

EVALUATION REPORT

Formative Evaluation of the Implementation of the Ministry of Public Health and UNICEF Pilot Child Protection Joint Initiatives (Thailand) 2018–2022



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Evaluation carried out by:

Oxford Policy Management, on behalf of UNICEF

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EXECUTIVE SUMMARY

Overview of the intervention

From March 2018 to December 2022, Thailand's Ministry of Public Health (MoPH) and the United Nations Children's Fund (UNICEF) collaborated to pilot the Child Protection Joint Initiatives (the CP Joint Initiatives) in Health Region 8. The aim of this initiative was to test innovative models for preventive and responsive child protection services that include the following elements:

1. Analysing health information system (HIS) data using the **Child Shield** information management platform and demonstrating that 'big data' surveillance can effectively identify children and families at high, medium, low, or no risk of violence, exploitation, abuse, and neglect.
2. Ensuring that children identified as at high risk are case managed by a trained MoPH One Stop Crisis Centre (OSCC) worker until the threat is removed and all services to assure the child's wellbeing are in place, using the **Primero case management** information system.
3. Enrolling families of children across all risk levels in the **Parenting for Lifelong Health (PLH)** parent education programme, as a violence prevention measure.

Evaluation purpose, objectives, and intended audience

An evaluation of the pilot was conducted during the period November 2022–January 2023 based on the Organisation for Economic Co-operation and Development Assistance Committee (OECD-DAC) evaluation criteria (OECD, n.d.),¹ to consider the relevance and appropriateness of the project design and to understand how the inputs, activities, and outputs contributed to the achievement of the outcomes (results). The evaluation has been carried out for the purposes of both accountability and learning (UNICEF Evaluation Office, 2017). The explicit rationale of the evaluation is to support the national scale-up of the pilot CP Joint Initiatives by assisting MoPH and UNICEF to reflect on the progress of the project and the lessons learnt from these experiences, to document successes, and to identify areas needing improvement.

The specific objectives of the evaluation are the following:

1. To assess the relevance, coherence, effectiveness, efficiency, and sustainability of the model/s applied in the pilot CP Joint Initiatives.
2. To engage with the MoPH team in analysing the strengths and weaknesses of the initiatives, to build on positive findings, to enhance the child-centred approach, and to carry out course correction if required.
3. To provide actionable recommendations for MoPH to feed into the OSCCs upcoming information system and services provision plan.

The evaluation is expected to benefit a range of rights-holders and duty-bearers, including children, families, and communities, health personnel, social workers, and, most importantly, UNICEF and the Government of Thailand.

Evaluation methodology

The evaluation team, comprising four core researchers, employed a mixed methods approach to capture a range of perspectives and ensure data triangulation. Data were collected in Bangkok and in two provinces of Health Region 8. The methods involved the following: document review; administrative data analysis; 53 key informant interviews (KIIs) and small group discussions involving 25 females, nine males, and four mixed-gender groups, with two respondents who self-identified as having a disability (difficulty with hearing); and observation of the information management systems in

¹ With the agreement of UNICEF, we excluded 'impact' on the grounds that it is too soon to identify the impact of the pilot.

practice. The evaluation data collection and analysis methodology was subject to receipt of UNICEF's Ethical Review Board approval.

Key conclusions on findings

RELEVANCE – Is the intervention doing the right things?

The CP Joint Initiatives are designed to respond to violence against children in Thailand. Children in Thailand are exposed to child protection violations that include child violence being seen as an acceptable social norm. More than 10,000 children are treated in hospital every year for injuries resulting from violence, the majority from sexual abuse. The initiatives are clearly designed with this in mind, to prevent and respond to violence against children.

MoPH's development of Child Shield made innovative use of routine HIS data to improve its decision-making. HISs generate information that is vital for planning, monitoring, and evaluating public health programmes and interventions. MoPH harnessed the technical capacity of HISs in Health Region 8 to target behavioural factors that influence children's exposure to violence. This aligns with the World Health Organization's (WHO's) call for governments to expand population-based surveillance of violence against children.

However, it is difficult to ascertain the overall relevance of the pilot because the CP Joint Initiatives are not anchored in a robust results framework that articulates expected results and the causal pathway to reach those results. The performance, results, and effectiveness of the CP Joint Initiatives are not directly linked to a theory of change (ToC), results framework, or monitoring and evaluation (M&E) plan.

The design of the CP Joint Initiatives has not paid sufficient attention to UNICEF's global and country-level strategies and guidance, or to earlier evaluation outcomes. As a result, the child protection system has developed in a fragmentary way, with *ad hoc* parallel structures.

MoPH does not have a primary mandate for child protection service delivery, as envisaged under the CP Joint Initiatives, thus compromising the effectiveness of the investment. The pilot did not pay enough attention to developing that mandate through policy and legislative reform.

COHERENCE – How well does the intervention fit?

The CP Joint Initiatives responded to the persistent and pernicious context of violence against children in Thailand. Child Shield, Primero, and OSCC Capacity Development operate within government systems and using government infrastructure and resources. The synergies with complementary interventions in the sector, and particularly those offered by the Ministry of Social Development and Human Security (MSDHS), are less distinct.

Situating the CP Joint Initiatives within the broader child protection system would have enhanced the overall design. For example, the interventions could have produced more sustainable results had a more considered focus been placed on engagement with child protection coordination and collaboration forums from the outset, such as the National Child Protection Committee.

EFFECTIVENESS – Is the intervention achieving its objectives?

Child Shield has generated data that indicate at least 5% of children in the region are at risk of exposure to violence, abuse, and exploitation. Given the dearth of child protection information in Thailand these are important planning data for government duty-bearers. Although the figure is significantly less than the Hillis *et al.* (2016) systematic review estimate that 50% of children in Asia experienced violence in the past year, suggesting the system is not yet fully sensitive to all necessary predictive variables for violence against children.

During the four-year pilot implementation a maximum of 700 children received at least one service. Of these, around 60% are children living in families that attended a PLH parent education programme. Less than 1% of the children identified by Child Shield as at risk of violence are being case managed

(and only 20% of those (n=55) using the Primero case management information system) and PLH is not being regularly and systematically delivered.

Despite their heightened risk of violence, children with disabilities represent only 0.16% of children identified as at risk by Child Shield, and there is no explicit content on positive parenting of children with disabilities in the PLH programme. Excluding design measures that support the full inclusion of children with disabilities, ensuring they have equitable opportunities to access services, fails to respect their rights and is a dereliction of duty-bearers' obligations.

The analysis in Child Shield, which relies on HIS data, does not assess the child's complete social ecology and does not accurately predict the child protection risk. Structural, institutional, and interpersonal factors, such as poverty and family stress, and the child's living situation, are not included in the predictive model.

Child Shield and Primero are effective tools for data management and analysis. Frontline practitioners told this evaluation that Child Shield could help them identify children at risk more quickly. However, as these tools are not yet operational within a wider child protection system, they are not effective in preventing the risk escalating and delivering a suitable set of interventions when violence has occurred.

Situating the initiatives within the OSCCs to an extent takes account of the intersection of violence against women and violence against children. However, the limited capacity to actively case manage, including to make and follow-up multi-sectoral referrals, limits children's access to preventive and responsive services.

EFFICIENCY – How well are resources being used?

It is challenging to draw conclusions about financial efficiency because this evaluation did not involve a rigorous cost-benefit analysis. The softer reflection considered efficiency in terms of total investment and results because start-up, scale-up, and recurring costs were not estimated during project design or tracked during project implementation.

There are opportunities which are not yet being exploited for the integration of management information systems (MISs), particularly those used by MoPH's OSCC and by MSDHS' Child Protection Information System (CPIS) with Primero. This would create efficiencies in terms of staff time and would serve as the platform for a multi-sectoral exchange of child protection information.

It is challenging to ascertain the degree of commitment to capacity building in its most comprehensive sense because there is no foundational institutional capacity assessment. Mechanisms for coaching and mentoring, for continuing professional development, and for effective supervision are not included. Building a state-of-the-art technological facility is without value if there are not enough qualified people to operate it.

SUSTAINABILITY – Will the benefits last?

Frontline practitioners' awareness of child protection violations is enhanced and they are clearly motivated to respond where child rights violations are identified. This competency can be enhanced further and more effectively operationalised as the child protection system continues to be strengthened, particularly in the public health system.

The focus on software and hardware for Child Shield and Primero does not yet include the 'brainware' required to make the systems function as intended to prevent and respond to child protection violations. Child Shield, Primero, and the investments in case management and parent education training can deliver on the government's obligations to protect children from violence when the well-documented capacity constraints in the social welfare and child protection system workforce are addressed.

The limited MoPH mandate for child protection makes it difficult for regional management to allocate resources in a resource-constrained context. This is compounded by a leadership gap in regard to advocating for future investments.

PLH does not have a statutory home and a strategy for expansion. This intervention for families of children under 10 has demonstrated positive effects in a randomised control trial. However, to make the most efficient use of the investment to date the PLH developers have identified opportunities for future delivery linked to further research in other locations in Thailand with alternative donor funding.

Lessons learned

Programme design should incorporate the recommendations from previous evaluations, or explicitly state why they are not considered relevant to a particular programme.

The planning for a pilot programme or testing a model for eventual scale-up should consider the proof of concept requirements at the design stage. Rather than focusing solely on developing the idea, the design should have built-in viability tests, with a focus on how the concept can become a reality.

Similarly, systemic and scheduled monitoring and oversight throughout the implementation, including a mid-line review, are critical for conducting course correction and adapting to the dynamic context.

Key recommendations

1. Embed continued support for the CP Joint Initiatives in a systems-strengthening approach, matched to a robust results framework and M&E plan that is jointly designed by UNICEF and MoPH. This plan should include a clear set of milestones to achieve the following: (i) the necessary policy and legislative changes so that MoPH allocates funding to the initiatives; (ii) a progressive increase by MoPH of their response capacity and their ability to operate more effectively within a multi-sectoral system; and (iii) collaboration between UNICEF and the government to reduce the acceptance of violent discipline and to increase parenting capacity.
2. Make the CP Joint Initiatives central to the dialogue on the government's ongoing national multi-sectoral child protection system visioning. It is incumbent on UNICEF to facilitate this process so as to create a plan for seamless cooperation and collaboration across sectoral ministries on child protection.
3. Increase UNICEF's internal coherence on PLH, by integrating UNICEF Country Programme Outcomes on Early Childhood Development (Outcome 1) and Child Protection (Outcome 4.2), in order to create an environment for multi-sectoral dialogue on parental engagement that is inclusive of fathers and male caregivers and children with disabilities.
4. Identify a partner for the development of a longer-term strategy for systematic PLH roll-out. Use this unique opportunity to advocate with MSDHS, the Ministry of Education, the Ministry of Interior, and MoPH to establish a home for PLH in social care facilities and Family Development Centres (FDCs), early childhood development centres, schools, and public health facilities, within the framework of a multi-sectoral strategy for PLH delivery.
5. Fully adopt UNICEF Thailand's recently introduced Guidelines for Scale-up Models and Pilots to improve the efficiencies and longer-term sustainability of innovative child protection programmes. In particular, the requirement to have and implement a robust results framework and M&E plan for pilot programmes should be non-negotiable.
6. Consider the benefits of conducting an institutional capacity assessment, which is fundamental to understanding how innovations in child protection systems development can be introduced and sustained.
7. Consider advocating and providing support for the integration of Primero with (i) internal MoPH databases managed by OSCC, and (ii) CPIS.
8. Review, and where necessary adjust, internal UNICEF programme documentation, paying explicit attention to equitable community inclusion of children with disabilities (see Office of the United Nations High Commissioner for Human rights (2023), and women and girls.

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List of abbreviations

ASEAN	Association of Southeast Asian Nations
CP Joint Initiatives	MoPH–UNICEF Pilot Child Protection Joint Initiatives
CPIS	Child Protection Information System
CPIMS+	Child Protection Information Management System – next generation
CP-MIS	Child protection management information system
CRC	United Nations Convention on the Rights of the Child
CRPD	United Nations Convention on the Rights of Persons with Disabilities
EMR	Electronic Medical Record
FDC	Family Development Centre
FGD	Focus group discussion
ICT	Information and communications technology
KII	Key informant interview
MIS	Management information system
MoPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
NDID	National Digital ID
OECD	Organisation for Economic Co-operation and Development
OECD-DAC	OECD Development Assistance Committee
OpenHIE	Open Health Information Exchange
OPM	Oxford Policy Management
OSCC	One-Stop Crisis Centre
Par	Paragraph
PDD	Principles for Digital Development
PDPA	Personal Data Protection Act
PID	Personal ID
PLH	Parenting for Lifelong Health
ToR	Terms of reference
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children’s Fund

Glossary

Best interests of the child. ‘The best interests of a child shall be a primary consideration when providing protection and care necessary for the child’s well-being, taking into consideration the rights and duties of parents, legal guardians or other persons legally responsible for the child. The objective is to ensure the child’s well-being and development, including their basic material, physical, educational, emotional, affection and safety needs. Consideration of the child’s safety must include protection against all forms of physical or mental violence, injury or abuse, sexual harassment, peer pressure, bullying, and degrading treatment, as well as protection against sexual, economic and other exploitation, drugs, labour, armed conflict, etc.’ (Department of Children and Youth, 2017, p. 10).

Caregiver. A caregiver is a person who is very closely attached to a child and is responsible for their daily care and support. Primary caregivers include parents, family members, and other people who are directly responsible for the child at home (UNICEF, 2020b, p. 5). For the PLH programme, a caregiver is defined as a person who spends at least four nights per week under the same roof as a child.

Case management. Child protection case management is the process of helping individual children and families through providing direct social work-type support and engaging in information management. The purpose of child protection case management is to provide children needing protection from violence, abuse, neglect, and exploitation with an optimal response ‘at the time of their greatest vulnerability’ (Department of Children and Youth, 2017). In Thailand, child protection case management consists of sequential steps: (a) intake (registration), (b) fact-finding and assessment, (c) case planning, (d) plan implementation and referrals to services, (e) follow-up, and (f) case closure.

Child. Children, including children with disabilities, are those under the age of 18, as per the United Nations Convention on the Rights of the Child (CRC), ratified by Thailand in 1992 (Office of the United Nations High Commissioner for Human Rights, n.d.). All persons aged 18 and over are considered adults. It is important to establish this because in some contexts persons with disabilities, particularly those with intellectual disabilities, are often incorrectly perceived and referred to as perennial children.

Child-centred approach. A child-centred approach means keeping the child in focus and including them, their family, and their support team in decision-making, adjusting and tailoring activities towards all children’s unique needs, and giving all children the same opportunity to access and participate in all parts of a service.

Child protection. Child protection refers to prevention and response interventions to protect a child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s), or any other person who undertakes the care of the child. (Article 19, CRC, reflected in Thailand’s Child Protection Act (2003)).

The Convention on the Rights of Persons with Disabilities (CRPD), ratified by Thailand in 2008, also refers to the right to protection for persons with disabilities, both within and outside the home, from all forms of exploitation, violence, and abuse, including their gender-based aspects (Article 16, CRPD).

‘Ensuring children are in social environments, whether in families, communities, educational institutions or other settings that children rely on and are part of, that are capable of providing care and development for children that meet the minimum standards prescribed under the Ministerial Regulations and protection against harms, whether physically, mentally or developmentally, and promoting good behaviours in children. (Sub-Committee on reviewing child rights-related laws by the Thai Constitution and the Convention on the Rights of the Child 2016).’²

Child protection system. The child protection system is made up of the specific formal and informal structures, functions, and capacities assembled to prevent and respond to violence against, and the

² Department of Children and Youth, 2017, p. 5. The Manual also provides detailed definitions of abuse, neglect, exploitation, and violence.

abuse, neglect, and exploitation of, children. A child protection system is generally agreed to comprise the relationships and interactions between and among several components and actors. It is the outcomes of these interactions that comprise the system.³

Gender-based violence. Gender-based violence is an umbrella term for *any harmful act that is perpetrated against a person's will* and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such actions, coercion, and other deprivations of liberty (IASC, 2015, p. 5). Girls are more likely to experience sexual violence and boys are more likely to experience physical violence. However, it is usually recommended that special attention be given to girls, due to their documented greater vulnerabilities to gender-based violence, the overarching discrimination they experience, and their lack of safe and equitable access to social services (UNICEF, 2021a).

Parent. The term parent refers to a child's father or mother.

Parenting. Parenting is the interactions, behaviours, emotions, knowledge, beliefs, attitudes, and practices associated with the provision of nurturing care for a child (UNICEF, 2020b).

Persons with disabilities. Persons with disabilities are children and adults who have long-term physical, mental, intellectual, or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others (Article 1, CRPD).

Prevention. Primary, secondary, and tertiary prevention are public health approaches that aim to (1) prevent a phenomenon before it occurs, (2) reduce the impact of a phenomenon that has already occurred, and (3) soften the impact of an ongoing phenomenon that has long-lasting effects (Baumann and Karel, 2013).

Public health. 'Public health is the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society' (Marks *et al.*, 2011). Prevention is a key public health term that denotes action to avoid, forestall, or circumvent a happening, conclusion, or phenomenon: for example, the prevention of violence against, and the abuse, neglect, and exploitation of, children.

Screening. The primary purpose of screening is to identify early signs and symptoms of a disease or health problem in order to implement early treatment or a programme intervention to reduce the likelihood of the emergence of a disease or health problem and/or mortality from the disease in an individual. Screening in populations is only undertaken when there is proven benefit to the screening and the natural history of the disease is well-established (Oleske, 2009).

Social protection. Social protection refers to a set of policies and programmes aimed at preventing, or protecting all people against, poverty, vulnerability, and social exclusion throughout the life-course, with a particular emphasis on vulnerable groups (UNICEF, 2019c). This includes protection against economic vulnerability and improving access to social services.

Social services. Social services can include the following: (i) social work services that provide information and awareness-raising, assessments, referrals to other services, and counselling and mediation; (ii) care services, provided by a range of specialists (in health, education, and social care); and (iii) other specialised services for specific groups and situations, such as access to assistive products and technologies or legal aid (Lindert *et al.*, 2020).

Surveillance. Surveillance is the systematic process of identifying, collecting, summarising, analysing, and evaluating data about specific diseases or health problems, and promptly disseminating the findings to those who need to know about, and those who need to act on, these issues (Oleske, 2009).

³ Adapted from UNICEF (2021f, p. 8).

1 CONTEXT OF THE EVALUATION

1.1 Global child protection context

This formative evaluation of actions that intend to improve outcomes for children in Thailand applies globally applicable child protection concepts that are tailored to the Thai context. The evaluation is shaped by a consideration of how public health, case management, child protection MISs, and parenting programmes contribute to a comprehensive child protection system that supports a child's right to protection (Annex D). A more complete analysis of the evaluation context is provided as Annex N.

The evaluation involves a consideration of gender equality and social inclusion principles as they relate to child protection, and as they are defined in United Nations global and country-level strategies, including the following:

- UNICEF Strategic Plan 2022–2025 (UNICEF, 2022a);
- UNICEF Gender Policy 2021–2030 (UNICEF, 2021a), and Gender Action Plan 2022–2025 (UNICEF, 2021b);
- UNICEF Child Protection Strategy 2021–2030 (UNICEF, 2021c);
- UNICEF Thailand Country Programme Document 2022–2026 (UNICEF, 2022b); and
- United Nations Disability Inclusion Strategy 2020 (United Nations, 2020).

1.2 Thailand's socioeconomic context

Thailand is an upper middle-income country, with a population of around 71.7 million persons,⁴ around 17% of whom are under 18 years old (12 million). The remarkable improvement in poverty reduction seen since 2015 has recently been negatively impacted by the COVID-19 pandemic and the current global phenomenon of rising energy and food prices (World Bank, 2022). Girls, children with disabilities, and children under five are particularly limited in their access to healthcare and income security, and poor children and migrant children are more likely to be out of school (World Bank, 2022). Around 3 million children are 'left behind' by migrant worker parents and are growing up in the care of grandparents and other extended family members (Global Health Now, 2017). As a result, these children are more likely to be exposed to child protection risks.

1.3 Policy and legislative context for child protection in Thailand

Thailand ratified the CRC in 1992 and the CRPD in 2008. Thailand is also a member of the Association of Southeast Asian Nations (ASEAN) and its Commission for the Promotion and Protection of the Rights of Women and Children and Intergovernmental Commission on Human Rights.

The principal Thai national legislation is the Child Protection Act (2003), which stipulates that those who are responsible for looking after children have the duty to notify or report incidents of child abuse. Through this act, a National Child Protection Committee was formed, chaired by the Minister of Social Development and Human Security. Guided by the Child Protection Act, UNICEF and MSDHS initiated the introduction of child protection case management for Local Administrative Organisations and Children and Family Centres, although standardisation across the country is considered to be underdeveloped (Yuhanngoh and Boonyarattanasoontorn, 2018).

The MoPH 20-year National Strategic Plan for Public Health includes measures to increase the quality standards of hospitals that provide care services for mother and child, to develop and improve the data system, surveillance system, and referral system, and to develop the support and care system for high-risk children (MoPH, 2018, p. 43).

⁴ <https://data.unicef.org/country/tha/>

Legislation specific to the development of information and communications technology (ICT) is discussed in Chapter 1.4.

A 2020 evidence review of the child protection system in Thailand described the situation as complex, in part because frequent changes in government institutions had made it difficult to obtain buy-in, and because of limitations in public awareness of and support for children's right to protection (UNICEF, 2020a).

1.4 Thailand's ICT context

Thailand's ICT sector has developed rapidly over the past two decades, with the private sector, government agencies, and households engaging in digital services and becoming more tech-savvy (Frost and Sullivan, 2019).

Digital services and the development of interoperable digital ecosystems for various sectors have also been enabled by the following digital enablers:

- The **digital literacy** of the Thai population has significantly increased, represented by increased utilisation of ICT (Frost and Sullivan, 2019, p. 16), including broadband Internet access and high mobile penetration.
- The **National ID and civil registration system**, under the management of the Ministry of Interior, is well-established, with near universal coverage of the population registry (just under 100%) (World Bank Group, 2021), including a **Personal ID (PID) number** generated at birth registration and a National Digital ID (NDID) for engaging in digital transactions and services.
- The development of the **eHealth ecosystem is based on the OpenHIE** (Health Information Exchange) architecture and framework (Kijsanayotin, 2016) that provides standards and best practice recommendations for the development of interoperable health systems, such as the Moh Prompt application.⁵

Alongside an enabling environment for interoperability and digital services, strong data management and governance standards are required to ensure consistency in how the information of Thai citizens and their PIDs are handled across the different databases. Due care and consideration must be taken to protect the data and privacy of citizens, especially children, through system design, and to safeguard their information and rights through the appropriate legal and regulatory frameworks. The Personal Data Protection Act (PDPA) is the first law in Thailand to govern data protection in the digital age; it became enforceable in 2022.⁶ The PDPA – comparable to the European Union's General Data Protection Regulation – sets out the requirements for data controllers and processors in regard to obtaining expressed consent when collecting, processing, storing, and disclosing personal data.

1.5 Situation of children exposed to violence and abuse in Thailand

There is an overwhelming body of evidence that demonstrates that data may reflect only the tip of the iceberg in regard to children's exposure to violence and abuse, which may often go unrecognised or unreported. In line with this body of evidence, child sexual abuse and exploitation in Thailand are thought to be under-reported when compared to the rest of the world (Trangkasombat, 2008).

It is also known that there is near universal social acceptance of violent discipline, such that 58% of Thai children are subjected to psychological and physical punishment (UNICEF, 2021d). UNICEF reports that more than 10,000 children are treated in hospital every year for injuries resulting from violence, mostly sexual abuse (UNICEF, n.d.). The rate of child marriage by age 18 stands at 20% (National Statistical Office Thailand and UNICEF, 2019), driven by gender inequalities related to level of education,

⁵ Website: <https://mohprompt.moph.go.th/>

⁶ Source: Thailand Personal Data Protection Act (<https://www.trade.gov/market-intelligence/thailand-personal-data-protection-act>)

adolescent pregnancy, poverty, traditional harmful practices, sexual violence against girls, and ethnicity (Girls Not Brides, n.d.). At the same time, 9% of internet-using children aged 12–17 in Thailand are victims of grave instances of online sexual exploitation and abuse (ECPAT, INTERPOL, and UNICEF, 2022).

In Thailand, about 38% of children with disabilities are out of school, 27% do not have access to health promotion services, and 4% do not have access to medical treatment when they are sick (UNICEF, 2021e). In addition, nearly half of children with disabilities are not registered with the government and do not receive a monthly disability grant (UNICEF, 2021e).

Thailand is home to more than 660,000 migrants, refugees, asylum seekers, stateless persons (UNHCR, 2022). Many of the children within this marginalised population are vulnerable to child protection risks because they are out of school or have limited access to health and social services.

1.6 Why the evaluation was commissioned

As set out in the terms of reference (ToR), the CP Joint Initiatives were piloted in all seven provinces of Thailand's Health Region 8 during the period 2018–2022. The UNICEF Thailand Country Office Child Protection section has commissioned this formative evaluation to generate evidence for advocacy towards the national scale-up of these initiatives.

2 OBJECT OF THE EVALUATION

2.1 Description of the programme

Table 1: Brief presentation of the object of the evaluation

Title of the project/programme	Ministry of Public Health and UNICEF Pilot Child Protection Joint Initiatives																																		
Country	Thailand																																		
Sources of project funding	UNICEF, MoPH (in-kind), University of Oxford																																		
Total budget	US\$ 756,000 (UNICEF US\$ 670,000, University of Oxford US\$ 86,000)																																		
Project duration	2018–2022																																		
Main objective	UNICEF Thailand Country Programme, 2017 – February 2022 , Outcome 4: ‘By 2021, boys and girls in Thailand are increasingly protected from violence, neglect and exploitation’. UNICEF Thailand Country Programme, March 2022 – December 2026 , Outcome 4: ‘By 2026, more children, especially the most vulnerable, are better protected from violence, exploitation, neglect and abuse’.																																		
Components (axes, effects, products, etc.)	<ul style="list-style-type: none"> • Child Shield, a management information system that ‘utilizes big data and artificial intelligence in real-time for timely screening of at-risk children and families’,⁷ and Primerio, ‘an information management platform supporting seamless child protection case management services’.⁸ • OSCC Capacity Development on case management and PLH. 																																		
Expected beneficiaries⁹	<p>The pilot expected to create a prototype that will benefit all children in Thailand through later national scale-up. The expected beneficiary numbers are not disaggregated by gender or disability.</p> <table border="1"> <tr> <td>Child Shield I (2018-2019)</td> <td>200</td> <td>children being screened</td> <td></td> </tr> <tr> <td>Child Shield II (2020-2021)</td> <td>2000</td> <td>children being screened</td> <td></td> </tr> <tr> <td>Primerio I (2020-2021)</td> <td>30</td> <td>children received services through Primerio</td> <td></td> </tr> <tr> <td>Primerio II (2022)</td> <td>120</td> <td>children received services through Primerio</td> <td></td> </tr> <tr> <td>Case Mgt training (2018-2019)</td> <td>70</td> <td>practitioners being trained</td> <td></td> </tr> <tr> <td>PLH (pilot) 2018-2020</td> <td>120</td> <td>children received services through PLH</td> <td></td> </tr> <tr> <td>PLH scale (2020-2021)</td> <td>300</td> <td>children received services through PLH</td> <td></td> </tr> <tr> <td></td> <td>180</td> <td>trainers being trained</td> <td></td> </tr> </table>			Child Shield I (2018-2019)	200	children being screened		Child Shield II (2020-2021)	2000	children being screened		Primerio I (2020-2021)	30	children received services through Primerio		Primerio II (2022)	120	children received services through Primerio		Case Mgt training (2018-2019)	70	practitioners being trained		PLH (pilot) 2018-2020	120	children received services through PLH		PLH scale (2020-2021)	300	children received services through PLH			180	trainers being trained	
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	180	trainers being trained																																	
Partners (institutional, implementing agencies)	MoPH																																		

UNICEF had earlier identified that ‘The MoPH’s capacity to deliver services would be enhanced with the provision of appropriate tools, staff capacity, and a comprehensive management information system. This will directly ensure timely prevention of violence, abuse and exploitation with the participation of all stakeholders’.¹⁰ Therefore, the MoPH and UNICEF Pilot CP Joint Initiatives programme was designed with the following components:

- The development of MISs that include ‘Child Shield’, which utilises big data and artificial intelligence in real time for the timely screening of at-risk children and families. This also includes a tracking

⁷ ToR for this assignment page 1 (provided as Annex A).

⁸ *Ibid.*

⁹ Data provided by UNICEF Thailand, November 2022.

¹⁰ ToR, Section 1, page 1 (see Annex A).

system to monitor identified cases and link those cases to the Primero, an information management platform that supports seamless child protection case management services.

- Capacity development for health personnel at the sub-national level, especially staff of the OSCCs, in regard to conducting case management, including risk assessment of cases identified through Child Shield, as well as services provision and referral; and the adaptation and delivery of PLH, an evidence-based positive parenting intervention for families identified through the screening process as being at risk.

These CP Joint Initiatives were implemented from 2018 to 2022, with financial support from UNICEF, with the following details:¹¹

- **Child Shield**
 - UNICEF and MoPH: The development of a screening tool and MIS targeting children and women at risk of being, or being, abused, for health sector (Child Shield) Phase I March 2018–October 2019.
 - UNICEF and MoPH: The development of a screening tool and MIS targeting children and women at risk of being, or being, abused, for the health sector (Child Shield) Phase II. June 2020 – December 2021
- **Primero**
 - Contract with vendors through UNICEF HQ, since March 2020 (ongoing), for the configuration, adaptation, and maintenance of Primero software in Thailand's context.
- **OSCC staff capacity development**
 - UNICEF and MoPH: The development of a curriculum and capacity on child protection for health personnel (Phase I) – Case Management Training: March 2018 – October 2019.
 - UNICEF and MoPH: The development of a curriculum and capacity on child protection for health personnel (Phase II) – PLH: June 2020 – January 2022.
 - Programme Cooperation Agreement with the Chancellor, Master and Scholars of the University of Oxford on a 'Feasibility study on an evidence-informed parenting intervention to prevent violence against young children by parents and primary caregiver in Thailand', implemented from March 2018-April 2020.

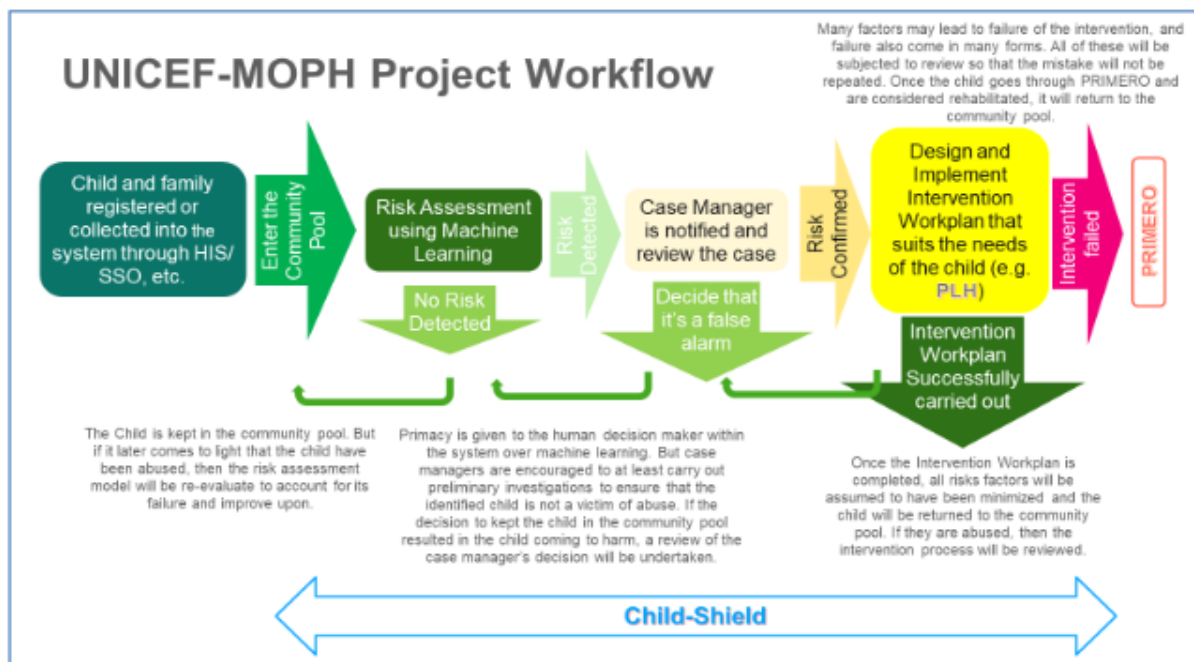
This evaluation is expected to benefit a range of rights-holders and duty-bearers, including children, families, and communities, health personnel, social workers, and, most importantly, the Government of Thailand.

2.2 ToC

The ToC, linking the three components of the CP Joint Initiatives, is to an extent described in the project workflow diagram (Figure 1).

¹¹ ToR, Section 1, pages 1 and 2 (see Annex A).

Figure 1: UNICEF–MoPH project workflow



Source: Evaluation ToR.

As with the ToC, the process flow was constructed based on the key informants’ perceptions of the CP Joint Initiatives concept. This describes the connection between investments in the three key inputs and their intended relationship to child protection prevention and response measures.

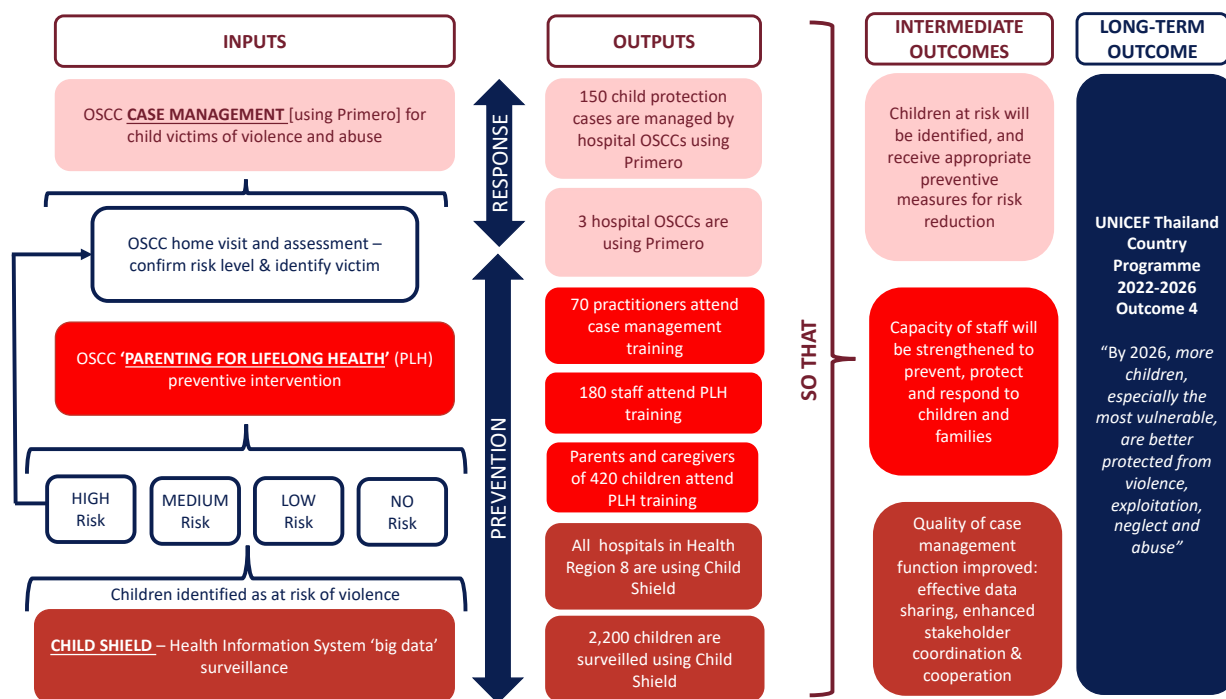
During the inception phase the evaluation team constructed a ToC for each component based on an *ex post facto* examination of the programme documentation (Annex E). Based on this, UNICEF provided a revised construction prior to the commencement of data collection. These assumptions were validated to the extent possible by benchmarking against programme documentation. An integrated ToC was constructed that connects the three activities to the UNICEF Thailand Country Programme 2022–2026 (Figure 2). This integrated ToC supported the analysis of the findings of this present evaluation, including the contribution of the inputs and outputs to the achievement of the Country Programme’s intended results.

Since this evaluation looks back at what was achieved in order to inform what happens in the future, we introduced the current UNICEF Thailand Country Programme Outcome 4 to describe the long-term outcome; this corresponds with the UNICEF Thailand Country Programme, 2017 – February 2022, Outcome 4: ‘By 2021, boys and girls in Thailand are increasingly protected from violence, neglect and exploitation’.

The agreements between UNICEF and MoPH for Phase II of the Child Shield, Primero, and OSCC Capacity Development describe the specific objectives and activities of the individual components within the framework of the UNICEF Child Protection Programme 2017–2021 results framework.

In the absence of an overarching programme document or results framework, the output targets and intermediate outcomes were obtained from several sources, including the PLH programme document that formed the basis of the funding agreement between UNICEF and the University of Oxford, the ‘Review of Project Proposal’ documents for funding the activities of the MoPH for Child Shield and Primero, and expected beneficiary data provided by UNICEF in November 2022.

Figure 2: CP Joint Initiatives ToC



Source: Authors.

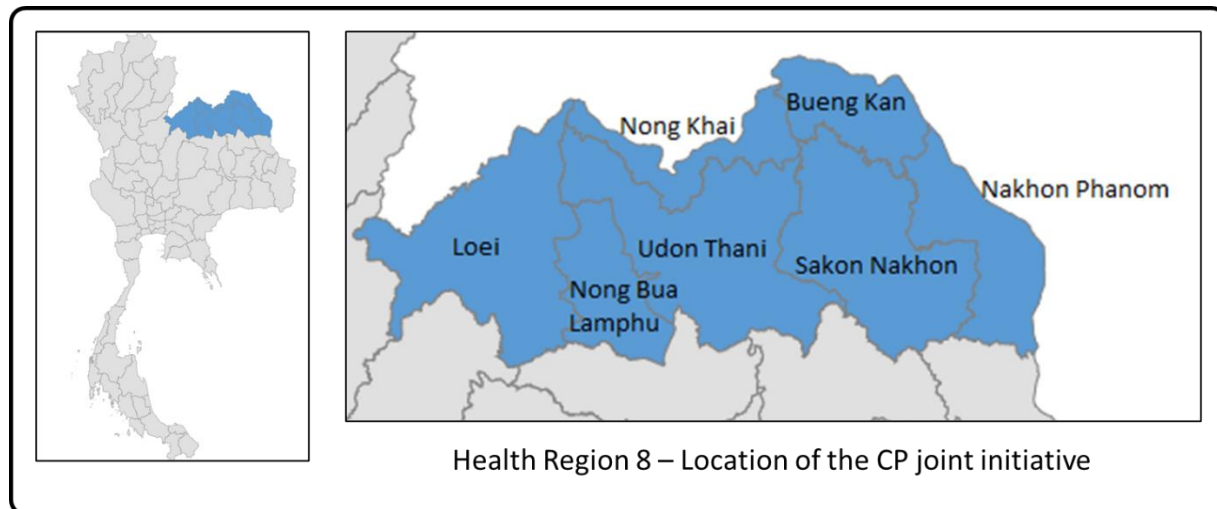
The ToC for the pilot CP Joint Initiatives hypothesises as follows:

1. If three *inputs* are integrated:
 - o HIS data are analysed by the **Child Shield** platform and this 'big data' surveillance identifies children and families at high, medium, low, or no risk of violence, exploitation, abuse, and neglect; and
 - o families of children across all the risk levels are enrolled in the **PLH** parent education programme as a violence prevention measure; and
 - o children identified as at high risk of exposure to violence are visited by an OSCC worker who conducts a more complete assessment and confirms the risk level or confirms that the risk has escalated to exposure, and these children are **case managed** by an OSCC worker until the threat is removed and all services to assure the child's wellbeing are in place using the **Primero** case management platform.
2. Then several *outputs* will occur such that:
 - o children and families in Health Region 8 will benefit from violence prevention and response services.
3. And the *outcomes* can be extended nationally:
 - o and all children at risk of violence and their families can benefit from preventive and responsive child protection services provided by a capacitated and coordinated workforce.
4. So that UNICEF's *long-term outcome* can be achieved: 'By 2026, more children, especially the most vulnerable, are better protected from violence, exploitation, neglect and abuse'.

