Best of UNICEF Research

2017

Best of UNICEF Research 2017

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The Office of Research – Innocenti is UNICEF's dedicated research centre. It undertakes research on emerging or current issues in order to inform the strategic directions, policies and programmes of UNICEF and its partners, shape global debates on child rights and development, and inform the global research and policy agenda for all children, and particularly for the most vulnerable.

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Front Cover: © UNICEF/UNI141626/Vishwanathan
Kasturba Gandhi Balika Vidyalaya Primary School, Tharthari, Nalanda Bihar District, India, 2013: Girls on a swing during evening play time. Bihar is one of the first states to educate girls who have certain disabilities.

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Foreword

The Best of UNICEF Research (BOUR) initiative celebrates its fifth year. Started in 2013 by the Office of Research – Innocenti, it was seen as a way to showcase excellence in research being carried out within UNICEF, to validate the role of UNICEF staff in evidence generation, and to strengthen the organisational environment and support for research. The exercise is open to research undertaken or managed by staff of UNICEF (excluding those at the Office of Research – Innocenti) and National Committees, by themselves or in partnership with other researchers and institutions. Submissions are reviewed internally by staff at Innocenti, with the shortlist then assessed by an external review panel. BOUR continues to grow in strength – as measured by the number and quality of submissions received.

Feedback from colleagues across UNICEF – and particularly from the field – tells us that BOUR is having a significant impact in several ways. Through it staff learn about research being conducted elsewhere in UNICEF – it highlights specific research projects but more importantly raises the visibility and shows the value of investing in good research. It validates the role of research in the organization and supports staff in advocating internally for their evidence programmes. BOUR has at times generated an enabling environment for research within offices, facilitated cross-office collaboration and helped to raise external awareness of (and sometimes funding for) research undertaken within UNICEF.

We at Innocenti hope that these positive examples of impact reported to us contribute collectively to a wider transformation in the evidence culture and environment across UNICEF.

The new Strategic Plan includes the aspiration that evidence is a key driver for effecting change and achieving results in all areas of UNICEF's work. There is increasing acknowledgement that UNICEF requires a stronger evidence base, more systematically used, to support its programmes, policy and advocacy; and that knowledge produced within, by or for UNICEF is a public good that should be available to all those working to improve the world for children. This evidence needs to be rigorous, reliable and obtained with attention to the highest standards of ethics – given the focus on children, and often children in particularly vulnerable circumstances. BOUR is only one of a number of initiatives led by the Office of Research – Innocenti which support this organizational shift towards stronger awareness, capacities, quality and ethical standards, and governance of research across UNICEF.

Beyond the generation of evidence, systems for knowledge sharing and its use become increasingly critical to UNICEF as the organization is increasingly called on more and more to support governments in a policy and advisory capacity, and as it positions itself as a strong knowledge actor and broker, promoting dialogue and shaping debates on issues of global concern for children. As an organization, this calls also for attention to and investment in understanding the impact of our research, and how research and evidence (whether generated internally or not) are used systematically to inform our work.

Once again, this publication showcases some of the best and most innovative pieces of research coming out of UNICEF. It reveals diversity in geography, themes and methodologies. The topics demonstrate the added value of UNICEF staff in the field identifying issues that are of relevance at national and local levels but which also have widespread application and the potential to shape the agendas of academic and policy communities. The studies demonstrate the particular capacity of UNICEF to facilitate research across multiple countries within a region, and even cross-regionally. Studies published in scholarly journals demonstrate that academic quality does not need to be compromised by the imperatives of programme timeframes. Others demonstrate how complex ideas can be made accessible to different audiences through more creative communication.

A number of studies in this volume focus on child protection issues – a welcome addition to research in a

field for which evidence is often limited or fragmented, and where the work of UNICEF has potential to drive a research and evidence agenda with global impact. The study from Indonesia, for example, pilots a methodology developed by UNICEF in 2014 to create a financial benchmark for government expenditures on child protection. Other studies focus on children in conditions of extreme vulnerability and exploitation – where issues of appropriate methods and ethical safeguards become paramount. The situation of children with disabilities is another welcome addition to the themes covered by BOUR – highlighting its growing importance on the agenda of governments and of UNICEF.

Once again, we congratulate all those whose research is highlighted in this report. We also thank all those who submitted their research projects: we receive many excellent studies, only a few of which can be highlighted here. Finally, my thanks go to the external reviewers who generously give their time to provide feedback on the selected studies, and to the small but dedicated team within Innocenti for once again making this exercise a huge success.

I hope you all find the efforts of your colleagues across UNICEF informative and inspiring. And, as always, we welcome your feedback.

Sarah Cook
Director
UNICEF Office of Research – Innocenti, Florence
December 2017

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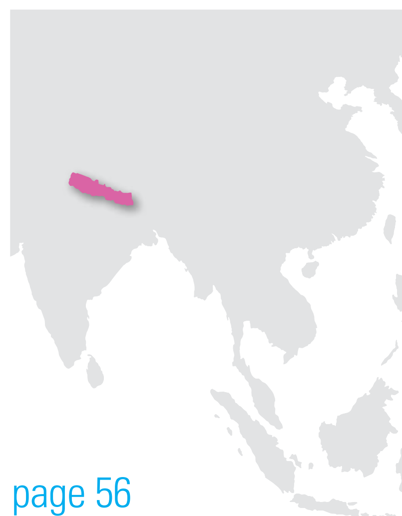

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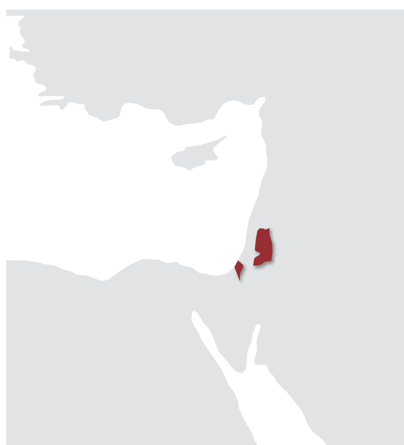

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CAMBODIA

Stability of Vitamin A, Iron and Zinc in Fortified Rice During Storage, and its Impact on Future National Standards and Programmes: Case study in Cambodia

Khov Kuong, Arnaud Laillou, Chantum Chea, Chhoun Chamnan, Jacques Berger, Frank T. Wieringa

© UNICEF Cambodia/Bona Khoy

Is fortifying rice the best way to counter nutritional deficiencies in Cambodia?

The elimination of deficiencies in micronutrients (vitamins and minerals) among vulnerable groups is a public health priority for many countries, regardless of their level of economic development. In low- and middle-income countries, where the burden of micronutrient malnutrition is enormous, it is an urgent public health problem.

The fastest way of reducing micronutrient deficiencies is for example through dietary supplements, such as administering vitamin A to young children, or iron plus folate to pregnant women. But the success of such programmes depends not only on the target group adhering to the protocol, but also on regular funding and robust health care distribution systems, which may or may not be equally accessible to the entire population.

Moreover, while changing people's diet may not be dependent on external funding or the health care system, it can take a very long time to achieve and interventions often struggle to change long-established behaviours among target populations.

Food fortification is thus often seen to be the most cost-efficient means of preventing micronutrient deficiencies. At the Copenhagen Consensus in 2008, fortification of staple foods with vitamins and minerals was ranked among the top three international development priorities. At the 2012 Consensus,

EDITORIAL INSIGHT

This highly technical piece of research was selected because of its solid conceptualization of the research question, the clarity of explanation of its research design, its rigorous methodology and the strength and transparency of its analysis. It frames the research question well and provides an important challenge to current thinking on how best to improve child nutritional status in many low- and middle-income countries, thus preventing potential wasted investment.

combating nutritional deficiencies was declared one of the most important strategies to improve global health.

Cambodia needs a viable method for reducing micronutrient deficiencies. The 2014 *Cambodian Demographic Health Survey* showed no significant reduction in the prevalence of anaemia among children and women, which remains high at 55.5 per cent and 45.4 per cent respectively. This is despite the fact that between 2010 and 2014, the Government of Cambodia distributed iron-folate supplements to women of reproductive age and micronutrient powders to children aged 6–24 months. This is because more than 40 per cent of the anemia was not caused by nutritional factors, according to UNICEF research in Cambodia. Moreover, more than 50 per cent of the country's mothers and children suffered from zinc deficiency. Zinc deficiency is considered an urgent public health problem in Cambodia, given the high levels of stunting – more than 30 per cent of the children under 5 years old were stunted in 2014.

The burden of malnutrition on the national economy is estimated at more than US$260 million annually, of which about two thirds of the loss is linked to micronutrient deficiencies. In Cambodia, where approximately 70 per cent of the daily energy intake comes from rice, fortification of staple foods could be a promising strategy.

RESEARCH QUESTION

The purpose of this quantitative research – conducted by the Institute of Research for Development, UNICEF and the Cambodian Government – was therefore to determine the stability of vitamin A, iron and zinc in rice, over time and in different storage and climatic conditions (including temperature and humidity). The research was designed to ensure that findings could feed directly into a new rice-fortification programme in Cambodia.

THREE WAYS OF FORTIFYING RICE

Hot extrusion passes dough made of rice flour, vitamin and mineral mix, and water through a screw extruder and cuts it into grain-like structures that resemble rice grains. This process involves relatively high temperatures (70°–110°C) obtained by pre-conditioning and/or heat transfer through steam-heated barrel jackets. It results in fully or partially pre-cooked simulated rice-like grains that have a similar appearance (sheen and transparency) to regular rice kernels.

Cold extrusion also produces rice-shaped simulated grains by passing dough made of rice flour, vitamin and mineral mix, and water through a simple pasta press. This technology does not utilize any additional thermal energy input other than the heat generated during the process itself. It is therefore primarily a low temperature (below 70°C), forming process resulting in grains that are uncooked, opaque, and easier to differentiate from regular rice kernels. Use of a binding agent such as alginate is necessary.

Coating combines the vitamin and mineral mix with ingredients such as waxes and gums. The mixture is sprayed on the surface of the grains in several layers, thereby forming the rice premix.

The premix made by these methods is then blended with natural polished rice to produce fortified rice. In this experiment the ratio of premix to natural rice was 1:99.

Source: Adapted from the Global Alliance for Improved Nutrition

"This piece of research has important and clear implications for policy, not only in Cambodia but more generally since rice is a big part of the diet in many countries worldwide"

Internal reviewer

RESEARCH METHOD: TESTING THREE KINDS OF FORTIFIED RICE

Fortified rice fit for human consumption is normally made by mixing artificially fortified rice kernels – also referred to as rice premix – with ordinary rice kernels – in this case, Thai jasmine rice. Three methods for creating this rice premix are described in the text box: hot extrusion, cold extrusion and coating.

The laboratory experimentation process tested fortified rice containing rice premixes created by all three methods and from six different producers. All rice premixes were made by using the same vitamin and mineral premix provided to the manufacturers by the Global Alliance for Improved Nutrition (GAIN) premix facility.

The vitamin and mineral premix for the fortified rice tested by the research project was supplied by GAIN. Each gram of premix contained 458 mg of ferric pyrophosphate, 7 mg of folic acid, 50 mg of vitamin B12, 100 mg of retinyl palmitate (vitamin A) and 183 mg of zinc oxide. These fortification levels were chosen to meet around 30 per cent of the recommended nutrient intake for a non-pregnant, non-lactating woman aged between 19 and 50.

The batches of fortified rice were stored within traditional bags under two sets of conditions normally encountered in developing countries:

- At a temperature of 25°C (plus or minus 5°C) and 60 per cent humidity.
- At a temperature of 40°C (plus or minus 5°C) and 75 per cent humidity.

The micronutrient concentrations in the rice batches were analysed at the outset (or baseline) then at three subsequent points: after 3, 6 and 12 months in the case of the rice kept in cooler, less humid conditions; and after 1, 3 and 6 months in the case of the rice stored in the hotter and more humid climate.

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RESEARCH FINDINGS

The findings showed that the concentrations of iron and zinc in the fortified rice were, in general, similar to those at the baseline. Retention levels at the end of the storage period were at least 89.4 per cent for iron and at least 96.3 per cent for zinc, even in the hotter and more humid conditions.

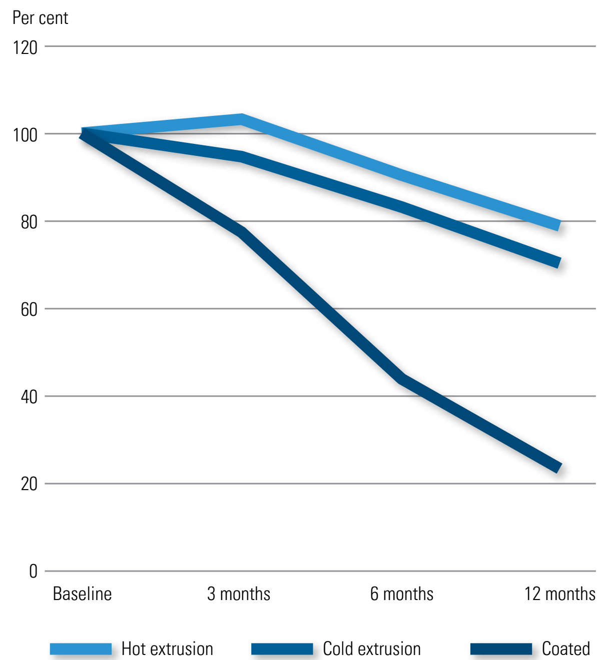
However, the results for concentration of vitamin A (retinyl palmitate) retained in the fortified rice differed greatly, depending not only on the climatic conditions in which the rice was stored, but also on the process used to make the rice premix. Significant storage losses of up to 90 per cent were experienced at the highest temperature and humidity.

Under both sets of climatic conditions and at every time point, the retention of vitamin A proved to be much better in fortified rice created by extrusion (whether hot or cold) than in rice that had been fortified through the coating process. After three months' storage at 25°C, the vitamin A concentration remained similar to the baseline for both extrusion methods, while the coated rice lost more than 20 per cent of its vitamin A content (see Figure 1). The retention gap between the extrusion and the coating methods becomes more marked as time progresses, with the coated rice retaining only 23 per cent of its vitamin A after one year.

However, at the higher temperature and humidity, all three types of fortified rice showed significant losses (see Figure 2). After three months the hot-extruded rice was the best performer, retaining 78 per cent of its vitamin A content, while the coated rice had lost all but 18 per cent of the initial concentration.

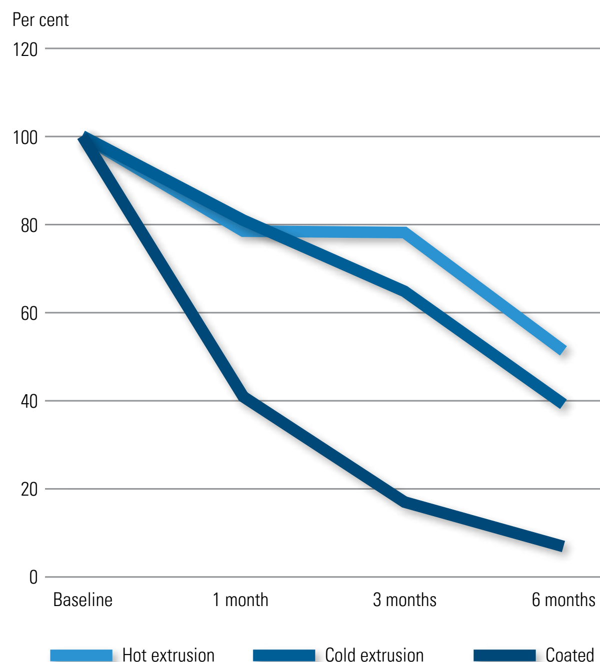
Taking both sets of results for vitamin A into account, after six months of storage, only the properties of the hot-extruded rice stored at 25°C were still not significantly different from the baseline.

FIGURE 1: RETENTION OF VITAMIN A OVER TIME BY FORTIFYING METHOD AT 25°C



Source: Extracted from Table 2, page 5 of full report

FIGURE 2: RETENTION OF VITAMIN A OVER TIME BY FORTIFYING METHOD AT 40°C



Source: Extracted from Table 2, page 5 of full report

CONCLUSIONS

The results of this study show that losses of iron and zinc in fortified rice during storage are negligible, even over longer periods of time, and at high temperature and humidity.

The fortification of rice with zinc could therefore be an effective solution to improve the zinc status of the Cambodian population.

Despite the proven stability of the iron in this experiment, it is less clear whether fortifying all rice consumed in Cambodia with iron would lead to a significant increase in iron status of the population. Mixed results in various countries have been reported on the effectiveness of iron-fortified rice on improving iron status, particularly when other micronutrients were included in the fortification. Wieringa et al. (2016) showed during a national survey in Cambodia that zinc deficiency, hookworm infection and haemoglobinopathy were significantly associated with anaemia in children, whereas in the women none of the factors was significantly associated with anemia. Iron deficiency anaemia (IDA) was more prevalent in children <2 years; but in older children and women, the prevalence of IDA was <5 per cent. Of particular concern is a Cambodian trial with fortified rice including iron that showed a significant increase in the prevalence of hookworm infection among schoolchildren.

On the other hand, since 2014, more than 40 producers of fish and soy sauce have been fortifying their products with iron, with almost 6.4 million litres produced to date. In Viet Nam, fortifying fish sauce with iron reduced the prevalence of anaemia and improved the iron status among women of reproductive age, and this could prove to be the most effective strategy for Cambodia too. However, further research would be needed before it would be possible to make a solid recommendation on the benefits of iron-fortified rice for Cambodia.

As regards vitamin A, concentration losses were considerable, especially at high temperature and humidity, with more than 80 per cent of vitamin A from coated fortified rice lost within three months. The current coating techniques for making rice premix appear to be inadequate to guarantee the desired vitamin A concentrations. Adding vitamin A to the premix for coated fortified rice is therefore not recommended.

Although vitamin A was more stable in extruded rice, after one year at high temperature and humidity, more than 50 per cent was lost. Even when using extruded rice, the addition of vitamin A to rice is of questionable value. While the amount of vitamin A added could be increased by a third to make good the losses during storage, a 2014 study in Cambodia by some of the same authors revealed that up to 80 per cent of vitamin A in rice is lost during the cooking process. Compensating for this loss by further increasing the vitamin A quotient is inadvisable, since high concentrations of vitamin A in the long term can be toxic for children. Adding vitamin A to vegetable oil may be a more effective way forward, though the quality of the vegetable oil determines the stability of the vitamin A. Overall, it is questionable whether rice is a suitable food for fortification with vitamin A. In order to maximize child growth, development and survival, other delivery mechanisms will need to be explored.

For full details of research methods and findings, link to the full report

http://www.mdpi.com/2072-6643/8/1/51/htm

EAST ASIA AND THE PACIFIC

Diversion Not Detention: A study on diversion and other alternative measures for children in conflict with the law in East Asia and the Pacific

Ingrid van Welzenis, Grace Agcaoili

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To what extent are countries offering alternatives to detention for children in conflict with the law?

The Committee on the Rights of the Child has emphasized the need to put mechanisms in place for alternatives to pre- and post-trial detention for children in conflict with the law in almost all its recent reports relating to East Asia and the Pacific. Such alternatives include 'diversion', whereby children either receive an unconditional police warning, or are referred to appropriate community-based organizations and social services, thereby avoiding the negative effects of formal judicial proceedings and a criminal record.

This in-depth study, commissioned by the UNICEF East Asia and Pacific Regional Office, focused on how 12 East Asian and 14 Pacific Island countries deal with children in conflict with the law, who are at, or above, the minimum age of criminal responsibility. The main purpose of the research was to carry out an analytical assessment of promising or good alternative practices in the region, while also identifying enablers and barriers to using diversion or other alternative measures. The research aimed to support efforts to implement, replicate and scale up alternative measures and to harmonize practices with international juvenile justice standards, in the best interests of the child.

EDITORIAL INSIGHT

Both internal and external reviewers rated this research highly across all criteria. This is clearly a neglected area of research and the research question is clearly defined with a sound analytical framework. Thorough assessment of the issue and careful comparison across countries led to highly context-specific policy recommendations. This multi-country approach and breadth and scope of analysis mean the potential for impact is high. Detailed documentation of a practical and innovative framework on the continuum of alternative measures that should be made available to young people in conflict with the law means replicability is possible in other regions. Finally, ethics procedures are well considered and reported to a high standard.

HOW WAS THE RESEARCH CONDUCTED?

The information on diversion and other alternative measures was collected through a combination of quantitative and qualitative research methods, including desk reviews of relevant documents, questionnaires, interviews and in-country visits. The results were presented, discussed and validated during a regional workshop.

The assessment process consisted of four consecutive phases:

- Preparing the methodology and templates for the desk review, questionnaire and interviews;
- Collecting data on diversion and other alternative measures through the desk review, questionnaire and interviews;
- Sampling of the countries for in-country visits and collecting detailed information about promising/good practices in selected countries, including the associated running costs; and
- Conducting a regional workshop to exchange and validate the findings.

THE RESEARCH FINDINGS

THE JUVENILE JUSTICE CONTEXT

In any study of 26 countries there is bound to be an enormous diversity of systems and approaches:

- 14 countries have specialized juvenile justice systems, while 11 countries have specialized professionals appointed to deal with cases of children in conflict with the law.
- 10 Pacific countries have neither juvenile justice institutions nor juvenile justice professionals, while that is the case in one East Asian country only.
- More than half the countries in the region have adopted child-specific legislation incorporating provisions on juvenile justice.
- Facilities where children are deprived of their liberty exist in 15 East Asian and Pacific countries.
- 10 East Asian and 2 Pacific countries have established a mechanism to coordinate the activities between the juvenile justice sector and the social welfare sector; 6 of these have developed inter-agency/sectoral protocols.
- Most countries (10 East Asian and 7 Pacific) have mechanisms in place to implement and monitor diversion and other alternative measures for children in conflict with the law.

