Developing capacities to realize the rights of children and women

Selected innovations and lessons learned from UNICEF-assisted programmes
Developing capacities to realize the rights of children and women: selected innovations and lessons learned from UNICEF-assisted programmes

FOREWORD

This document features 17 recent innovations and lessons learned from UNICEF-assisted programmes which are illustrative examples of some of our work on Capacity Development as a key cross-cutting strategy for promoting children’s rights. They are presented here to share the experience of UNICEF and its country-level partners in working to develop critical national and local capacities for children and women.

For UNICEF, Capacity Development is a process through which individuals, organizations and societies obtain, strengthen and maintain the capabilities to achieve their own development objectives and the sustained realization of human rights. Policy makers, national institutions, civil society organizations, communities, families and individuals all require certain capacities in order to plan, manage and utilize services, make decisions and take actions that support the realization of the rights of children and women.

The cases highlighted in this publication are diverse examples – creating community-based support system to increase pregnant women’s access to emergency obstetric care in Bangladesh, developing capacities of sub-district level for child-friendly school programmes in Mozambique, designing and implementing a diploma course on formulation of public investment projects in Peru, learning lessons from supporting the national programme for orphans and vulnerable children in Zimbabwe and building national capacity in support to the Core Commitment to Children in Humanitarian Action in Uganda.

It is important to recognize that lessons gained through cooperation in one country or context are not necessarily valid or transferable to the circumstances of another. We hope that this compilation will be useful in two ways: to provide a sense of the range of UNICEF work on Capacity Development across regions and to provide some indications of where to look for emerging experiences which could refine or sharpen programmes from this perspective.

Each of these pieces is a summary and more detailed information is available from the UNICEF offices which provided the original material. If you are interested in learning more about a particular topic or featured innovation, or would like to make comments, please contact Policy and Practice in UNICEF Headquarters (lessonslearned@unicef.org).

Richard Morgan
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A SPECIAL MESSAGE:
National capacity development in humanitarian situations – drawing on experience and evidence

The dramatic increase in the number and scale of emergencies over the last decade, combined with a situation in which many countries are simultaneously hit by various types of emergencies at the same time has challenged the ability of international agencies to guarantee speedy humanitarian assistance on multiple fronts. This has caused international humanitarian actors to seriously reconsider the way they work vis-à-vis national systems. There is an honest recognition that international assistance has in some instances demonstrated a difficult start-up phase and that it has later faced challenges in providing far deep-reaching assistance to the most vulnerable groups. Hence, not only are humanitarian principles jeopardized but also UNICEF’s determination to reach the most vulnerable populations – the equity approach – is at stake. Within this shifting landscape, developing national capacities for emergency response, preparedness and recovery is acknowledged – by UN agencies, INGOs and national actors – as fundamental to effectively address the increasingly complex humanitarian situations we face.

National Capacity Development (CD) in humanitarian situations does not always necessitate a decade-long process, which is often needed in development contexts. If clear and tangible CD benchmarks are identified from day one, the process can demonstrate concrete results in a relatively short period of time. However, in parallel, international agencies should then accompany these short and medium term initiatives with long term processes that aim at building or developing wider institutional systems, which requires long term dedication. Capacity Development in support to the 'Core Commitments for Children in Humanitarian Action' (CCCs) aims to strengthen the technical, organizational and institutional capacities of communities, organizations and national actors to ensure to effectively and quickly address humanitarian situations. For that to happen, evidence shows us that CD in humanitarian settings must be systemic as summarized in six points below:

a) It is important that all capacity development initiatives are nationally owned and led by a national actor in response to the national humanitarian priorities.
b) The CD process must be outcome oriented, which means that the focus is on the number of children and civilians accessing and using services and facilities (for example for education, health or supply facilities) rather than merely the number of trained or skilled professionals.
c) National and international partners must prioritize distinct benchmarks to be met in a relatively short period of time (one month to two years) and other benchmarks for long term results. We must start with asking capacity development for what exactly and by when?
d) National and international partners should conduct a Capacity Assessment for these specific benchmarks, in which existing versus desired capacities are identified (this ensures that we build on existing systems wherever possible and try to avoid parallel structures).
e) National and international partners must develop a Capacity Development Plan that addresses technical capacities at an individual level and organizational capacities at an institutional level. Developing only the technical capacities such as training teachers, without supporting the organizational capacities – safe school buildings with textbooks, blackboards etc – will result in a situation where the teachers will not have a venue to apply their capacities, and the investment in teacher training is hence lost.
f) National and international partners must identify a clearly phased exit strategy that shows how increased knowledge transfer is coupled with increased national takeover and finally the complete transfer of agreed upon humanitarian functions. Only then have we succeeded in national capacity development.

The case study from Uganda (on page 74) illustrates application of these principles in strengthening a supply and logistics system for children and women in emergency context. The new 'Technical Note-Capacity Development for the Core Commitments for Children in Humanitarian Action' and its complementary tools can be applied to guide the CD process in other emergency countries as well.

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Developing capacities to realize the rights of children and women: selected innovations and lessons learned from UNICEF-assisted programmes


Disclaimer
This compilation is based on internal field reports and is not edited or fact checked to official UN publication standards. Statements in these articles do not imply or constitute official opinions or policy positions of either the United Nations or UNICEF.

Acknowledgements
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DEFINITIONS

Innovations are summaries of programmatic or operational innovations that have or are being implemented under UNICEF’s mandate. These innovations may be pilot projects or new approaches to a standard programming model that can demonstrate initial results.

Lessons Learned are more detailed reflections on a particular programme or operation and extraction of lessons learned through its implementation. These lessons may be positive (successes) or negative (failures). Lessons learned have undergone a wider review than innovations and have often been implemented over a longer time frame.

Good Practices are well documented and assessed programming practices that provide evidence of success/impact and which are valuable for replication, scaling up and further study. They are generally based on similar experiences from different countries and contexts.
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Innovations

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CHAPTER I
CAPACITY DEVELOPMENT IN YOUNG CHILD SURVIVAL AND DEVELOPMENT
LEssonS lEARNED

bANGLADESH

Achieving MDG-5 for maternal mortality reduction – contribution of community support systems

ABSTRACT

Over the last few years, Bangladesh has made significant progress in maternal health. It is one of a few countries globally that is considered to be on track to achieve Millennium Development Goal 5 (MDG 5). There has been 40 per cent reduction of maternal mortality between 2001 and 2010. The recent BMMS 2010 survey however shows that each year about 7,300 women die from pregnancy or childbirth related complications. Progress in ensuring skilled attendance at delivery has been very limited. Only 29 percent of pregnant women who developed complications attended medical facilities in 2010.

The Community Support System (ComSS) for maternal health is a mechanism for establishing an enabling environment at the community level, through collective efforts and participation of community members, to provide support to pregnant women and their families. The initiative aims to increase their access and ability to obtain adequate services during any obstetric emergency, subsequently contributing towards reduction of maternal morbidity and mortality. In 2009, the component of newborn health was introduced in the mechanism, emphasizing the continuum of care approach. Lessons learned from the implementation of the ComSS initiative has fed into scaling up of the approach. The model has now been mainstreamed in two community-based initiatives in Maternal, Neonatal and Child Survival which cover 10 districts. These initiatives continue to be expanded to ensure the national scale up of the ComSS strategies.

BACKGROUND

Over the last few years, Bangladesh has made significant progress in maternal health with a 32 per cent reduction in maternal mortality during the period of 2000 and 2008; the estimated maternal mortality ratio has declined from 500 per 100,000 live births in 2000 to 340 per 100,000 live births in 2008.1 The proportion of babies delivered in health facilities has also increased from 4 per cent in 1994 (1993–94 Bangladesh DHS) to 15 per cent in 2007 (2007 Bangladesh DHS) although a majority of births still take place at home without a skilled attendant. Bangladesh is now one of a few countries globally that is considered to be on track to achieve MDG 5. Efforts to reduce maternal mortality became a matter of high priority to the nation in the late 1990s. This was the time when linkages between women’s status and maternal mortality were discussed extensively at the national policy level and the issue began to be addressed as a woman’s right. The role of the husband, family and community began to be perceived as central to the prevention of the tragedy of maternal deaths. Partnerships between the

Government, development partners, media and NGOs provided a rallying point for the issue to be brought to the forefront of the national agenda.

Despite the progress, maternal mortality in Bangladesh is still a major concern. About 3-3.5 million women become pregnant each year, about 2.4 million births occur at home annually.2 The major causes of maternal death are postpartum hemorrhage (31 per cent), eclampsia (20 per cent), obstructed prolonged labour (7 per cent) and other causes like complications of abortion (1 per cent).2 Around 550,000 pregnant women develop complications, of which only 29 per cent were attended in medical facilities in 2010.2 Seventy-five per cent of deaths due to pregnancy-related complications are observed at home without any professional assistance.3

In addition, Bangladesh still has one of the world’s highest rates of adolescent motherhood. On average, 23 per cent of women below the age of 20 have had at least one child. Of

1 Inter-agency (WHO/UNICEF/UNFPA/the World Bank) estimates of maternal mortality rate (available from the website ‘UNICEF-Childinfo-monitoring the situation of children and women’). www.childinfo.org/maternal_mortality_ratio.php
2 The Bangladesh Maternal Mortality and Health Service Survey (BMMS), 2010- summary of key findings and implications: www.dghs.gov.bd/dmdocuments/BMMS_2010.pdf
3 Bangladesh EmOC Services Availability Report, 2001
women who die in childbirth, only one in four of their babies will survive their first week of life.

There are several factors affecting the Emergency Obstetric Care (EmOC) utilization rate: the delays in deciding to seek care and treatment, the low status of women within the family, a poor understanding about illness or complications, the family’s economic or educational status, long distances between health centres, low access or high cost of transport. The ComSS initiative is an attempt to address the huge unmet needs in the utilization of EmOC in Bangladesh.

Rationale
An equity-focused reduction of maternal mortality and morbidity is on the national agenda of the Bangladesh government to achieve the MDG 5. The goal is to reduce maternal mortality to 143 per 100,000 live births by 2015. Another goal is to have 50 per cent of births delivered by skilled birth attendants in 2015 from the current rate (26.5 per cent in 2010). Government strategies to improve maternal health are based on a conceptual framework of three elements – rights, management and technology – required for successfully addressing the ‘three delays’ (delays at the family, community and health facility levels) that hinder women from receiving timely, quality health care. To date, efforts to improve utilization at the service facilities have largely focused on upgrading health facilities. While the supply component and the quality of case have been addressed, the demand for services among pregnant women, their families and communities were not given priority.

STRATEGY AND IMPLEMENTATION

Purpose and objectives
The ComSS seeks to increase women’s access and ability to obtain Maternal and Neonatal Health (MNH) services through mobilizing and empowering communities including women themselves and their families. The initiative is a joint effort by the Bureau of Health Education (BHE), the Directorate of General of Health Services (DGHS) and UNICEF as a part of its effort to reducing the maternal and neonatal mortality. CARE, an international NGO, has been engaged by BHE to support Upazila Health and Family Planning Officers in the selected upazilas.

Specific objectives of the ComSS initiative are to:

- Establish community support groups through advocacy meetings and community consultations.
- Conduct household visits through volunteers to identify newborn and the pregnant women in the community and facilitate their access to antenatal care (ANC), postnatal care (PNC), birth planning and their right to access the community support group services.
- Educate family members and the community on the ‘three delays’ in accessing EmOC to ensure better decisions are made.
- Link communities with facilities by involving community health workers and communicating their activity with health service facilities.
- Develop community-based emergency resources such as emergency funds, transportation and blood donors.

Community Support Groups (CSGs)
Each village covering 300-500 households created one community support group (CSG) which consists of selected 6-10 community facilitators. Operationally, CSG members and community facilitators sensitize and orient the community in identifying pregnant women and providing information on maternal health issues and encouraging them to seek care. The CSGs consisted of male and female community members and the volunteers are all females.

The main activities of the CSGs are following:

- Develop community-based emergency resources, such as sustainable emergency funds, transportation, and blood donors.
- Identify pregnant women in the community and facilitate access to antenatal care and birth planning; inform them of their right to access community support services.
- Educate the community about the ‘three delays’ in accessing EmOC and ensure that families are able to make decisions based on this knowledge.
- Create links between communities and facilities by involving family health workers (FHWs) and communicating their activities regularly with the upazila health center.
- Mobilize resources: All ComSS have been generating their own resources through monthly subscriptions from the members of families, local donors, donations from upazila chair/members, and other sources. On average, each ComSS developed a fund of three thousand taka (equivalent to US$ 42) per month. These funds are available to support poor pregnant women and newborns to ensure transportation and medicine during emergencies.

Some CSGs included key community members such as union parishad members, teachers and religious leaders. Those community leaders were also involved in supporting CSGs’ activities including advocacy on maternal health issues, regular dialogue with the health facilities and generating resources.

4 The upazilas are the second lowest tier of regional administration. In Bangladesh, the districts are divided into subdistricts called Upazila or Thana. Currently Bangladesh has 483 upazilas and 509 administrative thanas.

5 Union Parishad is a Government Organ to provide services to the people who lived in rural areas especially villages. It is normally constituted of one Chairman and 12 members. Among the 12 members, three seats are reserved for women.
Implementation
The ComSS initiative was officially launched in mid-2006 in six upazilas and the first CSGs were established in 2007. The six upazilas\(^6\) are known to have comprehensive EmOC services in place at health centers. However, they were among the lowest performing areas with poor maternal care-seeking behavior and high unmet need for EmOC. The objective of the pilot phase (2006-2009) was to establish 30 CSGs in these six upazilas. In 2009 the number of CSGs increased from 30 to 60 in the same upazilas.

Community mobilization and communication
Community mobilization and engagement with local service providers has been one of the key strategies to designing and implementing the initiative. The government has led the overall implementation of the initiative and as a part of its role, CARE has facilitated formation of CSGs, capacity building of community volunteers and implementation of community intervention in coordination with upazila health and family planning officer and other government officials.

Inter-personal communication and community media strategies (traditional and innovative media) have been part of community mobilization. Courtyard meetings, home visits and advocacy meetings have been organized by the community facilitators, CSG members and government upazila mangers at community level. Bengalis, particularly in rural areas, like to be entertained by songs and dramas as they do not have much access to recreation. Therefore, theatre teams and folk singers have been recruited to disseminate messages on Maternal Health and about the community’s responsibility in addressing the problem, particularly among husbands and male members in the community.

PROGRESS AND RESULTS
Since its inception in 2006, remarkable results have been achieved through initiatives that have emerged from the ComSS, with the support of 918 CSG members and 480 Community Volunteers in six upazilas. Key results and achievements from the ComSS are summarized below:

Results from the project: 2007-2009
In August 2009, UNICEF conducted an internal review of the ComSS pilot project in order to determine the feasibility of scaling up the ComSS model. The review methods included quantitative data analysis, desk reviews, interviews and informal group discussions with the government partners, project coordinators, CSG members, community volunteers and support group beneficiaries, and site visits to four CSGs in two upazilas. (Source: draft ComSS internal review report, UNICEF Bangladesh, August 2009). Although it is too early to expect any significant visible results on improvement of maternal health indicators, antenatal check-ups, delivery by skilled birth attendants and referral for complications have begun to increase in ComSS villages.

A total of 1077 women have accessed ComSS services as of August 2009. Quantitative analysis of the data from four out of six pilot upazilas revealed that ComSS villages had higher antenatal care-seeking behavior as early as 2007 than

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\(^6\) Six upazilas included: Shahazadpur, Patgram, Fatikchari, Ajmarigonj, Bauphal and Koyra.
the non-ComSS areas of the same upazilas. In particular, the increase in ANC coverage between 2007 and 2009 was significantly higher in ComSS villages compared with the non-ComSS villages of the same upazilas (figure 1).

Utilization of EmOC services has also increased significantly in the ComSS villages whereas it remained more or less stable across the upazilas between 2007-2009 (figure 2). The timing of referral appeared to be improved: qualitative data suggests that in all four communities visited, members of CSGs explained that they now only wait for 4-6 hours and refer women immediately if danger signs are present (previously waited for 10-12 hours). The number of institutional deliveries has also increased significantly in ComSS villages while it remained stable in the non-ComSS areas.

Results from the project: 2009-2010

In 2009, the ComSS initiative introduced Community Health Promoter (CHP) registration to collect the day to day information of pregnant mothers and newborns. Each ComSS developed a monthly report to analyze the data from CHP registration in the monthly meeting. According to the registry, during the period from November 2009 to October 2010, 3,601 pregnant women and 2,391 deliveries (2,365 live births) were registered in the ComSS villages in the six upazilas. During the same period, only one maternal death and 26 neonatal deaths were recorded in these villages. Table 1 below summarizes indicators in the six ComSS upazilas at community level. Although baseline data is not available, the performance of these sites has improved compared to the national average, especially considering that these sites were among the low performance areas before the initiative.

<table>
<thead>
<tr>
<th>Table 1: Indicators at Community level*</th>
<th>November 2009-October 2010 (source: CHP registration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of pregnant women receiving at least three antenatal care (ANC) sessions from a trained provider (National average in 2010: 23% for four ANC visits)</td>
<td>39%</td>
</tr>
<tr>
<td>% of pregnant women delivered by skilled health personnel (National average in 2010: 26%)</td>
<td>36%</td>
</tr>
<tr>
<td>% of women receiving Post natal care (PNC) by a trained provider within 2 days</td>
<td>36%</td>
</tr>
<tr>
<td>% of newborns receiving thermal care (drying and wrapping) within 10 minutes</td>
<td>70%</td>
</tr>
<tr>
<td>% of newborns receiving delayed bathing (by 72 hrs)</td>
<td>75%</td>
</tr>
<tr>
<td>% of newborns initiating breast feeding within 1 hr of birth</td>
<td>77%</td>
</tr>
<tr>
<td>% of sick newborns receiving care by trained provider/skilled health personnel</td>
<td>92%</td>
</tr>
<tr>
<td>% of pregnant women with completed Birth Planning Card</td>
<td>71%</td>
</tr>
<tr>
<td>% of Women from poor &amp; vulnerable group participating in development &amp; implementation of CG Action plan</td>
<td>40%</td>
</tr>
<tr>
<td>% of women from the community who received care for maternal complications**</td>
<td>95%</td>
</tr>
</tbody>
</table>

* Extracted from the Progress report by CARE International submitted to UNICEF-Bangladesh

**Pregnant women identified with danger signs during pregnancy by CHV
During this reporting period, ComSS has raised 26,130 taka (US$ 350-400) in support to the poor pregnant women. Total 720 pregnant women received various types of supports from their respective ComSS (e.g. financial supports for transportation, local transport arrangements and being accompanied by CSG member during emergency). Also during this period, the CSG member expanded their role beyond health issues. They are being involved in activities addressing social issues in their community and facilitating community discussion in cases of gender based violence, referral supports for childhood sickness, child education etc.

**Behavioural changes**
The internal review which took place in 2009 revealed that the CSG members had become aware of danger signs and better understood the need for their involvement in helping pregnant women and families during obstetric emergencies. They now have information about Essential Newborn Care (ENC) and have initiated dissemination of key messages in communities. Records of upazila health complexes in the pilot areas show that more women are coming from villages for delivery at health centres where CSGs are established, compared to the non-intervention villages.

Qualitative data also suggests that the CSGs are gradually affecting changes in social norms in addition to individual level behavioural change. CSG members, volunteers and a number of pregnant women suggested that the presence and work of the CSGs has led to a change in families’ awareness of their rights to access EmOC services. The change in awareness is most closely related to care seeking behavior for pregnancy complications.

The review also revealed a tangible change in each of the four unions regarding perceptions of pregnancy. Male community leaders spoke vehemently about the importance of EmOC and proudly explained that there had been no maternal deaths in any of the four communities since the community groups began. Young women and girls were proud of their role in identifying pregnant women and reminding them of attending their ANC visits and to look for danger signs. Pregnant women explained that they had informed CSG members of their pregnancies as soon as they knew.

**Scale up of the ComSS model**
As agreed by UNICEF, the financial and technical support from CARE has been stopped since October 2010. However many interventions and lessons learned from the initiative have helped design and scale up two similar community-based initiatives: the Maternal and Neonatal Health (MNH) Initiative implemented in four districts; and the Maternal, Neonatal and Child Survival (MNCS) Initiative in six districts. The model and strategies used in the ComSS initiative have been adapted to these larger initiatives which are now covering 57 sub-districts. Not only UNICEF, JICA and several other partners currently implementing a similar model, but the Government of Bangladesh has also incorporated this strategy in the next sector programme document.

In 2010, CARE Bangladesh together with DGHS-BHE and UNICEF organized an Exit plan workshop with participation of all stakeholders at each of the six upazilas. The aim of the workshop was to review and identify the best practices and ensure the support of the stakeholders for continuity of identified activities. In the day-long workshop, stakeholders discussed on ComSS activities, its achievements, challenges and lesson learned.

Main outcomes of the Exit plan workshop included:
- Stakeholders became more aware and committed to continue the ComSS activities
- An Action Plan (that includes a list of activities with schedule for sustainable ComSS, responsible persons for execution of the activities and follow-up status) was identified and agreed upon among stakeholders to execute and follow-up of ComSS activities.
- On behalf of the initiative, CARE staff handed over the files with respective Upazila project information to the health authority. The files contain information on the ComSS working area, statistics on households and population, name and contact address of CSG members, Community Volunteers and Community Health Promoters, update on upazila/ union ComSS federation, and the reporting format.
- The BHE has communicated with the concerned Upazila Health and Family Planning Officers to continue their support to ensure the sustainability of the ComSS activities.

**LESSONS LEARNED**
The ComSS initiative has been a continuous learning process on community mobilization and community engagement from which community interventions in two maternal, neonatal and child survival initiatives have stemmed. The main challenges for the ComSS initiative were to dedicate the time required to mobilize families and communities, to establish effective linkages with family, community and all levels of the health system, and to ensure quality services at health facilities for pregnant women and newborns. Integrated support from upazila, district and national levels in implementation and monitoring of ComSS activities was critical to the success of the initiative. Results from the internal review of the initiative (UNICEF-Bangladesh, August 2009) revealed that CSGs are gradually affecting changes in social norms in addition to behavioural change at individual level. In other words, they may be contributing to transform pregnancy and childbirth...
into a community development issue, rather than just a women's issue.

Moreover, the practical value of the CSG structure has started to produce unanticipated positive outcomes. Two of the four CSGs visited during the review have expanded their work in behavioural change and advocacy to other areas, such as domestic violence and early marriage. They also allowed emergency transport and funds for EmOC to be used for child health emergencies. Building upon their initial success on maternal health, CSGs could bring valuable support to communities' other mobilization and social change efforts as illustrated below:

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“……community support groups are playing a very crucial role in helping villages become model villages. If our community was always as much aware of the problem related to pregnant mothers as they are now, our village would not have seen so many tragedies in the past. In fact, this group is not only beneficial to pregnant mothers it is also helping the general people access and receive health services.”
− a joint secretary of Jugnidah CSG
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Capacity development activities such as initial and refresher training and on-the-job training for CSG members, community volunteers and community health promoters have contributed to their active participation as community change agents. These activities were crucial to develop as well as sustain the changes in attitudes, beliefs and behaviours among family and community members. This change is necessary to bring about a social transformation in the improvement of health status of women and children.

The capacity development activities also contributed to empowering the CSG members to speak on behalf of their communities. For example, by linking CSG members with government officials (health and family planning) through meetings, they have become capable of talking directly with the health centers, requesting the appropriate services for pregnant women in their communities.