2.3 The intervention area

As stated by UNICEF, the initiatives have been piloted in all seven provinces under Health Region 8: Udon Thani, Sakon Nakhon, Nakhon Phanom, Loei, Nongkhai, Nongbualumpoo, and Bungkan (Figure 3).

Figure 3: The intervention area



3 PURPOSE OF THE EVALUATION

3.1 Purpose

This evaluation has been conducted for the purposes of accountability and learning (UNICEF Evaluation Office, 2017). The explicit rationale is to support the national scale-up of the Pilot CP Joint Initiatives by assisting MoPH and UNICEF to ‘reflect on progress and lessons learnt from these experiences, and document successes and identify areas needing improvement’.¹²

3.2 Key users of the assessment and intended uses

As described in Table 2, it is intended that the evidence generated through this evaluation will be used by:

- the primary duty-bearers – UNICEF Thailand and MoPH – for their policy-level dialogue and advocacy in support of national scale-up of Child Shield, Primero, and OSCC Capacity Development; and
- other external duty-bearers for child protection, including MSDHS, UNICEF Regional, and UNICEF New York HQ.

Children’s participation is a core principle of the CRC, and although it was not anticipated that children would be directly involved in the evaluation as respondents, we propose that UNICEF determine a mechanism for disseminating the evaluation’s key findings and recommendations. This would be particularly useful if a feedback mechanism is included (for example, a U-Report) to ensure that children have the opportunity to share their opinions on this important matter, which affects them. Aligning with the key principles of accountability and respect, we also suggest that feedback should be provided to the respondents to the evaluation, including parents, other family members, and caregivers.

Table 2: Users and use of the evaluation

Evaluation users	Uses of the evaluation (how the findings and recommendations will be used)
UNICEF and MoPH	UNICEF and MoPH at the policy level will use the evaluation result for policy dialogue to advocate for further expansion of the model at the national level
MoPH	<ul style="list-style-type: none"> • Contribute to effective and efficient scaling up of the pilot CP Joint Initiatives • Provide data for MoPH to advocate for additional budget allocation and disbursement
MoPH Operations Team	The operations team of MoPH will use the evaluation results to improve the effectiveness and efficiency of the CP Joint Initiatives
MSDHS	The learning will contribute to the visioning process in regard to the national child protection system currently being led by MSDHS, with support from UNICEF
Ministry of Interior, Ministry of Justice	These government institutions are integral to a national child protection system and the evaluation will support the dissemination of, and awareness of, the cross-sectoral mechanisms for child protection
Child Protection Section, UNICEF Thailand Country Office	<ul style="list-style-type: none"> • Review the ToC and refining intervention strategies for scale-up • Develop a new advocacy strategy for greater engagement of national actors in child protection
Monitoring and Planning Section, UNICEF Thailand Country Office	Contribute to the adaptation of robust mechanisms for programme planning and monitoring
Child Protection Section of UNICEF Regional Office and HQ	<ul style="list-style-type: none"> • Support the adaptation of the innovative models for wider dissemination across similar contexts

¹² ToR, Section 2, page 2 (Annex A).

Evaluation users	Uses of the evaluation (how the findings and recommendations will be used)
	<ul style="list-style-type: none"> • Contribute to learning on the interoperability of child protection MISs, with particular reference to strengthening the Primero Case Management MIS • Strengthen high-level advocacy and resource mobilisation with donors in this area
Families and communities	Provide feedback to communities and families in Health Region 8 to build confidence and trust in the new models and encourage continued support and involvement in child protection screening, case management, and PLH
Children	Disseminate the evaluation outcomes and recommendations in a child-friendly format, incorporating a feedback mechanism that allows for children’s opinions to be considered in future programme design
MIS vendors and developers	<ul style="list-style-type: none"> • Develop new intervention strategies • Become familiar with the approaches identified as successful by the evaluation and introduce them more systematically in operations • Build on the lessons learned during the evaluation to strengthen their advocacy strategy with technical partners, and territorial and devolved administrations
Donors	Better define financial support for the prevention of child violence and abuse

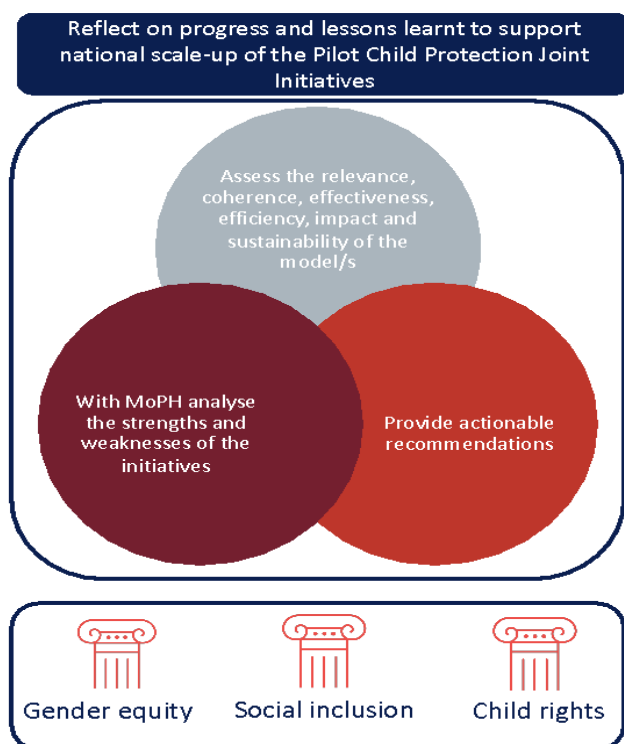
4 OBJECTIVES OF THE EVALUATION

The **specific objectives** (Figure 4) of this formative evaluation are as follows:

1. To assess the relevance, coherence, effectiveness, efficiency, and sustainability of the model/s applied in the pilot CP Joint Initiatives.
2. To engage with the MoPH team in analysing the strengths and weaknesses of the initiatives, to build on their positive findings, to enhance the child-centred approach, and to carry out course correction if required.
3. To provide actionable recommendations for MoPH to feed into OSCC’s upcoming plan for information system and services provision.

A cost–benefit analysis and an analysis of the resources required for the scale-up was envisaged in the ToR, under the heading ‘Purpose and objectives’. During inception, it was agreed by UNICEF that for the purposes of this evaluation this should be treated as a ‘soft’ reflection on efficiency, in terms of investment and results, which is relevant for future discussion on scale-up. It was agreed that a rigorous and robust cost–benefit analysis would be a separate and dedicated future action.

Figure 4: Formative evaluation of the pilot CP Joint Initiatives



Source: Authors.

5 SCOPE OF THE EVALUATION

5.1 Thematic scope

The UNICEF Thailand Country Office Child Protection section has commissioned this formative evaluation of the ‘Pilot Child Protection Initiatives implemented jointly between MoPH and UNICEF during 2019–2022’.¹³

The ToR explicitly and clearly defines what will and will not be covered: thematically (pilot, including Primero, Child Shield, and OSCC Capacity Development and PLH implementation), chronologically (time period for each component during 2019-2022), geographically (the provinces in Health Region 8 that implemented the pilot project).¹⁴

5.2 Geographical scope

The geographical scope of this evaluation is the intervention area of the CP Joint Initiatives (Chapter 2.3). The literature review considered all the sites covered by the assessment, while the primary data collection was carried out in two of the seven provinces in Health Region 8, and with relevant stakeholders at national level in Bangkok.

Three options for the selection of sites were identified. Two options were initially identified, based on various characteristics (Table 3): that is, poverty level, population size, number of hospitals/medical establishments, and number of registered social workers. For two other characteristics – percentage of children aged under 18 and percentage of persons with disabilities – there are no great differences across these seven provinces. In response to this initial identification, UNICEF proposed a third option based on the availability of province-level case management teams to undertake comprehensive case work.

Table 3: Province demographic data

No	Province	Population (2021)	% people below poverty line of total population (2020)	# of hospital and medical establishment (2021)	% children of total pop (2021)	% persons with disabilities of total population (2021)	# of social worker per 100,000 population
1	Bueng Kan	421,995	4.3%	8	23%	3.0%	3
2	Nang Bua Lamphu	509,001	8.7%	7	21%	4.0%	13
3	Udon Thani	1,566,510	9.3%	28	21%	2.9%	7
4	Loei	638,732	0.2%	16	21%	4.7%	6
5	Nong Khai	516,843	3.0%	12	21%	3.1%	13
6	Sakon Nakhon	1,146,286	6.5%	20	22%	3.4%	5
7	Nakhon Phanom	717,040	15.7%	13	22%	3.3%	6

Source: National Statistical Office Thailand, <http://statbbi.nso.go.th/staticreport/page/sector/en/01.aspx>; Open Government Data of Thailand, https://data.go.th/dataset/item_a6bfc320-5389-4f15-b1bf-97732cbdcda5 [Accessed 26 September 2022].

¹³ ToR, Section 1, page 2 (Annex A).

¹⁴ ToR, Section 3, page 3 (Annex A).

- Option 1: **Bueng Kan**, which is the province with the smallest population and the lowest number of social workers, and **Udon Thani**, whose capital city has the largest population and which has a relatively good number of social workers.
- Option 2: **Nakhon Phanom**, which has the highest percentage of people below the poverty line and has a good number of health facilities and social workers, and **Bueng Kan**, which has relatively few poor people and relatively low numbers of health facilities and social workers.
- Option 3: **Udon Thani**, because Primero is currently only implemented in this province, and **Sakhon Nakhon**, because comprehensive case work for at-risk cases identified by Child Shield is only implemented in Udon Thani and Sakhon Nakhon.¹⁵

With UNICEF’s input, Option 3 was selected as the most suitable to allow the tracking of cases from Child Shield to Primero, thus tracing the range of outcomes envisaged in the ToC (Chapter 2.2). This option also incorporates Udon Thani province, which was also included in Option 1.

5.3 Chronological scope

The ToR define the total chronological scope of the formative evaluation as the implementation period 2018–2022 (Table 4).

Table 4: Chronological scope

Component	Phase I	Phase II
Child Shield	March 2018 – October 2019	June 2020 – December 2021
Primero	March 2020 – 2021	2022 – current
OSCC Capacity Development – case management	2018 – 2019 ¹⁶	
OSCC Capacity Development – PLH	March 2018 – October 2019	June 2020 – January 2022

¹⁵ Written submission from UNICEF to the draft inception report, October 2022.

¹⁶ NB: This is not defined in the ToR but it is in UNICEF expected beneficiary and expenditure data provided to the evaluation team in November 2022.

6 CRITERIA AND EVALUATION QUESTIONS

6.1 Evaluation criteria

This formative evaluation references five of the six OECD-DAC criteria in examining the implementation of the CP Joint Initiatives (Box 1).¹⁷ Since it is too early to assess impact at this stage, UNICEF eliminated this criterion from the ToR. However, changes or improvements that occur as a result of the pilot implementation are discussed when we answer questions regarding ‘effectiveness’ criteria.

Box 1: OECD-DAC criteria and definition

- **Relevance:** Is the intervention doing the right things? This refers to the extent to which the intervention objectives and design respond to beneficiaries’, global, country, and partner/institution needs, policies and priorities, and continue to do so if circumstances change.
- **Coherence:** How well does the intervention fit? This refers to the compatibility of the intervention with other interventions in a country, sector, or institution.
- **Effectiveness:** Is the intervention achieving its objectives? This refers to the extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.
- **Efficiency:** How well are resources being used? This refers to the extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.
- **Impact:** What difference does the interventions make? This refers to the extent to which the intervention has generated, or is expected to generate, significant positive or negative, intended or unintended, higher-level effects.
- **Sustainability:** Will the benefits last? This refers to the extent to which the intervention continues or is likely to continue.

Source: Adapted from OECD (2019) *Better Criteria for Better Evaluation. Revised Evaluation Criteria Definitions and Principles for USE*. <https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf>

6.2 Evaluation questions

We refined the proposed evaluation questions, reflecting on the context of the CP Joint Initiatives and the objectives of this evaluation. This involved simplifying and prioritising so that the evaluation focuses on core questions, while at the same time ensuring the evaluation meets its objectives (Table 5). More detailed sub-questions guided the data collection process. The evaluation matrix (Annex F) describes the evaluation questions, sub-questions, indicators, methods of data collection, data sources, and approach to data analysis.

Table 5: Evaluation questions

Criteria	Key questions
Relevance	To what extent do the objectives and design of the interventions respond to Thailand’s context and environment? Do they align with the government’s, especially MoPH’s, policy framework and priorities; and to global standards and UNICEF priorities?
	Is there a clear intervention logic, with sound theories of change?
	Was the intervention designed in ways that respond to the needs of the intended beneficiaries?*
	To what extent were gender and social inclusion considerations built into the design (e.g. for the inclusion of women and children with disabilities, people from ethnic minorities, non-Thai people)?

¹⁷ ToR, Section 3, page 3 (Annex A).

Criteria	Key questions
Coherence	To what extent are the synergies and interlinkages developed across the different joint initiatives (between Primero, Child Shield, and PLH)? Did these three initiatives complement each other?
	To what extent is the pilot implementation coherent with other government initiatives, in order to achieve optimal utilisation of available resources? Did the pilots include complementarity, harmonisation, and coordination with others?
	How do the MISs of Child Shield and Primero link to each other (<i>OpenFn</i> , a data integration platform designed for the social sector) and the broader health and CPIS ecosystem at the regional and national level?
Effectiveness	To what extent have the initiatives achieved the expected results? What changes/improvements have taken place as a result of pilot implementation?
	Which were the most decisive factors that determined the achievement or non-achievement of the intended results?
	What was the user experience of Child Shield and Primero systems? Has user feedback led to any changes?
Efficiency	To what extent have the pilot initiatives been delivered in a financially responsible and timely manner?
	Are the MISs interoperable with each other and with MoPH MISs, with capacity to generate standard and comparable disaggregated data (age, gender, disability, ethnicity, location)?
Sustainability	To what extent can the pilot initiative activities continue after UNICEF withdraws? What mechanisms have been put in place to guarantee sustainability once this project support is over? What are the challenges that are foreseen in regard to sustaining the programme? Has MoPH been committed to these initiatives? Has MoPH also put resources into it? What follow-up/support has been provided by MoPH? Is the support they provided (both technical and financial) enough?
	What are the preconditions for scale-up? And what are the preconditions for sustainability?

Note: * There are two main direct beneficiaries in these pilot initiatives: a) children and women who are at risk of violence and abuse; and b) OSCC staff. This question applies for both beneficiaries.

Source: ToR, Oxford Policy Management (OPM) analysis.

7 METHODOLOGY

A more complete description of the methodology is provided at Annex O.

7.1 Approach to the evaluation

The evaluation approach was designed to support ongoing learning and adaptation and to reflect the United Nations' human rights-based approach to development (United Nations Sustainable Development Group, 2023).

7.1.1 Mixed methods

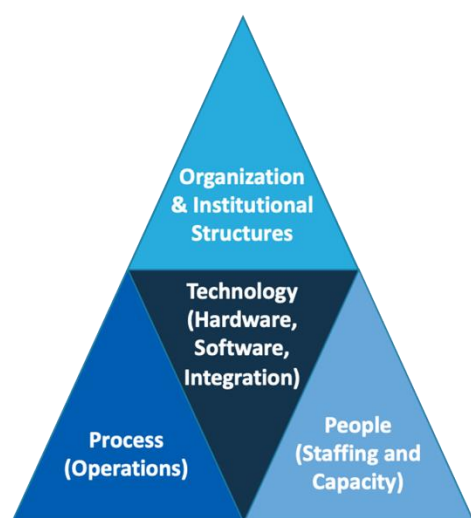
Structured around the OECD-DAC criteria, the evaluation uses evidence gathered through qualitative and quantitative data collection and applies a multidisciplinary analytical perspective. It combines the following methods:

- a desk-based literature review;
- a secondary quantitative data review;
- primary qualitative data collection in Bangkok and in two selected provinces of Health Region 8, including (i) **key informant interviews (KIIs)** with a wide range of stakeholders at the national and sub-national levels; and (ii) **small group interviews** with mixed-type respondents, including community and family members, social workers, and health practitioners;¹⁸ and
- **demonstration of, or direct observation of**, MISs and services provided at hospitals or at OSCCs.

7.1.2 Target operating model approach – technology and systems evaluation

The assessment of the Primero and Child Shield also employed a target operating model approach (see Figure 5 below) to consider the entire operating model and not only the technology components in isolation.

Figure 5: Target operating model approach



Technology remains a central component of the assessment, but its evaluation alongside all components of the operating model enabled a review of the 'As-Is' state and effectiveness of the child

¹⁸ Although we planned to conduct focus group discussions (FGDs) with distinct cohorts, in reality we were faced with mixed-type respondents at sub-district level; please see Chapter 7.6, 'Limitations and constraints' for more detail.

protection system. This supports identification of gaps, challenges and opportunities for improvement.

7.1.3 Multidisciplinary perspective

UNICEF's focus on the prevention of child abuse (as operationalised using the Child Shield component) calls for a multidisciplinary analysis, reflecting not only the child but also the wider circles of support and harm within which a child is situated – applying the socio-ecological model (UNICEF, 2016).

7.2 Inception

The inception report, including the detailed methodology and ethical review, was approved in October 2022, which allowed the primary qualitative data collection to take place in late November and early December 2022.

7.3 Primary data collection

Face-to-face KIIs and FGDs were conducted in Bangkok and in the two selected provinces of Udon Thani and Sakhon Nakhon, by the Team Leader, OPM Project Manager, Data and Information Specialist, and Thai Qualitative Researcher.

7.3.1 Fieldwork location

Please see Chapter 5.2.

7.3.2 Respondents for interviews and discussions

The range of KIIs and FGDs that were conducted was determined on the basis of efficiency and effectiveness. The proposed sample size of KII and FGD participants was considered sufficient to balance the requirement of quality data to inform a valid analysis, as well as the timelines and available resources.

A total of 53 respondents aged 18–64 were included in the data collection – nine males, 25 females, and four mixed-gender groups (Annex M). Only two respondents self-identified as having a disability (difficulty with hearing). In each of the provinces, at district and sub-district level we elicited the views of mixed-type respondents in small group interviews, rather than definitive KIIs or FGDs. It was also challenging to connect with beneficiary families as planned. Seven interviews were conducted online and the remainder were face-to-face. Please also see Chapter 7.6 for more information on limitations and mitigation measures.

7.3.3 Training on research instrument

The researchers were selected based on their substantial experience of conducting social policy evaluations, including the ethical considerations involved. All researchers were involved in the evaluation and data collection design, including development of the research guide. This guide informed the pre-data collection training and the refinement of instruments following field-testing. The team training involved several meetings in Bangkok to review and discuss the fieldwork plan and instruments, and to refresh knowledge on the key principles and guidelines for qualitative research, including obtaining informed consent. Acknowledging the significant research expertise within the team, this is considered sufficient to ensure the quality and validity of the data collection.

7.3.4 Qualitative data collection instruments

Table 6 describes the data collection instruments. A more detailed elaboration of these instruments can be found in Annexes G–J.

Table 6: Data collection instruments

Instrument	Description	Relevant respondents
Semi-structured interview guide	An interview guide was developed that corresponded broadly to the evaluation matrix and that was tailored to the specific respondent.	UNICEF staff; MoPH staff at national and provincial levels; hospital staff
FGD guide	There are two roles required to conduct a successful FGD: the facilitator and the note-taker. An FGD guide was developed with the main purpose of encouraging a productive discussion among participants.	Social workers/ health practitioners; community or family members
Observation guide	This instrument assisted the team to understand and interpret the social, cultural, and economic environment of the evaluation subjects. In this evaluation, this tool was used to observe how services are provided: for example, by social workers at OSCC.	Hospital and OSCC office

7.3.5 Quantitative data collection instruments

We examined quantitative data on Child Shield and Primero cases, as well as OSCC Capacity Development (Annex K). This enabled cross-referencing across the three initiatives, as well as the identification of data gaps that can be addressed during future scale-up. For example, we looked at the number of cases identified by Child Shield as at low, medium, and high risk, and, of these, which were selected for intensive case management and transfer to Primero. We also examined the personnel involved in supporting case management and PLH in terms of numbers, qualifications, experience, targeted training, level of effort (as part of the overall job description), and access to necessary resources.

7.4 Data analysis

We approached data analysis as an iterative and reflexive process that begins as data are being collected, rather than after data collection has concluded. We combined the notes that were written ‘in the field’ with notes taken in daily debrief sessions at the end of each day. The data are triangulated as much as possible to allow the reader to assess the strength of the finding. We used a simple coding matrix in Excel that corresponds to the main thematic areas of interest. As described in the research guide (Annex C), we have ensured that confidentiality is maintained and personal information is protected.

7.5 Ethical considerations and evaluation principles

The evaluation data collection and analysis methodology were subject to UNICEF’s Ethical Review Board approval, for which purpose we developed the research guide (Annex C). Ethical approval was provided on 2 November 2022 (Annex L).

7.6 Limitations and constraints

In Table 7 we summarise the limitations and constraints encountered, and the mitigation strategies we employed.

Table 7: Limitations of the evaluation and mitigation measures

Limitations and constraints of the evaluation	Mitigation strategies identified
Availability of adequate and appropriate respondents to the evaluation	We relied on UNICEF and MoPH to advise the provincial, district, and sub-district authorities of our intention to conduct data collection, and the proposed sample, dates, and times. We planned to convenience sample the geographic locations to make sure we visited areas where the CP Joint Initiatives were operational. During inception we anticipated that the large number of people reported as benefiting from the pilot initiatives would allow us to easily identify respondents. ¹⁹ We found that, because there had been a time lapse since some activities had taken place, some of the original beneficiaries (and intended respondents) – for example, OSCC staff – had moved to other positions or left MoPH. We indicated our availability to conduct interviews and FGDs during the weekend and on public holidays but the availability of family members and caregivers was still limited.
Time lapse between activity and evaluation	Because some interventions were conducted in 2020 respondents could not clearly remember the details of the activities or were no longer in post. For example, we found very little recall of the case management training. Therefore, we relied on the quantitative data provided by MoPH.
Adherence to KII and FGD formats as envisaged	In some cases we were flexible in conducting small group interviews with mixed-type respondents, rather than definitive KIIs or FGDs. For example, these mixed-type groups at provincial and district levels involved OSCC staff and beneficiaries participating jointly in the meetings, or national-level MoPH representatives attending meetings in the province with frontline workers. MoPH attendance in small group interviews also gave beneficiaries the confidence to attend and participate. Therefore, it was not considered appropriate, or conducive to the ambience of the data collection, to ask that the groups be reconfigured after we arrived on site.
Sense may have been lost during interviews and discussions where there was consecutive translation from Thai to English and vice versa	We validated information by asking questions in several iterations to make absolutely sure we understood. We held a daily team debrief to discuss the day's findings and to double-check with the translator, and with all team members, that we had a common understanding so that we could be confident that we had captured the necessary data. We also held several discussions involving the same stakeholders to discuss and test our understanding. We collected our primary data from multiple sources and used every opportunity to confirm what we had learned from several different respondents to ensure data quality.
The quantitative analysis for this assignment depends on the availability and quality of data, including our access to those data	We sought the help of UNICEF in facilitating access to these data and this information, so that we can ensure the comprehensiveness and rigour of the evaluation.
The availability of adequate and appropriate documentation pertaining to the CP Joint Initiatives	We depended on the availability of the main technical documents, including overarching project documents and the results framework, as well as monitoring reports. Where these are not available, we mined available information, to the extent possible, from associated project documents and checked the findings with the relevant UNICEF personnel.

¹⁹ In the assignment ToR, UNICEF report that 'more than 1 million children have been screened by Child-Shield, in which more than a thousand children are being considered as "high risk", while hundreds of children and families have received PLH intervention on parenting, and a few cases have been referred to Primero for more intensive case management services'.

8 FINDINGS AND PRELIMINARY CONCLUSIONS

8.1 Relevance – Is the intervention doing the right things?

- QE 1.1** To what extent do the objectives and design of the interventions respond to Thailand’s context and environment? Do they align with the government’s, especially MoPH’s, policy framework and priorities, and to global standards and UNICEF priorities?
- QE 1.2** Is there a clear intervention logic, with sound theories of change?
- QE 1.3** Was the intervention designed in ways that respond to the needs of intended beneficiaries.
- QE 1.4** To what extent were gender and social inclusion considerations built into the design (e.g. for the inclusion of women and children with disabilities, people from ethnic minorities, non-Thai people)?

8.1.1 Overall relevance

1. **The CP Joint Initiatives are designed to respond to violence against children in Thailand.** Children in Thailand are exposed to child protection violations that include child violence being seen as an acceptable social norm. More than 10,000 children are treated in hospital every year for injuries resulting from violence, the majority from sexual abuse. The initiatives are clearly designed against this background.
2. The MoPH’s development of Child Shield aligns with WHO’s call for governments to expand population-based surveillance of violence against children (Hillis *et al.*, 2016). MoPH made innovative use of routine HIS data to improve its decision-making. HIS generates information that is vital for planning, monitoring, and evaluating public health programmes and interventions. MoPH harnessed the technical capacity of HIS in Health Region 8 to target behavioural factors that influence children’s exposure to violence.
3. **The CP Joint Initiatives reflect the objectives of UNICEF’s global Child Protection Strategy.** The three components of the pilot are designed primarily to prevent children’s exposure to violence and abuse, ‘to prevent the child ever becoming a victim’,²⁰ and secondly to respond in cases where risk or actual abuse is identified. This matches UNICEF’s global child protection objectives: i) all children grow in a protective environment (universal prevention); ii) children living in situations of risk receive targeted support (leaving no one behind); and iii) children experiencing violations receive services (response and preventing recurrence) (UNICEF, 2021c, p. 20).
4. **Still, the initiatives address only one of UNICEF’s three recommended programming strategies:** ‘To support inclusive and effective child protection systems in preventing and responding to child protection violations’ (UNICEF, 2021c, p. 9). Strategies to address negative social norms, or to address child protection risk in humanitarian situations, are not part of the approach adopted by the CP Joint Initiatives. We did not identify any coordination with any initiatives addressing these strategic areas. This gap is of note because violent discipline is an accepted norm in Thailand,²¹ and because it is anticipated that climate risk will trigger humanitarian emergencies in the future that will require appropriate child protection intervention (World Bank Group and the Asian Development Bank, 2021). However, we did find that the UNICEF Child Protection Programme for 2022–2026 will address harmful social norms with regard to corporal punishment, as well as promoting positive child-rearing practices.

²⁰ MoPH presentation to the Reference Group for this evaluation, 28 November 2022.

²¹ See Chapter 1.5; and UNICEF, 2020a, p. 39.

5. **We did not identify a comprehensive results framework or ToC for the CP Joint Initiatives that are clearly aligned with the Country Programme Strategy.** While the 2013 evaluation of UNICEF’s support to the child protection monitoring and response system in Thailand strongly recommended that more attention be paid to results-based planning and monitoring, this adaptation is not evident in the design of the CP Joint Initiatives (Universalia and Child Frontiers, 2013). This may be because the individual components were introduced and added over time. UNICEF Thailand told the evaluation team that MSDHS was not in a position to explore innovations such as the Primero platform. Therefore, because they had an established relationship with OSCCs, they approached MoPH to demonstrate Primero as a tool for case management. MoPH then floated the idea of a ‘big data’ surveillance platform. The first agreement with MoPH was for the development of a screening tool, for the analysis of the existing OSCC database, and for management and coordination (UNICEF Thailand, 2018). The review of documentation also shows that separate Phase II agreements were signed with MoPH for individual components, one for Child Shield, a second for OSCC Capacity Building (including parenting education), and a third for Primero (UNICEF Thailand, 2020a; UNICEF Thailand, 2020b; UNICEF Thailand, 2021). PLH began life with a systematic review and meta-analysis of parenting interventions, part-funded by UNICEF, before moving to a randomised control trial of a Thailand-specific parenting programme to prevent violence against children (McCoy *et al.*, 2020; UNICEF and University of Oxford, 2020)
6. **The ToC in Chapter 2.2 was constructed from several UNICEF documents and partner collaboration agreements, to frame this evaluation.**²² Although, individually, the documents reference the Country Programme, and the project workflow description devised by MoPH provides an indication of the processes across the three initiatives (Figure 1), there is no clear results-based management pathway that links comprehensive situational analysis to activities, inputs, outputs, and outcomes, with associated indicators and targets. Neither is there a connection to child protection system developments under the purview of MSDHS, the Ministry of Interior, and the Ministry of Justice as part of the wider child protection system.
7. **MoPH’s Child Shield, Primero, and OSCCs (the frontline social services delivery agency) are not nested in Thailand’s policy and legislative framework for child protection.** Although UNICEF cites limited MSDHS capacity (as part of the rationale for implementing this programme with MoPH), as defined in the Child Protection Act 2003, MSDHS is the primary institution with the mandate for child protection (and, as per Section 6 of the act, “The Minister of Social Development and Human Security, the Minister of Interior, the Minister of Education, and the Minister of Justice shall be in charge for the enforcement of this Act”).²³ MoPH is not identified in the 2003 Act as a primary duty-bearer for child protection, although subordinate departments are included as members of multi-sectoral Child Protection Committees at national, regional, and provincial levels; and UNICEF reports that the CP Joint Initiative was presented to the Provincial Child Protection Committee in Udon Thani on 12 September 2019.²⁴

‘MoPH has more capacity [to implement this initiative]...we have more difficulty working with social services Ministry’. (Key informant, national level, 28 November 2022)

‘Child protection is not the main mission of the MoPH and that makes it difficult to continue implement into to the future’. (Key informant, regional level, 30 November 2022)

‘Unfortunately Primero isn’t in the MoPH policy yet... we need MoPH to send an official order from national level’ (Key informant, provincial level, 1 December 2022)

²² Several documents provided by UNICEF Thailand: project proposal reviews for Child Shield and Primero; a programme document for PLH; expected beneficiary data; and the Primero Implementation Plan.

²³ CHILD PROTECTION ACT B.E. 2546 Unofficial translation

http://web.krisdika.go.th/data/outside/outside21/file/CHILD_PROTECTION_ACT_B.E._2546.pdf

²⁴ UNICEF, written communication, 16 January 2023.

8. **Neither is protecting children from violence and abuse explicitly mandated in the MoPH's Twenty-Year National Strategic Plan for Public Health 2017–2036** (MoPH, 2018). This limits MoPH in regard to allocating and disbursing a recurring budget and including child protection prevention and response in the workforce job descriptions. This was referenced by respondents to this evaluation, one of whom said:

'The most important thing so that we can continue this work is for the MoPH to officially recognise it (policy, regulation, other) so these tasks can be included in our job descriptions and funds can be allocated'. (Key informant, sub-district level, 2 December 2022)

9. **There is a significant disparity between the identification of child protection risk and children's access to the necessary services to prevent escalation and respond to actual violations.** Because Child Shield analyses 'big data' it has the capacity to generate large numbers of at-risk-children. However, this type of surveillance by itself does not confer any benefit on children. Evidence indicates that the identification of risk without an adequate response intervention (appropriate and safe child protection services, including social care and access to justice) may not always be in the child's best interests, because it may increase the child's vulnerability to further maltreatment (CP MERG, 2012).
10. **Several reviews of Thailand's child protection system have consistently noted the limitations on the availability of social services, although there is no comprehensive child protection institutional capacity assessment and costing.** Notably, prior to the inception of the CP Joint Initiatives, the 2013 evaluation of the child protection system stated that 'the OSCC does not have the capacity or mandate to conduct follow-up [of child protection cases]'. The report also pointed to capacity and resource constraints amongst all duty-bearers (Universalis and Child Frontiers, 2013, pp. 42 and 56). These constraints should not be taken as advocacy for inaction on child protection, but rather as an appeal for a systematic approach to advocacy and capacity development within Thailand's structural and institutional framework.
11. **We did not identify special design measures across the CP Joint Initiatives to support the full inclusion of children with disabilities.** As noted in Chapter 1.5, children with disabilities are disproportionately exposed to violence and abuse, and therefore their inclusion should be considered a central feature of child protection system design. Full inclusion is a process that requires systemic reform, embodying changes and modifications in content, methods, approaches, structures, and strategies to overcome barriers (Office of the United Nations High Commissioner for Human Rights, 2023). We acknowledge that reference is made to children with disabilities – for example, whether or not a child has a disability is one of the Child Shield variables – but even in this case the system is not explicitly designed to be sensitive to disability as a risk factor (Paragraph (Par): 38). Disability is also excluded from PLH.

'PLH is a generalised approach, no part is specific for children with disabilities; the facilitators are nudged to understand there may be parents of children with disabilities in the training programme but there is no course content'. (Key informant, national level, 28 November 2022)

8.1.2 Child Shield

12. **The Child Shield component is the central application and functionality layer for the surveillance, monitoring, and prevention of at-risk cases for child protection.** The label Child Shield is loosely used by system administrators and frontline practitioners to represent all data and information management related to child records, to determine the appropriate risk screening and rating, and to share the child record information with the OSCCs and Primero components for child protection services and case management.

13. **The Child Shield information management system provides user access to review the child record details that have been sourced from the relevant HISs along with the assigned risk rating.** During several observations and discussions with key informants we identified that the child record is presented as an electronic medical record (EMR) on an MIS using an MoPH domain and server. The Child Shield MIS is administered by a business analyst/administrator who is part of the IT team at MoPH, who is responsible for managing user access and also importing/uploading the child data records manually onto the Child Shield MIS.²⁵
14. **The Child Shield MIS implementation and support model is not yet robust enough to manage and maintain data privacy, data integrity, and data quality in line with security protocols and standards.** The demonstration of the Child Shield information system conducted by key informants from the IT team presented the live production environment that is accessed by many users using personal email addresses for usernames/accounts, with no 2-factor authentication or password management rules enforced. Without a separate test and training environment, it was revealed that some test and fictitious user data had been entered onto Child Shield, which may impact case management services reporting. The maintenance of a development or test environment would encourage the use of only real live in the production environment and the maintenance of better data integrity.
15. **The calculation and assignment of the risk rating for child records is not performed or facilitated by the Child Shield MIS.** Rather, key informants advised that it is performed by a separate risk screening process and tool that is not run on a regular basis and that considers a varying number of records and not the entire dataset. The data are taken offline and are also exported by a systems administrator to Microsoft Excel and Microsoft Access solutions, to run the database scripts for the risk screening and determination of the risk ratings. We observed that each child's record that is included as part of the data script/calculation is assigned a risk rating value of a) high, b) medium, c) low, or d) no risk identified at this time. The risk calculation is based on the data from the HIS, including demographic and hospital visit details, but does not include other relevant drivers of child violence risk, such as poverty, migration status, living arrangements, or household composition data, among others, as these are not available as part of the HIS data captured. Key informants said the rationale for executing the risk screening and rating allocation for only a subset of the records via this process was due to the hardware and network capacity constraints.²⁶
16. **The centralised data warehouse on the cloud server aggregates the hospital and HIS patient data across all hospitals in the province.** Further, during our discussion and observation with system administrators and practitioners it was explained and shown that the integration and aggregation of this information enables the child protection services offered by MoPH to refer to this one standardised data source for child information records. This mitigates the risk of the HIS platforms being designed, implemented, and operated independently of each other and with different data and information exchange standards. The centralised data warehouse has created an HIS dataset of medical records, without the need for each individual HIS to apply a set of data standards.
17. **The eHealth Strategy (2017–2026) published by MoPH recommends the adoption of health data standards to enable the exchange of health administrative and clinical data.** The strategy proposes that the development of the eHealth ecosystem be based on the OpenHIE architecture and framework that provides standards and best practice recommendations for the design and development – or redesign and redevelopment – of HISs with data standards across accessible modular components to enable information sharing. The centralised HIS dataset has been

²⁵ Key informant, national level, 30 November 2022.

²⁶ Feedback received on the draft version of this document disclosed that Oxford University approved of the process for risk screening, including mixed risk levels, given that the project was still in the pilot phase.

implemented to facilitate interoperability, without needing to apply data standards directly to the HIS platforms.

8.1.3 Primero

18. **MoPH has leveraged its partnership with UNICEF to adapt and implement the Child Protection Information Management System – next generation (CPIMS+)/Primero platform for child protection case management services.** Primero is a health-centric child protection case management system that is used to manage registration, assessment, interventions, referrals, and case closure (Primero, 2017). According to key informants from the Global Primero team, the Primero system supports case management services in a social development context across 49 countries, with 63 live implementations. Similarly, these key informants reported that UNICEF’s leadership and oversight across Primero’s global footprint has enabled the development and maintenance of robust standards in data management and case management.
19. **The underlying platform and services of Primero in regard to the design and implementation of the case management functionality is managed by a central UNICEF team based at UNICEF HQ.** Key informants advised that Primero provides a base application that can be customised to a local context. Primero enables MoPH to leverage existing standards and practices for the management of child protection cases in the Thailand context, including standards for recording, managing, sharing, and securing sensitive data relating to children. Leveraging existing Primero modules and functions meant that MoPH was not starting from scratch in regard to the design and implementation of the case management database and workflow system. The expertise and capacity of the application development and support teams at UNICEF HQ and regionally supported a robust process in regard to the adaptation, testing, and implementation of Primero for MoPH.
20. **Primero has been implemented as a distinct end-to-end case information management solution that offers rich functionality and service capability for the management of child protection cases but that was developed in isolation from existing case management databases:** namely, the case management databases used by OSCCs and the CPIS solution implemented by MSDHS. During the field data collection, we found that both of these existing case management solutions capture and categorise case details and enable case status updates and have been rolled out nationally. An opportunity exists to review and strengthen the workflow and data management standards of the system based on best practice systems such as Primero.
21. **Primero is a standardised open source application that has been customised for the Thailand context and requires that the solution be hosted in Thailand.** Most implementations of Primero have leveraged UNICEF support for hosting of the data, in addition to the global and regional support available for customisation and implementation. Due to the sensitive nature of the child protection information managed on Primero, MoPH and the Global Primero team told us it has been agreed to host the software and data within a Thailand data centre. A test environment that mirrors the functionality of the production environment will be maintained to manage customisations and code drops.

8.1.4 OSCCs Capacity Development – case management and PLH

22. **Case management is an appropriate mechanism for OSCCs response to child protection risk and to violence against children.** This is a way of organising and carrying out work to address an individual child’s (and their family’s) needs in an appropriate, systematic, and timely manner, through direct support and/or referrals (The Child Protection Working Group, 2014). Case management is usually the responsibility of suitably trained case workers, supervised by an experienced case manager. Case management is also a cornerstone of MSDHS child protection service delivery.

23. **There is emerging regional and global evidence that suggests that parenting programmes can play a role in reducing violence against children** (UNICEF, 2020b). The PLH programme – a research initiative to design a culturally and contextually appropriate model for Thailand – was therefore included as part of the OSCCs Capacity Development. PLH targets parents and caregivers (mostly women) of children under 10 and does not currently include content for adolescent children, or for children, parents, and caregivers with disabilities. There is no strategy yet for engagement with male caregivers.
24. **The capability of MoPH to systematically and effectively case manage child protection violations, and to organise and deliver PLH, was not explored prior to implementation of either activity.** As noted above, the 2013 evaluation of the overall child protection system identified limited capacity (human and other resources) as a challenge for effectiveness and sustainability (Universalis and Child Frontiers, 2013). Similarly, the 2020 review of the research evidence for child protection in Thailand identifies gaps in capacity as a fundamental challenge in regard to strengthening the child protection system (UNICEF, 2020a). Although neither refer explicitly to MoPH, based on this evidence, a capacity assessment might have been considered as a prerequisite, in order to understand the potential for pilot implementation and eventual scale-up.

