# **Child protection risks across jF-cpie project locations**

# the baseline/ needs assessment report for The Joining Forces for Child Protection in Emergencies (jf-cpie) project

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### Acronyms/Glossary

**BNA** – Baseline/ needs assessment

**CP** – Child protection

**CPR** – Child protection risks

**CVA** – Cash and voucher assistance

**FGD** – Focus group discussion

**GFFO** – German Federal Foreign Office

**IDP** – Internally displaced persons

**IMT** – Interim MERL team (consultants)

**IP** – Implementing Partners

**JF-CPiE** – The Joining Forces for Child Protection in Emergencies

**KII** – Key Informant Interviews

**MERL** – Monitoring, evaluation, research, and learning

**NA** – Needs Assessment

**se** – Standard errors

### Executive Summary

The Joining Forces for Child Protection in Emergencies (JF-CPiE) project is a multi-country project bringing together the six largest child rights organisations in Germany to improve the protection of vulnerable children and adolescents living in refugee and internally displaced person (IDPs) settings and host communities across different locations within Bangladesh, Burkina Faso, Central African Republic, Colombia, Ethiopia, and South Sudan (i.e., 12 project locations in total). To support the project implementation, a baseline and needs assessment was carried out by independent consultants operating at the within-country and global level between November 2022 and January 2023.

The baseline study provided quantitative insights especially into knowledge and awareness levels around child projection risks and behaviours within target communities. That way, it provided initial values for JF-CPiE’s three outcome indicators, as specified in the project logframe. The sample-based baseline consisted of both the household survey as well as the unit survey. The former targeted household heads, caregivers, and young people. The latter targeted additional community members. In total, 16901 individuals were surveyed across all project locations.

Outcome indicators gauged self-reported awareness and protection behaviours with regards to child-protection risks amongst young people (indicator 1), caregivers (indicator 2), and community members (indicator 3). The baseline found stark differences within levels not only between indicators but also between implementing partners within each indicator. By and large, baseline levels around awareness and protection behaviours vis-a-vis child-protection risks appear to be rather low, something particularly true in the case of indicator 1. This in turn highlights the need for interventions to further strengthen awareness and protection and response behaviours to address child protection risks within emergency settings across the different project locations.

The needs assessments helped to further validate trends within child protection risks that were identified within the situational analysis and desk review that both guided the overall project design. It employed qualitative, child-friendly tools in the form of 146 focus groups and 93 key informant interviews with local child-protection experts across all 12 project locations. According to the needs assessment, the presence of comprehensive economic conditions such as poverty, state-programme weakness, lack of infrastructure, or armed conflict have been found to increase child protection risks. Common manifestations of child-protection risks are often in form of gender-based discrimination and violence, psychological and physical abuse of children, and negligence (of the needs of children with disabilities). However, results also show that despite some commonalities child protection risks are rooted in the specific social and historical contexts and backgrounds of each project location. Approaches to address child protection risks thus need to be adjusted to local contexts to ensure proper targeting of communities within ongoing emergencies.

In general, the baseline and needs assessment highlight the need of community-based networks and the strengthening of existing local relations between project partners and beneficiary communities to ensure effective implementation of child-protection interventions. Also, ongoing project monitoring should be seen as an opportunity to further validate baseline/ needs assessment data on local manifestations of child protection risks within local communities.

## Introduction and background

The Joining Forces for Child Protection in Emergencies (JF-CPiE) project is a multi-country project funded by the German Federal Foreign Office (GFFO) and led by Plan International Germany. The project brought together the six largest child rights organisations in Germany, also known as the Joining Forces Alliance (i.e., ChildFund, Terre des Hommes, SOS Children’s Villages, Save the Children, World Vision & Plan International), to improve the protection of vulnerable children and adolescents living in refugee and internally displaced person (IDPs) settings and host communities across different locations within Bangladesh, Burkina Faso, Central African Republic, Colombia, Ethiopia, and South Sudan. The target groups included children and adolescents with disabilities, girls and boys under 18 years of age, and survivors of gender-based violence. The project kicked off in July 2022 and has a total duration of 24 months.

The project evaluation design is centred around a pre/post comparison in which project attainment will be measured at midline as well as endline and then compared with the baseline values for a set of the following three outcome indicators:

1. % of children who report increased knowledge of child protection risks and how to stay safe due to participation at endline
2. % of caregivers who report increased knowledge of caring and protection behaviours towards children under their care compared to the beginning of the project
3. % of community members who report increased confidence in their ability to prevent and respond to child protection risks compared to the beginning of the project

To obtain initial values on these three outcome indicators, a baseline study was carried out across the project locations within the six countries between November 2022 and January 2023. The baseline study provided quantitative insights especially into knowledge and awareness levels around child projection risks and behaviours within target communities. In addition to the cross-country baseline study, country/implementing partner-specific qualitative needs assessments were concurrently carried out across the different project locations. The needs assessments were carried out with a focus on emerging child protection risks and to clarify initial data gathered from the original situational analysis and desk review. Both baseline and needs assessments were implemented by local consultants within each project countries and designed and coordinated by a team of 4 consultants hired at the global level (i.e., the interim MERL team - IMT).

This report provides a synthesis of both the baseline and needs-assessment findings. It is structured as follows. First, the methodology and the ethical standards that governed the baseline study and the needs assessment are outlined. A key aspect discussed in this respect is the operationalization of the above mentioned three outcome indicators. Second, the quantitative (baseline) and qualitative (needs assessment) results are presented. This section id divided into two parts. It starts with a discussion of the baseline values on each of the three outcome indicators. The data is not only broken down by country and implementing partners but also by gender and disability status where possible. Within the second part of the findings section, country specific child-protection risks profiles are generated based on both quantitative and qualitative data. These profiles consist of the most common child-protection risks that may have a direct bearing on the lives of young people within the target communities. Especially the child protection-risk profiles informed programme recommendations that were formulated based the qualitative and quantitative data. These recommendations are presented within the third section of the report. In the last section, a conclusion is drawn summarizing the main points of the report.