TABLE 1: SPECIALIZED JUVENILE JUSTICE INSTITUTIONS

Region	Child police units	Child prosecution	Child courts	Child legal aid	Child probation
10 East Asian countries	5 Indonesia, Mongolia, Myanmar, Thailand, Timor-Leste	2 China, Thailand	7 China, Lao PDR, Malaysia, Myanmar, Papua New Guinea, Thailand, Viet Nam	2 China, Lao PDR	1 Papua New Guinea
4 Pacific Island countries	2 Fiji, Samoa	2 Fiji, Samoa	3 Fiji, Samoa, Solomon Islands	0	2 Samoa, Cook Islands
East Asian and Pacific region	**7**	**4**	**10**	**2**	**3**

Source: *Specialized juvenile justice institutions*, Table 9, page 19 of full report

TABLE 2: PRESENCE OF SPECIALIZED JUVENILE JUSTICE PROFESSIONALS

Region	Child police	Child prosecutors	Child judges	Child lawyers/ paralegals	Child probation officers	Child social workers
8 East Asian countries	3 Indonesia, Myanmar, Philippines	4 China, Indonesia, Timor-Leste, Thailand	7 China, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand	1 China	4 Indonesia, Malaysia, Myanmar, Papua New Guinea	3 Indonesia, Papua New Guinea, Philippines
3 Pacific Island countries	1 Fiji	0	2 Samoa, Cook Islands (?)	0	1 Samoa	2 Fiji, Samoa
East Asian and Pacific region	**4**	**4**	**9**	**1**	**5**	**5**

Source: *Presence of specialized juvenile justice professionals*, Table 10, page 20 of full report

- Only 8 countries (6 East Asia and 2 Pacific) have statistics available on juvenile justice and alternative measures for these children.
- Only 6 countries (5 East Asia and 1 Pacific) have a minimum age of criminal responsibility that complies with international standards, though China and Mongolia do not comply simply because they have two minimum ages (both are over the internationally accepted minimum of 12 years).
- There are not enough community-based organizations and services for children in conflict with the law in the region.

"This study's strength lies in filling an important gap in the knowledge of juvenile justice practitioners on what is a successful diversion practice"

External reviewer

COMMUNITY JUVENILE JUSTICE

Almost all the region's countries (9 East Asian and 14 Pacific) apply some form of community juvenile justice. The researchers were not able systematically to collect detailed information on these practices but, in general, the data suggest that community justice actors do not hold children in conflict with the law responsible for their offending behaviour. Most conflicts are solved through financial or material compensation of the victim/victim's family by the child's parents/guardians. The research includes six promising practices of community juvenile justice that have been developed in the East Asian and Pacific region (Lao PDR, Myanmar, Papua New Guinea, the Philippines, Samoa and Timor-Leste).

In community juvenile justice there is no contact with the formal juvenile justice system before or during the mediation process. Only when the parties cannot reach an agreement, or the parties do not comply with the conditions agreed upon, may the case be referred to the formal juvenile justice system. When children are diverted back to the community by the police, prosecution or court to await trial or serve a sentence, these are formal juvenile justice responses that are carried out in the community and should be carefully distinguished from community juvenile justice.

SIX ALTERNATIVE MEASURES

The main tool the research team used to analyse the alternative measures applied in cases of children in conflict with the law is the continuum of six family/community-based alternative measures derived from international juvenile justice standards promoted by the Convention on the Rights of the Child and other international child-specific instruments.

1. Unconditional diversion

Unconditional diversion is applied frequently in 14 East Asian and Pacific countries. It usually takes the form of a police warning and is more often used in practice than it is incorporated into national legislation. Particularly promising police warning practices have been developed in Samoa and Papua New Guinea.

2. Diversion from formal judicial proceedings

Referring children to appropriate community-based organizations and social services avoids the negative effects of formal judicial proceedings and a criminal record. In practice, all but one of the 26 countries in the region apply diversion, and 17 do so frequently. Examples of diversion conditions with which children may have to comply are: school attendance, vocational training, life skills programmes, religious activities, community work hours, counselling and curfew. It is very common for the parents/guardians to have to compensate the victim(s) when their child is diverted. Particularly good practices have been developed in Cambodia, Indonesia, Kiribati, Myanmar, the Philippines and Thailand.

3. Alternatives to pre-trial detention

These provide family/community-based options to detention for the supervision of children awaiting trial. All 26 countries have incorporated provisions on alternatives to pre-trial detention into law and all but one country apply those alternatives in practice. All countries release children in conflict with the law to their parents/guardians at the pre-trial level, but they can also be released to family members (17 countries), other respected adults (16) or civil-society/faith-based organizations (4). Six promising practices are highlighted: in Fiji (2), Malaysia, Samoa, Thailand and Vanuatu.

4. Measures to minimize time in pre-trial detention

If pre-trial detention is unavoidable, the time children spend in detention should be limited to the shortest appropriate period. Most countries have incorporated provisions on release from pre-trial detention into law. Most also regularly review children's pre-trial detention but only four frequently release children in such circumstances.

5. Alternatives to post-trial detention

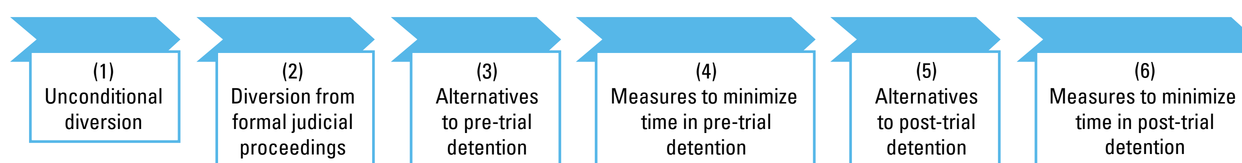
These offer family/community-based options for children's reintegration, rehabilitation and supervision, rather than sentencing them to any form of institution. All 26 countries have incorporated such provisions into law and 20 apply the alternatives frequently.

The most widely used alternatives are probation (19 countries) community service (14) and participation in a specific reintegration programme (12). Nine good practices of alternatives to post-trial detention are cited in: Fiji, Kiribati, Malaysia, Papua New Guinea, Samoa, Thailand (2), Vanuatu and Viet Nam.

6. Measures to minimize time in post-trial detention

The law in almost all the region's countries allows the early (conditional) release of children from post-trial detention and this happens frequently in 18 countries (6 East Asian and 12 Pacific). Children released from detention facilities and other closed institutions are monitored in 19 countries (7 East Asian and 12 Pacific).

FIGURE 1: CONTINUUM OF ALTERNATIVE MEASURES FOR THE FORMAL JUVENILE JUSTICE PROCESS



Source: *Continuum of alternative measures for the formal juvenile justice process*, Figure 3,page 36 of full report

TABLE 3: UNCONDITIONAL DIVERSION/POLICE WARNINGS IN NATIONAL LAW AND IN PRACTICE

Region	In national law	In actual practice		
		Scale unknown	Hardly used	Rather often or often used
East Asian countries	5 Cambodia, Indonesia, Lao PDR, Papua New Guinea, Viet Nam	5 Indonesia, Lao PDR, Malaysia, Mongolia, Thailand	3 Cambodia, Myanmar, Timor-Leste	2 Papua New Guinea, Viet Nam
Pacific Island countries	2 Samoa, Solomon Islands	1 Vanuatu	0	12 Cook Islands, Fiji, Marshal Islands, Micronesia, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu
East Asian and Pacific region	**7 East Asian and Pacific countries**	**23 East Asian and Pacific countries**		

Source: *Unconditional diversion/police warnings in national law and in practice*, Table 15, page 38 of full report

TABLE 4: DIVERSION IN PRACTICE

Region	Scale unknown	Hardly used	Rather often or often used
12 East Asian countries	4 China, Lao PDR, Malaysia, Myanmar	4 Cambodia, Mongolia, Philippines, Viet Nam	3 Indonesia, Papua New Guinea, Thailand
Pacific Island countries	0	0	14 Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu
East Asian and Pacific region	**4**	**4**	**17**

Source: *Diversion in practice*, Table 17, page 45 of full report

TABLE 5: RESTORATIVE JUVENILE JUSTICE IN PRACTICE

Region	Diversion	Alternatives to pre-trial detention	Alternatives to post-trial detention	Early release from
12 East Asian countries	8 Cambodia, China, Indonesia, Lao PDR, Mongolia, Philippines, Papua New Guinea, Thailand	1 China	5 China, Lao PDR, Mongolia, Papua New Guinea, Thailand	2 China, Papua New Guinea
14 Pacific Island countries	13 Cook Islands, Fiji, Kiribati, Marshal Islands, Micronesia, Nauru, Niue, Palau, Tokelau, Tonga, Tuvalu, Samoa, Vanuatu	0	13 Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia, Nauru, Niue, Palau, Tokelau, Tonga, Tuvalu, Samoa, Vanuatu	0
East Asian and Pacific region	**21**	**1**	**18**	**2**

Source: *Restorative juvenile justice in practice*, Table 32, page 71 of full report

RESTORATIVE JUVENILE JUSTICE APPROACHES

These include reconciliation, mediation, conferencing, compensation and settlement, while the study also considers community service an indirect restorative justice approach. Sixteen East Asian and Pacific countries incorporate provisions on restorative justice into law. In practice, a restorative juvenile justice approach is most often used but restorative alternatives to post-trial detention are also rather common.
The study describes seven promising practices of restorative juvenile justice in: Indonesia, Kiribati, Papua New Guinea (2), the Philippines, Samoa and Thailand.

"This research provides a platform of documented practices as well as analysis of policy and legal gaps, which is ideal for cross-country exchanges of best practice and for leap-frogging change"

External reviewer

BARRIERS – AND HOW TO OVERCOME THEM

Stakeholders identified key barriers to using diversion, restorative juvenile justice or other alternatives that involved insufficient supply. These included:

- Child-specific legislation on diversion, alternatives and restorative justice approaches;
- Funding guidelines, rules and policies on how to implement alternatives;
- Awareness, understanding and commitment of juvenile justice professionals; and
- Human resources, especially social workers, probation officers and specialized juvenile justice professionals and/or volunteers.

They were also constrained by opinion among juvenile justice professionals and the general public that crime should be punished.

The main enabling influences identified were:

- Capacity-building of juvenile justice professionals (and other stakeholders) on diversion and other alternative measures;
- Pilot schemes that prove the effectiveness of alternatives and show how to take them to scale;
- Support and commitment of national and local governments; and
- Existing traditions, customs and practices that support diversion and other alternative measures.

The researchers recommended that these barriers and enablers be taken into account when developing initiatives, policies or programmes for juvenile justice. They also offered recommendations specifically related to restorative juvenile justice, the continuum of alternative measures, community juvenile justice, diversion, and alternatives to both pre-trial and post-trial detention. It is hoped that this research may guide implementation, replication and scaling-up of diversion, alternatives to pre-trial and post-trial detention, and restorative juvenile justice approaches throughout East Asia and the Pacific.

For full details of research methods and findings, link to the full report

https://www.unicef.org/eapro/Diversion_Not_Detention_-_Alternative_Measures_for_Children_in_Conflict_with_the_Law_in_East_Asia_and_Pacific.pdf

FRANCE

Neither Safe Nor Sound: The situation of unaccompanied children in the north of France

Olivier Peyroux, Alexandre Le Clève, Evangéline Masson Diez

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EDITORIAL INSIGHT

This research was shortlisted because of its topical relevance and originality. Its timeliness guarantees wide-scale interest and hence enhanced potential for research uptake and impact. Both internal and external reviewers rated it highly for its conceptualization of the research question. The presentation style was also rated highly, with the voices of children and key policy messages being clearly and effectively presented.

What is the experience of unaccompanied children in France's migrant camps?

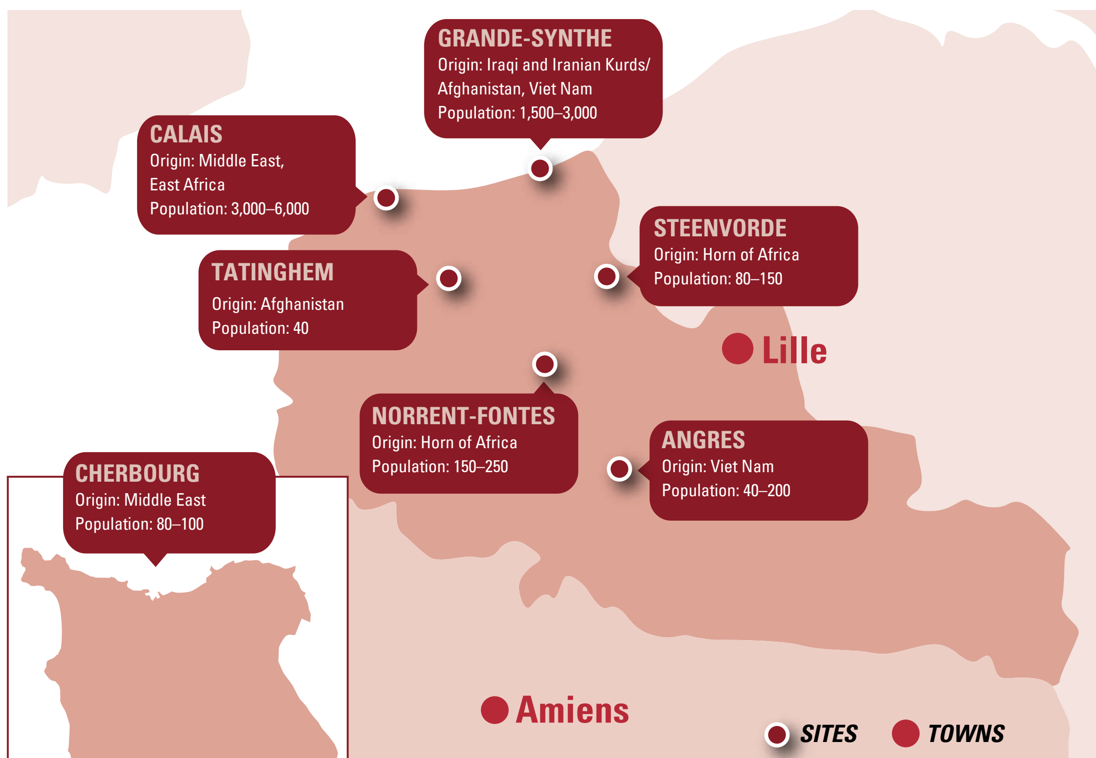
In 2015 and 2016, more than a million people made the perilous journey across the Mediterranean in an attempt to reach Europe. Increasing numbers of children were among them. As of June 2015, one in ten was a child. By the end of December 2015, the proportion had risen to one in three. Some of these children end up in the makeshift camps in northern France, bordering the English Channel, wanting to cross to the United Kingdom.

This sociological study, undertaken by Trajectoires on behalf of the UNICEF National Committee of France, sought to understand and document the risks to which such children are exposed, not just while in the camps, but throughout their hazardous journey to and within Europe.

The research was carried out between January and April 2016 across seven sites – Calais, Grande-Synthe, Angres, Norrent-Fontes, Steenvoorde, Tatinghem, and Cherbourg (see map).

Based on censuses carried out by various organizations, the researchers estimated that some 2,000 unaccompanied children passed through these seven sites between June 2015 and April 2016.
As of March 2016, the researchers estimated around 500 unaccompanied children were living in the seven camps in northern France, though such estimates are unreliable in the absence of registration and

SEVEN REFUGEE SETTLEMENTS IN NORTHERN FRANCE



Source: Adapted from map on page 14 of full report

monitoring by the authorities, and owing to the fact that the children are often on the move.

Based on the sample interviewed, the average duration of children's stay in the camps was five months, though some had been in this situation for nine months and one for over a year.

"The experience of the children emerges very well. One visualizes their living conditions, their paths and their expectations"
External reviewer

HOW THE RESEARCH WAS CONDUCTED

The study was based on three main qualitative data sources: interviews with voluntary organizations involved on the sites, with or without a charitable mandate; individual and group interviews with the child migrants; and documentary research and meetings with individuals qualified to comment on each country of passage and its migration patterns.

The core of the research was provided by 61 semi-structured individual and group interviews with unaccompanied children from the camps, all conducted in their mother tongue. Of these children, three were aged 11 to 12, nine were aged 13 to 14, and 49 were aged 15 to 17. Their countries of origin were: Afghanistan, Egypt, Eritrea, Ethiopia, Guinea, Iran, Iraq, Kuwait, Sudan, Syria and Viet Nam. The interviews lasted up to 90 minutes.

The examples of violence, trafficking and abuse described in this report were gleaned from the testimonies of the children interviewed. Most of these instances have not resulted in the filing of a complaint

and therefore there has been no investigation or prosecution. However, where children were exposed to major risks on the sites the researchers pursued a rigorous cross-checking process with the various actors on the ground, such as voluntary organizations, hospitals and temporary reception centres.

"This is a ground-breaking report that provides detailed sociological analysis of the plight of unaccompanied children in the north of France"

Internal reviewer

LIMITATIONS OF THE RESEARCH

This research faced numerous constraints:

- It took place during a complex period that attracted a great deal of media attention. Given the large journalistic presence and ongoing state of flux, access to migrants and unaccompanied children was not always easy.
- It was difficult to conducting confidential meetings on these sites. There were few neutral and closed spaces; the young peoplewere often accompanied by other migrants, who were often older and monitored what the younger individuals said.
- The study was carried out over a limited period of time so that it was impossible to meet all the unaccompanied children in the coastal camps.

The research should therefore be considered as a piece of qualitative research undertaken with a particular group of children and makes no claim to be exhaustive.

"The report is really well structured and rich with primary data. The interviews with the children provide a heart-breaking account of their personal journeys and the complexities experienced"

Internal reviewer

THE MIGRATION JOURNEY AND TRAFFICKING

Each child had a different point of origin and a different personal experience. Nevertheless, some common patterns emerged. Most had made use of traffickers. The routes taken varied according to the migrant's financial means. In some cases, the journey was organized and paid for before leaving their home country. In these cases, a guide (referred to as 'uncle') took over in each new country and escorted the children to the next border. The cost of this trafficking arrangement could be as much as €10,000 ($11,100) but it could result in the journey across Europe taking as little as 15 days. In contrast, unaccompanied children from poorer families had to pay as they went, negotiating with the local traffickers in each country along the way. In such circumstances, the migration journey took much longer – the longest such journey reported by a child was seven months.

Regardless of the chosen method, the route is highly dangerous. In many cases, the sea crossing between Turkey and Greece, or between Libya/Egypt and Italy, proved to be traumatizing owing to the loss of loved ones or the sense of impending death. Moreover, several children had been held by different criminal groups and a ransom request had been sent to their families. Some were forced to work in near slave-like conditions for many months in order to pay for their journey. Others were detained for long periods by the local authorities.

Relations with the 'uncle' were rarely benevolent in nature. There were stories of children who walked too slowly being abandoned in the mountains. Sexual abuse was commonplace.

Even once the children reached the camps in France, they were still at the mercy of the traffickers. An 'entry fee' was levied by traffickers for most sites in this study. The unaccompanied children who were unable to pay found themselves forced to perform chores for the adults: fetching water, queuing for showers on behalf of the adults, or reselling food at the informal night-time market.

Since different points of passage (such as parking areas for trucks or trains) were secured by the authorities,

it was practically impossible for those trying to cross to the United Kingdom to do so without help from traffickers, the going rate for which was between €5,000 and €7,000 ($5,600 and $7,800) per person. Some were desperate enough to take significant risks trying to reach the UK without paying, by hiding, for example, in refrigerated trucks or containers.

"The hardest thing is the waiting and the loneliness. I have nothing to do, I walk in circles"
Ahmed, a 17-year-old Syrian

LIFE IN THE CAMPS

Significant physical and mental health risks. All the children interviewed complained of cold and fatigue. The most vulnerable were living in shelters that were exposed to the elements and found it difficult to access meals and showers. Heightened border security meant that unaccompanied children ended up staying in the slums along the coast for longer and, as a result, the extremely difficult living conditions had a greater impact on their health. Many indicated that they could not stand the inactivity, which in some cases had triggered nervousness and depression. Some unaccompanied children spoke of their desire to be hospitalized in a psychiatric ward following instances of mental breakdown and violent episodes (directed towards themselves or towards other young people). Infectious and dermatological diseases as well as secondary infections related to living conditions in the camps were rife.

"We want the simple things in life, just not to live like dogs; learn French and English, go to school, be clean and safe"
A 14-year-old Egyptian

No access to schooling. None of the unaccompanied children had access to regular schooling, despite the fact that this is guaranteed by French common law and that an inter-ministerial decree of 25 January 2016 confirmed that: "In France, every child and adolescent has the right to education, regardless of his/her immigration status". On 23 March 2016, the Prefecture of Pas de Calais announced that a school for migrant children would open in mid-May 2016 inside the Jules Ferry Centre in Calais.

"I know that if I pay, or offer sex, I will cross more quickly"
Martha, a 16-year-old Ethiopian

Everyday violence. Migrants living in the slums along the coast were exposed on a daily basis to many types of violence-related risks during their attempts to cross to the United Kingdom, during fights between the various communities and during police operations. Fights between migrants were becoming more and more commonplace, particularly in Calais. On account of their vulnerability, children were among those at greatest risk. Children expressed their fear of violence by the police, civilian militias and traffickers.

"It was very hard, I didn't have control over anything, I depended on the traffickers"
Winta, 13 years old

Sexual assault and exploitation. Sexual violence was a constant threat for both girls and boys. Interviews conducted with young Ethiopian, Eritrean and Kurdish women identified practices involving offering sex in exchange for a promise of passage to the United Kingdom, or in order to access certain areas of the camp. Young women said that those who engaged in prostitution passed through faster. All the children interviewed said they worried about going out after dark, for fear of rape. Some accounts mentioned situations in which children were regularly sexually abused, often by traffickers and their friends.

