal camps experience, among other factors including lack of basic services. We believe it is important to point this out for two reasons:

- 1) It shows that PSS programming could be particularly important for children living in instability and
- 2) it shows that it is important to try to capture reflections of the children and/or their caregivers, as this can provide perceptions of change that the measured outcomes might not be able to capture.

This is especially important, we suggest, when working in a conflict or crisis zone because the execution of future rounds of research cannot always be relied upon. We also think that capturing reflections can help address the possibility that participating in the PSS program may alter the framework form which respondents answer questions in a baseline and endline situation. For example, the PSS program might help the children feel more comfortable talking about challenges they face, such as anxiety and fears, which prior to the program they were ashamed or unwilling to speak about. In such a circumstance, the measurement tools might show a decrease in wellbeing that might not be reflected by the child's lived experience.

Recommendations for PSS Programming Moving Forward

The findings from this study indicate that PSS programs operating in displaced persons' camps in northeast Syria should prioritize addressing children's hope for the future, followed by anxiety and then self-esteem.

Injaz and other PSS programs should integrate knowledge about the items that are of higher and medium concern into their planning (Figure 37 and Figure 38), determining which items they want to prioritize and adapting the curriculum moving forward to address them more directly or in new ways. In particular, we recommend emphasizing problem solving skills. The program should also take into consideration that most of the children were described as being shy.

Determining if PSS programming should feature certain aspects of a curriculum that are tailored to children of one gender or another is also something to be considered. For example, perhaps female children should be provided additional support for anxiety, where male children were reported to be doing better. Additional research could be done to try to understand why there are differences in anxiety levels by gender to determine if there is a need to create bespoke modules within the overall curriculum or not.

We also believe that research on children's understanding and sense of self-respect could be useful to determine the role that the concept of self-respect should play in future programming.

This evaluation suggests that children in informal camps should remain a focus of the Injaz PSS program. They regularly had lower scores than children in the formal camps, almost across the board, and their reflections indicate that children and their caregivers are seeing positive changes in the children's behavior and attitudes.

Final Thoughts

Every step towards greater self-esteem, lower anxiety, and more hope for the future for children living in northeast Syria should be celebrated as a success. Each of these plays a role in their overall psychosocial wellbeing. These children and their families have faced grave violence, danger, and insecurity, and many of them continue to do so daily. The findings from this evaluation provide supportive evidence to the anecdotal data from Injaz's

CBO partners in northeast Syria, Injaz staff, child caregivers, and other stakeholders that reported that children are benefiting from the PSS program, that their psychosocial wellbeing is improving.

This evaluation and its component parts are intended to provide Injaz and other PSS providers with insights into the psychosocial needs of the children in northeast Syria. It also provides evidence of differences between research groups, some of which are statistically significant, and indicates that children with the PSS programming are generally doing better than those who have not had it. While the research approach necessitated by the situation on the ground means that we cannot make statements about causality, we are optimistic that the PSS program has played a role in bringing this about and are encouraged by the findings from this evaluation.

The research also helps Injaz identify areas of concern that could be addressed in future iterations of the PSS program moving forward. This, in turn, will help Injaz provide psychosocial support to children in northeast Syria that improves their resilience, and that leads to happier and healthier lives, contributing positively to their communities and to the world at large. We believe that all children deserve this kind of support, especially those living in unstable environments of conflict or crisis such as northeast Syria.

We look forward to conducting a second round of data collection in the formal schools (control and intervention) and with the formal camp comparison group should circumstances allow. We hope that those findings will help us confirm the findings from this initial round of research and will further expand our knowledge of how the Injaz PSS program is influencing children's psychosocial wellbeing in northeast Syria.

Appendix

Child Survey A consists of only the first 3 columns of the questionnaire below, while Child Survey B includes all 4 columns shown below.

Child Survey

Hello. My name is _____ and I am helping with a learning exercise on how children are doing in Syria psychologically and socially. This learning exercise will be used to help determine if specific psychosocial support programs are providing the correct kind of support. We will ask you a set of questions now and then come back to speak with you again in three months to see how things might have changed for you. The information you provide us will be analyzed with information from hundreds of other children and their caregivers. The data will be used to make any needed improvements to our psychosocial programming to ensure that we provide the best possible support to children. Your responses will be confidential, meaning that your name will not be used or shared with anyone beyond myself and the data analysis team.