PRELIMINARY CONCLUSION – RELEVANCE

REL 1: The CP Joint Initiatives are partially relevant because the pilot was intended to demonstrate a model that prevents and responds to violence against, and abuse of, children in Thailand. However, the intervention logic and ToC are not sufficiently developed to identify a clear causal pathway that links activities to outputs and outcomes with associated indicators and targets. Neither are the initiatives situated within a policy and legislative mandate within the MoPH, nor benchmarked against any institutional capacity assessment. (Par: 1–8).

REL 2: Child Shield is the central application for identifying child protection risk. The development of MISs to generate data does not necessarily result in access to prevention and response services because capacity is limited and because the initiatives have been developed in isolation from the wider multi-sectoral child protection system. (Par: 9–10)

REL 3: The data management MISs are partially relevant to the Thailand context because, to an extent, they draw down on and utilise existing systems. However, (i) the application of Thai security standards and protocols for the maintenance of data privacy still has to be enforced consistently across all systems and processes, (ii) the HIS data, which serve as the basis for Child Shield analysis, do not yet contain information on significant drivers of violence, and (iii) although Primero enables MoPH to leverage existing standards and practices for the management of child protection cases for the Thailand context, it is not yet operating synchronously with other government databases. (Par: 12–21)

REL 4: PLH’s evidence-based design derived from a formative evaluation of successful parenting initiatives regionally and globally. PLH can increase its relevance by adapting so as to engage male parents and caregivers, to target parents and caregivers of adolescents, and to include specific strategies for working with children and parents with disabilities. (Par: 11, 23–24)

REL 5: The absence of a results framework means there are no contextually appropriate performance indicators for effectively monitoring the CP Joint Initiatives. Consequently, there is a deficit in regard to availability of regular and systematic monitoring data. UNICEF cannot track performance and results, which has implications for establishing efficiency, for demonstrating effectiveness, and for overall accountability. (Par: 5–6)

REL-Gender Equity and Human Rights: Data on non-Thai children that are included in the HISs are part of Child Shield analysis; however, measures are required to explicitly include children with disabilities in the CP Joint Initiatives. (Par: 11)

8.2 Coherence – How well does the intervention fit?

- QE 2.1** To what extent are synergies and interlinkages developed across the CP Joint Initiatives (between Primero, Child Shield, and OSCCs Capacity Development – case management and PLH)? Did these three initiatives complement each other?
- QE 2.2** To what extent is the pilot implementation coherent with other government initiatives, in order to achieve optimal utilisation of available resources? Does the pilot include complementarity, harmonisation, and coordination with others?
- QE 2.3** How do the MISs of Child Shield and Primero link to each other (OpenFn) and to the broader health and CPIS ecosystem at the regional and national level?

8.2.1 Overall coherence

25. **The relative advantage of choosing to pilot the CP Joint Initiatives with MoPH, over other options, was based on UNICEF’s self-described existing relationship with OSCCs, UNICEF’s estimate of MoPH’s capacity and mandate, and the interest and enthusiasm expressed by an internal MoPH ‘champion’.** Most key informants at government level referred to the ‘champion’, whose enthusiasm and motivation drove the development of the CP Joint Initiatives, and Child Shield in particular – evidenced by the several PowerPoint presentations and articles they authored, as echoed by collaborative partners and UNICEF during interviews.

‘We had long-term relationship with the OSCCs and approached them with Primero; then [our internal “champion” in the MoPH] suggested developing a screening system... MoPH has more capacity, and can make child protection more scientific, we have more difficulty working with MSDHS because they don’t have time to explore innovation... Child Shield doesn’t need manpower’. (Key informant, national level, 8 November 2022)

‘This was the vision of one colleague in MoPH and since his retirement the focus has been lost’. (Key informant, regional level, 30 November 2022)

26. **The intention of achieving a seamless flow from the identification of a child protection risk to service delivery and preventive risk mitigation has not yet been realised.** Child Shield, Primero, and OSCCs Capacity Development are three standalone components of the overall child protection system. All of the OSCCs respondents at provincial and district level said that most child protection cases are identified in the emergency department (rather than using Child Shield data), and that participants in PLH were not selected based on the Child Shield risk rating, but rather were selected based on proximity, access to smart phones (because the training was conducted online during the COVID-19 pandemic), or other characteristics.

‘Children come through Child Shield, but cases are also referred to the OSCCs by different departments within the hospital...most of the cases are walk-ins... but we use Primero even if the case originates outside Child Shield’. (OSCC key informants, provincial level, 1 December 2022)

‘When I delivered the PLH training I looked at risk level and contacted the families, but attendance was really based on convenience, who lived closest and had time to attend’. (OSCC key informant, sub-district level, 7 December 2022)

27. **Multi-sectoral coordination or collaboration to connect beneficiaries to necessary services beyond the health sector does not systematically occur.** Interviewed nurses, who were working at sub-district primary healthcare facilities, described the difficulties in making referrals even where child abuse is suspected. This indicates gaps in case management training for health

practitioners in terms of making referrals to other relevant parties to handle cases further, and gaps in training to provide appropriate psychosocial support to the child to support disclosure.

'An 11-year old girl with syphilis was referred to me following a hospital walk-in. We moved her from her step-grandfather's care to another relative in the same village. We didn't talk to the police or the community leaders or Department of Children and Youth (DCY) social workers because the girl didn't want to talk about it and we had no evidence. I asked the village health worker to watch out for the child.' (OSCC key informant, sub-district-level, 6 December 2022)

28. **The CP Joint Initiatives are not evident in MSDHS' ongoing child protection system visioning.** UNICEF, through a parallel programme, is currently supporting MSDHS to strengthen the national child protection system. Respondents noted that the MoPH child protection work was not visible in either the documentation provided to the process or during workshops. The associated evidence review conducted in 2020 refers only to a one-off hospital-based parenting programme.

'This work that UNICEF are doing with MoPH has hardly been mentioned during this visioning work with MSDHS.' (Key informant, national level, 5 December 2022)

8.2.2 Child Shield

29. **The child protection risk screening and rating facilitated by the information management solutions does not capture sufficient key determinants of child protection risk.** The data on children sourced by the risk screening tool – as part of the overall Child Shield model – are based on the EMRs of the various hospital HISs. System administrators and OSCCs' practitioners reported that data from other administrative databases are currently not sourced to complement the risk rating calculation and added to child records, including other categories of child protection risk, such as poverty, household composition and living arrangements, and migration status. Although disability status is captured, this is on the basis of a yes or no response, rather than a more detailed assessment of functioning capacity in line with the Washington Group/UNICEF Child Functioning Module. Although this Module cannot be considered a definitive assessment of disability, it is an appropriate tool for Sustainable Development Goals data disaggregation for children (The Washington Group on Disability Statistics, 2023).
30. **The computation for the risk screening and rating calculation has not been operationalised and is impacted by significant IT infrastructure resource and volume capacity constraints.** A key informant said that the process for risk screening and executing the risk rating calculation can take several hours, or may time out. As a result, the risk calculation has not been operationalised, is not operated on a managed software solution that is automatically triggered, nor run on a regular or frequent basis. Furthermore, the risk rating allocation based on location data requires the data to be processed offline, in a Microsoft Access solution.
31. **The risk calculation has also been applied on an inconsistent basis, with a different (reduced) number/volume of child records being used to address the performance constraints.** The efficiency and performance of the scripts that execute the risk rating calculation need to be improved in order to run the number of records for the entire dataset. The strategic and intended model would result in the execution of the risk calculation on the cloud infrastructure currently hosting the centralised data warehouse. By operationalising the risk calculation, the process could then be managed, scheduled, and auditable in the MIS.

8.2.3 Primero

32. **Primero provides the ability to integrate with the centralised warehouse of HIS databases to generate a child protection case linked to an HIS child record.** Key informants perceive that the

integration of the data is performed in ‘near real time’ when actioned by the user, whereby the 13-digit NDID is passed to the data warehouse to match with a child health record. The integration enables Primero to receive the risk rating assigned to the child record, but Primero utilises separate data fields for the risk rating sourced through the integration and that entered directly by the case worker. As a result, users are still able to generate a case where no risk rating has been assigned and the rating value assigned by the risk rating for the child record may remain blank. To maintain data integrity, the risk rating sourced when the case is created and linked to a HIS child record can therefore not be manually changed (i.e. it is read-only).

33. **The OSCC case workers are required to complete all cases in the OSCC case management system for monitoring and reporting by MoPH at the national level.** Frontline workers told the evaluation team that they are effectively entering identical information multiple times, which affects workload and compromises capacity. The case workers rationalised that the OSCC case record is mandatory, while Primero is an additional ‘nice-to-have’ functionality to manage cases.
34. **Primero is not connected to CPIS, a case management solution for child protection cases that has been developed and operated by MSDHS and rolled out nationally.** Both systems promote workflow capability with the ability to ‘hand-off’ or assign cases to external parties and are able to share data with external systems, thus an opportunity exists to review how integration between the two solutions could take place.

8.2.4 OSCCs Capacity Development – capacity development and PLH

35. **There are unexplored opportunities to create links between the CP Joint Initiatives and the 6,796 FDCs.** Although not all FDCs are yet fully operational, and despite their heavy reliance on volunteer workers, the 2020 evidence review for the child protection system visioning process with MSDHS identifies that these FDCs ‘can help support community awareness activities’, such as PLH (UNICEF, 2020a, p. 26).
36. **PLH is an intervention that can potentially be delivered by statutory and non-governmental health, education, and social care institutions.** Several policies demonstrate the Government of Thailand’s commitment to parenting support (UNICEF, 2020a, p. 20). UNICEF’s Country Programme pays attention to parenting in both early childhood development and child protection domains, although it is not clear if inputs are complementary and adding value. We did not identify within MoPH or UNICEF Thailand the prerequisites (such as effective mechanisms for cross-sectoral coordination and collaboration) for creating an environment for cross-sectoral dialogue and the implementation of parental engagement programmes. This type of collaboration could potentially expand the reach of PLH – if Ministry of Education and Research implemented PLH in schools and MSDHS introduced PLH to their facilities.

PRELIMINARY CONCLUSION – COHERENCE

COH 1: The CP Joint Initiatives were driven by an internal MoPH champion, with support from the UNICEF Child Protection team; there were not enough external allies to push the agenda to the attention of MoPH’s leadership. The consequent change in personnel both at MoPH and UNICEF has contributed to a loss of momentum. (Par: 25, 27, 28)

COH 2: The CP Joint Initiatives were also not designed to fit the broader multi-sectoral child protection system, both internally within UNICEF and externally with the Thai Government. (Par: 27–28)

COH 3: Child Shield has not yet reached its potential in regard to accurate assessment because (i) it does not yet capture sufficient key determinants of child protection risk, (ii) children without an EMR that are not

captured in the HIS are excluded, (iii) there are IT infrastructure resource and volume capacity constraints, and (v) the risk calculation has also been applied on an inconsistent basis. (Par: 29–31)

COH 4: Primero is integrated with the centralised warehouse of HIS databases but there is a duplication of effort on case management information systems through the parallel development of Primero by MoPH and CPIS by MSDHS, whilst integration with the existing MoPH OSCC case management information systems is also lagging behind. (Par: 32–34)

COH 5: There are unexplored opportunities to create links between the CP Joint Initiatives and the 6,796 FDCs. (Par: 35)

COH 6: We did not identify any work to create an environment for cross-sectoral dialogue and implementation of parental engagement programmes, which could expand the reach of PLH. (Par: 36)

8.3 Effectiveness – Is the intervention achieving its objectives?

QE 3.1 To what extent have the initiatives achieved the expected results? What changes/improvements have taken place as a result of pilot implementation?

QE 3.2 Which were the most decisive factors that determined the achievement or non-achievement of the intended results?

QE 3.3 What was the user experience of Child Shield and Primero systems? Has user feedback led to any changes?

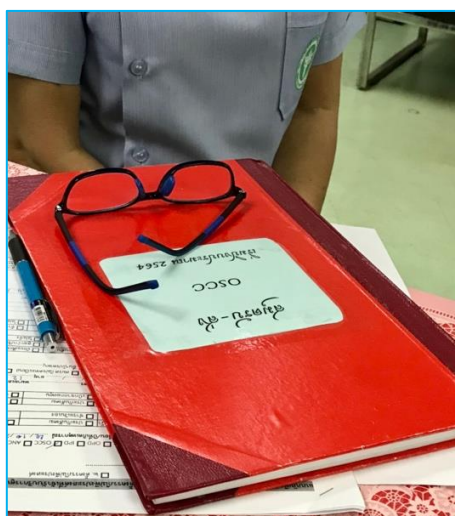


Figure 6. OSCC Register of cases Sub-district hospital

8.3.1 Overall effectiveness

37. **Child Shield has generated data that indicate that at least 5% of children in the region are at risk of exposure to violence, abuse, and exploitation.** Given the dearth of child protection data these are important planning data for the government duty-bearers. However, the figure of 5% is significantly less than the global estimate that 50% of children in Asia experienced violence in the past year, and 58% of children in Thailand are exposed to psychological and physical punishment (Hillis *et al.*, 2016; UNICEF, 2021d). This suggests that the system is not yet fully sensitive to the predictive variables for violence.

38. **It is complex to report on the extent to which the CP Joint Initiatives have achieved their expected outcomes, because there is no programme results-based management framework or monitoring data for reference.** See also Chapter 8.1.1 (Par: 5). Although UNICEF shared three monitoring reports for the years 2019–2021, these describe high-level Country Programme outputs; we did not identify any specific programme indicators or monitoring reports to track performance and results. We therefore rely on the ToC constructed to frame this evaluation (Chapter 2.2), as well as the quantitative and qualitative data collected within the scope of this evaluation, to complete Table 8. Although two of the expected outputs are rated good, three are average, and one is poor, we have reservations about the quality of the expected outputs and their link to expected outcomes, as discussed in Table 8.

Table 8: The extent to which the programme has achieved its expected outcomes

Expected results		Results achieved (based on data collected by the evaluation team)	Assessment of the level of achievement of results
Expected outcome	Expected output		
Outcome 1: Children at risk will be identified, and will receive appropriate preventive measures for risk reduction	2,200 children are screened using Child Shield	Child Shield analysed data for 955,988 children. The analysis was conducted once in 2020 and has not been updated. This expected output does not take into consideration the usefulness of Child Shield in regard to effectively analysing child protection risk, which is discussed in more detail below, nor the fact that screening by itself does not benefit children unless there is follow-up when risk is identified. The disparity between the intended numerical and eventual output (2,200 versus almost 1 million) may also mean there was insufficient pilot programme planning.	Average level
	All hospitals in Health Region 8 are using Child Shield	MoPH report that data for Child Shield were obtained from all provinces in Health Region 8. We have been unable to determine if this includes HIS data from all hospitals, including sub-district level, or only provincial hospitals. This output is ambiguous because it does not determine what 'using Child Shield' means, and because, as noted above, Child Shield is operationalised centrally and has only been run once.	Average level
Outcome 2: Capacity of staff will be strengthened to prevent, protect, and respond to children and families	70 practitioners attend case management training	MoPH report that 220 health personnel from seven provinces attended online case management training during 1 to 4 December 2020. We do not have data on the content of the training or follow-up coaching, mentoring, or supervision to understand if the training led to strengthened capacity. Key informants also referred to case management training provided by a professional council with funding attached to the implementation of MoPH OSCC databases (excluding Primero). We do not know what proportion of the 220 health personnel were trained using UNICEF's investment.	Average level
	24 public health staff are certified as facilitators and coaches	There are six certificated Thai coaches for PLH in Health Region 8, including one from the Ministry of Interior. The PLH programme was delivered online (because of the COVID-19 pandemic) to 111 nurses. Twenty-five of the trained facilitators have delivered the programme for parents and caregivers in the community, which is a requirement for the certification of facilitators.	Good level
	Parents and caregivers of	Between 180 and 424 children are living in families who have received the PLH intervention. Therefore, we have	Good level

Expected results		Results achieved (based on data collected by the evaluation team)	Assessment of the level of achievement of results
Expected outcome	Expected output		
	181 children attend PLH training	rated this a good level. However, we cannot confirm these numbers because respondents noted that there were significant drop-out rates and not all parents who registered completed the training.	
Outcome 3: Quality of case management function will be improved: effective data sharing, and enhanced stakeholder coordination and cooperation	150 child protection cases are managed by hospital OSCCs using Primero Three hospital OSCCs are using Primero	55 children are being case managed (cases registered in Primero) by two OSCC staff in one provincial hospital. Primero is confirmed as in use in Udon Thani hospital and confirmed as not in use in Sakhon Nakhon and Ban Dung hospitals.	Poor level

39. **During the lifetime of the programme, 2018–2022, data on almost 1 million children in Health Region 8 were analysed by Child Shield.** MoPH and UNICEF reports indicate that, of these, 50,016 were identified as at risk of violence and abuse, of whom less than 1% were actively followed up and case managed. In December 2022, in the two provinces visited, the evaluation team found that only 55 children were being case managed (cases registered in Primero) by two OSCC staff in one provincial hospital. Quantitative data provided by the MoPH indicate that more children (279) are being case managed, with data managed in OSCC MISs (Table 9). Using the MoPH data this amounts to around 0.55% of all children identified through Child Shield as at risk of violence and abuse who are in receipt of some kind of service. As previously noted in Chapter 8.1.1, this is because of limited capacity in general, and because of blurred lines over MoPH’s mandate. All of the frontline OSCC staff and respondents involved in delivering PLH training to nurses told the evaluation team that adding additional tasks to job functions without an update in the job description is not a welcome development for health personnel.

‘There isn’t enough capacity at OSCC to case manage all the cases that are identified, Udon Thani is better off for social workers and other regions may not have the resources; also a problem for PLH because you need resources and because it’s not in the mandate it’s not linked to resource allocation; Child Shield and OSCC case management, and PL) needs to be officially recognised in Health Region’s mandate by MoPH’. (Key informant, national level, 28 November 2022)

Table 9: Number of Child Shield and Primero child protection cases

Province	# Total children at risk following Child Shield analysis by end December 2021	Total # cases Child Shield			Total # at-risk Child Shield cases involving children with different characteristics				Total # Child Shield cases actively case managed	Total # active cases managed (as reported to this evaluation's researchers)	Total # Child Shield cases transferred to Primero case management ²⁷
		Low risk	Medium risk	High risk	Girls	Boys	Child with a disability	Child with an ethnic minority background			
Udon Thani	14,989	14,595	278	116	7,364	7,625	23	-	157	55	55
Sakhon Nakhon	10,275	10,111	198	66	4,991	5,284	12	-	13	0	0
Nakhon Phanom	5,487	5,334	100	53	2,842	2,645	5	-	15	-	-
Loei	7,033	6,766	192	75	3,387	3,646	14	-	-	-	-
Nongkhai	4,741	4,642	58	41	2,341	2,400	11	-	73	-	-
Nongbualumpo	4,358	4,264	74	20	2,144	2,214	10	-	21	-	-
Bungkan	3,133	3,041	70	22	1,522	1,611	5	-	-	-	-
Total	50,016	48,753	970	393	24,591	25,425	80	-	279	55	55

Source: MoPH, December 2022.

8.3.2 Child Shield

40. **The MoPH key informant told the evaluation team that the infrastructure and volume constraints of the risk screening tool, and its inability to execute the risk rating calculation across the entire dataset of children without errors or timeouts, has resulted in them considering introducing thresholds, which is contrary to a child rights approach.** Without the screening and calculation tool running as an automated and centralised server process, the process is still reliant on manual process intervention to export the data, run the scripts, and then import the data back into the relevant systems, including Child Shield. To run only a partial dataset will introduce data integrity issues and exclusion errors. One reason given for the introduction of thresholds was because violent child discipline is an acceptable social norm in Thailand and should therefore be excluded from the risk calculation.
41. **Child Shield is not yet sensitive to the needs of children with disabilities, with the MIS analytics and reporting identifying only 80 children with a disability that were at risk of violence and abuse** (Table 9). This represents 0.16% of all children identified as at risk, which is likely an underestimate since children with disabilities are considered to be at least one-third more likely than their peers without disabilities to be subject to violence (Chapter 1.5 and Annex N).
42. **Slightly more boys than girls are identified as at risk by Child Shield (F=49% and M=51%).** This may be because boys are more likely to experience physical violence than girls, who experience higher rates of sexual violence. Physical violence resulting in injury and hospital attendance may be easier to identify than sexual violence, which for the most part remains under-reported.
43. **Parent respondents who had been included in PLH said they did not know their data were being analysed in Child Shield and that they had not been asked for, and had not given, their consent.** The data capture processes when registering for hospital visits require consent to share data with third-party systems, including the centralised data warehouse and subsequent databases and

²⁷ Pending the completion of interoperability between Primero and Child Shield, which is expected to be completed by the end of 2022 (the system is now being tested).

systems that incorporate and make use of the patient records. This is required so as to take due care and consideration regarding safeguarding the privacy of citizens, especially children. Nevertheless, parents included in PLH said they did not know their data were being analysed in Child Shield and had not been asked for, and had not given, their consent.

'We know Child Shield is a screening tool, but we didn't know we were being screened and no one asked for our consent'. (Key informants, sub-district level, 2 December 2022)

8.3.3 Primero

44. **Primero was introduced to MoPH as a child protection case management tool at a time when the ministry did not have a primary mandate for child protection and while the MSDHS was developing its own CPIS.** An MSDHS key informant told the evaluation team that CPIS validates individual data based on the NDID and can manage the workflow case with status values and by forwarding cases to external parties, such as NGOs when applicable. Primero duplicates this government action, which is not efficient or effective as regards creating a multi-sectoral pathway for referral.

45. **Feedback on the workflow management capability of the Primero solution was very positive, but utilisation remains low.** The ability to integrate Primero with the centralised data warehouse to match patient-level data, and the general validation rules and processes for setting up case records, reduce data quality issues and provide a rich functional experience. Positive feedback was also received as part of the user acceptance testing of the solution, including reports that the development team were receptive of suggestions and ideas for change. However, the duplication of efforts with the OSCCs MIS minimises the capacity and motivation to create and manage a duplicate case record in Primero. The Primero platform is flexible enough to create a case record regardless of the risk rating or whether abuse has or has not occurred, but we do not know if there is clear guidance for OSCC staff on when the Primero case should be created.

'We would like to use Primero for case management, but we must use the OSCC system to record all our cases and visitation – and not just for child protection. That is the mandatory system for us to use and thus we have to choose that one and Primero would only create a duplicate record.' (Key informant, provincial level, 1 December 2022)

46. **The Primero platform had its last update of a new case record and update of information over 17 days prior to the system demonstration** (from 14 November to 1 December 2022). During the system demonstration an attempt to create a new case for an existing patient was attempted and it was learned that the integration with the HIS dataset was not working. The lack of a directive to use Primero for all child protection case management – and not just specific cases of abuse – results in infrequent use and a lack of awareness if issues arise with the integration of data with other systems. The OSCC case workers said their system remains a more familiar tool for case management, despite the comparative functionality disadvantages compared to Primero.

47. **The functionality of Primero case reporting includes a responsive web layout that is usable on a mobile device browser, but it is not used by OSCC workers.** Primero thus enables workers to enter the case information directly onto a mobile device during home visits, but workers stated that it was not used.

'We don't enter data during home visits because we are not detectives asking questions and writing down, we need to make eye contact we need them to feel that we are interested, so we only enter the information and data when we get back to the office. We were asked if we wanted tablets or mobile devices but we said no.' (Key informant, provincial level, 1 December 2022)

8.3.4 OSCC Capacity Development – case management and PLH

48. **Situating the CP Joint Initiatives within the institutional framework of the OSCC to an extent acknowledges the intersection of violence against women and violence against children.** Services that are intended to prevent and respond to violence against women and violence against children create opportunities for collaborative and integrated approaches that acknowledge the gender dimensions of violence. In 2015 almost 45% of cases referred to OSCC involved children (UN Women, 2020).
49. **Between 180 and 424 children are living in families which have received the PLH intervention.** This number is derived from the University of Oxford estimates for the feasibility study organised in Udon Thani, with 120 parents attending face-to-face training (119 female and one male) and an estimated 1.51 children per family.²⁸ MoPH data indicate that 281 parents and caregivers (278 female and two male) attended PLH training during the period, which suggests that around 424 children may have benefitted (Table 10). However, the respondents responsible for delivering the training told the evaluation team that there were significant drop-out rates and not all parents who registered completed the training.

‘It’s difficult for parents and caregivers to complete the PLH course and about 150 dropped out because of time constraints or because they had to work’. (Key informant, national level, 28 November 2022)

‘Eight families participated but three dropped out because they had to work, they were temporary labourers and have no fixed work schedule’. (Key informant, sub-district level, 7 December 2022)

‘Of the 15 selected participants, 10 completed the course. The drop-out was due to work commitments and difficulties with the smart phone technology’. (Key informant, sub-district level, 2 December 2022)

Table 10: Parents and caregivers involved in PLH programme

Province	Total # parents (primary caregivers) attending PLH		Total # parents attending PLH who self-identify as having a disability		Total # parents attending PLH with an ethnic minority background		Total # parents attending PLH by identified Child Shield screening risk		
	Female	Male	Female	Male	Female	Male	Low	Medium	High
Udon Thani	156	1	-	-	-	-	31	6	-
Sakhon Nakhon	13	-	-	-	-	-	13	-	-
Nakhon Phanom	15	-	-	-	-	-	13	2	-
Loei	-	-	-	-	-	-	-	-	-
Nongkhai	73	2	-	-	-	-	73	2	-
Nongbualumpo	21	-	-	-	-	-	14	7	-
Bungkan	-	-	-	-	-	-	-	-	-
Total	278	3					144	17	

Source: MoPH, December 2022.

50. **Feedback on PLH is largely positive.** In addition to the good outcomes reported in the initial research study (McCoy *et al.*, 2020; UNICEF and University of Oxford, 2020), parents, PLH coaches, and facilitators are encouraged by the change effected.

‘My 12-year-old child was aggressive before the training, but it is much better now. I spend

²⁸ Based on the 2016 fertility rate.

more time with him after school, I pay more attention to him now. I communicate more with him'. (Key informant, sub-district level, 2 December 2022)

'After only three weeks even my neighbours noticed that my child's behaviour had improved'. (Key informant, sub-district level, 2 December 2022)

'I didn't expect to see such results, and I was happily surprised because I see these results in my day-to-day interactions with these families'. (Key informant, sub-district level, 2 December 2022)

'There is good feedback from the first set of parents, who find it easier to manage their children'. (Key informant, sub-district level, 7 December 2022)

51. **Gender stereotypes which position men as breadwinners and women as carers has resulted in PLH being delivered predominantly to women.** Female caregivers who attended the training said that men would not have time to attend the training, and the PLH designers said that although the programme was open to all it was difficult to recruit men.

'In Thailand men work and don't have time to attend training like this for three hours every week'. (Key informant, sub-district level, 2 December 2022)

'If PLH pays people to come, so that for example day labourers get the same amount from PLH as they would for one day's work, perhaps you can get men to join'. (Key informant, sub-district level, 2 December 2022)

52. **The COVID-19 pandemic affected the implementation of PLH.** The PLH intervention with families was switched from in-person to online, leading MoPH to suggest that e-PLH could be a mechanism for future dissemination. However, coaches and facilitators strongly urge a return to in-person delivery because role-play and parent interaction are key features of the methodology.

'PLH is not built to be delivered online, it's not suitable because student facilitators need to observe and role-play and because its success is based on building good relationships'. (Key informant, provincial level, 30 November 2022)

'It was difficult to deliver online, there were a lot of technical issues and I struggled a lot, parents sometimes were connected but carried on with their housework, but there were also issues with the internet connection'. (Key informant, sub-district level, 7 December 2022)

53. **Child Shield at-risk status did not necessarily determine access to PLH.** MoPH reported that the information from Child Shield was not available when the PLH feasibility study with 120 parents was conducted, and that local health personnel selected participants they thought might benefit from the programme. The PLH designers reported that for the randomised control trial parents from schools and Early Childhood Development centres were invited to participate if they had difficulty managing their children's behaviour. MoPH data also indicate that the remaining 57% of PLH participants were selected because they were identified as at low and medium risk by Child Shield. However, this information does not reconcile with data provided by key informants, who said that selection for PLH was based on characteristics such as geographic location, participants' access to smart phones and data,²⁹ capacity to use the technology, as well as participants' involvement in other community support activities, such as working as health volunteers, or because they are considered a 'good parent'. Neither does this information concur with the PLH methodology, which recommends mixed-type groups of at-risk and no-risk parents for shared learning.

'We picked them because they are community health volunteers and can use the learning in

²⁹ Although designed as a face-to-face training the PLH training switched to an online format during the COVID-19 pandemic.

their interactions with other families, as well as apply personally in their own family’. (Key informant, sub-district level, 2 December 2022)

‘Many people wanted to join, but some couldn’t because they didn’t have a smart phone’. (Key informant, sub-district level, 2 December 2022)

‘In order to work, PLH has to mix at-risk parents with strong (no-risk) parents so they can learn positive methods for managing children; and because of this there is no stigma attached’. (Key informant, national level, 28 November 2022)

‘We try and recruit parents from the same area because this proximity allows them to attend easily and they can be a support to each other’. (Key informant, sub-district level, 2 December 2022)

54. **Similarly, identification of at-risk status by Child Shield does not automatically result in case management because there is a lack of confidence in the system amongst practitioners, and because there are too few practitioners.** See also Chapter 8.3.1 (Par: 37, 39). The OSSC staff who spoke to the evaluation team all said their cases were predominantly hospital walk-ins: that is, women and children who attended the hospital voluntarily because of accident, injury, or illness. When the Child Shield listing of risk cases was generated, social workers and nurses said it could be helpful in locating cases of violence more quickly, but that they randomly selected cases because of the overwhelming numbers.

‘We chose cases from Child Shield, but because there is some dysfunction in the system, we sample it can show in the system as low risk, but it can actually be high. If we only track by the number of hospital visits, we can’t be sure it’s accurate’. (Key informant, provincial level, 1 December 2022)

‘We randomly select for low-, medium- and high-risk case because we need to apply our social work knowledge and skills...for example, we cannot just base high risk on number of hospital visits we need to look what those visits were for and then make an assessment – because there are so many cases identified as at risk by Child Shield, we randomly sample and then look for more information on the HIS and in Child Shield to better understand the case before we decide to do a home visit’. (Key informant, provincial level, 1 December 2022)

‘Most of the cases we managed are identified when they attend the hospital, “walk-ins”, and referred to us from within the hospital system’. (Key informant, provincial level, 1 December 2022)

‘There isn’t enough capacity at OSSC to case manage all the cases that are identified’. (Key informant, national level, 28 November 2022)

55. **This may be attributed to Child Shield system limitations in that compounding factors may be missed, or it may be because child protection risk is dynamic and can change overnight.** One respondent described a complex high-risk case that they were alerted to through a hospital walk-in, where Child Shield had previously identified several children in the same family as being at low risk. The social worker concerned (Key informant, sub-district level, 2 December 2022) believed they were not properly identified because, in their view, Child Shield relies only on the number of hospital visits per individual to assign risk.

‘The case was opened as a walk-in and when we checked Child Shield, we saw that these children were considered low-risk, which means we cannot trust the system’. (Key informant, sub-district level, 2 December 2022)

‘Is Child Shield really reliable if it is a one-time assessment because risk can change overnight?’

It's a good attempt – but if it's not done regularly do children slip through the net? (Key informant, national level, 28 November 2022)

PRELIMINARY CONCLUSION – EFFECTIVENESS

EFFE 1: The ambitious vision for the CP Joint Initiatives – that the analysis of 'big data' can act as a predictive model that can identify child protection risk, and that interventions can then prevent and respond to violence – has not been fully realised. The Child Shield screening and calculation tool is not running as an automated and centralised server process but is still reliant on manual process intervention. This can mean only partial datasets are run, which introduces integrity issues. At the same time, variables used by the system are still not fully sensitive to child protection risk. Less than 5% of children screened are identified as at risk, significantly below the estimated regional average of 50%, and only 1% of children identified as at risk are actively followed up and case managed. The routine connection to PLH for caregivers of at-risk children is not systematically established. (Par: 37–39, 55)

EFFE 2: The absence of a robust programme architecture (ToC, results framework, systematic monitoring) has had adverse consequences for the CP Joint Initiatives' effectiveness. Nevertheless, the four-year pilot demonstrates some direct benefits for children exposed to child protection risk – 279 children are being case managed, of whom 55 have had their cases entered in Primero and as many as 400 children could be living in households exposed to PLH training. (Par: 38–39, 49)

EFFE 3: Child Shield at-risk status did not necessarily determine access to PLH as a prevention of violence mechanism, in part because the methodology recommends mixed-type groups of at-risk and no-risk parents, for shared learning. Although it is difficult to determine how many parents completed the PLH training because some parents who registered did not complete the course, of the three CP Joint Initiatives components, PLH is the most valued by parents and professionals and has the most potential in regard to providing direct benefits for children in the future. Neither did Child Shield at-risk status result in access to case management for prevention or response because there are too few practitioners and there is no multi-sectoral coordination or effective referral mechanism. (Par: 50–54)

EFFE 4: There has been a missed opportunity to integrate the MoPH OSCC case management, MSDHS CPIS, and Primero systems, and thus create an effective and efficient multi-sectoral case management mechanism (Par: 38,39,44)

EFFE-GEHR: Situating the initiatives in the OSCC, which provides services to women and children, to an extent acknowledges the gender dimensions of violence. However, (i) more boys than girls are identified as at risk in Child Shield; (ii) children with disabilities are largely excluded from the CP Joint Initiatives; and (iii) the PLH is delivered predominantly to mothers and caregivers, and there is limited male caregiver engagement. Identifying children who are at risk of violence without providing services or introducing thresholds into the risk calculation could also be considered a violation of child rights. (Par: 40–42,48,51)

8.4 Efficiency – How well are resources being used?

QE 4.1 To what extent have the pilot initiatives been delivered in a financially responsible and timely manner?

QE 4.2 Are the MISs interoperable with each other and with MoPH MISs, with the capacity to generate standard and comparable disaggregated data (age, gender, disability, ethnicity, location)?

8.4.1 Overall efficiency

56. **It is challenging to draw conclusions about financial efficiency because this evaluation did not involve a rigorous cost–benefit analysis.** The softer reflection on efficiency considered total

investment and results, because start-up, scale-up, and recurring costs were not estimated during project design or tracked during project implementation.

57. **A best estimate suggests that around 700 children can be said to have received a service, because of the US\$ 827,561 investment, over four years.** This includes 279 children reported by MoPH as being case managed by OSCC staff (although only 55 using the Primero management information system) and the approximate 424 living in families who have received the PLH intervention. We do not know the degree of overlap between these two cohorts. The expenditure breakdown is described in detail in Table 11.

Table 11: Pilot Joint Child Protection Initiatives Expenditure

	UNICEF	MoPH	University of Oxford	Total
Child Shield 2018-2021	THB 13,407,926.80	Staff (IT Staff, coordinator, OSCC practitioners); Equipment (computer and IT infrastructure that do not require new procurement); Office space		
Primero 2020-2022	THB 1,623,967.00			
Case Management Training 2018-2019	THB 1,890,213.95			
PLH (pilot) 2018-2020	THB 7,508,175.24		THB 3,195,786.67	
PLH (scale) 2020-2021	THB 2,933,700.00			
PLH Training Consultant	THB 407,000.00			
Total (Thai Baht – THB)	THB 27,423,982.99			THB 3,195,786.67
Total USD	USD 741,188.73		USD 86,372.61	USD 827,561.34

Source: UNICEF, December 2022

8.4.2 Child Shield

58. **The interoperability for child protection data across the different components, from HIS through to Primero, requires several touchpoints, with different systems, as well as manual process interventions.** The integration of the HIS data with a centralised data warehouse includes all HIS administrative and clinical data, not just child patient records, as needed by Child Shield and supporting tools. This integration, and the resultant HIS dataset, thus offer MoPH the ability to provide various eHealth services, although it is unclear what services are planned and if data consent for all services was obtained.
59. **The rationale for a centralised dataset of HIS information is due to the different hospital information management systems and their client registries being developed independently and with different data standards.** A centralised data warehouse managed by a MongoDB data management solution and hosted on the cloud (Microsoft Azure) enables interoperability with external systems. The solution mitigates the risk of different HIS platforms built in silos and following different data standards, although this contradicts the MoPH eHealth strategy, which aims to promote and adopt OpenHIE standards (interoperable data standards so that HIS can talk to one another) across HIS platforms.
60. **The HIS dataset that brings together all health administrative and clinical data from participating hospitals is a significant capability that enables sophisticated data analytics and can inform policy decision-making.** The MongoDB solution is a document-based database structure that enables the management and analysis of big data. There is more information in this data warehouse than just that required for child protection case management. The highly sensitive data

that are available mean particular attention is required to maintain data security, data quality, and data integrity. The administrative staff at MoPH have special access to review and interrogate the raw data in the database, which remains a risk without a client application layer facilitating access to these data and facilitating audit tracking of any view or change.

61. **The Child Shield MIS solution is thus quite separate from the HIS data, with various information management processes and tools that download the HIS data, screen for risk, and calculate the risk rating before importing the data into the Child Shield MIS platform.** While the HIS dataset is automated, several manual process interventions are required before the child records are available in the Child Shield MIS with the appropriate risk rating. To run the risk calculation, data are usually manually exported to MS Excel and then uploaded to MS Access, where the risk calculation is run, before uploading the results to Child Shield. Due to performance concerns related to response times, different volumes of Child Shield are usually run (not the entire dataset at once).

'I think Child Shield MIS should be more integrated with the hospital information system. It is not linked.' (Key informant, provincial level, 1 December 2022)

'Even though there is a level of integration and interoperability that takes place for the HIS data to be made available within Child Shield MIS, the child risk screening and risk rating is perceived to be a separate process.' (Key informant, provincial level, 1 December 2022)

62. **The manual process interventions and the resulting imports and exports of data to the Child Shield MIS are managed by an administrator user.** The integration of the data is therefore not tracked and audited. Without an available test environment to test interoperability, there is a risk of data quality and integrity issues being introduced.

8.4.3 Primero

63. **The Primero application and set of integration capabilities based on OpenFn integration standards and toolkits is capable of interoperating with the HIS dataset, but there may be issues with the cloud infrastructure being able to facilitate the real-time integration performance.** Primero facilitates integration with the HIS dataset for child record matching, based on the 13-digit identification number. The application has been designed to link in 'near real time' with the HIS dataset to facilitate validation of the details in the child record. In a demonstration of the solution, and specifically its interoperability with the HIS dataset, an attempt to find an existing patient EMR – with the paper file available for reference at the social worker's desk – that had recently been entered into the HIS was not successful. Several unsuccessful attempts were made by the social workers performing the demonstration to select and pre-populate the patient data in Primero. It was concluded by the social workers that there was a problem linking and sourcing the data and that the issue may have existed for several days, with the last new case entry occurring about two weeks prior. The issue of not being able to select and source the patient record was raised with a key informant from the national level who was accessible after the demonstration. The key informant stated that the issue was likely a result of Primero being linked with a local server copy of the HIS dataset for this specific hospital, due to the likely performance load on the cloud server, which has more data currency than the local server copy.
64. **Primero has monitoring and alert mechanisms in place to manage error handling for the integration of data.** OpenFn manages the middleware and benefits from the monitoring and alert mechanisms detailed in documentation on the Thailand Primero integration,³⁰ including capturing

³⁰ See GitHub repository documentation: UNICEF Thailand Primero Interoperability (<https://openfn.github.io/primero-thailand/>)

data sync errors and a detailed activity log when using the NDID to source and add HIS data for Primero cases.