TEN KEY RECOMMENDATIONS

The report argues that many unaccompanied children in the camps in northern France are at the mercy of exploitation networks. Without exception, they are in danger because of their isolation and living conditions. The researchers maintain that new measures are urgently needed, including changes to the child protection system, to enable children to avoid situations that increase their vulnerability. They suggest the following ways forward:

1. **Create a place of 'protection' within sites**, secure and specific to unaccompanied children. Children settling there would receive unconditional support, with the prospect of access to common law.
2. **Guarantee all children equal access to information and various services** through regular contact with professionals speaking the children's languages and through the use of age-appropriate information.
3. **Support and coordinate those working on the region's sites with the aim of implementing uniformity of practices and information distributed**, enabling access to all children, including those within the smaller camps.
4. **Introduce regular training on child protection** for the organizational workers, police forces, administrators and volunteers to help them identify situations involving human trafficking and provide guidance to unaccompanied children.
5. **Refer back to the legal framework for the protection of children**, which includes the importance of reporting to Public Prosecutor's departments, and of reporting unsettling information, which will allow the departmental councils to become empowered in their mission to care for children in danger.
6. **Report all evacuations** if there are no adapted arrangements for the reception and guidance of unaccompanied children, to prevent a trend of dispersal and the breaking of the bonds that children and young people may have formed with social workers or other trusted adults.
7. **Ensure that the French and United Kingdom governments dedicate sufficient resources to the family reunification process**, thereby significantly reducing the duration of this process to a maximum of three months.
8. **Ensure that children have received reliable information regarding the family reunification procedure** under the Dublin Regulation, including the criteria on which decisions will be based.
9. **Guarantee access to high-quality legal assistance for unaccompanied children**, so that their request for family reunification in the United Kingdom can be submitted as quickly as possible.
10. **Publish practical advice on how to handle family reunification cases under Dublin III**, including clarification of responsibilities and processes in the assessment of the unaccompanied children's families in the United Kingdom, ahead of transfers.

For full details of research methods and findings, link to the full report

https://www.unicef.fr/sites/default/files/atoms/files/ni-sains-ni-saufs_mna_france_2016_0.pdf

GUINEA-BISSAU

Contextual and Psychosocial Factors Predicting Ebola Prevention Behaviours in Guinea-Bissau

Anna E. Gamma, Jurgita Slekiene, Gregor von Medeazza,
Fredrik Asplund, Hans-Joachim Mosler

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EDITORIAL INSIGHT

Both the internal and external reviewers rated this piece highly for conceptualization of the research question, innovation and originality and potential for impact. It demonstrated a solid quantitative methodology and should be a useful tool to adapt for future Ebola epidemics. Ethics procedures were reported to a good standard and the writing and presentation of findings are succinct and clear.

How can people be motivated to prevent the spread of Ebola?

The outbreak of the Ebola virus disease in December 2013 in Guinea soon spread to neighbouring West African countries and became the largest and most complex Ebola epidemic in history. By March 2016, there had been 28,646 confirmed, probable and suspected cases of Ebola and 11,323 reported deaths. The most affected countries were Guinea, Liberia and Sierra Leone, though cases were also reported in Italy, Mali, Nigeria, Senegal, Spain and the United States.

Guinea-Bissau, which shares a border with Guinea, was at high risk throughout this period: cross-border market activities, risky burial ceremonies and poor water, sanitation and hygiene in many communities all contributed to the country's vulnerability. In July 2015, the Emergency Committee convened by the Director-General of the World Health Organisation therefore recommended strengthening Guinea-Bissau's Ebola preparedness as well as its prevention and response capacities.

Since no licensed Ebola vaccines exist so far, people's behaviour plays a vital role in preventing transmission of the virus. A person with Ebola needs to be isolated and treated in a health centre. To enable rapid communication in the event that someone was suspected of contracting Ebola, the Guinea-Bissau Health Ministry launched a national Ebola hotline. If people discovered someone in their household who might have Ebola, they were encouraged to ring the hotline immediately and also to avoid touching the person.

THE RESEARCH PURPOSE

The purpose of this research was to close the research gap in knowledge of the influencing contextual and psychosocial factors, in order to ensure Ebola prevention instructions are followed by a population at high risk of an Ebola outbreak or during an ongoing outbreak. The intention was to use these findings to strengthen the country's preparedness capacity and its health system in the face of a potential Ebola outbreak, including the ability to strengthen detailed coordination amongst partners.

This research, conducted by the Swiss Federal Institute of Aquatic Science and Technology on behalf of UNICEF Guinea-Bissau, aimed to determine how likely people were to take action on two Ebola prevention instructions – calling the national Ebola hotline or avoiding touching the potential patient. Given that there were no actual cases of Ebola in the country, the research project evaluated people's intended behaviour – as well as the underlying contextual and psychosocial factors that might affect the realization of that intention, either positively or negatively. The results cast light on how psychosocial factors affect people's response to health promotion messages and suggest that such messages may need to be carefully adapted to national and local contexts.

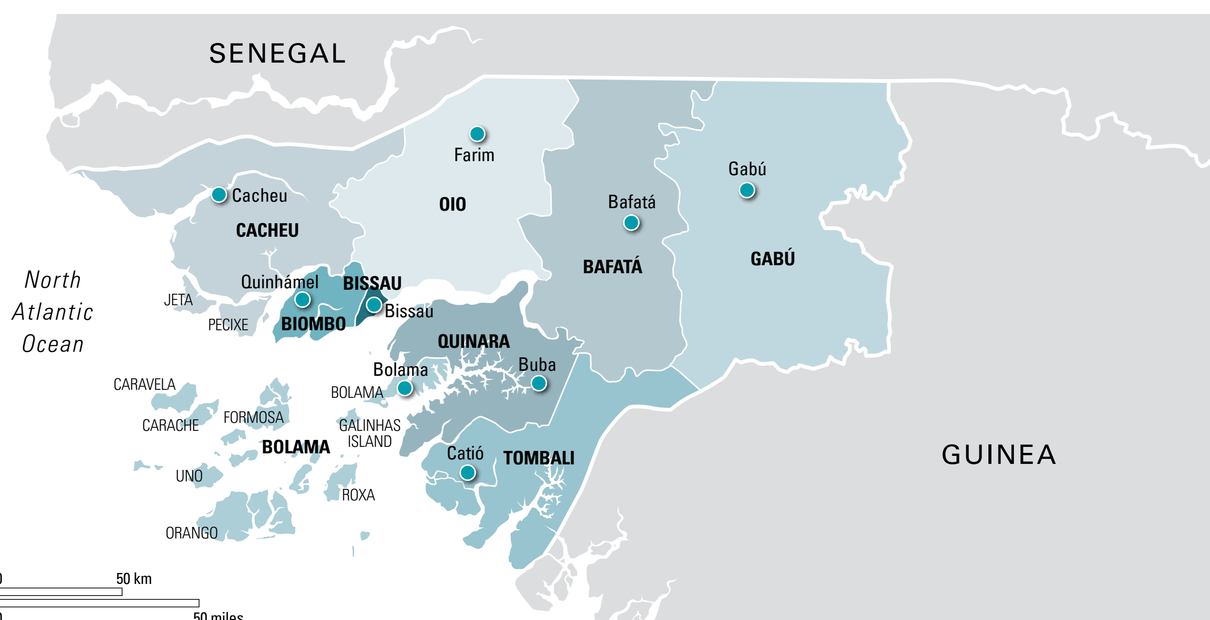
THE RANAS MODEL

The research team applied a theoretical framework and an established model for designing and evaluating behaviour change strategies in developing countries called RANAS (risk, attitude, norm, ability and self-regulation). According to this model, there are five blocks of psychological factors that have to be favourable if a new health behaviour is to be adopted:

- Risk factors refer to an individual's understanding and awareness of a health risk and the perceived consequences of a disease.
- Attitudinal factors include beliefs about the costs and benefits attached to a particular behaviour.
- Normative factors involve what the social environment thinks about a certain behaviour.
- Ability factors relate to the individual's perception of their personal ability to execute the behaviour.
- Self-regulation factors are responsible for maintaining the behaviour.

The first step is to determine the factors that influence the target behaviour in the population in question. Specific interventions can then be selected to tackle these influencing factors.

FIGURE 1: REGIONS OF GUINEA-BISSAU



It is also important, however, to take account of features of the physical environment as contextual factors that may have a bearing on the desired behaviour change, something often overlooked in theoretical studies in this field. The research team therefore looked at contextual as well as psychosocial factors when considering whether instructions aimed at preventing the spread of Ebola would be implemented.

HOW THE RESEARCH WAS CONDUCTED

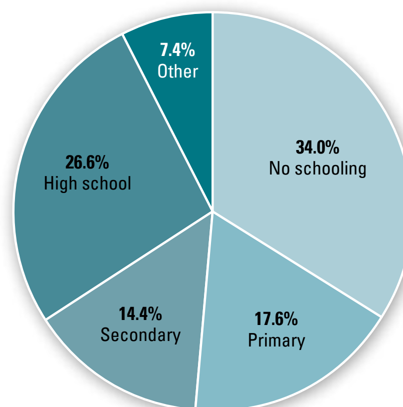
The data collection took place in July and August 2015 in rural, peri-urban and urban areas in all nine of Guinea-Bissau's regions (see Figure 1).

A team of 20 health sector employees carried out structured face-to-face interviews in 1,369 randomly selected households. Each interview took around one hour and most of the interviews were carried out in Creole, though some were conducted in Bijago, another local language. Prior to the data collection, the interviewers attended a seven-day intensive training on the study methodology. Some 54 per cent of the participants interviewed were women, who are generally the primary care providers in Guinea-Bissau, responsible for the care of sick family members. Men were interviewed too, as they can play a key role in terms of preventing or transmitting Ebola.

Participants were asked about their education level (see Figure 2) and type of work (see Figure 3), and were also assessed on six contextual factors: their gender, age, literacy, household size, wealth and whether they owned a mobile phone.

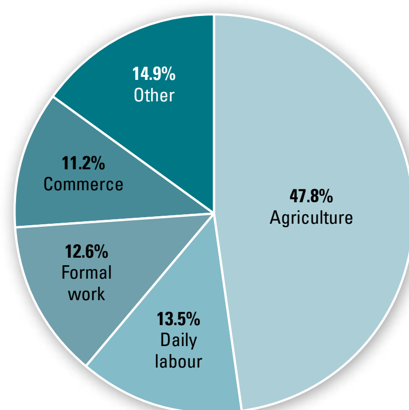
They were also asked questions to gauge their behaviour intention (motivation) and their behaviour willingness (what they were willing to do under certain cirumstances). While there was a high level of correlation between the two, there was some variance that could affect whether an intention is implemented. Behaviour intention was gauged by asking individuals to rate the strength of their intention to take action on one of the Ebola prevention instructions on a scale from 1 (not at all) to 5 (very strongly). For behaviour willingness the respondents were asked to imagine themselves coming home from the market to find someone in their household vomiting blood – and then to rate their willingness to take action on one of the Ebola prevention instructions, also on a scale from 1 to 5.

FIGURE 2: PARTICIPANTS BY EDUCATION LEVEL



Source: Based on data from page 7 of full report

FIGURE 3: PARTICIPANTS BY TYPE OF WORK



Source: Based on data from page 7 of full report

> *"A pertinent research question which could improve future programming in emergencies and help to save lives"*
>
> Internal reviewer

RESULTS

On average, the study participants scored 3.96 on a scale of 1 to 5 on the strength of their intention to call the national Ebola hotline and somewhat less – 3.69 – on the strength of their intention not to touch someone in their household who might have the disease (see Table 1).

TABLE 1: MEAN STRENGTH OF INTENTION ON THE TWO ISSUES

	Number	Mean (scale 1–5)	Standard Deviation
Calling the hotline	1,018	3.96	0.77
Not touching	1,092	3.69	1.04

Source: Adapted from Table 1 of full report

PSYCHOSOCIAL FACTORS

- Respondents saw their risk of contracting Ebola as low to medium, even though their health knowledge was medium to high and their perception of Ebola's severity was high.
- Participants were certain that calling the national Ebola hotline would help someone with Ebola and believed most people in their household would feel the same. However, they thought that only half of the rest of the village would do so and that key individuals in the community might be moderately disapproving.
- However, 91.3 per cent of respondents did not know the national Ebola hotline number.
- Those participating were clear that they should not touch someone with Ebola and also felt that this was within their control.

CONTEXTUAL PREDICTORS

- A linear regression analysis of contextual factors indicated that the significant predictors on calling the national Ebola hotline were age and wealth. In other words, younger people and better-off respondents tended to have a stronger intention to call the national Ebola hotline than others.
- A similar analysis of contextual factors suggested that people with higher levels of literacy and wealth tended to be more committed to avoiding touching someone with Ebola.

COMBINING THE TWO

The significant contextual predictors were then included in the statistical regression analysis with the psycho social factors. The result was that only one contextual factor (age) was shown to contribute significantly to predicting the intention to call the national Ebola hotline – in other words, younger people were more likely to call the hotline than older people. There were, however, some key psycho social factors that contributed significantly:

- Perception of Ebola's severity;
- Health knowledge;
- Personal belief that calling the hotline would make a difference;
- The behaviour and the approval of others in the household; and
- A sense of personal obligation.

While none of the contextual factors proved significant when predicting the intention not to touch someone who might have Ebola, some psychosocial factors did contribute:

- Health knowledge;
- Perception of Ebola's severity;
- Understanding risk attached to touching someone who might have Ebola;
- Personal belief that not touching would make a difference; and
- Self-regulation (having control over whether the person would be touched).

But it was also found that the opinion of others contributed negatively in two ways: people's resolve not to touch someone who might have Ebola was weakened by the thought that others would therefore think them either not such a nice person or someone who did not want to help.

HOW SHOULD THIS AFFECT FUTURE PRACTICE?

In this particular case, the intention to call the national Ebola hotline might be increased by providing a positive group identity: people who are already committed to calling the national Ebola hotline might be described, for instance, as 'modern', in order to increase the attractiveness of the behaviour itself. People's commitment to calling the hotline might alternatively be increased by numerous people pledging to do so in public places, or by radio spots encouraging the practice and raising awareness of the hotline number.

When it comes to strengthening people's determination not to touch someone who might have Ebola, various behaviour change techniques can be used: encouraging participants to seek practical or emotional support from relatives, friends or others, for example; or modelling the behaviour and its consequences in a theatrical play.

The Ebola epidemic in West Africa is now over but the lessons of this research can be applied in relation to other outbreaks of contagious diseases, including the recurrent endemic cholera bouts or the Zika threat in Guinea-Bissau and elsewhere. The findings of this research can help to design more efficient behaviour change interventions and to address the behavioural barriers.

This research also sheds light on important aspects with regard to the impact of public health interventions during emergencies and epidemics. Many health promotion activities focus primarily on disseminating knowledge around the risks and benefits of hygiene practices. If raising knowledge about the dangers of a disease is having a relatively small effect on people's behaviour, aid providers may need to adapt their messages accordingly.

For full details of research methods and findings, link to the full report

https://doi.org/10.1186/s12889-017-4360-2

INDIA

Formative Research Report on Knowledge, Attitudes and Practices of Caregivers of Children with Birth Defects and Developmental Delays

Geeta Sharma, Pravin Khobragade, Lakshmi Gopalakrishnan,
Deepak Seharawat, Ajay Khera, Arun Sigh

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EDITORIAL INSIGHT
Both internal and external reviewers highlighted good conceptualization and design of the research question, good use of mixed methods (qualitative and quantitative) to give an excellent sense of the scope of the issue, and a rigorous and comprehensive analysis of findings. Ethical issues were well considered and the potential for impact is high, given the clear policy recommendations and concrete next steps already under way regarding widespread roll-out of the social behavioural communications framework across India and direct links to UNICEF programming.

Why are children with birth defects and developmental delays not getting the help they need?

India has more children with birth defects and developmental delays than any other country in the world. This is largely due to its population size: it has a child population of more than 400 million and a prevalence of birth defects of between 61 and 70 per thousand live births, which translates to around 1.7 million children born with birth defects each year. On top of this, around 10 per cent of Indian children suffer from developmental delays, including physical and cognitive disabilities.

In 2013, the Indian Ministry of Health and Family Welfare launched a new Child Health Screening and Early Intervention Services initiative – 'Rashtriya Bal Swasthya Karyakram' (RBSK) – to provide free, targeted, comprehensive screening and care for all child health conditions to children aged 0–18 years. Under RBSK, children are screened for 4Ds – defects at birth, diseases, deficiencies, and developmental delays including disabilities – in order to identify early interventions where feasible. The programme has been implemented on a staggered basis, with some states introducing it before others.

However, India lacks a surveillance system to capture the full extent of birth defects and developmental delays. There are limited epidemiological data

in this area as well as very little social research. While there are other health programmes in place to address interventions related to diseases and deficiencies, interventions to address birth defects and developmental delays including disabilities (2Ds) are covered only under RBSK.

To address this gap, UNICEF India commissioned Deloitte India to undertake some formative research to build evidence on the social norms, knowledge, attitudes, practices, health-seeking behaviours, and barriers of caregivers of children with 2Ds and also of wider community members in consultation with the Ministry of Health and Family Welfare.

In addition, it documented the main challenges and barriers facing marginalized groups who wished to access RBSK services, while also seeking to understand the systemic and operational problems faced by workers charged with effectively delivering those services at state and district levels.

The findings from the formative research then informed the design of a National Communication Framework aimed at raising communities' awareness of the benefits of early diagnosis and increasing their readiness to use the services provided by RBSK. This Framework uses a socio-ecological model, reflecting a shift from a focus on the parents (usually the mother) alone to recognizing that a range of family, community members and social, political networks (policymakers, community and service providers) influence behavioural outcomes.

"The importance of conducting evaluative studies in real time is an important lesson from this piece of research"

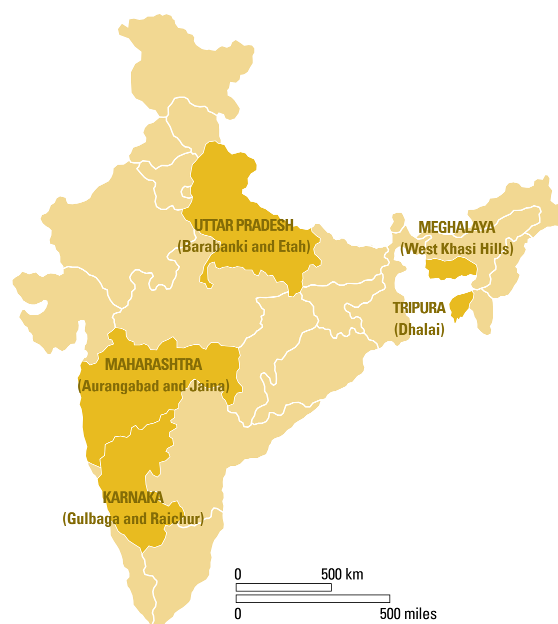
External reviewer

WHERE AND HOW?

The research was carried out in eight rural districts from five states: Karnataka, Maharashtra, Uttar Pradesh, Tripura and Meghalaya (see Figure 1).

This qualitative research involved in-depth interviews with 878 caregivers. Of these, 33 per cent had children with developmental delays and 22 per cent with birth defects. The researchers also established focus groups to which more than 170 community members contributed, including mothers-in-law, informal health providers and head teachers. Interviews were also conducted with more than 80 officials involved at various levels in the delivery of RBSK services.

FIGURE 1: MAP SHOWING THE FIVE INDIAN STATES IN WHICH THE RESEARCH TOOK PLACE



Source: *Districts chosen across study states*, Exhibit 7, page 32 of full report

TABLE 1: HOW RBSK HAS BEEN WORKING IN EACH STATE, 2014–2015

	Target children for screening	Children screened as % of target	Children referred as % of children identified with 4Ds	Children availing higher level of care as % of children referred
Karnataka	13.2 million	70%	100%	79%
Maharashtra	27.1 million	71%	12%	105%
Meghalaya	1.1 million	26%	8%	98%
Tripura	1.2 million	12%	71%	135%
Uttar Pradesh	51.7 million	35%	28%	76%

Source: *RBSK Division Report*, 2014-15

WHAT CAREGIVERS THOUGHT AND DID

Caregivers had:

- **Limited knowledge of their own children's health conditions.** They tended to describe problems vaguely. Around 40 per cent of caregivers of children who had easily discernible birth defects had known about the condition from birth, while that was true of only 15 per cent of those children with developmental delays. Some 55 per cent of caregivers knew about the RBSK programme.
- **Positive attitudes towards children with special needs.** These attitudes were measured via responses to a story about 'Kamla' and 'Ruth' – a fictional caregiver and her daughter who had a speech and hearing impairment.
- **Concerns over their child's future.** More than 50 per cent of caregivers worried about what would happen to their children in the longer term.
- **A tendency to focus on cure rather than care.** Around 80 per cent of caregivers believed that their child could be 'cured'. Some 10 per cent ascribed their child's condition to other forces such as divine will, black magic or past deeds.
- **Varied attitudes to health care.** Around a third of parents sought diagnosis and treatment in the private sector despite the expense involved. Some 16 per cent went to government health facilities while 7 per cent tried alternative forms of healing such as by Ayurvedic practitioners.
- **Problems with money or transport.** More than half of caregivers considered lack of money to be the main limiting factor when it came to caring for their child, while 21 per cent cited problems with transporting their child to a health facility.

THE VIEWS OF OTHER INTERESTED STAKEHOLDERS LOCALLY

- **Informal service providers:** Around 80 per cent of informal service providers had experienced children with birth defects or developmental delays coming to them for treatment. They generally had a positive attitude towards them and felt they could be treated with Western medicine, though there was a wide range of beliefs about how the child's condition might have arisen. Many were unaware of RBSK and its services.

