CHILD FRIENDLY SPACES IN MYANMAR

Myanmar Red Cross

CASE STUDY

Photo description: Myanmar Red Cross volunteer conducting CFS activities with parents
Photo credit: Myanmar Red Cross

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Photo description: Myanmar Red Cross volunteers organizing CFS activities with children
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Background

Myanmar is experiencing conflicts and multiple disasters, including an earthquake in March 2025, and multiple overlapping crises, including food insecurity, inflation, disease outbreaks, loss of livelihoods, and the breakdown of essential public services.

As local communities cope, the Myanmar Red Cross Society (MRCS) has been implementing Child-Friendly Spaces (CFS) as part of its Emergency Response since 2024. In emergencies, children face serious risks to their safety and well-being—from displacement, loss of loved ones, and disruption of daily life to psychological distress. Keeping children safe and supporting their psychosocial wellbeing is vital. Child Friendly Spaces (CFS) help by offering safe environments where children can play, learn, express themselves, and receive support to cope with the challenges they face. These spaces provide environments where children can engage in structured and unstructured activities, play, and receive psychosocial support in crisis-affected areas.

CFS have been established and operated in different locations based on humanitarian needs and access conditions. Sessions are typically conducted twice per week (8 times per month) or continuously, depending on local authorities' approval.

Currently, MRCS has implemented CFS in several locations across the country. These are: Sagaing, Rakhine – Sittwe, Magway – Saw Township, and Magway – Sinphyukyun Township, Mandalay Region, Naypyitaw, Southern Shan State– earthquake affected areas. This has included both mobile Child-Friendly Spaces that rotate between locations and fixed CFS set up in buildings or tents that remain in one place.

Currently MRCS is planning to extend child friendly space services for the affected community in whole Myanmar such as S Bago Region, Mon State, Kayar State, Kayin State, Tanintharyi Region.

Who was Supported and How

The MRCS CFS focus on reaching children ages 5 -15 years who are affected and/or displaced due to armed conflict and disaster.

Through the CFS, children have opportunities to participate in a variety of activities. In particular:

- Creative and Art-Based Activities: drawing, coloring, origami, storytelling, making lanterns, poem reciting.
- Myanmar traditional games: Shwe Son Nyo (run and catch) and Htoak See Toe (hopscotch-like game).
- Physical activities & sports: badminton, jump rope, football/soccer, and parachute games.
- Music based activities: singing, dancing, playing drums and guitars, Myanmar traditional music.
- CFS Activities from CFS Activity Catalogue (IFRC) –22 activities were translated in Burmese from the 7 topics.
- Integrated WASH: snakes and ladders (WASH version), songs and storytelling.
- Based on location and needs, Mine Risk Education.
- Collaborative games: puzzle, board and balls games.
- Free play time.

All activities are conducted in group sessions. Where facilitators were trained, Space Task Equipment People (STEP) approach was used to adapt activities so children with different abilities can participate.

All staff and volunteers involved in CFS are briefed on the MRCS child protection policy.

Volunteers have been provided with a series of training including the following topics: PFA for Children; communicating and working with children of different ages, genders and abilities; organizing CFS group activities in an inclusive and participatory way; and handling challenging behaviors and situations.

Community Engagement

The implementation of CFS activities actively involved communities in both the design and provision of activities. Various formal and informal strategies have been employed to encourage community participation, including consultations, caregiver engagement and discussion with community leaders depending on the different State and Regions.

One of the most common practices has been direct consultations with caregivers and community members before launching CFS activities. During these consultations, caregivers and community leaders were asked about the types of recreational and social activities available for children, the gaps in services, and the barriers to participation. They also contribute to the selection of CFS sites, to identify secure areas that are free from hazards or unsafe structures. ensuring that locations were safe, accessible, and acceptable based on MRCS CFS Minimum Standards.

The continuous discussions with the caregivers helped to identify the most suitable session times, locations, and preferred activities. In some locations, such as Magway, caregivers suggested the inclusion of parent-child activities, resulting in the introduction of shared storytelling sessions. This active participation of the caregivers in the activities is still not the case in all states and regions.