**INNOVATIONS**

Several innovative approaches have risen as a result of the lessons learnt from the ComSS initiative including:

- CSG membership identity card developed by the Upazila Health and Family Planning Officer and chairperson of the CSG
- Referral slips and birth planning cards provided to pregnant women. A referral slip generated at community level with signature by CSG chairperson made easier for pregnant women and their family members to obtain services at facilities.
- Vans purchased/organized with money from the groups to assist with transportation needs. In addition, some CSGs have entered into agreements with public transport owners/drivers including boatmen and rickshaw pullers, to take pregnant women to the health centres whenever necessary
- A network for family emergency created and cell phone numbers of service providers, CSG members and transport providers compiled to facilitate emergency contacts.
- Lists of blood donor groups at community level compiled
- Resource mobilization mechanism in the communities to help poor families of pregnant women meet expenses for obstetric emergencies
- Community assessment and preparation of community and upazila action plans.

**NEXT STEPS**

With the support of local health authorities, the action plan identified through the Exit plan workshop will continue to be rolled out. The MNH and MNCS initiatives will be scaled up to six additional districts to expand the coverage of the ComSS strategies.

While knowledge about Maternal and Neonatal Health issues and demand for EmOC services has increased in communities, 24 hour service provision remains limited at the facility level. In addition, quality of care for pregnant women remains inadequate. These issues need to be further addressed in further scaling up the ComSS model.

**RELATED LINKS**


'Community groups saving women's lives, FahimUddin Ahmed' (UNICEF Bangladesh website, May 2010: www.unicef.org/bangladesh/media_6239.htm)
INNOVATION

NEPAL
Reaching MDG 4 with equity – a continuum of care model for newborn care

ABSTRACT
Despite many years of conflict and political instability—and despite the country’s weak facility-based health services—Nepal has seen substantial improvements in Maternal and Child Health. However, neonatal mortality has not shown much change. Recognizing this, UNICEF has strategically shifted its attention to advocating for urgent action to this highly neglected group of newborns. Over the last 20 years, Female Community Health Volunteers (FCHVs) have had a tremendous impact on the reduction of under-five deaths due to pneumonia and diarrhoea. With low turnover rates, their close proximity to the community underlies their success in providing undisturbed services even during times of violent conflict. UNICEF together with the government and partners embarked on the development of a Community Based-Newborn Care Package (CB-NCP) that includes seven simple-to-learn and easy-to-implement interventions. Preliminary data on the performance of trained FCHVs is revealing their successful adoption and implementation of CB-NCP knowledge.

BACKGROUND
Despite a significant decrease in under-five and infant mortality in Nepal, neonatal mortality has not shown much change. Recent figures estimate neonatal mortality at 33 deaths per 1,000 live births accounting for 54 per cent of under-five deaths (NDHS 2006). Reduction of the high neonatal mortality rate is an urgent priority for achieving MDG 4. The country has high rates of home delivery without skilled assistance and poor access and utilization of facility-based services, particularly in rural areas. The NDHS 2006 reveals that the delivery rate at institutions is as low as 18 per cent and only 19 per cent of deliveries are assisted by a skilled birth attendant (SBA).

Even where the services of an SBA are available, focus is usually on the mother and the newborn is often only considered once the mother is taken care of. The status of newborn care in institutions is inadequate; most institutions lack even rudimentary care equipment/facilities and trained staff. Long distances to travel to reach an institution, poor transport facilities, and the high costs involved are additional unfavorable factors. Due to this situation, UNICEF has strategically shifted its attention to advocating for urgent action on this highly neglected age group of newborns.

A baseline survey of three UNICEF-supported project districts (Kavre, Chitwan, and Dang) revealed that community newborn care practices were far from satisfactory. Birth preparedness was poor and there was hardly any postnatal care.

Nepal has a well-structured public health infrastructure—sub health posts, health posts, primary healthcare centres, and district and regional hospitals. Each ward, consisting of 80–100 households, has an FCHV. FCHVs, based in their own community and often the nearest and easiest health workers to approach, were not involved in newborn care. It was clear from these findings that a community-based approach to newborn care, involving available resources (FCHVs and community health workers at the next level), was urgently needed and that without such an approach, many more newborns would die of preventable and treatable causes of neonatal mortality.

STRATEGY AND IMPLEMENTATION
UNICEF together with the government and partners developed a Community Based-Newborn Care Package (CB-NCP). Based on the Lancet series on newborn survival, the package has seven simple-to-learn and easy-to-implement interventions at its core and adopts the continuum of care approach.

1 www.thelancet.com/series/neonatal-survival
The CB-NCP has been rolled out from the community to the health facility, and covers the antenatal period, the intra-natal period, and the postnatal period. Interventions include the following:
1. Behavioral Change Communication (BCC) on key messages in Neonatal Health
2. Birth preparedness, and promotion of institutional delivery and clean delivery practices in case of home deliveries
3. Postnatal care for mother and baby on days 0, 3, 7 and 28 of birth
4. Community case management of pneumonia and possible severe bacterial infection
5. Care of low-birth-weight newborns
6. Prevention and management of hypothermia
7. Recognition of asphyxia, and initial stimulation and resuscitation of newborns

Adopting the continuum of care approach, the CB-NCP hopes to reduce the number of newborn deaths in the community. An important recommendation of the strategy is that FCHVs be present during deliveries, receive the newborn, provide immediate birth-related care, and follow up with care during the immediate postnatal period and afterwards, while the SBA takes care of the mother. It is hoped that the presence of two trained workers will ensure that the newborns are not neglected and given as much priority attention as mothers.

The policy, guidelines, training package and methods for imparting training and building skills have been developed, and training has been initiated in ten pilot districts. The CB-NCP involves training of workers at all the above mentioned levels so as to facilitate good referral care if needed. Those include FCHVs, facility- and community-based health workers, traditional/faith healers and mothers groups

PROGRESS AND RESULTS
In 2010, a large number of service providers were trained through the CB-NCP in three districts including: 2,062 FCHVs, 502 facility-based health workers, 275 community-based health workers, 662 traditional/faith healers and 30,960 mothers in mother's groups. UNICEF has also assisted the government to prepare a BCC strategy for the CB-NCP. Anecdotal evidence on the performance of trained FCHVs indicates their successful adoption and implementation of knowledge and skills in neonatal health, suggesting a potential impact on the reduction of neonatal mortality.

Changes in the performance against key indicators eight months after training in Dang District are found in Table 1. In addition, reported changes in their knowledge level include:
- More than 87 per cent of health workers, 70 per cent of Community level service providers and more than 80 per cent of FCHVs were aware of the six cleans during delivery (i.e. clean hands, clean perineum, clean delivery surface, clean cord cutting and tying instruments, and clean cutting surface).
- More than 90 per cent of health workers, 86 per cent of Community level service providers and more than 80 per cent of FCHVs were aware of the five essential newborn care services.
- More than 95 per cent of service providers of all levels were aware of at least five danger signs for newborns.

INNOVATION
The innovative aspects of this initiative are:
1. Development of a Community Based-Newborn Care Package that adopts the continuum of care approach and includes seven simple-to-learn and easy-to-implement interventions at its core. Use of simple training and capacity-building, community-based health volunteers (FCHV in Nepal context) can help provide essential newborn care services effectively in the absence of trained health professionals, and can assist in decreasing neonatal mortality and accelerating progress towards the achievement of MDG 4.
2. Focusing on providing adequate care to newborns who are often otherwise neglected at birth by health professionals who focus only on the mother. The strategy involves training and capacity building of FCHVs and making sure that they are present during deliveries to receive the newborn, and provide immediate newborn care, while a SBA takes care of the mother. It is hoped that the presence of two trained workers (trained FCHV and SBAs) will ensure that newborns are not neglected and given as much priority attention as mothers.
3. The programme also ensures training of health workers at all decentralized levels within the health system (sub health posts, health posts, primary healthcare centres, and district and regional hospitals). This contributes to quality emergency referral care of newborns.

POTENTIAL APPLICATION
This programme can be introduced and scaled up in countries where access to trained human resources for newborn care is limited, geographical access is difficult and the road and public infrastructure is poor or deteriorating, and where most deliveries take place in homes. The presence of community workers/volunteers is not a pre-requisite but greatly facilitates and accelerates the introduction of this strategy. If there is an existing community-based programme such as Community-Integrated Management of Childhood Illness (C-IMCI), relevant newborn care

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2 The principles of the 'six cleans' recognized by WHO
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline*: 2008</th>
<th>Service Data after 8 months: 2010-2011</th>
</tr>
</thead>
<tbody>
<tr>
<td># of newborns enrolled</td>
<td>NA**</td>
<td>45% (n=122257)</td>
</tr>
<tr>
<td>Biophysical profile (BPP) Counseling by FCHV</td>
<td>NA</td>
<td>40% (n=13623)</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td>32%</td>
<td>59% n=5455</td>
</tr>
<tr>
<td>Health Facility Delivery</td>
<td>66%</td>
<td>39% n=2114</td>
</tr>
<tr>
<td>Delivery conducted at home</td>
<td>2%</td>
<td>2% n=2567</td>
</tr>
<tr>
<td>Others ( on the road, or history not available)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Home Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery conducted by SBA</td>
<td>8%</td>
<td>12% n=1924</td>
</tr>
<tr>
<td>Clean Delivery Kit used during delivery</td>
<td>19%</td>
<td>60% n=1314</td>
</tr>
<tr>
<td>Presence of FCHV during delivery</td>
<td>5%</td>
<td>70% n=34</td>
</tr>
<tr>
<td>Immediate Newborn Care by FCHV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dried</td>
<td>51%</td>
<td>71% n=2114</td>
</tr>
<tr>
<td>Wrapped</td>
<td>51%</td>
<td>68% n=2114</td>
</tr>
<tr>
<td>Breastfeeding within 1 hr.</td>
<td>57%</td>
<td>72% n=2114</td>
</tr>
<tr>
<td>Birth weight taken by FCHV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight taken within 3 days of birth</td>
<td>14%</td>
<td>91% n=1924</td>
</tr>
<tr>
<td>Low birth weight identified by FCHV</td>
<td>4%</td>
<td>6% n=1314</td>
</tr>
<tr>
<td>Very Low birth weight identified by FCHV</td>
<td>NA</td>
<td>2% n=34</td>
</tr>
<tr>
<td>For Asphyxiated baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asphyxiated baby identified in home delivery where FCHVs were present</td>
<td>NA</td>
<td>7.40% n=110</td>
</tr>
<tr>
<td>No of baby cried after initiating stimulation</td>
<td>NA</td>
<td>46% n=51</td>
</tr>
<tr>
<td>No of baby cried after use of Dee Lee Suction Tube</td>
<td>NA</td>
<td>23% n=25</td>
</tr>
<tr>
<td>No of baby cried after use of Bag &amp; Mask</td>
<td>NA</td>
<td>31% n=34</td>
</tr>
<tr>
<td>Neonatal outcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of live births recorded***</td>
<td>NA</td>
<td>n=5291</td>
</tr>
<tr>
<td>Newborn deaths reported</td>
<td>NA</td>
<td>0.5% n=25****</td>
</tr>
<tr>
<td>Sick newborn identified by FCHV</td>
<td>NA</td>
<td>0.7% n=38</td>
</tr>
<tr>
<td>Treatment of sick newborn by FCHVs with Cotrim</td>
<td>NA</td>
<td>0.7% n=37</td>
</tr>
<tr>
<td>Treatment with Cotrim by VHW/MCHW/HF level staff</td>
<td>NA</td>
<td>2% n=96</td>
</tr>
<tr>
<td>Treatment with Gentamycin by VHW/MCHW/HF level staff</td>
<td>NA</td>
<td>1% n=68</td>
</tr>
</tbody>
</table>

*Baseline survey was a 30X20 -cluster survey where 600 Recently Delivered Women (RDW) were interviewed using a set of questionnaires. The service data is based on longitudinal time-series data to 8 months after completion of training.

**NA refers to the fact that the service was not available during the baseline survey and was included as part of the newborn intervention after the survey.

***In the baseline survey done in Dang and three other districts, out of 4885 live births recorded three years preceding the survey, 85 were reported to die within one month of birth resulting in a NMR of 17.4 per 1000 live births.

****The Neonatal mortality per 1000 live reported birth comes to approximately 4.7.
components of the CB-NCP can be added to it and similar results can be obtained.

In scaling up this intervention, it is important to consider addressing the quality of newborn care services in health facilities especially birthing centres and basic and comprehensive EOC sites, parallel to the introduction of the community-based interventions. This is because of the need to respond to sick newborn babies referred from the community and due to rising institutional delivery rates (as has happened in Nepal following the introduction of the Amaa Programme which provides free maternity services).

**NEXT STEPS**

The government has already planned to scale this intervention to 25 districts in 2011. Considering the need for rapid expansion of the CB-NCP to the remaining districts, the government has initiated a plan to integrate relevant newborn and postnatal components of the CB-NCP into C-IMCI, for which the FCHV remains the key service provider. However, progress has been slow as the government wishes to see the outcome of the CB-NCP pilot before taking a decision. An evaluation will be conducted to assess the efficacy and impact of this strategy on newborn mortality.

Advocacy by UNICEF Regional Office in South Asia with the South Asian Association for Regional Cooperation (SAARC) in 2008 on enhancing the availability and quality of newborn care in South Asian countries and supporting the initiation of programmes to reduce neonatal mortality led to SAARC’s commitment to support an institution-based newborn care programme in five countries in 2009. UNICEF is working closely with the Government of Nepal on the implementation of this SAARC Development Fund support project for the promotion of health facility based newborn care.
BACKGROUND
In 2010, as a result of poor quantity and distribution of rainfall, 47.7 per cent of households, representing about seven million people, were confronted with a situation of moderate to severe food insecurity. Consequently, the prevalence of acute malnutrition among children aged from 6-59 months rose from 12.3 per cent in 2009 to 16.7 per cent in 2010. Prevalence exceeded the emergency threshold (> 15 per cent) in four of the eight regions, and exceeded the alert threshold (> 10 per cent) in the rest of the country. Children aged between 6 and 23 months were the most seriously affected. According to Nutrition Cluster estimates, 384,000 children were affected by SAM and 1,215,000 by moderate acute malnutrition in 2010.

STRATEGY AND IMPLEMENTATION
Niger has a network of 50 In Patient Facilities (IPF) for the treatment of SAM with complications, and 772 Out Patient Treatment Program sites (OTP sites) spread across the entire country. UNICEF supported the Ministry of Public Health (MSP) through its decentralized services at regional and district levels to set up and implement a large scale case identification and referral plan for management of acute malnutrition cases. The goal of the initiative was early identification and successful management of acute malnutrition cases among children.

ABSTRACT
In 2010, as a response to the food and nutritional crisis, Niger successfully provided care for more than 330,000 children suffering from severe acute malnutrition (SAM) in 822 treatment centres. Integration of care for severe acute malnutrition into the existing health system was the key factor for successful management of a huge number of cases of malnutrition in a timely manner. This required strengthening of the health services through adopting the national directive and policy, and investing resources to recruit surge capacity based on the analysis of the implications of the crisis. Existence of a vast network of NGOs specialized in the treatment of acute malnutrition further supported local capacity development to provide quality care for acute malnutrition cases. The future plan is to extend this model to children with moderate acute malnutrition to increase coverage.

LESSONS LEARNED
NIGER
Providing care for severe acute malnutrition cases in the context of a fragile health system

Learning from the nutrition emergency response in 2005, MSP issued a directive to integrate the care and management of SAM cases into the existing health system as compulsory to every stakeholder to ensure sustainability. Since 2007, UNICEF has been working both with MSP and implementing partners to facilitate the implementation of this directive.

In 2010, the programme supported the following approaches to develop capacity in care and management of acute malnutrition cases:

- Training of more than 700 health officers in the care of acute malnutrition
- Capacity-building for the hospitalization of severely malnourished children. This includes, in addition to training service providers, extending hospitalization capacities by either adding extra beds or raising tents to increase space, or rehabilitating existing premises to accommodate more children affected by severe malnutrition, supply of medical equipment, and provision of additional human resources to adequately handle the caseload of SAM
- Supply of sufficient quantities of therapeutic inputs (Ready to Use Therapeutic Foods (RUTF), therapeutic milk, essential drugs, etc.)
- Capacity building of decentralised health units through supportive supervision

Each of the 822 treatment sites collect and send data on the number of new cases of SAM received and treated every week. Simple forms were designed and a compilation and dissemination system was set up. This system was strengthened through a series of training opportunities for data managers at central, region and district levels, improving their access to and use of information technology for data collection, compilation and dissemination. In each treatment center at least one person was trained and is in charge of data collection and compilation. Several innovative means were introduced to facilitate the data collection and transmission system between regional and central levels, including the use of SMS messaging and internet.

**PROGRESS AND RESULTS**

Niger now has a strong endogenous capacity to manage cases of acute malnutrition; as of the end of 2010, more than 90 per cent of IPF / OTP are integrated into existing government-run health facilities. In 2010, a total of 330,893 children with SAM had received treatment in the 822 nutritional rehabilitation centres available in Niger. A total of 40,660 children were hospitalised, while 290,233 children received outpatient treatment. The decentralization of the treatment of SAM without medical complications to all health centers units dispensing RUTF made it possible to significantly increase access to treatment for cases of acute malnutrition.

The ability to provide care for such a large number of cases of SAM reduced malnutrition-caused mortality; the death rate remained at about two per cent which is below the maximum threshold of 10 per cent by the SPHERE Standard, the Humanitarian Charter and Minimum Standards in Disaster Response. The recovery rate, at about 80 per cent, is above the acceptable minimum threshold of 75 per cent. In addition, the dropout rate is only 6 per cent compared to the acceptable maximum threshold of less than 15 per cent (source: Ministry of Health, Niger).

**LESSONS LEARNED**

The major factors that have enabled Niger to effectively handle such a huge number of cases of acute malnutrition are the following:

- **Integration of the policy of Integrated Management of Acute Malnutrition (IMAM) into the national health system has led to building capacity of the existing health system, contributing to improved quality of care for malnutrition cases**: Although this approach is unusual in situations of crisis/emergency (where it is more common to see parallel structures), this made it possible for international NGOs specialised in this area to bring their technical know-how and high standard of quality of services into the state-run health services.

In terms of strengthening human resource capacity, based on the caseload and the number of staff available, MSP made an analysis of surge capacity required to successfully roll out the nutrition emergency plan, jointly designed with other partners. UNICEF provided resources to the government to recruit additional staff when needed.

- **The presence of a large number of NGOs specialised in the treatment of acute malnutrition supported enhanced quality of treatment of state-run services** in accordance with international standards. This was also a decisive factor in boosting care-giving capacity.

- **The establishment of a mechanism for regular monitoring of new admissions in treatment centres permits more effective planning and implementation of the emergency response.**

- **Needs-based planning as opposed to planning based on available resources**: At the onset of the crisis, the Nutrition Cluster met to define the magnitude of the crisis and plan upon it. Estimation was made for the worst-case scenario, countrywide, irrespective of resources available. This approach allowed the cluster to mobilize resources for all, including those who would have been excluded if the planning was made based on the available resources and used various criteria to target beneficiaries.

**POTENTIAL APPLICATION**

Incorporating malnutrition management into the health system in Niger has helped prevent the critical situation of acute food insecurity among children aged between 6 and 59 months from turning into a major disaster. This policy could be adopted and implemented in other countries, especially in the Sahel countries, which are predisposed to natural disasters, in order to build their capacity to provide an adequate response to a major crisis.

**NEXT STEPS**

The priority for Niger is to build on the successful model for the management of SAM and adapt it to the management of moderate acute malnutrition. This will allow extended coverage, and improved access to care for children affected by moderate acute malnutrition. A special emphasis should be placed on the choice of inputs used so as to maintain the quality of care and other services delivered by the health centres. It is also critical to reduce caseload due to acute malnutrition to protect the health system. Emphasis will therefore be placed on scaling up interventions aiming at preventing onset of malnutrition among young children.

3 [www.sphereproject.org](http://www.sphereproject.org)
SIERRA LEONE

‘Making it Happen’—
capacity building of health personnel in maternal and neonatal care

ABSTRACT

Sierra Leone has the highest maternal mortality rate in the world, estimated at 857 per 100,000 live births. The country also faces a chronic human resources shortage which impedes health care staff recruitment and training. A key approach to reducing the high maternal mortality rate is to ensure that all women deliver with the assistance of skilled health workers and that they have access to quality emergency obstetric care. To increase the proportion of deliveries assisted by skilled health workers, UNICEF Sierra Leone partners with the Liverpool School of Tropical Medicine (LSTM) to implement ‘Making It Happen’, an innovative competency-based training programme for health personnel. Using mannequins for demonstrations, the project adapts a tested model to improve competency of health personnel in life saving skills, emergency obstetric & newborn care. Implemented in five countries in Africa and Asia, this cost-effective and time-efficient model is designed for countries facing human resource constraints in health. To date, nearly 120 health providers and 30 supervisors have been trained through this programme. There are early indications that neonatal survival is improving in participating facilities, due to an increased number of skilled deliveries and a reduction in stillbirth/intrauterine fetal death.

BACKGROUND

Sierra Leone faces a situation of high poverty, illiteracy and fertility levels, as well as high teenage child bearing rates and a low uptake of family planning. The country also faces a chronic human resource shortage, especially in underserved rural areas. These factors combine to produce the highest maternal mortality rate in the world, estimated at 860 per 100,000 live births (State of the World’s Children Report, 2011).

There have been recent improvements in Sierra Leone in childhood mortality indicators; nevertheless, they remain high. The under-five mortality rate is 140 deaths per 1000 live births; infant mortality is 89 deaths per 1000 live births and neonatal mortality is 36 per 1000 live births. Forty per cent of all infant deaths take place during the first 28 days of life. The newborns die from largely from four preventable conditions: birth asphyxia; neonatal infections; hypothermia and low birth weight (figure 1). Skilled attendance during delivery and skilled post natal care attendance during the first 24 to 48 hours offer the best survival lifeline for both mothers and newborns since most of the associated mortality takes place during this same period. However, many Sierra Leonean women and newborns are excluded from this lifeline because only 25 per cent of births occur in health facilities and about 42 per cent of deliveries are assisted by a skilled service provider (DHS, 2008). In addition, only 38 per cent of mothers receive their first post natal check-up within four hours after delivery. The skill level of the service provider and the number of such providers has long been a recognized bottleneck in Sierra Leone’s health care system that is in the process of recovering from long periods of neglect.

The country has approximately 1,275 health facilities, most of which are managed by the government. The public health sector has about 24 public health specialists, 29 medical specialists, 115 medical officers, 132 community health officers, 1017 nurses and 825 maternal child health aides. Following efforts to recruit additional staff as part of the Free Health Care (FHC) policy launched in April 2010, the number of health facilities with only one staff reduced from 59 per cent to 33 per cent. However, acute human resource shortages remain, particularly in rural areas.

STRATEGY AND IMPLEMENTATION

The goal of the project ‘Make It Happen’ is to improve knowledge and skills, leading to a better quality of clinical practice. The project uses a tested innovative model, developed by LSTM to provide competency to health personnel in Life Saving Skills, Emergency Obstetric & Newborn Care. The programme delivers a competency based training package adapted to country context which is sustained by training of in
country trainers (TOT) and through supportive supervision within the workplace. A common monitoring and evaluation framework has been applied across all target countries to measure project performance and impact at individual health care provider level, at facility level and where possible on health outcomes for mothers and babies.

A critical first step in the development of this training programme is to assess the baseline status of all target health facilities providing Emergency Obstetric Care (EmOC) and Emergency Obstetric and Neonatal Care (EmONC). In Sierra Leone, this assessment was conducted in 2 phases. The first phase took place in October 2009 and assessed selected hospitals in Freetown and selected district hospitals and Community Health Centres (CHCs) in Bo district. The current level of functioning with regard to Maternal and Neonatal Health and in particular skilled birth attendants, emergency obstetric care and newborn care, numbers and cadre of staff, the status of record keeping in each facility in the past three months was assessed and whether or not there were any ongoing quality improvement activities. The second phase took place in April 2010; assessing all district hospitals and CHCs in Bombali district. The data collected during these assessments has enabled the development of a realistic work plan for training activities and has provided a baseline to assess the effectiveness of training.