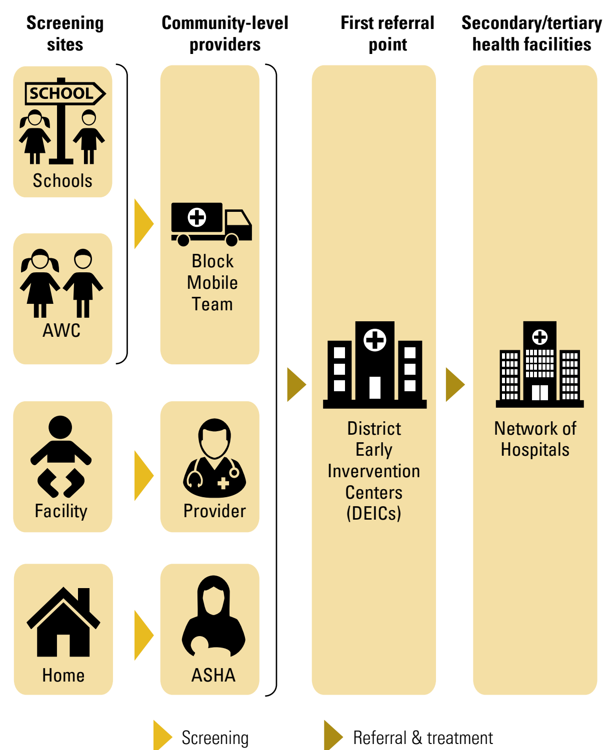
TABLE 2: LIST OF CONDITIONS EMBRACED BY THE TERMS 'BIRTH DEFECTS' AND 'DEVELOPMENTAL DELAYS'

	List of Birth Defects and Developmental Delays
Birth Defects	Neural Tube Defect
	Down's Syndrome
	Cleft Lip & Palate/Cleft Palate alone
	Club Foot/Talipes
	Developmental Dysplasia of Hip
	Congenital Cataract
	Congenital Deafness
	Congenital Heart Disease
	Retinopathy of Prematurity
Developmental Delays	Vision Impairment
	Hearing Impairment
	Neuro-Motor Impairment
	Motor Delay
	Cognitive Delay
	Language Delay
	Behaviour Disorder
	Learning Disorder
	Attention Deficit Hyperactivity Disorder

Source: Adapted from *List of Birth Defects and Developmental Delays*, page 7 of full report

- **Teachers:** Teachers generally showed great compassion for children with special needs, being prepared to give them greater attention in class. Many were aware of state health insurance schemes but their understanding of RBSK in particular was limited.
- **Mothers-in-law:** Like the caregivers, mothers-in-law were concerned about the long-term care of and future for the child. They tended to prefer medical treatment over other forms of care, though some expressed a fear of surgery. They were unaware of RBSK and its services.
- **Formal/informal groups:** Such community groups included members of gram panchayats (village councils), self-help groups, mothers' groups, village health and sanitation committees, and school development and management committees. Attitudes here ranged from supportive and compassionate to discriminatory, but many of the members of these groups are key influencers. They tended to have more knowledge of RBSK and to see it as beneficial for low-income families.

FIGURE 2 : HOW SERVICE DELIVERY SHOULD WORK UNDER RBSK



Source: *Service Delivery under RBSK*, Exhibit 4, page 20 of the full report

THE VIEWS OF STATE AND DISTRICT OFFICIALS

Interviews with officials across the five states revealed a wide variation in knowledge about RBSK and in attitudes towards it. Some felt insufficient priority was given to RBSK compared with other health programmes, including slow progress in training service providers and delayed progress in effective implementation of all aspects of RBSK, including a functional referral network:

- There was particular concern over the delays in setting up District Early Intervention Centres offering free care and treatment. At present, public health facilities are unable to diagnose and treat children with birth defects and developmental delays, forcing their parents into the private sector, which can be damaging not only financially but also psychologically.
- Officials felt constrained by the lack of formal agreements with other institutions potentially involved, such as medical colleges, hospitals run by religious charities and non-profit organizations. They felt there was insufficient orientation on RBSK for workers in the public health system let alone those in other government departments involved in similar efforts.
- Frontline health workers and mobile health teams have been neglected. In the absence of appropriate training, they are unable to give parents clear information on the right course of action for their child and what treatment involves. This has an adverse effect on caregivers' trust in the public health system, limiting further programme uptake.

POLICY RECOMMENDATIONS

- **Tertiary care services should be clearly mapped and strengthened; District Early Intervention Centres should be opened.** All public health facilities and mobile health teams – as well as all RBSK officers – should have a clear map of all services available in the state, whether government, private or non-profit. Governments at both national and state levels must be urged to expedite operationalization of District Early Intervention Centres so that caregivers are able to avail themselves of all services in one location.
- **Diagnostic facilities for affected children should be freely provided.** This could be ensured in a variety of ways, such as tie-ups with private providers or through the National Health Mission's free diagnostics service initiative at all public health facilities.
- **All service providers involved in RBSK should be adequately trained.** This should include sensitization on the rationale for the programme, to encourage a sense of engagement.
- **Train alternative practitioners as key link workers for RBSK.** Doctors in AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy) should be trained in interpersonal communication and counselling. Better-performing AYUSH doctors could be officially recognized and promoted. They could be provided with smartphone-based applications to track each child screened, to enhance their motivation and sense of purpose.
- **Set up dedicated help desks and kiosks for RBSK beneficiaries at public health facilities.**
- **Modify mobile health teams' daily screening targets.** Daily targets have been found to be too ambitious, and the emphasis on targets is compromising screening quality.
- **Address the transportation barrier.** The idea of providing a group of RBSK beneficiaries with transportation to a health facility once a month should be explored.

- **Set up regular meetings with other government departments.** Officials and frontline workers in other departments should also be given formal RBSK training.
- **Establish partnerships with non-profit organizations, religious charities, and the private sector.**

"An original evaluative and formative study about the perceptions, knowledge, attitudes and practices of caregivers of children with birth defects and developmental delays and that of the larger community including health system functionaries"

External reviewer

CONCLUSIONS

The Government of India's Ministry of Health and Family Welfare has begun to implement the research recommendations. In February 2017, a guidance note was issued to all states on how to leverage government health funds specifically for RBSK social and behaviour change communication interventions in the state annual implementation plans. The Government has disseminated the RBSK National Communication Framework to all 29 states and union territories of India for relevant roll-out. UNICEF is continuing to support this process. The research recommendations are also being factored into the design of UNICEF Early Childhood Development (ECD) programmatic interventions in the India Country Office including improving cross-sectoral linkages between education, nutrition, health and Communication for Development (C4D) interventions.

For full details of research methods and findings, link to the full report

http://nhm.assam.gov.in/sites/default/files/swf_utility_folder/departments/nhm_lipl_in_oid_6/menu/schemes/Formative_Research_Report_on_RBSK.pdf

A TALE OF TWO CAREGIVERS

Vanlalhruaia, a villager in Tripura state, is the father of a four-year-old boy, Samsona, who was born with a cleft lip. In Samsona's early years the family felt unable to seek health care help due to their poverty.

Then they heard about RBSK screening visits to the local maternal and child health centre. Samsona was duly screened and referred to a hospital in Agartala for surgery. The RBSK mobile health team transported them to a hospital in Agartala and Vanlalhruaia stayed in the government guest house there for no charge while the operation on his son was conducted.

The operation was successful and Samsona's family remain full of enthusiasm about RBSK.

In contrast, Nithin is a six-year-old boy from Kalaburagi in Karnataka state who suffers from Down's Syndrome. Although his family realized within his first year that Nithin was a slow developer, they did not learn about his condition until a screening visit by an RBSK mobile health team to the local maternal and child health centre.

Kalaburagi has no District Early Intervention Centre and so they were referred first to the closest community health centre then to the Kalaburagi District Hospital, with each journey involving transport costs and the loss of a day's wages. When they were finally offered treatment, it involved five growth-hormone injections over a year, each involving considerable cost. After two injections that seemed to have little impact the family decided they could not afford to complete the course of treatment and were left dejected and frustrated.

INDONESIA

A Financial Benchmark for Child Protection

Alta Fölscher and Stephanie Allan
Data collection support from Andhika Maulana, Akbar Halim, Matthew Cummins, and Naning Pudji Julianingsih

© UNICEF Indonesia/Esteve

How much should a government spend on protecting children?

Child protection has become a higher priority as the world has come to recognize the scale of child exploitation and abuse over the past two decades. Yet government funding for child protection programmes often lags behind and expenditure estimates are unreliable.

In 2014, UNICEF established a financial benchmark methodology that aims to provide an accurate estimate of a country's per-child expenditure on child protection and to compare that with its spending per person overall. The objective is not only to better measure national expenditure on child protection for analysis and advocacy purposes, but also to allow for a degree of comparability across and within countries over time.

This research piloted the application of this methodology within a particular country for the first time – in Indonesia.

Indonesia has the third-largest child population in the world, and its children face a broad range of child-protection risks. The financing and delivery of services to prevent, and respond to, children coming to harm are, however, fragmented between central, provincial and district governments. Successfully estimating the existing allocation of resources to child protection in Indonesia at both national and local levels would therefore represent an important step towards better protection of the country's children.

EDITORIAL INSIGHT

This piece was commended by the internal and external reviewers in particular for its research approach, which was co-designed and jointly implemented by UNICEF staff and consultants. This provided an effective means of capacity-building for UNICEF staff, as well as allowing broader access to government counterparts, thus enabling contextual insights through engaging potential research users. The internal reviewers highlighted its innovative attempt to better document the costs of child protection programmatic interventions and to develop a systematic methodology for further financial benchmarking and replicability – a difficult area given existing data limitations. The authors were also commended for honest documentation of some of the limitations of the data and research findings.

HOW THE RESEARCH WAS CONDUCTED

Spending on child protection during 2013 and 2014 was assessed both for the national government and for the government of the province of Jawa Tengah (Central Java). Data were collected between April and September 2015 by a team comprising UNICEF staff, and national and international consultants.

The definition of child protection used was "the prevention of and response to violence, abuse, exploitation and neglect of children". This was narrower than the definition commonly used in Indonesia, which includes all services aimed at safeguarding children's rights.

Expenditure by the following ministries was included: Social Affairs; Women's Empowerment and Child Protection; Health; Law and Human Rights; and Religious Affairs. Spending by the National Police and the Commission for the Protection of Children was also taken into account. Expenditure covered direct services, such as child welfare institutions, shelters, social and education services, child units in prisons, and detective services for crimes against children. Expenditure on support functions such as on policy development, coordination, capacity building, and monitoring and evaluation, was also included.

> *"Data in the field of child protection are often difficult to find or use. This paper has made a valiant effort in proving otherwise. It effectively uses fractured bodies of indicators, adapts these to the context and provides solid methodology with a clear, honest and instructive limitations section"*
>
> Internal reviewer

Data on government spending for each service were collected through a combination of interviews, analysis of budget documents and expenditure reports. A set of consistent rules were applied to ensure that all expenditures were included, and to estimate expenditure for services in cases where funding was split across budget lines. The data were recorded in a standard database that classified spending according to:

- Whether it aimed to prevent child harm or to respond to it;
- Whether it constituted support (such as on capacity building, policy development and monitoring and evaluation) or direct spending (financing the services directly);
- Which type of child harm it addressed; and
- Which level of government was responsible for the spending.

SPENDING BY THE NATIONAL GOVERNMENT

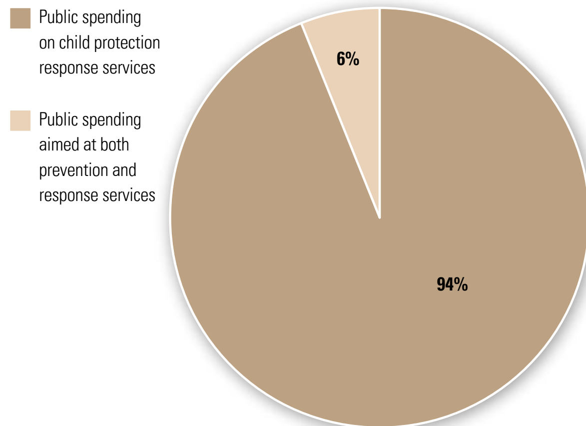
Average spending by the Indonesian Government on child protection during 2013 and 2014 was estimated at 0.072 per cent. This means that for every 1,000 rupiah spent per person at central level, 72 cents per child were spent on child protection (this did not include any expenditure at the provincial, district or municipal level).

An alternative way of gauging the size of central government spending on child protection is to compare it with the total amount of central government spending minus debt service. This works out at 0.027 per cent – or 27 cents for every 1,000 rupiah spent on goods and services for the people of Indonesia.

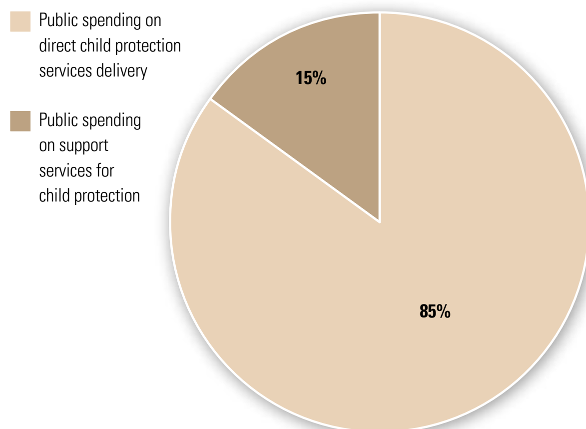
As the two pie charts in Figure 1 indicate, central government spending on child protection is skewed towards paying for the delivery of response services, rather than for preventative services or support functions. A tiny proportion of spending was earmarked for policy development and monitoring-type support services that covered both prevention and response activities.

FIGURE 1: DISTRIBUTION OF CENTRAL GOVERNMENT EXPENDITURE ON CHILD PROTECTION

Between prevention and response services
(Average spending in 2013 and 2014)



Between direct delivery and support functions
(Average spending in 2013 and 2014)



Source: Adapted from Figure 1, page 6 of the full report: *Distribution of central level CP expenditure.*

Source: CP Financial Benchmark data collection and analysis

SPENDING AT THE PROVINCIAL GOVERNMENT LEVEL

Jawa Tengah (Central Java) is the third most populous province in Indonesia – see Figure 2.

The benchmark for spending on child protection at the provincial level proved to be significantly higher than at the national level, with 3.13 rupiah spent per child on child protection for every 1,000 rupiah per person spent by the province, and all its cities and districts. Child protection expenditure represents 0.1 per cent of primary expenditure in Jawa Tengah, or 1 rupiah for every 1,000 spent.

However, the data were extrapolated from detailed data from just three localities – Surakarta City, Magelang District and Klaten District – and this small sample means that the result should be seen only as a proxy indicator of likely expenditure for the province as a whole.

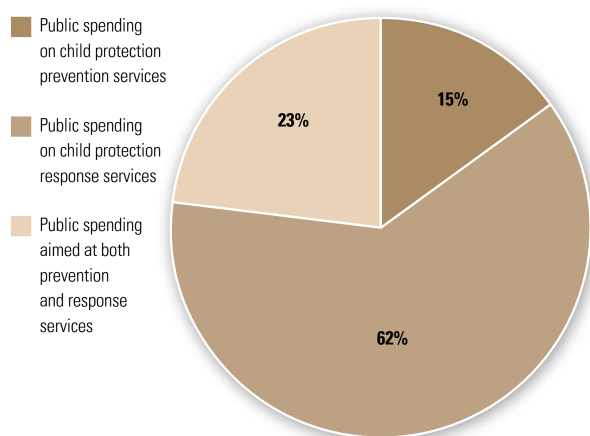
> *"Considerable effort was taken to classify and unpack child protection expenditure as understood by UNICEF versus country definiton and accounts"*
> Internal reviewer

FIGURE 2: MAP OF INDONESIA SHOWING THE LOCATION OF JAWA TENGAH (CENTRAL JAVA) PROVINCE

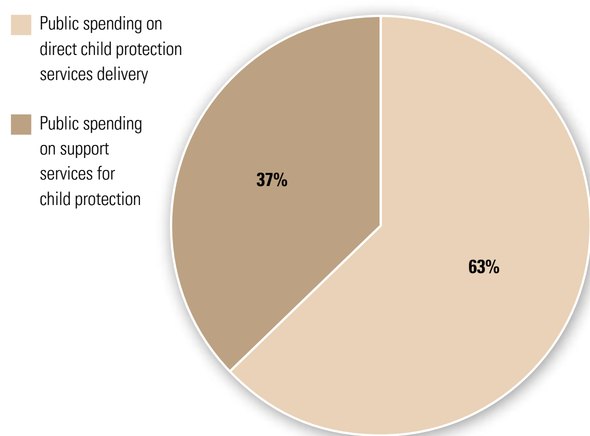
Interestingly, as the pie charts in Figure 3 indicate, the distribution of expenditure in Jawa Tengah is more orientated towards prevention than at the central level, and also more focused on support services. This reflects the higher prevalence of awareness-raising, coordination and capacity-building activities at the local level of government.

FIGURE 3: DISTRIBUTION OF EXPENDITURE ON CHILD PROTECTION IN JAWA TENGAH PROVINCE

Between prevention and response services
(Average spending in 2013 and 2014)



Between direct delivery and support functions
(Average spending in 2013 and 2014)



Source: Adapted from Figure 2 of the full report: *Distribution of Jawa Tengah child protection expenditure.*

Source: Child protection Financial Benchmark data collection and analysis

BREAKING DOWN THE SPENDING

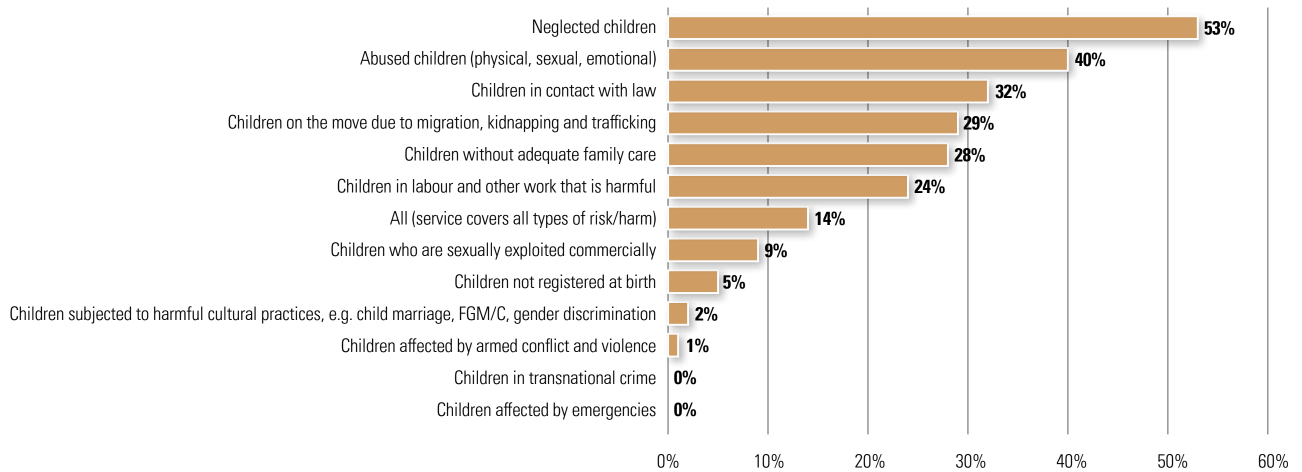
A key finding of the study is that funding at the local level is vital to child protection. This becomes clear when spending contributions from the various levels of government to child protection services in any one district are analysed. This analysis reveals that expenditure by local government constitutes 52 per cent of all services – 39 per cent of total estimated average spending on direct services per locality, and 80 per cent of expenditure on support services.

The largest contribution to spending on child protection comes from the social protection function of government (56 per cent across all levels of government), with the remainder coming from the recreation, culture and religion functions. A key component of social protection expenditure is social transfers targeting abused and neglected children, while the lion's share of the remaining expenditure is on the Ministry of Religious Affairs' 'Dikterapan' programme, which provides shelter and education services to children at risk and children who have come to harm.

Analysis of spending by type of risk indicated that 53 per cent of records were related to neglected children, 40 per cent to abused children and 32 per cent to children in contact with the law (records often covered more than one risk). In contrast, only 9 per cent of database records related to services for children who were sexually exploited commercially and 5 per cent to children who had not been registered at birth (see Figure 4).

While the purpose of the benchmarking exercise is to count spending on services rather than to assess the quality of these services, the data did make clear the extent to which the financing of services is fragmented across levels of government. This hampers coordination of services, leads to overlapping of services and gaps in coverage, and ultimately limits the impact of the funding available.

FIGURE 4: PERCENTAGE OF RECORDS PER TYPE OF CHILD PROTECTION RISK



Source: Adapted from Figure 3, page 24: *Percentage of records tagged per type of risk*

LIMITATIONS OF THE RESEARCH

Expenditure data for some key services were not collected through this research – some of which would be likely to add significantly to the total expenditure. These included: central government funding of court-based services for children in contact with the law; child labour and birth registration services; national police funding of child protection focal officers; and the national health insurance fund's financing of medical response services for the victims of neglect, abuse, exploitation or violence.

Moreover, expenditure on overheads was not systematically collected and in some cases estimates of actual expenditure had to be made based on best available information from budgets.

In addition, the most appropriate apportionment data were not always available, forcing the team to use less appropriate apportioning methods. Small subnational samples, data gaps and difficulty in sourcing official documents to support claimed expenditures may compromise the findings.

However, even if the benchmark and expenditure data cannot be taken as definitive, they provide relevant stakeholders in Indonesia with substantiated findings on the order of magnitude of child protection expenditure.

IMPLICATIONS FOR POLICYMAKERS

The following policy implications are apparent:

- The remarkably limited funding allocated by the Indonesian Government to these services indicates the low budget priority given to child protection.
- It also implies that reprioritizing funding from other sectors can make a significant difference.
- The fragmentation of the child protection sector across institutions and levels of government may contribute to this low budget priority.
- This implies that reprioritizing funding from other sectors of government can make a significant difference to child protection services.
- Fragmentation of the sector is also likely to result in gaps, overlaps and mismatches in the financing of services, as already confirmed by the qualitative – if limited – data collected during the study.
- There is an implicit need to strengthen the cross-government policy frameworks for child protection services.
- More robust, evidence-based coordination in budget processes may be required to assess the adequacy and distribution of financing for child protection services and to act to improve the situation.
- The data provide an opportunity to identify gaps in the financing or delivery of services, particularly with regard to preventative services and to some types of harm.

For full details of research methods and findings, link to the full report

Forthcoming.

MEXICO

Children and the Hotel Industry in Mexico: Taking action to protect, respect and support children’s rights

Samah Abbasi, Francis West, Romain Sibille

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EDITORIAL INSIGHT

The internal and external reviewers rated this research highly in terms of its conceptualization and research design. They commended it for innovation, originality and constructive engagement with the private sector. Critically, it was seen as having a high potential for impact as a result of: active stakeholder engagement throughout the research process; clear documentation of actionable and practical recommendations for business and government; and development of a toolkit enabling replicability and scale-up in other sectors and other countries across the region.