## The Methodology of baseline and needs assessment

The implementation of both baseline and needs assessment was implemented in country through local consultants but coordinated at the global level by the IMT. To coordinate and harmonize the implementation of both baseline and needs assessment in country, the IMT developed methodological guidelines and standards for both exercises. Jointly these guidelines and standards constitute the baseline/needs assessment (BNA) protocol implementing partners, and their local consultants, adhered to when completing both exercises. All in-country teams were oriented on the tools, safeguarding and the same standard of ethical practice for data collection. The BNA protocol presents a detailed account of the methodologies followed within baseline and needs assessment. Thus, the overall BNA methodology will only be briefly summarized here.[[1]](#footnote-1) Given their different focusses, the methodologies of the baseline study (e.g., quantitative and inferential in nature) and the needs assessment (e.g., qualitative and exploratory in nature) are hardly overlapping. Thus, the key methodological principles of each study are outlined below separately. First, the methodology of the baseline study is briefly described. Then, key methodological principles of the needs assessment are explained. Overall, the methodology employed in this baseline study and needs assessment was designed to ensure that the study is conducted in an ethical and child-sensitive manner, while also providing a thorough and comprehensive understanding of the needs of the target population.

### The baseline study

The baseline study centred around collecting data on the aforementioned three project outcome indicators. Table 1 below summarizes key aspects of each of the three indicators the design of the baseline methodology took into account. Amongst others, it highlights that outcome indicators refer to the target groups of young people (indicator 1), their caregivers (indicator 2), and members of the communities these young people and their caregivers live in (indicator 3). The baseline design thus included a survey of both households (i.e., the household survey) as well as communities (i.e., the unit survey). The household survey helped to collect data on households, their heads, caregivers within households, and eventually young people living within these households. Given the setup of the project, households to be surveyed were either host-community households, internally displaced households, or refugee households. The former two were expected to be located in villages (in rural areas) or in urban neighbourhoods. The latter one were expected to be found in refugee camps (see table 3 on page 6 for a breakdown of the sample composition for each implementing partner).

The unit survey targeted facilities such as health care centres, schools, local authorities within those areas target households live. Each survey targeted around 3 individual respondents. In case of the household survey, it was the household head, a caregiver, and a young person. In cases where more than one young person or caregiver lived within a household, one member form each subgroup was randomly selected for interview. In case of the unit survey, respondents included three different staff members of the facility visited. The ones interviewed were randomly selected out of the pool working there. Data provided by young people and caregivers were used to determine baseline values on indicator 1 and 2. In case of indicator 3, data provided by household heads as well as data given by unit members were merged.

Table 1: key characteristics of the outcome indicators

|  |  |  |  |
| --- | --- | --- | --- |
| **No** | **Outcome indicator** | **Target group** | **Level** |
| 1 | % of children who report increased knowledge of child protection risks and how to stay safe due to participation at endline. | Young people aged 7 to 17 | Household level |
|
| 2 | % of caregivers who report increased knowledge of caring and protection behaviours towards children under their care compared to the beginning of the project. | Adults who take care of children 0 to 17. | Household level |
| 3 | % of community members who report increased confidence in their ability to prevent and respond to child protection risks compared to the beginning of the project. | Households heads, teachers, health-care workers, local authorities | Unit (i.e., village, neighbourhood/ quarter, camp) |
|

Given the project focus, both the baseline study and the needs assessment were implemented within emergency settings. Thus, baseline data collection targeted individuals within the categories of refugees, internally displaced people, and their host communities. Sampling for both household and unit survey was complex. The technical details for both sampling approach and sample size are provided within the BNA protocol. In short, the selection approach incorporated a cluster sampling approach with random-walk elements to find households.

Table : # of individuals surveyed by implementing partner/ country

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Country** | **Bangladesh** | | **Burkina Faso** | | **Central Afr. Republic** | | **Colombia** | | **Ethiopia** | | **South Sudan** | |
| **Implementing partner** | **Plan International** | **World Vision** | **Child Fund** | **Terres des Hommes** | **Plan International** | **SOS** | **SOS** | **Terres des Hommes** | **Child Fund** | **Save the Children** | **Save the Children** | **World Vision** |
| Households | 398 | 457 | 795 | 287 | 719 | 406 | 386 | 160 | 396 | 768 | 766 | 425 |
| Young people  (all) | 393 | 447 | 606 | 268 | 593 | 346 | 365 | 112 | 274 | 745 | 335 | 274 |
| Young people (female) | 201 | 233 | 282 | 149 | 241 | 171 | 186 | 61 | 126 | 332 | 160 | 139 |
| Young people  (male) | 192 | 214 | 324 | 119 | 352 | 175 | 179 | 51 | 148 | 413 | 175 | 135 |
| Caregivers  (all) | 398 | 456 | 776 | 286 | 713 | 403 | 385 | 152 | 367 | 768 | 579 | 411 |
| Caregivers  (female) | 225 | 239 | 443 | 181 | 349 | 266 | 276 | 103 | 129 | 424 | 371 | 238 |
| Caregivers  (male) | 192 | 214 | 324 | 119 | 352 | 175 | 179 | 51 | 148 | 413 | 175 | 135 |
| Community members (all) | 431 | 598 | 831 | 298 | 755 | 442 | 390 | 161 | 416 | 850 | 749 | 528 |
| Community members (female) | 76 | 70 | 148 | 57 | 116 | 121 | 306 | 105 | 87 | 198 | 382 | 170 |
| Community members (male) | 343 | 515 | 659 | 235 | 544 | 284 | 62 | 34 | 283 | 634 | 115 | 264 |
| Total respondents (all) | 1222 | 1501 | 2213 | 852 | 2061 | 1191 | 1140 | 425 | 1057 | 2363 | 1663 | 1213 |
| Total respondents (female) | 502 | 542 | 873 | 387 | 706 | 558 | 768 | 269 | 342 | 954 | 913 | 547 |
| Total respondents (male) | 727 | 943 | 1307 | 473 | 1248 | 634 | 420 | 136 | 579 | 1460 | 465 | 534 |