The training programme uses anatomical models (mannequins) instead of the traditional model of using actual patient cases in the wards. For the traditional training model, patients with particular conditions may not be there all the times hence not all skills may be demonstrated in a real setting. The training agenda takes 4 days and includes core ‘modules’ on: Communication, triage and referral; Resuscitation of mother and newborn; Shock and the unconscious patient; Severe pre-eclampsia and eclampsia; Haemorrhage; Obstructed labour; Sepsis; Assisted delivery; Other common obstetric emergencies; Complications of abortion; and Early newborn care. The training package includes a section on surgical skills and on normal delivery (Skilled Birth Attendance). More details are available upon request.

Lectures and content of breakout sessions, discussions and demonstrations are standard and documented in a Facilitator Guide. This also contains practical details of the course infrastructure. Both the manual and course content were designed with an awareness of the very real barriers to accessing care that women in resource poor countries have, as well as with the realization that many health care providers trying to provide Skilled Attendance at Birth and Essential (or Emergency) Obstetric Care for women with complications, work in difficult circumstances with limited resources. All case scenarios are based on actual everyday scenarios. A multidisciplinary approach is the basis for effective delivery of this training programme; all cadres of staff involved in obstetric and newborn care are targeted and preferably trained as a team.

**PROGRESS AND RESULTS**

In Sierra Leone, a total of 194 health service providers and 25 retired midwives have been trained since the start of ‘Make It Happen’ in October 2009. The support supervision function was strengthened with the training of 29 supervisors. The programme has improved capacity of health care providers to deliver quality maternal and newborn health and emerging evidence points to improving maternal and neonatal outcomes (Similar findings are emerging from Bangladesh and Kenya as well). Below highlights key results from the baseline and a three months post-training assessment (Source: Liverpool School of Tropical Medicine and Royal College of Obstetrics and Gynecologists. ‘Making It Happen’ Report on Supportive Supervision and Monitoring and Evaluation visits. Sierra Leone. April 2010).

**Changes in performance indicators**

There is a reported increase in the number of deliveries in these participating facilities (from the baseline level of 934...
to 1219 at 3 months post interventions) which appears to be above and beyond the increase experienced more generally across the country following implementation of the Free Health Care policy. Reduction in Case Fatality Rate (CFR) was noted in five direct obstetric complications three months after the training as compared with baseline data. These complications were retained placenta (7.7% to 0%), postpartum haemorrhage (33% to 7%), prolonged-obstructed labour (3.5% to 0%), puerperal sepsis (50% to 25%), and ruptured uterus (40% to 27%). No fatalities occurred from women with prolonged/obstructed labour and retained placenta. There are early indications that neonatal survival is improving in these participating facilities. The April 2010 launch of the ‘Free Health Care initiative’ for pregnant women and under-fives in the country, which ensures adequate supply of drugs, equipment and staffing, is helping to support the progress of ‘Make It Happen’.

Behavioural change

Improved staff skills and clinical practice have been documented in about half of the targeted health facilities. For instance, before receiving training, 79 per cent of the providers assessed (N=39) reported not being competent in venous cut down and management of shoulder dystocia. About 50% of the providers reported not being competent in various skills including: cardiac compression, assisted breech vaginal delivery, management of pregnancy related sepsis, vacuum extraction, and management of neonatal sepsis, etc. A post-training assessment showed that although the sample size was small (N=22), 86 per cent of the respondents reported being confident in management of the unconscious patient and episiotomy repair. Seventy-nine percent were competent in cardiac compression, newborn resuscitation, use of the partograph, management of third stage of labour and manual removal of placenta and perineal tear repair. Focus Group Discussions with participants conducted for a post-training assessment also indicates an increased knowledge and confidence level among health providers:

“Two things have come to mind.....we have been using the partograph all along but then the manner in which we used to plot was...always start at zero, you know... the zero line before the training but after the training we know now we have to start on the last line ..... 4cm dilated, that is one......” – FGD2 Number 1

There is a change of management of patients with eclampsia as not all eclamptic patients now undergo caesarean section:

“Well we see a number of eclamptic patients, before the training we tended to rush them to the theatre... not all people can afford it.... so the care we give them now is better, we stabilise them and plan for vaginal delivery.....” – FGD1 Number 2

Changes at national level

In Sierra Leon, clinical practice guidelines and protocols were not available before. The project helped MOHS develop protocols for managing EOC and Neonatal Care which are now displayed in labour rooms and maternity unit of all government facilities in Sierra Leone. Three sets of training equipment have been provided to hospitals and been used to train maternal and neonatal health providers. The training has also led to health care providers requesting for Kiwi vacuum sets from UNFPA. UNFPA has procured 100 Kiwi sets all facilities nationally. The Kiwi system is easy-to-use, easy to maintain, effective and has proven to be less psychologically threatening for mothers than the older Malmstrom equipment. Further training on vacuum assisted delivery has been organized for doctors and Community Health Officers.

INNOVATION

The training programme uses mannequins for demonstrations and incorporates support, supervision, monitoring and evaluation. The use of mannequins for demonstrations significantly reduces training time and has been proven to be highly effective in imparting competency training within the broader context of the country’s chronic human resources shortage. Specifically, this model makes it possible to train more health workers per session than is possible with traditional facility-based training as more people can practice with the mannequins as opposed to what would be possible with actual patients. In addition, the training is four days long (previous trainings were ten days long) and therefore decreases the number of days health care workers spend away from work. Due to the human resources shortage, there are not enough workers to replace those who are out for training.

POTENTIAL APPLICATION

Traditional facility-based training requires high patient case load and most existing training programmes take no less than 10 days. Even then, some complications can be missed so that it is difficult for trainees to achieving comprehensive competency in relation to most important complications. This training is therefore ideal for countries where there is a chronic human resources shortage, lack of skills, weak supervision systems and where the case load may not be sufficient in supporting competency based training. LSTM and UNICEF are replicating the programme in Bangladesh, India, Kenya, and Zimbabwe.

NEXT STEPS

The project launched in October 2009 with the objective to cover 65 health facilities in three districts in two years, and is still ongoing. The fact that the innovation has shown positive results implies potential for replication in similarly challenged countries.
CHAPTER II
CAPACITY DEVELOPMENT IN WATER, SANITATION AND HYGIENE
ABSTRACT

UNICEF, Practica, and Enterprise Works/VITA have developed a toolkit for African countries wishing to embark on the professionalization of manual drilling. The toolkit is used to build capacity of the local private sector in order to respond to the ever increasing demand for safe water in rural areas. Based on the experiences from Niger, Chad, and Senegal, the toolkit includes technical notes and manuals, advocacy materials, mapping of suitable areas for manual drilling, case studies, and implementation and training manuals which provide a step-by-step methodology for the promotion of a local professional manual drilling sector. Drawing on these experiences and using the expertise available in the partnership, country programmes are tailored to meet the needs and means to support the individual countries. As of February 2011, 16 African countries are participating in one or more steps of the process.

BACKGROUND

In Sub-Saharan Africa, it is estimated that in order to reach the MDG water supply target, an additional 33 million people need to gain access each year. The high cost of developing potable water sources is a major impediment to improved water access for many rural people. In Africa, UNICEF estimates the cost of concrete-lined, hand-dug wells (up to 25 metres deep) equipped with hand pumps to be USD 4,000-6,000, and medium depth drilled wells (50-200m) equipped with a hand-pump to cost about USD 12,000-25,000. These figures include all of the associated training and overhead costs.

A number of factors contribute to the high costs of drilling in Africa including the limited number of drilling rigs and the lack of competition, which have resulted in large profit margins, high costs of spare parts, poor infrastructure, dispersed markets, and high costs of pumps and casings. In addition, the lack of adequate infrastructure including roads and bridges make it difficult for large rigs to reach the drilling sites, even in the dry season, and impossible once the rains begin to fall. At the prevailing prices, neither the local communities nor donors can satisfy the huge demand for potable water, especially from small communities in rural areas which account for a high percentage of the unserved population. Therefore, there is a need to provide solutions that are affordable and allow households in rural communities to obtain access to potable water.

STRATEGY AND IMPLEMENTATION

Manual drilling offers a practical solution for the construction of wells less than 40 metres deep in alluvial soils or soft rock formations. There are many areas in Africa where it can effectively provide drinking-water to unserved rural populations at a fraction of the cost of conventional drilling.

The activities were designed to support these countries through tested and proven approaches such as collaboration with local private enterprises; utilization of locally made tools; provision of technical and business training, ensuring that auxiliary service providers are adequately trained to assume their functions; development of a quality control mechanism, national well standards, and centralized data collection; and promotion of the technologies of manual drilling to donors, NGOs, and governments as well as to individuals and communities.

Specific activities that were implemented at global level to support these countries included:

• Raise awareness at both country and international levels of the role that manual drilling can play in meeting the MDGs through promotional materials such as videos and technical notes
• Collect data from governments, donors and users demonstrating the viability and acceptability of manually drilled wells
• Identify favourable zones in Africa where manual drill-
ing is feasible and estimate costs of manually drilled water points in each country
• Develop a Practice Guide and Drilling Manuals for the creation of a sustainable manual drilling sector
• Document methodologies for social marketing and enterprise training

UNICEF is leading the data collection and mapping to identify suitable manual drilling areas, and raising awareness at global and country level. UNICEF in partnership with Enterprise Works/VITA and Practica is developing the materials to support Country Offices in their professionalization process at country level.

PROGRESS AND RESULTS
Currently, 16 African countries are mainstreaming manual drilling activities and professionalizing the sector, which demonstrates the high level of interest in this initiative. These activities have helped expand the capacity of local enterprises in Africa to respond to the need for boreholes in Africa by:

• Identifying favourable zones where the hydro-geology is suitable for manual drilling
• Improving or creating local capacity to provide professional manual well drilling services
• Creating a market for manually drilled wells through promotion and advocacy among donors, governments, and individuals
• Enhancing the local capacity to provide independent quality assurance
• Building the local capacity of pump installers and repairmen, and reinforcing the supply chain for spare parts
• Strengthening local capacity to provide training and follow-up for communities to ensure sustainable management of the water points

In Chad, for example, a total of 208 boreholes were manually drilled between 2006 and 2008, serving approximately 80,000 people. As part of the direct capacity building process, 43 manual drilling enterprises are currently in training and of those, 13 enterprises have reached the stage of being ready for their final test. The government has endorsed the ‘Technical well standards’ documents and officially accepted the technique. A group of 20 quality controllers have been trained to create a quality control system of boreholes.

Key elements of success
Demand for potable water in rural areas is enormous, and most countries in Sub-Saharan Africa have a large territory that falls in the category of ‘high or medium suitability’ for manual drilling. One of the key factors of success was the cost-effective and demand-driven approach used in activities to promote manual drilling of boreholes in those countries. Support from the UNICEF Regional Office was critical to raising the interest and commitment of country teams to this initiative.

LESSONS LEARNED
• The process of creating capacity at country level takes time. Typically three to four years is required to see the impact of the capacity building process
• Transfer of capacity to the local private sector makes improved access to potable water in rural areas more replicable and sustainable. If Governments incorporate this strategy into national sector policy, manual drilling could make a significant contribution to increasing access to potable water in rural areas

NEXT STEPS
Sixteen African countries are currently mainstreaming manual drilling activities and professionalizing the sector, each of them at a different stage in the process. There is a need to monitor the outcomes, and support the introduction of manual drilling to other countries in Sub-Saharan Africa that are considered to have similar potential. Manual drilling can make a valuable contribution to achieving the MDG water supply target, and this contribution needs to be carefully documented to facilitate the further scaling-up of this valuable strategy.

RELATED LINKS
Toolkits and materials on manual drilling are available on UNICEF site, Water, Sanitation and Hygiene: Groundwater Development:
www.unicef.org/wash/index_49090.html

‘Case Study: The Impact of Manual Drilling for the Construction of Sustainable Water-points in Chad’ UNICEF, Practica, EnterpriseWorks/VITA, August 2009:
www.unicef.org/wash/files/CHAD_Case_Study_Aug14_lowRes.pdf
BACKGROUND
Sustainability of water supply infrastructure, defined as the continued, satisfactory functioning and effective use of the infrastructure, is one of the main challenges facing rural water supply interventions in developing countries. In Sub-Saharan Africa, an average of 36 per cent of water supplies were non-functioning in 2007, with highest level of breakdowns noted in Zimbabwe, Ivory Coast and Malawi, where percentages of non-functioning hand-pumps exceed 60 per cent (RWSN, 2007). Low quality of installed hand-pumps, low post-construction maintenance support, and lack of community ownership of water points all contribute to a persistent lack of access to safe water. Recent studies indicate that it is more cost-effective to maintain or rehabilitate existing water points rather than construct new ones.

Koestler et al (2010) have proposed a new indicator to measure the impact of investments in water supply infrastructure, the ‘water-person-years’, which takes into account both the number of people to be served by a water supply infrastructure and the number of years this access will last. This indicator has the potential to help sustainability of water supply infrastructure at the top of the international water and sanitation agenda.

ABSTRACT
Guro district, situated in the central Mozambican province of Manica, is one of the few districts with serious problems of availability of freshwater sources. The district has historically suffered from both low safe water coverage and sustainability. However, following the development and implementation of a new approach to post-construction support and maintenance at the local level, it has become an exemplary district as regards the sustainability of water supply infrastructure. The sustainability model was developed within the framework of the ‘One Million Initiative’, a seven-year programme implemented by the Government of Mozambique, UNICEF and the Government of the Netherlands. The successful experience in Guro district is a Water, Sanitation and Hygiene sector good practice that could be replicated across the region.

STRATEGY AND IMPLEMENTATION
The One Million Initiative helped create an enabling environment for improved water supply and sustainability in the district of Guru. This was achieved through supporting the district and communities to strengthen their capacities and plans, thereby creating locally sustainable support structures and frameworks for improved maintenance and repair of existing water points.

The first step in the process was to organize a series of sustainability workshops in the four administrative posts of Guro district, where all community leaders were ‘triggered’ on the importance of sustainability related to water points. The objective of these workshops was twofold: (i) to create awareness of the importance of water points and the costs associated with their construction, maintenance and rehabilitation; and (ii) to brainstorm ideas on how to effectively implement a locally sustainable system for the maintenance and repair of water points. One of the tools used to create awareness of the cost of water points was to translate their monetary value into numbers of livestock. Following these workshops, a meeting with community leaders, administrative post chiefs, officers from the district Government and the district administrator was held in the district capital.
An action plan was developed with the following components:

- Set up a spare part supply chain at the district level through identification and subsequent association of artisans and spare parts dealers
- Promote agreements between local artisan associations and communities with price lists for different types of repairs
- Establish regular routine/preventive maintenance checks of existing water points through compulsory visits conducted every three-months
- Set up a database of water points with information on hand pump breakdowns, combining manual databases maintained at the administrative post level and updated weekly and an electronic database maintained at the district level and updated on a monthly basis
- Ensure regular monitoring of the plan at the district and province level

Applying this model to Guro district, a first step was the establishment of water committees in all existing water points, which was facilitated by APRODES, the NGO tasked with local social mobilization in Guro. Water committees are community-based organizations responsible for the operation and maintenance of water points. They decide on and collect water charges, establish rules for the use of the water points, and carry out routine maintenance operations. The next step was to support the establishment of local artisan (mechanics) associations in order to create a locally sustainable support structure for communities to call on for the maintenance and repair of water points. As such, local artisans were trained and tasked with the rehabilitation of all existing non-functioning water points across the district.

Afterwards, each community in the district designed their own sustainability plan for water points through a series of workshops, organized in 2008 with the support of local leaders, the district administrator the district planning and infrastructure office, and APRODES. With the support of the provincial Government, non-functioning water points were rehabilitated and new water points constructed, and a database of all water points in the district was established. In addition, artisan associations were identified to support water committees with the repair of water points, and to strengthen the supply chain of spare parts. This collaboration was formalised through an agreement between local water committees and artisans associations, as well as between spare part dealers and the local government.

**PROGRESS AND RESULTS**

In 2007, Guro district had 97 water points, of which 30 were not working. About 45,000 people were served by functioning water points. Through the One Million Initiative, all non-functioning water points were rehabilitated and an additional 25 new water points were constructed. The number of functioning water points therefore increased from 67 in 2007 to 122 in 2009. A survey carried out by the district authorities indicated that at the end of 2009 all water points were operational, and water committees actively contributing to their operation, maintenance and repairs with funds available for spare parts (Distrito de Guro, 2009). Furthermore, all water committees were shown to have an agreement with artisans to carry out repairs, and prices had been established for spare parts. Artisans, through associations, had established links with spare parts dealers in the district capital.

In 2010 another 21 new boreholes were drilled and fitted with hand pumps, and water coverage in the district reached 100 per cent. New water committees adopted the same approach for maintenance, operations and repairs. From 2007 to 2010, about 23,000 people in Guro district gained access to safe water through the rehabilitation and construction of new water points. Moreover, these efforts further contributed towards reducing the burden of unreliable water supply to women and children, who are mainly responsible for fetching water in rural areas in Mozambique.

The main success of this initiative was the ability of Guro district and its partners to take advantage of the momentum created by the One Million Initiative to focus on improving the sustainability of water points within the district. This was achieved through providing and institutionalizing post-construction support to local communities responsible for managing their own water points. Important success factors include the active leadership of the district administrator, the strong facilitation skills of APRODES, and the knowledge and active participation in sustainability workshops by local leaders, in particular administrative posts chiefs. In addition, social communication tools such as theatre and songs were used to underline the importance of water and hygiene for improved health outcomes, as well as other benefits of functioning water points. These communication tools proved to be important means to trigger communities to support the sustainability strategy being implemented.

Key challenges faced during implementation of the sustainability model in Guro district included the initial resistance among local leaders to put water supply at the top of the agenda in sub-district level meetings. In addition, the sensitization of local leaders and chiefs of administrative posts on the importance of social mobilization was a long and time-consuming process; similarly the delegation and transfer of responsibility, first from District Government to chiefs of administrative posts and local leaders, and then to the whole community. Finally, facilitating communication between water committees and artisan association at sub-district level required targeted and sustained effort.
The successful experience of applying the sustainability model to water supply infrastructure in Guro district has attracted the interest of the water and sanitation sector in Mozambique. In June 2010, the chiefs of the district service for planning and infrastructure of Guro district and of the provincial department of water and sanitation of Manica province presented this experience to the national Water and Sanitation Group in Maputo. In light of the increased interest and potential for replication of this experience in other parts of the country, the province of Manica plans to organize an exchange of experience between Guro and other districts, so that district administrators, technical staff and other stakeholders can benefit from the experience and lessons learned from improving sustainability of water supply in Guro.

GOOD PRACTICE
The ‘One Million Initiative’ is a water supply, sanitation and hygiene (WASH) programme implemented by the Government of Mozambique, UNICEF and the Government of the Netherlands. The programme, which began in 2006, aims to reach at least one million users with safe water supply in 18 target districts (including Guro) by 2013. As part of this initiative, a model for sustainability of water supply infrastructure was successfully developed and piloted in Guro district, situated in the province of Manica. The model allocates specific roles and responsibilities for the maintenance of water supply infrastructure to different stakeholders, notably the province, the district and the communities, with the support of the National Water Directorate (DNA), UNICEF and local artisan associations.

This new approach has yielded excellent results. In less than two years Guro moved from being nearly the lowest to being the highest ranking district in terms of sustainability of water points in Manica province, and is now looked upon as a reference and model district for the sustainability of water supply infrastructure in Mozambique.

POTENTIAL APPLICATION
The Government of Mozambique and its development partners are well aware of the importance of addressing the low sustainability of rural water services to improve the cost-effectiveness of water and sanitation programmes implemented in the country. In Mozambique, more than 60 per cent of the population lives in rural areas, while only 30 per cent of rural households have access to improved water sources (INE, 2009). In light of this low coverage and the Government’s commitment to achieve the MDG target for drinking water (68 per cent), approximately 15,000 new groundwater supplies need to be constructed by 2015 (1,500 annually from 2005 to 2015).

Clearly, the construction of new water points without due attention to sustainability will not lead to the desired coverage and use of improved water supply sources. The successful experience of Guro district in improving the sustainability of public water points through local post-construction support has much potential for replication in other districts in the country, thereby entailing efficiency gains and cost savings for the entire water and sanitation sector in Mozambique. The Guro experience has further potential for replication in other African countries, given the similarities in context and challenges faced by many countries in the continent.

NEXT STEPS
Several initiatives are currently underway to expand and further encourage the productive use and sustainability of existing water points in Guro district. First, the district administration is supporting communities to cultivate small vegetable gardens and orchards near their water point in order to promote cash generating activities. In addition, water committees are encouraged to invest the monthly cash contributions made by communities in exchange for water use into livestock, which at the time of breakdown of the water point can be sold off at a profit – thereby releasing funds for the purchase of spare parts and repairs. Finally, in order to further improve and strengthen the existing supply chain of spare parts, Guro district is assisting local vendors to liaise with wholesale dealers in Tete city, the capital of the bordering Tete province, which is closer and easier to access from Guro district than Chimoio city, the capital of Manica province.

REFERENCES
CHAPTER III
CAPACITY DEVELOPMENT IN BASIC EDUCATION AND GENDER EQUALITY
ABSTRACT
Social exclusion is one of the key factors preventing citizens to contribute to and fully participate in the Bosnia and Herzegovina society. Implemented during a period of 2008 and 2009, the project ‘Building Child Friendly Schools and Communities Initiative’ has successfully mobilized around 1,000 professionals from five communities to prevent social risks among hard to reach children. The project also promoted social unity and cultural diversity among 20,000 children and adolescents. Although the project was ended early 2009, comprehensive community-based approaches used in the project, including the one for capacity development, have been applied in the design of a new project ‘Strengthen Social Protection and Inclusion Systems for Children (SPIS).’ The SPIS programme aims at the development of an integrated system of services for the social protection and inclusion of children in BiH.

BACKGROUND
A joint UN assessment on the situation in Bosnia and Herzegovina (BiH) in 2003 identified social exclusion as the key factor preventing citizens to contribute to and fully participate in the BiH society. This was further confirmed by UNDP’s National Human Development Report on social inclusion in 2007. Underlined as the most significant causes of social exclusion are: institutional as well as individual discrimination, rooted in political and administrative fragmentation along ethnic lines, lack of an enabling environment for participation in civil society, as well as attitudes within families and communities.

STRATEGY AND IMPLEMENTATION
Objective: Social risks among children in BiH, particularly those who are socially economically and politically excluded are prevented, and social unity and respect of cultural diversity among children and adolescents are promoted in BiH.

Duration: The project was initially designed to be implemented in two phases, the first phase for one year (February 2008-January 2009) and the second phase for 4 years (2009-2012), although it was ended in January 2009.

Budget: USD 999,995 for the first phase.

Strategy: The main strategy used in the project was based on a holistic cross-sector approach. This implied joint participation in the project of social sectors responsible for child development and well being i.e. education, health and social welfare. Apart from developing the the overall concept and project, UNICEF provided technical assistance for the implementation of activities. In the context of the Child-friendly school project, the following strategies were applied:

1. Strengthening of existing and development of new standards for quality, inclusive education. This built on already developed core standards and policies, and involved:
   • Upgrading of teacher training modules on child-centered teaching, critical thinking and life-skills education by integrating gender and inclusive teaching for Roma and children with special needs;
   • Development of child-friendly (accessible, quality inclusive, gender-sensitive, safe schools) schools standards to formalise the application of upgraded teacher modules and put them into the context of the education strategy and specific strategy for professional development of teachers.

2. Strengthening the quality and inclusiveness of BiH educational services including ongoing monitoring and evaluation. This involved:
   • Supporting Ministries of Education to assess, plan and
implement the training needs of teachers to fill in the gaps in education provision for children with special needs and Roma children, as per the new Framework Law and inclusive education policies. This assessment included priority needs for in-service training and outlined the approaches to pre-service training in the long run.