How can we best assess the impact of the hotel industry on child rights?

Mexico is the world's ninth most visited country, with Mexican hotels receiving almost 20 million guests in 2015. As such, tourism plays a vital role in its economy – accounting for 16 per cent of GDP in 2016 – and with continued growth projected over the next decade. In 2015, there were 3.8 million people employed in the tourism sector: 8.3 per cent of the total workforce.

The hotel industry therefore has immense potential to promote and respect children's rights in Mexico. The ultimate aim of this research was to help hotel businesses operating in Mexico and in the broader Latin American and Caribbean context to implement their responsibilities – under the UN Guiding Principles on Business and Human Rights of 2011 and under Save the Children, UN Global Compact and UNICEF's Children's Rights and Business Principles – with the goal of ensuring they fully understand and respect human rights and child rights across their operations and supply chains.

First, it sought to develop a practical human and child rights impact assessment tool and guidance (HRIA) to support and strengthen travel and tourism businesses undertaking their own due diligence processes to identify, prevent, mitigate and account for their impact on human/child rights in Mexico. Second, it aimed to identify the salient child rights impacts of the hotel industry in Mexico through desk research, additional direct research, interviews and analysis. The researchers then drew on their findings to recommend and advocate for actions that could be undertaken

by businesses and by government officials within Mexico and beyond to prevent and address negative impacts on child rights throughout their operations and value chains.

DESIGNING RESEARCH TO HEAR THE VOICES OF CHILDREN

During the design process, the researchers felt it was critical for the voices of children and their caregivers to be heard directly, as part of a 'human rights due diligence' process, so that tourism stakeholders could understand how their practices affect children's lives directly – and indirectly, through their parents and communities.

Thus, following an extensive literature review of human rights and child rights issues relating to the hotel industry in Mexico, UNICEF undertook exhaustive qualitative research with industry, hotel workers, government and community stakeholders in tourist destinations, but also with children. Interviews and focus groups were conducted with more than 300 hotel employees in three locations in Mexico. More than 80 stakeholders from government, civil society and the hotel industry were interviewed, as were 50 children whose parents work in hotels, or who live in business travel and tourist destinations and who could be potentially affected.

RESEARCH FINDINGS AND RECOMMENDATIONS

The research concluded that the hotel industry has immense potential to promote and respect children's rights in Mexico. It creates jobs, including for women and migrant workers. It can help accelerate career development opportunities for the young and unskilled. It can expand local sourcing of goods and services for an inclusive economy and extend the practices to prevent child sexual exploitation. However, there is still some way to go to ensuring that human and child rights are fully respected across operational and value chains.

> *"Dad is waiter in a hotel. He arrives [home] at 12 at night, I hardly see him. He works on rest-days"*
>
> Child of hotel employee

The research considered the impacts of the hotel industry on human and child rights in three areas:

- Decent work for parents and caregivers;
- Child labour and sexual exploitation of children; and
- The community and the environment.

The final report makes specific recommendations for business and government in each area.

DECENT WORK FOR PARENTS AND CAREGIVERS

Most hotel employees work a rotating schedule; with their shifts switching between mornings, afternoons and evenings. Those with evening and weekend shifts often struggle to spend sufficient time with their children and partners.

The problem is exacerbated by a lack of affordable or accessible childcare and by short school days. The long hours and anti-social patterns of work commonly result in (young) children being left unsupervised for long periods, putting them at higher risk of injury, violence and exploitation.

> *"Children left unsupervised in Cancun is an open gate to school dropout, drug addiction and prostitution"*
>
> Teacher interviewed for this report

A large proportion of hotel workers – including housekeepers, waitpersons and bell-persons – earn around the national minimum wage. But Mexico's minimum wage is actually below the per capita poverty line, so all these workers are wrestling with poverty – especially those with children to support. Some hotels also make extensive use of the illegal 'time-for-time' approach, where employees are required to work overtime during the high season and receive the equivalent time off in the low season or when hotel activity allows. This means that the hotel avoids paying the higher overtime rates required by law. Such low incomes can mean children miss out on education or medical treatment, lack safe and decent housing, and suffer from poor nutrition.

"My salary isn't sufficient to look after my children"
Hotel employee

Hotels in Mexico are also exploiting their workers by using temporary contracts for 'seasonal jobs'. In practice, many hotel employees on temporary contracts end up working all year round without the job security, pension entitlements and state benefits of permanent employees.

"If you don't have 'planta' [a permanent contract] they can fire you for anything. They are not just affecting you, but your families also"
Hotel employee

New and expectant mothers face discrimination, with interviewees stating that hotels have required employees to take pregnancy tests, so as to avoid having to offer maternity leave. New mothers also often face difficulties in continuing to breastfeed upon return to work, since hotels seldom offer support and a safe space for mothers to breastfeed or express breastmilk.

"There isn't a place to breastfeed or extract milk. The operational demands would make it impossible"
Hotel employee

RECOMMENDATIONS

- Hotels should offer working parents regular schedules and greater leave flexibility to attend to their children's needs.
- The Government, with the support of the industry, should map the childcare needs of working parents and expand access where required.
- Hotels should increase wages to meet the Government's well-being guidelines and ensure that all hours worked are accurately tracked and paid for in line with legal requirements.
- Hotels should only use temporary contracts for work that is truly short term. The Government should close the loophole in the law that is currently being exploited.
- Hotels should cease pregnancy testing for female applicants and should implement the UNICEF Guidance on Breastfeeding in the Workplace.

CHILD LABOUR AND SEXUAL EXPLOITATION OF CHILDREN

The research found that while Mexico's large hotels appear to have eliminated child labour within their direct operations, it continues to exist in the informal economy and in the industry's vast supply chains, especially in the agriculture, textile and construction sectors.

"I've seen entire families working in the field. They are … indigenous families and the children probably don't go to school"
Fresh produce supplier to hotel

Poor families sometimes see the arrival of wealthy tourists as an opportunity to supplement family income by having their children sell goods in the vicinity of hotels. Tourists may be involved in the sexual exploitation of children, even though the researchers found that major hotel chains appeared to recognize the risks of sexual exploitation on hotel premises, and under the initiative of the Government, many are taking measures to prevent it.

"There are a lot of children selling on the beach … they rob, take drugs, and are exploited. They are 8, 9, 10 years old"

Hotel employee

RECOMMENDATIONS

- The hotel industry should use its leverage with the Government to advocate for greater investment in local child protection systems.
- Hotels should contribute to existing initiatives that aim to address existing cases and the root causes of child labour.
- Hotel procurement staff should receive training on how to spot child labour and what to do if child labour is found.

"A lot of children leave school, don't do their homework and go and sell flowers, look after cars – any activity to do with tourism"

NGO in Puerto Vallarta

- Hotels should consider collaborating with local schools, technical colleges and non-governmental organizations (NGOs) to expand vocational training for 15–17-year-olds, especially those who are at risk of vulnerability and/or marginalization.
- The Government needs to ensure regular inspections and enforce the labour law across all industries.
- Other actors in the travel and tourism sector beyond the major hotel chains need to be encouraged to prevent the sexual exploitation of children, such as taxi firms, smaller independent hotels and tour operators.

THE COMMUNITY AND THE ENVIRONMENT

The migration that has accompanied tourism development, particularly along Mexico's coastlines, has increased pressure on basic services and social infrastructure such as housing, schools, water and sanitation, and health centres. The lack of access to services is aggravated by price inflation in many tourist zones.

"The zone is growing quickly. The services are the same as they were 20 years ago"

Industry stakeholder

The development of hotel zones has also resulted in the de facto privatization of public areas such as beaches, even though the Mexican constitution stipulates that these are public property. This undermines the community's enjoyment of beaches – including children's right to play – and jeopardizes the possibility of earning a living from fishing.

"Access to the beaches – we can't go there – they are forbidden, private properties, I'm upset about it"

Child, Puerto Vallata

RECOMMENDATIONS

- The hotel industry should advocate for adequate investment in development plans in tourist zones.
- It should also partner with local government authorities to strengthen existing service provision for children.
- Security guards should receive training on individuals' legal rights of access to Mexico's beaches.

The UN Working Group on Business and Human Rights – which visited Mexico in September 2016 after the research for this report had been conducted – reinforced many of these research findings and recommendations identified by UNICEF.

"Before, lots of people used to fish. Now they don't have access to the sea…There are access points, but the hotel security guards don't let people pass. They should respect the law"

Hotel employee

CONCLUSIONS

The leverage of the hotel industry in Mexico must not be underestimated. However, to advance children's rights, the hotel industry needs to go beyond legal compliance and establish family-friendly workplaces that enable parents and caregivers to support children during the crucial phase of early childhood, when interactions with family have a profound influence on a child's development and growth. This is also in the interests of hotels. Difficult working conditions contribute to high staff turnover, which in turn has an impact on productivity, competitiveness and service quality.

"This is an important area of research for UNICEF and one of a few studies that examine the holistic impact of the tourism sector on the realization of children's rights"

Internal reviewer

In November 2016, UNICEF organized a Roundtable on Human and Child Rights Impacts of the Hospitality Sector in Mexico (linked to this research), where UNICEF aimed to raise awareness of the potential and actual impacts of the hotel industry on human and child rights as well as testing HRIA findings and sharing good practices in managing human-rights risks. Further meetings and workshops will seek to encourage action within the industry.

As a result also, a Human Rights in Tourism industry working group is being established to take forward the recommendations within this report. The authors are now working with the hotel sector to expand this work across Latin America and the Caribbean.

"What distinguishes this report from previous ones on the tourism industry is the analysis of the impact on parents and caregivers and how this, in turn, affects child well-being"

Internal reviewer

With the UN General Assembly declaring 2017 as the International Year of Sustainable Tourism for Development, it is more important than ever that the hotel industry determines the ways in which its operations and supply chains affect children. It is also vital that it demonstrates leadership in global efforts to realize child rights through assuming responsibility for its full range of effects on employees, their families and local communities.

"This is a new and sensitive area of research and the methodology used is innovative. The study identifies practical and creative areas where progress can be made to improve the lives of children affected by the hotel Industry. Stakeholder participation, especially on the part of the hotel industry, is a strength"

External reviewer

For full details of research methods and findings, link to the full report

https://www.unicef.org/mexico/spanish/UNICEF_Report.Children_and_the_hotel_industry_in_Mexico.pdf

NAMIBIA

Study of Positive Deviant Schools in Namibia

Mzabalazo Advisory Services

© UNICEF/UN036992/Torgovnik/Verbatim Photo Agency

Why do some Namibian schools perform better than others?

Education has been a top priority in Namibia ever since independence in 1990. Education receives the lion's share of the government budget and in recent years the country has committed itself to universal education; fee-free primary schooling was introduced in 2013, and fee-free secondary schooling in 2016.

Nevertheless, there is a common belief in Namibia that the high levels of spending on education are not being matched in terms of school quality or exam results. It is against this background that the Ministry of Education, Arts and Culture, together with UNICEF, commissioned a research project to study why some schools perform better than others despite serving similar communities.

WHAT IS 'POSITIVE DEVIANCY'?

Positive deviancy is a methodology borrowed from the community development and health sectors, and is relatively new in the field of education. It is based on the premise that in many communities, there are individuals, groups or institutions whose different (deviant) behaviour – or strategies – allow them to find better solutions than their neighbours to the challenges they face. This is especially true when the 'positive deviants' start from the same point as their neighbours, have access to the same resources and are exposed to the same external conditions as other members of the community.

EDITORIAL INSIGHT

Both the internal and external reviewers highlighted the innovative application and potential added value of the 'positive deviancy' approach to better understanding the drivers of school effectiveness. In addition to the very thorough initial literature review on which the research was based, the internal reviewers highlighted: sound documentation of the different stages of research; high transparency of methodology and documentation of the study limitations; a good attempt at data triangulation; and clear translation of key findings into actionable policy recommendations.

Unlike traditional needs-based or problem-solving approaches, which focus first on identifying barriers to development and then on providing external inputs to address these, this approach explicitly seeks solutions internally, by encouraging the adoption of existing, sustainable solutions generated from within the community.

In the field of education, high-performing schools in difficult circumstances have been a subject of study by school effectiveness practitioners for decades, yet only recently have such schools been termed 'positive deviants' and considered as case studies, using this methodology. This approach has been used in Argentina to address high dropout rates from primary schools, and in Ethiopia to assist communities seeking to reduce school dropout and improve girls' attendance.

"Applying the positive deviancy approach to understand the critical factors behind school success in adverse settings has high potential to inform high-return interventions that can be scaled up"
External reviewer

THE QUESTIONS TO BE ANSWERED IN NAMIBIA

The core objective of the research into high-performing schools in Namibia was to understand what made them stand out from their peers in terms of learner performance. The underlying research question was therefore simple:

"What are the features that typify high-performing schools in contexts where other schools struggle to perform?"

Behind this broad question, the research team posed a number of other questions about the high-performing schools studied:

- What management and governance arrangements stand out as being unusually effective?
- Are the teachers unusual in their teaching strategies or abilities?
- Is higher performance related to the funding levels in those schools?
- Is higher performance related to explicit or hidden forms of selection of learners?
- What other elements are related to their high performance?

The research team used a case-study methodology with a mixed methods approach to examine how the elements associated with high performance related to each other. Data for each case study were generated from a range of interview, observation and data tools. At the same time, the team created space for unexpected elements to be identified and examined while the research was in progress.

"They must take responsibility for their own learning – we expect learners to behave – we trust them"
Head teacher of a secondary school

HOW THE SCHOOLS WERE CHOSEN

The schools were selected from five of Namibia's provinces (see Figure 1) and included all types of school – from primary to senior secondary. Only schools serving poor communities, both in rural areas and from under-resourced urban areas, were included – thus ensuring that the greater wealth of a given catchment area was not a reason for better performance. Schools were judged to be performing above expectations on the basis of national exam results – or in the case of primary schools, national standardized achievement tests – and also on whether (according to the regional offices of the Ministry of Education) they provided a 'rounded education'.

Two sets of seven schools were studied, each containing six better-performing schools and one school with more average results with which they could be compared. The breakdown of the stakeholders interviewed is contained in Table 1. Each school completed a data sheet covering contemporary and historical data on learner and teacher enrolment and attendance, learner dropout and repetition rates, staff qualifications and gender, the number of orphans enrolled, and the performance of the school in national exams.

In addition to lesson observations, learning walks and focus group interviews were held with school board members, parents, teachers and students. An in-depth interview with the head teacher was also conducted; generally at the end of the school visit.

> "If we set a target of 85 per cent, we are expecting 15 per cent of our learners to fail. How can we plan for failure?"
>
> Senior teacher in a positive deviant secondary school

FIGURE 1: THE FIVE NAMIBIAN REGIONS SELECTED FOR STUDY

Source: *Namibia 2011 Population and Housing Census Main Report*, Namibia Statistics Agency, 2012

RESULTS THAT CONFOUNDED EXPECTATIONS

Based on a preceding literature review, the research team hypothesized that the four main factors accounting for positive deviant schools outperforming neighbouring schools were likely to be:

- The leadership skills of the school head teacher and the setting of high expectations;
- High-quality teaching practices and time on task;
- A safe and nurturing supportive school environment; and
- Cooperation and consensus both internally and externally.

Although these factors were important elements in the findings, the reality was more complex than anticipated. The main findings were as follows.

Effective leadership, with high levels of trust and accountability, is key to success. The head teacher set the tone and was considered a role model: nearly all scored 4 on a Likert scale of 1 to 4 offered to students, parents, teachers and school board members, which corresponded to 'excellent leadership skills'. There was no single model of leadership to which these head teachers conformed; each had their own leadership style. There were, however, some 'common denominators':

- An explicit vision for the school that focused on the high performance of teachers and learners and a belief that the school was "on a path to greater things";

TABLE 1: BREAKDOWN OF STAKEHOLDERS INTERVIEWED IN THE RESEARCH PROCESS

Stakeholder Group	Number Interviewed	Gender
Principal	12 (including one acting principal)	3 female, 9 male
Senior Teachers	18	50% female
Teachers	66	56% female
Learners	85	51% girls
School Board Members	24	13 female, 11 male
Parents	46	34 female, 12 male
Regional Directors	1	1 male
Senior Regional Officials	14	5 female, 9 male
Total	**266**	**54% female, 46% male**

Source: *Interviewees in the Study*, Table 3, page 26 of full report

- A belief that all teachers and learners can succeed;
- A belief in lifelong learning, which translated into supporting teachers in their studies and even encouraging them to seek promotion;
- A total commitment to the school, which could be almost excessive in relation to being in the school at all hours;
- An open management style, which made them approachable by teachers, parents and learners;
- A desire to communicate and engage with parents and the community as a whole;
- A good knowledge of the school's regional ranking, but a stronger knowledge, and professed interest in how individual teachers were doing;
- A belief in the power of internal competition within the school between teachers and between learners;
- An innate confidence that the school (and its head teacher) can overcome any barrier; and
- An immense pride in their school, their teachers and their learners.

Teaching excellence is not a key factor in school success. Few of the 40 lessons observed were rated highly, and most were mediocre, teacher-centred lessons with little innovation. There were few learner-centred activities and little use of group or pair work. However, the commitment of teachers in the better-performing schools was palpable; this is what set them apart.

Maximizing teaching time and time on task is vital. This leads to high performance in national exams and regional tests.

"The positive deviancy approach is not typically applied to education, where it could certainly add value and lead to important lessons learned"
External reviewer

Selective enrolment is not a key factor in these schools' success. Most of the schools studied are not selective in their enrolment. Staff realize that when learners are discouraged and it is assumed they will fail, they will often fulfil that prediction. In the same vein, if it is assumed that all learners can and will succeed, they are more likely to do so.

"We are the architects of our own destiny!"
Written on the office wall by one head teacher

The schools manage external pressures while nurturing a culture of constant improvement. The head teachers protect teachers from external challenges, policies and regulations that could be detrimental to success, instead involving them in the running of the schools. Achievement targets are important but these are set first at the learner level – not impossibly high but allowing room for improvement. Hence, the role of teachers in mediating the learner targets is probably key to success.

School infrastructure does not determine success. There was nothing extraordinary about the infrastructure of these schools. Most classrooms had bare walls and desks in rows. Most schools had access to clean water, but many lacked enough clean, functional toilets. In half of the schools, students had to use the bush as a toilet, which was a particular problem for the teenage girls. Only two of the southern and two of the northern schools had computer rooms; none of the others offered students any access to computers. However, all the positive deviant schools provided access to photocopiers – a vital resource for teachers.

The schools provide a caring and safe environment. The core reason for the positive deviant schools being declared safe was not the physical infrastructure or the presence of security guards or teachers, but rather the inclusive and 'democratic' school leadership. This seemed to create an environment where violence was unacceptable and learners did not indulge in anti-social behaviour.

LIMITATIONS OF THE RESEARCH

When using a case-study approach, there is always concern that results are not always generalizable and are impossible to replicate.

Another concern was that one of the comparison or 'control' schools turned out to be a high-performing school. This somewhat compromised both the 'positive deviant' sample and the 'comparison' sample.

One limitation was the composition of the research team, which did not include an interpreter in a number of ethnic areas where a range of languages are used, so they had to rely instead on a local interpreter.

A further limitation was the fact that the interview and other data collection tools were not field tested in Namibian schools prior to the start of the data collection process. This was due to various factors, including the timing of the data collection immediately after the school holidays.

Finally, budget and time constraints, as well as the distances covered, meant that it was only possible to spend one day collecting data in each school.

"In our school everybody wants to be the best; we can do as well as the private schools"

Head teacher of a school with poor infrastructure

CONCLUSION

The researchers concluded that there were specific triggers that set most of these high-performing schools on the road to success. These included:

- The arrival of a new, committed and hard-working head teacher who is determined to make a success of the school and acts as a role model;
- The focus on learner and teacher discipline as a starting point towards school improvement, with an emphasis on fairness and firmness;
- The encouragement of a school culture that inspires all staff to work together towards a common goal;
- The use of school-generated data to set goals for improvement; and
- The fostering of a climate of trust and openness between the school and its stakeholders, particularly parents.

Understanding these triggers may help the Ministry of Education, Arts and Culture to assist other schools to improve. However, while the arrival of a new head teacher seems to be the key trigger, it is important to note that the success of these schools does not depend upon all the teachers being excellent or even innovative educators. What is important is that they approach their work with dedication and a sense of belonging to a successful educational community.

The key elements that make these schools different seem to involve a work ethic, time on task, setting clear targets that assume every learner can succeed, and caring for students. All these elements should be transferable through training programmes. This said, this research should not be used to draw up a list of successful elements that are then imposed on weaker schools. Weaker schools can learn from their more successful peers, but learning must take place on their own terms and must be adjusted to fit their specific reality.

Perhaps the overarching message is that schools that are better-performing foster a climate of trust between staff, students and the local community based on openness, fairness and transparency; it is this element of trust that the weaker schools should nurture.

For full details of research methods and findings, link to the full report

https://www.unicef.org/namibia/na.MoEAC_-_Positive_Deviant_Schools_Report_(2016)_-_web_quality.pdf

NEPAL

Reducing Perinatal Mortality in Nepal Using 'Helping Babies Breathe'

Ashish KC, Johan Wrammert, Robert B Clark, Uwe Ewald, Ravi Vitrakoti, Pushpa Chaudhary, Asha Pun, Hendrikus Raaijmakers, Mats Målqvist

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EDITORIAL INSIGHT

Both internal and external reviewers rated this research highly across all categories. The research design was rigorous, well conceived and well developed – demonstrating high scientific quality. The chosen methods were appropriate, and data analysis sound and transparent with ethical issues well addressed. The research was seen as addressing a high-burden problem with a high potential for impact, with scalability and replication considered from the outset.

How effective are 'Helping Babies Breathe' practices in reducing stillbirths and newborn deaths?