***Note****: ‘(all)’ may not always be the sum of ‘male’ and ‘female’. In cases where the gender of a number of respondents has not been determined, the sum of each subset is smaller than the number within ‘(all)’. ‘Community members’ refer to teachers, health care workers, and household heads interviewed. They do not include caregivers and young people.*

As for the household survey, the sample size chosen was a function of both methodological and budgetary concerns. Sample-size calculations thus provided a “small solution” and a “big solution”. The former implied 385 households to be surveyed across all types of households (i.e., host-community household, internally displaced households, and refugee households). The latter implied ideally the sampling of 385 households within each of the household types covered by an implementing partner (see table 3 for what household type is served by what implementing partner). Since implementing partners varied in terms of the budgetary resources, they also varied in terms of the actual sample size implemented. As for the unit survey, the agreement was to cover all facilities (e.g., health care centres, schools) within the areas of the households targeted. Again, project locations seem to vary in terms of the density of public facilities that existed. Table 2 on page 4 provides a breakdown of the sample sizes attained. Across all locations 16901 individuals were interviewed. Numbers were particularly high in Ethiopia with 3420 respondents and lower in Colombia with a total number of 1565 respondents.

Table : # of units surveyed by implementing partner/ country (unit survey only)

|  |  |  |
| --- | --- | --- |
| **Country** | **Implementing partner** | **# units surveyed** |
| Bangladesh | Plan International | 30 |
| World Vision | 72 |
| Burkina Faso | ChildFund | 19 |
| Terres des Hommes | 10 |
| Central African Republic | Plan International | 17 |
| SOS children's villages | 14 |
| Colombia | SOS children's villages | 4 |
| Terres des Hommes | 6 |
| Ethiopia | ChildFund | 9 |
| Save the Children | 51 |
| South Sudan | Save the Children | 16 |
| World Vision | 40 |
| **Total** | | **288** |

Variation was also stark in case of community-level units surveyed. As table 3 highlights, 288 individual units were surveyed across all project locations. In Bangladesh, the number was 102 in total whereas in Colombia it was only about 11 in total. Additional information on country contexts is also provided within section on risk profiles below. Table 4 provides a breakdown of the type of household surveyed. Globally, host-community households constituted the most common type of household surveyed (52.36 percent). Globally, refugees constituted the smallest type of household surveyed with just under 10 percent. This, however, may have been due to the fact that only refugee households constitute target groups in only 2 of the 6 countries (Bangladesh and Colombia).[[2]](#footnote-2) Colombia is the only country that targets all three types of beneficiary groups.

Table : Sample proportion within each type of household

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country** | **Partner** | **% of households within host communities** | **% of internally displaced households** | **% of refugee households** |
| Bangladesh | Plan International | 74.87 |  | 25.13 |
| World Vision | 24.51 |  | 75.49 |
| Burkina Faso | ChildFund | 51.57 | 48.43 |  |
| Terres des Hommes | 51.22 | 48.78 |  |
| Central African Republic | Plan International | 47.01 | 52.99 |  |
| SOS | 50.25 | 49.75 |  |
| Colombia | SOS | 50.25 | 49.75 |  |
| Terres des Hommes | 28.76 | 33.16 | 38.08 |
| Ethiopia | ChildFund | 50 | 50 |  |
| Save the Children | 49.74 | 50.26 |  |
| South Sudan | Save the Children | 69.45 | 30.55 |  |
| World Vision | 72.24 | 27.76 |  |
| Global average | | 52.36 | 37.72 | 9.93 |

Baseline data collection was implemented using Kobo toolbox. For that purpose, a household and unit survey tool were developed at the global level by the IMT. The corresponding Kobo forms were then shared with the local consultants implementing the baseline surveys at each location. At the very core of each survey tool was a set of questions to measure the aforementioned outcome indicators. For young people (indicator 1), caregivers (indicator 2), and community members (indicator 3), each set of question to operationalize outcomes always covered two aspects pertaining to awareness around child protection. In case of indicator 1, questions thus measured young people’s knowledge of child protection risks (i.e., awareness component) and how to stay safe (i.e., the behavioural component). In case of indicator 2, questions measured caregivers knowledge of child-protection and parental caring practices. The former is thus about awareness around child protection risks whereas the latter is about parenting. In case of indicator 3, questions measured community members knowledge around preventing and responding to child protection risks. Both implies not only a behavioural component (i.e., preventing and responding) but also a awareness component (i.e., the identification of child protection risks). Thus, the need to gauge awareness levels around child protection risks applied to all three outcome indicators.