- Building capacity of pedagogues, school principals and pedagogical advisors in developing and monitoring implementation of professional development plans in modern teaching methods.

3. Developing capacities and building partnerships and networks between key service providers at the community and policy level. This cross-cutting strategy involved:

- Supporting co-operation among 13 Ministries of Education including 10 cantonal Ministries, and Ministry of Civil Affairs to address and prioritize issues of access and quality in education.
- Supporting Cantonal Ministries of Education to utilize existing education networks and resources through dialogue with the education service providers, community and specialized CSOs representatives.
- Increasing awareness of selected schools and communities to include children with special needs and Roma children into mainstream education, through the development of publications and guidelines for children, parents and teachers.
- Promoting Child-friendly Communities. This component was aimed at increasing awareness and knowledge of local communities on various aspects of child protection issues, in order to improve prevention, detection and response. One of the key strategies was to develop capacities of local level by providing them with skills and tools for improved planning, development, implementation and monitoring of child protection, through a mapping of needs (using the Human Rights Based Approach to Programming) and the mobilization of existing resources at local level.

Implementing partners:

- Line ministries: BiH Ministry of Civil Affairs, two Entity Ministries of Education, 10 Cantonal Ministries of Education, 5 Municipalities
- Donor: Dubai Cares

PROGRESS AND RESULTS

During the first phase of the project the following results were achieved:

- 184 pre-school children (age 3-6) participated in the project and received qualified early childhood development programme
- 824 teachers from 15 primary and 9 secondary schools have improved school environments through supporting the participatory life skill education and increasing parents’ involvement in school life through their participation in working groups for action plan development, benefiting around 16,500 children.
- With the support of 773 adults, 1,500 children from 10 selected municipalities organized 140 workshops and meetings with different stakeholders to assess the status of children in their communities, prioritise issues and develop action plans which have reached around 8,400 children during the first year of the project implementation.
- 395 marginalized children, 191 Roma, resettled and returnee parents and 137 pregnant women from five locations had their health and development status checked and through participation in workshops have improved their knowledge and practices on Early Childhood Development.
- 1,019 children and 66 parents from 5 municipalities directly benefited from basic social services i.e. health, education, social care provided by special focus projects, and 150 professionals gained knowledge and skills on child protection systems and child protection issues.
- 2,530 children from five municipalities participated in media and mobilization activities, out of which 130 children produced 40 short films, and 2,400 children participated in 30 interactive educational puppet shows.
- The project contributed to the implementation of a policy plan as defined in the country strategic documents in Education including but not limited to equal access to education
- Municipal leaders supported the project and demonstrated commitment to work for the well-being of all children in the community – they established five Municipal Management Boards (MMBs).
- Action Plans for the development of child protection systems (2009-2010) were developed in all five targeted municipalities, providing a tool for systemic identification of beneficiary groups and enabling local planning of quality interventions, along with a reduction of social exclusion of children in local communities.
- 50 professionals (members of the Municipal Management Boards and key service providers) increased their knowledge of child protection and the human rights based methodology, and gained skills to establish child protection systems, with multi-sector referral mechanisms.
- 100 professionals from the public and civil society sector increased their knowledge in child protection issues (including violence, juvenile justice, and children with disabilities).
- Databases on Primary School Enrollment Monitoring were set up in all five municipalities and data on chil-
Elements for success
The project integrated the following comprehensive community-based approaches:

• **Capacity development** through training NGOs, adolescent’s organizations, teachers and education authorities including those from ‘family directed referrals’ and early childhood interventions services, and the development of Mobile Pre-school projects.

• **Partnership building** – networks of peer educators and adolescent activists from various locations worked on addressing common issues of risk reduction and conflict resolution among children as well as creating networks and partnerships among schools, social and municipal governance services, and community interest groups.

• **Advocacy and social mobilization for definition of adolescent vulnerability, risk reduction and social unity** – risk reduction strategies were defined to address the issues through social service delivery, life skills education, and provision of information on specific risks and how to prevent them. Participation mechanisms for children were also set up at school and community levels as means of prevention of social risk and rehabilitation of those who are affected.

• **Child participatory action approach** – NGO partners experienced in community work established a core group of adolescents who were engaged in assessing the situation of their peers and served as the focal point of the project for school, community and local government in the development of the action plans for their communities.

• **Service delivery to vulnerable adolescents** – Informal and alternative services were provided to vulner-

able adolescents in collaboration with schools and children’s action groups, when this type of services could not be provided through the formal service delivery system – for example, in cases of family violence, exploitation, abuse, and other risk behaviors.

• **Network development** – in order to strengthen cooperation between adolescents and relevant adult supporters and service providers, as well as networking amongst the service providers and interest groups, formal and informal communication mechanisms were created via meetings, forums and electronic information exchange.

Application to other programmes:
The project ‘Build Child-Friendly Schools and Communities’ ended in January 2009, due to the donor’s decision to focus on Water and Sanitation programmes. However, a similar approach was used in designing a new and comprehensive programme: Strengthen Social Protection and Inclusion Systems for Children (SPIS), which is still on-going as of May 2011. The multi-faceted and multi-sectorial SPIS programme aims at the development of an integrated system of services for the social protection and inclusion of children in BiH.

This programme, funded by the European Commission, DFID, the Government of Norway and UNICEF, builds on the results achieved in social sector and public sector reforms within the country and is in line with the results of the Medium Term Development Strategy of BiH (2002-2007). Intensive efforts were made to assess and develop the capacity of government institutions and service providers through trainings, workshops, and joint project activities. The Programme is also providing innovative services for children in target municipalities by coordinating and supporting joint activities of government, civil society and public institutions. Through support to small community projects, significant improvements in the work of Centres for Social Work, schools, institutions for children with special needs, and NGOs have been noted. Support to the establishment of Centres for Integrated Early Childhood Development is also commended. The project also contributes to strengthening of knowledge in fiscal planning and budgeting for children among Government officials from social sectors.

The programme is able to gradually build ownership over its approach, which is significant in the complex BiH context. The municipalities attach significant importance to this programme and see it as a very good opportunity to provide strengthened support to service providers and improve the quality of social protection and inclusion service delivery. The high level government involvement, positive feedback and support received reflect the strategic relevance of the
programme, which builds, among others, on the lessons learned gained during the implementation of the Building Child Friendly Schools and Communities Project.

LESSONS LEARNED
The strategies used under this project and other subsequent programmes in BiH have been assessed as programmes of high value for the following elements:

a) A multi-pronged approach of building the institutional and policy framework for social protection and inclusion serving children and families in BiH
b) The provision of innovative services for children at the local level, with piloting of new approaches
c) The use of the human rights based approach to programme and emphasis on capacity development
d) A particular focus on hard to reach populations
e) Strengthening the evidence base, with the piloting of a comprehensive and inclusive approach to working jointly with government, civil society and public institutions (health institutions, schools, Centres for Social Work) for data collection on children.

• Municipal officials and managers of social welfare, schools, health centres and NGOs have gaps in skills and knowledge in project management (designing, planning, implementation, reporting, monitoring and evaluation). Although they received technical assistance throughout the project implementation, they needed to be exposed to more training to strengthen their skills and knowledge in these areas.

• Continuous attention should be paid to raising awareness on child rights, the promotion of cultural diversity and social inclusion. Municipalities are often not aware of the national or entity/cantonal strategies and policies that are related to the educational, social and child protection issues, neither do they receive any guidance or assistance on how to implement them at local level. There is an obvious gap in vertical communication with higher level administration. This has been addressed under the programme ‘Strengthening Social Protection and Inclusion Systems for Children’ through the establishment of a vertical cross-sector governance structure.
ABSTRACT

In Mozambique today, only 50 per cent of children complete primary education. The figure is even lower for girls at 42 per cent (Ministry of Education, 2010). While the quality of education depends on the synergy of several factors, one of the most critical factors is the low quality of teachers’ performance in the classroom. Over 35 per cent of teachers are young people with a limited general education (tenth grade) and no professional training. Added to this is the absence of any form of continuous teacher support and supervision. So-called Zona de Influência Pedagógicas (ZIPs) – the lead school in a school cluster – have existed at sub-district levels since independence in 1975. However, there has been a trend of ZIPs being used for administrative purposes and diverting from their pedagogic role. Under the UNICEF supported Child Friendly Schools (CFS) programme, the traditional roles of ZIP schools and of ZIP coordinators are now undergoing a significant transformation to serve instead as teacher resource centres and as pedagogic supervisors of their school clusters. It is expected that the transformation of the role of the ZIP coordinator and of the ZIP school will bring in the much needed support for improvement in the quality of teachers with the potential of being up-streamed as a national model of pedagogic supervision and support.

BACKGROUND

Despite a protracted civil war that lasted sixteen years until 1990, Mozambique has made credible efforts towards universal primary education in response to the Jomtien Declaration¹ and the Millennium Development Goals (MDGs). As a result, its gross enrolment rate rose remarkably from a low of 60 per cent in the 1990s to 99 per cent in 2008, due to significant efforts to increase access to schools through abolition of school fees and provision of free textbooks. However, only 50 per cent of children complete primary education. School completion is even lower for girls, standing at 42 percent (Ministry of Education, 2010).

While the quality of education depends on the synergy of several factors, one of the most critical factors is the low quality of teachers’ performance in the classroom. In Mozambique, over 35 per cent of teachers are young people with a limited tenth grade general education and no professional training. Added to this is the absence of any form of continuous teacher support and supervision. The low quality of the one-year pre-service teacher training programme run by the Ministry of Education (MINED), while giving teachers the qualification certificate, is producing a weak and low-skilled work force. There is also inequitable distribution of the so-called qualified teachers between provinces and school levels², with a greater number of unqualified teachers placed in Northern provinces and at lower primary level which otherwise should see the placement of best teachers (Table 1).

Given the large percentage of unqualified teachers in the system and the low quality of teachers considered as qualified, it is imperative that locally based, in-service teacher development mechanisms are promoted to provide close guidance to teachers in order that the quality of schools and student learning does not suffer. A study by the Matola Institute of Teacher Training, one of the better known teacher training colleges in the country, shows a high percentage of repeaters in 2008 and 2009 (Table 2), clearly indicating the low capacity and quality of human resources being recruited as teachers (Mahalambe, 2009).

Within the Mozambican education system, schools are supposed to be monitored by Government staff from district, provincial and central levels. However these monitor-

¹ World Declaration of Education for All adopted by the World Conference on Education for All Meeting in Jomtien, Thailand 5-9 March 1990.
² There are three types of primary schools in rural Mozambique: (i) Primary Education Level 1 (EP1) covering grades 1-5; (ii) Primary Education Level 2 (EP2) covering grades 6-7; and (iii) Primary Education Complete (EPC) covering grades 1-7.
ing functions are not performed on a regular basis, nor are any methods or tools in place to provide teachers with learning opportunities. The CFS initiative\(^3\) has therefore supported the in-service, short-term training of all teachers covering all primary schools of the selected districts, with a focus on child-centered, teaching and learning methods. However, experience has shown that teacher participation in one-time training events does not guarantee that training contents will be put into practice.

In Mozambique, so-called Zona de Influência Pedagógicas (ZIPs) – the lead school in a school cluster – have existed at sub-district levels since independence in 1975. However, contrary to their name, ZIPs serve as an extension of the district education administration with the director of the school serving as ZIP coordinator. In addition, the lack of sub-district governmental structures and the long distances from the district level to schools prevented ZIP coordinators from regularly monitoring all schools. This led to a trend of ZIPs being used for administrative purposes and diverting from their pedagogic role. As such, ZIPs became involved in issues such as assets, salaries, and the organization of sports and culture festivals, and ZIP coordinators were also called to attend meetings and other political-governmental duties not directly related to the schools and to pedagogy.

\(^3\) The CFS initiative in Mozambique has been rolled out incrementally since 2006, starting in Maganja da Costa district in 2006, and subsequently expanding to Mossurize and Búzi districts in 2007, Changara and Chibuto districts in 2008 and Montepuez and Angoche districts in 2009.

**STRATEGY AND IMPLEMENTATION**

The strategy of improving the quality of education by transforming the function and role of ZIP schools and ZIP coordinators is being led by MINED through its provincial and district bodies.

Specifically, it involves:
- The revision of ZIPs regulations and the development of a user-friendly ZIP manual, clearly defining the roles and functions of ZIP coordinators and containing specific tools to work with. This is complemented with in-service training of ZIP coordinators on strategies and methods to plan and re-organize the ZIP activities.
- The establishment of a small library in each ZIP in order to provide supplementary reading enabling teachers to expand their knowledge base. These libraries start with 150 books and 50 different titles of mainly pedagogic content, and will be upgraded annually to bring in other types of learning materials.

Under the renewed ZIP system, school directors and teachers will be enabled to put into practice their new learning, receive regular support which in turn will keep their morale and motivation high, given the dire conditions teachers have to work in. As such, ZIPs will serve as resource centres for teacher learning, lesson planning, problem solving and exchange of experiences, thereby providing a permanent teacher support and monitoring station at the most decentralised level of the education system catering to the local specific needs of the teachers. ZIP coordinator meanwhile will serve as pedagogic supervisors in school clusters, facilitating opportunities for regular sharing of experiences, good practices and mutual problem solving among teachers.

**PROGRESS AND RESULTS**

The ZIP interventions in the seven CFS districts were designed in 2009, with actual implementation starting in 2010. It is therefore too early to conclude on achievements. However, concrete steps have been taken towards building and implementing this innovative approach aimed at improving the quality of education with a focus on school cluster and school cluster coordinator strengthening at the decentralised level. As such, provincial and district trainer teams were constituted and trained to provide training to all ZIP coordinators, thus building training

<table>
<thead>
<tr>
<th>Year</th>
<th>Target</th>
<th>Admitted</th>
<th>Repeaters</th>
<th>Percentage of Repeaters based on Target (%)</th>
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<td>2007</td>
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<td>2010</td>
<td>128</td>
<td>41</td>
<td>87</td>
<td>68%</td>
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capacity at decentralised levels. This reflects a new and unprecedented approach in the area of in-service teacher training in Mozambique.

In addition, a draft ZIP manual was developed and used during the training. The manual is further being reviewed by MINED and will be provided to all ZIP coordinators for use in selected CFS district in 2011. ZIP school libraries have also been developed to provide resource materials for teachers. This will be further strengthened in 2011. The ultimate objective is to scale up the use of ZIP schools and coordinators as teacher resource centres and pedagogic supervisors of school clusters nationwide. The third annual CFS annual assessment took place recently (October 2010) and is expected to yield valuable results on the functioning of ZIPs.

Some of the main challenges faced include the fact that ZIP coordinators also are directors and teachers of their own schools, and therefore, have limited time to perform the tasks as ZIP coordinators, without prejudicing their other responsibilities. This significantly limits the time ZIP coordinators can dedicate to visiting other schools of the ZIP cluster.

In addition, the lack of public transportation to facilitate ZIP coordinators' travel to schools in the cluster presents another challenge. Finally, current conditions in schools such as the lack of adequate infrastructure and teachers contribute to very crowded classes (teacher/pupil ratio of 1:65, data from Ministry of Education, 2010) thus limiting the practice of participatory learning methods in classrooms and the frequency and quality of interaction between teachers and students. The challenge lies in finding innovative ways for teachers to efficiently manage large classrooms.

Key results and lessons learned from the process of providing teacher support and pedagogic supervision through lead cluster schools and coordinators in seven pilot districts in Mozambique will be documented more extensively in 2011 as part of the end-cycle CFS evaluation. This will then serve as a basis for considering and planning the national scale up of this process country-wide.

INNOVATION

The quality of educational provision in primary schools has not kept pace with the massive school enrolment rates in the country, exacerbating the already weak teacher capacity and adversely impacting the quality of learner performance and subsequent high drop-outs rates in schools. In order to ensure a minimum and acceptable quality of classroom teaching and learning processes, it was clear that a one-time training of teachers would not be sustainable.

The 2008 CFS Assessment recommended that teachers trained in the CFS approach needed continuous supervision and support. This was discussed during the 2009 programme planning meeting with the MINED and UNICEF. The ministry therefore requested UNICEF to support the development and consolidation of ZIP coordinators' competences as pedagogic supervisors at the school cluster level and to transform ZIPs into teacher resource centres in the seven model CFS districts of Búzi (Sofala province), Mossurize (Manica province), Chibuto (Gaza province), Changara (Tete province), Angoche (Nampula province) and Montepuez (Cabo Delgado province), covering all primary schools and promoting a multi-sectoral approach to quality education. ZIPs are therefore an effective mechanism to provide the much needed teacher supervision and create an environment of continuous teacher learning and support in a sustained manner and training school directors to adopt a new perspective on school quality.

ZIP coordinators are trained on how to organize and perform comprehensive supervision visits, how to observe teachers and how to organize sessions at the ZIPs, providing an opportunity to teachers for regular sharing of experiences, good practices and mutual problem solving.

POTENTIAL APPLICATION

While ZIP structures exist country-wide, they seldom performs a pedagogic function and hence has been largely ineffective. The transformation of ZIPs in the seven CFS districts initiated in 2009 and the expected changes in classroom teaching and learning practices will provide valuable evidence and information needed for scaling this model up from the seven CFS pilot districts to a national model.

In addition to increasingly being able to perform improved pedagogic supervision functions, ZIP coordinators are beginning to play an active role in organizing sports activities at the cluster level as part of the initiative on physical education and sports recently introduced under the CFS programme. Furthermore, with UNICEF's upcoming focus on streamlining its disaster risk reduction strategy through the education and protection cluster, ZIP coordinators will play an active role in promoting emergency preparedness activities at the cluster level.

In terms of materials and guidelines, a school supervision manual is currently being finalized at the national level containing basic minimum standards for schools to maintain. This will further professionalise the role of ZIP coordinators and help them to systematically identify the weaknesses of individual schools and to focus on systematic monitoring and follow-up. The capacity of ZIP coordinators will further be strengthened through training to promote the development of simple and creative teaching aids with
locally available materials and to organize different training sessions based on teachers' needs in school clusters.

**NEXT STEPS**

The immediate goal is to ensure the gradual adoption of the new role of ZIP schools and ZIP coordinators, which will take quite some time to change. ZIP schools are also in the process of being developed into teacher resource centres, commencing with the establishment of a resource library for teachers. The subsequent and longer term step will be to ensure that adequate district level monitoring mechanisms are in place to support ZIP schools and coordinators in making the transition from performing administrative duties to providing pedagogic support and teacher supervision.

Other priority areas include the constitution of teacher teams within each school cluster to support the ZIP coordinators in school supervision. This is critical to ensure that the new role of ZIP coordinators as pedagogic supervisors does not negatively impact on their primary function as school director and teacher of the ZIP school. Finally, the supervision manual is currently under finalization and will serve as a tool for auto-assessment of schools by school directors.

**REFERENCES**


**RELATED LINKS**

CHAPTER IV
CAPACITY DEVELOPMENT IN CHILD PROTECTION FROM VIOLENCE, EXPLOITATION AND ABUSE
BACKGROUND
Prior to the introduction of the IA CP IMS, several agencies had introduced databases and other information management systems in a number of countries in response to emergencies and for DDR (Disarmament, Demobilization and Reintegration) programmes. Different systems being used in the same emergencies led to confusion over the type and quality of information available on vulnerable children. This adversely impacted tracing, collaboration and information-sharing efforts. Following a review of the different systems in 2003, the agencies involved in child protection in emergencies decided to develop standard forms to help manage cases, tracing and reunification, and to collect statistical information, which could more easily be used for reporting and/or advocacy purposes.

STRATEGY AND IMPLEMENTATION
The IA CP IMS was developed in 2005, focusing mainly on supporting emergency response child protection case management, including programming for unaccompanied and separated children and children associated with armed forces and armed groups (CAAFAG). The initial purpose of the IA CP IMS was to support programme monitoring assisting unaccompanied and separated children and CAAFAG. Since its inception, the IA CP IMS has promoted compatibility across child protection programs and agencies, enabling more coherent and efficient case management along the continuum of preparedness, emergency and early recovery to development.

Three key components of the CP IMS

Standard forms are comprehensive, covering rapid registration of vulnerable children, particularly the needs of CAAFAG, children under five and girls. While the standard set of forms is distributed as the IA CP IMS is introduced, these forms can be customized to fit the needs of each programme or agency. Such adaptation will take into consideration the relevant local and national cultural norms including sensitivities surrounding particular ethnic groups.

ABSTRACT
Save the Children, the International Rescue Committee (IRC) and UNICEF have been working together since 2005 to promote the use of a standard inter-agency child protection information management system (IA CP IMS). The IA CP IMS is a practical, field-level tool that supports effective case management in the Child Protection Sector. It is comprised of database software and accompanying resources such as standard template paper documentation forms and data protection protocols. The original demand for the system came from Family Tracing and Reunification (FTR) programmes in emergencies since data were fragmented due to utilization of multiple data collection tools and information management systems. However it also supports case management, tracing and reunification within release and reintegration programs and programs for children in camp settings. As of January 2011, the IA CP IMS has been used in 17 countries by a range of child protection actors.

A comprehensive evaluation carried out in 2009 revealed positive results of the CP IMS as well as challenges and recommendations for improvement. It revealed that the CP IMS has fostered better coordination and collaboration among agencies working in emergency child protection programmes in different countries. One of the key recommendations was to increase support to country programs, which resulted in expansion of the project support team and the development of guidance and resources for information sharing and case management. The IA CP IMS continues to be a strong tool to support child protection programmes and provides solid technical assistance and trainings, as well as IT support and guidance for new and current users of the system.
in respect to family names and locations. Therefore, some questions may be taken out while more relevant ones may be added. Alternatively, changes may be made to the forms following more detailed, specific assessments during the first phase of an emergency.

**Database** is an electronic system that organizes and stores information inputted from the forms to assist in case management. The database generates statistical information on children assisted in programmes. There are a range of functions within the database, including a matching function that can be used in FTR programmes. A comprehensive list of reports can be produced from information stored in the database. Reports can inform managers supervising case management and senior staff overseeing programme management who may be responsible for producing donor reports and proposals and for advocacy purposes. Written resources and guidelines on efficient use of the database are available prior to training and to complement training.

**Confidentiality protocols** are a set of protocols and guidelines relating to data protection, information-sharing and confidentiality. These protocols cover the appropriate storage of information in hard copy (e.g. case files on individual children) and electronically in the database. The protocols provide guidance on sharing information between agencies and on how staff within agencies should respect confidentiality. As of 2008, versions of the forms, database and protocols are also available in French.

**Introduction of IA CP IMS at the country level** Agencies who are interested in using the IA CP IMS must contact either a member agency of the steering committee or the project team through lead agencies or their HQ. Prospective users need to show how and why they would like to use the tool. Discussions between the steering committee member or the project team and the interested agency concern the suitability of the tool to the context and the programme.

**Technical capacity building** Training has predominantly been provided by the IA CP IMS project team and a database consultant. The timing of trainings has varied, with some country programmes receiving training from the global team when the IA CP IMS was introduced (e.g. Sri Lanka), while other countries did not receive training until after starting to use the IA CP IMS (e.g. Ethiopia). Users include social workers, middle-level management staff (project managers and coordinators), monitoring and evaluation officers and IT staff (database officers). In addition to the training, users are supported real-time by a helpdesk based in New Delhi for technical issues, the coordinator and manager based in IRC (London and New York respectively) for other issues related to management and coordination.

**Coordination** Collaboration and coordination are strongly promoted through the use of the IA CP IMS. In most of the countries where the IA CP IMS is being used, it is done so by inter-agency groups or networks where various agencies are carrying out different activities (e.g. registration, family tracing or follow-up) in varying locations within a country, and who need to share information on a regular basis. Information gathered in this way can be shared confidentially among agencies.