Around 1.2 million stillbirths worldwide per year occur after the onset of labour and a further 1 million babies die during their first day of life. These statistics drive home the importance of high-quality care at the time of birth and just after. Around 10 million babies are born not breathing each year and the first minute after birth (the 'Golden Minute') affords a vital window for resuscitating them.

Global evidence suggests that resuscitation training at health facilities can reduce infant deaths during labour and delivery by 30 per cent. With this in mind, a basic neonatal resuscitation protocol called 'Helping Babies Breathe' has been developed for use in low-resource settings.

In Nepal, 20 per cent of stillbirths occur during the intrapartum period (during labour and delivery) while 36 per cent of neonatal deaths are due to complications arising in this period. This piece of research introduced the 'Helping Babies Breathe' protocol and a quality improvement cycle to Paropakar Maternity and Women's Hospital, a tertiary hospital with 415 beds that also provides obstetric and

gynaecological services in the Nepalese capital, Kathmandu. The research team then monitored adherence to the new protocol and the consequent effect on the rate of neonatal mortality in the hospital.

HOW THE RESEARCH WAS CONDUCTED

There were two phases to the research: a baseline period from July to December 2012 and actual implementation between January and September 2013. The quality improvement cycle introduced included:

- 'Helping Babies Breathe' training;
- Weekly review and reflection meetings;
- Daily checks on the skills involved in bagging and masking babies;
- Self-evaluations;
- Peer review of adherence to the 'Helping Babies Breathe' protocol;
- Daily debriefings; and
- Refresher training after six months for staff in all delivery units.

A cohort design, including a nested case control study, was used to measure changes in clinical outcomes and adherence to the resuscitation protocol through video recording, before and after implementation of the quality improvement cycle.

All women who delivered babies of more than 22 weeks' gestation were included in the study. Information was collected on the infant's birthweight, gender, gestational age, and Apgar score (a standard measure of the physical condition of a newborn infant) at one and five minutes. Interviews were conducted with mothers to obtain information on education, socio-economic background and antenatal care attendance.

The incidence of all the various outcomes was then measured, including perinatal mortality, stillbirth, antepartum stillbirth, intrapartum stillbirth and first-day neonatal mortality. Whether clinical staff adhered to procedures such as stimulation or suction or alternatively initiated bag-and-mask ventilation within 60 seconds of the baby's birth (as recommended under 'Helping Babies Breathe') was monitored via a motion-triggered video recorder mounted on the radiant warmer (a device used to maintain the body temperature of newborn infants) above each resuscitation table. The recorder was positioned to provide a field of view that included the entire infant but only the hands of resuscitation team members. It was connected to a 24-hour clock to time-stamp images.

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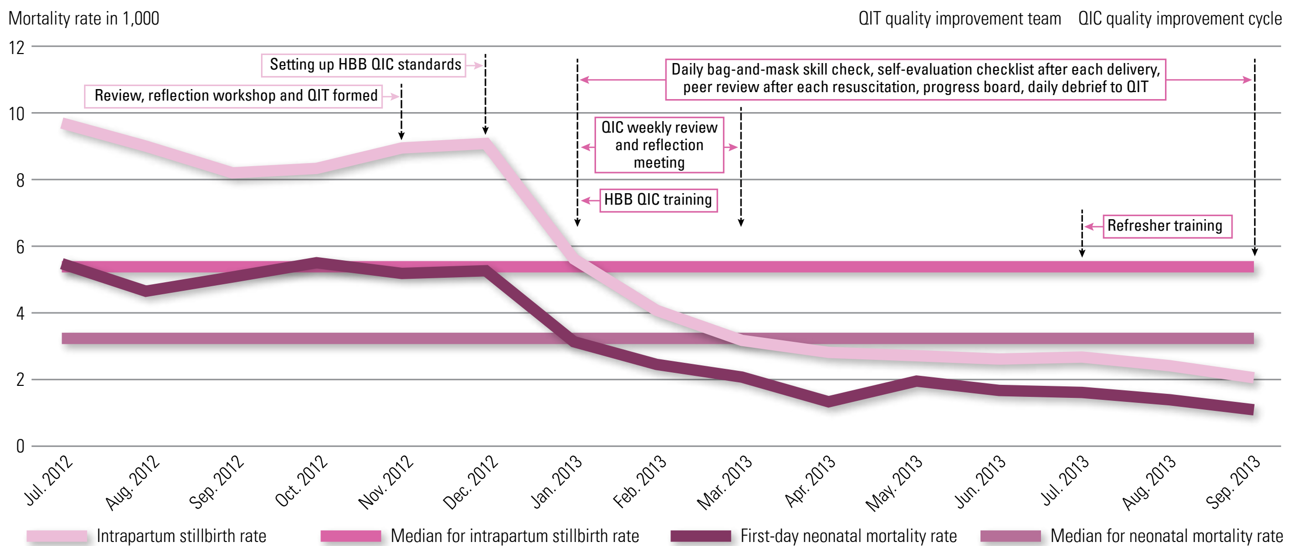
RESEARCH FINDINGS – MORE CHILDREN SURVIVING

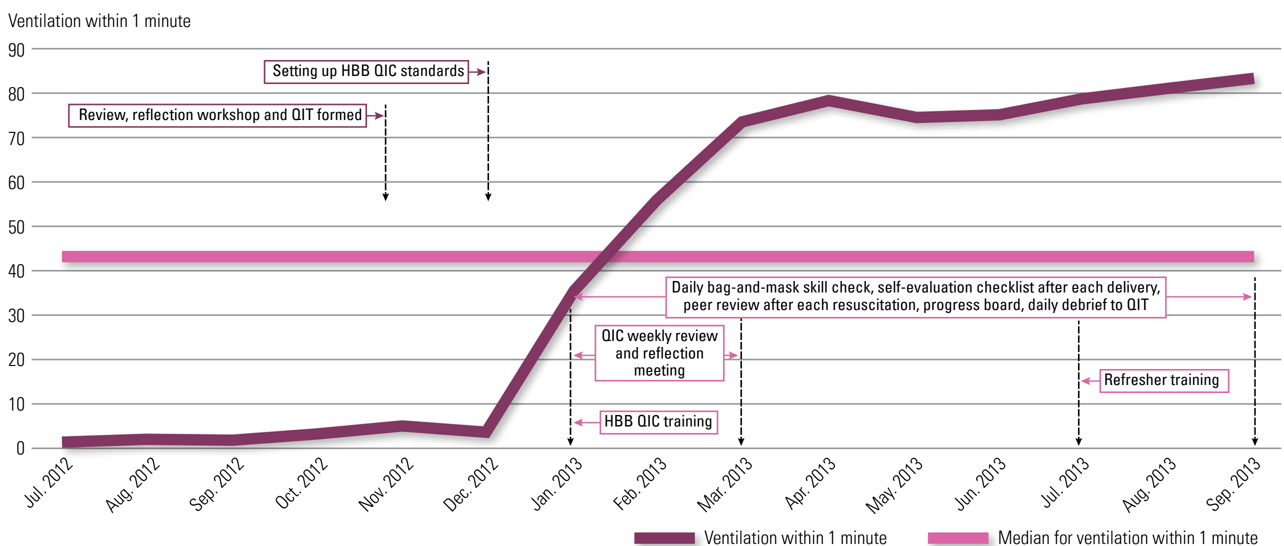
The dramatic impact of the new procedures on the incidence of intrapartum stillbirths and first-day newborn deaths is evident from the graphs below. The run chart in Figure 1 tracks these two rates throughout the baseline and intervention periods and shows a steep reduction in both, from the point where the 'Helping Babies Breathe' training and the quality improvement cycle were introduced. Figure 2 shows over the same period the steep increase in the proportion of babies given bag-and-mask ventilation within a minute of birth.

FIGURE 1: THE INTRAPARTUM STILLBIRTH RATE AND FIRST-DAY NEONATAL MORTALITY RATE ON A MONTHLY BASIS OVER TIME WITH MEDIAN LINES. THE RUN CHART IS ANNOTATED WITH THE ACTIVITIES CONDUCTED DURING DIFFERENT TIMES



Source: Adapted from Figure 2, page 6 of full report

FIGURE 2: THE PERCENTAGE OF BAG-AND-MASK VENTILATION WITHIN ONE MINUTE ON A MONTHLY BASIS OVER TIME WITH MEDIAN LINE. THE RUN CHART IS ANNOTATED WITH THE ACTIVITIES CONDUCTED DURING DIFFERENT TIMES



Source: Adapted from Figure 3, page 6 of full report

"This research [...] constructively approaches a difficult underlying problem and succeeds (through demonstration) in challenging fixed mindsets"

External reviewer

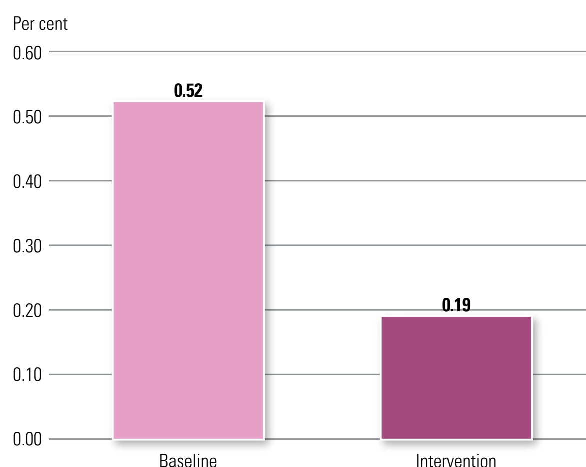
The positive effect on babies' survival rates is just as evident when the results over the whole of the baseline and intervention periods are summarized. The incidence of newborn deaths on the first day of life declined from 5.2 per 1,000 live births in the baseline period to just 1.9 per 1,000 live births in the intervention period, as Figure 3 makes clear.

The effect on the intrapartum stillbirth rate was just as striking, with a reduction from 9.0 deaths per 1,000 deliveries in the baseline period to 3.2 deaths per 1,000 deliveries in the intervention period, as Figure 4 shows.

The researchers considered a number of different possible reasons for the improvement in performance that they registered:

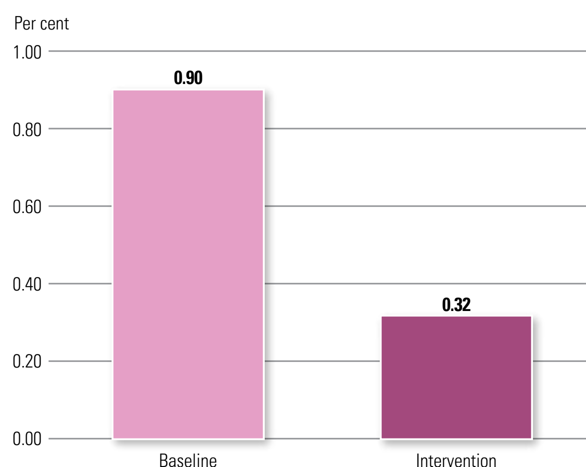
- The hospital leadership team recognized the inadequate adherence to standard protocols within the hospital, and thus identified a need for change. Several previous studies have shown that leadership plays a vital role in the quality improvement process.
- Unit-based reviews and reflection allowed individual health workers to discuss their experiences and to be involved in the creation of the quality improvement cycle. This can create an environment conducive to implementing a quality improvement plan and to building teamwork.
- The introduction of self-evaluation checklists can improve compliance with best clinical practice.
- The progress boards placed in each unit provided a constant reminder to staff of the quality improvement effort.

FIGURE 3: DECLINE IN THE FIRST-DAY NEONATAL MORTALITY RATE



Source: Extracted from the results in Table 4, page 7 of full report

FIGURE 4: DECLINE IN THE INTRAPARTUM STILLBIRTH RATE



Source: Extracted from the results in Table 4, page 7 of full report

"The research question clearly addresses a very relevant policy question and tries to answer questions essential for programming, such as the cost-effectiveness of the intervention and the key reasons for success of the intervention"

External reviewer

RESEARCH LIMITATIONS

The research team also identified several limitations to the research, including:

- The choice of research design meant that while inferences on the association between the intervention and the desired effects are possible, direct causation cannot be established;
- The quality improvement cycle was comprised of a package of interventions so it was not possible to unbundle the package to demonstrate the association of individual components with the outcome; and
- There may have been some measurement bias based on the inaccurate identification and/ or documentation of an infant as stillborn rather than live-born with neonatal death, thus leading to differential misclassification of individual outcomes and exposures.

"This type of targeted research is integral to meeting the Sustainable Development Goals [SDGs]"

Internal reviewer

"This is a high-quality paper published in a peer-reviewed academic journal employing scientific methods for both sampling and data analysis and aware of the limitations of the methods employed"

External reviewer

CONCLUSIONS

The study effectively demonstrated within this particular hospital in Nepal that the implementation of a 'Helping Babies Breathe' quality improvement cycle was associated with an improvement in the adherence of health workers to neonatal resuscitation protocols. It also showed that it was associated with a reduction in intrapartum stillbirth and first-day neonatal mortality.

This was also the first such study to have provided, through the use of video recording, clear evidence of the improvement in health workers' performance during the intervention period. Bag-and-mask ventilation of babies within the Golden Minute increased by 84 per cent between the two periods. Most importantly of all, the study demonstrated that a quality improvement approach to enhancing neonatal resuscitation practices in a tertiary hospital is feasible and that it can result in substantial improvements in clinical outcomes.

The research team concluded that this new approach of improving clinical performance by using a 'Helping Babies Breathe' quality improvement cycle in a tertiary hospital could be readily implemented in similar hospital settings in other countries as well as in Nepal. It is a relatively low-cost intervention and this element of affordability would clearly be vital if it were to be replicated elsewhere. However, further studies are needed in order to evaluate whether a similar approach would be successful in district hospitals and peripheral health facilities.

For full details of research methods and findings, link to the full report

http://pediatrics.aappublications.org/content/pediatrics/early/2016/05/23/peds.2015-0117.full.pdf

STATE OF PALESTINE

Every Child Counts: Understanding the needs and perspectives of children with disabilities in the State of Palestine

Nicola Jones, Bassam Abu Hamad, Kifah Odeh, Paola Pereznieto, Ola Abu Al Ghaib, Georgia Plank, Elizabeth Presler-Marshall, Mohammed Shaheen, with Kumiko Imai

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What barriers do Palestinian children with disabilities face and how can these be overcome?

Children with disabilities (CWDs) are one of the most marginalized and excluded groups of children. All too often, they experience widespread violations of their rights that result not from the intrinsic nature of disability but from the social exclusion arising from it. Palestinian CWDs typically face a particularly dire situation, not just because of the continuing conflict surrounding them – which has devastated infrastructure, fractured the economy and overwhelmed service providers – but also because of the cultural stigma attached to disability.

This situation analysis and needs assessment, conducted by UNICEF State of Palestine and the United Kingdom's Overseas Development Institute, investigates the extent to which Palestinian CWDs are marginalized and excluded. It uses a life cycle approach that captures differences at the individual, family and community levels. Differences by age, gender, disability type and family characteristics were taken into account. Through gathering and analysing quantitative data, but also through listening to the perspectives of children and their caregivers, the researchers aimed to identify the obstacles CWDs face in fulfilling their rights. They then considered what mechanisms might be put in place by the Government, donors and non-governmental organizations (NGOs), communities and families so as better to support their development and to fulfil their rights.

EDITORIAL INSIGHT

Both internal and external reviewers rated this study highly in all categories. The research question was both well defined and original, addressing an acknowledged global evidence gap. The research design and choice of mixed methods were appropriate with good involvement of stakeholders in their definition from the outset, despite a challenging context. The analysis was sound and acknowledged research limitations. The research demonstrated high potential for impact on UNICEF policy and programming and developed a framework that can be used in scaling up beyond the State of Palestine. Finally, the analysis, recommendations and findings were written in an accessible style for experts and non-experts alike.

HOW THE RESEARCH WAS CONDUCTED

The research team began with an extensive literature review of existing national reports on disability in general and on CWDs in particular. This enabled the team to assess the evidence base and design research methods by which to gather primary quantitative and qualitative data from seven governorates in Gaza and the West Bank.

Not all CWDs are registered with the Ministry of Social Development (MOSD), so it was critical that the quantitative sample used both government and non-government databases and aimed to include a wide variety of children. The 851 children (and/or their caregivers) who completed the survey comprised boys and girls, children of varying ages and types of disability, and those both in and out of school. Around 10 per cent of children personally completed the whole survey, though caregivers were on hand to assist them when required. The main caregiver answered the questions when the children were either under 12 or cognitively disabled.

Children and other people with disabilities find it difficult to get their voices heard within Palestinian culture so the qualitative research made a particular effort to capture the unique voices of CWDs. A variety of participatory tools were employed, along with sign language interpreters and researchers with extensive experience working with CWDs. The qualitative sample included 62 key informants at local and national levels and individual and group interviews with 241 individuals who were either CWDs themselves or their siblings/caregivers.

Once this fieldwork was complete and a preliminary analysis prepared, seven participatory workshops were organized – four in Gaza and three in the West Bank. Participants were encouraged to offer their perspective on the preliminary findings and to generate additional information about the causes of poor access to services and support.

KEY FINDINGS

The legal framework is weak. The 1999 Palestinian Disability Law ostensibly guarantees equal rights to people with disabilities. But only since 2011 have the sector strategic plans of the Palestinian Authority begun to address people's needs, such as moves towards inclusive education and offering a comprehensive set of basic health care services. In any event, services are supplied not only by the Government – and by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in the case of refugees – but also by multiple NGOs. CWDs and their families are often effectively abandoned.

Many children have multiple disabilities. While government registries listed only 10 per cent of CWDs as having multiple disabilities, this research found the proportion to be much higher, at 41.8 per cent. In addition, 41.4 per cent of households had at least one person with a disability in addition to the CWD – most often another child. Nearly 40 per cent of families with CWDs had monthly incomes that were about half the level considered to mark extreme poverty.

The social assistance for CWDs is grossly inadequate. Very few children receive any sort of disability-targeted assistance or even disability-related education from the ministry tasked with ensuring their well-being. Many of the children who require the most expensive support, such as wheelchairs and hearing aids, are simply forced to do without.

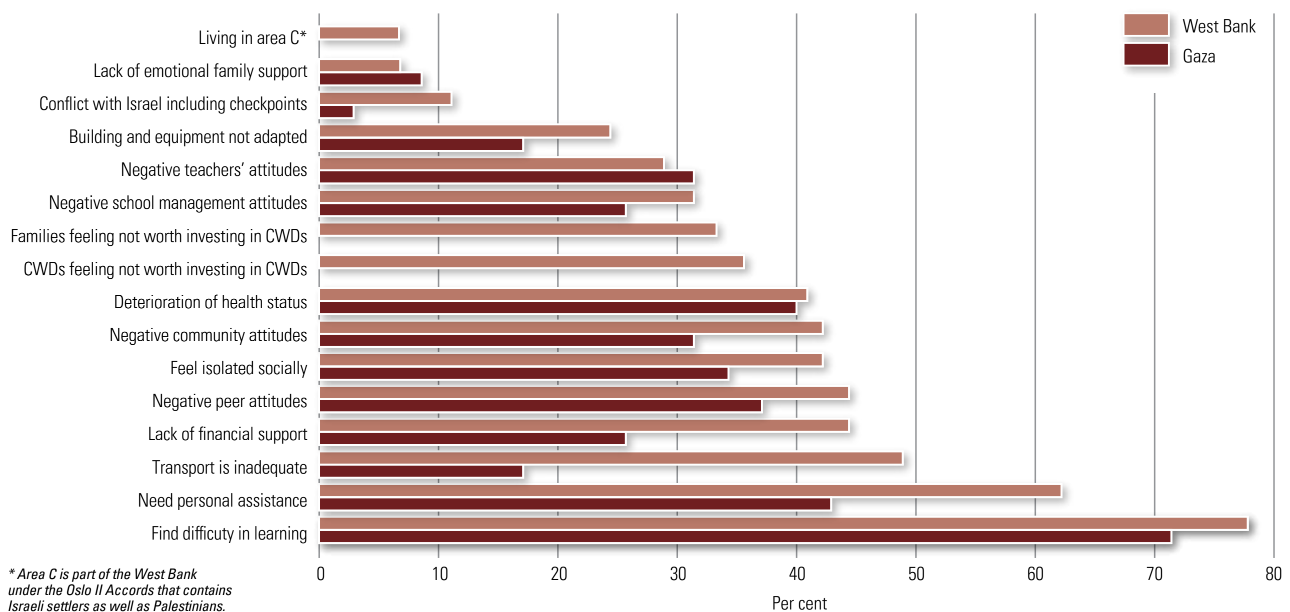
"This is a robust, credible and analytical piece of work on disabilities. It provides depth and breadth of analysis in the area of child disability where insufficient progress has been made in overcoming the constraints to the provision of services and access as well as in addressing deep-rooted stigma"

External reviewer

Access to education is difficult. Public schools are overcrowded, poorly adapted and largely lacking the specialized teachers and teaching materials that make inclusion possible. Bullying – even from teachers – appears to be rampant, and transportation to and from school is very expensive. The average age at which CWDs in this sample left school was only 11.85 years. Children in tailored educational settings generally have better psychosocial outcomes than those at mainstream schools, but demand for such education far outstrips supply.