Moreover, in Magway, caregivers took on active roles in monitoring CFS spaces to ensure security, which increased trust in the program and helped facilitators focus on running the activities. In Rakhine, where security made site selection difficult, local volunteers helped facilitators identify safe and accessible locations, allowing CFS sessions to continue despite logistical challenges.

The presence of caregivers and their engagement in activities has strengthened trust in the initiative and helped to reinforce positive relationships between children and their families.

Religious and community leaders have also played a role in building trust and encouraging participation. In Sagaing and Magway, facilitators engaged with local religious leaders to address community concerns about CFS, which led to greater acceptance of the activities. This approach helped to overcome initial hesitations and ensured that CFS activities were seen as a supportive space rather than an external intervention.

Children themselves have influenced the design of activities through direct feedback. Facilitators regularly ask children which activities they enjoy most, ensuring that sessions remain engaging. In Rakhine, children expressed a preference for traditional games over structured games, leading to the introduction of Shwe Son Nyo and Htoak See Toe. Similarly, in Sagaing, children requested more active, group-based sports, prompting facilitators to include relay races and ballons games matches in the activity schedule.

Beyond activity selection, regular feedback sessions with caregivers and volunteers have helped improve the overall structure of CFS. In Magway for example, community discussions highlighted the need for more structured learning opportunities alongside play-based activities. As a result, facilitators introduced short educational sessions on health, hygiene, and personal safety, which were well received by both caregivers and children.

Successes

Through structured play, creative expression, and psychosocial support, CFS activities have provided a supportive space for children affected by emergencies. For example, through 46 sessions in Mandalay Region and Sagaing, 2,288 children participated (1,180 males and 1108 females).

Based on an internal MRCS CFS review with CFS volunteer facilitators conducted in February 2025, one of the most notable successes has been the strong community trust and engagement in CFS activities. In Magway, for example caregivers not only encouraged their children to attend but actively participated by ensuring the security of the spaces, helping to organize activities, and providing feedback on how sessions could be improved. This sense of ownership has strengthened the sustainability of CFS.

Another key outcome has been positive changes in children’s behavior and emotional well-being. Facilitators observed that children attending CFS regularly showed increased confidence, better cooperation with peers, and improved emotional regulation. In Rakhine and Sagaing, children who initially struggled with social interactions gradually became more engaged in group activities. The introduction of structured routines—such as mindfulness exercises, singing, and saying goodbye in fun ways—helped children feel emotionally secure and contributed to their ability to regulate their emotional state.

Increased inclusivity and accessibility for children with disabilities was another change. In Rakhine, even if staff and volunteers faced several challenges at the beginning, they noticed that more children with disabilities joined the CFS. Facilitators learned how to adapt activities to ensure all children, regardless of ability, could engage in games and storytelling. In some locations, during the review it was shared that “peer support systems emerged” with older children assisting younger ones and children helping their peers with disabilities participate more actively.

The integration of play-based learning into CFS also proved to be a success. Beyond providing recreational activities, in some of the location CFS became a space where children gained knowledge about hygiene, health, and emotional well-being. Specifically in Magway, for example, basic health education was integrated into CFS, training children about handwashing, personal hygiene, and nutrition, which was welcomed by the caregivers.

One of the most rewarding aspects of CFS implementation has been the growing demand for expansion. In multiple locations, caregivers, community leaders, and even children themselves requested more frequent sessions or additional CFS sites. For example, in Rakhine, displaced families living in the camps expressed interest in establishing CFS where none previously existed.

Based on testimony and case stories, children have found joy and relief in play, caregivers have gained confidence in the importance of psychosocial support, and trained facilitators have developed stronger skills in engaging children and adapting activities to their needs.

Challenges and Difficulties

The implementation of CFS activities faced several challenges, some of which were anticipated, while others emerged during the implementation. Planning efforts considered potential difficulties such as security risks, limited resources, and logistical constraints.

One of the expected challenges was limited access to resources, particularly age-appropriate toys, materials, and heathy snacks. To manage this, teams introduced traditional games that required minimal equipment and sometimes caregivers contributed locally available items, such as handmade toys and storybooks. However, in some locations, the shortage of materials remained a barrier to fully implementing planned activities.