**Steering Committee** Initially, a consortium agreement was drawn up between Save the Children and IRC to illustrate the commitment to use standard tools (paper forms and electronic database) in the case management of unaccompanied and separated children and to foster better cooperation and collaboration at the country level. This consortium has developed into a technical steering committee that includes UNICEF. At the global level, the IA CP IMS is hosted by IRC and two key positions (project coordinator and manager) are managed by IRC. One of the main roles of the steering committee has been to promote the use of the IA CP IMS at the global level to donors and through coordination bodies such as the Child Protection Working Group and to advise on the future direction and use of the IA CP IMS.

**Funding** At the global level, the IA CP IMS project has been funded by UNICEF and the European Commission’s Humanitarian Aid and Civil Protection (ECHO) Unit. At the country level, the IA CP IMS has predominantly been funded by UNICEF through governments including Spain, France, UK, Japan, Canada and Belgium, who have provided grants to UNICEF. These funds were either used by UNICEF itself in countries where UNICEF implements the IA CP IMS directly or were shared with NGOs closely involved with the project, mainly Save the Children and IRC.
PROGRESS AND RESULTS

IA CP IMS roll-out
At its inception, the IA CP IMS was developed in three countries – Liberia, Côte d’Ivoire and Sudan – and was used mainly by Save the Children and/or IRC in those countries in collaboration with UNICEF. As of January 2011, the IA CP IMS has been used in 17 countries worldwide by these and other agencies, including CARE, Jesuit Refugee Service, War Child and World Vision. Countries where it is currently being used include: Chad, Ethiopia, Kenya, Myanmar, Nepal, Sri Lanka, Sudan, Uganda, Haiti. Some countries that initially used the IA CP IMS in emergency contexts have now stopped as it was no longer necessary as programs transitioned to post-emergency responses (e.g. Liberia and Aceh/Indonesia).

Upgrades
Based on the user feedback, the IA CP IMS has been going through regular upgrades to ensure that enhancements reflect the increased needs of users and that it is constantly improving.

The last upgrade was rolled out in early 2011 and enhancements include:
• a window that opens upon login that lists the overdue tasks;
• a function that allows users to use a phonetic search for a child if they are not sure of the exact spelling of the child’s name;
• an option to customize time-scale targets by individual child OR by observations on forms
• a memo text field that allows users to include lengthy narratives with up to 4,500 characters.

Key results from the evaluation in 2009
The CP IMS steering committee commissioned an independent evaluation in 2009. The survey was done through administering a questionnaire (available in English and French) with current user agencies and interviewing members of the current steering committee, global team and other key informants.

The evaluation found that the IA CP IMS has had a positive impact on emergency child protection programmes – it has encouraged and fostered better co-ordination and collaboration among agencies. In several country programmes, the quality of information gathered through the IA CP IMS that are guided by internationally recognized minimum standards and guidelines has increased understanding by agencies of children’s circumstances. In turn, agencies have endeavored to address these issues.

While the system is generally seen to be working well, the evaluation report highlights the need to focus more on the technical support to each country to ensure its implementation of the IA CP IMS is as effectively as possible.

The evaluation has also shown significant gaps in understanding by agencies of the key purpose and benefits of the IA CP IMS, and in some key aspects of emergency child protection programming. Weaknesses and limitations of the tool itself have prevented agencies using the IA CP IMS to its full potential. For example, staff turn-over has created gaps in institutional knowledge and intermittent usage of the IMS tool. Additionally, concerted effort has been required in some contexts to ensure that users understand that the IMS is a tool that facilitates case management and FTR programming, and not a project in and of itself. Limited short-term funding and a lack of long-term funding (particularly at country level) have restricted the full benefits of the tool, as well as a long term vision, being realized.

Challenges
One of the main challenges identified through the evaluation is the ability of the Steering Committee to solidify and diversify funding for the IA CP IMS project. Sustained funding would facilitate planning long term strategies to support countries and to make improvements to the database and related tools based on user input. To this end, in August 2010, the Steering Committee commissioned a donor analysis which maps potentially interested donors and new partners with an exploration of how collaboration may be established. The report will be used by the steering committee and the project team to develop a strong and targeted fundraising strategy during 2011. This, in turn, will ensure an ongoing and adequate support structure to respond to the expanding demands on the project as it develops.

GOOD PRACTICE
The IA CP IMS helps the management of cases (vulnerable children), tracing and reunification of children separated from families in emergency settings and collects statistical information for reporting and/or advocacy purposes. One standard tool used by multiple child protection actors in multiple countries streamlines resources for
development, support and training required for operationalization of such a harmonized data management system. A comprehensive evaluation carried out in 2009 concluded that the CP IMS has achieved the original aims.

Key benefits of the CP IMS are following:
- Quickly implemented at the earliest stages of an emergency
- Easily customized to meet the specific needs of the programme (e.g. the system can provide lists of children which can be filtered by different criteria such as location or those requiring follow-up visits)
- Allows the evaluation of trends in caseloads over time to facilitate strategic planning and resource allocation for programming (i.e. aggregated data allows programs to better understand the profile of the children they are servicing, thereby responding appropriately to their needs)
- Supports tracing and reunification in FTR programs through a ‘match’ function that compares information on separated children with tracing requests from caregivers
- Promotes best practices
  - use of standard forms and guiding principles developed by the Inter-agency working group on separated children
  - data confidentiality protocols is in place- protects data informants and gatherers; protective standards in case management

**POTENTIAL APPLICATION**

While the IA CP IMS is seen as a good practice tool when responding to child protection needs in emergencies (natural or conflict-related), its applicability extends beyond child protection in emergencies. A new version of the IA CP IMS made available to country programmes in 2010 can now be used to assist in the management of a much wider range of vulnerable children, not only those affected by emergencies.

With this new version and the expansion of its utility across the continuum of preparedness, emergency and early recovery to development, the scope of the IA CP IMS use could potentially increase significantly over time. Issues around funding and partnerships with existing and new agencies will need to be explored. Some government departments are interested in using IA CP IMS and in several countries selected government staff have been trained to use the forms, including for their work with NGOs in tracing activities. However, there are also reservations in government agencies using the IA CP IMS or having access to information generated through it, due to the potentially sensitive nature of information related to vulnerable children—another issue to consider as the IA CP IMS is being used more widely.

**NEXT STEPS**

As the upgraded version of the IA CP IMS became available in 2011, the project team will review feedback from current users and make further revisions and upgrades based upon that feedback. The next upgrade is planned for 2012. During 2011 the database and related tools will also be translated into Spanish and Arabic, thus widening the reach of the IA CP IMS to new regions and countries.

**RELATED LINKS**

Inter-agency Child Protection Information Management System (website): [www.childprotectionims.org](http://www.childprotectionims.org)
BACKGROUND
Spiralling levels of poverty coupled with collapsed social protection, welfare, justice, and education systems, high levels of child abuse and exploitation have compounded child vulnerabilities and seriously compromised children's access to the most basic social services and their right to protection. For instance regarding their nutrition status, one in three children is stunted. The poorest children carrying a heavy burden due to HIV and lack access to the most basic social services. The 2007-2010 Programme of Support (PoS) to the National Action Plan (NAP) for Orphans and Vulnerable Children (OVC) was conceptualized and implemented in order to address these needs. Managed by UNICEF, this multi-donor pooled funding mechanism contracted more than 180 NGOs and civil society organizations to provide services to more than 500,000 children. An independent review of the PoS in 2010 noted that the Programme was effective, relevant and efficient future programming and should continue in a second phase that adopted a multi-dimensional approach to child vulnerability and incorporated social protection and child protection perspectives. The pooled-fund model is recognized by donors in the country as a good model of coordination and cost-effectiveness in a period of complex transition and will be extended in a future national fund, the 'Child Protection Fund' (CPF). The new fund will aim to support new Government policy in both social and child protection sectors.

STRATEGY AND IMPLEMENTATION
The 2007-2010 Programme of Support (PoS) to the National Action Plan for Orphans and Vulnerable Children (NAP for OVC) was designed to cope with the burgeoning vulnerabilities faced by children, particularly in response to the HIV epidemic. Managed by UNICEF, the PoS was a pooled fund mechanism of more than 80 million USD over four years which, through partnerships with civil society organizations, aimed to assist government to deliver essential services for vulnerable children. The programme involved activities across a number of areas of support to OVC including: school-related support, birth registration, psycho-social support, food and nutrition, health care, water and sanitation, child participation, child protection, education on nutrition, economic strengthening, life-skills and vocational training, and shelter support.

At its inception, the objectives of the PoS were to:
- Mobilize increased and more predictable funding for orphans and vulnerable children; and
- Ensure that funds were channelled directly to communities, families and children

More specifically, the PoS aimed to:
1. Increase the number of 'OVC' receiving free external support, care and protection through civil society organizations;
2. Put in place structures for effective coordination and management of the Programme, including with support from multi-donor funding;
3. Strengthen the capacity of Programme partners supporting 'OVC'; and
4. Implement Programme-wide Monitoring and Evalu-
ation (M&E) systems to measure impact and ensure good practice in innovations in ‘OVC’ programming.

As a pooled fund, the design shared many elements of a SWAp common in many social sectors but rarely seen in protection service delivery. Activities were coordinated, monitored and evaluated by the government, but implemented through a network of over 180 partner organizations. Civil society and children directly received the bulk of funding. UNICEF transaction costs were very low at less than two per cent by the end of 2010.

PROGRESS AND RESULTS

From its inception until end 2010, the PoS successfully managed to reach more than 400,000 children with basic social services including free education, health, protection, livelihoods, water and sanitation, nutrition, and psychosocial support. The Basic Education Assistance Module (BEAM), a national educational social protection instrument was revitalized with PoS funding in 2009, reaching 514,000 primary school children. The Government of Zimbabwe was able to match donor funding for primary school BEAM allocations in 2010 and a further 300,000 secondary school children were supported. 10 per cent of BEAM funding was allocated for children with special needs.

UNICEF worked closely with the National Secretariat of the NAP for OVC, the National AIDS Council and the Working Party of Officials to provide support to 32 NGOs directly, and 150 partners indirectly. Capacity support to government resulted in the development of draft targeting guidelines for vulnerable children; a national conceptual framework for child participation in OVC programming and national ownership of the Monitoring and Evaluation Framework for tracking OVC activities of all 180 PoS partners. Two data collection tools were developed to measure programme outcomes: the My Life Now (MLN) tool collecting information on the overall well-being of the child, and the Community Perception Index (CPI) tool measuring perceived outcomes of the NAP for OVC in the community. Data collection took place in March 2010 with the participation of more than 3,000 children and 1,000 adults in 20 districts across the country.5

Child Protection Committees were strengthened in a number of districts providing a forum for raising child protection concerns, coordination of OVC activities and links to referrals for child abuse, violence, and exploitation cases. A total of 570 participants from NGOs were trained in governance, financial management, project management, partnership management, rights based approaches to programming, participatory monitoring and evaluation, strategic planning, documentation and communication, gender, child protection, and child participation. Eleven capacity development manuals covering the above thematic areas and online learning resources were developed for these partners. Government capacity was strengthened in several key areas including coordination, monitoring, OVC programming and child protection in emergencies although this was limited due to restrictions on donor funding.

LESSONS LEARNED

A 2010 independent outcome evaluation of the PoS using OECD criteria, including field research with more than 1,300 children, found that the Programme was well aligned with the priorities of vulnerable children and the country’s development needs, achieved good government ownership and broad geographical and thematic coverage. Many elements of the approach are valid in the context of complex emergency and transition and will continue to be so in the future.

However, whilst the Programme was effective, relevant and efficient, this evaluation recommended that future programming should adopt a multi-dimensional approach to child vulnerability which simultaneously addresses household poverty, gender disparities, disability, HIV and risk of violence, exploitation and abuse to expand the reach and impact of interventions. Special attention should also be paid to bolstering child protection interventions, particularly those to prevent and respond to violence against children according to feedback from children and communities. My Life Now research highlighted that as many as 22 per cent of children benefiting from PoS interventions reported violence by their caregivers.6 Future programming of this nature should therefore invest in not only service delivery but follow-up care; tracking each individual child to determine their unique circumstances and ensure a continuum of support.

Almost three quarters (70 per cent) of community respondents7 in the My Life Now research said that the support that vulnerable children received in their communities from PoS interventions had improved their lives, particularly in rural areas (72 per cent). Interestingly, in high programme saturation areas children reported a higher increase in well-being against the defined objectives of the NAP (65 per cent) than in low saturation areas.8

UNICEF’s coordination role with Government, donors and civil society was recognized by the evaluation as was its function as ‘grants manager’.9 A separate Financial Assessment also highlighted that the Programme could have achieved higher overall value-for-money especially from

4 Sector Wide Approach (SWAp) a shift away from project based assistance towards programme based approaches which are considered to promote country leadership and increase the use of local systems for programme design, implementation, financial management and monitoring and evaluation. 5 This research is collated in the Report: My Life Now, UNICEF DRAFT May 2011.


7 The Community Perceptions Index tool (CPI) is a researcher-administered questionnaire, was designed to capture information on the community’s perceptions pertaining to the delivery of services through the PoS.


the viewpoint of reaching children more quickly and with more services per child. For example, by spending a little more (e.g. to procure vehicles more quickly, to employ a Grant Manager and necessary staff earlier, and to monitor quality and learn lessons in a timely manner), it could have increased the efficiency of the programme, thus reaching more children.

A summary of challenges faced by the PoS included:

- Unclear targeting of children due to different definitions of ‘OVC’ resulting in fragmented programming that did not necessarily benefit the most vulnerable children equally.
- No systematic range of services were available to children, as services were determined by the presence of an NGO in a particular geographic area rather than need, for example where an NGO was active and recognized in a district.
- In practice, the programme tended to focus on the number of children served rather than on the quality of service provided. This approach tended to emphasize outputs at the expense of outcome and impact.
- Due to restrictions on donor funding, there is limited or no support for capacity development of government structures, which negatively impacted service quality and coordination;
- Child poverty was not originally addressed as a key cause of vulnerability.

Despite these challenges, the PoS played a critical role in bringing together a variety of actors in the child protection sector, particularly with regards to OVC programming. The framework developed by the PoS up to 2010 enabled the programme to respond swiftly and effectively to the political and economic crises of 2008 and 2009. Partnerships across the country helped to quickly mobilize support for communities affected by the cholera crisis, for example. By acting as a national platform to support government in a polarized environment, the PoS successfully boosted specific funding and political support for re-building child protection and social protection systems in the country.

Further, the programme’s ability to deliver results for children amidst an emergency and fragile operating context in 2008-9 highlights innovative methods and strategies that have potential for informing large scale child protection and social protection programming in fragile states, for example in programming for children on the move and displaced children.

There is limited evidence regarding what works for sustainability in child protection, or indeed in other sectors, in Zimbabwe’s fragile context where infrastructure is strong but human and financial resources are limited. Thus NGOs continue to play an important role in bolstering Government service delivery. However in order to maximize efficiency and effectiveness the second phase of support, the Child Protection Fund (CPF) will channel the greater part of resources to households directly through cash transfers and to system building (e.g. training social workers, supporting lawyers for children in contact with the law, etc) for longer term positive effects. This approach will build on the successes of first phase; continued pooled funding which allows predictable multi-year funding and not the stop-start of many OVC initiatives and harmonized coordination amongst partners to avoid duplication and gaps in responses. This will ensure a more effective response by providing predictable transfers to the most vulnerable households, and will create better linkages between child protection and social protection approaches, which can be scaled up and nationally owned i.e. social transfers becoming embedded within national policies and programmes, thus contributing to sustainability.

POTENTIAL APPLICATION

The PoS model is being replicated by UNICEF Zimbabwe’s Education Transition Fund and potentially by a new health fund in 2011. Further, extensive reviews of the programme have highlighted evidence of good practice and opportunities to advance small scale pilot projects to national scale interventions in areas of sexual violence, justice for children, children with disabilities and child participation.

The establishment of a comprehensive monitoring and evaluation system for vulnerable children, led by government and supported by UNICEF, has generated global interest on this topic. This system contributes to an evidence base used to advocate for programmatic shifts and provides a platform for further outcome and operational research programming in 2011. The tools developed for tracking children’s well-being and community perceptions of interventions will also be replicated in future programme efforts.

New programmatic shifts from 2011 and beyond include a renewed design that incorporates child sensitive social protection and child protection programming in one programme model supporting Government national policies. The new programme, the Child Protection Fund (CPF) attempts to target families as well as individual children through cash grants and applicable social welfare and justice services, whilst simultaneously building positive policies and legislation for the most vulnerable children and their families, including children exposed to violence, abuse and exploitation.

Noting the need for follow up of individual children benefiting from the CPF, case management and strengthening of the social worker workforce are central to the CPF’s design. The CPF will include case management interventions at national and sub-national levels with a community-based verification system for monitoring outcomes. Learning and placement opportunities for para professional social workers will be scaled through global and regional
partnerships with Universities and other partners as well as through amendments to national legislation.\textsuperscript{10}

At policy level, the programme is incorporated into the Zimbabwe Government’s renewed focus on social protection for the poorest and most vulnerable as well as a revised NAP for OVC II (2011-2015) launched in March 2011. As such, the Government has matched donor funding for the Programme in its own national budget. Combined donor and Government resources are likely to reach approximately 100 million USD over three years targeting up to 80,000 households for cash transfers and an additional 25,000 children every year with specific child protection services. UNICEF will work closely together with the World Food Programme, the World Bank and other social protection actors for complementary interventions aimed at poverty alleviation.

Based on the experiences of implementation of the first phase, the CPF has already engaged children in the design of the programme and will consistently continue to involve children in implementation monitoring, and evaluation. Specifically, the use of the My Life Now and Community Perception Index tools will be rolled out annually. The CPF will also incorporate a robust Justice for Children\textsuperscript{11} approach linking the welfare system, legislative and policy reform, advocacy and services for children in contact with the law. Civil society’s role involves capacity building, targeting, identifying vulnerable children, delivering specialised services and enhancing community accountability.

Emergency programming is now embedded into the programme thereby addressing humanitarian risks and shocks through longer term development approaches, for example addressing long-standing domestic violence and abuse in families as well as other forms of gender-based violence related to child trafficking on the border with South Africa. This second phase therefore incorporates humanitarian and development strategies simultaneously, reflecting the transition context of Zimbabwe.

**NEXT STEPS**

The CPF, or second phase of the PoS 2011-2013, represents Government, donor and UNICEF commitment to aligning national priorities with humanitarian and development programming in Zimbabwe’s transition context. Pooling funding is now targeting children and families directly through cash transfers, and with specialised services delivered through civil society within a national social protection approach as well as policy and legislative reform geared towards long term changes for children. Child-sensitive social protection approaches are twinned with a ‘systems approach’ to child protection to provide a multi-faceted Programme addressing a range of vulnerabilities, including poverty, violence and abuse. Together these approaches aim towards building back Zimbabwe’s renowned social welfare, social protection and justice systems.

Baselines are being developed to determine families eligible for the cash transfer component of the programme and also to track broader social sector impacts of the interventions. A pilot of the cash transfer has already been launched in one of Zimbabwe’s poorest districts. Zimbabwe’s CPF agenda is ambitious; aiming to positively influence nutrition, education, protection, HIV and the poverty status of children in one comprehensive Programme. This Programme is the first in the region to comprehensively investigate a broad range of social sector and protection outcomes simultaneously.

UNICEF will continue to play a sector coordination role by issuing bids to partner organizations in the country to offer specialised services for vulnerable children, including children living outside family care, separated children including children on the move, children living with disabilities and more. Opportunities for development of parenting skills, including for children and families affected by HIV, is also included.

Operational research on child sensitive social protection and child protection aimed at generating key lessons for programming to tackle economic and other disparities in the country and beyond is set to begin in the third quarter of 2011. Specific areas for learning will include practical solutions for community based alternative care in a context of chronic poverty and collapsed social services, the economic impact of gender-based violence and the impacts of paternal and maternal orphaning on children, families and communities.

\textsuperscript{10} These activities are in line with the Ministry of Labour and Social Services Department of Social Services Institutional Capacity Assessment Report developed by OPM and funded by UNICEF in November 2010.

\textsuperscript{11} Justice for Children extends beyond children in conflict with the law and survivors and witnesses. It ensures access to rights based traditional justice and civil remedy (including restitution and inheritance rights). It also covers the implementation of other legislation that affects children such as legal entitlements to access basic social services such as health and education.
CHAPTER V
CAPACITY DEVELOPMENT IN POLICY ADVOCACY AND PARTNERSHIPS FOR CHILDREN’S RIGHTS
ABSTRACT
In 2009, UNICEF Egypt's successful advocacy and outreach led to the development of a Diploma Course on Public Policy and Child Rights. The development of the course was guided by a consortium of eight universities and higher education institutes from the Middle East and Northern Africa (MENA) region and Europe. For the first time in the region, a university in Jordan is now offering this advanced professional post-graduate university training, while two others in Egypt and another university in Jordan are to follow starting September 2011.

The Diploma has been established in response to the urgent need for developing capacity of practitioners on the issues relevant to fulfilment of children’s right. The Diploma aims to build a cadre of researchers, activists, members of Parliament, social workers, national and local planners and local NGOs capable of advocating for and implementing public policies and legislations from a child rights perspective. The consortium, responsible for developing the Diploma, was brought together based on their comparative advantage in specific fields that are being taught and their value added in the design and the implementation of the Diploma course. The strategic selection and partnership with these universities and academic institutions will ensure sustainability of the course beyond the project’s lifetime. The initiative has further inspired UNICEF Egypt to initiate work on a Diploma course on Research and Evaluation.

BACKGROUND
Egypt experiences persisting levels of poverty – one fifth of households with children live below the national poverty line1 in spite of significant economic growth, globalization and an increased awareness on children’s well-being. Fulfilment of children’s rights is pivotal in advancing human development and achieving the MDGs. As children’s issues and violations of their rights increasingly acquire attention in Egypt, there is still an absence of child friendly policies based on solid evidence and with a focus on respect, protection and promotion of children’s rights.

The inter-disciplinary systematic study around children’s rights in Egypt is limited. The situation of children in education, law, health and nutrition, inclusion and empowerment, representation and media access, as well as young people’s engagement in policy making, are marginal issues in mainstream social sciences faculties at national universities. The initial assessment of similar courses and university level training programmes in Egypt revealed none of the training programmes included a combination of children’ rights, child development, public policy, economics and finance for a professional audience. While many practitioners working with and for children are passionately committed to their cause, they are not always qualified with skills and knowledge on policy and children’s rights to enable them to become strong advocates for children. There is an urgent need to build holistic capacity around children’s rights issues in Egypt.

STRATEGY AND IMPLEMENTATION
Initial implementation (pilot phase)
In early 2008, UNICEF and Cairo University (Faculty of Economics and Political Science [FEPS]) deliberated on initiating a training course on children’s rights and public policy. The aim was to establish an institutionalized university level post graduate training on this theme. Initially, it was agreed that a single course would be developed and integrated into

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an existing one year graduate Diploma on Civil Society and Human Rights in the academic year 2008-2009. At the same time, there was an understanding that both groups would strive to develop a full one year Diploma.

In 2008, the Cairo University accepted to replace an existing course within the on-going Diploma on Human Rights with a course on public policy and child rights. The faculty was drawn from various departments at Cairo University and the American University in Cairo to cover a wide range of topics. The course was tailored to provide students with the knowledge and skills necessary to map and advocate for children’s issues in the public sector (such as law making, policy making, budgeting, and local administration) as well as the public sphere (civil society). The course was well received and the number of students registered for the course at least doubled compared to the previous years. As a result, FEPS decided to continue the course for the following academic year 2009-2010.

Partnership and funding
Partnership with universities and academic institutions within and outside of the region has been central to the development of the Diploma. Potential partner universities and institutions were identified based on a preliminary research on the existing masters or other training programmes on the subjects related to public policy and children’s rights. The two universities in Jordan were identified together with UNICEF Jordan, building on the existing partnership with these universities. UNICEF Egypt then contacted these potential partners and presented the project as an opportunity to establish a unique diploma, highlighting the benefit they would derive from it too.