8.4.4 OSCC Capacity Development – case management and PLH

65. **The investment in PLH has resulted in a model that has been explicitly developed for the Thai context, and that has been demonstrated to have positive effects in reducing violence and increasing positive parenting.** MoPH staff perceive the PLH model positively, yet also express concerns about the potential for scale-up in the current context. The pilot did not include the development of a strategy for scale-up, including meeting the costs of scaling up the initiatives. Without this, the model has no mandated home with a budget allocation.
66. **The envisaged process flow from the identification of risk to enrolment in PLH as ‘the prevention mechanism’ assumes that a single intervention, rather than a systemic approach, can mitigate the complex and dynamic drivers of violence.**
67. **Despite investment in case management training and the introduction of Primero, the numbers of children at risk who are being case managed by OSCC workers remains low.** The absence of an evidence-based results framework and equity-based ToC limits programme optimisation.

PRELIMINARY CONCLUSION – EFFICIENCY

EFFI 1: Because we did not identify an equity-based ToC for the CP Joint Initiatives (with specified beneficiaries and outcomes, activities, delivery processes, monitoring system, or assessment of costs) it is challenging to draw conclusions about financial efficiency. At a best estimate, around 700 children can be said to have directly benefitted from the US\$ 827,561 investment, over four years. The system components – Child Shield, Primero and PLH – have potential, but the capacity to fully operationalise the system is not evident and the sustainability of the components is not confirmed. (Par: 56–57, 66–67)

EFFI 2: The capabilities of the MISs are not being exploited to their full extent, most likely because of the capacity issues previously identified. There are not enough administrators and users (including case managers) with a wraparound package to respond quickly and efficiently to deliver on the promise of the MISs. (Par: 58–64)

EFFI 3: The investment in PLH has demonstrated positive effects at a small scale on violence risk-reduction, although the model has no mandated home with a budget allocation; and despite investment in case management training and the introduction of Primero, the numbers of children at risk who are being case managed by OSCC workers remains low. (Par: 65–67)

8.5 Sustainability – Will the benefits last?

QE 5.1 To what extent can the pilot initiative activities continue after UNICEF withdraws? What mechanisms have been put in place to guarantee sustainability once this project support is over? What challenges are foreseen in regard to sustaining the programme? Has MoPH been committed to these initiatives? Has MoPH also put resources into them? What follow-up/support has been provided by MoPH? Is the support sufficient (both technical and financial)?

QE 5.2 What are the preconditions for scale-up and for sustainability?

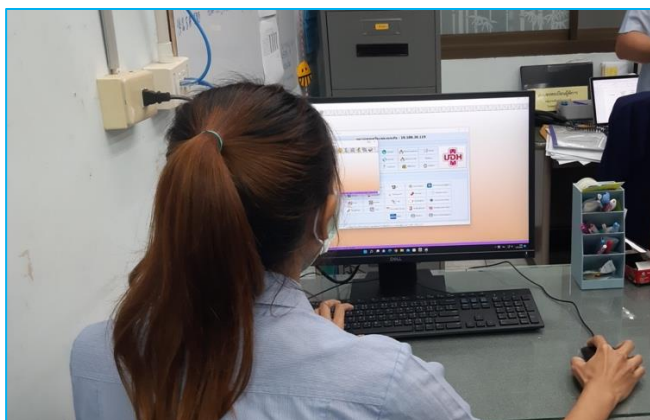


Figure 7: OSCC Staff demonstrating Primero

8.5.1 Overall sustainability

68. **Frontline practitioners' awareness of child protection violations is enhanced and they are clearly motivated to respond where child rights violations are identified.** This competency can be more effectively operationalised as the child protection system continues to be strengthened, particularly in the public health system.
69. **Challenges to sustainability include the absence of MoPH's mandate to engage in child protection prevention and response.** The pilot was implemented in one health region, and that region is considered to be well-resourced in comparison to the others. However, senior management in the region told the evaluation team that child protection is not their primary mission and that additional investment is required to revise HIS and Child Shield variables. Managers, supported by OSCC frontline staff, all said that a legal mandate is required to make sure that funds can be allocated to support scale-up (for additional personnel and other resources) and ensure that job descriptions are amended to take into consideration the additional tasks (see Chapter 8.1.4).
70. **There are significant capacity needs beyond training.** Successful capacity building relies not only on training but also on follow-up coaching and mentoring to address training demands emerging from practical experiences. In our extensive interviews with OSCC personnel, staff of the nursing school in Health Region 8, and nurses at district hospitals, we did not find that coaching, mentoring, or continuing professional development on case management was offered. The key informants told the evaluation team that there are not enough OSCC personnel to deliver preventive and responsive services in the communities in which children and families live. Child Shield and Primero are technical tools that are only useful if they are complemented by an appropriate workforce who can analyse and disseminate data, follow up and supervise to make sure action has been taken, implement a feedback loop, and make decisions etc. Similarly, an adequate workforce is needed to plan, prepare, and deliver the intensive eight-week PLH course.

"I have no plans to deliver the PLH training again because I am a registered nurse and I have to do my regular job. PLH is not part of my job description" (Key Informant Sub-district level, 7th December 2022)

71. **There is not enough evidence to prove the effectiveness of the implementation, so it is also challenging to establish whether the pilot can be scaled up to a wider area.** We have mentioned in Chapter 8.3.1 Par: 38 the complexities in assessing the effectiveness of the CP Joint Initiatives in delivering its outputs and outcomes.

72. **Top-down leadership, to take the initiatives to scale, is missing.** As described in Chapter 8.2.1 Par: 25 the CP Joint Initiatives relied on the strong commitment of an internal MoPH champion at the national level. This person is no longer in post and a replacement has not been found, which has contributed to a loss of momentum. This has also had implications for the dissemination of MoPH child protection initiatives with multi-sectoral duty-bearers during the child protection system visioning process currently underway with MSDHS.

‘To convince people to take this on board, a task force at the national level is needed’. (Key informant, national level, 28 November 2022)

‘This is not a two-year project, it’s a long-haul, complex intervention working to resolve a complex problem with many players. It requires a lot of effort and leadership over the long term to scale-up’. (Key informant, national level, 28 November 2022)

73. **Enthusiasm and the motivation to sustain the initiatives in Health Region 8 is dependent on internal MoPH leadership, further external inputs, and funding.** Senior MoPH management in Health Region 8 told us the following: (i) after the ‘champion’ retired the focus on Child Shield was lost; (ii) expansion is unlikely because of this, and because of budget limitations; (iii) adjustments to the several HIS systems and to Child Shield (adding variables) are required to increase the reliability of the predictive model; (iv) although Primero could be adapted to become a model for OSCC it needs to include more MoPH-required variables and there should be more services available to respond; and (v) because child protection is not the primary mission of MoPH, it is difficult to continue implement the initiatives in the future. All of the frontline government staff involved in the CP Joint Initiatives told us that this was additional work, and was not a part of their role, which made it difficult for them to sustain the initiatives.

8.5.2 Child Shield

74. **The technical sustainability of, and opportunity to scale up, the Child Shield solution is first dependent on operationalising the existing solution more effectively.** This includes addressing several key technical risk areas and ICT resourcing constraints, by doing the following:
- a. Review and strengthen the security protocols that support the end-to-end data integration model to limit any deliberate or accidental data tampering or breach of data privacy.
 - b. Deploy a separate, mirror test and training environment to limit creating test data in the production system and ensure all changes are appropriately tested for quality assurance before being released in a live environment.
 - c. Standardise, quality assure, and automate the risk screening and calculation process as part of the Child Shield MIS or an integrated supporting system to ensure that no manual intervention is required, and that the data do not need to be taken offline to process them.
 - d. Strengthen and increase the capacity of the underlying infrastructure of the cloud server hosting the dataset or procure an operational database layer to execute all processes without risk of time-out failures and other performance issues.
 - e. Deploy a robust operational monitoring and alert mechanism to pick up and address performance or other underlying infrastructure issues.
75. **While the centralised HIS dataset for Health Region 8 mitigates the risk of different HIS platforms adhering to different standards, this solution would not be sustainable if scaled up nationally.** As per the MoPH eHealth strategy, there is a need to adopt common data and architectural standards for all health systems to facilitate interoperability and a more robust operating model.

8.5.3 Primero

76. **The scale-up of the Primero solution is, from a technical perspective, dependent on the resource capacity and availability to manage the administration, operational support, and enhancements of the solution.** Without a sufficient volume of data, and without sufficient transactions being performed in the system, it is challenging for administrators, analysts, and developers alike to remain engaged and to continuously learn how to manage the platform independently, before UNICEF support ceases.
77. **The scale-up and sustainability of the Primero solution is also dependent on a robust data-hosting solution that is managed and operated by the government at an appropriate national data centre.** The current hosting environment for the region is currently being impacted by performance issues and a suitable data centre may need to be secured for scale-up. Currently, the Primero solution and the volume of cases are being managed by linking up with the local server of a hospital information system, due to performance constraints on the cloud server.

8.5.4 OSCC Capacity Development – case management and PLH

78. **The capacity development comprised a one-off generic case management training in 2020 for MoPH staff and a research study on PLH.** Other aspects of MoPH capacity have not been strengthened: for example, making sure there are enough people with the right qualifications in the right place and with adequate resources to actively case manage the huge numbers of child protection at-risk cases generated and to deliver PLH. The research team behind the development of PLH have identified an alternative external donor but hope to retain UNICEF's support for continued advocacy.

'It's one of the few evidence-based pieces that could change the discourse and see it as an investment in ECD because there are a variety of outcomes including nurturing/responsive caregiving'. (Key informant, national level, 28 November 2022)

PRELIMINARY CONCLUSION – SUSTAINABILITY

SUST 1: Frontline practitioners' awareness of child protection violations is enhanced and they are clearly motivated to respond where child rights violations are identified. PLH has gone through a formative evaluation and randomised control trial that have shown its positive effect on violence reduction. PLH has acquired an alternative funding source and established partnership with a Thai university for further research and development. However, there is not enough overall evidence to prove the effectiveness of the CP Joint Initiatives as an integrated prevention and response system. This limitation suggests that the initiatives will not all continue if UNICEF withdraws. (Par: 68–71, 74, 78)

SUST 2: At the policy level, MoPH does not have a mandate for child protection and this means funds cannot be allocated at practitioner level to implement the CP Joint Initiatives. (Par: 69)

SUST 3: We did not find internal top-level leadership or a mechanism for multi-sectoral collaboration that would help to sustain MoPH child protection case management. The programme has been driven internally within the MoPH by a single 'champion', who is no longer in post, which has contributed to a loss of momentum. At the same time, the wider child protection system visioning process, led by MSDHS with UNICEF's support, has not embraced the CP Joint Initiatives. (Par: 72–73)

SUST 4: The capacity requirements for Child Shield, Primero, and PLH were underestimated in the design of the pilot. (Par: 70, 75–78)

9 LESSONS LEARNED

79. **Programme design should adhere to UNICEF’s own guidance for results-based management (RBM).** ‘The building blocks of RBM include the situation analysis that lays the foundation for well-articulated theories of change, the identification of measurable results and risk responsive strategies, and the systematic monitoring and reporting of the programmes’ progress and evaluation’ (UNICEF, 2017a). Systemic and scheduled monitoring and oversight throughout the implementation, including a mid-line review, is critical for course correction and adaption to the dynamic context. Without structured monitoring, the investment provided will not produce the expected output and outcome, with the potential to lead to a waste of resources. Monitoring is also useful, in order to learn from the pilot initiatives and to provide feedback on possible improvements that can be made. This can ensure that the project does not only focus on the details of the implementation. Evaluation is useful in helping to determine what works well and what could be improved in a programme or initiative. The insights from evaluations should enable reflection and assist in bringing about changes for the better. For example, had the recommendations of the 2013 evaluation of UNICEF’s support for the child protection monitoring and response system in Thailand (Universalis and Child Frontiers, 2013) been adopted, the CP Joint Initiatives programme design might have been more robust.
80. **The planning for a pilot programme and/or the testing of a model for eventual scale-up should consider the proof-of-concept requirements at the design stage.** Rather than focusing solely on developing the idea, the design should have built-in viability tests, with a focus on how the concept can become a reality. UNICEF Thailand’s recently introduced ‘Recommendations on Scale-up and Pilot Models’ provides a clear framework for designing pilot models (UNICEF Thailand, 2022). This guidance proposes a design phase assessment of whether an initiative is fit for the context – the external country environment and internal Country Programme priorities – and the government’s capacity and appetite for financing the pilot and the scaled model.
81. **In the case of the CP Joint Initiatives, this would have involved an assessment of the potential for integrated multidisciplinary child protection systems for prevention and response.** Such an integrated system would be able to provide a seamless transition between the data generated (children identified as at risk of violence) and the services provided by MoPH, MSDHS, the Ministry of Interior, and the Ministry of Justice.
82. **UNICEF’s global Guidance on Child Protection Systems Strengthening references several ‘must-haves’ that are required in order to take a child protection prevention and response mechanism to scale.** By using this as a starting point during the programme design phase, any missing components could be scheduled as part of the programme activities. To consider the potential for the sustainability of the design beyond the pilot phase the evidence base for new child protection models should also include:
- o a thorough multi-sectoral institutional capacity assessment that identifies challenges and opportunities; and
 - o a full costing, with the implications for budget allocations in the immediate, medium, and longer term (capital investment and running costs).

10 FINAL CONCLUSIONS

10.1 Relevance

83. **The CP Joint Initiatives have been designed to prevent and respond to the context of violence against children in Thailand.** Children in Thailand are exposed to child protection violations that include child violence being seen as an acceptable social norm, and more than 10,000 children are treated in hospital every year for injuries resulting from violence, the majority from sexual abuse.
84. **MoPH's development of Child Shield aligns with global guidance on expanding population-based surveillance of violence against children and made innovative use of routine HIS data to improve its decision-making.** HISs generate information that is vital for planning, monitoring, and evaluating public health programmes and interventions. MoPH harnessed the technical capacity of HISs in Health Region 8 to target behavioural factors that influence children's exposure to violence. This aligns with the WHO's call for governments to expand population-based surveillance of violence against children.
85. **However, it was difficult to ascertain the overall relevance of the CP Joint Initiatives as they are not anchored in a robust results-based management framework that articulates measurable results and the causal pathway to reach those results.** The performance, results, and effectiveness of the CP Joint Initiatives are not directly linked to a ToC, results framework or M&E plan. Therefore, it was challenging to identify the intended causal pathway – from the evidence base to intended outputs and outcomes.
86. **Regular and systematic monitoring of the CP Joint Initiatives would have allowed course correction to ensure the three components worked more effectively together:** for example, by identifying early on that access to case management and PLH services was not connected to Child Shield, with feedback received from key informants (social/case workers) indicating that Child Shield data, when accessed via mobile devices, are not regularly updated. To an extent, these challenges have been well-noted internally and UNICEF is currently taking action to revise and amend mechanisms for the coordination of planning and monitoring, and is initiating regular reviews to make sure these mechanisms are working properly.
87. **The design of the pilot CP Joint Initiatives has not paid sufficient attention to UNICEF's global and country-level strategies and guidance, or to earlier evaluation outcomes.** As a result, fragments of the child protection system and *ad hoc* parallel structures have developed. UNICEF's commitment to a child protection system-strengthening approach, in which a set of laws, policies, regulations, and services work together 'requires various elements or components – from policy and legislation to services and data collection – to work in tandem to deliver results for children. For the system to work, individual parts of the system need to be strengthened while also strengthening the relationships between these various parts' (UNICEF, 2021f, p. 9). This requires 'a well-resourced lead ministry for child protection at the national level and national, subnational and local level inter-ministerial/sectoral mechanisms to ensure coordination between sectors and services' (UNICEF, 2021f, p. 21).
88. **MoPH does not have a primary mandate for child protection service delivery, as envisaged under the CP Joint Initiatives, which compromises the effectiveness of the investment.** The pilot did not pay enough attention to developing that mandate through policy and legislative reform.
89. **The MoPH Twenty-Year Public Health Strategy makes no mention of violence.** Although there is a debate on the nature of violence against children and how to classify it in the public health space (as a communicable (Forum on Global Violence Prevention, 2013) or non-communicable disease (Greene, 2018), the discussion should at the very least move beyond traditional approaches to

injury control and focus on wider social determinants. That said, acknowledgement as a communicable disease may allow prevention and response to violence against children to find a home in a revised public health strategy.

90. **The focus on software and hardware for Child Shield and Primero does not yet include the ‘brainware’ required to make the systems function as intended to prevent and respond to child protection violations.** The MISs are tools that need a robust strategy, workforce, and resources to allow them to be operated successfully. Child Shield, Primero, and the investments in case management and parent education training can deliver on the government’s obligations to protect children from violence when the well-documented capacity constraints in the social welfare and child protection system workforce are addressed.

10.2 Coherence

The review of the CP Joint Initiatives through the ‘relevance’ lens contributes to the analysis of the complementary criteria related to coherence because the two are linked along the causal pathway.

91. **The CP Joint Initiatives operate within government systems and use government infrastructure to address the persistent and pernicious context of violence against children in Thailand.** However, child protection is not a priority for MoPH and the synergies with complementary interventions in the sector, and particularly those offered by MSDHS, are less distinct.
92. **Situating the CP Joint Initiatives within the broader child protection system would have enhanced the overall design.** For example, the interventions could have produced more sustainable results had a considered focus been placed on engagement with child protection coordination and collaboration forums from the outset, such as the National Child Protection Committee. This may have reduced duplication of effort, such as the development of two separate child protection case management MISs – the CPIS introduced by MSDHS, and Primero introduced by MoPH with UNICEF support. Despite the acknowledged capacity limitations, MSDHS’s Department for Children and Youth has built and is implementing a national database for case management. Whilst still in its infancy (and not a subject of this evaluation), had the CP Joint Initiatives not been fragmented, there may have been an opportunity to integrate the best features of both systems. Similarly, this may have been a platform for more robust multi-sectoral government leadership, and thus contributed to the strengthening of the child protection system. At the same time, the potential for FDCs to act in tandem with OSCCs to provide a continuum of services, and for cross-sectoral dialogue on expanding reach for the PLH, has not yet been realised.

10.3 Effectiveness

93. **Child Shield has generated data that indicate that at least 5% of children in the region are at risk of exposure to violence, abuse, and exploitation.** Given the dearth of child protection information in Thailand, these are important planning data for the government duty-bearers. At the same time, this figure is less than the 58% of children in Thailand known to experience psychological and physical punishment (UNICEF, 2021d), suggesting the system is not yet fully sensitive to all necessary predictive variables for violence against children.
94. **Taking into consideration the adjustments required by the COVID-19 pandemic, during the four years of pilot implementation a maximum of 700 children received at least one service.** Of these, around 60% are children living in families that attended a PLH parent education programme. Less than 1% of the children identified by Child Shield as at risk of violence are being case managed (and only 20% of those (n=55) using the Primero case management information system), and PLH is not being regularly and systematically delivered.

95. **PLH was confirmed, through rigorous research, to be an effective parenting education programme for families with children under 10.** This was confirmed by parents and caregivers who completed the programme and who said they are more likely to use positive discipline methods than other methods.
96. **Despite their heightened risk of violence, children with disabilities represent only 0.16% of children identified as at risk by Child Shield, and there is no explicit content on positive parenting of children with disabilities in the PLH programme.** Excluding design measures that support the full inclusion of children with disabilities, ensuring they have equitable opportunities to access services, fails to respect their rights and is a dereliction of duty-bearers' obligations.
97. **The analysis in Child Shield, which relies on HIS data, does not assess the child's complete social ecology and does not accurately predict child protection risk.** Structural, institutional, and interpersonal factors, such as poverty and family stress, and the child's living situation (for example, living with an older grandparent or in institutional care), and community factors, such as social norms that support violence (for example, violent discipline at home and in school) or a 'code of silence' according to which violence is not reported, are not detailed in the predictive model. Neither does the system yet take account of the dynamic nature of child protection risk: for example, a child who is not at risk today may be at risk tomorrow if their primary caregiver grandparent dies or if a violent step-parent is introduced to the household.
98. **Child Shield and Primero are effective tools for data analysis and data management.** Frontline practitioners told this evaluation that Child Shield could in some cases help them identify children who are at risk more quickly. However, to fulfil their potential in contributing to child protection these tools need to be operated within an effective system so that children identified as at risk are immediately followed up. These tools are not yet fully operational within a wider child protection system that is effective in preventing the risk escalating and in delivering an appropriate set of interventions when violence has occurred.
99. **Situating the initiatives within the OSCC to an extent takes account of the intersection of violence against women and violence against children.** However, the limited capacity to actively case manage, including to make and follow up multi-sectoral referrals, limits children's access to preventive and responsive services.

10.4 Efficiency

100. **This evaluation did not include a comprehensive value for money assessment, in part because there is no accurate costing of the CP Joint Initiatives' start-up, scale-up, and recurring operational costs, which makes it challenging to draw conclusions about financial efficiency.** At a best estimate, around 700 children can be said to have directly benefitted from the almost US\$ 1 million investment over four years. The system components – Child Shield, Primero, and PLH – have potential, but the capacity to fully operationalise them is not evident, and the sustainability of the components has not been confirmed.
101. **There are opportunities which are not yet being exploited for the integration of MISs, particularly those used by OSCC, with Primero, and for the integration of Primero with MSDHS' CPIS.** This would not only create efficiencies in terms of staff time but would also serve as a platform for a multi-sectoral exchange of child protection information. Integrating Primero in this way would take advantage of national government-owned systems and could contribute to a strengthened child protection system.
102. **It is challenging to ascertain if there is a commitment to capacity building in its most comprehensive sense because there has been no foundational institutional capacity assessment.**

A commitment to child protection systems-strengthening by default requires tools that allow the system to function, and the workforce to operate them: that is, ensuring there are enough people in the right places with the right qualifications with access to appropriate and adequate resources. This includes training. While there has been one-off case management training and training of coaches for PLH, mechanisms for coaching and mentoring, for continuing professional development, and for effective supervision have not been included in the pilot CP Joint Initiatives overall. Building a state-of-the-art technological facility is without value if there are not enough people to operate it.

103. **PLH does not have a statutory home or a strategy for expansion.** The intervention for families of children under 10 has demonstrated positive effects in a randomised control trial. To make the most efficient use of the investment to date the developers of PLH have identified opportunities for future delivery linked to further research in other locations in Thailand, with alternative donor funding.

10.5 Sustainability

104. **Frontline practitioners' awareness of child protection violations has been enhanced and they are clearly motivated to respond where child rights violations are identified.** With good planning, this competency can be more effectively operationalised as the child protection system continues to be strengthened, particularly within the public health system.
105. **The focus on software and hardware – Child Shield and Primero – has overlooked the 'brainware' that is required to make the systems function as intended, in order to prevent and respond to child protection violations.** The MISs are tools that need personnel and resources for them to be operated successfully. PLH also requires intensive inputs from a dedicated workforce to systematically raise awareness in communities, and plan and deliver a rigorous eight-week course. This missing capacity gap prevents MoPH delivering on the government's obligation to protect children from violence. At the same time, the lack of costing data limits MoPH's ability to engage in informed decision-making.

11 RECOMMENDATIONS

As per the evaluation guidance, the priority levels assigned to the recommendations set out in the table below are defined as follows: high – to be achieved within three months maximum; medium – to be achieved within nine months; and low – to be achieved within one year or more, up to a maximum of two years.

Table 12: Strategic recommendations

Preliminary conclusion	Recommendation	Recipient(s)	Level of priority
REL-1 REL-2 COH-2 SUST-2	Continued support for the CP Joint Initiatives should be embedded in a systems-strengthening approach, matched to a robust results-based management framework and M&E plan jointly designed by UNICEF and MoPH. This plan should include a clear set of milestones in regard to the following: (i) achieving the necessary policy and legislative change for MoPH to allocate funding to the initiatives; (ii) MoPH progressively increasing its response capacity and its capacity to operate more effectively within a multi-sectoral system (for example, integrating Primero with MoPH and MSDHS case management information management platforms and implementing an approved multi-sectoral referral mechanism); (iii) UNICEF and the government collaborating on social norms change to reduce the acceptance of violent discipline and to increase parenting capacity.	UNICEF and MoPH	High
COH-3 COH-7 SUST-4	Although multi-sectoral collaboration can be complex and challenging, UNICEF has a unique opportunity to play a role in mediating the relationship between MSDHS and MoPH in order to strengthen the child protection system. As a first step, the CP Joint Initiatives should be central to the dialogue on the government’s ongoing national multi-sectoral child protection system visioning. It is incumbent on UNICEF to facilitate this process in order to create a plan for seamless cooperation and collaboration across sectoral ministries on child protection.	UNICEF	High
	At the same time, UNICEF is an important interlocutor with MSDHS, the Ministry of Education, the Ministry of Interior, and MoPH in regard to establishing a home for PLH in social care facilities, FDCs, early childhood development centres, schools, and public health facilities, within the framework of a multi-sectoral strategy for PLH delivery. The University of Oxford is continuing the PLH research with private funding in Thailand and is well-placed to be an appropriate continuing partner for the development of a strategy for systematic multi-sectoral roll-out. This could explore adaptations to promote men’s engagement in PLH, to include activities for parents of children with disabilities, and expansion of PLH to encompass positive discipline for adolescent children 10–14 and 15–17. Even if it does not invest further financially, UNICEF is in a unique position to advocate with government for investment through Early Childhood Development and other education and social care strategies.	UNICEF and University of Oxford	Medium
COH-3 COH-7 EFFE-4	Increased UNICEF internal coherence on PLH, through the integration of UNICEF Country Programme Outcomes on Early Childhood Development (Outcome 1) and Child Protection (Outcome 4.2), can also create an environment for this multi-sectoral dialogue on parental engagement, thus expanding PLH’s reach and contributing to UNICEF’s intended outcomes on social norms change.	UNICEF	High

Preliminary conclusion	Recommendation	Recipient(s)	Level of priority
SUST-1	There is a need to fully adopt UNICEF Thailand’s recently introduced ‘Guidelines for Scale-up Models and Pilots’ to improve efficiencies and the longer-term sustainability of innovative child protection programmes. In particular, the requirement to have and implement a robust results framework and M&E plan for pilot programmes should be non-negotiable. Amongst other principles, these Guidelines advise that the pilot concept should be assessed as ‘fit for context’ and ‘evidence-based’, and have a specific M&E framework to measure progress and evaluate outcomes and impact, before being scaled up.	UNICEF	High

Table 13: Operational recommendations

Preliminary conclusion	Recommendation	Recipient (s)	Level of Priority
COH-1, COH-3, 6, and 7 EFFI-3 SUST-5	Consider the benefits of conducting an institutional capacity assessment, which is fundamental in order to understand how innovations in the development of child protection systems can be introduced and sustained. This relates not only to the numbers and qualifications of available workers, but also to the required resources. This assessment should also cover the capacity of FDCs to undertake a role in awareness raising for social norms change, bearing in mind their largely voluntary nature. Matched to a costing, this would provide evidence for government planning in the medium to longer term.	UNICEF and MSDHS, MoPH and Ministry of Interior	Medium
REL-3 COH-5 EFFE-4 EFFI-1	Consider advocating and providing support for the integration of Primero with (i) internal MoPH databases managed by OSCC, and (ii) CPIS. The Primero MIS modules strengthen the multi-sectoral case management function, which has the potential to increase implementation efficiency, as opposed to having several systems operating in parallel.	UNICEF, MoPH, and MSDHS	High
REL-4 REL-GEHR EFFE-GEHR	Review, and where necessary adjust, internal UNICEF programme plans, paying explicit attention to equitable community inclusion of children with disabilities (see Office of the United Nations High Commissioner for Human Rights (2023)) and women and girls.	UNICEF and MoPH	Medium

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Annex A Terms of reference

TERMS OF REFERENCE FOR INSTITUTIONAL CONTRACTS

Requesting Section: Child Protection, UNICEF TCO

Formative evaluation of the implementation of UNICEF-MoPH pilot child protection joint initiatives
(Secondary Bidding under LTAS)



1. Background

Child protection as a field of work within UNICEF has a long tradition, dating back to the Declaration of the Rights of the Child in 1959 and cemented through the Convention on the Rights of the Child in 1990. This area of work relates primarily to children's right to be protected from violence, exploitation and abuse. Although the nature and extent of child protection problems and issues vary widely across various contexts, there is sufficient evidence to show that violations of children's rights to protection are widely prevalent.

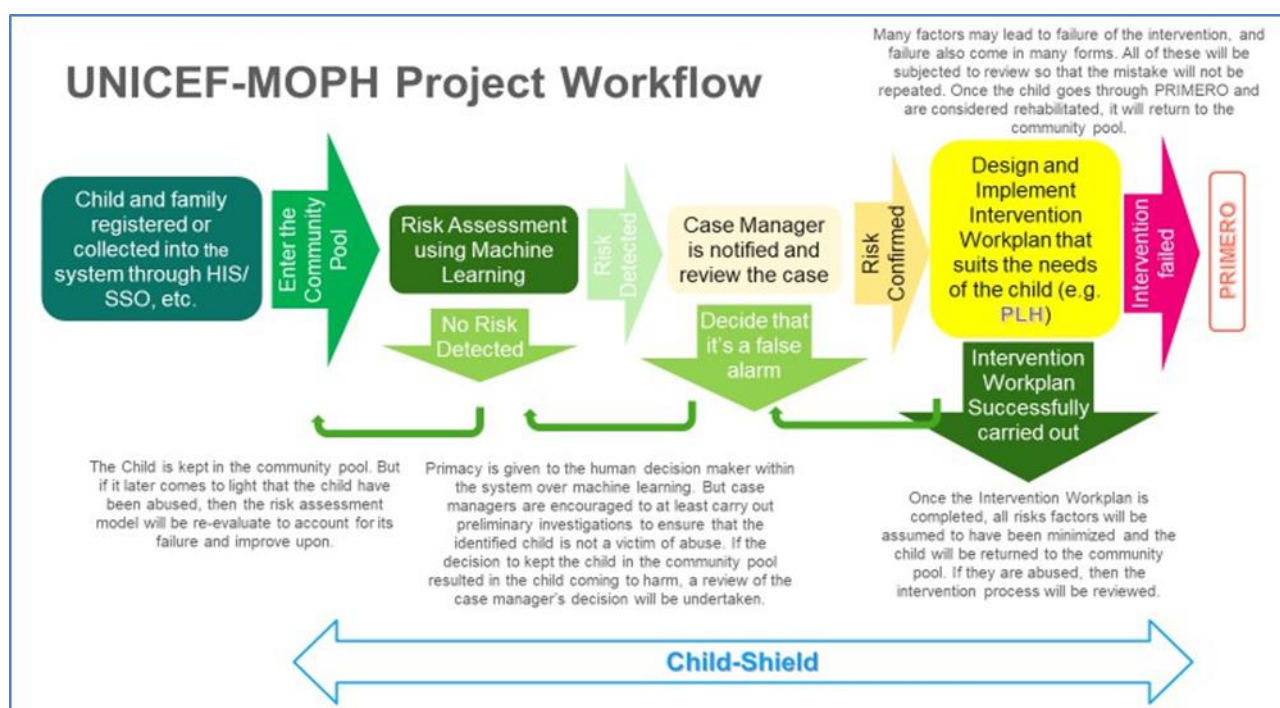
The Child Protection Section of UNICEF TCO has worked closely with the Ministry of Public Health (MoPH). This ministry has been providing services to child and women victims/survivors of violence since 1999 through its One Stop Crisis Centers (OSCC) within the hospital setting. While OSCCs provide critical life-saving services for child and women victims and survivors of violence, they lack appropriate tools and data for practitioners at the community and services level. They also have limited capacity in the prevention and monitoring of service provision. The MoPH's capacity to deliver services would be enhanced with the provision of appropriate tools, staff capacity, and a comprehensive management information system. This will directly ensure timely prevention of violence, abuse and exploitation with the participation of all stakeholders.

The UNICEF-MoPH child protection joint initiative has the following components: 1) The development of management information systems that include "Child-Shield", which utilizes big data and artificial intelligence in real-time for timely screening of at-risk children and families. This also includes a tracking system to monitor identified cases and link those cases to "Primero." This information management platform supports seamless child protection case management services. 2) The capacity development for health personnel at the sub-national level, especially staff of the OSCCs, to conduct case management, including risk assessment of cases identified through Child-Shield, as well as services provision and referral; and the adaptation and delivery of Parenting for Lifelong Health (PLH) an evidence-based positive parenting intervention for at-risk family identified through the screening process.

These initiatives were implemented from 2018-to 2021 with financial support from UNICEF, with the following details:

- Child Shield:
 - UNICEF and MoPH: The Development of a screening tool and management information system targeting children and women at risk of or being abused for health sector (Child Shield) Phase I. March 2018 - October 2019
 - UNICEF and MoPH: The Development of a screening tool, and management information system targeting children and women at risk of or being abused for the health sector (Child Shield) Phase II. June 2020 – December 2021
- Primero:

- o Contract with vendors through UNICEF HQ since March 2020 (ongoing) for the configuration, adaptation, and maintenance of software to Thailand's context
- OSCC staff capacity development on case management and Parenting for Lifelong Health (PLH):
 - o UNICEF and MoPH: The Development of curriculum and capacity on child protection for health personnel (Phase I) – PLH: March 2018 - October 2019
 - o UNICEF and MoPH: The Development of curriculum and capacity on child protection for health personnel (Phase II) - PLH: June 2020 - January 2022
 - o Programme Cooperation Agreement with The Chancellor, Master and Scholars of the University of Oxford on "Feasibility study on an evidence-informed parenting intervention to prevent violence against young children by parents and primary caregiver in Thailand" implemented from March 2018-April 2020



The initiatives have already been piloted in all seven (7) provinces under Health Region 8, including Udonthani, Sakhon Nakhon, Nakhon Phanom, Loei, Nongkhai, Nongbualumpoo, and Bungkan; with impressive results of more than 1 million children being screened by Child-Shield, in which more than a thousand children are being considered as "high risk", while hundreds of children and families have received PLH intervention on parenting, and a few cases have been referred to Primero for more intensive case management services.

The plan for these initiatives is to scale up in all MoPH hospitals across Thailand to help more children across the country receive efficient and comprehensive social services as well as care and protection.

Recognizing the importance of programme evaluation to help generate evidence and advocate in decision-making for national scale up, the Thailand Country Office (TCO) Child Protection (CP) section is planning to conduct a formative evaluation of the pilot child protection initiatives implemented jointly between MoPH and UNICEF during 2019–2021.

2. Objectives, Purpose & Expected results

This evaluative work aims to implement an evaluation of the pilot, including Primero, Child Shield and OSCC Capacity development and PLH implementation. The second phase of the pilot project has been completed, except for Primero, which is ongoing in terms of expanding the scopes and pilot sites, and it's a critical time to consider expanding the project to other health regions, with further expansion assessment for national scale up. The evaluation shall reflect on progress and lessons learnt from these experiences, and document successes and identify areas needing improvement. The evaluation should also factor in a cost-benefit analysis and required resources for the scale-up.

The evidence generated will be used by the following audiences:

- Primary audiences: UNICEF and the Ministry of Public Health at the policy level will use the evaluation result for policy dialogue to advocate for further expansion of the model at the national level.
- Secondary audience: Operation team of the Ministry of Public Health will use the evaluation result to improve the effectiveness and efficiency of the projects.

The primary objectives of the evaluation are:

- To assess the relevance, effectiveness, efficiency, coherence, and sustainability results on the implementation of the model;
- To engage MoPH team in analyzing the strengths and weaknesses of the projects, focusing on key aspects to enhance the child-centre approach that should be built on and what corrective actions should be taken;
- To provide actionable recommendations for MoPH to feed into OSCC's upcoming plan for information system and services provision.

3. Description of the assignment

The ToR explicitly and clearly defines what will and will not be covered: thematically (pilot, including Primero, Child Shield, and OSCC Capacity development and PLH implementation), chronologically (time period for each component during 2018-2021), geographically (the provinces in Health Region 8 that implemented the pilot project).

The OECD/DAC evaluation criteria of relevance, effectiveness, efficiency, coherence and sustainability will be prioritized to provide evidence-based analysis to answer a number of strategic questions. The evaluation criteria and questions will analyze the extent to which human rights, child rights, and gender equality and equity have been addressed within the program.

Some initial questions are suggested below. During the inception phase, the evaluation team will reconstruct ToC and review and confirm these questions' feasibility and appropriateness. The firm can propose alternative or refined questions that are meaningful and respond to the methodological approach, and the availability of data is finally agreed upon. As a general rule, the number of questions should be kept small to ensure the process is timely and rapid. The final list of questions will need to be part of the evaluation matrix within the inception report.

Relevance

- To what extent has Primero/ Child-Shield/ PLH proved adequate and aligned with national priorities and the context in Thailand?
- To what extent has Primero/ Child-Shield/ PLH been appropriate for the work and mandate of MoPH, especially OSCC?
- How adequate and robust are the pilots' designs? Is there a clear intervention logic with sound theories of change?

- Was the program design open and participatory?
- Has the Primero adoption been in line with the expectation of MoPH?
- Is the current configuration of Child Shield and Primero in line with the current needs of the OSCCs?

Coherence

- To what extent do the pilots develop synergies and interlinkages among the different joint initiatives (Primero/ Child-Shield/ PLH) with other Child Protection interventions carried out by the government?
- To what extent does the pilot implementation tie in with other government initiatives to achieve optimal utilization of available resources?
- Did the pilots involve all the key stakeholders during the design and implementation phases? Did the pilots include complementarity, harmonization, and coordination with others?
- To what extent are the pilots in line with UNICEF global standards and relevant international norms and standards?
- How do child shield and Primero link to each other and the broader health information management ecosystem at the regional and national level?

Effectiveness

- To what extent have the expected results been achieved?
- What changes have taken place as a result of pilot implementation? Has there been any change in the case management function? Is the data sharing between different units that utilized Child-Shield, and Primero now more or less efficient/ secure?
- Which were the most decisive factors that determined the achievement or non-achievement of intended results?
- What was the user experience of Child-Shield and Primero systems like? Whether their feedback have led to any changes?
- Has the implementation of Primero supported the coordination and cooperation among different stakeholders?
- Have at-risk children and families identified by Child-Shield received services to reduce their risk?
- Has OSCC capacity development and PLH helped improve the capacity of staff to prevent and respond to children and families?

Efficiency

- Has there been any delay in the program implementation? Specify the reason?
- What are extra resources required to implement the Primero/ Child-Shield/ PLH?
- What does the cost-benefit analysis of each project show; including an analysis in terms of value for money? What are the required resources for the scale-up?
- Does interoperability between HIS and Primero deliver value? How? What does this integration between systems mean in terms of results for children? Better services? More timely services? More confidential sharing of data, and therefore less associated risk?

Sustainability

- What mechanisms are put in place to guarantee sustainability once this project support is over?
- Can the activities continue after UNICEF withdraws? What are the challenges that are being foreseen in sustaining the program?
- What are the preconditions for scale-up? and what are the preconditions for sustainability? (Laws, policies, structures, staff, funding, procedures, monitoring and reporting systems, training etc). If not, what needs to be modified or strengthened to allow for a nationwide scale up (including institutional framework and political will)?

4. Methodology

The evaluation is proposed to be carried out using mix-method of qualitative and quantitative approaches. Based on the objectives of the evaluation, this section indicates broad guidelines on methods and processes for the evaluation. Methodological rigour will be given significant consideration in the assessment of proposals. Hence bidders are invited to interrogate the approach and methodology pre-offered in the ToR and improve on it or propose an approach they deem more appropriate to evaluate such pilot programmes.

Data collection and analysis methods with a range of stakeholders should be used to facilitate the triangulation of data. These should include document review (including progress reports), and semi-structured interviews with key stakeholders (most probably online interviews). Key stakeholders to be involved in the data collection should be selected from UNICEF, critical national government agencies, policymakers, implementing partners, CSOs, NGOs, and beneficiaries.

The evaluation team members will need to draw on available quantitative data from recent assessments, reviews, research, studies, progress reports, situation reports, national datasets, surveys, and other sources.