Participation in our learning exercise is entirely your choice; even if you decide to participate, you can change your mind at any point and ask me to stop. There are no negative repercussions to stopping at any point. That being said, we would be grateful for your participation, as it will help us better understand how children are coping in this camp/school, and how we can provide better support. The questionnaire will take about 30-45 minutes. Are you willing to participate? If yes, please provide your signature below, indicating that you are providing your consent to participate in this learning exercise.

Child's Signature: _____

Administration			
No	Question	Answer	
1.	Enumerator Name		
2.	Date of Interview (day.month.year)		
3.	Start time of interview (24-hour clock)		
4.	Camp name (circle one)		
Child Demographic and Tracking			
5.	CBO child code (from sample list provided by CBO)		
6.	Gender of the child (circle one: please do not ask, just make a note of the gender)	a. Male b. Female	
Please start asking questions aloud starting here.			
7.	What is your name?		
8.	How old are you?	_____ years old	
9.	What is the name of your main caregiver?		
10.	Where are you originally from?	a. Governorate: _____ b. District: _____ c. Name of town, city, or camp (circle which it is): _____ a. Is that urban, rural, or do not know (circle one)	
11.	How long have you been displaced? (they can answer either in months or years, please note that if both months and years are provided, they will be added together)	_____ months _____ years	
12.	How long have you lived at this camp? (they can answer either in months or years, please note that if both months and years are provided, they will be added together)	_____ months _____ years	
13.	Who do you currently live with? (circle all that apply)	a. Parents: please specify the number: _____ b. Other family aunt/uncle, grandparents, cousins, etc.) d. Other, not family: Please specify relationship: _____	

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14.	What is the highest education level started of your: <i>If the child does not know, enter DNK for "do not know"</i>	a. Mother: _____ b. Father: _____ c. Other caregiver (<i>if they do not live with a parent</i>): specify relationship _____ and provide education level _____	
15.	How many months have you participated in the psychosocial programming of _____ (<i>insert name of active CBO in this camp</i>)?	_____ months	
16.	Have you participated in psychosocial activities besides those of _____ (<i>insert name of active CBO in this camp</i>)?	a. Yes b. No c. Do not know	
Exposure			
	Question	Answer	
17.	When schools in your area closed, did you have the chance to continue your education or to receive education? <i>school, training facility, mosque, center, etc. (circle one)</i> <i>If no, skip to Question 21.</i>	a. Yes b. No c. Do not know	
18.	What kind of education was it? <i>(circle all that are applicable)</i>	a. Home school b. Other type of school c. Religious training d. Other training facility: Specify _____ e. Other: Specify _____	
19.	Where was the facility held? <i>(circle all that are applicable)</i>	a. At someone's home b. At a mosque c. At a center d. Other: specify _____	
20.	Who or what managed the facility? <i>If they provide just a name, ask them to describe what role that person played in their life or society.</i>	Name: _____ Role or Title: _____	
21.	When schools in your area closed, did any of your siblings have the chance to continue their education or to receive education? <i>school, training facility, mosque, center, etc. (circle one)</i> <i>If no, skip to the next section and to Question 25.</i>	a. Yes b. No c. Do not know	
22.	What kind of education was it? <i>(circle all that are applicable)</i>	a. Home school b. Other type of school c. Religious training facility d. Other training facility: Specify _____ e. Other: Specify _____	
23.	Where was the facility held? <i>(circle all that are applicable)</i>	a. At someone's home b. At a mosque c. At a center d. Other: specify _____	
24.	Who or what ran the facility? <i>If they provide just a name, ask them to describe what role that person played in their life or society.</i>	Name: _____ Role or Title: _____	
Self-Esteem			
	<i>Directions: Please circle one answer for each question. If they do not have an answer right away or are looking for further explanation, say: "for</i>		These questions should be asked ONLY of those children who have