In April 2009, a consortium of eight universities and academic institutions submitted a three year proposal to the European Union's (EU) TEMPUS programme to implement the one year Diploma in Egypt and Jordan in the academic year 2010-2011. In October 2009, the EU provided Euro 1 million to cover the project for the entire duration. Currently, the consortium members are developing the course content and new teaching techniques.

Partnership with universities in Europe has also been developed and was strengthened through the funding opportunity through TEMPUS. As a result, the Diploma curriculum will benefit from international expertise and students will have the opportunity to use their academic credits at higher educational institutes in Europe. For example, international student seminars and research workshops will be organized as a part of the Diploma.

Objective and content of the Diploma
The Diploma aims to build a cadre of practitioners working with and for children that effectively use their skills and knowledge to influence adequately funded, evidence-based and child rights oriented public policies, programmes and practices. For a long term, it seeks to create a culture in Egypt where children’s rights are respected, protected and fulfilled through improved policies and practices. The Diploma will be a one year full time study programme consisting of eight courses. The curriculum is currently being developed by a multidisciplinary team of scholars in Egypt, Jordan and the EU. It will be developed to closely link theory and practice. Human and children’s rights and their core principles will determine the overarching approach for the design of the Diploma. The programme composition was agreed on by the consortium as following:

1. Growing up in the Arab World
2. Children’s Rights and the Law
3. Public Finance and Social Budgeting
4. Children in a Changing Economy
5. Improving Services for Children (case studies)
6. Researching children (Methodology)
7. Monitoring and Evaluation of Child Policy

Target audience
The primary teaching language of the Diploma is Arabic while all teaching material is provided in English and Arabic. The Diploma is primarily targeting mid-career professionals (such as policy makers, civil servants, NGOs, front line professionals, journalists, activists) with five to 10 years work experience and a first degree. Indirectly the Diploma targets high level decision makers and members of Parliament, all those with whom the students will work to influence public policies for children. In this way, the students will act as multipliers of the knowledge acquired through the Diploma in their respective work environments. Classes will be held in the evening.

Monitoring and Evaluation
Monitoring and evaluation exercises have been conducted for the course on public policy and child rights (integrated into the existing Diploma on Civil Society and Human Rights) at the Cairo University for the academic years 2008-2009 and 2009-2010. The progress of the course has been monitored through regular meetings between the Cairo University and UNICEF, as well as through on-line discussion groups for the course. Administration of ques-
tionnaires is the principal means of verification for evaluation, complemented with selected in-depth interviews and additional qualitative information such as documented interaction during the course. Furthermore, the following monitoring and evaluation exercises were conducted to measure the direct outcomes of the course:

- Pre-training baseline and post course impact knowledge tests
- Post-training survey on satisfaction with the quality of the course
- Follow-up after six months on the application of knowledge and skills gained from the course into students' fields of work
- Survey on impact on ability to do work after one year
- Establishment of alumni network for continuous information gathering.

**PROGRESS AND RESULTS**

The Diploma course has officially commenced at the Hashemite University in Jordan in February 2011. Three additional universities (Cairo University and Assuit University in Egypt and the University of Jordan) will follow in September 2011. The curriculum development of the Diploma is currently being delayed mainly due to the revolution in Egypt and the civil unrest in other countries in the region. To date, curriculum and study materials for four out of eight courses of the Diploma have been finalized. The rest of the four courses will be finalized in time for the next semester starting in September 2011.

For the course on public policy and child rights which was integrated in the existing Human rights and civil society diploma at the Cairo University, 70 students were enrolled for the academic year 2008-2009 and only five (7 per cent) failed. For the academic year 2009-2010, 36 students were enrolled in the same course and all except one student passed the course. One of the possible reasons for the decrease in the number of students is that the admission of students was more restrictive for the second year. Based on the qualitative data, students from both academic years were overall satisfied with the performance of the lecturers in regard to pedagogical teaching methods, interactivity between students and lecturers and flexibility.

For the academic year 2008-2009, a follow-up of a small sample of students for six months after the course revealed only few of the participants had the ability to apply what they have learned in the course in their work in the field. This was attributed to the fact that only few of the participants worked in the field or a position that gave him/her the opportunity to apply what they had learned.

Unlike the students of the academic year 2008-2009, some of the students from the academic year 2009-2010 reported that they were able to connect theory (what had been taught in the course) and practice. For instance, some of the participants initiated the process of establishing an association on children’s rights together with their colleagues. Others adopted a project concerned with the rights of children in the slums. Two participants were honored in their field of work which they attribute to applying what they had learned during the course.

The initiative has further inspired UNICEF Egypt to initiate work on a Diploma on Research and Evaluation. Various other UNICEF offices have asked for information on this successful experience.

**INNOVATION**

Research of university level teaching programmes and training courses in Egypt revealed a lack of institutionally recognized programmes that offer a combination of children’s rights, social development, economic development and public policy. The Diploma is therefore expected to fill a vacuum in Egypt’s academic programmes and potentially beyond to the region.

The initiation and the roll out of the Diploma course demonstrates successful collaboration between the eight universities and higher education institutes from the region and Europe, brought together in a consortium. The partnership has resulted in sustainability of the Diploma beyond the project’s lifetime.

Key factors resulting in successful development and implementation of the diploma course are as follows:

- Identifying and networking with relevant counterparts in the Government and at local and European universities to advance the idea;
- Strategic selection of partner universities based on their comparative advantage and value added in the design and the implementation of the initiative;
- Development of a long-term plan with clear objectives for each phase of the initiative;
- Willingness to take risks and investment of UNICEF funds at the initial stages of the project;
• conducting monitoring and evaluation of the course even at the initial stages of the project: this has proven to be effective in re-structuring the course in its second year based on the feedback.

According to the evaluation of the single course, the application of what has been learned in the course depends upon the individual student’s area of work and context where they return after the course. Further, the evaluation process itself should be less labour intensive and more functional. The initial tools that were used for the evaluation and the frequency of evaluations (after every lecture and after every semester) appeared to be too heavy. These lessons learned will be considered when determining the monitoring and evaluation mechanism for the full Diploma.

POTENTIAL APPLICATION
Since the Diploma on Public Policy and Child Rights is the first course of its kind in the region it has the potential to attract academia from universities other than those participating in the current project. The Diploma will be widely promoted in the universities of Egypt, Jordan and across the region via mailing lists of both national and the regional partners such as NGOs working with children, relevant ministries (Education, Social Justice and Health) and national councils and organizations working for children’s rights.

In Egypt, the project has chosen to include a partner university from Cairo and Upper Egypt (Assiut University) in order to also offer the Diploma to students that do not live in the capital city. Further, TEMPUS funding will ensure multimedia teaching, including on-line and e-learning, as well as facilitate purchase of crucial teaching and reference material. It will also permit for exchange of students and teachers between EU and MENA regions.

NEXT STEPS
All eight courses and accompanying study materials will be made available by September 2011. By the end of the academic year 2011-2012, the first graduates will complete the full Diploma course. The consortium is using online Blackboard facilities, which facilitate secure online spaces to exchange information, to finalize the curriculum. For the monitoring and evaluation of the academic year 2011-2012, similar methodology and tools that were tested for previous academic years will be followed although the process will be less intensive and more functional.

RELATED LINKS
Diploma Public Policy and Child Rights (DPPCR) website: http://dppcr.wordpress.com

The decentralization process which began in 2002 in Peru has significantly empowered sub-national governments with the authority and resources to improve the lives of their citizens and develop their regions. However, due to limited experience, technical and institutional capacity for formulation of evidence-based policies, plans and projects and for results-based budgeting, investments that directly benefit children remained significantly low. By the end of 2008, 88 per cent of the functional authority had been transferred to the decentralized governments. This includes social sectors directly related to child wellbeing, such as health, education and social services. As the decentralized governments acquired more authority, the share of the public budget allocated to regional and municipal governments increased from 17 per cent of total public budget in 2002 to 38 per cent in 2008.

The decentralization process, however, is not accompanied by an effective transfer of technical and managerial capacity. As a result, there is a huge gap between available funds and implementation levels. For example, the execution rate of public investment projects was 50 per cent for regional governments and 43 per cent for municipal governments in 2007. Moreover, almost all PIPs were ostentatious infrastructure projects with limited interventions to improve the quality and availability of social services. Observing the capacity gap for the formulation of the public investment projects oriented for child wellbeing, and the absence of capacity building initiatives to strengthen technical capacity of social sectors especially at sub-national levels, UNICEF in 2007, identified capacity development in this area as a great opportunity. In addition to the other interventions that UNICEF has undertaken to improve the financial allocative efficiency of local governments, the Diploma course was developed as a unique opportunity to influence and leverage significant public sector investments in favour of children and other vulnerable groups.

### Strategy and Implementation
Between 2007 and 2010, the MEF, USAID/Project of Decentralization (PRODES) and UNICEF, in alliance with local universities and regional governments implemented the Diploma course. By the end of 2010, the course had...
been offered 17 times in 10 departments of the country. In 2011, four additional courses are confirmed to be delivered.

Objectives and contents
The objective of the course is to develop capacity of government professionals at sub-national levels to formulate public investment projects oriented for improvement of child wellbeing in the most marginalized situations. It consists of four modules; (1) Human and Child Development, (2) Identification of the problems, (3) Formulation of public investment projects, and (4) Evaluation of alternative interventions. Each module is divided into three phases, starting with the investigation phase which includes reading assignments and site visits; the second phases consists of a three-day workshop, while the third phase requires applying the acquired knowledge on project formulation. An evaluation of the contents of the Diploma course is conducted together with the partners including the MEF, USAID/PRODES, and local universities on an annual basis in order to incorporate necessary changes in the course content.

The course places strong emphasis on site visits and vulnerability assessments in order to analyze human rights violations among vulnerable and excluded populations. The results of the analysis are reflected in the formulation of public investment projects which are directly oriented towards improvement of the quality of public services targeting children. This reinforces the human rights-based approach (HRBA) in formulation of public investment projects. In addition, at the final stage of the course participants have to defend their projects to specialists from the MEF and the regional governments. The duration of the Diploma course is approximately six months, equivalent to 422 hours. The participants receive the Diploma certified by the MEF only when they achieve 70 per cent of the total qualification, which is a combination of the scoring notes of the four modules and the quality of the public investment projects presented at the defence session.

Partnership
UNICEF’s partnership with USAID was critical to the success of the Diploma course. UNICEF initially contacted various institutions which had capacity building programmes for elaboration of public investment projects. Instead of developing a new course, UNICEF identified the capacity building programme developed by USAID/PRODES as a basis for developing curriculum for the Diploma course with a specific focus on children. This increased the cost effectiveness of the initiative by reducing the duplication of work in creating a new curriculum altogether. In 2007 as a result of the alliance with USAID/PRODES, UNICEF was able to influence their existing capacity building programme to include a human development and child wellbeing focus. Further, the new capacity building programme included an exclusive module on human and child development. The initial partnership between UNICEF and the MEF was also established through USAID/PRODES, as they had already had a close relationship.

Another strategic element was the involvement of local universities from the beginning of implementation, which enhanced the attractiveness, credibility, quality and the sustainability of the course. The local universities had roles both in academic and administrative aspects. In terms of the academic aspect, the Diploma course was accredited by the universities and participants of the course receive university diplomas. The university professors that participated played the roles of co-trainers and co-facilitators, with the purpose of transferring the capacity to the university. The universities also managed the administration and logistics for the organization of the face-to-face workshops, with the aim of strengthening their capacity in this aspect as well. As a result, the National Universities of Ucayali and Peruian Amazon have decided to implement the Diploma course as a part of their post-graduate programmes.

Funding
The running cost of a Diploma course is approximately US$35,000. Around 45 participants are included in a course, making the cost per alumni approximately US$780. It is co-financed by UNICEF, regional governments, and through other co-operations such as with USAID and local NGOs. The participants are required to pay a small portion of the fee which varies from US$100 to US$180 per person depending on the location of the course. The fee is feasible for the participants to pay and is symbolic of their commitment to the course. It could be paid in two or three instalments if necessary. For each Diploma course, an executive committee is formed at the local level with participation of a representative from the university, regional government, NGOs and UNICEF. The executive committee defines the contribution of each institution in the development of the course. It is also in charge of promotion of the Diploma course and later the selection of the participants, as the number of applicants usually exceeds the quota. Preference is given to the professional staff directly in charge of formulation or evaluation of public investment projects.

PROGRESS AND RESULTS
Between 2007 and 2010, 608 officials of the sub-national government were trained through the courses and 93 public investment projects were developed in areas such as health, education and child rights protection, amounting to more than US$30 million. All the projects were presented to regional and local governments for their approval and
The Ministry recognizes this approach to be effective for the quality of all types of public investments that improves the standard of living of the target population. For this reason, the MEF has certified the Diploma as a recommended course for formulation of public investment projects. The MEF is also involved in dissemination of the course material (such as the manual for organizers, training modules and assignments in Spanish) to the wider public and is looking at scaling up its implementation at the national level.

**INNOVATION**

The most significant innovative element is the initiative’s high leveraging effect in securing investments for children. As a result of systematic advocacy by UNICEF and civil society actors over the last few years, the government, both at the national and sub-national levels, has made clear commitments to improve child wellbeing, especially in areas of health, nutrition and education. However, child-oriented policies have not been adequately matched by required budgets and technical capacity. In parallel, with an increase in government’s income from the mining industry in recent years, additional funds generated have been legally bound to be allocated for public investments. This created an important opportunity to influence the allocation of funds towards improving child wellbeing already prioritized by the government, by creating public investment projects focused on children.

Further, the stringent regulations laid down by Peru’s National System of Public Investment made it difficult to implement public investment projects with the present technical capacity. The continuous rotation of public servants, including as a result of the local elections in 2010, adds to the need for on-going and long term capacity building. Initial evaluation reveals that building capacity in this area has resulted in an increase in the public budget and investments for children. The Diploma course has also obtained the commitment of public officials to undertake social development initiatives for the benefit of children.

Assuming that the trained officials will continue formulating policies and projects, incorporating the HRBA after completing the Diploma course, its impact is even greater in the medium and long term. According to initial evaluation results, several alumni of the course are now placed in influential positions in the government where they are in a better position to leverage investments for children. This finding has surpassed the objectives of the course. For middle income countries like Peru with high levels of disparities and limited capacity to mobilize external resources, it is indispensable that the government – and more so local governments – invest more to meet the needs of the most vulnerable.

The alliance with sub-national governments and local universities made it possible to implement the project through co-financing; for the Diploma course implemented in 2009 the cost covered by UNICEF was 40 per cent, and the rest was financed by the regional governments, universities and other local counterparts. Given the high acknowledgement received by the course, in many instances NGOs are beginning to implement and finance the course without UNICEF contributions. This in turn strengthens the local ownership and sustainability which will support scaling up the Diploma course in due course.

Another innovative element is the development of a strong partnership both at national and local levels. At the national level, a strategic alliance was fostered with the MEF through the co-design and co-implementation of the Diploma course. This partnership was crucial in maintaining high standards of the course. The certification of the Ministry received upon completion of the Diploma has added strong value to the course. The partnership with other cooperation agencies such as USAID made it possible to implement the course in four departments in addition to six departments in Amazon and Andean regions prioritized by UNICEF due to their vulnerability in terms of child-related indicators. Further, USAID is rolling out a revised capacity building programme with a child focus in their interventions areas.

**POTENTIAL APPLICATION**

The MEF is investigating the possibility of scaling up the implementation of the Diploma course nationally. As a part of advocacy, a public event is being organized by the MEF, UNICEF and USAID, where the outcomes of the Diploma
course will be shared. The event is also expected to result in the identification of more universities for implementation of the course, as well as other cooperation agencies to share the cost. The Diploma course can be applied in other countries in the region such as Ecuador and Bolivia, as well as Central American Countries since they face common capacity gap issues. These countries have a similar system of formulating public investment projects as Peru, which are regulated by their respective National System of Public Investment.

**NEXT STEPS**

In order to scale up the implementation of the Diploma course at the national level, strengthening the capacity and number of trainers will be critical. Due to the nature and contents of the Diploma course there are limited numbers of trainers who are able to train on how to effectively incorporate the HRBA into public investment projects. In this regard, UNICEF will organize a training course for trainers together with the MEF and USAID in 2011.

Public dissemination events both at both national and sub-national levels will be undertaken, aiming to involve more universities and cooperation agencies in implementation. Some adjustment to the course contents is envisaged in order to incorporate the focus on result-based budgeting. An additional course on Project Management will be designed and implemented, since some weaknesses have been identified in the implementation of public investment projects targeting child wellbeing. Results from the qualitative and quantitative evaluation of the Diploma course are expected to become available by May 2011.

**RELATED LINKS**


CHAPTER VI
CAPACITY DEVELOPMENT IN CROSS-CUTTING AREAS
BACKGROUND

In 2006, Morocco celebrated the 50th anniversary of its independence. A few years before, the highest political authority (King Mohamed VI) had commissioned a nation-wide study to evaluate successes and shortfalls in terms of human development since independence to strategically inform national policy for the next few decades. A report "The 50 Years of Human Development and Perspectives to 2025" is based on the assessment carried out between 2003 and 2006 by academics and key national actors. It provides an in-depth analysis of Morocco human development trends and scenarios which should strategically guide UN and UNICEF in terms of their support in the future, in line with the ongoing debates on new forms of engagement in Middle Income Countries.

The report recognizes that few important public decisions have been made based on solid quantitative and qualitative research/studies that assessed the relevance of the process, approach, and impact. Persisting deficits and shortfalls in terms of generation of and access to knowledge products and their dissemination and utilization hindered establishing linkages between expertise/knowledge and policy making. Evaluation has been insufficiently practiced; and public policies have not always been readjusted considering their impact on the population’s well-being, including children. The case presents how the Moroccan Evaluation Association was built up through identification of champions with expertise and knowledge in Evaluation who are willing to volunteer their time and effort to promote the culture and function of evaluation. It highlights how UNICEF has supported the whole process by providing strategic guidance while strengthening the sustainability and the ownership of the Association.

STRATEGY AND IMPLEMENTATION

Based on the deficit described above, UNICEF’s office in Morocco has moved from an approach focused on internal capacity building of Monitoring and Evaluation (M&E) toward broader national capacity and systems building. As a part of this strategic shift, it supported the creation of a national evaluation association (Morocco Evaluation Association: MEA) to contribute to national debate and advocacy for the systematic evaluation of public policies. The whole initiative was based on the widely accepted assumption that if national M&E capacity is weak, it is unlikely that any development efforts, including contributions from international development cooperation, will reach significant positive results for citizens, including children. The MEA aims to:

1. Raise awareness of the importance of evaluation of public policies to assess and identify their successes and shortfalls;
2. Contribute to debate about evaluation of public policies and the impact on the development of the country;
3. Strengthen the evaluation community in Morocco through training, exchange of experiences at national and international level as well as capacity building;
4. Advocate for the institutionalization of evaluation of public policies in Morocco

Initial phase

Being aware of the risk related to sustainability of this type of initiative, the role of UNICEF was not to cre-

1 www.rdh50.ma/fr/general.asp
ate the National Evaluation Association, nor provide substantial funding. It was rather to identify national ‘champions’ with expertise and knowledge in evaluation, willing to volunteer and dedicate a part of their time to promote the culture and function of evaluation throughout the Moroccan political and administrative spheres. A few key resource persons expressed interest to embark on such an initiative after informal discussions during side meetings and conferences.

In early 2008, 4-5 people with a variety of profiles (academicians, public administration, civil society) and UNICEF gathered in a small committee and started to meet regularly, to prepare a concept paper outlining the core idea (why, what, when, etc), key steps to undertake, the profile of people to be mobilized and resources needed.

UNICEF provided space for meetings, documentation on the lessons learned from evaluation associations in the world, and guidance on the concept note, in addition to some small funding.

Launching of the MEA
Almost nine months of preparation with bi-monthly meetings led to the finalization of background documents and presentations. About 50 people were contacted by email and confirmed their interest and willingness to attend the constitutive assembly, held in December 2008 during which 8 board members were elected.

UNICEF hosted the assembly with the National Child Rights Observatory, one of its key partners. The assembly was undertaken in two phases; 1) an opening by the Chair of the Steering Committee, UNICEF Representative and the Executive Director of the Child Rights Observatory focusing on the importance of such an initiative and the role it could play in promoting the culture and function of evaluation in the public sector to maximize chances of achieving development results for citizens; and 2) closed sessions between members of the MEA to hold elections. A file was distributed to all participants including key documents on evaluation (UNG norms and standards, DAC M&E glossary, an article on the role of evaluation associations and other relevant documentation).

Since its launch in 2009, ad hoc and regular meetings were held by the members of the association to monitor the progresses and produce annual strategic plans (2010-2011 and 2011-2012),

Communication
A website (www.ame.ma) was designed as a tool for communication and advocacy. A leaflet was also designed and printed including the presentation of the association, its mandate and a summary of its plan for 2010-2011. By the end of 2009, jointly with an M&E training workshop for national partners, a public roundtable was organized to discuss on the role of Evaluation Associations where they presented the action plan for 2010-2011. Key international experts on Evaluation presented an overview of international experiences and how Morocco could learn from them.

Budget and Human Resources
The total budget invested in this process to date has been $15,000, as well as a small amount of staff time from UNICEF. Most of the time necessary for the creation of the association was by founding members who could invest time and energy to lead the initiative throughout the process.

PROGRESS AND RESULTS
1. A fully operational evaluation association was established and a strategic plan of action for 2010-2011 has been developed and implemented;
2. The Association has been recognized as a national independent association being invited to speak on evaluation matters in public events. It was also approached by many national and international institutions to build long term partnerships focusing on promoting evaluation culture and function in Morocco. Recent constitutional changes announced by His Majesty the King have given an opportunity to ensure that Evaluation of Public Policies would be enshrined in the new constitution.

To date, the Association took part in four international events on evaluation: 1) Francophone Evaluation Networking Meeting in April 2009, 2) Middle Eastern and North African region Evaluation Networking Meeting on the side of the International Conference in Evaluation held in Egypt in 2009, 3) an international conference held by the National Human Develop-
ment Observatory in collaboration with UN system in Morocco, and 4) UNDP-Observatory International Conference on the Evaluation of Public Policies held in Casablanca early 2010. The chair of the association also undertook a mission to Yemen to share Morocco's experience and find ways to revitalize an evaluation network supported by the UNICEF Yemen country office.

3. In October 2010, the Association, in partnership with UNICEF and the National Child Rights Observatory organized the first 'National Moroccan Week for Evaluation.' The objectives of the event were to create a forum of expertise and share experiences in order to better understand the function of evaluation as an approach for results based management in development and to promote criteria and standards for good practice in development evaluation. Public debates and discussions took place on the institutionalization of evaluation, measuring the impact of development policy and initiatives and existing mechanisms and good practices on M&E in Morocco. The discussions were followed by four thematic trainings on Evaluation for capacity development and drafting a national road map on Evaluation. More than 115 experts (representatives from government institutions, students, international experts, UN agencies, NGOs, and media) participated in this event.

The main outcome of the event included identification of key partners and setting of a plan for their future capacity development in Evaluation. Furthermore it contributed to a realization by the government that evaluation should not be project-based but should be a fundamental part of public policy in the country.

LESSONS LEARNED
The following factors have contributed to the success of setting up an operational National Evaluation Association in Morocco:

- Identification and involvement of the national evaluation 'champions' who are willing to volunteer to promote evaluation culture and function through public debate, research communication and advocacy
- Provision of strategic support from UNICEF including linking with key international experience and expertise on evaluation to promote mutual learning, while leaving key decisions and daily work to the association with a minimum external funding
- Existing political will and national context favorable to develop such initiative
- Inspiration from other UNICEF-supported similar initiatives such as the African Evaluation Association (AFREA)

Challenges to date include the difficulty to follow up on recommendations of evaluation, as well as a relatively limited pool of local resources. The complexity of the subject matter makes rapid upgrading of partners' capacity unrealistic and thus longer term plans are required to develop their capacity. The other challenge is the lack of documentation or training available in French from International Organizations or known universities.