Gauging levels of awareness of child protection risks is methodologically challenging. It requires a comprehensive list of child protection risks being administered to respondents (see question CHKR1, CGKP1, and HHCR1 within the adolescent, caregiver, and household-head section of the household survey as well as question CMCR1 within the unit survey) and then to determine to what extent the responses by interviewees is in line with the actual child-protection risks that prevail within a location. The questions were constructed based on a review of the grey literature around child protection within emergency settings. To determine the extent to which respondents are aware of child-protection risks in turn requires “knowing” what child-protection risks are of relevance at each project location. It was not possible to determine these benchmarks through a review of the corresponding child-protection literature. To determine a set of “objective” sets of child protection risks that can be used as benchmarks to analyse the survey questions on child-protection risks (i.e., questions CHKR1, CGKP1, HHCR1, and CMCR1), project staff within implementing partners ranked the different protection risks listed in each of those questions based on their local relevance. This was guided by the assumption that project staff (e.g., child-protection and gender focal points etc.) must have gained familiarity with the ground-level realities at each of the project locations their organizations work in the context of JF-CPiE. Thus, they must be amongst the most knowledgeable stakeholders when it comes to child-protection risks target communities face. The top-5 protection risks where then used to construct a benchmark to be employed during the analysis of the survey questions on child-protection risks. Within the finding sections these risks are discussed. All quantitative analysis of the baseline data was performed using the statistical programming application R supported by the R Core Team. All graphs were produced using ggplot2, a data-visualization package developed for R.

### The needs assessment

Despite being qualitative and exploratory in nature, the methodology for the needs assessment involved using standardised data collection tools and targeted registry spaces to collect information about child protection (CP) needs and risks faced by girls, boys, adolescent girls, and adolescent boys in the 6 JF countries. The standardization of qualitative tools ensured that local consultants followed the same data-collection approaches and thus emerging data was at least roughly comparable across project locations. At least twelve focus group discussions (FGD) were organised per country and were conducted to address questions related to key child protection needs and gaps. We also considered community-based child protection systems, gender-specific barriers, current knowledge and capacities of caregivers, capacities of stakeholders, specific child protection needs, solutions, humanitarian coordination mechanisms, and the use of cash and voucher assistance (CVA) for at-risk children. These methods were chosen to provide a comprehensive understanding of the needs of the target population and to obtain a range of perspectives. All the data collected was analysed using both qualitative and quantitative methods to provide a comprehensive and robust understanding of the needs of the target population and the condition of child protection risk across participating countries. Qualitative data were recorded, translated, and transcribed, and sent to the IMT for further data processing and analysis. The analysis at country level was led by national consultants, whilst global data review has been assessed in this report.

Sampling involved splitting the target group into three categories: children (5-9 years old), adolescents (10-17 years old), and adults (above 18 years old) of all genders. The FGDs were conducted in a child-friendly and inclusive manner, using creative, active, and participatory methods, while ensuring equal representation of children with disabilities. As part of the process, four ‘key informant interviews’ (KII) per country were also conducted to complement the FGDs. A standardised Child Protection KII tool will be implemented across the board and subject-specific Key Informants will be identified in each country. In total, 4 KII will be implemented by each implementing Partner (IP) according to the following criteria:

1. CP KII with an informant specialised in sexual and gender-based violence.
2. CP KII with an informant specialised in arm groups and arm conflict violence.
3. CP KII with teachers, guardians, and caregivers of children (including foster parents for unaccompanied children) or relevant local or community authorities (health workers, community, and religious leaders, etc.)
4. CP KII with project staff.

The sampling process was a combination of random and targeted selection. Network coordination with local authorities was essential to identify and include children with disabilities in the FGDs. The FGDs and KII were conducted in accessible locations, and the approach was based on positive communication and ability-focused adaptation to ensure the participation of all children and community members.

### Ethics process

In line with the IMT ethical approach, the baseline and needs assessment used several ethics research guarantees. Informed consent was obtained from all participants and confidentiality was maintained throughout the data collection, data sharing, and analysis processes. Additionally, all data collected was kept securely and used only for the purposes of this NA. Research teams followed global ethical guidelines produced standards but locally adapted their approach in each participating country to incorporate different ethical challenges.

The consent process for the JF-CPiE BNA research process was based on obtaining written informed consent following established procedures when working with children and adolescents, parents/guardians, and adults. For young people under 18 years old, a dual consent process was introduced where both parental/guardian consent and child assent were obtained before inclusion into the research. Children aged 18 and above did not require parental/guardian consent, but a dual consent process may have been considered appropriate in some contexts. Community entry points and strategies were used by in-country consultants to inform local communities about the upcoming data collection, and special attention was paid to clearly explaining and discussing the informed consent forms. These forms were previously translated to local languages following customary language use in all research locations. Participants were not tied to monetary rewards, but expenses incurred through research participation were covered by JF-CPiE and a token of appreciation, such as snacks or soft drinks, may have been provided for longer interviews.

The BNA process also incorporated a strong focus on child protection, with measures in place to ensure the safety and well-being of children and young people involved in the study. This included obtaining parental consent for children and implementing measures to protect their identities, as well as avoiding any harm to their physical, emotional, or psychological well-being. The participation of boys and girls with disabilities was required where possible, and their inclusion was encouraged through close collaboration with local or community authorities. Following existing agency networks and continuous consultation with local groups, schools, community networks as well as peers supported the identification of persons with disabilities to take part.

### Approval of the BNA process and tools

The needs assessment tools were shared with the Plan International technical team for ethical approval, which provided input, feedback, and guidance. The design of the tools was conducted in partnership with the IMT and the JF-CPiE technical team including Gender, child protection and Safeguarding focal points. Tools were also shared with IP teams for review and relevance check to ensure they meet local needs and standards. The tools were then compiled and streamlined to meet a generic need across all IP locations with adaptations where required. The Ethics review process of Plan international helped to ensure that tools were intentional about their targets, questions, and method, and participation groups, including the most marginalised (e.g., young people).