At a minimum, the assessment will draw on the following methods:

- Comprehensive desk review of available documentation – Project Documents, annual reports, mid-year and end-year reviews, datasets, government documents, publications, and studies.
- Review of data in the existing management information system, including Primero and Child-Shield
- Data from user acceptance tests from both child-shield and Primero
- Interviews and focus group discussion (online or offline – upon situation permit).
- The evaluation team shall conduct individual key informant interviews with staff representatives of UNICEF (country, regional and HQ), and government officials, and vendor support.
- A survey can also be launched to complement the evidence collected through the above-mentioned data collection tools and access stakeholders such as former staff.

Data collection and analysis should be human rights-based and gender sensitive. Any data collected should be disaggregated by age, gender, state/region, disability, etc., where possible. Data triangulation will be of crucial importance. Data analysis should also include aspects of gender, equity, and human rights into consideration.

A sampling strategy should be included in the Technical Proposal, setting out how institutions and organizations, and different stakeholder groups will be sampled. This applies to both quantitative and qualitative data collection.

The evaluation team members, and specifically the team lead, will be expected to conform to guidelines and standards set by the UN and UNICEF. The team will be guided by [UNICEF's revised Evaluation Policy](#) (2018), the [United Nations Evaluation Group \(UNEG\) Norms and Standards for Evaluation](#) (2016), [UNEG Code of Conduct for Evaluation in the UN system](#) (2008), [UNEG Ethical Guidelines for Evaluation](#) (2020), [UN SWAP Evaluation Performance Indicator](#) (2018), [UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation](#) (2014), and [UNICEF-Adapted UNEG Evaluation Report Standards](#) (2017)

Ethical considerations

The bidder will set out how they expect the evaluation process to be designed and undertaken in accordance with ethical guidelines as set out in UNEG Ethical Guidelines for Evaluation (2020) and the UNICEF Procedure for Ethical Standards and Research, Evaluation, and Data Collection and Analysis (2015). During the evaluation process, full compliance with all UNEG and UNICEF ethical guidelines will be required. All informants should be granted full confidentiality for all methods used, informed

consent procedures shall be observed, and risks/benefits shall be disclosed with informants. Dissemination or exposure of results and any interim products must follow the rules agreed upon in the contract. In general, unauthorized disclosure is prohibited. Any sensitive issues or concerns should be raised as soon as they are identified with the evaluation management team.

All evaluations shall have ethical clearance issued either by an external board of review or by an internal one. In 2015 the UNICEF Procedure for Ethical Standards in Research, Evaluation and Data Collection and Analysis was issued to guide UNICEF's evidence generation activities and to support the integrity of UNICEF's evidence base to ensure that UNICEF's programmes, policy and advocacy activities are grounded in ethical principles and practices. Under the UNICEF Procedure for Ethical Standards (2015) all proposals involving research, evaluations or data collection and analysis covered by this procedure and meeting one or more of the following criteria must go through a relevant external ethical review board or panel:

- Evidence generation that involves vulnerable cohorts whose personal agency is limited due to age, situation or capabilities and for whom an additional duty of care is required. (includes all evidence generation involving children).
- Evidence generation involving primary data collection that has the potential to result in direct harm to the participant during the course of the programme
- Evidence generation that has the potential to compromise the privacy of subjects and the confidentiality of data
- Evidence generation that has the potential to compromise the safety and well-being of individuals in their context
- Evidence generation that involves non-universal distribution of resources (ie. RCTs involving the provision of cash transfers, or other goods and services, to one group and not to another group)

Where not required by National law or a partner institution to utilize a National or Institutional Review Board/Ethics Review Committee, the use of a private ethics review vendor can be considered.

5. Reporting Requirements and Deliverables

- **An inception report** (English): Building on the Terms of Reference, the desk review and preliminary interviews, the evaluation team will produce an inception report (using UNICEF's standard Format that will be shared with the evaluation team after the contract has been signed) which will present the detailed evaluation methodology. The report will be structured as follows:
 - Introduction presenting the object of the evaluation, its purpose, scope and objectives;
 - Preliminary results of the documentary review summarized in the evaluation context section;
 - Evaluation criteria and questions refined through the desk review and preliminary interviews;
 - A detailed description of the evaluation methodology, including relevant data collection methods that will allow answering evaluation questions and sampling strategy;
 - Evaluation Matrix: The Evaluation Matrix forms the 'spine' of the evaluation. It will provide the main analytical framework against which data will be gathered and analyzed. It will be shaped around the evaluation questions and embed the criteria above. All other enquiry tools, such as interview guides and the field study template, will be geared towards it. The Evaluation Matrix, including the evaluation criteria and associated questions, indicators and prescribed data gathering tools and methods, will be developed by the evaluation team leader and cleared by the evaluation reference group before the start of fieldwork as part of the inception report. Criteria for success should be agreed upon at the inception phase and included in the Inception Report.
 - Methods of data analysis and presentation of Analytical Framework to be used;

- o Limitations of the evaluation and section on ethics and ethical considerations;
- o Work Plan; and
- o Appendices: List of the main documents reviewed; Proposed data collection tools; Initial list of key informants.

The Inception Report will be key in confirming a mutual understanding of what is to be assessed, including additional insights into executing the consultancy. No field work will be undertaken prior to the approval of the inception report. At this stage, the evaluation team will refine and verify evaluation questions, confirm the scope of the assignment, and further improve on the methodology proposed in the ToR to strengthen its rigor.

- **A PowerPoint presentation with preliminary findings, conclusions, and recommendations** (English/ Thai). After the data collection process, the evaluation team leader shall present the preliminary findings, conclusions, and recommendations that can feed into future initiatives.
- **Draft and final report** (Thai and English) of ideally 25 pages but not more than 40 plus executive Summary (max 5 pages) and annexes that will be revised until approved by UNICEF. The draft, subsequent versions and the final report must be submitted using UNICEF's standard evaluation report format that will be shared with the evaluation team after the contract has been signed.
- Draft evaluation report integrating the stakeholders' observations during the debriefings (this deliverable will be shared with the ERG members for comments).
- To be approved, the draft report shall have a quality review by an external firm to verify it complies with the **GEROS** evaluation standards (<https://www.unicef.org/evaluation/global-evaluation-reports-oversight-system-geros>)
- Full final evaluation report integrating all comments provided by the ERG members. This report should be submitted to UNICEF for final approval. Therefore, the team should make sure to indicate in their proposal what strategies they will use to meet the deadline. The full final report shall be structured as follows:
 - o Table of Contents including List of Tables and List of Figures
 - o Executive Summary (covering all main sections of the report: background, methodology and process, main findings and recommendations, lessons learnt – not more than five pages)
 - o Acknowledgements (all who supported the evaluation and provided strong cooperation and collaboration during the process)
 - o List of abbreviations and acronyms
 - o Introduction (object of the evaluation, evaluation purpose, objective, scope, intended users and users)
 - o Evaluation context
 - o Methodology, including sampling strategy and data analysis methods
 - o Key findings (by criterion – each question will need to be answered) + Preliminary
 - o Conclusions (given that all findings will be numbered, each conclusion will need to indicate these specific findings and corresponding paragraph numbers which it is based on)
 - o Conclusions
 - o Lessons Learnt
 - o Recommendations (strategic and operational, maximum five priority recommendations)
 - o Appendices (ToRs; List of persons interviewed and sites visited; List of documents consulted; More details on methodology, such as data collection instruments, including details of their

reliability and validity; Evaluators biodata and justification of team composition; Evaluation matrix; Results framework)

- **Raw data:** All raw data, code books and complete transcripts from primary data collection will be delivered to UNICEF. All original research instruments with their recorded field data, transcripts, and copies of all excel files/databases used for data analysis will be delivered to UNICEF to validate the analyses. UNICEF shall be entitled to all property rights, including but not limited to patents, copyrights, trademarks, and materials that bear a direct relation to or are made in consequence of the services provided. At the request of UNICEF, the evaluation team shall assist in securing such property rights and transferring them to UNICEF in compliance with the requirement as is applicable
- **Final Presentation/Webinar and a reader-friendly evaluation brief** that summarizes the key findings, conclusions and recommendations of the evaluation needs to be produced. The agency can choose the format, but it is expected that innovative formats will be used for enhanced readability. UNICEF withholds the right to alter this evaluation brief upon dissemination.

Note: All reports as part of the deliverables (such as inception report, draft report and final report) must meet the standards of quality assurance by UNICEF.

- Methodological rigor will be given significant consideration in the assessment of the quality of deliverables. In the domain of ethical compliance, the research should be guided by **UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis** and when relevant the approval of an ethical review board will be a prerequisite for the research. (<https://www.unicef.org/evaluation/documents/unicef-procedure-ethical-standards-research-evaluation-data-collection-and-analysis>)
- Reports as part of the deliverables (including both Inception Report and Final Report) must meet the standards of quality assurance by UNICEF in line with **UNICEF Standard Operating Procedures for Research Studies and Evaluations**. The Final Report will need to be rated as satisfactory or above by UNICEF's quality assurance review facility. (<https://www.unicef-irc.org/files/upload/documents/UNICEF-%20Quality-Assurance-Research.pdf>)

6. Location and Duration / Timeline

One or more members of the evaluation team will be based in Thailand during the primary data collection phase and will work remotely (in their home country) during the rest of the assignment when physical presence in the country is not required. Field visits are expected for this assignment to different provinces in Health Region 8.

It is expected that the team would travel to Thailand (if located outside), including areas outside Bangkok, for fieldwork as per the methodology and tools finalized for this assessment. All international and domestic travel costs should be budgeted for and included in the total lump sum value and described in the financial proposal. The selected institution will be responsible for making its own travel arrangements. When relevant and necessary, UNICEF may facilitate the logistics arrangement for field visits in coordination with the relevant government counterparts. Please note that if selected, UNICEF will issue supporting documents to obtain an entry visa (if necessary). UNICEF will be unable to secure travel visas. The evaluation team will not be entitled to payment of overtime. All remuneration must be within the contract agreement. No field visits can take place before the approval of the inception report.

The consultancy will be four months in duration between July to October 2022 and will consist of three main phases as described below in the table. The evaluation team is expected to propose a detailed work plan indicating the roles and responsibilities of each team member in the technical proposal. Please note that the final revised evaluation reports will need to be submitted to UNICEF Thailand Country Office by October 30,

2022. Therefore, the interested bidders are strongly encouraged to take that into account

Phase	Tasks and Deliverable	Timeline
Preparatory phase	Kick off telecon / video conference with UNICEF staff	As soon as possible after the ET is contracted
	Desk review – Development of the draft inception report (Deliverable 1)	Two weeks after kick-off
	Comments and Q&A on inception report draft	One week after the draft submitted
	Final inception report (Deliverable 2)	One week after the comments
Field data collection phase	Pilot testing of the tools in the field	One month and a half after the inception report
	Data collection: KIIs and MIS review	One month and a half after the inception report
Data analysis, report writing, validation and dissemination	Draft evaluation report - English/Thai (Deliverable 3), Draft PPT with preliminary findings (Deliverable 4) and online validation workshop	Two weeks after data collection is finalized
	Comments and QA on draft	Two weeks after submission of draft
	Final report produced – Eng/Thai (Deliverable 5) and final PPT with findings and recommendations (Deliverable 6)	Two weeks after comments

7. Mandatory and Desirable Qualification Requirements

This contract will be awarded to an institution and not to an individual or team of individuals not sponsored by an institution. A consortium of 2 or more institutions may make a joint bid. In this case, there must be a lead institution named that will be the sole point of contact with UNICEF for contract management purposes. The firm must have a history of working in Thailand. If a consortium, at least one partner must have a history of working in Thailand.

The institution should have experience in designing, planning, organizing, managing and conducting evaluations. Demonstrated expertise in research design, methodologies, data validation and data quality assurance. Previous experience with UN agencies, large NGOs and Government. Very strong communication and presentation skills of team members with government and community members. Demonstrated experience in collecting data in the field on tablets using online platforms, telephonically, and other non- face-to-face modalities

The team should have a good knowledge of the country-specific context of Thailand, as well as of the child protection country programmes. The team will work closely together to develop and implement an appropriate methodology and approach to address the evaluation questions and achieve the expected results of the evaluation.

The evaluation team:

It is desirable that team members have extensive experience both at the national and international level. The bidder should propose a minimum of two technical team members/ personnel and at least one of the team members has to be national of Thailand and fluent in Thai with skills in facilitation of participatory processes in Thai languages. Firms committed to achieving workforce diversity in terms of gender, nationality and culture are encouraged to apply.

Evaluation Team leader:

The Team Leader will coordinate the evaluation team and ensure the design of the evaluation, the management of the evaluation process, the quality assurance and the delivery of the expected products in close collaboration with the other team members. She/He shall conduct the evaluation applying an approach that is conducive to the transfer of competencies to the national members of the evaluation team. She/He should have the following profile:

- Advanced university degree in evaluation, child protection, public health, social science research or another relevant field;
- Must be familiar with child protection programming and evaluation approaches;
- More than ten years of experience in programme evaluation for child protection, including evaluation of child protection interventions with a focus on prevention and response to violence against children, and must have completed at least three high-quality programme/project evaluations in that period (a copy of an evaluation report in which the Team Leader has been a primary author will need to be submitted as a part of the application);
- Knowledge about the overall governance of the child protection system in Thailand, including the delivery of social welfare services and child protection services through the health sector by the sub-national structures, case management, CP-MIS, child protection capacity development, and decentralization.
- Strong statistical and analytical, quantitative and qualitative research skills: Have a perfect command of quantitative and qualitative methods of research and evaluation methods based on equity, human rights and gender;
- Substantive, relevant experience in Thailand and knowledge of the social, political and economic environment of the region.
- Have excellent oral and written communication skills in English as well as skills in facilitation of participatory processes;
- Good knowledge of UNICEF approaches and evaluation standards, including UNICEF-Adopted UNEG Evaluation Report Standards
- Good knowledge of results-based programme management.

Other Evaluation team member

Evaluation team member will participate in all stages of the evaluation process and will be primarily responsible for collecting and analyzing the data that will be used to establish the evaluative judgment. The team will also contribute to the analysis of the national context and to contextualize the results of the evaluation. This will involve both secondary data analysis and primary data collection with beneficiary communities and key stakeholders involved in the implementation of the programmes. This evaluation team should consist of at least one expert besides the Team Leader; the detailed composition is to be proposed by the evaluation team leader. The evaluation may also require the employment of local translators. The proposal will need to indicate how the fieldwork will be organized clearly. However, it is expected that all international team members to travel to Thailand at least once

Data and information systems specialist

- IMS specialist with 8+ years of professional experience as a system designer/system architect for system development projects of similar nature and scale as this consultancy.
- Has at least an advanced university degree in data and information management
- Experience and knowledge of open source platforms and development environments is mandatory.
- Experience on MIS, CP-MIS, will be considered a big advantage.
- Prior experience in the systems and technology for managing social welfare and health-related services is highly desirable.

8. Evaluation of offers and contract award process (secondary bidding under LTAS)

This is a secondary tender under existing framework agreements (LTAS). The UNICEF evaluation panel will first review each response for compliance with the mandatory requirements of these ToR. Failure to comply with any of the terms and conditions contained in this tender, including provision of all required information, could result in a response or proposal being disqualified from further consideration.

Each valid proposal will be assessed by an evaluation panel first on its technical merits and subsequently on its price. The weight allocated to the technical proposal is 70 % (i.e. 70 out of 100 points). To be further considered for the financial evaluation a minimum score of 49 points is required. Only proposals with a score of 49 or more points in the technical evaluation will be financially evaluated (i.e. the financial proposal will be opened). For further details and the distribution of points kindly refer to **table 1** below.

The weight allocated to the financial proposal is 30 % as per the following: the maximum number of 30 points will be allotted to the lowest technically compliant proposal. All other price proposals will receive points in inverse proportion to the lowest price. Commercial proposals should be submitted on an all-inclusive basis for providing the contracted deliverables as described in the ToR.

The proposal(s) obtaining the overall highest score after adding the scores for the technical and financial proposals is the proposal that offers best value for money and will be recommended for award of the contract.

Table 1: Evaluation Criteria and distribution of points

#	Assessment criteria	Sub-criteria	Score	Total score
1	Understanding of ToRs	Understanding of ToR (according to the value-added of the technical proposal)	10	10
2	Methodology	Methodological reference framework to address evaluation questions (according to the relevance of the methodological framework for answering evaluation	10	25
		The quality and robustness of proposed data collection and sampling methods for answering the evaluation	10	
		Data analysis methods (according to the relevance and consistency of the proposal for answering the evaluation questions)	5	
3	The organizational capacity of the evaluation team to execute the mandate	Evaluation Work Plan (according to the relevance of the proposed timeline for the delivery of expected	7	10
		Roles and Responsibilities of the Evaluation Team members (according to the appropriateness of the distribution of roles and responsibilities for the achievement of expected results within the required time)	3	
4	Expertise and experience of the Team Leader	The expertise of the Team Leader (according to the conformity with the required profile and the expertise evaluation in general and in equity-focused and gender and human rights-based evaluations)	5	10
		Experience of the Team Leader (according to the quality of the evaluation report submitted as part of the proposal and the team's experience in evaluations)	5	

5	Expertise and experience of the Evaluation team members	The expertise of the team member (according to the conformity with the required profile, the expertise in the targeted thematic area, knowledge of the national context and evaluation and research methods in general and in the targeted thematic area in particular and as an evaluation team	8	15
		Experience of the team members (<i>according to the experience in evaluation in general and in the thematic targeted area</i>)	7	
Total Score attributed to the technical proposal (passing score = 49 points)				70
6	Financial Proposal	Full marks are allocated to the lowest priced proposal. The financial scores of the other proposals will be in inverse proportion to the lowest price.		30
TOTAL POINTS				100

9. Administrative issues and responses to be submitted

- Bidders are requested to provide a detailed technical proposal in the provided **Technical response form**. The technical proposal must include all information needed to fully evaluate the proposal against the requirements and evaluation criteria outlined in sections 7 and 8 of this ToR.
- Bidders are requested to provide a detailed cost proposal in the provided **Financial response form**, factoring in all cost implications for the required services.
- The financial proposal must be based on the agreed LTAS unit / daily rates. A special discount or lower rates can be offered for this specific assignment, if applicable.
- If the bidder wishes to include additional or optional elements outside the defined deliverables as per this ToR, these should be clearly marked as such in both, the technical and financial proposal.
- The bidder is required to include the estimate cost of travel in the financial proposal noting that i) travel cost shall be calculated based on the most direct route and economy class travel, regardless of the length of travel and ii) costs for accommodation, meal and incidentals shall not exceed applicable daily subsistence allowance (DSA) rates, depending on the location, as promulgated by the International Civil Service Commission (<https://icsc.un.org/>).
- Unexpected travels shall be treated as above.

The technical proposal (maximum 30 pages) should cover the following aspects:

- Understanding of the terms of reference (including the nature of this evaluation)
- Evaluation methodology
 - Methodological reference framework to address evaluation questions
 - Special consideration will be given to the capacity of the firm to conduct this evaluation and deliver the final evaluation report by Sept 2022
- Data collection and analysis methods
- The organizational capacity of the evaluation team to execute the mandate:
 - Evaluation work plan
 - Roles and responsibilities of evaluation team members
- Expertise and experience of the proposed evaluation team (CV of no more than 3 pages per person)
 - Expertise and experience of the Team Leader
 - Expertise and experience of other team member

Links or QR codes of two evaluation reports produced by the Team Leader during the last 5 years should be shared as part of the application.

The Financial Proposal should include but not be limited to the following:

- **Resource Costs:** Daily rate multiplied by number of days of the experts involved in the evaluation.
- **Travel Costs:** All travel costs should be included as a lump sum fixed cost. For all travel costs, UNICEF will pay as per the lump sum fixed costs provided in the proposal. A breakdown of the lumpsum travel costs should be provided in the financial proposal.
- **Any Other Costs (if any):** Indicate nature and breakdown.

The IT and communication equipment necessary for the proper implementation of the evaluation will be the responsibility of the Evaluation team. It should be noted that UNICEF will bear the costs of organizing meetings or technical workshops.

10. Payment Schedule

Payments will be made, as follows:

- Deliverable 1: Upon submission of draft Inception Report: 20%
- Deliverable 2: Upon approval of Final Inception Report: 20%
- Deliverables 3 and 4: Upon submission of Draft Report and PowerPoint with Preliminary findings, and Online Validation workshop: 40%
- Deliverables 5 and 6: Upon approval of Final Report and Final Presentation/ briefs with findings, conclusions, and recommendations: 20%

The payment schedule must be based on completed deliverables. If the bidder wishes to propose an alternative payment schedule, it must be included in the financial proposal. The final payment schedule is to be reviewed and agreed with UNICEF. Payment terms 30 days net upon receipt of approved invoice.

11. Any other Information

Governance

The following summaries set out the main roles and responsibilities of those involved in the evaluation.

The Evaluation Team Leader

Leading role and responsibilities include:

- Delivering against the evaluation requirements set out in the ToR and ensuring these are compliant with UNICEF standards
- Ensuring deliverables (see above) are completed within agreed timeframes, budget, and quality standards
- Responding to, and factoring in, stakeholder feedback in redrafting deliverables
- Team Members
- Contributing technical inputs to all deliverables and helping ensure requirements & standards are met
- Assuming lead role in specific technical and / or cross-cutting areas as assigned by the team leader, and contributing analysis on these areas

The Evaluation Manager

This role would be taken up by the Multi-Country Evaluation Specialist. Primary responsibilities include:

- Help develop scoping for the evaluation
- Set out and update a detailed plan for the process, and day to day management and communication of this process with stakeholders
- Leads on recruitment of the Evaluation Team, and provides supervision and support to the ET
- Day-to-day oversight and management of the evaluation process and budget, in coordination with other key stakeholders. Leading on quality assurance throughout the process, assuring the quality and independence of the evaluation and guarantee its alignment with UNEG Norms and Standards and Ethical Guidelines and other relevant procedures, managing stakeholder engagement in this (gathering and collating feedback), and ET performance against ToR deliverables

The Evaluation Reference Group (ERG)

An Evaluation Reference Group (ERG) should be set up and comprise a small group of key UNICEF internal stakeholders led by the TCO Deputy Representative, and including the in-country Planning, Monitoring and Reporting Specialist, the Multi-Country Evaluation Specialist, members of the Child Protection section; and Government counterparts.

Primary responsibilities include:

- Make decisions on scope, timing and resourcing of the evaluation
- Conduct consultations with Government and partners as appropriate
- Contributions to, and approval of, the ToR (signed off by the Deputy)
- Ensuring lists of contacts, data and information is prepared for the ET, the in-country introduction of the evaluation team, arranging interviews, briefings, meetings
- Providing logistical and admin support
- Contributing to Quality Assurance through comments and feedback on draft deliverables
- Develop the Evaluation Management Response in consultation with stakeholders, with the Representative signing off on this and monitoring progress in the coming two years

Quality Assurance

Quality assurance through the process will be undertaken by:

- The Evaluation Team will ensure the quality of the evaluation through assurance mechanisms, including the triangulation of data, etc.
- The Evaluation Manager, leading on quality assurance of all deliverables, will provide quality assurance in line with UNEG Norms and Standards and Ethical Guidelines and other relevant procedures checking that the evaluation methodologies, findings and conclusions are relevant and recommendations are implementable, and contribute to the dissemination of the evaluation findings and follow-up on the management response. S/he will review the initial deliverables (such as draft inception report, first draft of the final report) and work with ET on necessary revisions to ensure the deliverables meet minimum quality standards. Once the minimum standards are met, the Evaluation Manager requests feedback from stakeholders, consolidates all comments from Reference Group, Regional Evaluation Advisor and other RO staff and key stakeholders on a response matrix and requests the ET to indicate actions taken against each comment in the production of the penultimate, and final draft.

- ERG provides provide comments and substantive feedback to ensure the quality – from a technical point of view – of key evaluation deliverables including the inception report and draft report.
- Regional advisors from each sectoral discipline will provide quality assurance inputs on technical areas of the evaluation
- The Deputy Representative is responsible for final quality assurance checking and final sign off on all deliverables of the evaluation

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At the request of UNICEF, the contractor will submit all the necessary deliverables on a standard format which will be shared with the contractor upon the signing of the contract.

Annex B Document review

The table below summarises the documents that were provided to the evaluation team during the inception phase (Table 14). See also the bibliography of the ‘Inception Report for the Formative Evaluation of the Joint Child Protection Initiatives’ for additional documents that were consulted by the evaluation team.

Table 14: Documents provided to the evaluation team

Description	Type of document	Language	Author, date	Key issues
Primero Implementation Plan			UNICEF, updated October 2021, Primero Implementation Plan, Thailand Roll-out 2020–2021	Includes advice to follow Primero CPIMS+ Workplan which has not been updated since October 2020
Primero/CPIMS+ Workplan			2019 and 2020	Complete up until 19 October 2020, with some outstanding actions
Primero THA Workplan Child Shield Interoperability				
CPIMS+ Roll-out Guidelines			Not dated; https://www.cpims.org/introduction	
CPIMS+ Rollout Guidelines Part 11: Configuration Promotion Process YouTube Video			26 July 2021; https://www.youtube.com/watch?v=K4Ukn_GfXTU	
Key Documentation – Link in Primero Implementation Plan Section 1.2				Contains links to Google Docs, with several folders and documents containing detailed technical information and specs
SOPs for Case Management – Link in Primero Implementation Plan Section 1.3				Link to UNICEF Share Point could not be accessed by the evaluation team
CPIMS+ Programmatic and Technical Assessment – Link in Primero Implementation Plan Section 1.5				Link to UNICEF Share Point could not be accessed by the evaluation team
Thailand Requirements for Configuration – Link in Primero Implementation Plan Section 1.6				Includes system requirements checklist, service mapping, user mapping
OpenFn security, compliance, and terms of service – Link in Primero Implementation Plan Section 1.6			https://www.openfn.org/trust https://www.openfn.org/compliance https://www.openfn.org/terms	Platform to create interoperability with external systems
Manual of Protocols and Procedures. Protecting and Responding to Children at Risk of Abuse, Neglect, Exploitation, and Violence	PDF	English	Department of Children and Youth, January 2017	This manual contains the procedures that agencies and staff with responsibilities to protect children must follow when working with children who are at risk and their families. Does not appear to be endorsed by MoPH

Description	Type of document	Language	Author, date	Key issues
Executive Summary – National Child Protection Strategy	PDF	English	Author not cited; report not dated	Provides a series of recommendations, including connecting the database of the Department of Children and Youth to other child protection MISs
Review of Research Evidence: Evidence base for national child protection vision development	Power Point	English	Department of Children and Youth / MSDHS, UNICEF Thailand, Child Frontiers, December 2020	Does not reference child protection screening, Child Shield, Primero, or OSCC; authors could be potential key informants
Thailand Child Protection System: Evidence Review Notes; internal document, not for external dissemination; Data directly inserted from original referenced sources	PDF	English	No author, no date [possibly connected to above?]	As above
Twenty-Year National Strategic Plan for Public Health (2017–2036) First Revision 2018	PDF	English	MoPH	Does not explicitly reference violence prevention, or screening for child violence prevention and response; NB. UNICEF suggests MoPH is planning to categorise child violence as a non-communicable disease in further revisions to this strategy, which is incorrect
Final CP PSN 2022–2026	PDF	English	UNICEF, not dated	PSN - programme strategy note? References scale-up of Primero 'after which interoperability with Department of Children and Youth databases will be sought' (page 12)
Draft Strategic Note Child Protection 2017–2021	PDF	English	UNICEF, not dated	Does not reference Child Shield, Primero, OSCC, or screening
National Health Act 2007	PDF	Mixed Thai and English		Legislation governing the health system
Kingdom of Thailand Health System Review	PDF	English	Asia Pacific Observatory on Health Systems and Policies, 2015	Detailed description of Thai health system and of policy initiatives in progress or development; does not include violence prevention
Healthcare System and Healthcare Policy	Power Point	Mixed Thai and English	Chanodom Piankusol, 11 January 2021	Presentation without explanatory notes
eHealth in Thailand: Interoperability and Health Information Standards	PDF	English	Thai Health Information Standards Development Center (THIS), Health Systems Research Institute (HSRI), 2016	General knowledge about eHealth, interoperability, and health information standards. The second part describes health

Description	Type of document	Language	Author, date	Key issues
				information standards development in Thailand and the Thai Health Information Standards Development Center (THIS)
Primero Implementation Plan Thailand Roll-Out (2020–2021)	PDF	English	UNICEF (?), October 2021	Refers to interoperability with hospital information system but not to Child Shield (which is not mentioned)
UNICEF Thailand Country Programme 2022–2026	PDF	English	UNICEF, July 2022	Building on achievements of piloting Primero and data from the surveillance system Child Shield, UNICEF will support MSDHS and MoPH in quality improvement of the data system and national-level scale-up. The aim is for Primero to be scaled up nationally, after which interoperability with the DCY system will be sought
UNICEF [Monitoring] Reports for years 2019, 2020, and 2021	Other	English		Three Excel spreadsheets with child protection monitoring data; Outcome Statement for 2021 refers to 21 cases in Primero; Output-level statement for 2021 refers to 15 hospital staff trained in use of Primero and states 'The platform will be integrated with the UNICEF supported Child Shield surveillance and information system and Parenting for Lifelong Health (PLH) interventions'
Child Violence Management Framework in 8th Region	Power Point	Mixed Thai and English	Chanvit Tharathep, 2019	Presentation, no notes, unclear
New Business Model: Digital Transformation for Child Protection	Power Point	Mixed Thai and English	Chanvit Tharathep, 20 August 2021	Presentation, no notes, unclear
Briefing Child Shield	PDF	Mixed Thai & English	UNICEF (?) 2021	Includes data on Child Shield achievements
Child Shield Briefing	PDF	Thai	No author, undated	Comprises 23 pages
Child-Shield Project: The first stages implementation, Thailand experience	Word	English	Sun Tharathep, Chanvit Tharathep, undated [possibly 'as of July 2020']	Draft journal article? Describes the design and early implementation of Child Shield
Child Shield Specification	Word	English	No author, undated	

Description	Type of document	Language	Author, date	Key issues
INSPIRE Child Shield Thailand	Power Point	Mixed Thai & English	UNICEF (?) undated	Presentation, no notes, unclear
Presentation Steering Committee	Power Point	Mixed Thai & English	No author, 1 March 2022	Presentation, no notes, unclear
Result Child Shield	Power Point	Thai	No author, undated	Presentation, no notes, unclear
Review of Project Proposal Child Shield signed	PDF	English	UNICEF, June 2021	Recommendation to finance a project proposal submitted by MoPH to expand Child Shield
Review of Project Proposal on OSCC Capacity Development signed	PDF	English	UNICEF, June 2021	Recommendation to finance a project for expansion of OSCC capacity development
Risk Factors and Intervention	Power Point	Mixed Thai & English	No author, undated	Presentation, limited notes, unclear
Thailand Child Shield for Global CP Bulletin	Word	English	No author, undated	One-page article: 'Thailand: development of a child protection surveillance and case management information system in health sector'
ความคืบหน้าโครงการประเมินความเสี่ยงเด็ก [Child Risk Assessment Project Progress]	PDF	Thai	No author, undated	
โครงการคัดกรอง และ IT [Screening and IT Projects]	PDF	Thai	No author, undated	
ประชุมคณะกรรมการ 24 ก.ย. 2562 [Board of Directors Meeting 24 Sep 2019]	Power Point	Thai	No author, undated	
สรุปผลการวิเคราะห์ข้อมูลผู้ที่ถูกรังแกรุนแรงเพื่อหาปัจจัยเสี่ยง [Summary of data analysis of victims of violence to determine risk factors]	PDF	Thai	Office of Inspector General, Health District 8, Office of Health District 8, Government Inspectorate, 2018	
01ขอหน่วยกิจนักสังคมสงเคราะห์ ฉบับแก้ไข [01Ask for the Social Welfare Unit, revised edition]	PDF	Thai		Scanned on government (?) letterheaded paper; request for capacity development for PLH
02รายงานการประชุม คกก. Parent Education 25 พย 63 02 [Minutes of the meeting of the Parent Education Committee 25 Nov 63]	PDF	Thai	25 November 2020	Scanned PDF
สรุปผลการดำเนินงานโครงการเพื่อพัฒนาระบบการเฝ้าระวัง ติดตาม และบำบัดรักษา ผู้ใช้ที่ถูกกระทำรุนแรง ระยะที่สอง [Summary of project results to develop surveillance, monitoring and treatment systems The victims of violence, the second phase]	PDF	Thai	No author, undated	
Minutes of the Meeting of the	PDF	Thai	23 July 2021	Scanned PDF

Description	Type of document	Language	Author, date	Key issues
Parent Education Committee				
Briefing PLH-YC 2021	PDF	Thai	UNICEF and University of Oxford	Two-page briefing in Thai
Evaluation of an evidence-based parenting intervention for violence prevention embedded within the Thai public health system	Power Point	English	UNICEF and University of Oxford	PowerPoint in PDF format presenting results of evaluation
INSPIRE Digital Transform of Parenting for Lifelong Health (PLH) for Young Children	Power Point	English	Chanvit Tharatep, undated	Introduces e-PLH as a digital platform that is part of Child Shield that can be used to deliver PLH during COVID-19
Designing Parenting Programmes for Violence Prevention: A Guidance Note	PDF	English	UNICEF, May 2020	Global guidance
Parenting for lifelong health for young children (PLH-YC) in Thailand	PDF	English	MoPH, UNICEF, and University of Oxford, draft 3 August 2020	Brochure; evidence of effectiveness three months after the end of the programme
Parenting for lifelong health for young children (PLH-YC) in Thailand	PDF	Thai	MoPH, UNICEF, and University of Oxford, draft 3 August 2020	Brochure; evidence of effectiveness three months after the end of the programme
Parenting for lifelong health for young children (PLH-YC) in Thailand: Policy Brief	PDF	English	UNICEF and University of Oxford, draft 22 July 2020	
Parenting for lifelong health for young children (PLH-YC) in Thailand: Policy Brief	PDF	Thai	UNICEF and University of Oxford, draft 22 July 2020	
Preventing Violence Against Children in the Home: Summary of the Lessons Learned from Positive Parenting Programmes in East Asia and the Pacific	PDF	English	UNICEF East Asia and Pacific Regional Office, 2019	Regional evidence paper
Scale-up Planning Workshop PLH-YC	Power Point	Thai	UNICEF and University of Oxford, 29 April 2020	
Briefing Primero 2021	PDF	Thai	No author, undated	One page
INSPIRE Primero	Power Point	Mixed Thai& English		Presentation on Primero business process
MoPH Request for Primero Support	PDF	Thai	MoPH, November 2018	Scanned PDF on government letterheaded
Open Fn Platform & Security	Power Point	English	No author, undated	Technical briefing
องค์ความรู้ในการทำงานของศูนย์พิทักษ์เด็ก(OSCC) กระทรวงสาธารณสุข [Knowledge of the work of Ng Dai Center (OSCC), Ministry of Public Health]	Power Point	Thai	Worapat Saengkaew Pathum Thani Hospital	
Primero Innovation Case Study	PDF	English	UNICEF, November 2019	The innovation case examined in this report concerns the development of Primero as a strong example of UNICEF

Description	Type of document	Language	Author, date	Key issues
				leveraging its unique position in the market as a facilitator to foster inter-agency coordination and collaboration that was essential to enable improvements in case management for child protection services globally
Signed Primero Agreement Health Region 8	PDF	Mixed Thai and English	MoPH and UNICEF, December 2021	

Annex C Research guide

The research guide is an annex to both the inception report and the Ethical Review Board submission. It is provided in a separate file.

Annex D Child protection concepts

Through Child Shield, Primero, and OSCC Capacity Development on Case Management and PLH, the Government of Thailand and UNICEF are investing in the components of the wider child protection system in Thailand. Here we briefly describe our understanding of how public health, case management, child protection MISs, and parenting programmes, which are foundational child protection concepts, contribute to the development of the child protection system.

Child protection systems

The emphasis on developing and strengthening child protection systems marks a shift away from issue-based programming. The child protection systems-strengthening approach seeks to protect all children across the humanitarian-development-peace nexus. In contrast to the fragmentation resulting from an issue-based approach to child protection, a systems approach can be more 'efficient, comprehensive, inclusive, and sustainable' (UNICEF, 2021f).

Defined originally as a 'set of laws, policies, regulations and services needed across all social sectors...to support prevention and response to protection-related risks (UNICEF, 2008), UNICEF expanded the concept of child protection systems in 2012 to include 'certain formal and informal structures, functions and capacities that have been assembled to prevent and respond to violence, abuse, neglect, and exploitation of children' (UNICEF, 2012).

The child protection system categorises services into three types:

- primary prevention;
- secondary prevention; and
- tertiary response.

The tertiary response often includes specialised services, which necessitates legislative and policy mandates and adequately resourced and monitored services.

A child protection system comprises seven components, as identified in UNICEF's latest Child Protection Strategy (Figure 8) (UNICEF, 2021c). For any child protection system to work effectively, each part and its relation to other components requires strengthening.

Figure 8: Components of a child protection system

Child Protection System Components

Source: UNICEF (2021) Child Protection Strategy 2021 - 2030



The role of public health in child protection systems

The prevention of, and response to, violence against and abuse of children has traditionally been seen as the responsibility of social services and the justice system. However, if we view violence as a disease, the harm to victims when they are children and the lasting effects of this into adulthood can also be considered a public health emergency. A May 2016 World Health Assembly resolution endorsed the first ever WHO Global Plan of Action on strengthening the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children (WHO, 2016).

Health professionals are first responders when violence occurs but are also in a unique position in that they have regular and continued access to children and families, especially during the early years. There is emerging evidence that screening for childhood abuse in primary care settings is an effective mechanism to prevent and respond to child protection risk (Shakil *et al.*, 2018; Ellonen *et al.*, 2019; Chen *et al.*, 2022). Screening refers to the application of a test in relation to all individuals in a defined population to identify cases and offer interventions. Screening can also contribute to surveillance, by monitoring incidence and prevalence data that can be useful for resource allocation. The quality of screening tools for child protection surveillance has yet to be conclusively evaluated, including for discrimination and bias based on ethnicity, gender, and disability.

Screening programmes can incorporate big data analytics in order to contribute to public health prevention programmes. 'Big data' (a collection of data that is huge in volume and is expanding at a steady and rapid rate, that can be mined for information) are increasingly being used in the health sector to make faster and more informed decisions, although this is not without challenges (Ma, 2022). There are conflicting views on how big data predictive analytics can effectively contribute to the identification of risk without bias. Predictive models can be subject to human bias, which can translate into algorithmic and analysis bias, based on the data that are chosen and how they are used. There is also a risk when previous marginalisation serves as a proxy for future risk, and this can perpetuate longstanding inequities. Social bias in algorithms can result in discrimination against vulnerable groups (Norori *et al.*, 2021).

Despite this, screening in public health programmes is a valuable paradigm for prevention and for

targeted response.

Child protection case management

Child protection case management is the process of helping individual children and families through providing direct social work type support, and information management. Child protection case management focuses on the child needing protection from violence, abuse, neglect, and exploitation. The purpose of child protection case management is to provide children with an optimal response 'at the time of their greatest vulnerability' (Department of Children and Youth, 2017).

Case management systems are guided by several critical principles:

- Do no harm.
- Prioritise the best interests of the child.
- Ensure non-discrimination.
- Adhere to ethical standards.
- Seek informed consent and/or informed assent.
- Respect confidentiality.
- Ensure accountability.
- Empower children and families to build upon their strengths (strengths-based approach).
- Base all actions on sound knowledge of child development, rights, and protection.
- Facilitate meaningful participation of children.
- Provide culturally appropriate processes and services.
- Coordinate and collaborate among agencies.
- Maintain professional boundaries and address conflicts of interest.
- Observe mandatory reporting laws and policies.

While MSDHS plays a lead role in the child protection system in Thailand, professionals and service providers in various fields have an equally crucial role to play within the system. A multi-sectoral approach to case management allows for individualised assessment and tailored referrals to required services outside of the leading case management agency. The competent officer managing a case thus leverages the services of key professionals for the child. This also allows for the added benefit of collaboration, shared communication, and case conferencing.