NEXT STEPS
To boost the work of the Association further, and in line with the UNICEF supported programme of cooperation 2011-2012, a partnership framework was developed including following activities:

- Undertake a study on the state of the art of evaluation in Morocco and use findings for advocacy and communication activities to promote the evaluation of public policies
- Pursue the reinforcement of local capacity, with existing actors, but also key new partners such as the parliament and universities and internal ministerial training divisions
- Develop the existing website as an interactive national platform on evaluation including learning materials, a discussion forum, dissemination of norms and standards, as well as announcements of evaluation related events;
- In collaboration with UNICEF’s HQ and the Regional Office, translate the content of the global M&E website ‘My M&E’ (www.mymande.org) into Arabic to increase accessibility among Arab countries including Morocco.
- Develop South-South collaboration, especially with sub-Saharan countries and the Maghreb
- Explore reinforcement of sub-National capacity on evaluation in the framework of accelerated decentralization

RELATED LINKS
The Moroccan Evaluation Association official website (French): www.ame.ma
BACKGROUND

Due to increasing poverty, children in the Kyrgyz Republic have limited access to essential education. The inability to provide good textbooks continues to be a pressing issue, as is the maintenance and development of school infrastructure. In addition, a baseline survey of childrearing practices in Kyrgyzstan conducted by UNICEF in 2004, as well as several focus groups, revealed a pervasive lack of adequate knowledge and skills among parents and caregivers as to what constitutes stimulating, child-friendly environment. The survey and the focus groups also exposed parents’ concern that children are not able to excel in developing language and reading skills, and that as a result they remain unprepared for entering first grade.

To help address these recurring issues, UNICEF set out to organize a national contest and a workshop to support production of five booklets for young children and their parents. These booklets were the first of their kind in the Kyrgyz language. The idea was to include a mix of stories, games, poems, songs and illustrations built around core messages as described in Facts for Life. Specifically, the messages were to emphasize the critical importance of love and care for children in the first three years of their lives; learning through early stimulation and play; modeling of positive behaviors; intake of vitamin A and iodine; good hygiene practices; and protecting children from any form of violence.

The popularity of booklets and their lead characters ‘Aky-lai’ and ‘Aktan’ eventually led to a first locally developed animated series for children in late 2006, setting a milestone in early childhood development in the Kyrgyz Republic and transforming a single media-related activity into a growing media-based movement for and about children.

The series was launched by the Kyrgyz National TV and Radio Corporation (NTRC). Supported by the Presidential Administration and three donors under the umbrella of ‘Early Childhood Development Programme,’ a five-minute programme aired within the prime time slot during the weekdays, with a twenty-five minute compilation on Sundays. The se-

ABSTRACT

Learning is a lifelong process. Quality experiences during the early years play a vital part in promoting readiness for school. The children's books, magazines and newspapers in Kyrgyz language are rare and of varying quality. While there is a growing demand for books in native Kyrgyz, they have proven to be expensive and unaffordable for the majority who still live below the poverty line. Moreover, the parents often underestimate the role of print media in child development. Further, the country has almost universal television coverage, but children's TV is virtually non-existent. The technical skills needed to develop effective children's programming remain a critical bottleneck. The Kyrgyz Republic was one of the five Central Asian countries that was part of a UNICEF sub-regional workshop on developing Early Childhood Development (ECD) communication strategies in 2003. As a result of the workshop, the first print materials for and about children in the Kyrgyz language were developed. Following this initial success, an idea sparked among the local television writers and producers to create an animated series for children – ‘Keremet Koch/The Magic Journey’. UNICEF, together with partners supported the production of this animated series for children. This required significant capacity development efforts over the years, including but not limited to fund raising activities and workshops to strengthen technical skills of production and communication among partners and UNICEF’s sectoral programme teams for areas such as script writing, animation and communication skills. This example describes skill-development efforts carried out through a series of workshops and study tours.
ries had an instant appeal to children, the main characters of ‘Aktan’ and ‘Akylai’ becoming their most popular ‘national heroes.’ In the second season, the programme was improved to include live action, and episodes were created in a longer 15-minute format. The role of adult caregivers changed, there were more gender progressive messages, children with disabilities were included, there was more ethnic diversity and music became a core part of each episode. A two-season’s production released a total of 387 episodes.

Through its story-telling and, problem-solving skills and by being curious and exploratory, the characters have inspired children to learn and develop many of the skills necessary to prepare for school. All over the country children and parents were actively involved in shaping the production, sharing feedback and suggestions on improving the programme. It is said that children call NTRC to speak to the main characters. They also like to sing the theme song as well as other songs from the series.

The series has now been in production for four seasons acquiring a huge following among Kyrgyz children. This effort required significant capacity development over along the years, encompassing:

a) Fund raising activities
b) Identifying and engaging various partners
c) Designing workshops to strengthen technical skills such as script writing, animation, live action production and communication skills; and increase general knowledge about the latest ECD research and how this can be translated into effective media practices.
d) Organizing study tours

STRATEGY AND IMPLEMENTATION

Design and implementation of workshops
An internationally renowned expert on children’s media contracted by the UNICEF’s Kyrgyzstan Country Office was chiefly responsible for the design and content development of the workshops. The emphasis was on cultivating an incremental model of capacity development, built over the course of four workshops spanning a two-year period between November 2007 and November 2009. Specifically, each workshop served as a stepping stone and a foundation for the next phase of capacity development.

The first workshop, held upon the conclusion of the first seasonal production, brought together 60 participants including UNICEF staff, professionals from ECD and health sectors, journalists, teachers, script writers, composers, television and radio producers. The workshop was designed to review the content, provide recommendations for the next phase of Keremet Koch, and to suggest ways to conduct a more formal evaluation. It also focused on strengthening skills necessary for multidisciplinary approach to media production while emphasizing the need to engage creative talent from various disciplines as part of creative process.

The second and third workshops both provided an intense week-long training in script writing and live action production. In addition to foundational knowledge of writing for young children, the latter workshop elaborated on inclusiveness, disability, affection and emotions, safety, character development, etc. As a result of the training, new characters were developed for the animated programme.

The fourth workshop demonstrated a new level of ownership as the NTRC offered to hold a five-day training at its own premises. The producers were also more actively engaged in shaping the content, expressing more vocally what types of skills or areas of knowledge needed to be strengthened. A major focus was on how to effectively reach caregivers of the Magic Journey target audience – as well as parents of newborn children. In addition to the pool of artists and other creative talent that took part in previous workshops, this training attracted interest of a wide array of practitioners including psychologists, teachers, child-care workers, neonatologists, and government civil servants from ministries directly responsible for ECD related issues. This reflects changes in the overall country approach towards ECD and educational goals, and a need to further strengthen the knowledge and skills of key practitioners and decision makers.

The workshop offered a hands-on practical training on how to produce effective media for parents and children, including script writing, video recording and editing skills while also focusing on building self-confidence and competence. As a final product of the workshop, participants produced a one-minute video or a radio spot.

The workshop offered a hands-on practical training on how to produce effective media for parents and children, including script writing, video recording and editing skills while also focusing on building self-confidence and competence. As a final product of the workshop, participants produced a one-minute video or a radio spot. Prior to each of the workshops, past episodes of Keremet Koch were reviewed to identify which areas needed strengthening in the following workshop.

5 The first workshop was held in November 2007; the second workshop was held in September/October 2008; the third was organized in July/August 2009; and the fourth in November 2009
Mainstreaming C4D and ECD as guiding principles
The workshops were based on the supposition that the practice of C4D can be considered both as a 'science' and an 'art'. The 'scientific' aspects include the "knowledge and application of concepts, methodologies and techniques based on social and behavioral sciences to research, plan, manage, monitor and evaluate C4D interventions across a range of issues such as gender, child survival and health, child protection, etc" (UNICEF Capability Development Framework, 2009, p. 21). The ‘artistic’ aspects include the skilful translation of hard research into communicable, easy to understand and empowering material for audience. The art of C4D also gives special consideration to human interaction, values and principles as part of the communication process.

Following the guiding principles, the the consultant had to find a right balance between the two approaches in combining subject matter expertise (i.e. media for children, ECD practices, etc) with principles of adult learning theory in the workshop format and content. With regards to the latter, special attention was given to various learning styles using images, observations and music alongside techniques such as problem solving, learning by doing, interaction, dialogue and reflection. Specifically, the instructor demonstrated ways of how children learn best from media as well as effective ways to reach caregivers – especially those most disadvantaged. For both — a combination of building confidence as well as competence/skills was central.

Study tours
To support overall capacity development and to strengthen the impact of the workshops, UNICEF also organized several study tours that included NTRC and government staff. For instance, the NTRC executive producer, together with UNICEF, attended Prix Jeunesse International Film Festival in Munich in 2008. In 2009, three senior executives from NTRC – including the General Director – spent a week in Ankara, negotiating terms of collaboration with Turkish television.

Similarly, in an effort to increase knowledge and awareness around ECD agenda, a member of Kyrgyz Ministries of Health and Education spent several days in UNICEF’s Regional Office in Geneva. During the visit, the officials were exposed to current ECD research, policies and practices, and upon return became an ardent advocate of early education within the parliament and other ministries. A successful upshot of this lobbying campaign was evident in the increased level of parliamentary debates about preschool education.

6 Prix Jeunesse Foundation was established in 1964 by the Free State of Bavaria, the City of Munich, and Bayerischer Rundfunk (BR). The aim of the Foundation is to promote quality in television for the young worldwide. It brings forward television that enables children to see, hear, and express themselves and their culture, and that enhances an awareness and appreciation of other cultures.

PROGRESS AND RESULTS
While numerous anecdotes and direct feedback from children and caregivers around the country provide a testimony to the programme’s popularity, lack of funding has until recently prevented a more rigorous evaluation. The Queen’s University from Belfast has been contracted by Kyrgyzstan Country Office to conduct an evaluation of the series starting in spring 2011. The preliminary results of the evaluation suggest that over 90% of children of 5-6 years old watch the TV programme.

Over the course of three years, about 200 people benefitted from the CD training organized through the initiative. In addition to the formal evaluation, an assessment of the CD effort at the individual and organizational levels was conducted with the Kyrgyzstan Country Office. Three different methods were used to document the overall impact of CD effort: desk review, semi-structured interviews and project ethnography.

The National Partners
The national partners who participated in the workshops are now more independent in strategizing and designing action plans for behavior change campaigns. The managers of kindergartens also saw a rise in the status of their institutions. There was greater visibility of teachers and principals who took part in UNICEF-supported workshops; as a result the number of applications for enrolment of children submitted to their preschool institutions has increased.

Similarly, participants working as web designers and internet site hosts, now could offer a wider selection of services — elaborate advice for parents to stimulate development of their children and include doctors’ advice to parents of sick children. As a result, an increased visits to their websites has been reported.

An increase in job offers from the private sector as well as invitations to share expertise outside their immediate professional circle was also noted. Journalists, for example, reported that they were teaming up with friends trained as graphic designers and architects to create new programmes for children using 3D technology. Radio programming for children was also conceived as a result of workshops (i.e. radio programme titled My Healthy and Smart Baby, catering to young parents).

As for NTRC, their capacity to independently sustain production has grown, though there is still room for improvement requiring donor support. At the institutional level, NTRC demonstrates greater awareness around issues relating to capacity development. For example, they are establishing a School for Journalists that will among other courses teach casting. In the past, producing was seemingly a one-man show – the same person would be writing, editing and directing. This has significantly changed since the first workshop as the
production jobs and responsibilities have become increasingly diversified. It is not uncommon that every television programme now employs a script-writer and an animator, the latter increasingly becoming a popular profession throughout the country. The executives are also recognizing advanced skills of talent, rewarding them with competitive salaries. Script writers and animators working on Keremet Koch series are easily making US$900 per month, which more than triple the regular salary of their colleagues.

Many of the professionals are in high demand, both internally with their primary employers in Kyrgyzstan, but also throughout the region. The Executive Producer of Keremet Koch is now leading several other programmes. One of the most successful script writers was lured by television programme is Kazakhstan, while several employees reported they were offered shorter stints with Russian television programmes.

At the individual/personal level, most participants reported that they became quicker to respond with suggestions and constructive criticism when reading material written for and about children. Those who participated in all four workshops confirmed the incremental improvement in their skills – i.e. in slowly shedding resistance to working as a team; in becoming more responsive to issues relating to disabilities and gender; and in the growing ability to perceive children as active participants and observing the world from their point of view.

Most importantly, improved communication skills opened possibilities for better work relations and new ways of learning within institutions (i.e. peer to peer coaching, seminars, etc). Finally, as a result of increased self-esteem the professionals are more confident to look for work outside their communities. A young radio journalist, for example, reported that a failure to get support from superiors upon return from the workshop prompted her to look for more opportunities.

The focus groups revealed that many participants feel they became more creative and entrepreneurial at home, capable of designing toys with readily available material such as used boxes or cans, cardboard, rope, etc. Some also reported a marked improvement in being patient with their children, while others spoke of how they became advocates against punishment and promoters of healthy early childhood practices among friends and other parents.
Funding Partners
While partners see UNICEF as a leader in the Keremet Koch initiative, they take particular pride in it being a collective achievement and in the programmes’ increased visibility in the international market (2 million viewers). Until recently, the bulk of Soros’ Fund in Kyrgyz Republic was linked to policy formulation, project proposals and teacher training campaigns, work that by its nature did not lend itself to much visibility. This has changed with the appearance of Keremet Koch. Soros’ continued support to education is now more visible and affirmed by its logo appearing every night in a prime time television slot. Similarly, Aga Khan Foundation notes the improvement in the quality of children’s books they support.

South-South cooperation
Keremet Koch sparked an immediate interest in the president of Turkish National Television Avaz (TRT) during one of the international feeds, a daily exchange of programme among television networks. Since July 2009, ‘The Magic Journey’, with subtitles in Turkish language, has been shown twice a day (9 a.m. and 3:45 p.m.) on Turkish television’s international channel, and is being dubbed into Turkish for domestic broadcasts. The Kyrgyz team was invited for an exploratory study tour to Ankara, and soon after an offer was extended to broadcast all current and future episodes of Keremet Koch.

Turkish television also expressed interest in developing a regional collaborative project in partnership with the respective UNICEF offices. Tapping into the talents and expertise of Kyrgyz production team is a major part of this cooperation, as they will assume a leading role in training the Turkish television staff. More interestingly, perhaps, the cooperation agreement stipulates support for a variety of programmes, only one of which is catering to children. This is a testament to the multiplying positive effects of the workshops, as the training obviously provides an array of skills that can be reapplied and diversified in various programmes and contexts.

The quality of ‘Kermet Koch/The Magic Journey’ is being increasingly recognized internationally. In 2009 and 2010, the programme was short-listed for the prestigious Japanese prize, beating out such giants as ‘Sesame Street’, Nickelodeon and Hallmark Entertainment (see a list of short-listed counties). The programme also participated in the Prix Jeunesse festival. While it did not make the final selection, the programme was available at the video bar where a lot of good TV production for children is placed. An independent US broadcaster, delivering international educational programmes that reaches 27 million households (both in America and internationally) via satellite, saw ‘The Magic Journey’ in Japan, has expressed interest in broadcasting it.

INNOVATION
The incremental impact of the workshops was significantly shaped by the initial commitment to recognize local culture and the importance of writing and producing for children. Whereas capacity development initiatives often focus on short-term, one-off opportunity for skill improvement, this was a carefully designed needs-based initiative that introduced and integrated new elements one step at a time. Each of the workshops served as a stepping stone for the next level of skill development. The key to the incremental approach was to weave theoretical knowledge with practical experience, and to balance drive for competence (technical skill) with confidence (individual self-esteem). This enabled participants to develop a critical stance towards their own achievement, solidify gains, and define areas for further improvement. Recognition of good work with either verbal praise or symbolic awards (i.e. a box of cookies, small educational gifts), helped maintain a drive for results and a high level of motivation.

POTENTIAL APPLICATION
The method and techniques lend themselves for wide applicability in a variety of settings. For example, similar training is particularly relevant in the area of Communication for Development (C4D) – when creative and engaging interventions are needed to develop strategic communication for social change (e.g. media for, about and with children; programmes concerning persons with disabilities; interventions designed to actively engage households and communities, etc.). The workshops can be used to raise awareness, demonstrate ways of fostering positive attitudes and to address social norms that enable or inhibit desired behaviors and practices.

Issues to consider when replicating
The uniqueness of the product, based on cultural traditions, conceived and executed by local talent solidified the success in the Kyrgyz television market, and had an instant appeal to the audience. In turn, this proved to be a strong motivational factor to further Capacity Development (CD) goals both internally within UNICEF and with other partners, including NTRC, Soros and Aga Khan Foundation.

Phasing of the CD was critical. Each step helped to...
provide a building block for the next stage of CD initiative. This ensured ample time for the knowledge to ‘sink-in’ and strengthens participants’ confidence eventually giving way to greater ownership and participation.

**Simultaneous application of various CD methods reinforced overall results and intended outcome.** Intensive workshops focusing on technical skill development should be accompanied by study tours, advocacy campaigns and language-learning skills.

**The offshoot of CD efforts extends far beyond the workshops’ original intent to strengthen the local talent in producing one quality television programme for children.** Workshops helped heighten interest in ECD and influence overall country strategy. Alliances among partners whose interests are vested in the ECD agenda have become stronger and more collaborative. At the same time, it has been recognized that visible institutional progress can further evolve only if higher echelon of managers undergo similar workshop training.

The workshops have helped build interpersonal relationships, provided opportunity for networking and served as a spring board to launch new careers. The participants have been reaching out to other professionals they met through the workshops to help out as resource people for various ECD-related trainings organized within their own work places. They have also built web-resources and helped produce independent video programmes.

**Successful CD initiatives can be built with relatively small seed funds.** Overall expenditure of about $100,000 for two seasons of programming can be considered a modest investment when contrasted with Meena’s production cost of about $2.7 million for 30 episodes. The UNICEF Country Office was prescient in recognizing the initial creative spark, providing adequate managerial support to sustain the momentum. At the same time, a quick agreement among partners to support the initiative with available seed money afforded the necessary impetus from the outset.

An entrepreneurial instinct and openness to experiment with new ideas and technology can gradually pave the way for success. It is a prevailing common be-

11 UNICEF’s Meena Communication Initiative (MCI) launched in September 1999 is a widely recognized and successful advocacy and teaching tool for girls’ and children’s rights. The Meena stories, revolving around a spirited, nine-year-old girl who braves the world – whether in her efforts to go to school or in fighting the stigma surrounding HIV/AIDS in her village, are presented through a variety of media, involving story books, radio series, posters, flip charts, animated videos and discussion guides. Visit: [www.unicef.org/rosa/media_2479.htm](http://www.unicef.org/rosa/media_2479.htm)
lief that projects with clearly designed process and defined outcomes are more likely to succeed. Some of those who have been actively involved with this CD initiative, however, firmly believe that a planning-laden process at the initial stage could have produced the exact opposite effect, killing the creative spark. There was a chance that NTRC, overwhelmed by high expectations and its own inexperience could have become ‘paralysed’ and unable to act.

**NEXT STEPS**

**Evaluation**
The Queen’s University from Belfast has been contracted by Kyrgyzstan Country Office to conduct an evaluation of the series starting in spring 2011. The purpose of the evaluation is to assess the overall impact of Keremetskoch/the Magic Journey over the period 2008-2010. The evaluation will focus on short-term indicators of impact, with specific attention to audience reach, influence and learning outcomes.

**Additional Training and Transfer of Ownership**
UNICEF to date has provided a substantive support toward CD and played the leading role in workshops’ planning and design. At this stage, transfer of ownership should be considered as this would be a key determining factor for the future success of the animated programme as well as for the overall impact of ECD interventions. With UNICEF technical input and supervision, NTRC seems empowered to take this initiative upon themselves.

**RELATED LINKS**


*Keremetskoch (Magic Journey) Kyrgyzstan* video on youtube: [www.youtube.com/watch?v=DifVX64SE2o](http://www.youtube.com/watch?v=DifVX64SE2o)


**ABSTRACT**

Lesotho’s gains in reducing child and maternal mortality have been reversed over the past decade as a result of the HIV epidemic. In support to various interventions in accelerated young child survival and development that will contribute to MDGs 4 and 5, the country implemented the first Child Health Day (CHD) initiative across ten districts in May through June 2008. The goal of this annual initiative is to increase coverage of child survival, care and development services through a structured outreach method that incorporates a communication for development (C4D) strategy at every step. The CHD aimed to reach under-five children with screening for HIV and TB, malnutrition, especially protein-energy malnutrition (PEM), immunization, and supplementing with Vitamin A and de-warming tablets Albendazole. The communication strategy used for CHD was intensive social mobilization, coupled with training and material development. The messaging primarily focused on prevention while also addressing care, support and treatment as well as capacity building of community health workers and health care providers. The CHDs reached out to 10,000 children in 2008 and over 3,000 children in 2010 and received immunizations, HIV counseling and testing and screening for malnutrition among others.

**BACKGROUND**

Efforts to achieve MDG 4 and MDG 5 are being severely constrained by the HIV epidemic, which has also reversed previous gains in reducing child and maternal mortality. According to Lesotho Demographic Health Survey 2009 report (LDHS), under-five mortality has increased in the past decade from 90 per 1,000 live births in 2000 to 117 per 1,000 live births in 2009. About eight in ten of these deaths occur in the first year of life where infant mortality is 91 deaths per 1,000 live births, and child mortality is 28 deaths per 1,000 children at age 1. Neonatal and postneonatal mortality in the same period accounted for 47 and 45 deaths per 1,000 live births, respectively. The pattern shows that deaths occurring during the neonatal and postneonatal periods account for 79 percent of all deaths under age 5. The report also highlights glaring inequalities with an under-5 mortality rate of 107 per 1,000 live births in the poorest quintile compared to 80 for the richest quintile. It furthers reveals high levels of chronic malnutrition with 39 per cent of under 5 children being stunted.

A continuing rise in maternal mortality rate (MMR) is highlighted by the LDHS, with an increase from 762 per 1,000 live births in 2004 to 1,155 in 2009. According to the report, pregnancy complications remain the primary cause of maternal and child morbidity and mortality. It also highlights that 53 percent of the women who had a birth in the five years preceding the survey and who received antenatal care for the most recent birth report that they were informed of the signs of pregnancy complications. An important factor highlighted by the LDHS is Women in the highest wealth quintile are more likely to have been informed about complications than women in the lower quintiles (69 percent compared with 58 percent or lower).

Access to health to health care is a serious problem despite a move by the Ministry of Health and Social Welfare in 2008 to provide health services in public health centres free of charge. Problems of access as highlighted in the 2009 LDHS include geographical terrain and remoteness of villages from health centre, transportation costs, getting permission or money to go for treatment, concern on availability of drugs and not wanting to go alone.

Despite the challenges, significant strides have been made in an effort to increase coverage in child survival interventions including HIV. There is a notable increase in of uptake of PMTCT services where the percentage of HIV-positive pregnant women receiving ARV for PMTCT...
has increased from 27 per cent in 2007 to 64 per cent in 2009,¹ with all 182 health centres expected to deliver Mother-Baby Package (MBP) by June 2012. Only twenty-three per cent of the estimated 13,000 children in need of ARV treatment are receiving a treatment in 2009.² According to LDHS 2009, 62 percent of the children age 12-23 months received all recommended vaccinations, that is, a BCG and measles vaccination and three doses of the DPT and polio vaccines. Fifty-three percent of children age 12-23 months had received all recommended vaccinations by their first birthday.