### Data quality control and assurance

Regular check in and support was provided by the management team and IMT. For example, the IMT developed a Power-Bi live-dashboard that visualized data-collection progress of the in-country baseline undertakings. The IMT also monitored the incoming quantitative and, where possible, qualitative data to ensure it met pre-defined quality standards. Upon completion of the different data-collection exercises, follow-up and eventually validation calls were organized to present the data, and their implications to the country teams. This in turn allowed discussing anomalies as well as gaps within the qualitative and quantitative data. During the data analysis of the needs assessment, for example, we identified specific instances in which we believe that data reporting was influenced by the consultant’s perceptions and other instances in which participants answers may have been influenced by the contextual situation. Follow-up calls then enabled us to address these biases jointly with the respective in-country teams. This helped to further improve the quality of the data. We are therefore confident that the findings presented below are thus as free of misconceptions as is possible within data-collection exercises that were not implemented by the IMT first hand.

### Limitations of the baseline and needs assessment

Despite all efforts to ensure high quality within the global coordination of the baseline and needs assessment, a number of limitations need to be acknowledged. First, child-protection risks are complex subject matters. Each type of child-protection risk is the product of various socio-economic, and cultural factors. Thus, no quantitative and qualitative study, designed and coordinated globally across 12 project locations suffices to fully explore the complexities around issues that threaten the wellbeing of children within emergency settings. Thus, we consider the baseline as well as the needs assessment as further contributions to better understand the ground-level realities around child protection within partner countries. However, they should not be understood as the final answers as to what determines challenges to the protection of children. This is particularly true given that child protection, and the risks thereof, are dynamic phenomena that themselves may be subject to change over time. As will be discussed below, the consortium of the JF-CPiE is urged to further explore child-protection risks within the target communities in the context of the project monitoring as well as during midline and endline. For example, as will be discussed below, perceptions around what are the most relevant child protection risks within communities partly differs between project staff, as expressed during the ranking exercises, as well as community members, indicated within baseline surveys (also see section on limitations). Further interactions between project staff and community members during project monitoring and future follow-up surveys may help to better understand the nature of these differences in perception.

Second, to ensure comparability of the data between project locations the IMT designed standardized tools. This might have come at a cost. All project locations have their own context and situational realities that cannot be harmonised into one tool. Thus, especially the baseline tools might not always have been fully responsive to the ground-level realities within communities. The needs assessment might provided my flexibility. However, tools here were also standardized to some extent. Thus, local consultants may not always have fully exploited the flexibility the needs-assessment tools may have provided. Here, one also needs to keep in mind that the administration of qualitative research especially within vulnerable communities requires extensive research skills and experiences. The IMT tried to address potential quality concerns proactively through reaching out to local consultants. However, it was beyond the control of the IMT to perform spot and back checks of the data collection efforts on the ground. Thus, some issues during the implementation of the data collection on the ground may have remained unnoticed.

Third, the baseline and needs assessment produced a wealth of information and data. This was necessary given that complex topics such as child protection within emergency settings were explored. At the onset it is not always clear what type of questions need to be asked. However, it is beyond the scope of this report to discuss all intricacies of the data to the full extent. This is particularly true given that this report constitutes a global synthesis of findings. We partly tried to accommodate this by additional figures within the annex of this report. Figures in the annex amongst others covered a breakdown of indicator data by gender, disability status, and type of household (i.e., host-community household, internally displaced households, and refugee households). Altogether, this report contains 46 graphs on implementing partner- and country specific aspects of child protection risks have been included. Nonetheless, a significant part of the data was not included into this report. Data collected for the baseline and needs-assessment but not presented here may still be of use especially in the future. Combining baseline and needs-assessment data with data collected, for example, during the midline and endline may further help to fully understand the topic of child protection within target communities. It is for this reason that the IMT has developed a data warehouse where the raw data of both baseline and needs assessment is stored. In addition to the raw data, all coding scripts compiled to analyse the data have been included as well.

Fourth, outcome indicators are operationalised through self-reports. These operationalizations often relate to child-protection related behaviours such as parenting practices or responding to child protection incidents. However, the baseline data does not include observations. Outcome indicators are gauged through self-reports by community members, caregivers, and young people; this means the data is acceptable to social desirability. Social desirability implies the notion that what respondents report defers from what they actually do in order to meet local or general societal norms and standards. We were partly able to explore the possibility of social desirability within the data by comparing responses between caregivers and young people.[[3]](#footnote-3)

## The Findings of baseline and needs assessment

The findings part of the report largely consists of the following two sections. Within the first section, the baseline data especially on the outcome indicators are presented. This section thus helps to populate the baseline levels for the outcome indicators within project logframe (also see annex 2). Secondary analyses are presented that help to further understand the child-protection situations within communities quantitatively. This concerned especially a breakdown of the data and results by gender and disability status. This in turn cast some light on the differences between male and female as well as between people with and without disability status. The first section also provides some critical reflections of the benchmarks constructed based on the ranking exercises that were used to determine baseline levels. As will be argued, there are some mismatches within perceptions around child protection risks between project staff (ranking exercise) and target populations (baseline responses). Thus, the outcomes of the ranking exercises cannot be taken as face value.