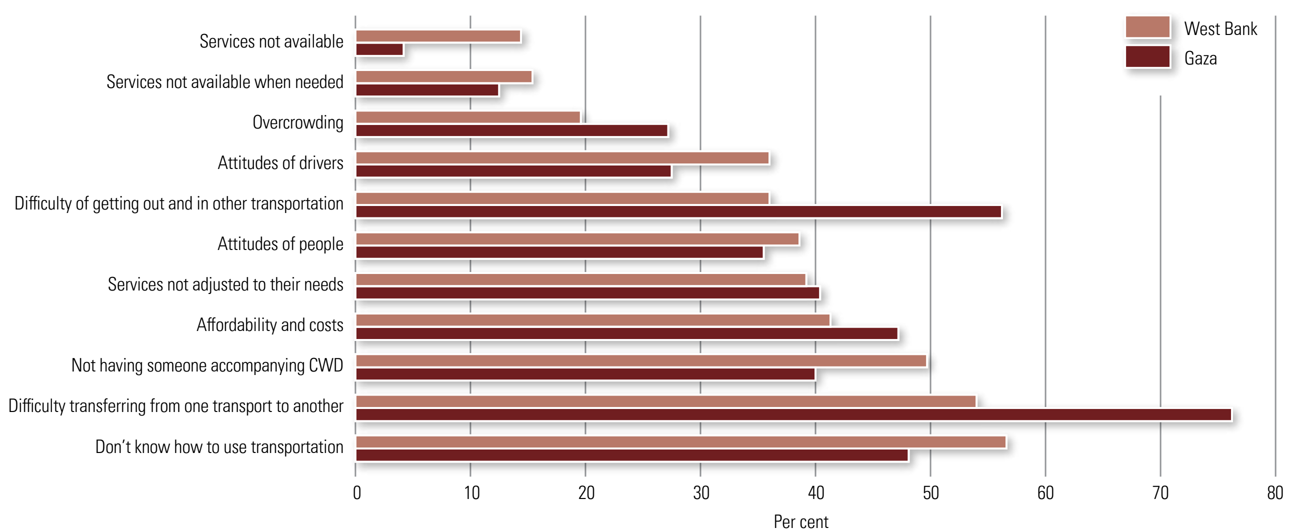
Access to health care is inadequate. The basic package of available health services is not tailored to address the specific needs of those with disabilities. The free medical insurance available does not cover medication, medical disposables or transport to and from appointments. In addition, coordination to facilitate follow-up and improve continuity of care is almost completely lacking. Mainstream medical providers were at times even hostile to CWDs, particularly to those with disabilities that were not a result of conflict. Prevention efforts

FIGURE 1: REASONS FOR CWDS DROPPING OUT OF SCHOOL



Source: *Reasons behind stopping education*, Figure 3, page 47 of full report

FIGURE 2: REPORTED REASONS FOR FACING DIFFICULTIES IN USING PUBLIC TRANSPORTATION



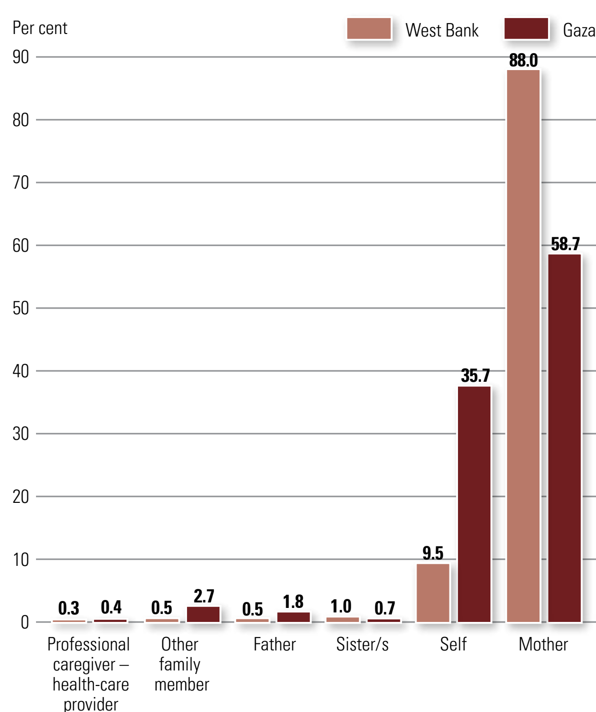
Source: *Reported reasons for facing difficulties in using public transportation*, Figure 5, page 59 of full report

are negligible, despite the high incidence of disability owing to cousin marriage and birth injury, while early diagnosis and intervention are comparatively rare, particularly given the high number of children with congenital disabilities.

The Palestinian environment is poorly adapted. Schools and health clinics are often unaccommodating to those with special needs, while specialized transport is unavailable.Private homes are often unadaptable because of overcrowding, making home environments a challenge to children with vision and hearing difficulties as well as those with mobility constraints.

Mothers bear the primary burden, as illustrated in Figure 3. Most mothers in the sample worked extremely long hours with little respite. Gender-based violence is common, with both in-laws and husbands emotionally, verbally and physically abusing mothers. In some cases, mothers are forced to accommodate co-wives, as husbands seek to produce healthy children. Those women with more than one CWD bear an even greater burden. Nearly half of families were unaware that their children were eligible for community-based rehabilitation.

FIGURE 3: MAIN PERSON RESPONSIBLE FOR HELPING CWDS DAILY



Source: *Main person responsible for daily help of CWDs in ADL*, Figure 6, page 61 of full report

The stigma around disability is pervasive and strong. Outside the home, CWDs are far more likely to encounter hostility and abuse than actual support. Over a third of children avoided doing things simply because they could not bear the attitudes of those in the community and only 5 per cent said they could always rely on their friends.

Children with other vulnerabilities face an added risk. Those in rural areas have far less access to services. Bedouin children appear particularly vulnerable, with reduced access to services and little community awareness of disability rights and needs. Adolescent girls with a disability are also at heightened risk of neglect and abuse.

THE WAY FORWARD: QUICK WINS

- Raise policymakers' and communities' awareness of disability by revising the Palestinian Disability Law, which is both dated and pejoratively named.
- Develop a national strategy for disability prevention, early detection and management.
- Involve CWDs and their families to ensure that policies and programmes are better centred on users' needs.
- Strengthen the registration of CWDs.
- Strengthen the disability mandate within government by enhancing coordination.
- Allocate consistent fiscal space for disability-related needs and make longer-term commitments to purchase services from NGOs and the private sector when they are not publicly available.
- Step up efforts to prevent disability. Many childhood disabilities are preventable, as they result from marriage within families and/or poor antenatal and neonatal health care.
- Improve early detection and intervention.
- Educate parents on early detection and support for CWDs.
- Implement community- and facility-based early intervention programmes.
- Support pre-primary and primary teachers to recognize signs of developmental delay and disability and build systems that facilitate their coordination with health care providers and social workers.
- Invest in community education to reduce stigma.

THE WAY FORWARD: LONGER-TERM GOALS

Map and align service providers. Given the fractured nature of service provision in State of Palestine, a detailed mapping exercise will help identify gaps and overlaps and allow for a more rational allocation of resources. The mapping will also serve as the backbone of future plans to establish a continuum of care for CWDs.

Direct more human resources to disability to focus on the fact that CWDs are first and foremost children. Donor grants to train and resource social workers would be welcome, though their salaries should be included in the government budget to guarantee sustainability over time.

Improve and tailor social protection for CWDs. They should be provided with categorical, rather than means-tested, support to ensure their disability-specific needs are met – possibly using the Palestinian National Cash Transfer Programme as a delivery mechanism. There should also be an in-kind support package for CWDs that covers medication, transport, adapted educational materials, care and – for older CWDs – economic empowerment programming.

Accelerate efforts to make inclusive education a positive experience. This must include efforts to make school buildings, classrooms, play spaces, and water, sanitation and hygiene facilities fully accessible to CWDs but should also expand educational opportunities for teachers. Dedicated schools may provide a good alternative in the short to medium term, especially for children with the most complex needs, but these must include free transportation.

Step up efforts to provide tailored education for the youngest and oldest CWDs.

Expand health insurance to meet the real needs of CWDs.

Increase the capacity of organizations for people with disabilities to diagnose and treat CWDs by providing training and exposure to state-of-the-art practices and consistent financial support.

Adapt physical and information infrastructure for better accessibility.

Provide support for the families of CWDs. Invest in disability-specific support groups for mothers; engage with mothers – and with fathers, who are often less supportive; and reach out to Bedouin communities, where stigma is especially high. Respite care for mothers of children with severe/multiple disabilities and/or multiple children with disabilities would help. Web-based information and diagnostic tools should be provided, perhaps using social media such as WhatsApp to send regular tips.

Strengthen the social work network to provide better outreach to CWDs and their families.

Address the gender dimensions of disability and disability-related care.

Strengthen the role of international NGOs as champions for CWDs. Those that have been actively engaging on the issue of disabilities – such as Save the Children and Diakonia – could play a key role in the donor/multilateral community, championing the needs and rights of CWDs.

For full details of research methods and findings, link to the full report

https://www.unicef.org/oPt/ODI_Report_01-06-2017_FINAL.pdf

SERBIA

How to Be a Caring School: A study of the effects of prevention and intervention measures on the rates of student dropout from the education system of the Republic of Serbia

Vitomir Jovanović, Jasminka Čekić Marković, Žaklina Veselinović,
Ana Vušurović, Tijana Jokić

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EDITORIAL INSIGHT

Both internal and external reviewers rated this piece highly on conceptualization, framing of the research question and potential for impact, with scalability and replicability of the model considered from the outset. Concrete steps were also taken to help stakeholders transform results into implementation with clear, evidence-based policy recommendations. Ethical issues were considered by the research team and reported to a high standard. The real strength of this research, however, lies in its strong user-centred design approach, engaging stakeholders throughout the research process to maximize buy-in.

How can school dropout in Serbia be reduced?

The World Education Forum sees inclusive education (including marginalized and excluded groups and those with disabilities or special educational needs), together with the prevention of school dropout, as one of its five strategic priorities. Everyone who leaves school before completing secondary education lessens their chances of personal and professional development and is exposed to a higher risk of poverty and social exclusion. Moreover, the country loses significant economic and human capital. Reduction of dropout of students is associated with improvement of education quality and equity.

Preventing school dropout was established as a key priority in the Serbian Government's strategy for education development, which targets an early school leaving rate of below 5 per cent. As things currently stand, data from the latest Serbian census indicate that 12 per cent of people aged between 20 and 24 have failed to complete secondary education. This includes those who have not even completed primary education. Studies show that the dropout rate is significantly higher among members of marginalized groups. Effective dropout prevention and intervention measures in schools and local communities have yet to be developed and tested.

This study by the Centre for Education Policy, in partnership with the Serbian Government and UNICEF Serbia, analysed the international and national literature on school dropout and early school leaving, in order to develop and test a Dropout Prevention Model. It then monitored the implementation of this model in 10 primary and secondary schools to evaluate its effectiveness in practice, with a view to rolling it out eventually to all schools in the country.

WHAT ARE THE MAIN FACTORS THAT LEAD TO DROPOUT?

There is a tendency to assume that dropout risk factors are associated with individual students and their contexts. This is understandable given that poverty and low socio-economic status (SES) significantly increase the risk of a child dropping out of school. But a wide range of factors can contribute to school dropout.

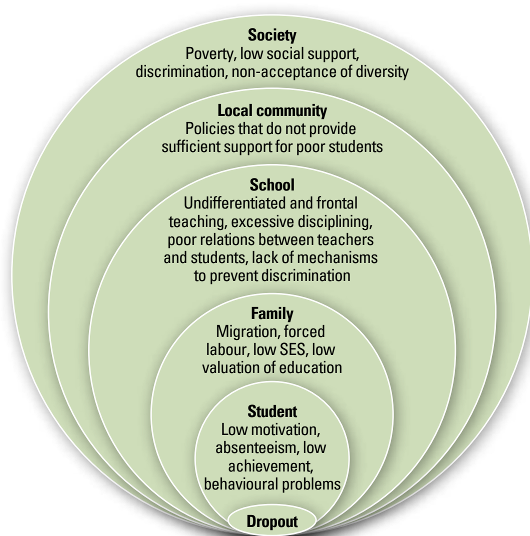
The research team therefore began by developing an analytical framework, which included all these factors, broadening the scope from the individual child through to family, school, the local community and society as a whole (see Figure 1).

In recent years more research into dropout has focused on the schools instead of the students; it is vital to understand the factors within a school that contribute to dropout and to identify how to offer better support to at-risk students.

RESEARCH DESIGN

The research design began with an extensive literature review of other countries' experiences, where dropout was successfully prevented. The team then proceeded to develop the analytical framework to identify the factors that influence dropout in the local context, including widespread consultation with academics, civil society and schools. The third step was to review existing regulations, legal and strategic frameworks within Serbia, in order to design a Dropout Prevention Model that was built within existing legal frameworks and did not require any additional financial or human resources from schools. The prototype model was then further tested through consultation with a wide range of policymakers who also participated in a study tour to the Netherlands to learn from identified good practice.

FIGURE 1: IMPACT OF DROPOUT RISK FACTORS AT DIFFERENT LEVELS



Source: *Impact of risk factors from different levels*, Picture 1, page 34 of full report

WHAT PRACTICAL MEASURES CAN BE ADOPTED TO REDUCE THE RISK OF DROPOUT?

The final Dropout Prevention Model designed by the research team had three main components based on a decision to target all key groups of stakeholders – students, parents and schools:

- **An early warning and intervention system.** This covers not only activities and interventions at school level, but also joint activities with partners within the local community. Through this system, students at the highest risk of dropout are identified and tailor-made support measures are designed in the form of an individual plan of dropout prevention (IPDP).
- **Prevention and intervention measures at the school level.** These include activities to involve parents, to generate peer support, and measures to re-conceptualize and develop remedial teaching.
- **Measures to enhance the capacity of the school and change the school culture.** This covers the capacity-building, which includes different types of training seminars, mentoring and coaching in order to facilitate successful planning and implementation of the dropout prevention and intervention activities.

In order to evaluate effectiveness of the Drop-out Prevention Model, the following indicators were selected as being the most important: the reduction in dropout per grade, the reduction in absenteeism at the school level, the reduction in average grade repetition, and the improvement in students' average achievement.

The Dropout Prevention Model was then implemented in 10 primary and secondary schools. In order to

evaluate its effectiveness, the research team gathered data in three ways:

- A baseline study questionnaire was completed by each school's dropout prevention team.
- Class teachers filled out a form that identified the students at risk based on both the objective data available and their own subjective assessment.
- Focus groups were constituted involving teachers, parents and students.

"This research shows how interventions and targeting, based on a bottom-up approach, have the potential to overcome implementation challenges ad effectively address complex links in programmatic theories of change"

External reviewer

RESULTS IN THE PILOT SCHOOLS

Four primary and six secondary vocational schools were selected for the pilot, from amongst schools from all over the country – on the basis that their students were at a particularly high risk of dropout.

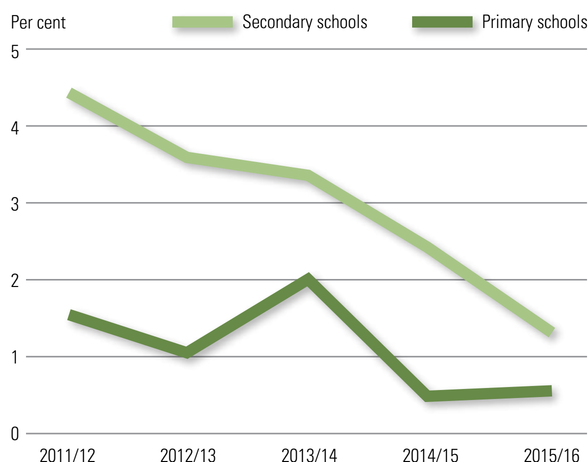
The implementation of the Dropout Prevention Model educed the student dropout rate in these schools by an average of 66 per cent (see Figure 2, which separates the dropout rate in primary schools from that in secondary vocational schools). Before the start of the project, an average of 221 students left these schools in any academic year; two years after its implementation, the average number of students dropping out fell to 75.

The data show that there has been a large decrease of absence per student in secondary vocational schools. This can, with great probability, be attributed to different components of the Dropout Prevention Model, which sought to increase attendance (through peer support, information on absence, inclusion of parents, support measures for students, etc.). The trend of absenteeism per grade is similar before and after the implementation of the model (e.g. it is the lowest in the first grade of secondary school). On the whole, absenteeism amounted to 117 classes per student in a year before the implementation of the model, but after the project it was reduced to 83 classes per student in a year (a reduction of 30 per cent).

Academic achievement did not improve in the secondary vocational schools that participated in the project. This may in part be due to the reform of grade repetition practices or to lower dropout rates that may have had an impact on average grades. However, it was enhanced in the fifth grade of primary schools – a point of transition from classroom teaching to subject teaching when the risk of dropout is highest (see Figure 3). In addition, the grade repetition rate was reduced by an average of 23 per cent in the pilot schools.

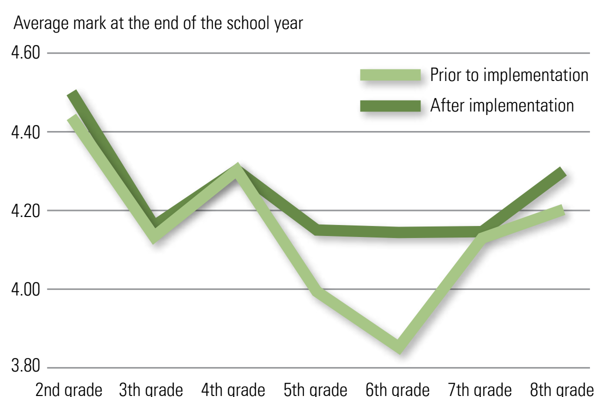
These overall results indicate the success of the strategy, including the creation of IIPDPs. Out of the

FIGURE 2: DROPOUT RATE IN THE PILOT SCHOOLS, 2011/12 TO 2015/16



Source: *Dropout rate in pilot schools*, Chart 2, page 53 of full report

FIGURE 3: ACADEMIC ACHIEVEMENT PRIOR TO AND AFTER THE IMPLEMENTATION OF DROPOUT PREVENTION MODEL IN PRIMARY SCHOOLS



Source: *Academic achievement prior to and after the implementation of the Dropout Prevention Model in primary schools*, Chart 5, page 56 of full report

450 students for whom an IPDP was developed, only 25 students (5.5 per cent) dropped out of school. It is important to recognize that all these students were at a very high risk of dropout, subject to multiple risk factors. The range of possible risk factors – and how these might differ between schools – was another important contribution of the research, which developed a 'typology' of dropout risk factors in primary schools and in secondary vocational schools – the 'heart' of the early warning system.

The results suggest that schools can exert a preventive influence that counters the impact of factors usually perceived as beyond the school's control, such as extreme poverty, early pregnancy and marriage, family problems, and serious behaviour issues.

One lesson from this study is that when a student drops out it is the culmination of a process and not a momentary decision. For example, although a student may appear to leave because of lack of motivation, this 'lack of interest in education' is the ultimate product of poor living conditions and a number of systemic inadequacies, for which the individual student cannot be held responsible. The researchers concluded that it was vital to recognize dropout as not simply a matter of the student's personal choice but as something for which institutions and policymakers needed to take some responsibility. They considered this to be the first step towards systemic change to increase the chances for each individual student to remain in the education system until she or he gained a formal qualification.

It was clear from the findings that by the end of the project, students at high risk of dropout had a greater sense of well-being and of being accepted as part of the school community than at the beginning. The importance of peer teams in changing the 'climate' within a school points to the need to empower such teams and enhance their activities, and to increase the participation of students in school entities, such as the school board. Enhanced engagement of students in peer teams and students' parliaments also led to increased parental participation in school life, as parents were keener to get involved in school activities when the request came from the students.

As a consequence of the changes produced by the project – including more developed processes of internal cooperation, coordination and planning – schools tended to gain more recognition within their communities as 'caring institutions' that considered their students' welfare and future life prospects.

TABLE 1: HOW SCHOOLS CHANGED FOR THE BETTER – SUMMARY OF THE QUALITATIVE ANALYSIS

School/Aspects	Sense of well-being of students in the school	High expectations of teachers for all students	Quality of teaching (including additional support and assessment)
ACS "Dr Đorđe Radić", Kraljevo	Considerable improvement	Considerable improvement	Considerable improvement
Technical School, Vladičin Han	Considerable improvement	Small improvement	Small improvement
Polytechnic School, Kragujevac	Small improvement	Unchanged situation	Small improvement
Technical School "23. maj", Pančevo	Considerable improvement	Unchanged situation	Unchanged situation
SVS "4. juli", Vrbas	Small improvement	Small improvement	Small improvement
THS "Toza Dragović", Kragujevac	Small improvement	Unchanged situation	Considerable improvement
PS "Branko Radičević", Vladičin Han	Considerable improvement	Considerable improvement	Small improvement
PS "Ljupče Španac", Bela Palanka	Unchanged situation	Unchanged situation	Unchanged situation
PS "Jovan Jovanović Zmaj", Surdulica	Considerable improvement	Considerable improvement	Considerable improvement
PS "Bratstvo jedinstvo", Vrbas	Considerable improvement	Small improvement	Small improvement

Source: *Summarized results of the qualitative analysis*, adapted from Table 13, page 145 of full report

Considerable improvement
Small improvement
Unchanged situation
Deterioration

The other key change was in the role of teachers. A considerable number of teachers became aware, for example, that they needed to change their interpretation of the phenomenon of grade repetition: accepting more responsibility for failure, rather than assuming this was a result of the students' own shortcomings. More broadly, many teachers with a narrow understanding of their role as a subject expert came to appreciate that their responsibility within the education system included caring for students. A number of teachers in each school, however, still had some distance to travel in this regard.

The overall sense of improvement in the 10 pilot schools is reflected in Table 1, which broadly summarizes the results of the qualitative analysis and suggests that this is a model that could be widely applied.

CONCLUSIONS

This pilot project clearly indicates the effectiveness of the prevention and intervention measures implemented, at least in the short term. The research team therefore advocates that the model be considered for scale-up throughout the education system in erbia, both in primary and secondary vocational schools, not only to reduce the current risk of dropout, but also to improve the climate in schools and the overall support they offer to students.

After two years of implementation of the Dropout Prevention Model, evidence shows that not only is it effective in preventing dropout in the selected pilot schools in Serbia, but that it also influences other important aspects of school functioning that relate to the whole school, not only to at-risk students. This is echoed by the external evaluators who found indicators of educational quality standards to have significantly improved. The model also appears to have the potential to change the culture within schools to create a more 'caring school' that is more participatory, open and inclusive, and in which all teachers and students have developed a greater sense of well-being.