The case management process consists of sequential steps being taken when providing case management services. A robust case management system is essential, but equally important is the mechanisms of identification. At present, child protection cases in Thailand are identified via two broad channels: OSCC and MSDHS (Children's Reception Homes and Hotline 1300). Evidence suggests that only the most severe cases get reported at these levels.

In Thailand, case management steps include:

1. intake (registration);
2. fact-finding and assessment;
3. case planning;
4. plan implementation, and referrals to services;
5. follow-up; and
6. case closure.

These steps are implemented by the competent officer appointed under Thailand's Child Protection Act of 2003. Child protection case management is intended for *all* children in need, regardless of their

nationality and the availability of civil registration documents.

Child protection MISs

The management of information and the use of technology has provided considerable benefits and brought about considerable improvements in relation to the delivery of social development programmes. The ability to use innovative approaches to collect, process, analyse, report, and integrate data results in greater efficiency, effectiveness, accountability, and transparency of child protection systems, and is facilitated by a child protection management information system (CP-MIS) that can range from a largely paper-based system to a highly digital solution. Although the CP-MIS does not need to be fully computerised – there are many child protection systems that rely on paper- and Excel-based processes³¹ – the more digital or computerised it is, the higher the chance that the system is more transparent, contains more checks and balances, and is more efficient.

An effective CP-MIS should aspire to have the following key attributes:

- **Process-centric.** The CP-MIS should be designed based on the operational processes of the relevant programme, including the case management steps and workflow functionality to deliver the child protection case management. The CP-MIS user interface and experience should correspond with (and seamlessly mimic where possible) the operational delivery processes, provide a guiding template for the tasks required by system users, and enable tracking of the workflow status of the case record. In other words, the system should be driven by clear processes and events, rather than simply by reporting requirements.
- **End-to-end data integration and audit.** Information systems that handle large amounts of management information are best served through the digitisation of end-to-end processes, to maintain data integrity. For information systems supporting child protection, integration with the digital health ecosystem and identification systems provides an opportunity to validate and authenticate individual child details where appropriate and necessary. For example, data would be collected and validated through an automated process based on the channels from which the child protection case has originated. Once the data are entered into the CP-MIS – automatically or by manual data entry – there should be an audit record of any changes made to the data items. Some solutions that require interoperability between systems take data offline for validation, deduplication, aggregation, or other transformation (i.e. to process database changes). This mechanism inadvertently exposes the MIS and programme to errors, risks, and data integrity issues.
- **Robust security model and a tiered access architecture.** Standards and protocols for data security, protection, and privacy are imperative for information systems supporting child protection, due to the sensitive nature of the information maintained for child protection cases. CP-MIS solutions should provide tiered security and role-based access for users, including responsibility-based and position- (data ownership) based rules for secured data access. It is also imperative that data are secure (i.e. encrypted) during transmission when integrating the CP-MIS with external systems and databases.
- **Scalability through parameterisation.** Many social programmes start with pilot interventions before scaling up for additional coverage and interventions and associated functionality. The CP-MIS should be able to scale up with limited supported from the IT application software development team. A good level of parameterisation of the administrative and reference data items enables the CP-MIS administrators to support expansion of the programme.
- **Principles for Digital Development (PDD).** UNICEF has endorsed the PDD as a guidance framework for applying digital technologies to development programmes, including for CP-MISs. UNICEF was in fact a part of the stakeholder group that founded the PDD and the principles have also been

³¹ An example is the case management forms for the Integrated Social Protection Services programme, managed by the Department of Social Welfare, Myanmar.

informed by UNICEF’s Innovation Principles of 2009.^{32,33} Table 15 presents some key highlights regarding the PDD’s potential application to information systems supporting child protection in Thailand.

Table 15: Application of PDD to CP-MISs in Thailand

Principle	CP-MIS context
Design with the user	Develop context-appropriate solutions that are informed by users’ priorities and needs, including ensuring that the design is sensitive to and considers the needs of the vulnerable and marginalised children of Thailand, including those with disabilities, and those affected by conflict and disaster.
Understand the existing ecosystem	Ensure that the CP-MIS solutions align with existing technological, legal, and regulatory policies, and coordinate with other relevant actors working on the same issues, including the National ID system, the HISs, and how information management is decentralised to sub-national administrative levels.
Design for scale	Plan and design for scale from the start, especially when first implementing a pilot of the systems. Scalability options and opportunities should be considered through the operating model, including consideration of technology choices, the funding model, the institutional setup, and the strengthening of capacities.
Build for sustainability	CP-MIS solutions looking to implement a sustainable model should invest in local information technology providers, engage local governments, and integrate with national systems and strategies in programming.
Be data-driven	Design the CP-MIS to ensure the child protection case record can be analysed and measured for impact. Create a data-use and assessment culture through capacity building of data analytics efforts.
Use Open Standards, Open Data, Open Source, and Open Innovation	Adopt and apply open standards for data integration and case management programming. Share non-sensitive data – once data privacy needs are addressed – to enable innovation. Avoid proprietary software in favour of open source software that emphasises portability. Choose appropriate service providers, to prevent vendor lock-in and promote local adoption of the solution.
Reuse and improve	The use of Primero as an existing technology platform for CP-MIS that can be adapted to the local context demonstrates the use of existing technology solutions. The integration of the National ID system and data sharing with the HIS also involves reusing the data and framework that are used in the local geography and context. The CP-MIS should be developed with modular and interoperable design approaches, as opposed to standalone solutions.
Address privacy and security	The CP-MIS needs to promote the best interests of the child and associated stakeholders whose data are collected. Informed and customised data consent will need to be designed and obtained before the data are collected. Primero adheres to the ‘privacy by design’ principles that prioritise the rights of data subjects throughout the product development life cycle.
Be collaborative	The CP-MIS processes and data cuts across stakeholders, from MoPH and MSDHS to the Ministry of Interior, Ministry of Justice, and UNICEF, among various others. The design and development of the CP-MIS should engage and work across sector silos in order to foster more coordinated and holistic approaches.

Parenting programmes for child protection

‘Parenting programmes are broadly defined as a set of activities or services aimed at improving how parents approach and execute their role as parents, specifically their parenting knowledge, attitudes, skills, behaviours, and practices’ (UNICEF, 2020b, p. 10).

³² Source: <https://digitalprinciples.org/about/>

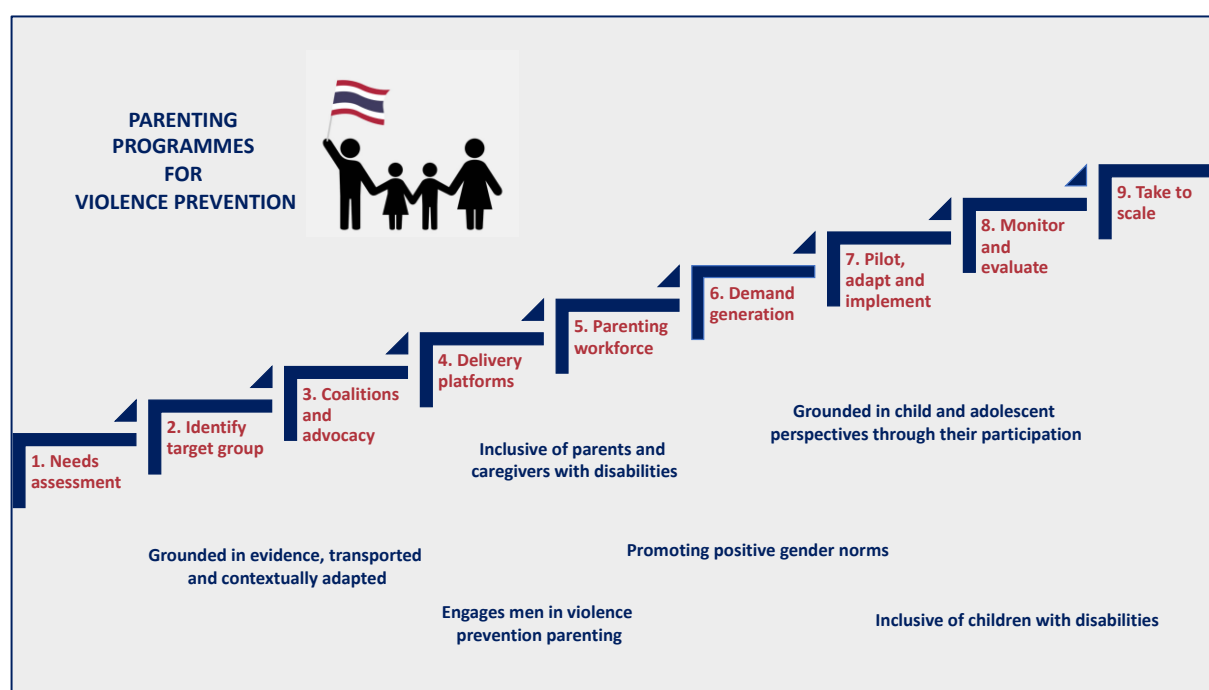
³³ Extensive guidance on the design and development of digital solutions applying the PDD is available at <https://digitalprinciples.org/>

The widely endorsed *INSPIRE Handbook: Action for Implementing the Seven Strategies for Ending Violence Against Children* (WHO, 2018) describes how parenting programmes that support parents and caregivers to reduce harsh parenting practices can comprise several types of group and individual approaches:

- community interventions that target all parents and contribute to changing social norms and societal support for non-violent discipline;
- programmes focused on children in families where a risk of violence or actual violence is identified;
- home-visiting programmes for parents of infants and young children; and
- multi-layered approaches involving one or more interventions.

Drawing on a wide range of global evidence, UNICEF describes nine steps in designing and implementing a parenting programme for violence prevention, which require designers to be aware of several underpinning focus areas (Figure 9) (UNICEF, 2020b).

Figure 9: Designing and delivering effective violence prevention parenting programmes



Source: Authors, adapted from UNICEF (2020b).

Annex E ToC and results chain

An initial ToC for each component of the CP Joint Initiatives was constructed based on the documentation provided by UNICEF. Consequently, a revised results chain was proposed by UNICEF at the outset of the data collection phase. During the field data collection phase, in combination with and against the background of extensive UNICEF documentation, a joint ToC for the integrated CP Joint Initiatives was devised (Chapter 2.2). This incorporates Child Protection Programme outcomes and Country Programme outcomes, and was developed against the background of the global ToC for child protection case management (mHelp/Health Enabled, 2016).

Child Shield

A review of the existing documentation for the CP Joint Initiatives provides an overview of the current operating model for Child Shield (Table 16).³⁴

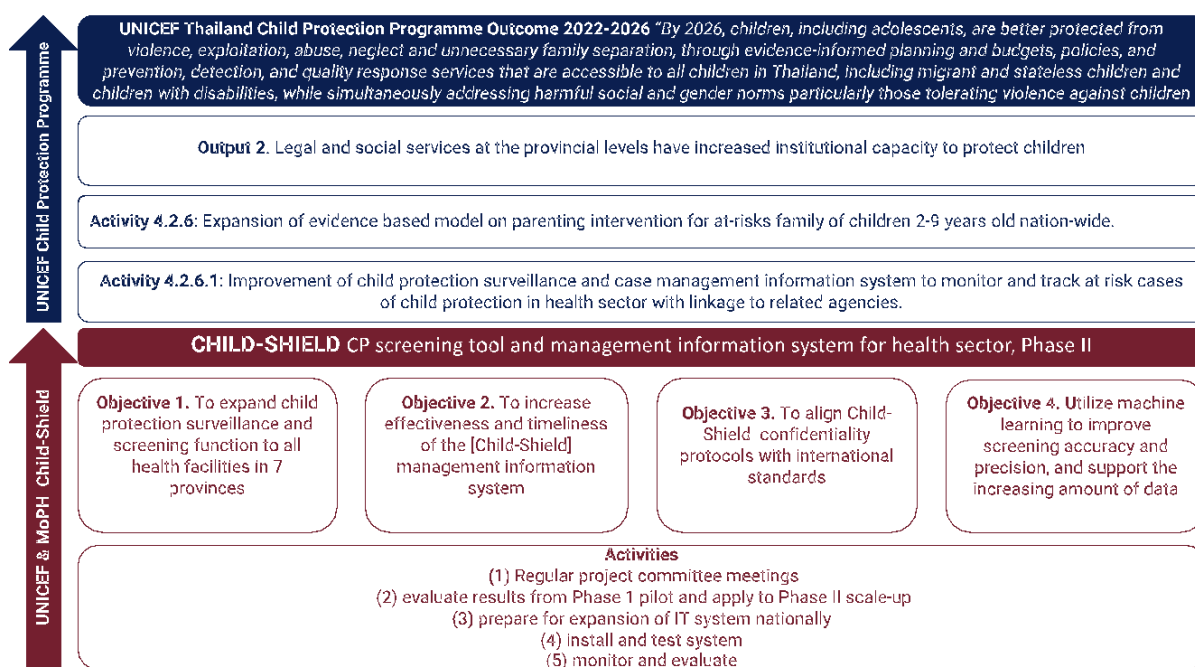
Table 16: Operating model for Child Shield

Current state review: Child Shield	
Objective	To implement a surveillance and primary and secondary prevention system for child protection. The Child Shield system was designed to screen and track children and families at risk of violence, exploitation, abuse, and neglect, in order to organise preventative action.
Coverage/ roll-out	Health Region 8 provinces: <ul style="list-style-type: none"> • Udon Thani (Phase 1 roll-out – all hospitals). • Sakon Nakhon (Phase 1 roll-out – all hospitals). • Remaining provinces rolled out in second phase (2020–2021) for data screening but limited case management function.
Process overview diagram	<p>The diagram, titled 'The Child Shield Eco-system', illustrates the process flow and feedback loops. At the top, three boxes are connected to the main flow: 'Monitor and Screen for Risks' (pointing to 'Community'), 'Recommend course of actions – effective interventions' (pointing to 'Risk Identified'), and 'Record results so failure will not be repeated – Monitor to prevent further abuses' (pointing to 'Victimized/Offended'). The main flow consists of four boxes: 'Community' (blue), 'Risk Identified' (orange), 'Victimized/Offended' (red), and 'Seriously Harmed (Hospitalized) – entered Criminal Justice System' (dark grey). Below this flow, there are two feedback loops: a green one for 'Intervention – to prevent harm from occurring' (from 'Risk Identified' back to 'Community') and a red one for 'Rehabilitation – to ensure that the child can return to society' (from 'Victimized/Offended' back to 'Community'). At the bottom, two boxes describe failures: 'Failure in detection resulting in the child being harmed – recorded so failure will not be repeated' (with a red arrow from 'Community' to 'Victimized/Offended') and 'Failure in intervention resulting in the child being harmed – recorded so failure will not be repeated' (with a red arrow from 'Risk Identified' to 'Victimized/Offended').</p>
Functional components	<p>Component A: Child-focused database and data integration</p> <p>This component will maintain the data and integration services for Child Shield.</p> <ul style="list-style-type: none"> • Database: MongoDB (a noSQL database program).

³⁴ Sources: Tharathep and Tharathep (n.d.) (documentation provided by UNICEF); ChildShield Specifications ENG.doc (documentation provided by UNICEF).

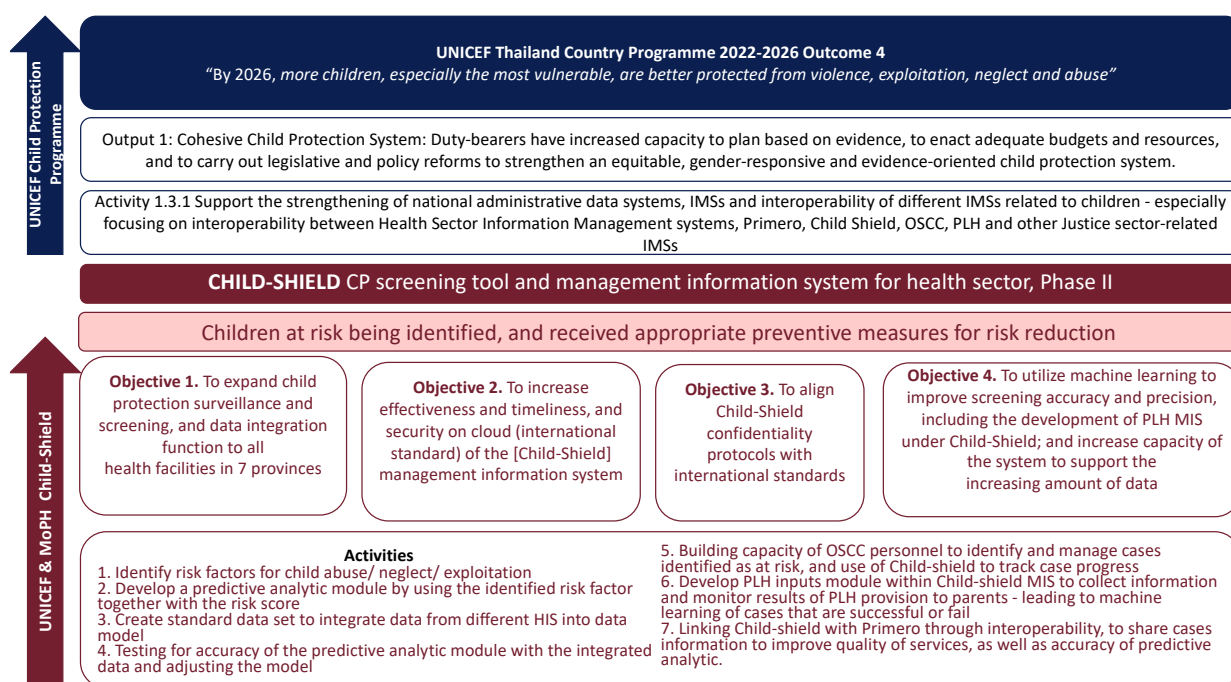
Current state review: Child Shield	
	<ul style="list-style-type: none"> ○ Database entity of personal child data records. ● Integration: <ul style="list-style-type: none"> ○ Health services (hospital information system): API (real time) with NodeJS scripts. ○ Child Shield application component: the Central MongoDB database to facilitate integration via webservice. <p>Component B: Child Shield application The information system is the central application and functionality layer for surveillance, monitoring, and prevention in regard to children at risk of violence.</p> <ul style="list-style-type: none"> ● Key functions/modules: <ul style="list-style-type: none"> ○ Child and Family Focus. ○ Case Manager and Team (Professional view for ChildShield2). ○ Support Parent Education Support. <p>Component C: Risk case predictive system Employs machine learning concepts to improve the accuracy of the screening model to identify children at low, medium, and high risk, and to support linkages back to the Child Shield application for surveillance, monitoring, and prevention in respect of children at risk of violence. Machine learning concepts and functions generally use one or more of the following categories of rules-based algorithms to perform computational tasks at scale:</p> <ul style="list-style-type: none"> ● Recommendation: Data entities are selected based on past examples with similar characteristics where a successful selection was made. ● Matching: Data entities are selected based on a set of characteristic or value matches through the review of the dataset. ● Scoring: Data entities are selected based on a percentage tolerance or congruence with a set of matching characteristics or values. <p>It is currently unclear what the method of machine learning algorithms are applied by the risk case predictive system.</p>
Infrastructure	Application hosting: Regional centre cloud server.
Resourcing and capacity	To be reviewed and expanded upon during the project.

Figure 10: Ex post facto constructed results chain for Child Shield



Source: Authors.

Figure 11: Ex post facto results chain for Child Shield shared by UNICEF in response



Source: UNICEF.

Primero

UNICEF has supported the adaptation and implementation of the CPIMS+/Primero platform for the Ministry of Public Health with case management services for the child protection response. Project implementation documentation has been provided for review and informs the following high-level

summary of the Primero solution (Table 17).³⁵

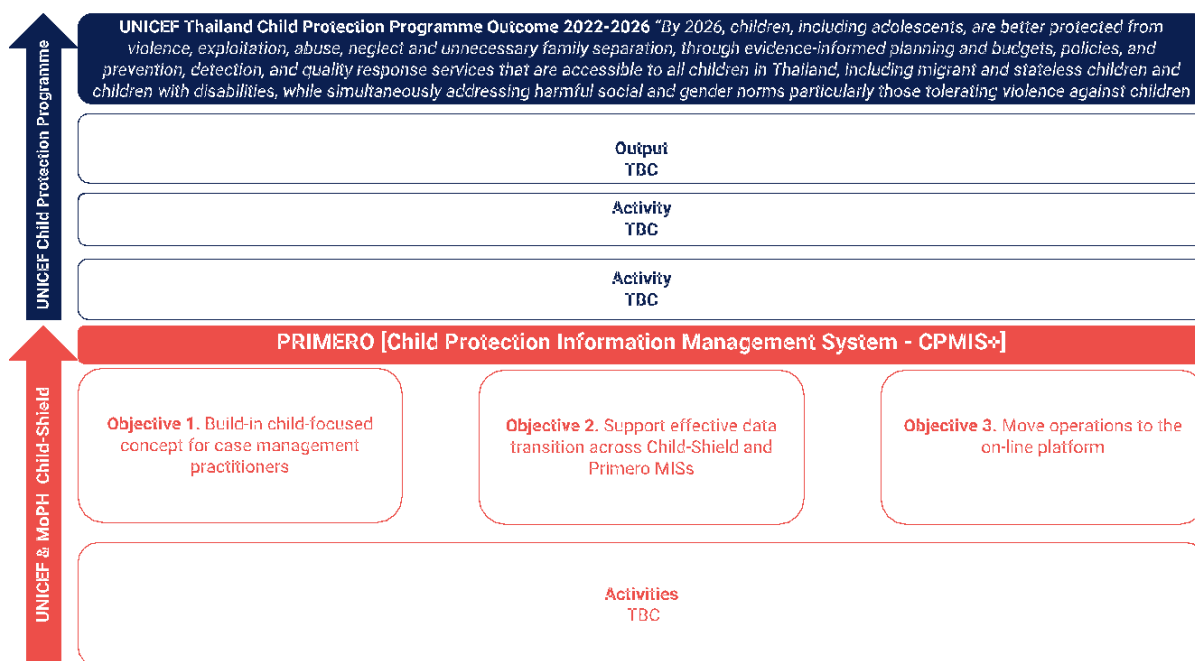
Table 17: Operating model for Primero

Current state review: Primero	
Objective	<p>To digitise and implement child-focused case management for the child protection response system.</p> <p>Primero is a health-centric child protection case management system that is used to manage registration, assessment, interventions, referrals, and closure. Primero also manages interoperability with Child Shield to provide case management services for identified at-risk children. Primero facilitates interoperability with the hospital information system for the exchange of patient data.</p>
Coverage/roll-out	<p>Initial pilot phase (2021): one hospital – Udon Thani Hospital in Udon Thani.</p> <p>Second phase (2022): two hospitals – Ban-Dung Hospital and Nong-Han Hospital (both in Udon Thani).</p> <p>Further expansion to extend to other hospitals in Health Region 8 (as per Child Shield coverage).</p>
Process overview diagram	<p style="text-align: center;">แผนภูมิแสดงเส้นทางการใช้งาน User Journey Diagram</p> <p>The diagram illustrates the user journey for the Primero system. It starts with a 'Vulnerable Child' who is registered at a 'Hospital'. The Hospital is connected to the 'HIS' (Hospital Information System) and the 'Primero' system. The flow involves 'Registration', 'Assessment', 'Intervention', and 'Closure' within the Primero system. A 'Referral' step is also shown. Data exchange includes 'National ID' and 'Patient Information' between the Hospital and HIS, and 'National ID' between the Hospital and Primero.</p>
Functional components	<p>Module: Case management</p> <p>This module will enable the management of the case workflow and the creation of new cases. Key information areas include the following:</p> <ul style="list-style-type: none"> • Case record: Identifies the case and status. • Registration: consent; patient identification; patient education and career; department identification; perpetrator details; incident details. • Assessment: preliminary assessment; physical assessment; health assessment; social assessment: unexpected pregnancy; age evaluation; conclusion. • Case plan. • Follow-up. • Transfer and refer cases to internal and external agencies • Referral of cases to the competent officer, in compliance with the Child Protection Act 2003. • Child Shield information. • Case closure. <p>User types:</p> <ul style="list-style-type: none"> • Case worker.

³⁵ Source: Primero Implementation Plan – Thailand Rollout (2020 – 2021). Documentation provided by UNICEF.

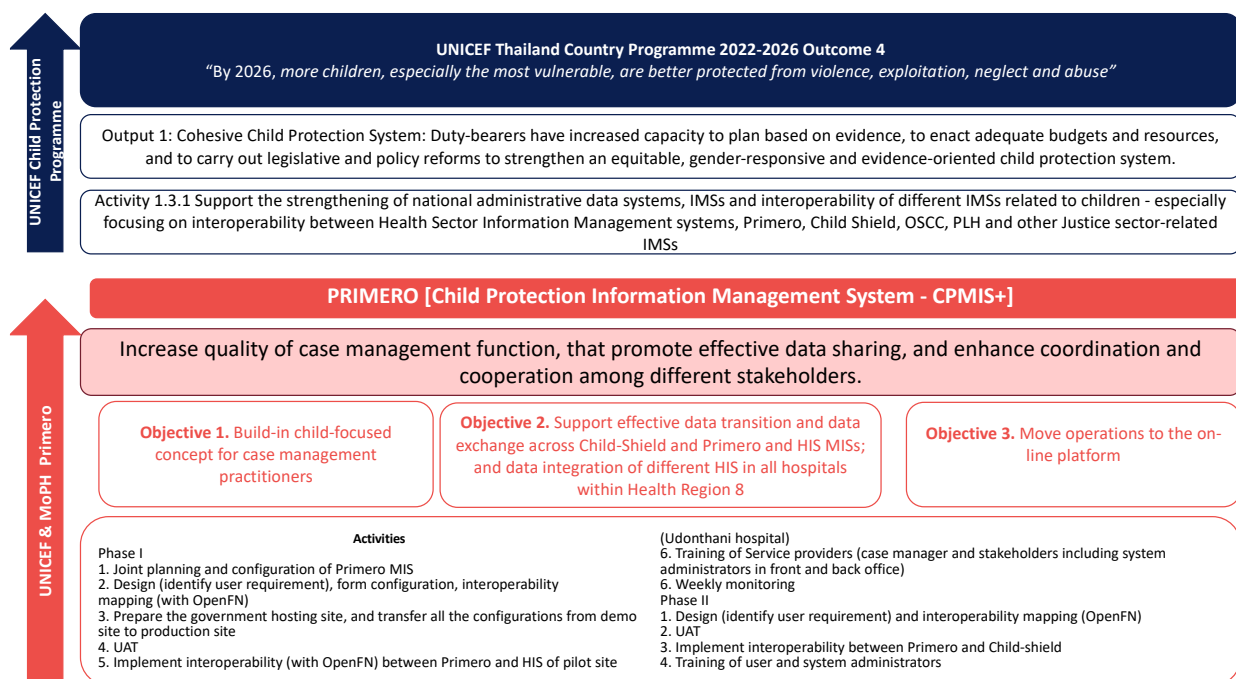
Current state review: Primero	
	<ul style="list-style-type: none"> • Child protection manager / coordinator. • National administrator. Dashboard monitoring and reporting.
Infrastructure	Local infrastructure hosting: Government data centre and cloud server.
Resourcing and capacity	Current plan for 30 end-users to support the roll-out within one province. Primero System Administrators (MoPH): two users. UNICEF in-country deployment support: Two focal points/analysts + three deployment leads. Training materials: <ul style="list-style-type: none"> • Case Worker and Supervisor User Guide. • System Administrator User Guide. • System Administrator Configuration Guide. Training videos

Figure 12: Ex post facto constructed results chain for Primero



Source: Authors.

Figure 13: Ex post facto results chain for Primero shared by UNICEF in response



Source: UNICEF,

Key project activities/tasks undertaken for the design, testing, and implementation of the Child Shield and Primero systems as an integrated CPIMS solution include the following:³⁶

1. Identifying risk factors for child abuse/neglect/exploitation.
2. Developing a predictive analytic module by using the identified risk factor together with the risk score.
3. Creating a standard dataset to integrate data from different HIS into the Primero data model.
4. Testing the accuracy of the predictive analytic module with the integrated data and adjusting the model.
5. Building the capacity of OSCC personnel to identify and manage cases identified as at risk, and to use Child Shield to track case progress.
6. Developing the PLH inputs module within the Child Shield MIS to collect information and monitor the results of PLH provision to parents – leading to machine learning of cases based on successful or failed results.
7. Linking Child Shield with Primero through implementing interoperability, to share cases information in order to improve the quality of services, as well as the accuracy of predictive analytics

OSCC capacity development

Child protection is identified as one of five focus areas under UNICEF Thailand’s Country Programme (2022–2026). Acknowledging the inadequacy of the available social service workforce capacity, the programme seeks to strengthen that workforce using data and evidence. The social service workforce includes ‘paid and unpaid, governmental and non-governmental, professionals and para-professionals, working to ensure the healthy development and well-being of children and families’ (UNICEF, 2019a). Capacity building is key for strengthening the social service workforce, particularly in the ‘prevention, detection and referral capacities of caregivers, children and communities’ (UNICEF, 2022b).

PLH is an initiative led by the WHO, UNICEF, and the universities of Oxford, Bangor, Cape Town, and Stellenbosch. It focuses on positive parenting for low-income and at-risk families identified through a screening process. The PLH approach seeks to develop and test ‘a suite of effective, freely available,

³⁶ Source: UNICEF project team, via feedback on the inception report.

culturally relevant, and scalable parenting programmes to reduce the risk of violence against children and improve child wellbeing in low- and middle-income countries' (UNICEF and University of Oxford, 2020).

The initiative on OSCC capacity development in regard to case management and PLH addresses Outputs 4.2 and 4.4 respectively of the 2017–2021 Strategic Note for Child Protection (UNICEF, 2017b):

Output 4.2: Legal and social services at the provincial levels have increased institutional capacity to protect children.

Output 4.4: Families have increased awareness of the risks and consequences of violence, abuse, neglect, and exploitation of children, and of existing services.

Under the CP Joint Initiatives, capacity building was targeted towards health personnel at the sub-national level: in particular, the staff at the OSCCs. Staff were trained on case management, adaptation, and delivery of the PLH intervention. These initiatives were implemented between 2018 and 2021, in all seven provinces under Health Region 8. Key activities included the following:

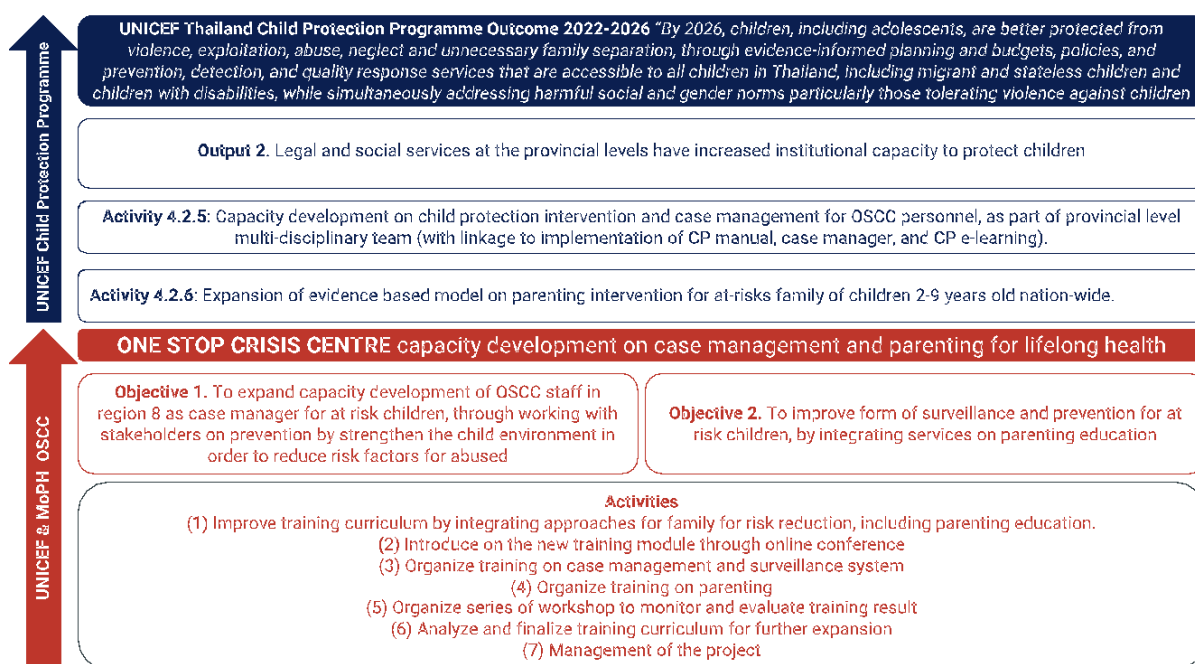
- March 2018 – October 2019: Development of a curriculum and capacity on child protection for health personnel (Phase 1).
- June 2020 – January 2022: Development of a curriculum and capacity on child protection for health personnel (Phase 2).
- March 2018 – April 2020: Feasibility study on an evidence-informed parenting intervention to prevent violence against young children by parents and primary caregivers in Thailand.

The feasibility study was managed by the Department of Social Policy and Intervention at the University of Oxford and the Mahidol-Oxford Tropical Medicine Research Unit in Bangkok, in partnership with MoPH and Udon Thani Provincial Public Health Office. PLH focuses on families with children between two and nine years of age, with the curriculum delivered across eight sessions. The feasibility study was conducted in three steps:

1. Formative evaluation based on interviews and FGDs with 26 respondents.
2. Feasibility pilot with 60 low-income families (including interviews with 11 parents/caregivers, and eight FGDs with facilitators between November 2018 – April 2019).
3. Randomised control trial conducted between May 2019 and January 2020, with 120 participating families.

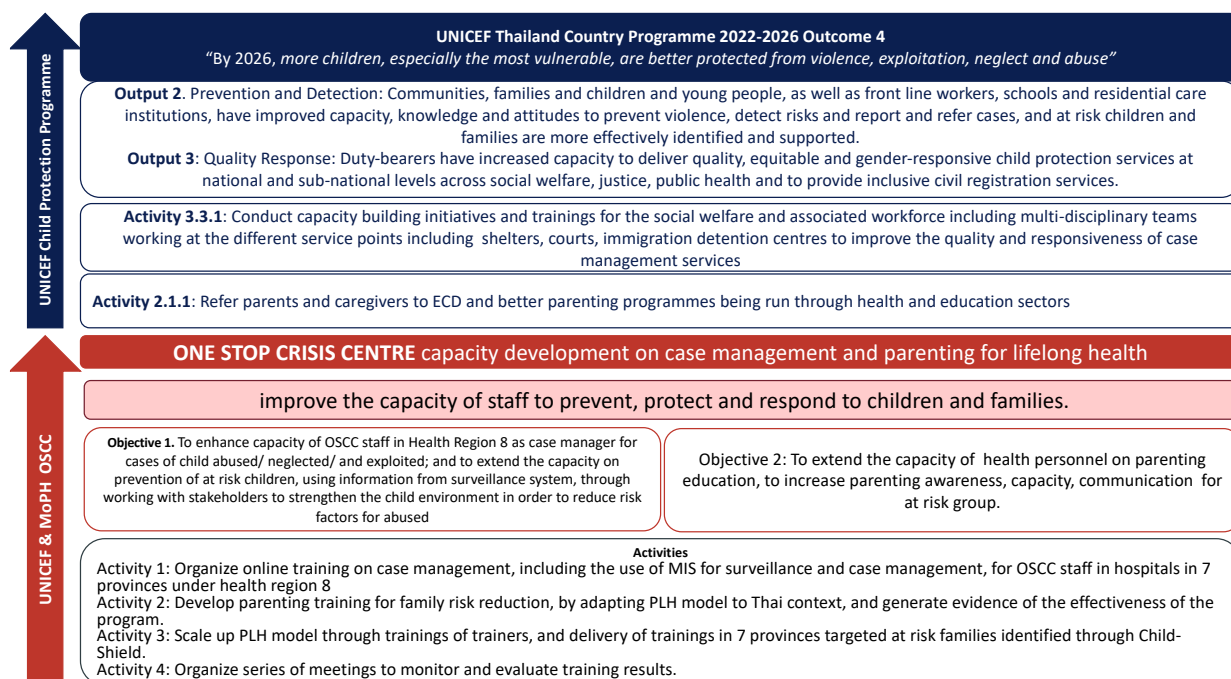
The feasibility pilot was delivered by eight facilitators from the public health sector, over a span of eight weeks, and showed promising results, including reductions in overall abuse. The randomised control trial was delivered at four health promotion hospitals and used follow-up assessments at the three- and six-month post-intervention marks to draw its conclusions. The results showed a reduction in child maltreatment by 58%, in abusive and harsh parenting by 44%, in parent mental health problems by 40%, and in child behaviour problems by 60%.

Figure 14: Ex post facto constructed results chain for OSCC Capacity Development



Source: Authors.

Figure 15: Ex post facto results chain for OSCC shared by UNICEF in response



Source: UNICEF.