Within the second section of the findings part, the attempt to draw up child protection risk profiles for each of the 6 countries and implementing partners. The profiles imply the most relevant child protection risks for each of the different project locations. To compile the profiles, we combined both qualitative (needs assessment) and quantitative data (baseline surveys). The profiling was further supported by additional analyses that casts light on the contextual and situational factors associated with the most relevant child-protection risks identified. The country profiles thus may help implementing partners to further contemplate what programmatic priorities to choose for their project implementation. The country profiles also form the basis upon which the recommendations were developed that are presented towards the end of this report.

### Baseline data on outcome indicators 1 through 3

This section discusses the baseline data on the outcome indicators presented in table 1 above. It is structured as follows. First, the results of the ranking exercise are presented. Then, the data on outcome indicators are summarised. We start the summary with a discussion of the potentially least vulnerable target group (i.e., community members), and then move on to the more vulnerable target groups consisting of caregivers and in particular young people. Thus, the discussion is structured around indicator 3, 2, and finally indicator 1. We start with indicator 3 and conclude with indicator 1 because we generally feel that the way indicator 2 and 3 were operationalized seem to have worked well. By contrast, the way indicator 1 was operationalized seem to have encountered some challenges. The reader may be better position to follow this conclusion after having studied the results on indicator 2 and 3. The baseline section concluded with a critical reflection of the results ranking data in light of the survey data. As will be argued, both ranking and survey data appears to be only weakly correlated when it comes to the potential relevance of the different child protection risks locally.

#### Project staff and child protection risks (results of the ranking exercise)

Within the baseline surveys, the questions CHKR1 (young people/household survey), CGKP1 (caregivers/household survey), HHKP1 (household head/household survey), and CMCP1 (other community members/unit survey) were used to determine awareness of child-protection risks with target populations. For each of the three outcome indicators awareness of child-protection risks was deemed an important element. The design and answer options are identical across the three questions. Answers provided by respondents could be assigned to altogether 28 different child-protection risks that pre-populated the answer options of the three questions. As discussed above, to obtain benchmarks by which to judge whether or not a respondent knew (i.e., was aware of) all locally relevant child-protection risks we used a ranking of the corresponding risks provided by project staff within each of the 12 country teams. During the analysis, we concluded that the full list of 28 might have been too granular to obtain insights into the extent to which respondents “knew” locally relevant child protection risks. We therefore grouped the different child-protection risks into altogether 10 different types of child-protection risks. Table 5 below presents the results of the staff-internal ranking of child-protection risks. Within the 10 child-protection risks, we removed ‘poverty’ as a distinct child protection risk. During BNA validation calls, it was discussed that poverty may constitute a root cause of many child protections risks (e.g., child labour or neglect). As such, it may thus lead to different child protection risks that children in poverty are then exposed to. Being a root cause of child protections risks and not a distinct of manifestation of child protections risks, we therefore excluded ‘poverty’ from the set of child protections risks.

The ranking data already highlights that the different country contexts, and partner-specific contexts within countries, partly starkly differ. For example, child labour was amongst the three most relevant child-protection risks within Bangladesh. By contrast, child labour does not seem to be that relevant in South Sudan. According to project staff in South Sudan, it is not even amongst the 10 most relevant risks.

One could make the case for the assumption that even above completion of the JF-CPiE initiative respondents that are sensitized to child protection may not know all 18 child-protection risks. To construct country/implementing partner-specific benchmarks to be used during the data analysis, we therefore used only the 5 most relevant child-protection risks. Again, however, we did not expect well-aware respondents to know all 5 child-protection risks. Thus, we classified respondents as ‘aware’ if they named 3 out of the 5 most relevant child protection risks. As discussed below in detail, we consider this methodological approach not to be feasible within the case young people.

Table 5: Results of staff-internal ranking exercises by implementing partner and country