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	<i>example: _____</i> " and then read the words in italics. <i>To Read Aloud:</i> For the next 10 questions, I am going to make statements and I want you to think about how you feel about them and then tell me if you Strongly agree, Agree, Disagree, or Strongly disagree with each statement.		participated in Injaz PSS. How has this changed since you started the psychosocial program with (insert name of CBO)?
25.	On the whole, I am satisfied with myself. <i>(I feel I am a good person)</i>	3 Strongly agree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
26.	At times, I think I am no good at all. <i>(I fail at everything)</i>	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
27.	I feel that I have a number of good qualities.	3 Strongly disagree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
28.	I am able to do things as well as most other people.	3 Strongly disagree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
29.	I feel I do not have much to be proud of.	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
30.	I certainly feel useless at times. <i>(nobody needs me)</i>	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
31.	I feel that I'm a person of worth, at least on an equal plane with others. <i>(I am as good as others)</i>	3 Strongly disagree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
32.	I wish I could have more respect for myself.	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
33.	All in all, I am inclined to feel that I am a failure.	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
34.	I take a positive attitude toward myself. <i>(I believe in myself)</i>	3 Strongly disagree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. I don't know
Questions about fears			
	<i>Directions: Please circle just one answer for each question.</i> <i>To Read Aloud:</i> Now I am going to ask you five questions about feeling scared or anxious. For each statement, I want you to tell me if the statement is Not true or hardly ever true, Somewhat true, or sometimes true, or Very true or often true.		How has this changed since you started the psychosocial program with (insert name of CBO)?
35.	I get really frightened for no reason at all.	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. I don't know
36.	I am afraid to be alone in the home/tent.	0 Not true or hardly ever true	i. Increased

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		1 Somewhat true or sometimes true 2 Very true or often true	ii. Unchanged iii. Decreased iv. I don't know
37.	People tell me that I worry too much.	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. I don't know
38.	I am scared to go to the: <i>Please read the appropriate option below, depending on where the type of interview you are conducting</i> a. <i>Formal camp:</i> child learning center b. <i>Informal camp:</i> the education tent c. <i>Formal school:</i> school	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. I don't know
39.	I am shy.	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. I don't know
Questions about Children's Goals			
	<i>Directions: Please circle just one answer for each question.</i> <i>To Read Aloud:</i> Now I am going to ask you a few questions about your future goals by reading you some statements. Please let me know if you feel this way None of the time, A little of the time, Some of the time, A lot of the time, or Most all of the time.		How has this changed since you started the psychosocial program with (insert name of CBO)?
40.	I think I am doing pretty well.	1 None of the time 2 A little of the time (<i>once in a while</i>) 3 Some of the time (<i>here and there</i>) 4 A lot of the time (<i>often</i>) 5 Most all of the time (<i>regularly</i>) 6 All of the time Do not know	i. Increased ii. Unchanged iii. Decreased i. I don't know
41.	I can think of many ways to get the things in life that are most important to me.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time Do not know	i. Increased ii. Unchanged iii. Decreased ii. I don't know
42.	I am doing just as well as other kids my age.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time Do not know	i. Increased ii. Unchanged iii. Decreased i. I don't know
43.	When I have a problem, I can come up with lots of ways to solve it.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time Do not know	i. Increased ii. Unchanged iii. Decreased i. I don't know
44.	I think the things I have done in the past will help me in the future.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time Do not know	i. Increased ii. Unchanged iii. Decreased i. I don't know

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45.	Even when others want to quit, I know that I can find ways to solve the problem.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time 7 Do not know	i. Increased ii. Unchanged iii. Decreased iv. I don't know
Wrapping Up			
46.	What are your personal dreams/aspirations for the future?		
47.	Thank you very much for taking the time to answer my questions. Do you have any final questions for me? <i>Please note any questions they have.</i>		
End time of interview (24-hour clock)			
Enumerator's signature			

Caregivers Survey A consists of only the first 3 columns of the questionnaire below, while Caregivers Survey B includes all 4 columns shown below.

Caregivers Survey

Hello. My name is _____ and I am helping with a learning exercise on how children are doing in Syria psychologically and socially. This learning exercise will be used to help determine if specific psychosocial support programs are providing the correct kind of support. We will ask you and your child separately a set of questions now and then come back to speak with you both again in three months to see how things might have changed. The information you and your child provide us will be analyzed with information from hundreds of other children and their caregivers. The data will be used to make any needed improvements to our psychosocial programming to ensure that we provide the best possible support to children. Your responses will be confidential, meaning that your name will not be used or shared with anyone beyond myself and the data analysis team.