For full details of research methods and findings, link to the full report

https://www.unicef.org/serbia/HowToBeACaringSchool.pdf

Remedial teaching	Practices of dropout prevention	Involving parents	Involving peers	Cooperation with the local community
● (dark green)	● (light green)	● (dark green)	● (light green)	● (light green)
● (dark green)	● (light green)	● (dark green)	● (light green)	● (dark green)
● (dark green)	● (light green)	● (light green)	● (light green)	● (light green)
● (orange)	● (dark green)	● (dark green)	● (dark green)	● (dark green)
● (dark green)	● (light green)	● (dark green)	● (dark green)	● (dark green)
● (light green)	● (dark green)	● (dark green)	● (light green)	● (light green)
● (dark green)	● (light green)	● (dark green)	● (light green)	● (dark green)
● (orange)	● (dark green)	● (dark green)	● (orange)	● (orange)
● (light green)	● (light green)	● (light green)	● (light green)	● (dark green)
● (dark green)	● (light green)	● (light green)	● (dark green)	● (dark green)

SOUTH AFRICA

Removing Barriers to Accessing Child Grants: Progress in reducing exclusion from South Africa's Child Support Grant

Department of Social Development, South African Social Security Agency, UNICEF South Africa

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Why are some children missing out on South Africa's Child Support Grant?

Providing direct financial payments to poorer families with children has, in recent years, been a vital tool used by the Government of South Africa to reduce child poverty and promote social and economic inclusion. Recent evaluations have confirmed the effectiveness of such grants, not only in tackling poverty and vulnerability, but also in providing care and support to those affected by HIV and AIDS, and reducing risk behaviours that leave adolescents prey to HIV infection.

The Child Support Grant (CSG) was first introduced in 1998, when it applied to children under the age of 7. The age range was progressively extended over the first decade of the twenty-first century. By 2012, all children under 18 whose caregivers met the income threshold were eligible. In 2008, the income threshold for grant eligibility (the level below which households became eligible) more than doubled. The income threshold has since been adjusted annually, as has the value of the grant. Today, almost two in three South African children receive the grant each month.

Nevertheless, many vulnerable children who are potentially eligible are still not receiving the grant. This research, conducted by the Department of Social Development, the South African Social Security Agency (SASSA) and UNICEF South Africa, meticulously examined which children are taking up the CSG and which are excluded. The research deployed both quantitative and qualitative methods, including spatial analysis to identify exclusion rates to a high level of disaggregation, while also seeking

EDITORIAL INSIGHT

This research was rated highly by both internal and external reviewers for its comprehensive contextual analysis of the system, including its performance over time and for using multiple data sets in innovative ways. It was also commended for its research design, including its mixed methods approach, originality and the quality and depth of documentation of data, which should provide a solid evidence base for future research on this topic.

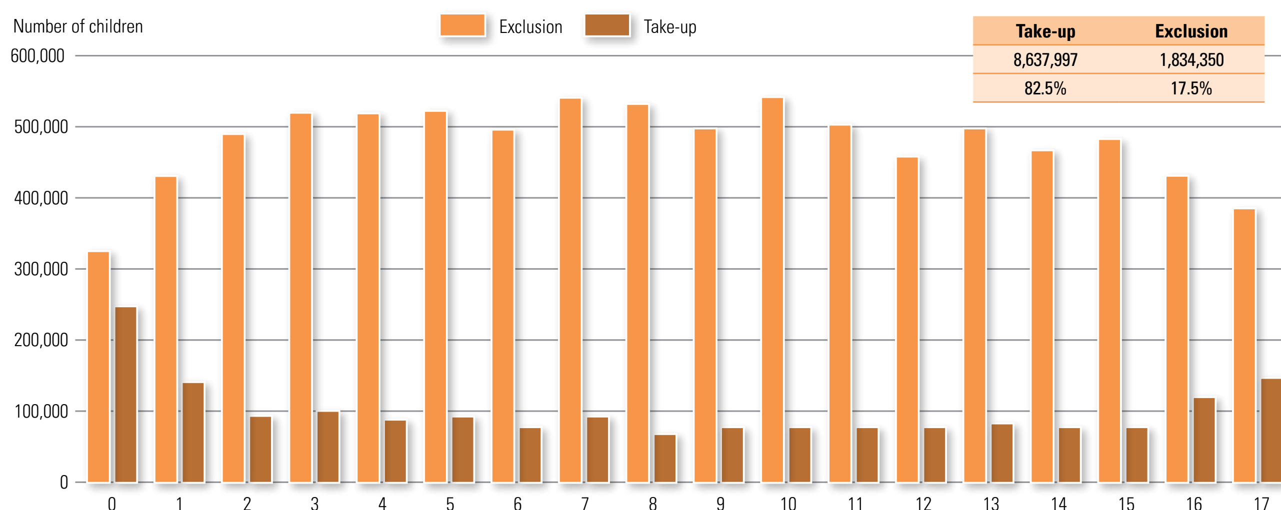
to identify the barriers that prevent people from accessing the grant, through focus group discussions, key informant interviews and participatory workshops. It also reviewed government policies and outreach strategies, with a view to further improving uptake.

WHICH CHILDREN ARE LOSING OUT?

In 2014, 82.5 per cent of eligible children (8.6 million children) received the CSG, while 17.5 per cent of eligible children (1.8 million children) did not. In both number and percentage terms, this represented an improvement since 2011. Breaking down recipients and non-recipients by age revealed that children in the first year of life were much more likely to lose out, compared with those of any other age (see Figure 1). The exclusion rate for infants was 16 percentage points higher than the next highest exclusion rate by age, that for 17-year-olds. Nevertheless, this still constitutes an improvement; while more than 50 per cent of eligible under-ones were excluded in 2011, 43 per cent were excluded in 2014. Moreover, the extension of eligibility to children aged 15 and over since 2009 has been successful in so far as the take-up rates for older children are broadly comparable with those for younger children.

Breaking down access to the CSG by race – particularly necessary given South Africa's apartheid legacy – reveals significant differences. Black children make up by far the biggest proportion of the child population, with 84.1 per cent of eligible Black children (8.1 million) receiving the CSG in 2014. As Table 1 shows, although the numbers of children involved are much smaller, exclusion rates are much higher among eligible children from the three other racial groups. Nonetheless, CSG uptake has improved since 2011 among all racial groups, except Asian/Indian children.

FIGURE 1: TAKE-UP AND EXCLUSION BY AGE, 2014



Take-up	Exclusion
8,637,997	1,834,350
82.5%	17.5%

Source: *Total take-up and exclusion by age, GHS 2014*, Figure 1, page 5 of full report

TABLE 1: EXCLUSION RATES BY RACE, 2014

Race	Exclusion	0–1 year	1–2 years	3–11 years	12–15 years	16–17 years
African/Black	1,539,076	218,999	202,413	614,718	282,200	220,747
	15.90%	41.80%	18.90%	12.30%	13.60%	22.30%
Coloured	215,716	23,563	20,461	88,541	47,241	35,910
	30.20%	56.20%	29.60%	24%	31.10%	44.20%
Indian/Asian	40,536	2,448	6,815	16,319	7,995	6,959
	75.30%	100%	87.20%	66.50%	74.80%	83.40%
White	39,022	2,270	3,573	21,813	8,884	2,482
	86.70%	100%	100%	89.70%	77.20%	74.30%

Source: *Take-up and exclusion rates by age, GHS 2014*, Figure 2, page 6 of full report

The report analysis revealed there were higher rates of exclusion among eligible children with:

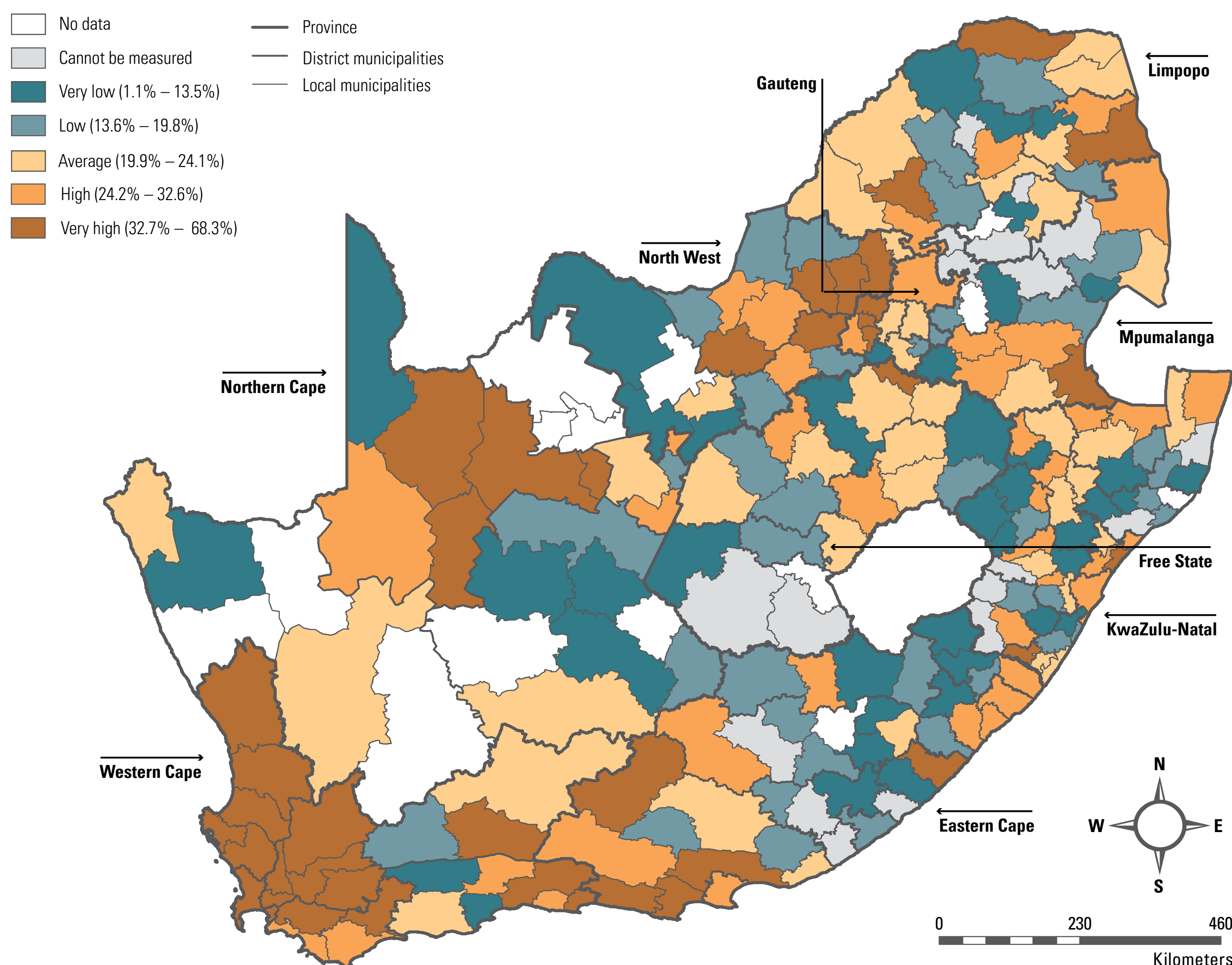
- No schooling and those attending high school, compared with those at primary school;
- Illiterate or semi-literate caregivers;
- A male caregiver;
- Unemployed caregivers;
- Mothers with mobility difficulties;
- Parents who do not have HIV and AIDS, compared with those who do;
- Mothers with no education or with secondary education or above – uptake was highest when mothers had reached R grade in primary school; and
- Households above the poverty line, but below the means-test threshold (whereas almost 85 per cent of eligible children in the cohorts living below the poverty line are receiving the CSG).

THE GEOGRAPHY OF EXCLUSION

There were wide geographical differences in uptake and exclusion (see map, Figure 2). Western Cape and Gauteng are the two provinces with the highest rates of exclusion, while poorer Eastern Cape and KwaZulu-Natal have the lowest.

The study examined eligibility and take-up of the CSG right down to ward level, which clearly revealed that the greater the level of urbanization in the municipality, the higher the rate of exclusion from the grant. In fact, the 25 wards with the largest estimated number of excluded eligible are predominantly in urban areas. Of these 25 wards, 13 are in Cape Town and 8 in Johannesburg – the country's two biggest cities.

FIGURE 2: RATES OF EXCLUSION BY MUNICIPALITY, 2014

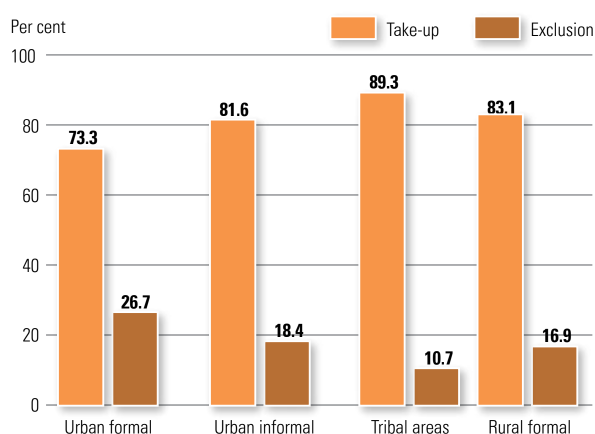


Source: *CSG exclusion by municipality, South Africa, 2011*, Map 1, page 39 of full report

However, estimates of poverty in most of these 25 wards are lower than the national median poverty rate – in some cases 20 percentage points lower, as is the case, for instance, in urban areas across Gauteng and the Western Cape. This suggests that there may be either a measure of self-exclusion in those wards, or pockets of deprivation in otherwise relatively affluent wards. It also suggests that the approach of targeting the poorer wards of South Africa with the CSG has generally been effective.

Analysis by type of settlement bears this out (see Figure 3). The highest rates of exclusion are in formal urban areas, with much higher rates of uptake in urban informal, rural formal, and above all, in 'tribal' areas.

FIGURE 3: UPTAKE AND EXCLUSION BY GEO-TYPE, 2014



Source: *Take-up and exclusion by geotype, GHS 2014*, Figure 3, page 7 of full report

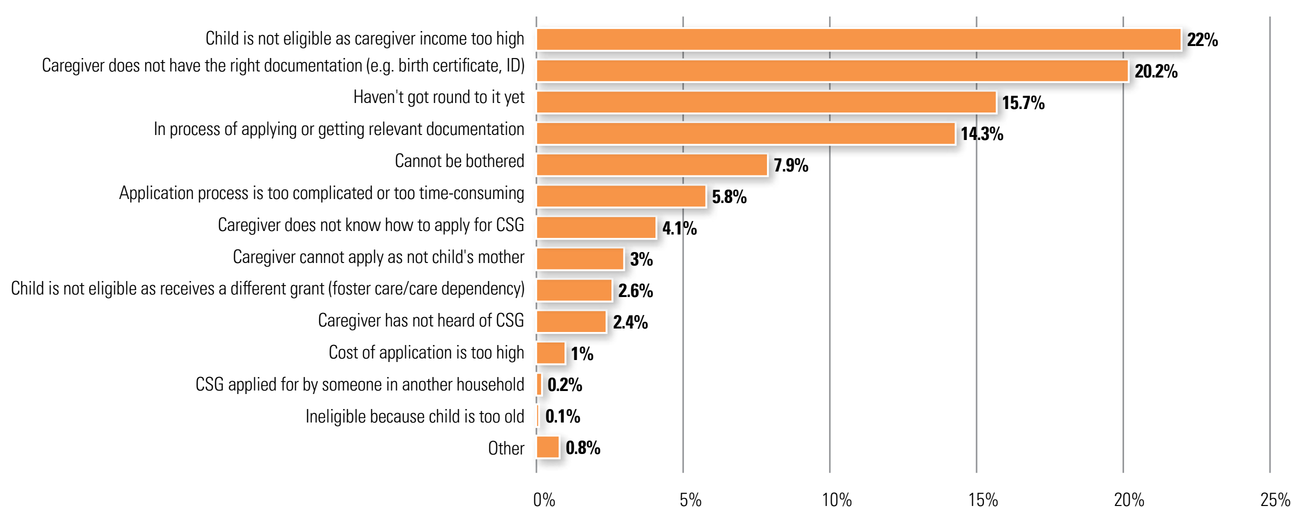
WHY ARE CHILDREN EXCLUDED?

In addition to identifying which eligible children are still missing out, the study endeavoured to determine the barriers that prevent them from accessing the CSG. Information was drawn from the first three waves of the National Income Dynamics Study, in 2008, 2010 and 2012.

The most common reason caregivers gave for not applying for the grant (22 per cent) was that they mistakenly believed their income was too high for them to pass the means test. Almost as many (20 per cent) reported they did not possess the documentation needed to apply for the grant, though they could have begun receiving the money immediately while the correct documents were sought. The range of reasons given by caregivers for not applying is shown in Figure 4.

The study found the complexity of the application process and the difficulties associated with obtaining the correct documents to be the biggest barriers preventing caregivers from accessing the CSG. Caregivers are required to present an official identity document in order to register and must also submit a copy of an original birth certificate, yet more than 7 per cent of eligible children do not possess these. Since 2008, SASSA accepts a sworn statement from a reputable referee to verify a child's name, age and parentage. However, this facility is not widely used.

FIGURE 4: REASONS GIVEN BY CAREGIVERS OF EXCLUDED CHILDREN, FOR NOT APPLYING FOR THE CSG



Source: *Reasons for CSG non-application amongst caregivers of eligible children, NIDS 2012*, Figure 5 page 28 of full report

Lack of knowledge about the CSG was also a significant factor; in 2012, around 50,000 eligible caregivers failed to apply, either because they were not aware of the grant, or because they did not know how to apply.

"The strength of the analysis, which focuses on the scale, trends, drivers and barriers for access to South Africa's Child [Support] Grant, lies in its policy focus and its high relevance and potential contribution to making the social provision for children more successful"

Internal reviewer

THREE SIGNIFICANT NEW INITIATIVES

The study undertook a detailed evaluation of SASSA's policies and practices in delivering the CSG, which have evolved over a 10-year period. It also assessed three significant initiatives launched in recent years – the Integrated Community Outreach Programme (ICROP) in 2007, SASSA's Re-registration Initiative in 2012; and Project Mikondzo in 2013:

- ICROP was introduced to target marginalized rural and semi-urban areas earmarked as the most excluded in the 2007 Index of Multiple Deprivation. It uses trucks as mobile satellite offices to facilitate grant registrations that can be approved on the same day they are submitted, in addition to disseminating information about new programmes and laws. The period of ICROP's operation coincided with a significant surge in grant uptake in the targeted areas, though the expansion of the CSG and the changes in the means test make it difficult to establish exactly what spurred the improvement.
- SASSA's Re-registration Initiative was designed with the intention of eliminating fraud. Beneficiaries were required to re-register for their grants on a biometric basis in order to continue to receive them. This led to a significant drop of around 1 million in the number of children receiving the grant in the last quarter of 2013. Many of these were subsequently reinstated and uptake improved again, under the new conditions.
- Project Mikondzo aimed to improve service delivery by SASSA and the Department for Social Development, prioritizing areas of greatest deprivation. This targeting seems to have been effective and to have coincided with an increase in CSG uptake.

THE HURDLES STILL TO BE OVERCOME

In February 2014, SASSA launched a plan of action to address the main barriers to CSG uptake; this study assessed how successfully this had been implemented. There has been significant progress in many areas but some of the remaining obstacles identified are:

- Children of 16 or 17 who have been orphaned are still unable to claim the CSG as the primary caregivers for younger siblings.
- Street children are not being reached by the system.
- Refugee children are still losing out, despite a scheme to fast-track identity documents and birth certificates.
- Asylum seekers face even more insurmountable hurdles.
- Financial constraints have delayed SASSA's plans to make its offices more accessible, though the use of mobile service points in the Western Cape and North West provinces could point to a way forward. Plans to make offices more child-friendly are also not very far advanced.
- Senior Grant Administrators (Level 7 officials) in SASSA are now certified Commissioners of Oaths and help reduce waiting times and the number of visits for applicants. However, these staff are not usually assigned to mobile service points.
- Poor people in urban settlements have not received as much information about the CSG as those in rural areas. Exclusion rates are therefore higher. Increased targeting of such communities should help; but the results have still to be seen.
- The public is still not sufficiently aware of how the means test works. These persistent information gaps need to be plugged, not least by better training of government officials.

For full details of research methods and findings, link to the full report

https://www.unicef.org/southafrica/SAF_resources_csgremovebarriers.pdf

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INDONESIA: A Financial Benchmark for Child Protection Indonesia. Pilot Study Benchmark Report
Study undertaken by Mokoro Inc. with the support of the Indonesian Ministry/Agency of National Development Planning (Kementerian Perencanaan Pembangunan Nasional/Badan Perencanaan Pembangunan Nasional – KEMENPPN/BAPPENAS). Key partners at subnational level were the provincial/district agencies of development planning (Badan Perencanaan Pembangunan Daerah (BAPPEDA) Jawa Tengah, Kota Surakarta, Kabupaten Magelang and Kabupaten Klaten)

MEXICO: Children and the Hotel Industry in Mexico: Taking action to protect, respect and support children's rights
UNICEF UK National Committee; UNICEF Mexico

NAMIBIA: We are the Architects of Our Own Destiny! Study of Positive Deviant Schools in Namibia
Ministry of Education, Arts and Culture, Government of the Republic of Namibia (main partner); Mzabalazo Advisory Services (research contractor)

NEPAL: Reducing Perinatal Mortality in Nepal Using Helping Babies Breathe
Ministry of Health, Nepal; Latter-day Saints Charities, United States; Uppsala University, Sweden

STATE OF PALESTINE: Every Child Counts: Understanding the needs and perspectives of children with disabilities in the State of Palestine
Overseas Development Institute (ODI), United Kingdom; State of Palestine Ministry of Social Development, Ramallah; Government of Japan; UNICEF State of Palestine

SERBIA: How to Be a Caring School: A study on the effects of prevention and intervention measures for preventing the dropout of students from the education system of the Republic of Serbia
Centre for Education Policy (research organization, Serbia); Ministry of Education, Science and Technological Development of the Republic of Serbia; UNICEF Serbia

SOUTH AFRICA: Removing Barriers to Accessing Child Grants: Progress in reducing exclusion from South Africa's Child Support Grant
Department of Social Development (DSD); South African Social Security Agency (SASSA); UNICEF South Africa

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