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country** | **Bangladesh** | | **Burkina Faso** | |
| **Implementing partner** | **Plan International** | **World Vision** | **ChildFund** | **Terres des Hommes** |
| Most relevant risk (1) | Child labour | Substance abuse | Violence | Migration/displacement |
| 2 | Neglect | Child labour | Child marriage | Neglect |
| 3 | Child marriage | intrafamily conflicts | Child labour | Substance abuse |
| 4 | Abduction/trafficking | Lack of legal identity | Neglect | Recruitment by armed forces |
| 5 | Separation from family | Violence | FGM | Teenage parenthood |
| 6 | Violence | Teenage parenthood | Lack of legal identity | Violence |
| 7 | Trauma | In conflict with law | Trauma | Trauma |
| 8 | Teenage parenthood | Child marriage | Migration/displacement | Child labour |
| 9 | Lack of legal identity | Trauma | Recruitment by armed forces | Child marriage |
| 10 | Substance abuse | Neglect | Teenage parenthood | Abduction/trafficking |
| 11 | intrafamily conflicts | Abduction/trafficking | Bullying | In conflict with law |
| 12 | In conflict with law | Migration/displacement | In conflict with law | Separation from family |
| 13 | Recruitment by armed forces | Separation from family | Separation from family | FGM |
| 14 | Bullying | Bullying | intrafamily conflicts | Lack of legal identity |
| 15 | Migration/displacement | Harmful cultural practices | Substance abuse | Bullying |
| 16 | Harmful cultural practices | Recruitment by armed forces | Harmful cultural practices | intrafamily conflicts |
| Least relevant risk (17) | FGM | FGM | Abduction/trafficking | Harmful cultural practices |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country** | **Central African Republic** | | **Colombia** | |
| **Implementing partner** | **Plan International** | **SOS** | **SOS** | **Terres des Hommes** |
| Most relevant risk (1) | Lack of legal identity | Violence | Separation from family | Migration/displacement |
| 2 | Teenage parenthood | Lack of legal identity | Migration/displacement | Recruitment by armed forces |
| 3 | Violence | FGM | Violence | Violence |
| 4 | FGM | Neglect | intrafamily conflicts | intrafamily conflicts |
| 5 | Neglect | intrafamily conflicts | Neglect | Neglect |
| 6 | Child marriage | Child marriage | Recruitment by armed forces | Substance abuse |
| 7 | Child labour | Child labour | Lack of legal identity | Teenage parenthood |
| 8 | Bullying | Harmful cultural practices | Teenage parenthood | In conflict with law |
| 9 | Substance abuse | Teenage parenthood | In conflict with law | Bullying |
| 10 | Recruitment by armed forces | Substance abuse | Child labour | Trauma |
| 11 | intrafamily conflicts | Trauma | Trauma | Child marriage |
| 12 | Trauma | Bullying | Child marriage | Separation from family |
| 13 | Separation from family | Recruitment by armed forces | Substance abuse | Child labour |
| 14 | In conflict with law | In conflict with law | Bullying | Abduction/trafficking |
| 15 | Migration/displacement | Separation from family | Harmful cultural practices | Lack of legal identity |
| 16 | Harmful cultural practices | Migration/displacement | Abduction/trafficking | FGM |
| Least relevant risk (17) | Abduction/trafficking | Abduction/trafficking | FGM | Harmful cultural practices |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Country** | | **Ethiopia** | | | **South Sudan** | |
| **Implementing partner** | **ChildFund** | | **Save the Children** | **Save the Children** | | **World Vision** |
| Most relevant risk (1) | Child marriage | | Abduction/trafficking | Abduction/trafficking | | Child marriage |
| 2 | Poverty | | Bullying | Child marriage | | Teenage parenthood |
| 3 | Trauma | | Child marriage | Neglect | | Poverty |
| 4 | Child labour | | FGM | In conflict with law | | Trauma |
| 5 | Violence | | Child labour | Violence | | Violence |
| 6 | Neglect | | Harmful cultural practices | Trauma | | Neglect |
| 7 | intrafamily conflicts | | In conflict with law | Poverty | | Migration/displacement |
| 8 | FGM | | intrafamily conflicts | Separation from family | | Substance abuse |
| 9 | Separation from family | | Lack of legal identity | Recruitment by armed forces | | intrafamily conflicts |
| 10 | Migration/displacement | | Neglect | Substance abuse | | In conflict with law |
| 11 | Bullying | | Migration/displacement | Child labour | | Recruitment by armed forces |
| 12 | Abduction/trafficking | | Poverty | Lack of legal identity | | Harmful cultural practices |
| 13 | Substance abuse | | Recruitment by armed forces | Bullying | | Child labour |
| 14 | Teenage parenthood | | Separation from family | Teenage parenthood | | Separation from family |
| 15 | In conflict with law | | Violence | intrafamily conflicts | | Abduction/trafficking |
| 16 | Recruitment by armed forces | | Substance abuse | Harmful cultural practices | | Bullying |
| Least relevant risk (17) | Lack of legal identity | | Teenage parenthood | Migration/displacement | | Lack of legal identity |

#### Caregivers and child-protection risks (indicator 2)

In full, indicator 2 reads ‘% of caregivers who report increased knowledge of caring and protection behaviours towards children under their care compared to the beginning of the project’. Awareness of child-protection risks was also one of the two thematic aspects (i.e., knowledge of protection behaviours) implied by outcome indicator 2. The assumption is that being able to protect children from any risks requires being aware of the potential child-protection risks. The other thematic element implied by indicator 2 is parenting behaviours. To measure self-reported application of good parenting, we used scales on ‘Nurturing Values’, ‘Strength Identification & Boosting’, and ‘Involvement’ of the Nicomachus-Positive Parenting (NPP) Questionnaire (see questions CGKC1 through CGKC15 within the caregiver section of the baseline household survey. Also see table 13 in the annex for listing of the different items). The combination of both components allows operational.

Figure : Global baseline values for indicator 2 by implementing partner/country

Chart, bar chart

Description automatically generated

***Note:*** *the figure is based on questions CGKP1 and CGKC1 through CGKC15 in the household survey. Numbers express proportions in %.*

Across all countries, 5694 caregivers were surveyed (see table 2). On average, they appeared to be female and slightly younger than household heads (see table 8). With the exception of caregivers in Colombia and Central African Republic, parents interviewed also tend to be married. In Colombia, marital marriage levels were as low as 5 percent (SOS Children’s villages). In Colombia, the share of those caregivers without primary education was also very low, which was in stark contrast to countries such as Burkina Faso or Ethiopia. In Burkina Faso (ChildFund only), and South Sudan (Save the Children and World Vision), caregivers were also less likely to be working. Child-caring requirements could be part for the explanation for the lower working rates. Within those locations, the average number of children were slightly higher with around 2.94, 2.52, and 3.34 compared to a global average of around 2.35. This average was the lowest in Ethiopia with just under 2. Also, within South Sudan the proportion of host-community households surveyed are particularly high (69.45 and 72.24 percent versus a global average of 52.36 percent). This may suggest that caregivers within host communities may be less likely to work, at least in South Sudan.