Annex F Evaluation matrix

Criteria	Evaluation questions	Sub-questions*	Indicators	Methods of data collection	Data sources	Approach to data analysis
Relevance	To what extent do the objectives and the design of the interventions respond to Thailand’s context and environment? Do they align with the government’s, especially MoPH’s, policy framework and priorities, and to global standards and UNICEF priorities?	<ul style="list-style-type: none"> • What is the main challenge and issue currently faced by Thai society regarding child protection? • What is the evidence underlying the design of the pilot? • Why were these pilot initiatives designed and implemented? • Were the objectives of the pilot initiatives (Child Shield/Primer/PLH) in line with the challenges/problems faced? 	The pilot initiatives are aligned with the policy and priorities of the Government of Thailand, as well as with global standard and UNICEF priorities.	<ul style="list-style-type: none"> • Project document review. • Interviews with national stakeholders. 	<ul style="list-style-type: none"> • Project documents. • Thailand Government policies and priorities. • Global standards and UNICEF priorities. • Evaluation respondents (interview notes). 	Qualitative data analysis
	Is there a clear intervention logic with sound theories of change?	<ul style="list-style-type: none"> • How was the ToC followed or used during the pilot implementation? • Did the given input produce the planned output? • Did deviation/variation occur? Why? 	Inputs, activities, and outputs in the programme logic are clearly arranged, interconnected, and easy to follow.	<ul style="list-style-type: none"> • Project document review. • Interviews with national and sub-national stakeholders. 	<ul style="list-style-type: none"> • Project documents. • Evaluation respondents (interview notes). 	Qualitative data analysis
	Was the intervention designed in ways that responded to the needs of intended beneficiaries?	<ul style="list-style-type: none"> • Did the design of the interventions address the needs of children and women at risk of violence and abuse? How? • Did the design of the interventions also address the needs of OSCC staff in terms of building their capacity? How? • Is Primer configured for and adapted to the Thailand context? 	Pilot initiatives are designed based on the needs of the intended beneficiaries.	<ul style="list-style-type: none"> • Project document review. • Interviews with national and sub-national stakeholders. • Interviews and FGDs with community and family members. 	<ul style="list-style-type: none"> • Project documents. • Evaluation respondents (interview and FGD notes). 	Qualitative data analysis

Criteria	Evaluation questions	Sub-questions*	Indicators	Methods of data collection	Data sources	Approach to data analysis
	To what extent were gender and social inclusion considerations built into the design (e.g. for the inclusion of women and children with disabilities, people from ethnic minorities, non-Thai people)?	<ul style="list-style-type: none"> • Did the pilot design take into account gender and social inclusion? • How was the pilot designed to realise that inclusion? • Have barriers to inclusion been overcome? If so, have they been permanently removed or are they likely to return? • Was there any clear process and procedure to ensure inclusion? 	Gender and social inclusion are well explained in the pilot design, with clear processes and procedures.	<ul style="list-style-type: none"> • Project document review. • Interviews with national and sub-national stakeholders. • Interviews and FGDs with community and family members. 	<ul style="list-style-type: none"> • Project documents. • Evaluation respondents (interview and FGD notes). 	Qualitative data analysis
Coherence	To what extent are synergies and interlinkages developed across the different joint initiatives (between Primero, Child Shield, and PLH)?	<ul style="list-style-type: none"> • How did the synergy between initiatives take place? • Did the three initiatives connect to each other? • Did the three initiatives complement each other? In what way? • Did the pilot overlap with or duplicate other initiatives? • How do the MISs of Child Shield and Primero link to each other (OpenFn) and the broader health and child protection information management (CPIS) ecosystem at the regional and national levels? 	There are synergies and linkages between the three initiatives implemented.	<ul style="list-style-type: none"> • Project document review. • Interviews with national and sub-national stakeholders. • Observation. 	<ul style="list-style-type: none"> • Project documents. • Project data. • Evaluation respondents (interview notes). 	Mixed method analysis
	To what extent is the pilot implementation coherent with other government initiatives, to achieve optimal utilisation of available resources?	<ul style="list-style-type: none"> • Are there other initiatives that have the same objectives as this pilot initiative, in terms of using tools and monitoring services for children and women who are at risk? 	The pilot initiative is carried out through coordination and harmonisation with other government initiatives.	<ul style="list-style-type: none"> • Project document review. • Interviews with national and sub-national stakeholders. 	<ul style="list-style-type: none"> • Project documents. • Project data. • Evaluation respondents (interview notes). 	Mixed method analysis

Criteria	Evaluation questions	Sub-questions*	Indicators	Methods of data collection	Data sources	Approach to data analysis
		<ul style="list-style-type: none"> • Did the pilot include complementarity, harmonisation, and coordination with others? • Was there a shared use of resources? How? • Can data sharing across multiple systems be carried out properly? 		<ul style="list-style-type: none"> • Observation. 		
Effectiveness	To what extent have the initiatives achieved the expected results?	<ul style="list-style-type: none"> • What were the targets to be achieved by the pilot? • What benefit has the pilot provided to children, women, and families? What benefit has it provided for social workers? • What changes/improvements have taken place as a result of pilot implementation? • Have at-risk children and families identified by Child Shield received services to reduce their risk? • Has OSCC capacity development and PLH helped improve the capacity of staff to prevent violence, and respond to children and families? 	<ul style="list-style-type: none"> • Pilot targets achieved. • Improved situation of children and women at risk of violence and abuse. • Improved capacity of social workers. 	<ul style="list-style-type: none"> • Project document review. • Interviews with national and sub-national stakeholders. • Interviews and FGDs with community and family members. • FGDs with social workers. 	<ul style="list-style-type: none"> • Project documents. • Project data, such as target of child protection screening, cases recorded, case management timeline, # of trainings, # of parents attending PLH, etc. • Evaluation respondents (interview and FGD notes). 	Mixed method analysis
	Which were the most decisive factors that determined the achievement or non-achievement of the intended results?	<ul style="list-style-type: none"> • What are the factors that influenced the successful implementation of the pilot? • What are the factors that hindered the pilot's implementation? • Are these related to human resources, time, or cost/budget? 	The pilot can take advantage of supporting factors to ensure the implementation of its activities.	<ul style="list-style-type: none"> • Project document review. • Interviews with national and sub-national stakeholders. 	<ul style="list-style-type: none"> • Project documents. • Project data. • Evaluation respondents (interview notes). 	Mixed method analysis

Criteria	Evaluation questions	Sub-questions*	Indicators	Methods of data collection	Data sources	Approach to data analysis
		<p>Are all of these resources available adequately?</p> <ul style="list-style-type: none"> • What has been the quality and utility of the resources used under the pilot? 				
	<p>What was the user experience of the Child Shield and Primero systems? Has user feedback led to any changes?</p>	<ul style="list-style-type: none"> • Did the Child Shield/Primero system make it easier to identify children and women who are at risk? • Was the system easy to use by the parties involved? • What percentage of cases can be better recorded using the Child Shield/Primero system? Was there an improvement compared to the situation without the Child Shield/Primero system? • Did this also speed up the process of providing case management to affected people? 	<p>Child Shield and Primero data and information system facilitates improvement of screening and case management.</p>	<ul style="list-style-type: none"> • Project data and documents. • Interviews with sub-national stakeholders. • Observation of Child Shield/Primero MIS. 	<ul style="list-style-type: none"> • Project documents. • Project data. • Evaluation respondents (interview and observation notes). 	<p>Mixed method analysis</p>
Efficiency	<p>To what extent have the pilot initiatives been delivered in a financially responsible and timely manner?</p>	<ul style="list-style-type: none"> • How well are inputs being converted into outputs? • Who is involved in the pilot implementation at each level, and in particular on the ground? • How much funds were allocated for the pilot? Were they adequate? • Were the pilot initiatives (or specific activities) worth the money spent? 	<p>Pilot maximises resources spent to improve the situation of children and women who are at risk.</p>	<ul style="list-style-type: none"> • Project data and documents. • Interviews with sub-national stakeholders. 	<ul style="list-style-type: none"> • Project documents. • Project data. • Evaluation respondents (interview and observation notes). 	<p>Mixed method analysis</p>

Criteria	Evaluation questions	Sub-questions*	Indicators	Methods of data collection	Data sources	Approach to data analysis
		<ul style="list-style-type: none"> Has there been any delay in the programme implementation? 				
	Are the MISs interoperable with each other and with MoPH MISs, with the capacity to generate standard and comparable disaggregated data (age, gender, disability, ethnicity, location)?	<ul style="list-style-type: none"> How were child data collected and tracked through HIS, Child Shield, Primero, and OSCC operations? How did integration between systems take place? Are the data in the system disaggregated? 	The data and information systems used in the pilot are interoperable with each other and also with the MIS within the government.	<ul style="list-style-type: none"> Review of project data and documents. Interviews with sub-national stakeholders. Observation of Child Shield/ Primero MIS. 	<ul style="list-style-type: none"> Project documents. Project data. Evaluation respondents (interview and observation notes). 	Mixed method analysis
Sustainability	To what extent can the activities continue after UNICEF withdraws?	<ul style="list-style-type: none"> What mechanisms have been put in place to guarantee sustainability once this project support is over? What challenges are foreseen in regard to sustaining the programme? Has MoPH been committed to these initiatives? Has MoPH also put resources into them? What follow-up/support has been provided by MoPH? Is the support it has provided (both technical and financial) sufficient? 	Child Shield, Primero, and PLH activities can be sustained, even without support from UNICEF.	<ul style="list-style-type: none"> Review of project data and documents. Interviews with national and sub-national stakeholders. 	<ul style="list-style-type: none"> Project documents. Project data. Evaluation respondents (interview notes). 	Mixed method analysis
	To what extent can the activities be scaled up to other areas?	<ul style="list-style-type: none"> What are the preconditions for scale-up (laws, policies, structures, staff, funding, procedures, monitoring and reporting systems, training etc)? 	Child Shield, Primero, and PLH activities can be scaled up to other areas.	<ul style="list-style-type: none"> Review of project data and documents. Interviews with national and sub- 	<ul style="list-style-type: none"> Project documents. Project data. Evaluation respondents (interview notes). 	Mixed method analysis

Formative Evaluation of the Implementation of the MoPH-UNICEF Pilot Child Protection Joint Initiatives (Thailand)

Criteria	Evaluation questions	Sub-questions*	Indicators	Methods of data collection	Data sources	Approach to data analysis
		<ul style="list-style-type: none"> • What are the preconditions for sustainability? • Can this be provided by the Thai Government? • What needs to be modified or strengthened to allow for a nationwide scale-up (including institutional framework and political will)? 		national stakeholders.		

Note: Please also see Annex G, Annex H, Annex I, and Annex J for further sub-questions posed during data collection.

Annex G Semi-structured interview guide – professionals

For each interview with national and provincial stakeholders, we will start by asking them to provide their consent, using the text set out below.

Hello, my name is _____. My colleague’s name is _____. We are part of a team conducting a series of interviews on behalf of UNICEF and the Ministry of Public Health to find out more about the Pilot Joint Child Protection Initiatives – Child Shield, Primero, and OSCC Case Management and Parenting for Lifelong Health.

This is important, to make sure that the initiatives are ready for scale-up so that more children and families can benefit. We have assessed that there is minimal risk to you from participating.

Thank you for agreeing to take part in this interview. Before proceeding, we want to make sure that you understand there is no obligation for anyone to speak to us if they do not want to, and you may freely choose not to answer questions, or to end the interview at any time you wish. Your personal contributions and views will not be shared with anyone else in a way that can identify you. In other words, everything you discuss today will be treated in complete confidence. When the evaluation is finalised, we will transfer the data in an anonymised form to UNICEF (no names or geographic location), and we will delete them from all our devices.

However, if during an interview a person discloses that they or someone else has been subject to harm or abuse (physical, mental, or sexual), mandatory reporting is required in line with Thailand’s Child Protection Act Section 29. We understand that local social workers involved in the pilot initiatives are trained to respond appropriately to reports of child protection violations in a manner that should not expose you or the other person/child to further risk. This applies to all the respondents that we meet with.

With your permission, we will make written notes and may record the discussion so that we can summarise it in writing after the meeting. The audio will be deleted after the evaluation is completed and only the anonymised summary will be saved.

It is also our intention to cause minimum disruption to your day and we will do everything we can not to interfere with normal activities. The discussion should take between 30 minutes and one hour. We may also request any documents you think will help to improve our understanding of the situation.

We will ask you to give your verbal consent to proceed. We will also give you a copy of this Informed Consent Form to take away with you. It will have the contact details of a researcher in case you have any questions.

Do you have any questions for me? Is it ok to proceed?

Verbal consent provided: Yes/no

We will also record data about each respondent in the following format.

UNICEF, national and provincial governments, Primero vendor (or government supervisors) etc.									
Location:		Date:		Name of interviewers:			Method (online, phone, face-to-face):		
Key informant name	Key informant designation	Key informant gender (male; female; non-binary; prefer not to answer)	Age 18–64, 65+	Does the key informant have a disability/difficulty functioning?					
				Vision	Hearing	Mobility	Cognition	Self-care	Communication

Note for researchers: The questions below should guide your interview. Your role as interviewer is important as you will have to ensure that only relevant questions are asked (for example, if the interviewee is a Primero data administrator you may not ask questions related to underlying design etc.) and that follow-up questions and probes are asked based on the answers provided by the respondent. The guide identifies the key questions for each type of respondent, which may be adjusted.

Criteria		Question list			
		UNICEF	Nat government	Prov government	Vendors
Relevance	<p>Alignment with the policy framework/priorities:</p> <ul style="list-style-type: none"> What is the main challenge and issue currently faced by Thailand society regarding child protection? What is the evidence underlying the design of the pilot? Why were these pilot initiatives designed and implemented? Were the objectives of the pilot initiatives (Child Shield/Primero/PLH) in line with the challenges/problems faced? Is there an overarching programme logframe for the three initiatives, with defined activities, outputs, outcomes, and detailed indicators, baseline, and targets? 	X	X		
	<p>Respond to the needs of intended beneficiaries:</p> <ul style="list-style-type: none"> Did the design of the intervention address the needs of children and women who are at risk of violence and abuse? How? Did the design of the intervention also address the needs of OSCC staff in terms of building their capacity? How? How was the theory of change followed or used during the pilot implementation? 			X	
	<p>Considerations built into the design:</p> <ul style="list-style-type: none"> How was the Child Shield algorithm developed and by whom? What criteria does it rely on? What are the cut-off points for low-, medium-, and high-risk cases? How was the inclusion of certain groups (including women and children with disabilities, people from ethnic minorities, migrants, and non-Thai people) considered in the design of the pilot initiatives? 	X			X
Coherence	<p>Compatibility of pilot initiatives:</p> <ul style="list-style-type: none"> Did the pilot develop synergies and interlinkages between the different joint initiatives (between Primero, Child Shield, and PLH) and with the case management system for child protection developed by the Ministry for Social Development and Human Security (for local administrative organisations and Child and Family Centres)? Did these three initiatives complement each other? Were there any inconsistencies? 	X	X	X	
	<p>Linkages with other government initiatives:</p> <ul style="list-style-type: none"> Were there any programme/project/initiatives similar to this pilot? Is there a possibility of duplication? 	X	X	X	

Criteria	Question list	UNICEF	Nat government	Prov government	Vendors
	<ul style="list-style-type: none"> Were there any programmes/projects that could be used to support this pilot implementation? Did the pilot include complementarity, harmonisation, and coordination with these other programmes/projects? How do the MISs of Child Shield and Primero link to each other and the broader health and child protection information management ecosystem at the regional and national levels? 				
Effectiveness	<p>Achievement of the expected results:</p> <ul style="list-style-type: none"> How many cases have been opened and closed? What is the median length of time a case remains open? What is the average caseload for an OSCC social worker? How do communities and families perceive Child Shield? Is it a good thing? Why? Is it a bad thing? Why? How responsive is the child protection system? How long does it take for the case to be identified and interoperable across systems? Have at-risk children and families identified by Child Shield received services to reduce their risk? How? How has OSCC capacity development/training and PLH helped improve the capacity of staff to prevent and respond to children and families? What capacity factors influence the achievement of outcomes – availability of appropriately qualified and experienced personnel, delivery of training and mentoring programmes, access to adequate infrastructure and resources (equipped office, including ICT, working internet, transport etc.)? Is there any unintended effect from the implementation of the pilot? Was this identified at the time of design? In your opinion, what are considered to be the successes of the pilot implementation? 	X		X	
	<p>Influencing factors:</p> <ul style="list-style-type: none"> What has been challenging during the implementation of the pilot? How did the pilot overcome this? Were there any changes in implementation from the plan? Why did these changes occur? Were these changes recorded? Where and how were they recorded? Which were the most decisive factors that determined the achievement or non-achievement of the intended results? What was the user experience of Child Shield and Primero systems like? Did user feedback lead to any changes? 	X		X	X
Efficiency	<p>Economic/financial efficiency:</p> <ul style="list-style-type: none"> What inputs (funds, expertise, time, etc) have been spent for this pilot's implementation? Were the human and financial resources used as planned and appropriately, and fully utilised (or were resources misallocated, budgets underspent/overspent)? Were resources redirected as needs changed? Were risks managed? Were decisions taken which helped to enhance efficiency in response to new information? 	X			

Criteria	Question list	UNICEF	Nat government	Prov government	Vendors
	<ul style="list-style-type: none"> Can the desired results be achieved within the expected timeframe? Were there any delays? 				
Sustainability	<p>Capacity and inclusion:</p> <ul style="list-style-type: none"> Does interoperability between HIS and Primero deliver value? Are the system MISs interoperable, with capacity to generate standard and comparable disaggregated data? Are the personal details stored and shared in the different systems appropriately secured and in line with the Personal Data Protection Act? If the pilot commits to reaching specific groups (including women and children with disabilities, people from ethnic minorities, migrants, and non-Thai people), are sufficient resources allocated and justified to do this successfully? 	X		X	X
	<p>Enabling environment:</p> <ul style="list-style-type: none"> What mechanisms are put in place to guarantee sustainability once this project support is over? What are the challenges that are foreseen in regard to sustaining the programme? 	X	X		
	<p>Scale up:</p> <ul style="list-style-type: none"> Can the pilot initiatives be scaled to other provinces outside Health Region 8? What are the preconditions for doing so? Are there sufficient human and technological resources to enable the Government of Thailand to maintain, adapt, enhance, and scale the child protection systems? Are the different initiatives designed and developed based on standardised approaches to ensure a consistent approach and service? Are the current information management functions and services appropriately documented and transparent, to ensure they can be replicated? 	X	X		
	<p>Continuity and sustainability</p> <ul style="list-style-type: none"> In your opinion, are the pilot initiatives likely to continue after UNICEF withdraws? What needs to be prepared by you or other institutions so that this can continue to be implemented? 	X	X	X	

Annex H FGD guide

H.1 FGD guide – strength and weakness analysis

Objective:

- To understand the real needs of social workers and the challenges faced in providing services to children and women at risk of being, or currently being, abused.
- To understand their experiences and perspectives about capacity-building programmes provided to them as part of the pilot initiatives.
- To understand their experiences and perspectives relating to Child Shield, Primero, and the PLH system.

Participants: OSSC staff and social workers.

Method: Strengths and weaknesses analysis. This is a quick icebreaker to familiarise the pilot programme staff and social workers with the research and the evaluation matrix, as well as to ask them to score their programme on its strengths and weaknesses, and to reflect on what went well and what did not. This scoring will enable the researcher to ask further probing questions about the strengths of the pilot programme and what the challenges that led to its weaknesses were.

Materials required: A medium-sized table and six to eight chairs (according to the number of participants). Chart paper and a marker to draw the strengths–weaknesses line. Cards or post-its for participants to write their opinions down on. A notebook and pen will be needed for the note-taker to record the discussion as it develops.

Time required: 1–1.5 hours.

Description of the activity

Step 1. Setting the activity. Facilitator asks the participants to sit around a table and places the materials on the table.

Step 2. Introduction. The consent and research objectives are introduced (using the format below). The activity of the FGD is explained: that is, to understand from the participants’ point of view the strengths and weaknesses of the pilot initiatives. After the introduction, the role of the researcher is minimal, with the research participants taking a leading role in the discussion. The researcher will facilitate discussion and ensure that one person does not dominate the discussion.

Hello, my name is _____. My colleagues’ names are _____. We are part of a team conducting a series of discussions on behalf of UNICEF and the Ministry of Public Health to find out more about the Pilot Joint Child Protection Initiatives – Child Shield, Primero and OSCC Case Management, and Parenting for Lifelong Health.

This is important, to make sure that the initiatives are ready for scale-up so that more children and families can benefit. We have assessed that there is minimal risk to you from participating.

Thank you for agreeing to take part in this discussion.

Before proceeding, we want to make sure that you understand there is no obligation for anyone to speak to us if they do not want to, and you may freely choose not to answer questions, or to end the interview at any time you wish. Your personal contributions and views will not be shared with anyone else in a way that can identify you. In other words, everything you discuss today will be treated in complete confidence. When the evaluation is finalised, we will transfer the data in an anonymised form to UNICEF (no names or geographic location), and we will delete them from all our devices. We also ask that you don’t share anything that is discussed today with

people who haven't been part of the group.

However, if during the discussion a person discloses that they or someone else has been subject to harm or abuse (physical, mental, or sexual), mandatory reporting is required in line with Thailand's Child Protection Act Section 29. We understand that local social workers involved in the pilot initiatives are trained to respond appropriately to reports of child protection violations in a manner that should not expose you or the other person or child to further risk. This applies to all the respondents that we meet with.

With your permission, we will make written notes and may record the discussion so that we can summarise it in writing after the meeting. The audio will be deleted after the evaluation is completed and only the anonymised summary will be saved.

It is also our intention to cause minimum disruption to your day and we will do everything we can not to interfere with normal activities. The discussion should take between 30 minutes and one hour.

We will ask you to give your verbal consent to proceed. We will also give you a copy of this Informed Consent Form to take away with you. It will have the contact details of a researcher in case you have any questions.

Do you have any questions for me? Is it ok to proceed?

Verbal consent provided: Yes/no (please record above).

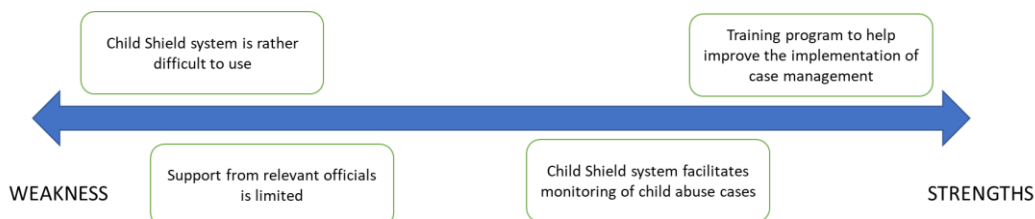
Step 3. Ask participants to introduce themselves and the note-taker to record this in the following format.

Name of FGD facilitator:		Date of FGD:		Location:					
FGD respondent #	Gender (Female, male, non-binary, prefer not to answer)	Age 18-64, 65+	Verbal consent Y/ N	Does the respondent have a disability/ difficulty functioning?					
				Vision	Hearing	Mobility	Cognition	Self-care	Communication
1									
2									
3									
4									
5									
7									
8									

Method of FGD (online, phone, face-to-face):

Step 4. Exercise. Draw a line from one end of the chart paper to the other, with 'STRENGTHS' written on one end and 'WEAKNESSES' written on the other. OSCC staff/social workers are asked to write their opinion on a card/post-it and place it on the chart paper, with the stronger cards closer to the left and weaker cards closer to the right. The majority must agree on the final arrangement. If there are disagreements, this should be noted.

Arrange cards along different points on this continuum. Example of the strengths and weaknesses line:



Step 5. Once participants have arranged the cards, the researcher must ask them to justify their

arrangement, with the note-taker taking notes during the conversation. Ask the team why they may have scored certain criteria as strong and others as weak. Go over each of the criteria and ask the questions below. Please note that the questions serve as a guide, and that the process of arranging the cards should help facilitate discussions and elicit answers to most of these questions. Steps 1–4 need to be completed in around 30–45 minutes to allow time to move on to discussion using the follow-up questions below.

Step 6. Follow-up questions after exercise.

- What are the challenges you face in carrying out your child protection duties as OSCC staff /social workers (understanding the process and forms, enough time, no feedback, how to close a case, enough resources, access to transport, other)?
- What evidence was the pilot based on? How was it designed to address the challenges?
- What written documentation on planning and implementation does the programme have? Did you find this useful or not – why?
- Were you involved in designing the pilot programme or training programme? If yes, in what way?
- How has OSCC capacity development/training and PLH helped improve the capacity of staff to prevent violence against and respond to children and families?
- How did the programme work and engage with the community? Which elements with the community were engaged?
- Did you receive support from or engage with other institutions/parties in implementing pilot activities to support the community, family members, and affected children/women? Who are they and what are their roles?
- How did the programme work with, and engage with, the government? Which government institutions/departments were engaged?
- In your opinion, what are considered to be the successes of the pilot implementation?
- What plans does the programme have for scale-up?
- What plans does the programme have in place for it to continue after UNICEF support is over?
- Have the pilot activities been replicated? How?
- Have the pilot activities proven to be effective in different contexts (geography, society, etc.?)

H.2 FGD guide – matrix scoring exercise

Objective:

- To understand their experiences and their perceptions of challenges or barriers in raising children.
- To understand their experiences and their perceptions of the benefits from the pilot initiatives.

Participants: Community or family members, organised separately.

Method: Matrix scoring exercise, to understand the opinions of community and family members by asking them in a group to score the programme/activities against the various indicators.

Materials required: A piece of chart paper with the matrix scoring format given below. A marker for the group to mark a score. You can also use pebbles to indicate the score. A notebook and pen will be needed to for the note-taker to record the discussion as it develops.

Time required: 1–1.5 hours.

Description of the activity

Step 1. Setting the activity: Facilitator asks the participants to sit in a circle in a casual setting.

Step 2. Introduction. The consent and research objectives are introduced (using the format below). The activity of the FGD is explained: that is, to understand from the participants' point of view the challenges, barriers, and experiences encountered in raising their children, and their participation in the pilot implementation. The facilitator may need to explain the details of the pilot implementation. The researcher will facilitate the discussion and ensure that no single person dominates the discussion.

Hello, my name is _____. My colleagues' names are _____. We are part of a team conducting a series of discussions on behalf of UNICEF and the Ministry of Public Health to find out more about the Pilot Joint Child Protection Initiatives – Child Shield, Primero, and OSCC Case Management and Parenting for Lifelong Health.

This is important, to make sure that the initiatives are ready for scale-up so that more children and families can benefit. We have assessed that there is minimal risk to you from participating.

Thank you for agreeing to take part in this discussion.

Before proceeding, we want to make sure that you understand there is no obligation for anyone to speak to us if they do not want to, and you may freely choose not to answer questions, or end the interview at any time you wish. Your personal contributions and views will not be shared with anyone else in a way that can identify you. In other words, everything you discuss today will be treated in complete confidence. When the evaluation is finalised, we will transfer the data in an anonymised form to UNICEF (no names or geographic location), and we will delete them from all our devices. We also ask that you don't share anything that is discussed today with people who haven't been part of the group.

However, if during the discussion a person discloses that they or someone else has been subject to harm or abuse (physical, mental, or sexual), mandatory reporting is required in line with Thailand's Child Protection Act Section 29. We understand that local social workers involved in the pilot initiatives are trained to respond appropriately to reports of child protection violations in a manner that should not expose you or the other person or child to further risk. This applies to all the respondents that we meet with.

With your permission, we will make written notes and may record the discussion so that we can summarise it in writing after the meeting. The audio will be deleted after the evaluation is completed and only the anonymised summary will be saved.

It is also our intention to cause minimum disruption to your day and we will do everything we can not to interfere with normal activities. The discussion should take between 30 minutes and one hour.

We will ask you to give your verbal consent to proceed. We will also give you a copy of this Informed Consent Form to take away with you. It will have the contact details of a researcher in case you have any questions.

Do you have any questions for me? Is it ok to proceed?

Verbal consent provided: Yes/no (please record above).

Step 3. Ask the participants to introduce themselves, and the note-taker to record this in the following format.

Name of FGD facilitator:		Date of FGD:		Location:					
FGD respondent #	Gender (Female, male, non-binary, prefer not to answer)	Age 18–64, 65+	Verbal consent Y/ N	Does the respondent have a disability/ difficulty functioning?					
				Vision	Hearing	Mobility	Cognition	Self-care	Communication
1									
2									
3									
4									
5									

7									
8									
Method of FGD (online, phone, face-to-face):									

Step 4. Matrix scoring exercise 1. Exercise 1 starts with jointly listing what factors make it difficult for parents to raise children. The facilitator writes each factor on a coloured card and puts it on a flipchart. (It is allowed for the facilitator to mention a factor that has emerged during previous FGDs but that should not be mentioned yet here.) The participants can then decide if they find it relevant or not. If at least one person finds it relevant, it should be added. There will probably be around 10 factors mentioned. Then write the factors down on a flip chart that already has a matrix and put it down on the ground or on a table. Give each participant in the group a number of pebbles or other small items (the same number of pebbles as the number of factors listed) and ask them to divide them between the factors that apply most to them.

Step 5. Discussion of the scoring. Count the pebbles and discuss one by one the three factors that have received the most pebbles.

- Why are they important? What happens exactly?
- What do they do if they encounter that difficulty – for example, if children break the rules, what do they do and why?
- What do they really need to solve the problem?

Step 6. Matrix scoring exercise 2. The exercise then continues to discuss what the participants consider changed/improved after being involved in PLH or case management activities. The facilitator does the same as is set out under Step 3 above: writes down the changes in the matrix and distributes the pebbles according to the number of identified changes. Ask participants to divide the pebbles between the changes that apply most to them.

Step 7. Discussion of the scoring. Count the pebbles and discuss one by one the three factors that have received the most pebbles.

- Why are they important? What happened exactly, after they were involved in PLH or case management?
- What benefits do they feel the most?
- Will this affect their child-rearing process?
- What, if anything, do they think could be done better?

Annex I Semi-structured interview guide – family members

For each interview with a family member, we will start with asking the individual to provide consent, using the below text.

Hello, my name is _____. My colleagues’ names are _____. We are part of a team conducting a series of discussions on behalf of UNICEF and the Ministry of Public Health to find out more about the Pilot Joint Child Protection Initiatives – Child Shield, Primero, and OSCC Case Management and Parenting for Lifelong Health.

This is important, to make sure that the initiatives are ready for scale-up so that more children and families can benefit. We have assessed that there is minimal risk to you from participating.

Thank you for agreeing to take part in this discussion.

Before proceeding, we want to make sure that you understand there is no obligation for anyone to speak to us if they do not want to, and you may freely choose not to answer questions, or to end the interview at any time you wish. Your personal contributions and views will not be shared with anyone else in a way that can identify you. In other words, everything you discuss today will be treated in complete confidence. When the evaluation is finalised, we will transfer the data in an anonymised form to UNICEF (no names or geographic location), and we will delete them from all our devices. We also ask that you don’t share anything that is discussed today with people who haven’t been part of the group.

However, if during the discussion a person discloses that they or someone else has been subject to harm or abuse (physical, mental, or sexual), mandatory reporting is required in line with Thailand’s Child Protection Act Section 29. We understand that local social workers involved in the pilot initiatives are trained to respond appropriately to reports of child protection violations in a manner that should not expose you or the other person or child to further risk. This applies to all the respondents that we meet with.

With your permission, we will make written notes and may record the discussion so that we can summarise it in writing after the meeting. The audio will be deleted after the evaluation is completed and only the anonymised summary will be saved.

It is also our intention to cause minimum disruption to your day and we will do everything we can not to interfere with normal activities. The discussion should take between 30 minutes and one hour.

We will ask you to give your verbal consent to proceed. We will also give you a copy of this Informed Consent Form to take away with you. It will have the contact details of a researcher in case you have any questions.

Do you have any questions for me? Is it ok to proceed?

Verbal consent provided: Yes/no (please record above).

Respondent data will be recorded in the following format.

Family member							
Location:	Date:	Name of interviewers:			Method (online, phone, face-to-face):		
KI gender: (Male, female, non-binary, prefer not to answer)	Age: 18–64, 65+	Does the key informant have a disability/difficulty functioning?					
		Vision	Hearing	Mobility	Cognition	Self-care	Communication

In the in-depth interview with the family member, we will ask the following questions:

- Tell us about your experience of Child Shield/PLH? How did you hear about it? How well was it explained? Did you have a chance to say no/to refuse to participate?
- What happened after the Child Shield screening? Were you selected for more interventions? What were these interventions (case management, PLH, other?) Were you told why you were selected? Did you get the services that you were selected for?
- If you weren't selected for more interventions after the screening, were you told why you weren't selected?
- From your personal point of view, what part of being involved was the most positive for you and your child/children?
- From your personal point of view, what was the part of being involved that could have been done better?
- Is there anything else you would like to tell us that would help make the Child Shield/PLH experience better for other families in the future?

Annex J Observation guide

Observation will start with obtaining consent, as set out below.

Hello, my name is _____. My colleagues' names are _____. We are part of a team conducting a series of discussions on behalf of UNICEF and the Ministry of Public Health to find out more about the Pilot Joint Child Protection Initiatives – Child Shield, Primero, and OSCC Case Management and Parenting for Lifelong Health.

This is important, to make sure that the initiatives are ready for scale-up so that more children and families can benefit. We have assessed that there is minimal risk to you from participating.

Thank you for agreeing to take part in this discussion.

Before proceeding, we want to make sure that you understand there is no obligation for anyone to speak to us if they do not want to, and you may freely choose not to answer questions, or to end the interview at any time you wish. Your personal contributions and views will not be shared with anyone else in a way that can identify you. In other words, everything you discuss today will be treated in complete confidence. When the evaluation is finalised, we will transfer the data in an anonymised form to UNICEF (no names or geographic location), and we will delete them from all our devices. We also ask that you don't share anything that is discussed today with people who haven't been part of the group.

However, if during the discussion a person discloses that they or someone else has been subject to harm or abuse (physical, mental or sexual), mandatory reporting is required in line with Thailand's Child Protection Act Section 29. We understand that local social workers involved in the pilot initiatives are trained to respond appropriately to reports of child protection violations in a manner that should not expose you or the other person or child to further risk. This applies to all the respondents that we meet with.

With your permission, we will make written notes and may record the discussion so that we can summarise it in writing after the meeting. The audio will be deleted after the evaluation is completed and only the anonymised summary will be saved.

It is also our intention to cause minimum disruption to your day and we will do everything we can not to interfere with normal activities. The discussion should take between 30 minutes and one hour.

We will ask you to give your verbal consent to proceed. We will also give you a copy of this Informed Consent Form to take away with you. It will have the contact details of a researcher in case you have any questions.

Do you have any questions for me? Is it ok to proceed?

Verbal consent provided: Yes/no (please record above).

Systems assessment

Observation Guide – Information systems to support Child Protection in Thailand

The operating model for health-centric child protection case management require the capture, processing, sharing and reporting of sensitive data across multiple systems and stakeholders and analysis to facilitate the end-to-end operational objectives. The following guiding questions and the adjacent observation notes will assess the efficiency and effectiveness of the digital solutions, processes, capacity and the central and local level operating models.

Introduce yourself and the reason for the demo or meeting / Explain the aims of the assessment (to understand more about their operational processes supported by digital solutions for Child Protection) / Explain that the session should take 30 - 40 minutes / Explain that you will be writing-recording answers so you can analyse everyone's answers / Ask if they have questions before you start...

A. Stakeholder details

Name:		Date: _____
Designation:		Time: _____
Institution:		Conducted by : _____ (initials)
Contact details:	Email / Telephone...	Sections to complete: _____

Institution Type and Administrative Level:

- | | |
|---|--|
| <input type="checkbox"/> Government Health Facility / Hospital
<input type="checkbox"/> Other Government
<input type="checkbox"/> National level
<input type="checkbox"/> Hospital or Community Location | <input type="checkbox"/> Non-Government Organization / Private
<input type="checkbox"/> Donors / Development Partners
<input type="checkbox"/> Provincial Level
<input type="checkbox"/> Other: _____ |
|---|--|

Overview and background details of current role / operations / programme:

Scope of work / team details...
Operational objectives...

How do you engage with and support child protection in your role? Specifically, how do you engage with children and their data?

Geographic coverage:

Systems assessment

B. Operations Focus

This section is to be completed for users that operate child protection systems at the local level (i.e., OSCC / hospital).

1. Systems used : Please also detail any Government systems that they use for other purposes (outside of child protection)

2. Operational processes:

Services provided / target group:
Do they explain the different risks types / severity?

Child Shield
 Primero
 HIS
 View / manage cases
 Supervisory role

End to end processes:
Ask them to list processes and keep a record to correspond with demo Delivery mechanism for services (incl. who, how, frequency, etc.)

Does it follow the child protection ACT and other regulatory policies?

Is the system inclusive and responsive for all cases? Are there scenarios where the system does not process the case and thus must be managed offline / manually?

3. Demo Observations

Demonstrate a thorough understanding of the end-to-end workflow processes?
 Demonstrate a thorough understanding of the different risk scenarios?

STATUS (or other key category/identifier role) values: _____
 Are there appropriate STATUS values for each record?

What are the supervisory and approvals processes and mechanisms?

Exceptions handling Process overrides Flag and alert supervisors

Does the user receive notifications/alerts when required to work on a case?
 Can refer a case (where: _____)

Once Referred:
 - What information is recorded: _____
 - How are case updates and progress (status) maintained: _____

What are the expected timelines based on risk category or other criteria?
 Can prioritise work Delegate Delay alerts/notification Lock case Stop-Archive

Are process events are auto-scheduled (pre-defined process rules)? If Yes: _____

Can they create a Child Care Plan (or similar intervention)?

What worked well: _____ Challenges / Gaps: _____

4. Recording personal details:

Do you record individual child details? What is recorded?
 Purpose?
 What consent is taken?:

5. Documentation:

Standard Operating Procedures (SOP) document readily available?
*Has it been signed off?
 Follows the above answers and demo observations?*

Are business processes documented? Do they refer to them OR were they part of training provided?
Do they include an operations manual? Can we get a copy?

Systems assessment

B. Operations focus – continued (data and systems detail)

This section is to be completed for users that operate child protection systems at the local level (i.e., OSCC / hospital).

1. Infrastructure / digital literacy:

Please describe the different infrastructure and facilities being utilized and the stakeholders involved?

_____. Owned / operated / shared by _____

_____. Owned / operated / shared by _____

_____. Owned / operated / shared by _____

What is the setup of local service offices?
Are mobile devices used? BYOD? Computers? What software? Print and Scan? Storage? Internet?

Any issues with electricity? How is information stored (filing cabinets or c drive or server)?

If mobile devices used, are they personal or issued by the organization?

Were they trained on using the device?
What other use do they have for the mobile devices?
Would they be able to use Tablets for data collection?

3. Managing / processing information:

How is information / records maintained for the child protection system? (Offline processes?)

Are there any verification processes? For case type, risk level, identity of family? What supporting documents or records are used?

What grievances do the child or family member or other have? Are they captured / acted upon?

Are there any potential benefit/opportunities for interoperability with other systems?

What are the key challenges to use the systems and complete your tasks / role / function?

How do you think other systems should interact with your current processes / functions?
What benefits do you envision?

4. Reporting:

How is information sent to the national / central level? Yes No

Transfer mechanism: MIS Paper-based Storage devices (i.e. USB) Other: _____

What information reporting is sent?
 About number of children engaged
 About predictive risk levels
 About workflow status
 About referrals
 About trends in category, risk levels:

What is the format of the information sent:
 Pre-defined electronic format (i.e. mobile/tablet)
 Paper format
 Other: _____

How is the data stored locally?
 Printed and stored in cabinets
 Electronically on computer/mobile/tablet
 No information is kept

Frequency:
 Daily Weekly Monthly
 Quarterly Twice a year Annually

Level of disaggregation (totals vs screened risk vs referred): _____

5. Capacity:

Is there adequate capacity at this level to operate the systems and handle case load?
What capacity plans and measures are important to have in place for effective administration?

Describe the training provided?
Are there training manuals? What do you refer to?

6. Data security and privacy

Describe the security and visibility rules for this case? training provided?
Do they understand the security rules and the need for them?

Describe the user types / roles?
How many users?
Are there appropriate segregation of duties?

Anonymised data – when they don't need to see something?

Individual logins
 Password change policy
 Data encryption
 Segregation of duties
 Data edit vs view only
 Data visibility of their own jurisdiction

Systems assessment

C. Information Management Focus

This section is to be completed for system users that manage child protection information at either the central or local levels.

1. Information management systems:

What system are you using to manage child protection?
Name of the system? How long has it been used? Is it effective?

How did you learn to use the system?

2. Data identifier:

How is the child or carer/family member identification verified?

What case details are maintained to enable follow-ups / reviews?

Are there any issues for beneficiaries to satisfy identity requirement? Alternatives? *Migrants / Non-Thai citizens?*

ID numbers / formats:
 National ID

 format

Hospital ID

 format

Other: _____

 format

3. Interoperability:

How is the child data collected and tracked through HIS – Child Shield – Primero – OSCC Operations

Able to demo data across systems

How effective is the integration?

Audit log and tracking

Summary of case view

What interaction is there with other childcare services / systems:

Ability to export / share data

4. Case data analytics

Can data be organised for analytics and reporting? Is the data disaggregated for quantitative analysis?
Self-generating OR pre-build standard reporting

Are they aggregated across systems? In real-time or based on 1 day delay to copy data into a reporting database?

Do you have the data to analyse the lifecycle of the case?

Causes for delay coded and able to be analysed?

Number of cases per screening risk level

Number of cases per risk category

Number of cases per source

Can they review the data pipeline from Child Shield through to current workflow status

Causes for delay coded and able to be analysed?

Number of cases per [period (e.g. day)]

Number of cases per workflow status

Is there a reporting dashboard? Can reports be shared? Who completes and shares the reports?

Per category: _____

Per category: _____

5. Data quality and integrity:

How to measure and optimise the predictive risk screening? What is the evidence of the predictive risk analysis being improved over time?
Trends for risk rating / scoring over time? How has the trend impacted?

What is the level of data quality on the program? Any data quality or integrity concerns?
Risk mitigation processes in place for data quality concerns?...

6. MoPH reporting:

Does the MoPH receive updates/reports ? Yes No *[go to next section]*

Transfer mechanism: MIS Paper-based Storage devices (i.e. USB) Other: _____

What information reporting is received?

About number of children engaged

About predictive risk levels

About workflow status

About referrals

About trends in category, risk levels:

What is the format of the information received:

Pre-defined electronic format

Paper format

Other: _____

Frequency:

Daily Weekly Monthly

Quarterly Twice a year Annually

Systems assessment

D. Systems implementation and support

This section is to be completed for system owners or administrators at the central level.

1. How customised are the Thailand from existing Primero case management workflows accessible?

Has Primero been suitably customised / localised for the local context (language / date-time settings / colour and branding / documentation and links?)

Can the administrators / users create their own reports and update the monitoring and reporting dashboards

2. What changes can be made by Govt Admin users? What requires IT Dev teams?

Who are the vendors implementing / managing the system?