Security risks posed significant challenges, particularly in Sagaing and Rakhine, where ongoing conflict and checkpoints made it difficult for children and volunteers to access CFS sites. In some cases, sessions had to be rescheduled or relocated to safer areas. To address this, facilitators worked with community leaders to continuously identify secure locations for sessions and adjusted CFS hours to match periods of safer movement. In Rakhine, the use of mobile CFS allowed facilitators to reach children in different areas while minimizing exposure to risks.

An unexpected challenge was low attendance in some locations, particularly in the early stages of CFS implementation. In Magway some caregivers were hesitant to send their children to CFS, either because they were unfamiliar with the program or worried about safety. To address this, facilitators conducted community meetings to explain the purpose of CFS and reassured families about the safety measures in place. Over time, attendance increased as caregivers saw the benefits of structured play and learning for their children.

Children's engagement with activities was another challenge, particularly in situations where the content did not match their interests or energy levels. In some locations and occasions, children became restless during structured games or lost interest in prolonged activities. Facilitators responded by incorporating more interactive elements such as races, storytelling, and music-based activities. In Sagaing, children requested more sports, leading to the introduction of ballons and group competitions, which improved participation.

Gaps in volunteer capacity and training have also become evident as not every volunteer in all locations is trained to manage children's behavior, respond to emotional distress, or adapt activities for children with disabilities. In Rakhine, at the beginning of the implementation facilitators struggled to ensure full inclusion of children with disabilities due to a lack of adaptive strategies. To address this, MRCS technical team introduced peer learning sessions during the CFS Review where volunteers could exchange experiences and learn from each other and ensure more training sessions for CFS implementers and facilitators.

Another challenge was the engagement of caregivers in CFS activities. They have been engaged in preparation and logistics aspects, but facilitators shared that in some locations, caregivers are more observing and less participate in the activities.

Related to the monitoring and evaluation, the different standards tools from the IFRC CFS package can't be fully operationalized in the current context. Only the observation tool for facilitators can be used and MRCS is currently defining the process to pilot it in some locations.

Lessons Learned

1- Strengthen community engagement

Engage caregivers, community leaders, and local authorities early to build trust and ownership. Participation was highest where families were involved from the beginning; delayed engagement required extra effort to gain acceptance.

2- Prioritize peer support and mentorship

Facilitators need ongoing, practical support. Peer exchanges and mentorship were found to be more effective than standalone trainings in building confidence and improving child behavior management and psychosocial skills.

3- Stay flexible and responsive

Adapt activities, schedules, and locations based on children's energy levels, local routines, and community feedback. Flexibility improved participation, especially when responding to religious observances, security issues, or school reopening.

4- Promote culturally familiar content

Use traditional games, local stories, songs, and customs to make CFS more engaging. Children responded more positively to familiar, culturally relevant activities than to standardized tools.

5- Encourage long-term sustainability

Explore options to transition CFS into community-led spaces. In several areas, caregivers expressed interest in continuing CFS even after emergency needs declined, showing potential for locally owned models.

Lessons Learned

6- Foster program integration

Link CFS with other sectors like health, nutrition, and WASH to offer more comprehensive support for children and their families, and to increase overall impact.

7- Include caregivers

Design sessions that involve caregivers and provide psychosocial support tailored to their needs. Supporting caregivers directly helps create a more stable environment for children.

8- Strengthen monitoring and evaluation

Introduce M&E systems from the start to track participation, well-being outcomes, and community feedback. This helps measure impact and adjust activities to meet evolving needs.

Recommendations

1- **Continue to build relationships with caregivers and community leaders** to ensure trust and long-term support.

2- **Prioritize peer support** supervision and mentorship for facilitators so volunteers benefit from "on job" training, peer exchanges to continuous strength knowledge and skills in child protection, psychosocial support, and behavior management.

3- **Continuous feedback** (link with CEA) to ensure that activities, schedules, and locations are adapted based on the evolving needs of children and communities.

4- **Promote local games, stories, and traditions** to make CFS feel familiar and engaging for children.

5- Consider how CFS can **transition into a community-led initiative** over time to ensure long-term impact, even beyond the initial humanitarian response.

6- Advocate more strongly for **integrating CFS with other supported programs** such as nutrition and health, to create a more holistic support system.

7- **Design activities for caregivers** and propose psychosocial support to them.

8- **Adapt monitoring and evaluation** systems from the start to better track the psychosocial impact on children.