Your and your child's participation in our learning exercise is entirely your choice; even if you decide to participate, you and your child can change your mind at any point and ask me to stop. There are no negative repercussions to stopping at any point. That being said, we would be grateful for your participation, as it will help us better understand how children are coping in this camp/school, and how we can provide better support. The questionnaire will take about 30-45 minutes. Please provide your signature below, indicating that you are providing your consent for you and your child to participate in this learning exercise.

Caregiver's Signature: _____

Administration			
No	Question	Answer	
1.	Enumerator Name		
2.	Date of Interview (day.month.year)		
3.	Start time of interview (24-hour clock)		
4.	Camp and school name (circle one)		
Child Demographic and Tracking			
5.	CBO child code (from sample list provided by CBO) Provide sample for them		
6.	What is the gender of the caregiver? (circle one: please do not ask, just make a note of the gender)	a. Male b. Female	
7.	What is your name?		
8.	What is your relationship to the child? (circle one)	a. Mother b. Father c. Aunt or Uncle d. Sibling e. Other: Specify _____	
9.	What is the name of the child?		
10.	What is the gender of the child? (circle one)	a. Male b. Female	
11.	How old is the child?	_____ years old	
12.	Where is your child originally from?	a. Governorate: _____ b. District: _____ c. Name of town, city, or camp (circle one): _____ d. Is that urban, rural, or do not know (circle one)	
13.	How long has your child been displaced? (they can answer either in months or years, please note that if both months and years are provided, they will be added together)	_____ months _____ years	
14.	How long has your child lived at this camp? (they can answer either in months or years, please note that if both months and years are provided, they will be added together)	_____ months _____ years	

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15.	Who does your child currently live with? <i>(circle all that apply)</i>	a. Parents: please specify the number: _____ b. Other family (<i>aunt/uncle, grandparents, cousins, etc.</i>) e. Other, not family: Please specify relationship: _____	
16.	What is the highest education level started of the: <i>If the caregiver does not know, enter DNK for "do not know"</i>	a. Mother of the child: _____ b. Father of the child: _____ c. Other caregiver (if they do not live with a parent): specify relationship _____ and provide education level _____	
17.	How many months has the child participated in the psychosocial programming of _____ <i>(insert name of active CBO in this camp)?</i>	_____ months	
18.	Has your child participated in psychosocial activities besides those of _____ <i>(insert name of active CBO in this camp)? (circle one)</i>	a. Yes b. No c. Do not know	
Exposure			
	Question	Answer	
19.	When schools in your area closed, did your child have the chance to continue their education or to receive education? <i>school, training facility, mosque, center, etc. (circle one)</i> <i>If no, skip to Question 23.</i>	a. Yes b. No c. Do not know	
20.	What kind of education was it? <i>(circle all that are applicable)</i>	a. Home school b. Other type of school c. Religious training d. Other training facility: Specify _____ e. Other: Specify _____	
21.	Where was the facility held? <i>(circle all that are applicable)</i>	a. At someone's home b. At a mosque c. At a center d. Other: specify _____	
22.	Who or what managed the facility? <i>If they provide just a name, ask them to describe what role that person played in their life or society.</i>	a. Name: _____ b. Role or Title: _____	
23.	When schools in your area closed, did any of the siblings of the child have the chance to continue their education or to receive education? <i>school, training facility, mosque, center, etc. (circle one)</i> <i>If no, skip to the next section and to Question 27.</i>	a. Yes b. No c. Do not know	
24.	What kind of education was it? <i>(circle all that are applicable)</i>	a. Home school b. Other type of school c. Religious training facility d. Other training facility: Specify _____ e. Other: Specify _____	
25.	Where was the facility held? <i>(circle all that are applicable)</i>	a. At someone's home b. At a mosque c. At a center d. Other: specify _____	