Is the technology appropriate for being maintained and enhanced locally?

3. Quality Assurance details

Test activities / cycles?

Backup-restore (Disaster Recovery) Testing? Yes No

Performance Testing? Yes No Details: _____

Security (Penetration) or Independent Sec. Audit? Yes No

How was test data created and purged during the test cycles?

4. Maintenance and support

Describe the support model in place?

SLAs: Yes No Details: _____

Network Monitoring: Yes No Details: _____

Tech design doc: Yes No Details: _____

Data breach protocols and remediation: Yes No

5. What changes / enhancements can be Government administrator led?

Any planned enhancements / additional integration points?

Expansion plan? (Who does what?)
For new provinces / hospital integrations:

Creation of new reports and update the monitoring and reporting dashboards?

Additional Feedback / Notes:

Risks and Challenges?

Wishlists?

Follow up required?

Annex K Quantitative data collection instrument

Number of Child Shield and Primero cases											
Province	# Total children screened by end December 2021	Total # cases Child Shield			Total # high-risk Child Shield cases involving children with different characteristics				Total # Child Shield cases actively case managed	Total # Child Shield actively case managed cases closed	Total # Child Shield cases transferred to Primero case management
		Low risk	Medium risk	High risk	Girls	Boys	Child with a disability	Child with an ethnic minority background			
Udon Thani											
Sakhon Nakhon											
Nakhon Phanom											
Loei											
Nongkhai											
Nongbualumpo											
Bungkan											

Parents and caregivers involved in Parenting for Lifelong Health Programme									
Province	Total # parents (primary caregivers) attending PLH		Total # parents attending PLH who self-identify as having a disability		Total # parents attending PLH with an ethnic minority background		Total # parents attending PLH by identified Child Shield screening risk		
	Female	Male	Female	Male	Female	Male	Low	Medium	High
Udon Thani									
Sakhon Nakhon									
Nakhon Phanom									
Loei									
Nongkhai									
Nongbualumpo									
Bungkan									

Capacity for delivery of Child Shield, Primero, and Case Management for Child Protection															
Province	Total # MoPH personnel involved in active case management	Total # MoPH personnel involved in active case management by qualification								% level of effort for child protection case management of total job role (estimated)	Total # health personnel attended case management training	Total # health personnel attended PLH training	Total # vehicles available for case management per province	Total # Child Shield-compatible IT devices per province	Total # Primero-compatible devices per province
		Social worker (bachelor's)	Social worker (other)	Nurse	Doctor	Psychologist	Sociologist	Therapist (physio, speech etc.)	Other health personnel						
Udon Thani															
Sakhon Nakhon															
Nakhon Phanom															
Loei															
Nongkhai															
Nongbualumpo															
Bungkan															

Annex L Ethical approval



Research Ethics Approval

2 November 2022

Revita Wahyudi
Oxford Policy Management
Clarendon House, Level 3
52 Cornmarket Street
Oxford, OX1 3HJ United Kingdom

RE: Ethics Review Board findings for: *Formative Evaluation of the Implementation of Ministry of Public Health and UNICEF Pilot Child Protection Joint Initiatives (Thailand)*
(HML IRB Review #632THAI22)

Dear Revita Wahyudi,

Protocols for the protection of human subjects in the above study were assessed through a research ethics review by HML Institutional Review Board (IRB) on 10 October – 02 November 2022. This study's human subjects' protection protocols, as stated in the materials submitted, received **ethics review approval**.

You and your project staff remain responsible for ensuring compliance with HML IRB's determinations. Those responsibilities include, but are not limited to:

- ensuring prompt reporting to HML IRB of proposed changes in this study's design, risks, consent, or other human protection protocols and providing copies of any revised materials;
- conducting the research activity in accordance with the terms of the IRB approval until any proposed changes have been reviewed and approved by the IRB, except when necessary to mitigate hazards to subjects;
- promptly reporting any unanticipated problems involving risks to subjects or others in the course of this study;
- notifying HML IRB when your study is completed.

HML IRB is authorized by the United States Department of Health and Human Services, Office of Human Research Protections (IRB #1211, IORG #850, FWA #1102).

Sincerely,

D. Michael Anderson, Ph.D., MPH
Chair & Human Subjects Protections Director, HML IRB

cc: Catalina Salazar Silva, Koorosh Raffii, Wassana Kulpisitthicharoen, Oscar Ernesto Huertas Diaz, Penelope Lantz, JD

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Annex M List of people involved in KIIs and FGDs

Name	Designation	Gender	Difficulty functioning						Location	Face-to-face or online	Notes
			Vision (a)	Hearing (b)	Mobility (c)	Cognition – remembering (d)	Self-care (e)	Communication (f)			
Robert McTavish	UNICEF Primer Lead	Male								Online	
Dr Amalee McCoy	PLH developer and researcher	Female							Bangkok	Face-to-face	
Nantaporn leumwananonthachai	UNICEF	Female							Bangkok	Face-to-face	Introductory meeting with Rafiq and Nantaporn at UNICEF
Ms Watcharawan	MoPH	Female							Bangkok	Face-to-face	
Ms Tippawan	UNICEF T4D	Female							Bangkok	Face-to-face	
Dr Chanvit	MoPH (retired)	Male							Bangkok	Online	As part of Reference Group Meeting
Dr Pitchitpong	MoPH	Male							Bangkok	Face-to-face	
Rafiq Khan	UNICEF	Male							Bangkok	Face-to-face	During informal lunch meeting
Head of Udon Thani School of Nursing	MoPH	Female							Udon Thani	Face-to-face	
Child Shield IT Administrator (4)	MoPH	Male							Udon Thani	Face-to-face	With Ms Watcharawan and Dr Pitchitpong and other IT support team members
Director of Health Region 8	MoPH	Male							Udon Thani	Face-to-face	
Regional IT analyst, Health Region 8	MoPH										
Director of shelter for children and families	DCY	Female							Udon Thani	Face-to-face	
Nonghan District Hospital OSCC (3)	MoPH	Female							Udon Thani	Face-to-face	3 x nurses in small group discussion
Udon Thani Hospital OSCC (3)	MoPH	Female							Udon Thani	Face-to-face	3 x nurse and social worker plus Dr Pitchitpong and Ms Watcharawan
Na Khang Sub-district Healthcare Centre (6)	MoPH	Mixed		Yes					Udon Thani	Face-to-face	2 x nurses plus 2 x OSCC Udon Thani Hospital plus representative of District Governor plus Community Health Volunteer
Na Khang Sub-district (2)	Family	Mixed							Udon Thani	Face-to-face	Discussion with mother and father of children currently case

Name	Designation	Gender	Difficulty functioning						Location	Face-to-face or online	Notes
			Vision (a)	Hearing (b)	Mobility (c)	Cognition – remembering (d)	Self-care (e)	Communication (f)			
											managed by OSCC social worker
Sam-Phraow Sub-district Healthcare Centre (5)	MoPH	Female							Udon Thani	Face-to-face	2 x participants in PLH plus 1 x sub-district nurse PLH facilitator plus 2 x Udon Thani OSCC
Vimala Crispin	Child Frontiers	Female							Bangkok	Online	
Oscar Huertas	UNICEF	Male							Bangkok	Online	
Sakhon Nakhon Hospital OSCC (2)	MoPH	Mixed							Sakhon Nakhon	Face-to-face	1x former OSCC staff now hospital management and 1 x OSCC social worker
Sakhon Nakhon Hospital IT (2)	MoPH	Female							Sakhon Nakhon	Face-to-face	1 x former and 1 x current IT personnel
Nong Lad Thai Sub-district hospital	MoPH	Female							Sakhon Nakhon	Face-to-face	
Bankoklao Sub-district Hospital	MoPH	Female							Sakhon Nakhon	Face-to-face	
Kyungsun Kim	UNICEF Representative	Female							Bangkok	Online	
Ms Chanapa	DCY, MSDHS								Bangkok	Online	Social worker CPIS
Severine Leonardi	UNICEF Deputy Representative	Female							Bangkok	Face-to-face	With Rafiq Khan
Dr Pornpet Panjapiyakul	MSDHS (retired)	Male							Bangkok	Online	
Reference Group Meeting		Mixed							Bangkok	Face-to-face	
Mr Anoop	UNICEF Planning and Monitoring	Male							Bangkok	Face-to-face	
Ms Ravi	UNICEF Planning and Monitoring	Female							Bangkok	Face-to-face	

Notes:

(a) = [Do/Does] [you/he/she] have difficulty seeing, even if wearing glasses

(b) = [Do/Does] [you/he/she] have difficulty hearing, even if using a hearing aid(s)?

(c) = [Do/Does] [you/he/she] have difficulty walking or climbing steps?

(d) = [Do/does] [you/he/she] have difficulty remembering or concentrating

(e) = [Do/does] [you/he/she] have difficulty with self-care, such as washing all over or dressing?

(f) = Using [your/his/her] usual language, [do/does] [you/he/she] have difficulty communicating (for example, understanding or being understood)?

Annex N CONTEXT OF THE EVALUATION

N.1 Global child protection context

Through Child Shield, Primero, and OSCC Capacity Development on Case Management and PLH, the Government of Thailand and UNICEF (the primary duty-bearers obligated to fulfil and uphold children’s rights) are investing in components of the wider child protection system in Thailand. Thus, this formative evaluation applies globally applicable child protection concepts that are tailored to the context of Thailand. These are considered critical for preventing and responding to child violence and abuse. In particular, the evaluation is shaped by considering how public health, case management, child protection MISs, and parenting programmes contribute to the development of a more comprehensive child protection system.

This is an evaluation of actions that intend to improve outcomes for children. The assessment, analysis, and recommendations concern children and families, as rights-holders. Therefore, the evaluation also involves consideration of gender equality and social inclusion principles as they relate to child protection and as defined in United Nations global and country-level strategies, including the following:

- UNICEF Strategic Plan 2022–2025 (UNICEF, 2022a);
- UNICEF Gender Policy 2021–2030 (UNICEF, 2021a) and Gender Action Plan 2022–2025 (UNICEF, 2021b);
- UNICEF Child Protection Strategy 2021–2030 (UNICEF, 2021c);
- UNICEF Thailand Country Programme Document 2022–2026 (UNICEF, 2022b); and
- United Nations Disability Inclusion Strategy 2020 (United Nations, 2020).

N.2 Thailand’s socioeconomic context

Thailand is an upper middle-income country, with a population of around 71.7 million persons,³⁷ around 17% of whom are under 18 years old (12 million). The remarkable improvement in poverty reduction seen since 2015 has been negatively impacted by the COVID-19 pandemic and the current global phenomenon of rising energy and food prices (World Bank, 2022).

A 2021 analysis of the policy and legislative framework, administrative data, and the 2019 Household Socio-Economic Survey (National Statistical Office of Thailand, 2020) found that poverty is ‘concentrated in difficult-to-access pockets of geographically and socially marginalised groups, and particularly in the ‘Southern region (13.7%), with rural poverty concentrated along the borders with Myanmar in the north and Malaysia in the south’ (Sammon *et al.*, 2021). The regional disparities contribute to significantly worse development outcomes for children in these geographic locations: in particular, stunting, wasting, and education losses (UNICEF, 2021g). Girls, children with disabilities, and children under five are particularly limited in their access to healthcare and income security, and poor children and migrant children are more likely to be out of school (UNICEF, 2021g). Around 3 million children are ‘left behind’ by migrant worker parents and are growing up in the care of grandparents and other extended family members (Global Health Now, 2017). As a result, these children are more likely to be exposed to child protection risks.

N.3 Policy and legislative context for child protection in Thailand

Thailand ratified the CRC in 1992 and the CRPD in 2008, thus committing to upholding and protecting the right of children to be protected from violence and abuse, including children with disabilities – although with a reservation to Article 22 of the CRC on the rights of refugee and asylum-seeking

³⁷ <https://data.unicef.org/country/tha/>

children. This has implications for non-Thai children's access to services, and impacts on the birth registration of children born to migrants in Thailand, which in turn affects their access to social services, including education and health (UNICEF, 2019b).

Thailand is also a member of the ASEAN and its Commission for the Promotion and Protection of the Rights of Women and Children, and its Intergovernmental Commission on Human Rights. These two ASEAN bodies play important roles in the promotion and protection of children's rights in the ASEAN region, including the right of children to a life free from violence. Several ASEAN declarations and commitments have been adopted for action by its Member States, including Thailand, such as the following:

- the 2020 Ha Noi Declaration on Strengthening Social Work Towards Cohesive and Responsive ASEAN Community;
- the 2019 Declaration on the Protection of Children from all Forms of Online Exploitation and Abuse; and
- the 2016 Commitment to the Elimination of all Forms of Violence Against Children in ASEAN Member States.

The principal Thai national legislation is the Child Protection Act (2003), which stipulates that those who are responsible for looking after children have the duty to notify or report incidents of child abuse. Through this act, a National Child Protection Committee was also formed, chaired by the Minister of Social Development and Human Security. Following this, each province also established the same committee, chaired by the governor. This committee is tasked with formulating guidelines on, providing a budget for, and monitoring and evaluating the implementation of child protection in their respective areas. Guided by the Child Protection Act, UNICEF and MSDHS initiated the introduction of child protection case management for Local Administrative Organisations and Children and Family Centres, although standardisation across the country is considered underdeveloped (Yuhanngoh and Boonyarattanasoontorn, 2018).

The Criminal Code (1956) provides that sexual intercourse with a person under the age of 15 years is an indictable offence. Thai law permits an individual to consent to sex from 15 years of age.⁷ However, the Penal Code Amendment Act of 1997 outlines a number of amendments that ostensibly sets the age of consent at 18 years of age (Penal Code Amendment Act, 1997) (Singh and Chareka, 2018). Family law is codified in the Civil and Commercial Code, which defines the rights and duties of a parent and a child, as well as the rules on guardianship and adoption.

The MoPH 20-year National Strategic Plan for Public Health includes measures to increase the quality standards of hospitals that provide care services for mothers and children, to develop and improve the data system, surveillance system, and referral system, and to develop the support and care system for high-risk children (MoPH, 2018).

Legislation specific to the development of ICT is discussed in Chapter 1.4.

A 2020 evidence review of the child protection system in Thailand described the situation as complex, in part because frequent changes in government institutions make it difficult to obtain buy-in, and because of limitations in public awareness of and support for children's right to protection (UNICEF, 2020a; MSDHS-DCY *et al.*, 2020).

N.4 Thailand's ICT context

Thailand's ICT sector has developed rapidly over the past two decades, with the private sector, government agencies, and households engaging in digital services and becoming more tech-savvy (Frost and Sullivan, 2019).

One of the central themes for Thailand 4.0 – which sets out a model for economic development in

Thailand – is the progression of digital and technological engagement by Thai society.³⁸ Thailand’s Twenty-Year National Strategic Plan for Public Health (2017 – 2036) has been developed in line with the Thailand 4.0 agenda and recognises technological advancements as a key factor in and component of the development of the healthcare system (MoPH, 2018, pp. 16 and 48). This includes the development of data and information systems at health facilities across all levels and services, to ensure continued programme development and for the purposes of M&E.

Digital services and the development of interoperable digital ecosystems for various sectors have also been enabled by the following digital enablers:

- The **digital literacy** of the Thai population has significantly increased, represented by increased utilisation of ICT (MoPH, 2018, p. 16). **Broadband internet access** is considerable, with more than 47.5 million internet users (according to a survey in 2019).³⁹ **Mobile penetration** is high in Thailand, with over 90% of the adult population owning a mobile phone and thus able to access online services.⁴⁰ Agenda 2 of the Thailand 4.0 model, *Development of Technology Cluster and Future Industries*, emphasises the use of digital tools and Internet of Things as platforms that can enhance productivity, quality, and innovation across various economic activities within the agriculture, industrial, service, and education sectors.
- The **National ID and civil registration system**, under the management of the Ministry of Interior, is well-established, with near universal coverage of their population registry (just under 100%) (World Bank Group, 2021). A PID number is a unique 13-digit code that is provided to every child at birth registration and links the birth registration certificate with the National ID. The National Digital ID (NDID) was launched in 2019, enabling citizens to leverage third-party digital identity and authentication providers to access digital transactions and services.
- The development of the **eHealth ecosystem is based on the OpenHIE** architecture and framework (Kijsanayotin, 2016) that provides standards and best practice recommendations for the development of health systems – as modular components – that are accessible and interoperable, to enable information sharing. Numerous functional components are recommended as part of the OpenHIE architecture, including patient-level EMRs that are managed by the Health Management Information Service and Client Registry, among others.
- The **interoperability** within the eHealth systems is facilitated by the NDID and population registry, which enables the unique identifier to match the patient record across databases and systems. The level of interoperability that is possible was evident during the COVID-19 pandemic, when the strength of the linkages between government administrative databases enabled rapid selection and payment of relief payments to eligible citizens.
- The **Moh Prompt application**⁴¹ has been developed to be Thailand’s digital health platform and links health-related data of the general public from more than 15,000 medical service units at all levels and establishments across Thailand, including public and private hospitals, clinics, and pharmacies.⁴²

Box 2: Moh Prompt Application⁴³

“The Ministry of Public Health has a policy of supporting the use of digital technologies in the development of health service systems for enhanced quality and efficiency, which can thus be easily accessible to the target groups. We have therefore teamed with other public agencies and the private sector in upgrading the Moh

³⁸ Source: <https://thaiembdc.org/thailand-4-0-2/>

³⁹ Source: Digital Government Development Plan of Thailand 2020 – 2022 (www.dga.or.th/)

⁴⁰ *Ibid.*

⁴¹ Website: <https://mohprompt.moph.go.th/>

⁴² Source: KASIKORNBANK, via website: www.thaipr.net/en/general_en/3216765

⁴³ Source: KASIKORNBANK (via Ministry of Public Health upgrades Moh Prompt application to be Thailand’s digital health platform, https://www.thaipr.net/en/general_en/3216765)

Prompt application to be the digital health platform for Thai people. Until now, the application has offered services related to COVID-19 and its vaccinations. This cooperation aims to provide greater convenience to Thais, allowing them to gain improved access to health-related services. With the aim of elevating quality of life for all Thais, the 12 new features include linkage of treatment history, medical benefit checking service, physician appointment, telemedicine, digital medical certificate and health pass service, and online payment systems, with linkage to all health-related service units, thus effectively facilitating the work of medical personnel. Development of the application will be continuous for the benefit of Thai people. As of now, more than 32 million users have signed up for the Moh Prompt application. We believe that the improved accessibility of this application will make it easier and faster for all users, thus advancing the nation's healthcare system."

Dr. Sathit Pitutecha, Deputy Minister of Public Health: (Ministry of Public Health, Nonthaburi, 25 July 2022)

With the enabling environment for interoperability and digital services, strong data management and governance standards are required to ensure consistency in how the information of Thai citizens and their PIDs are handled across the different databases. Due care and consideration must be taken to protect the privacy of citizens, especially children, through system design, and to safeguard their information and rights through the appropriate legal and regulatory frameworks. The PDPA is the first law in Thailand to govern data protection in the digital age and entered into force in 2022.⁴⁴ The PDPA – comparable to the European Union's General Data Protection Regulation – sets out the requirements for data controllers and processors regarding how to obtain expressed consent when collecting, processing, storing, and disclosing personal data.

N.5 Situation of children exposed to violence and abuse in Thailand

Violence and abuse can take different forms and can be manifested at different levels, but always harms a child's health, development, and future opportunities. Violence can happen in any context, in any family, no matter their socioeconomic status. However, there is an overwhelming body of evidence that demonstrates a causal link between a family's economic situation and violence against and abuse of children (Bywaters *et al.*, 2022).

It is important to acknowledge that data may reflect the tip of the iceberg, as violence and abuse may go unrecognised or unreported. This point is particularly relevant in Thailand, since child sexual abuse and exploitation in Thailand are thought to be under-reported when compared to the rest of the world (Trangkasombat, 2008).

It is also known that there is near universal social acceptance of violent discipline in Thailand, such that 58% of Thai children are subjected to psychological and physical punishment (UNICEF, 2021d). UNICEF reports that more than 10,000 children are treated in hospital every year for injuries resulting from violence, mostly sexual abuse (UNICEF, n.d.). Child marriage prevalence by age 18 stands at 20% (National Statistical Office Thailand and UNICEF, 2019), driven by gender inequalities related to level of education, adolescent pregnancy, poverty, traditional harmful practices, sexual violence against girls, and ethnicity (Girls Not Brides, n.d.). At the same time, 9% of internet-using children aged 12–17 in Thailand have been victims of grave instances of online sexual exploitation and abuse (ECPAT, INTERPOL, and UNICEF, 2022).

Globally, data on children with disabilities can be complex to collect and are therefore often underestimated. Regardless, children with disabilities are considered at least one-third more likely than their peers without disabilities to be subject to physical punishment (UNICEF, 2021h). In Thailand, about 38% of children with disabilities are out of school, 27% do not have access to health promotion services, and 4% do not have access to medical treatment when they are sick (UNICEF, 2021e). In addition, nearly half of children with disabilities are not registered with the government and do not

⁴⁴ Source: Thailand Personal Data Protection Act (www.trade.gov/market-intelligence/thailand-personal-data-protection-act)

receive a monthly disability grant (UNICEF, 2021e).

Thailand is home to more than 660,000 migrants, refugees and asylum seekers, and stateless persons (UNHCR, 2022). Many of the children within this marginalised population are vulnerable to child protection risks because they are out of school or have limited access to health and social services. For example, an estimated 200,000 migrant worker children are 'legally entitled to free education under the 15-year Free Education Policy, [but] are de facto excluded because they face administrative barriers such as difficulties in obtaining the required documentation' (Sammon *et al.*, 2021, p. 17). Access to healthcare is also limited for non-nationals or ethnic minorities, who are the least likely to be protected through the Universal Health Coverage (30.2% of children in this group are not covered, compared to 0.6 % of the Thai children population) (Sammon *et al.*, 2021, p. 15).

Annex O Methodology

O.1 Approach to the evaluation

The evaluation approach has been designed to support ongoing learning and adaptation, and to reflect the United Nation’s human rights-based approach to development (United Nations Sustainable Development Group, 2023). It has involved identifying the processes required to achieve the desired results (children’s right to protection from violence and abuse) and then observing whether and how those processes were implemented in the CP Joint Initiatives being evaluated. The evaluation investigates the causal links between the processes and includes a mix of design features that take into account the objectives and methodological guidance, as expressed in the ToR. Structured around the OECD-DAC criteria, the evaluation uses evidence gathered through a mixed method approach of both qualitative and quantitative data collection and a multidisciplinary analytical perspective.

O.1.1 Mixed methods

We applied a mixed methods approach involving the following elements:

1. **Desk-based literature review** of the Government of Thailand and UNICEF legal framework, policy documents, and research, and the international literature on child protection systems, including on data and information systems
2. **Secondary quantitative data review** of existing and available data or statistics from MoPH, and the Child Shield, Primero, and OSCC initiatives, including data pertaining to child protection (including Multiple Indicator Cluster Survey and other relevant census data).
3. **Primary qualitative data collection** in Bangkok and two selected provinces of Health Region 8:
 - o **KIIs** with a wide range of stakeholders at the national and sub-national levels; and
 - o **small group interviews** with mixed-type respondents, including community and family members, social workers, and health practitioners.⁴⁵
4. **Demonstration or direct observation** of MISs and services provided at hospitals or OSCC.

O.1.2 Target operating model approach – technology and systems evaluation

Within the mixed methods approach, the assessment of the Primero and Child Shield systems through the prescribed methodology also employed a target operating model approach for the review of their effectiveness and efficiency to support the child protection processes, data integration and sharing requirements, and sustainability of the solutions. This approach made it possible for the evaluation of the Child Shield and Primero MISs to consider the entire operating model, and not only to consider the technology components in isolation.

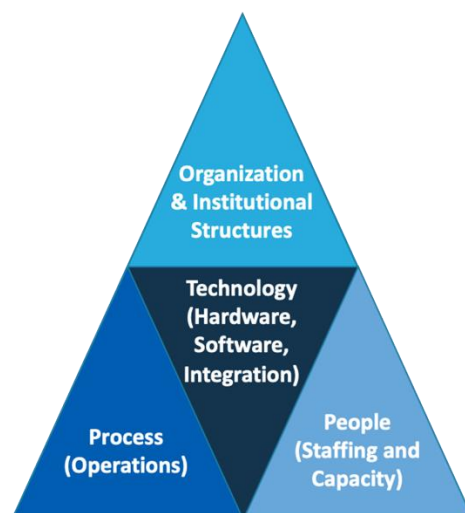
As explained in Chapter 7.1.2, the data and systems assessment considered four key areas:

1. The **institutional, administration, and management** structures in place to support and govern the Primero and Child Shield systems, including the different external units and child protection services that interact with the systems.
2. The **business processes** and operations required to manage the systems, including the reengineering or harmonisation of processes where required across different child protection services in different locations and at different administrative levels.
3. The **resources – staffing and capacity** – required for the effective operations and sustainability of the systems, including additional support for scale-up, as required.

⁴⁵ Although we planned to conduct FGDs with distinct cohorts, in reality we were faced with mixed-type respondents at sub-district level; please see Chapter 7.6, Limitations and constraints, for more detail.

4. The **technology** (hardware, software, support tools, database, and integration) components of the systems were evaluated on their ability to capture, process, distribute, and report on information based on the child protection workflow and functional requirements of the programme and their stakeholders. The interoperability of the data for efficiency is a requirement, but a key consideration through the entire operating model will remain the integrity and security of the data to ensure the privacy of children, given the sensitive nature of the information being retained and shared. Additionally, the approach to the design, development, and ongoing maintenance of the systems was reviewed, to evaluate the continued sustainability of the solution to meet the programme's strategic objectives.

Figure 16: Target operating model approach



Technology was a central cog of the evaluation; its evaluation alongside all components of the operating model enabled us to review the 'as-is' state and effectiveness of the child protection systems. This, in turn, helped to identify opportunities for improvement and associated gaps and challenges to better support child protection screening, case management, and the overall information management and reporting requirements.

O.1.3 Multidisciplinary perspective

Since the CP Joint Initiatives involve different fields of study, we analysed the data and evidence using a multidisciplinary perspective, not only related to child protection (as the main theme of the pilot) but also considering gender, equality, and social inclusion, and the analysis of data and information systems.

In particular, the focus on prevention (as operationalised using the Child Shield component) called for a multidisciplinary analysis, reflecting not only the child but also the wider circles of support and harm within which a child is situated. The socio-ecological system model is useful in understanding the drivers of violence against children, as well as the circles of support a child may access. It can also show the child's potential exposure to abuse – that is, it can be in the family, at school, or in the community (UNICEF, 2016). Finally, it shows that both the support and risk to the child can be impacted by larger social factors, such as policies and programmes available (or lacking) in the community, and how social norms and cultural practices affect children (UNICEF, 2018).

O.2 Inception

A kick-off meeting was held with UNICEF and OPM on 19 September 2022. The OPM team presented an overview of the evaluation and discussed and clarified several aspects, including the following:

- The context and expectations relative to the assignment, including in regard to the scope of the evaluation, particularly in terms of conducting a soft reflection on the value for money of the pilot initiatives, rather than a robust cost–benefit analysis.
- The workplan, including the agreed dates for the inception report and in-country visits.
- The requirement for ethical review to be conducted internally.
- Engagement with an MoPH-led Technical Reference Group for the review of evaluation outputs.

The inception report, including the detailed methodology and ethical review, was approved in October 2022, which allowed the primary qualitative data collection to take place in late November and early December 2022.

O.3 Primary data collection

Face-to-face KIIs and FGDs were conducted in Bangkok and the two selected provinces of Udon Thani and Sakhon Nakhon by the Team Leader, OPM Project Manager, Data and Information Specialist, and Thai Qualitative Researcher.

O.3.1 Fieldwork location

Please see Chapter 5.2.

O.3.2 Respondents for interviews and discussions

The range of KIIs and FGDs was determined on the basis of efficiency and effectiveness. The proposed sample size of KII and FGD participants was considered sufficient to balance the requirement for quality data to inform a valid analysis, as well as the timelines and available resources.

UNICEF guided the purposeful selection of key government personnel at national and provincial level and liaised with government officials at provincial level to purposefully select communities and households for the qualitative data collection.

Before carrying out any interviews we provided a verbal and written introduction explaining why we were there and what we were trying to learn. This included issues around confidentiality, anonymity, and informed consent of respondents to participate in this research.

In each selected province, we identified KII and FGD respondents using a mix of purposeful and convenience sampling: that is, we selected respondents based on their existing knowledge and experience of the pilot implementation, and the ease with which they could be reached (geographic spread), to maximise efficiency. While we aimed for a balanced gender profile, this was not possible given the predominance of women in the health and social welfare workforce, both in Thailand and globally. A snowball sampling strategy was also used to recruit respondents based on a recommendation from an already identified respondent.

We sought to identify a selection of people who were screened by Child Shield but not selected for further intervention, as well as those screened and selected. We anticipated that this would provide general feedback on the experience of interactions with MoPH, and consequent family outcomes (although we did not expect to evaluate impact at this early stage).

We disaggregated KII and FGD data by gender and age group (adults of working age – 18 and above, older persons 65+) and across the range of functional difficulties per the Washington Group Short Set Questions.

Two Technical Reference Group meetings were attended by UNICEF, government, and former-government personnel at the beginning and end of the data collection. A total of 53 respondents aged

18–64 were included in the data collection: nine males, 25 females, and four mixed-gender groups (Annex M). Only two respondents self-identified as having a disability (difficulty with hearing). In each of the provinces at district and sub-district level we elicited the views of mixed-type respondents in small group interviews, rather than definitive KIIs or FGDs. It was also challenging to connect with beneficiary families as planned. Seven interviews were conducted online and the remainder were held face-to-face. Table 18 below summarises the indicative number of KIIs and FGDs, alongside the actual number of respondents. Please see Chapter 7.6 for more information on limitations and mitigation measures.

Table 18: Indicative number of KIIs and FGDs

Location	Indicative number of KIIs/FGDs and respondents	Estimated number of respondents		Actual number of respondents
		KIIs	FGDs	
National level	<ul style="list-style-type: none"> 2–3 KIIs with UNICEF Thailand Country Office staff 3 KIIs with national government staff 	6	0	21
Provincial level	<ul style="list-style-type: none"> KII with provincial health office = 2 people KII with provincial child protection committee = 2 people KII with regional health office = 2 KII with hospital/OSCC staff = 2 Vendor of Child Shield and/or government staff that manages the vendor = 2 (We assumed at least 2 representatives would meet us in each interview) <ul style="list-style-type: none"> FGD with social workers and health practitioners = 8 	22 (11 x 2 provinces)	16 (8 x 2 provinces)	17
Community level	<ul style="list-style-type: none"> 1 FGD with community = 8 2 FGDs with family members = 2 x 5 = 10 Interviews with family members = 3 	6 (3 x 2 provinces)	36 (18 x 2 provinces)	15
Sub-total		34	52	
Total respondents		86		53

0.3.3 Training on research instruments

The researchers were selected based on their substantial experience of social policy evaluation, including the ethical considerations involved. All researchers were involved in the evaluation and data collection design, including development of the research guide. This guide informed the pre-data collection training and the refinement of instruments following field-testing. The team training involved several meetings in Bangkok to review and discuss the fieldwork plan and instruments, and to refresh knowledge on the key principles and guidelines for qualitative research, including in regard to informed consent. Acknowledging the significant research expertise within the team, this is considered sufficient to ensure the quality and validity of the data collection.

This training was led by the Team Leader and included the following elements:

- **Introduction to the evaluation and the context**, to provide an understanding of the issues and challenges relating to child protection in Thailand, and the UNICEF pilot initiative that aimed to overcome those challenges.
- **Training on research methods and tools**. This was the core agenda of the training, including a review of the methods and tools to ensure that the team were familiar with the evaluation objectives and key questions.

- **Ethical considerations and safeguarding policy.** This equipped all team members with an understanding that their work could impact the safety and wellbeing of children and vulnerable population, and how to act responsibly around them.
- **Field training via pilot.** The data collection instruments were tested in a ‘real-life’ situation, which contributed to adaptations, particularly to the Thai translations.

0.3.4 Qualitative data collection instruments

Table 19 describes the instruments. A more detailed elaboration of these instruments can be found in Annex G for the semi-structured interview guide – professionals, Annex H for the FGD guide, Annex I for the semi-structured interview guide – family members, and Annex J for the observation guide.

Table 19: Data collection instruments

Instrument	Description	Relevant respondents
Semi-structured interview guide	An interview guide was developed that corresponded broadly to the evaluation matrix and that was tailored to the specific respondents.	UNICEF staff; MoPH staff at national and provincial levels; hospital staff
FGD guide	There are two roles required to conduct a successful FGD: the facilitator and the note-taker. The FGD guide was developed with the main purpose of encouraging a productive discussion among participants.	Social workers/health practitioners; community or family members
Observation guide	This instrument aimed to assist the team to understand and interpret the social, cultural, and economic environment of the evaluation subjects. In this evaluation, this tool was used to observe how services are provided: for example, by social workers at OSCC.	Hospital and OSCC office

0.3.5 Quantitative data collection instruments

We examined quantitative data on Child Shield and Primero cases, as well as OSCC Capacity Development (Annex K). This allowed for cross-referencing across the three initiatives, as well as the identification of data gaps that may be addressed during future scale-up. For example, we looked at the number of cases identified by Child Shield, as low, medium, and high risk, and, of these, which were selected for intensive case management and transfer to Primero. We also examined the personnel involved in supporting case management and PLH in terms of numbers, qualifications, experience, targeted training, level of effort (as part of overall job description), and access to necessary resources.

0.4 Data analysis

We approached data analysis as an iterative and reflexive process that begins as data are being collected, rather than after data collection has concluded. We combined the notes that were written ‘in the field’ with notes taken in daily debrief sessions at the end of each day. The data were triangulated as much as possible to allow the reader to assess the strength of the findings.

We used a simple coding matrix in Excel that corresponds to the main thematic areas of interest. This enabled patterns underlying the data to be extracted. Datasets coded in this way will be useful as future reference points, and can be revisited, compared, and reanalysed as required during the research.

The team integrated the initial reflections from the quantitative and the qualitative data prior to

providing feedback to UNICEF and the Reference Group. This contributed to the ‘sense-checking’ and triangulation noted above.

The Child Protection Specialist team member provided a level of quality assurance, reviewing the final report to ensure children, as rights-holders, were adequately represented in the discussion on CP Joint Initiatives and their contribution to the wider child protection system in Thailand.

As described in the research guide (Annex C), we have ensured that confidentiality is maintained and personal information is protected.

0.5 Ethical considerations and evaluation principles

The evaluation applies the principles and standards described in the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation (United Nations Evaluation Group, 2020). The evaluation data collection and analysis methodology was subject to UNICEF’s Ethical Review Board approval, for which purpose we developed the research guide (Annex C). Ethical approval was issued on 2 November 2022 (Annex L).

As discussed in the technical proposal, given the time and resource implications of establishing robust safeguarding policies and protocols, we did not engage with children directly.⁴⁶ Instead, we aimed to identify parents or primary caregivers, to represent their experiences of interaction with the public health system, Child Shield, OSCC case management, and PLH. We did not directly engage with participants to discuss traumatic life experiences. Although we presumed negligible disclosure of individual incidents of child violence and abuse, we did have a protocol for reporting disclosure through the statutory channels should this occur.

We were attentive to the perspectives and concerns of health and social care services personnel and families and caregivers.

In line with the UNEG principles of integrity, accountability, respect, and beneficence, we ensured that all personnel under OPM’s purview adhered to the following fundamental standards:

- **Respect for individual self-determination** – Participants made the decision to take part on a voluntary basis.
- **Informed consent** – Participants were given as much information as possible about the evaluation and how the information they provided would be used. The data collectors explained the research and its implications to the participants, and made sure that all participants could comprehend the proposed evaluation. All participants were informed of their right to withdraw from the evaluation at any point. Written information about the evaluation was provided to each respondent and verbal consent was obtained prior to the start of any interview or discussion
- **Confidentiality and data protection** – Participants were assured that all data would be presented in such a way that they cannot be identified. All data collectors were and are obliged to maintain data securely and in line with prevailing local legislation.
- **Participation of persons with disabilities** – The research was attentive to the inclusion of persons with disabilities and made provision for impairment-related requirements throughout. Such reasonable accommodations included conducting interviews and discussions in a place where participants felt most comfortable and, where available, the provision of sign language interpreters, extending the timing of interviews for persons with communication difficulties, the provision of transport, and making sure that language and terminology was comprehensible.
- **Safeguarding** – Measures were put in place to make sure that individuals and communities participating in the research were not subject to harm as a result of the actions of the persons employed to participate in the data collection, analysis, and reporting. Safeguarding was included in

⁴⁶ However, we suggest that any future evaluations take into consideration the right to participation, as defined in Article 12 of the CRC, such that children’s perspectives can be properly considered.

the training and a procedure for reporting concerns to the evaluation Team Leader was provided. Researchers always operated in pairs and female respondents were interviewed by female researchers.

O.6 Limitations and constraints

Here we refer to the limitations and constraints encountered, and the mitigation strategies we employed (Table 20). We report in Chapter 8, Findings and preliminary conclusions, on particular cases where it was not possible to fully moderate the limitations by these measures.

Table 20: Limitations and mitigation measures of the evaluation

Limitations and constraints of the evaluation	Mitigation strategies identified
Availability of adequate and appropriate respondents to the evaluation	We relied on UNICEF and MoPH to advise the provincial, district, and sub-district authorities of our intention to conduct data collection, and the proposed sample, dates and times. We planned to convenience sample the geographic locations to make sure we visited areas where the CP Joint Initiatives were operational. During inception we were of the belief that the large number of people reported as benefiting from the pilot initiatives would allow us to easily identify respondents. ⁴⁷ We found that because there had been a time lapse since some activities had taken place some of the original beneficiaries (and intended respondents) – for example, OSCC staff – had moved to other positions or left MoPH. We indicated our availability to conduct interviews and FGDs during the weekend and on public holidays but the availability of family and caregivers was still limited.
Time lapse between activity and evaluation	Because some interventions were conducted in 2020, respondents could not clearly remember the details of the activities or were no longer in post. For example, we found very little recall of the case management training. Therefore, we relied on the quantitative data provided by MoPH.
Adherence to KII and FGD formats as envisaged	In some cases, we were flexible in conducting small group interviews with mixed-type respondents, rather than definitive KIIs or FGDs. For example, these mixed-type groups at provincial and district levels involved OSCC staff and beneficiaries participating jointly in the meetings, or national-level MoPH representatives attending meetings in the province with frontline workers. MoPH attendance in small group interviews also gave beneficiaries the confidence to attend and participate. Therefore, it was not considered appropriate nor conducive to the ambience of the data collection to ask that the groups be reconfigured after we arrived on site.
Sense may have been lost during interviews and discussions where there was consecutive translation from Thai to English and vice versa	We validated information by asking questions in several iterations to make absolutely sure we understood. We held a daily team debrief to discuss the day's findings and to double-check with the translator, and with all team members, that we had a common understanding so that we could be confident that we captured the necessary data. We also held several discussions involving the same stakeholders to discuss and test understanding. We took our primary data from multiple sources and used every opportunity to confirm what we learned from several different respondents, to ensure data quality.
The quantitative analysis for this assignment depends on the availability and quality of data, including our access to those data	We sought the help of UNICEF in facilitating access to these data and information, so that we could ensure the comprehensiveness and rigour of the evaluation.
Availability of adequate and	We depended on the availability of the main technical documents, including the

⁴⁷ In the assignment ToR, UNICEF report that 'more than 1 million children have been screened by Child-Shield, in which more than a thousand children are being considered as "high risk", while hundreds of children and families have received PLH intervention on parenting, and a few cases have been referred to Primero for more intensive case management services'

appropriate documentation pertaining to the CP Joint Initiatives	overarching project documents and results framework, as well as monitoring reports. Where these were not available, we mined available information to the extent possible from associated project documents, and checked the findings with the relevant UNICEF personnel.
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