From place to space: field insights on adapting child-friendly spaces during COVID-19

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While COVID-19 is not currently perceived as a serious disease threat to children, its indirect effects on their lives and psychosocial well-being may be profound. Child-friendly spaces may therefore be all the more important, particularly in fragile contexts of displacement.

Child-friendly spaces (CFS) – one of the most widely used humanitarian interventions to support, care for and protect refugee and displaced children – provide physical places that are safe and stable environments for children to thrive and reach developmental milestones. The primary aims of CFS are to promote the psychosocial well-being of children, to serve as a protective mechanism against abuse, exploitation and violence, and to mobilise communities towards the support, care and protection of children.[1] Although mobile versions exist, CFS are often static; they provide a range of structured and free-play activities that encourage children to form meaningful attachments with peers and adults, foster functional literacy skills, and improve psychosocial well-being.

Traditional models for mental health and psychosocial support (MHPSS) programming, however, have not been designed for contexts of epidemics, such as Ebola or the COVID-19 pandemic, in which life-saving public health measures to reduce transmission of infectious diseases impose drastic restrictions on movement, social interaction and the delivery of services.

In the midst of the coronavirus pandemic, as interventions such as CFS are forced to halt due to risk of transmission, practitioners are challenged as never before by how best to support the social and emotional well-being of children – primarily through remote means. We have been asking ourselves how we can translate the original premise of these place-based service delivery models for the context of COVID-19. How can we shift the physical place to a conceptual space that would stay true to the original aims and proven results[2] of CFS? Is it possible to promote positive mental health and psychosocial outcomes for children, while also mitigating the risk of COVID transmission?

We began exploring these questions in CFS programming in the refugee response in West Nile, Uganda, within a randomised controlled trial started in 2018. With the declaration of the pandemic in March 2020, the Ugandan government ordered the closure of all education institutions including CFS. Only services deemed essential and life-saving were allowed to continue. We are now drawing on our existing work to determine how best to adapt CFS to address the current mental health and psychosocial support needs of children and their families as a result of and within the context of COVID-19. From this experience we have developed four sets of recommendations for the adaptation of CFS programming and the identification of different learning modalities in use or accessible to children within communities.[3]

Caregivers' well-being

Over one third of children and caregivers surveyed reported new stressors for caregivers or related to caregiving in the context of the COVID-19 pandemic. Some of these include closed churches, closed borders (restricting movements back to South Sudan), economic insecurity, lack of material goods to support basic needs, lack of support from relatives, and fear of the coronavirus itself. New COVID-related stressors were also reported for caregivers where children's exposure to friends was reduced. The two most frequently reported stressors related to lack of food and education.

In West Nile, local staff had already organised mobile activities that enable them to reach caregivers and their children in the camps while adhering to safety measures and

social distancing. Caregivers are provided with positive parenting sessions following the Ugandan Ministry of Gender, Labor and Social Development's Parenting Manual and World Vision's Parenting Module. When caregivers and children were asked what learning method they preferred for education during the COVID situation, radio was most mentioned, although books and printed materials were also overwhelmingly reported. Radio broadcasts may therefore be a wide-reaching and helpful medium to promote positive parenting messaging and to dispel any stigma or misinformation related to COVID. Radio broadcasts can feature information on COVID, violence prevention, self-care and mindfulness, self-directed sports and physical exercise, and functional literacy and numeracy activities. Given that only roughly a quarter of participants own a radio in the household, distribution of radios and a related maintenance programme would be vital. Existing campaigns to provide radios to child-headed households can be expanded to further support the aims of CFS for all children in the settlement camp. These campaigns can also provide direct materials to households, such as information, education and communication materials or psychosocial play kits to accompany facilitator-led activities during the broadcasts.


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With schools closed in Uganda because of the pandemic, teachers have set up home-learning classes to keep refugee children engaged.