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26.	Who or what ran the facility? <i>If they provide just a name, ask them to describe what role that person played in their life or society.</i>	a. Name: _____ b. Role or Title: _____	
	Self-Esteem: From the Rosenberg Self-Esteem Scale (Rosenberg, 1965). The higher the score, the better.		
	<i>Directions: Please circle one answer for each question. If they do not have an answer right away or are looking for further explanation, say: "for example: _____" and then read the words in italics. To Read Aloud: For the next 10 questions, I am going to make statements and I want you to think about the child and then tell me if you Strongly agree, Agree, Disagree, or Strongly disagree with each statement.</i>		These questions should be asked ONLY of caregivers whose children who have participated in Injaz PSS. How has this changed since the child started the psychosocial program with (insert name of CBO)?
27.	On the whole, the child is satisfied with them self. <i>(they feel they are a good person)</i>	3 Strongly agree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
28.	At times, the child thinks they are no good at all. <i>(they feel they fail at everything)</i>	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
29.	The child feels that they have a number of good qualities.	3 Strongly agree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
30.	The child believes they are able to do things as well as most other people.	3 Strongly agree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
31.	The child feels they do not have much to be proud of.	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
32.	The child certainly feels useless at times. <i>(they feel that nobody needs them)</i>	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
33.	The child feels that they are a person of worth, at least on an equal plane with others. <i>(they believe that they are as good as others)</i>	3 Strongly agree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
34.	The child wishes they could have more respect for them self.	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
35.	All in all, the child is inclined to feel that they are a failure.	0 Strongly agree 1 Agree 2 Disagree 3 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
36.	The child takes a positive attitude toward them self. <i>(they believe in them self)</i>	3 Strongly agree 2 Agree 1 Disagree 0 Strongly disagree	i. Increased ii. Unchanged iii. Decreased iv. Do not know
	Fears: Comes from SCARED-5. The lower the score, the better.		
	<i>Directions: Please circle one answer for each question.</i>		How has this changed since the

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	<i>To Read Aloud:</i> Now I am going to ask you five questions about the child feeling scared or anxious. For each statement, I want you to tell me if the statement is Not true or hardly ever true, Somewhat true, or sometimes true, or Very true or often true for the child.		child started the psychosocial program with (insert name of CBO)?
37.	The child gets frightened for no reason at all.	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. Do not know
38.	The child is afraid to be alone in the home/tent.	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. Do not know
39.	The child worries too much.	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. Do not know
40.	The child is scared to go to: <i>Please choose one of the following based on the type of interview you are conducting.</i> d. <i>Formal camp:</i> child learning center e. <i>Informal camp:</i> the education tent f. <i>Formal school:</i> school	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. Do not know
41.	The child is shy.	0 Not true or hardly ever true 1 Somewhat true or sometimes true 2 Very true or often true	i. Increased ii. Unchanged iii. Decreased iv. Do not know
Questions about Children's Goals: Comes from the Strengths and Difficulties Questionnaire. The lower the score the better.			
	<i>Directions: Please circle just one answer for each question.</i> <i>To Read Aloud:</i> Now I am going to ask you a few questions about the child's future goals by reading you some statements. Please let me know if you feel the statement applies None of the time, A little of the time, Some of the time, A lot of the time, or Most all of the time.		How has this changed since the child started the psychosocial program with (insert name of CBO)?
42.	The child thinks they are doing pretty well.	1 None of the time 2 A little of the time (<i>once in a while</i>) 3 Some of the time (<i>here and there</i>) 4 A lot of the time (<i>often</i>) 5 Most all of the time (<i>regularly</i>) 6 All of the time	i. Increased ii. Unchanged iii. Decreased iv. Do not know
43.	The child can think of many ways to get the things in life that are most important to them.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time	i. Increased ii. Unchanged iii. Decreased iv. Do not know
44.	The child believes they are doing just as well as other kids their age.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time	i. Increased ii. Unchanged iii. Decreased iv. Do not know
45.	When the child has a problem, they can come up with lots of ways to solve it.	1 None of the time 2 A little of the time 3 Some of the time	i. Increased ii. Unchanged iii. Decreased

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		4 A lot of the time 5 Most of the time 6 All of the time	iv. Do not know
46.	The child thinks the things they have done in the past will help them in the future.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time	i. Increased ii. Unchanged iii. Decreased iv. Do not know
47.	Even when others want to quit, the child knows that they can find ways to solve the problem.	1 None of the time 2 A little of the time 3 Some of the time 4 A lot of the time 5 Most all of the time 6 All of the time	i. Increased ii. Unchanged iii. Decreased iv. Do not know
Wrapping Up			
	Question	Answer	
48.	What are your personal dreams/aspirations for the child's future?		
49.	Thank you very much for taking the time to answer my questions. Do you have any final questions for me? <i>Please note any questions they have.</i>		
	End time of interview (24-hour clock)		
	Enumerator's signature		