The CHD initiative in Lesotho is an effort by Ministry of Health and Social Welfare (MOHSW) with support from partners such as UNICEF to redress drops in vaccine coverage and expand outreach services to marginalized children under the age of five. In a country like Lesotho where access to services remains a problem, the CHD is not a panacea but an effort to augment health related outreach services. Though the country is yet to develop a national communication strategy for accelerated young child survival and development, incorporation of C4D in the CHD’s approach entails on-going community education around all helms of child health. The ultimate communication strategy will go beyond the CHD and amongst other things be informed by the results from the EPI 30 cluster, IMCI and Health Seeking behavior studies undertaken in the first quarter of 2009 and other supporting studies.

STRATEGY AND IMPLEMENTATION

Goals and objectives
The CHD approach is to reach 10,000 children ages five and below in all ten districts who did not have full access to health services. Intensive social mobilization and community education play a very important role in the success of the CHDs.

The goals of CHDs are:
• To screen all under five children for HIV and TB
• To identify children with malnutrition, especially protein-energy malnutrition (PEM)
• To immunize all eligible children
• To provide/administer vitamin A and Albendazole to all eligible children
• To conduct rapid assessment of dentition status of all under five children
• To promote PHC in general and preventative activities
• To refer all eligible children for further management

Micro-plans, budgets and activities for CHD were developed at district level and submitted to central level for financial and technical assistance. Hence all activities are community driven. The key audiences for prevention messages included parents and caregivers of these children while secondary audiences included the communities in which they reside.

Behavioral Communication Change
The behaviors that the C4D initiative seeks to improve and sustain are therefore to:
• Strengthen level of knowledge and practices on hygiene and diarrhoea treatment for mothers and caregivers;
• Improve exclusive breastfeeding knowledge and practice among mothers and care-givers;
• Improve knowledge and practice on nutrition in the context of infant and young child feeding;
• Improve sanitation and hand washing practices in communities
• Improve utilization of facility services (Antenatal care, PMTCT, routine immunization, pediatric HIV);
• Increase target audience response to and participation in child health days campaigns; and
• Advocate with local authorities, mobilize communities and the private sector to participate in social mobilization and commit resources to the initiative.

Interpersonal communication channels utilized include community health workers, churches, local health centre, community gatherings, community leaders and district public health nurses. District efforts were supported through letters and circulars to the district, distribution of communication materials and continuous announcement over the national radio station on the dates for the CHD. UNICEF technically and financially supported MOHSW with this initiative and hence was fully involved in planning and monitoring activities. Key partners included faith-based organizations and NGOs.

Participation and ownership
In preparation for the CHD, a national task team was set

up to coordinate preparation, implementation and reporting in all the ten districts. The team drew up a template that was dispersed to district and community level through various orientation meetings. At district level each stakeholder was oriented on their roles they were expected to play. The bulk of social mobilization and community education activities were undertaken by the community health workers themselves who would report to health centre nurses via SMS or letters.

The community health workers (CHWs) engaged in the following communication activities:

- Updating lists of eligible children at communities and sharing these with health centers to enable adequate stock up of resources to be used.
- Door to door mobilization to ensure that all parents and care-givers of eligible children are aware of the initiatives and dates as well as venue for the child health day.
- Village chiefs were also mobilized as communication channel having also been oriented by the community health workers on the initiative. Their role would be making sure that the community knows about the initiative and supports it. They would also ensure that all eligible children attend.
- Church leaders were also informed and asked to announce the dates for the CHD during their sermons. Communication materials in the form of banners, pamphlets and posters were developed and used to support information dissemination about the CHD. Announcements were also made on local radio stations announcing dates for the CHD.

**Facilitating and hindering factors**

The communication strategy utilizes the strength of CHWs who are based at village level and are in everyday contact with communities. The CHWs are also in regular contact with District Public Health Nurse and Local District Management Teams who coordinated the CHD at district level. No major challenges related to resistance to bring children were reported. The only exception was of children who were not in the community during the CHD, but plans were made to accommodate these children upon return. In many of the instances the children were brought by fathers or grandmothers and caretakers in instances where mothers are working, have passed away, sick or not present on the day.

**Timing** was very crucial for the success of the CHD. In 2008 the CHDs were held in early winter before it snowed and when most of rural communities were not spending a lot of their time tending to the fields. However in 2008, the CHDs were held during the rainy season, as a result of which rivers were full and service providers could not access some remote villages, hence less than 10,000 children were reached. However in 2010 the CHDs were expanded beyond children to include parents/caregivers who were tested for HIV, had their blood samples taken for CD4 count and also screened for TB.

Partners involved in this CHD initiative were:

- UNICEF
- Baylor College of Medicine/ Baylor COE
- Clinton Foundation HIV/AIDS Initiative
- Irish Aid
- Kick for Life
- Medecins Sans Frontiers (Doctors without Borders)
- OH Africa
- Peace Corps of America
- Private sector and other partners
- Elizabeth Glaser Pediatric AIDS Foundation

**PROGRESS AND RESULTS**

When the CHDs were first implemented in 2008, 10,000 under five children were examined. Below were the main achievements:

- A total of 4,191 were tested for HIV and of these 83 (2%) were positive and referred to the next level of service delivery (Paediatric ward in the district hospital).
- A total of 5,602 were screened for TB and 32 were found to be suspects and referred to the hospitals for further investigation.
- A total of 5,626 were screened for malnutrition and of these 227 were found to be moderate to severely malnourished and 19 to be severely malnourished all of them were referred to the nearby, local health centers for further assessment and enrollment in the therapeutic and/or supplementary feeding programme.
- A total of 591 children were found to not have been immunized. They were vaccinated during the CHD against Measles, DPT3 and Hep B. 3,786 were given Vitamin A capsules while 3,939 were given de-worming tablets.
- Over 95% of mothers and care-takers who took their children to the CHD sites volunteered to be tested and counseled for HIV.
- All adults (mothers/ parents and care takers) and the children found to be positive for HIV were registered and referred to the nearest health facility for follow-up.
- All malnourished under five children were registered and enrolled in either Inpatient or Outpatient Therapeutic Feeding Programme through reference to the health centers and local district hospitals.

In 2010 the CHD focus was on HIV and malnutrition as a massive National Immunization Day (NID) where measles and polio antigens had been given to all children aged 16 and below had just been undertaken in September in the country.
• 3,358 children were reached, out of which 1,532 were offered HIV testing and counseling. 30 of these tested HIV positive. All HIV exposed infants were referred to the into care at their nearest facility
• 34 dried blood spot samples were collected.
• 50 children were initiated on Cotrimoxazole and 54 Cotrimoxazole refill were given.
• 19 CD4 samples drawn and 9 children were referred to the nearest health facility.
• 1,312 were screened for malnutrition of which 8 were found to be malnourished, vitamin A was distributed to 816 children, 1002 reached with Albendazole. 174 Children were screened for TV of which 11 suspects were reached and 4 TB exposed completed treatment. TB

GOOD PRACTICE
The following two key components mainstreamed in the C4D strategy for the CHD are identified as good practices:

Partnerships, local structures, services and resources
The whole initiative is community driven with strong partnerships forged between District Health Management teams, local chiefs, churches, schools, community health workers, HIV support groups, village development councils and the local government councils. The local business community, especially the transport industry, played a significant role in the implementation of the CDHs. Local transportation is used to transmit messages and to ferry beneficiaries and caregivers to places where the services was provided. Churches and pre-schools including houses of chiefs are used as health centres for the day CHDs are undertaken in the community. Micro-plans, budgets and activities are developed at district level and submitted to central level for financial and technical assistance.

Community decision making and information dissemination
Especially for health related issues, health care workers are viewed as credible sources of information. They are also cited as the best communication channel for all health related information at community level. Local Chiefs also respect community health workers and hence easily work with them to address all health information dissemination. Churches and teachers are also viewed as credible sources of information. Health centre nurses coordinate such activities at community level with great support from CHWs. Cell phones also play a significant role in relaying information such as numbers of eligible children identified by the CHW. Communication through SMS between CHWs and health centre nurses is common to convey information such as dates and venues, and is crucial for the success of the CHDs

NEXT STEPS
The same objectives will continue to be upheld during the 2011 CHD, and will contribute towards achieving the following five year results (2008-2012):

(i) A comprehensive package of high impact maternal, neonatal and child survival interventions is accessible to at least 90 per cent of women and children;
(ii) Quality PMTCT and pediatric AIDS care services will be available to 80 per cent of affected and infected mothers and children; and
(iii) The number of new HIV pediatric infections reduced by 50 per cent.
ABSTRACT

Despite sustained reductions in child mortality, Mozambique continues to shoulder one of the heaviest burdens of under-five mortality in the world. In 2008, about 138 children per 1000 live births still died before their fifth birthday (INE, 2008). Availability of essential drugs and medical supplies is a necessary condition for providing quality health care and reducing child mortality due to common diseases such as malaria, HIV/AIDS and tuberculosis. Against this backdrop, UNICEF, as part of its overall Country Programme of Cooperation with the Government of Mozambique, supports the Ministry of Health (MoH) by making available essential medical supplies such as vaccines, mosquito nets and food supplements. In addition, since early 2009, the MoH and UNICEF have piloted a new initiative focused on building the national logistics and supply chain capacity with the aim of enhancing the efficiency in delivery and accountability for donated supplies and those procured through Government systems. The financial and technical support provided by UNICEF to the MoH in this area may be considered as relatively small when compared to other partners such as the US Government, which deploys a large team of experts and disposes of a multi-million budget for technical assistance. However, it is evident that the Government of Mozambique greatly appreciates the assistance provided by UNICEF and welcomes the new initiative and achievements to date.

STRATEGY AND IMPLEMENTATION

Against the backdrop mentioned above, and on the specific request of the Minister of Health, the technical expertise to support the storage and distribution of health products (CA) has been made available by UNICEF. Unlike CMAM, the CA had received little attention until UNICEF started to provide assistance in early 2009. At present, two separate entities are involved in the logistics of health products in Mozambique:

(i) The Central de Medicamentos e Artigos Médicos (CMAM) focused on the procurement and supply chain management of pharmaceuticals, rapid tests and laboratory reagents;
UNICEF assistance to the national storage and distribution of health products covers a wide range of activities, including:

- Daily on-the-job training and capacity building by working closely with the CA staff;
- Detailed assessment of processes, procedures, physical warehouse organization and human resources including recommendations for the short term;
- Review of and recommendations to improve processes, documents and reporting systems;
- Development of a standard product list as a preparation for the introduction of a computerised stock management program;
- Development of an operational plan for rehabilitation and re-design of warehouses (preparations for the introduction of a palletized racking environment);
- Physical inventory count planning;
- Development of a training manual and pilot training on basic stock management in the Mozambican health system context;
- Assessment of some of the provincial and district Supply Centers.

All these activities have been well received by the MoH and partners alike. Most of the activities are ongoing and require continued efforts by the Ministry and UNICEF alike. To date, the operational plan has been finalized and approved by the Government, and financial support for its implementation has been secured from several partners, including UNFPA and the US Government. Operational support for progressive implementation of the plan has been obtained from UNICEF’s Supply Division in Copenhagen.

**PROGRESS AND RESULTS**

Significant progress has been made towards strengthening the logistics and supply chain management of health products in Mozambique since early 2009.

One key result is the development and progressive implementation of an operational plan for sustainable improvements at the CA – the Government entity focused on storage and distribution of health products. Technical and financial support for the implementation of the plan has been secured from several partners, including the World Bank, the US Government and UNFPA. Another result is the increased awareness among all stakeholders of the existence of an equally important supply chain of crucial health products in parallel to the supply chain of pharmaceuticals. In recognition of that fact, the Ministry and development partners are supportive of the idea of moving towards an integrated supply chain for all health products, as advocated for by UNICEF.

In addition, achievements to date and new partnerships have earned UNICEF a seat at the table when systems strengthening, procurement and supply chain management are concerned. UNICEF has been participating actively in the Government and donor working group on medicines established under the Health Sector Wide Approach (SWAp). Further to the seat at the table that UNICEF earned, UNICEF was requested to Co-Chair the Working Group together with one of the MoH National Directors. In this role, UNICEF is in a position to address exactly the strategic issues that need to be addressed, such as the further development and implementation of a Pharmaceutical Logistics Master Plan. This plan aims at establishing a model that merges both pharmaceuticals and non-pharmaceutical medical supply chains into a single chain for the national health system in Mozambique.

Even though capacity development efforts seem straightforward at first, they proved to be more complex in practice. Every time a specific issue is addressed, a series of other issues emerges. For example, the foreseen installation of a tailor made computerised stock management programme in Portuguese has lead to the need to first invest considerable time and energy in developing a standard product list, making use of existing medical nomenclatures. In addition, the more familiar UNICEF has become with the internal MoH procedures, the more evident it became that certain aspects had to be re-done from scratch. As such, a physical inventory count planned to be carried out by MoH staff needed to be re-scheduled because of the magnitude of the operation, for which support from the UNICEF Supply Division Copenhagen is now foreseen.

Finally, it is challenging for both the MoH and for UNICEF to make recommendations without being able to secure the necessary funding for implementation and follow up. As such, both partners depend on third parties with implications on time and speed of progress.

**INNOVATION**

Globally, the majority of supplies procured by UNICEF are used to support the scaling up of key results for child survival and development. The main focus lies in procuring and shipping supplies to countries in a smooth, transparent and efficient manner. However, risks associated with efficiency losses and wastage of supplies once these are introduced into the national supply chain systems are rarely taken into consideration. In that context, an innovative approach focused on strengthening the national supply chain systems is being piloted within the health sector in Mozambique.
UNICEF support covers a wide range of activities, including on-the-job training, development of an operational plan for the rehabilitation and re-design of warehouses, introduction of a computerised stock management system and development of a strategic approach for professionalizing the public health supply chain in Mozambique.

**POTENTIAL APPLICATION**

Based on the successful experience in Mozambique, UNICEF may consider adapting a broader – regional or global – approach to technical assistance focused on logistics and supply chain management of health products – and indeed other products as well. An initial step would be to make the internal expertise and lessons learned from Mozambique available to other countries where similar initiatives are underway or in the pipeline. It is evident that many countries in the region could benefit from the technical support provided by UNICEF to the MoH in Mozambique.

The establishment of a technical multidisciplinary ‘mobile taskforce’ able to provide this type of assistance and covering a variety of sectors such as health, nutrition, water and sanitation may be considered at the global level. Country offices could then be encouraged to call upon the taskforce, especially for shorter-term assistance. In addition, the exchange of information and experiences among country offices should be encouraged and facilitated through regional workshops and improved knowledge management in the area of national logistics and supply chain management.

**NEXT STEPS**

In close collaboration with the MoH and partners like UNFPA, WHO, the World Bank and the US Government it is foreseen that the operational plan for sustainable improvements at the CA will be gradually implemented throughout 2010 and beyond. Amongst others, the plan envisages the rehabilitation of one warehouse, some minor repairs to other warehouses, a complete physical inventory count with support UNICEF’s Supply Division in Copenhagen, and the introduction of a computerised stock management system.

At the same time, a longer term strategic plan laying out concrete steps towards the harmonization of the two national supply chain systems and focused on training and capacity building efforts, will be implemented from 2010. UNICEF will also take the leadership in harmonizing the overall UN support to the Ministry of Health in the area of logistics and supply chain management.

In parallel, due attention should be given to the absorption capacity of the MoH to manage the technical assistance provided by partners. The Ministry must ensure that its development in the area of procurement and supply chain management is fully in line with its vision, and that the necessary internal capacity is built up to run and manage the national supply chain system for health products without external support and the need for ongoing technical assistance.

**REFERENCES**


**RELATED LINKS**

ABSTRACT
National Capacity Development in humanitarian situations does not need to be a decade-long process, which is often needed in development contexts. On the contrary, if specific and tangible capacity development benchmarks are identified from day one, the process can be outcome-oriented and yet demonstrate concrete results in a relatively short period of time. The outcome-orientation ensures that progress is measured by outcome indicators related to the improved situation for children and women (versus output which merely measures capacity indicators at organizational level). In Uganda the Office of the Prime Minister (OPM), district authorities and NGOs are working together with UNICEF and partners on the very specific objective of strengthening a supply and logistics system which serves children and women in and out emergencies and is managed and coordinated by the OPM. Through identifying this concrete objective and having a phased exit strategy, the capacity development process has been predictable and effective. Key lessons include the importance of identifying tangible benchmarks for the expected outcome that are realistically achievable through the increasingly developed capacities. It is also important to develop a clearly phased exit strategy – which means a complete hand over of responsibilities following the transfer of knowledge and skills. The new ‘Technical Note – Capacity Development for the Core Commitments for Children in Humanitarian Action’ and its complementary Tools were used to guide the capacity development process in Uganda.

BACKGROUND
In 2010, the Office of the Prime Minister (OPM) initiated a close partnership with UNICEF Uganda and other humanitarian agencies to strengthen humanitarian preparedness and response. One of the objectives was to enhance the national supply and logistics system. In the existing system, the provided supplies were not always sufficient in quantity, timely or context specific to the exact needs of the population or to the nature of disaster. Also, there was a need to enhance a national coordination mechanism for supplies in order to rely less on international structures.

STRATEGY AND IMPLEMENTATION
UNICEF’s Uganda Country Office and the Capacity Development Specialist from UNICEF Headquarters worked in close collaboration with the OPM and national partners to first develop and agree on the capacity development process. A workshop in Emergency preparedness and response planning was convened by the OPM and supported by UNICEF in the capital Kampala. This workshop was based on an initial gap analysis of existing preparedness mechanisms and drew in various line ministries and partners. The recommendations of the workshop allowed the OPM to identify key areas of intervention – one area was to strengthen the existing supplies and logistics systems to improve humanitarian action.

Step 1: UNICEF supported the capacity development initiative by working with all partners to clearly define tangible and measurable benchmarks for the capacity development process. In other words, to articulate what exactly the capacity development should lead to and by when. In that initial meeting with the OPM, Line Ministries and more than 10 national and international agencies it was agreed that the main objectives of the Supply and Logistics System would extend beyond the original objective of emergency response. Given the recovery and development indicators for Uganda the OPM and partners widened the objectives to encompass a Supply and Logistics System which a) supports programmes for enhanced recovery and b) ensures Coordinated Response to assist at least 10,000 people in times of emergencies.
Having a system which would serve both recovery/development programmes as well as emergency response was regarded to be crucial for two reasons: 1) the OPM wanted one Supply and Logistics system that would be consistently functional and hence continuously useful in non-emergencies yet have the capacity to “switch” to emergencies whenever they would erupt, rather than a dormant system which would be activated only in case of emergency; and 2) large emergencies are relatively rare in Uganda but recovery/development programmes are conducted on daily basis.

**Step 2:** For UNICEF it was then important to link the capacity development objective to the 'Core Commitments for Children in Humanitarian Action,' and an internal discussion took place in which there was an agreement that the priorities of national counterparts were fully consistent with UNICEF’s own CCC Programme benchmarks for supply and logistics.

**Step 3:** A one day consultation was facilitated by the OPM and UNICEF in Kampala, and was attended by key stakeholders (Ministry of Health, Ministry of Social Affairs, Ministry of Planning, Ministry of Works, Ministry of water and environment, CDC, WFP, WHO, International Federation of Red Cross- IFRC, OCHA and UNDP). Led by the OPM, the objectives of the consultation were to a) design and conduct the Capacity Assessment (including to assess existing and needed capacities) and b) develop the Capacity Development Plan (including actions, timeframes, outputs, outcomes and exist strategies).

UNICEF’s team for Supply and Logistics also participated and shared – based on their experiences – the technical capacities that are needed for a functioning system. The participants then engaged in a technical discussion on Supply and Logistics and conducted a Capacity Assessment of the existing versus existing capacities in the current system at the national and district level.

**Step 4:** Two other consultations in two Districts — Soroti and Katakwi were then coordinated with the national District Disaster Coordinators (DDCs). The District Disaster Management Committees (DDMCs) played a critical role in terms of assessing existing capacities for Supply and Logistics on district level. The district consultations started with brief emergency simulations followed by a debrief to stimulate discussion on currently existing capacities compared to capacities that are needed to a) support programmes for enhanced recovery and b) ensure Coordinated Response to assist at least 10,000 people in times of emergencies.

The stakeholders represented in the national workshop/consultation in Kampala were all represented by district representatives in Soroti and Katakwe.

**PROGRESS AND RESULTS**

- **Concrete benchmarks identified** by the OPM for the capacity development initiative. These benchmarks are also consistent with the CCCs benchmarks for Supply and Logistics.
- **Capacity Assessment conducted** at national and district level (including the assessment of existing and desired capacities and root causes).
- **The Capacity Development Plan developed** including actions, timeframes, outputs, outcomes and exist strategies.
- **Work Plan developed for implementing the Capacity Development Plan and ToR developed for a national expert** to be employed by UNICEF yet physically embedded in the OPM to manage at the implementation of the capacity development actions.
- **The first phase of the Capacity Development Plan implemented and included specific CD actions which are crucial for a functioning supply and logistics system, such as:**
  1) Standardized and simple multi-sector Supply Master List a for regular and emergency service delivery per type of disaster
  2) Standardized operating procedures for clear and consistent modalities of distribution (off loading, security, concern for vulnerable persons),
  3) Standardized reporting format – beneficiary feedback form – to document end user use of supplies and satisfaction

**LESSONS LEARNED**
The systemic approach to capacity development is crucial in order to truly support a solid progress towards a capacity development objective. The approach can be summarized as follows:

- a) **It is important that all capacity development initiatives respond to nationally identified priorities, are nationally owned and led by a national actor** – in this case the Office of the Prime Minister
- b) The Capacity Development process must be outcome oriented, which means that the focus is on the number of children accessing and using services and facilities (for example education, health or supply facilities) rather than merely the number of trained or skilled professionals (output level).
- c) National and international partners must prioritize distinct benchmarks to be met in a relatively short period of time (one month to two years) and other benchmarks for long term results. We must start with asking capacity development for what exactly and by when?
- d) National and international partners should conduct a **Capacity Assessment** for these specific benchmarks, in which existing versus desired capacities are identi-
fied (this ensures that we build on existing systems wherever possible and try to avoid parallel structures)
e) National and international partners must develop a **Capacity Development Plan** that addresses technical capacities on an individual level and organizational capacities at an institutional level. Developing only technical capacities such as trained teachers, without supporting the organizational capacities – safe school buildings with textbooks, blackboards etc – will result in a situation where the teachers will not have a venue to apply their capacities, and the investment in teacher training is hence lost.
f) Most importantly, national and international partners must identify a **clearly phased exit strategy** that shows how increased knowledge transfer is coupled with increased national takeover and finally the complete transfer of agreed upon functions.

**POTENTIAL APPLICATION**
The systemic approach to capacity development for the CCCs is applicable to any country. In 2011 an additional number of countries will be supported to use this model in different sectors such as education, water and sanitation, nutrition and Child Protection.

**NEXT STEPS**
Upon finalization of the “tools” and “components” of the supply and logistic system UNICEF will work with the Office of the Prime Minister to develop an on-the-job training package that will ensure standardized utilization the of the tools as part of the national supply and logistic system. Many CD processes in the past have given training a disproportional focus with little attention to venues for application of training. The systemic CD process first ensures that there is a platform for application i.e. tools and functional components of a supply and logistics system – and only then does it address the issue of training. Training is conducted through partnership and on-the-job training with specific indicators for knowledge transfer and is linked to a clearly phased exit strategy.

Another next step is to conduct a light Progress Report for the first quarter, so any challenges and hurdles can be identified and addressed in real time instead of conducting a full evaluation at the end of 2011 (when little can be done to improve implementation).

**RELATED LINKS**

**Note:** Further documents related to this initiative from Uganda (e.g. The Technical Note – Capacity Development for the Core Commitments for Children in Humanitarian Action, Benchmark Prioritization Matrix, the Capacity Assessment or the Capacity Development Plan) can be provided upon request. Email to: opsen@unicef.org
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