Table : Caregivers’ self-reported practices of child caring and protection behaviours (indicator 2)

|  |  |  |  |
| --- | --- | --- | --- |
| **Country** | **Partner** | **# of CP risks**  **named (se)** | **Respondents that indicate adequate caring behaviours** |
| Bangladesh | Plan International | 2.45 (0.98) | 58.54% |
| World Vision | 1.47 (1.13) | 77.19% |
| Burkina Faso | ChildFund | 1.60 (1.15) | 46.01% |
| Terres des Hommes | 2.11 (0.87) | 39.16% |
| Central African Republic | Plan International | 1.64 (1.17) | 92.99% |
| SOS Children’s villages | 2.42 (1.01) | 66.75% |
| Colombia | SOS Children’s villages | 1.19 (1.08) | 57.66% |
| Terres des Hommes | 1.52 (1.28) | 51.97% |
| Ethiopia | ChildFund | 1.19 (0.77) | 33.24% |
| Save the Children | 1.45 (1.27) | 71.61% |
| South Sudan | Save the Children | 1.39 (1.15) | 53.20% |
| World Vision | 2.04 (1.52) | 68.37% |

***Note****: ‘CP’ refers to child protection.*

Figure 2 above presents the baseline values for indicator 2. It is an unweighted aggregation of both the levels of awareness around child-caring and protection. Like in the case of indicator 3, implementing partners differed in terms of the baseline values on indicator 2. Again, baseline levels appear to be particularly low in case of ChildFund, Ethiopia and again the highest especially in the case of SOS Children’s villages, Central African Republic, but also Plan International, Bangladesh, and Word Vision, South Sudan. However, in no project location awareness levels around child-caring and protection amongst caregivers exceeded 30 percent. This suggests child caring and protection constitute thematic areas to be underserved within project locations.

Figures starting from page 72 in annex 1 provide a breakdown of the baseline data pertaining to indicator 2 by gender, disability status and type of respondents (i.e., households in host communities, internality displaced households, and refugee households). Unlike in the case of indicator 3, female and male caregivers do not seem to differ in terms of their self-reported child-caring and protection levels. The same also applies when comparing caregivers with and without disabilities.

Table 9 above disaggregates the baseline data on indicator 2 by its elements. This again allows determining what drives the baseline levels on indicator 2. On average, caregivers were aware of as many child-protection risks as community members (around 1.7 on average). Again, these figures seem to be slightly higher in the case of Bangladesh (Plan International), and Central African Republic (SOS Children’s villages). As for self-reported child-caring practices, implementing partners across the different project locations varied substantially. The percentage of caregivers that indicated adhering to all good parental practices indicated by questions CGKC1 through CGKC15 within the household survey ranged from 33.24 percent (ChildFund Ethiopia) to almost 93 percent (Plan Central African Republic). High levels of good parental practices suggest that projects may not have to consider interventions to further raise awareness around what constitutes a good parent.

Table 13 in the annex provided a breakdown of self-reported behavioural levels around parenting practices at the item level. Parents generally seem to exhibit all parenting practices questioned about. Across items and countries, parents report levels of around 90 percent. In this respect, there also do not seem to be any gender differences between female and male caregivers. There is, however, an exception. Both female and male parents seem to be less likely to discuss with their daughters and sons how to avoid HIV/AIDS and unwanted pregnancies. Across all countries, reporting levels are just around 60 percent. This suggests that with regards to parenting practices project partners may want to focus on sex education within their awareness raising campaigns towards parents.

A caveat of the survey data is that they generally rely on self-reports. Thus, what respondents do within their daily lives may be different to what they indicate when surveyed. The household survey allows testing to what extent data has been subject to social-desirability bias. Questions about parenting behaviours were administered not only to parents (i.e., questions CGKC1 through CGKC15) but also to young people (i.e., questions Ad30.1 through Ad30.10 within the adolescent section of the baseline household survey). For example, whereas caregivers were asked whether or not ‘you discuss how to avoid getting pregnant with your daughters/sons (i.e., CG19.10/CG19.11)’, young people were asked whether or not ‘you discuss how to avoid getting pregnant’ (Ad30.10). Thus, comparing data on each set of questions allows collating evidence on whether or not parents may overreport good practicing behaviours. Interestingly, parenting levels indicated by young people seem to match the ones reported by parents (overview table not provided here). At face value, this may suggest that self-reports on parenting skills are not subject to social desirability.

Another reading could be that social desirability is at work not only in the case of caregivers interviewed but also in the case of young people interviewed. One could argue that whereas caregivers may want to overreport their own parenting behaviours, young people may feel obliged to overreport the parenting behaviours of their caregivers. Again, evidence emerging from the survey data may suggest otherwise. Within both the caregiver (CG20.1 through CG20.8) as well as the adolescent section (Ad31.1 through Ad31.9) of the survey, we asked respondents when physical punishment of children is justified. A comparison of the data is presented in table 14 within the annex. Across all items and countries, there is a stark difference between caregivers and young people. Both female and male within each population group are somewhat at par. However, whereas around 40 percent of caregivers agree that physical punishment is justified on average across survey items and countries, it is almost 60 percent amongst young people. Across items, disagreement is particularly high in areas such as when children do not look after their siblings, are not in line with gender norms (e.g., a boy plays with dolls), or when a child wets his/her bed. Disagreement levels are lower in areas such as when children steal or takes psychoactive substances. Across locations, disagreement levels are particularly high within the Central African Republic and the smallest within Ethiopia. Within other countries, disagreement levels seem to vary locally.

1. For further information, see the BNA protocol in the file “JF-CPiE BNA Protocol\_20221114\_V02”. As of writing, the latest version is dated 14th November 2022. [↑](#footnote-ref-1)
2. See file ‘JF-CPiE GFFO Consortium\_Annex 6 Beneficiary Table’. [↑](#footnote-ref-2)
3. We partly find some evidence that social desirability may be at work. However, this is a general challenge many households surveys face and it would have been beyond the scope of this baseline undertaking to develop such a methodological approach. [↑](#footnote-ref-3)