Community-based support for families

With access to the community now more difficult due to COVID-19 restrictions, several community-based groups have been leading efforts to reduce disease transmission and identify families in need of general psychosocial and specialised mental health support. Trained health workers and community volunteers have been working together to support dissemination of COVID messaging. This initiative can be extended to develop and disseminate child-friendly MHPSS messaging and capacity-strengthening efforts for community groups, child protection committees (CPCs) and faith leaders already working to provide information to prevent the spread of the virus and address stigma and other misconceptions.

Case workers and CPC members have been working together to identify and refer high-risk mental health cases and mobilise additional support for children with a disability. Traditional methods of case management have been adapted to provide remote support using mobile phones to monitor cases, and regularly checking in with caregivers, particularly those with identified high-risk cases. However, very few households have access to mobile phones. In this void, CPC members have been playing an important role as intermediaries between the case worker and caregivers. Strengthening the capacity of CPC members in Psychological First Aid as a key component of a broader toolkit can improve their understanding of how best to respond to those in distress, leading to appropriate screening and referral of high-risk mental health cases. A recent study following the Ebola outbreak in Sierra Leone noted that even a one-day training was effective, though those trained should receive ongoing refresher training with skilled trainers to ensure those skills are applied correctly.[4]

Children and youth clubs

Overwhelmingly, children surveyed reported not being able to go back to school – and be with friends – as the primary source of their concern. Prior to the closure of CFS within the settlement, children and youth clubs (CYCs) were able to bring children together and to promote social cohesion, peacebuilding and child protection, and were also useful for enabling child-led advocacy. In the absence of CFS, these smaller CYCs have thrived outside the confines of their formerly place-based home. Facilitated by community groups and faith leaders, activities include opportunities which they would normally have in the CFS. The groups follow a set of sessions adapted from a child-led peacebuilding curriculum. Child club members trained in journalism have also been helping with COVID response activities through promoting child-friendly information on coronavirus prevention and personal hygiene, either face to face or through mobile phones, sharing information on child protection through the radio and during community meetings, and promoting children's safety from violence. Members of the clubs also reach out to child-headed households to provide basic child protection and psychosocial support messages.

While not recommended during the health response surge of an outbreak, these CYCs can prove a useful vehicle for child-led response efforts including the development and dissemination of life-saving MHPSS and child protection information. These small groups can further be supported by community members and volunteers to adapt existing psychosocial curricula (such as the CFS Activity Catalogue) for socially distant small group or peer-to-peer exercises.[5] Finally, a newly developed World Vision infectious disease module can be used to help CYCs tailor mental health and psychosocial messaging and materials in child- and adolescent-friendly ways.

Advocating for MHPSS and child protection as essential services

The closure of the CFS by the government as a non-essential service meant that the most needed child protection and MHPSS support were inaccessible. Through the advocacy efforts of the CFS programme and in collaboration with the local Task Force on Child Protection, child protection and MHPSS services were gradually re-introduced through case workers, trained health workers, teachers and community leaders. The modalities of service provision as described above were quickly adapted in consultation with communities, including children. High-risk mental health and child protection cases were identified by working closely with the various groups and sectors in the camps. The child protection coordination groups frequently engage with local authorities to share new and emerging assessment information to support advocacy and encourage improved response on gaps in child protection and MHPSS services.

Conclusion

Evidence from past epidemics shows that children in such contexts may face increased risk of violence, neglect, abuse and exploitation, and the interruption or breakdown of services including systems of protection, making programming such as MHPSS even more critical.[6] Since humanitarian operations around the world have been significantly affected by COVID-19, adaptation of programming has become a key focus for agencies: how can tools and approaches be adapted to maintain equally essential services and humanitarian support?[7] We hope our insights will prove useful to others as they try to answer this question and make adaptations in the coming years as we continue to grapple with this and future pandemics. World Vision is now prioritising learning and adaptation of its core tools and approaches to COVID-19 and is seeking collaboration and partnerships to do so, particularly in child protection and MHPSS.

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3. The authors are grateful for the contribution from the WV Uganda and Africhild teams supporting the CFS study that this article draws upon, which was funded by Elrha, R2HC, DFID, Wellcome Trust and NIHR.

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