Sharpening the equity focus

Selected innovations and lessons learned from UNICEF-assisted programmes 2009-2010
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Acknowledgements
This compendium is a collaborative effort between UNICEF Country Offices, Regional Offices, Programme Division and Division of Policy and Practice of UNICEF Headquarters, coordinated and compiled by Rinko Kinoshita of the Information and Knowledge Management Unit. Design support was provided by Upasana Young. We acknowledge following contributors.

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FOREWORD

This document features some of the most notable innovations, lessons learned and good practices from UNICEF’s 2009 and 2010 programme reporting, incorporating updated information and results obtained as of late 2011. These examples represent just a few of the numerous activities UNICEF supports in more than 150 countries and territories around the world. They are presented here to highlight innovative initiatives of UNICEF and its country-level partners and to share lessons learned and good practices we have identified in working to reach the most deprived children and families.

After more than two years of implementation, the seventeen examples included in this compilation provide evidence of results in all five focus areas of UNICEF’s Medium Term Strategic Plan (MTSP) 2006-2013* as well as in its cross-cutting areas. Notably, these innovations and lessons learned are relevant for UNICEF’s intensified focus on equitable development results and the rights of the most deprived children.

It is important to recognize that lessons gained through cooperation in one country or context are not necessarily valid for 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 across regions and to provide some indications of where to look for emerging experiences which could refine or sharpen future programmes from an equity perspective.

Each of these pieces is a summary. More detailed information is available from the UNICEF Country 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).

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* Five focus areas of UNICEF’s MTSP are: 1) young child survival and development; 2) basic education and gender equality; 3) HIV/AIDS and children; 4) child protection from violence, exploitation and abuse; and 5) policy advocacy and partnerships for children’s rights (UNICEF Medium term strategic plan 2006-2013).
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*Case studies that also focus on Communication for Development (C4D)

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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.
LE S S O N S  L E A R N E D

BANGLADESH

The 'RED' strategy: Reducing disparities in immunization coverage

ABSTRACT

Despite reasonable national coverage of the routine Expanded Programme for Immunization (EPI) in Bangladesh, there were wide gaps between high and low coverage districts: some districts were identified as chronically low performing and hence contributing to the stagnated routine immunization coverage at national level. Using survey data, 15 low-performing districts were identified for implementation of the Reach Every District (RED) strategy, supported by UNICEF since 2006. The strategy addresses common obstacles to increasing immunization coverage such as poor quality district planning, quality of service delivery, inadequate monitoring and supervision of health workers. Empowering districts to plan, implement and monitor activities is a key feature. The 2010 Coverage Evaluation Survey revealed a substantial and sustained increase in EPI coverage in the RED districts that largely eliminates geographical disparities. The RED approach has also inspired UNICEF and the United Nations in Bangladesh to develop the intersectoral district strategies within the UN Development Assistant Framework (UNDAF) to reduce inequity among districts.

BACKGROUND

The Government of Bangladesh (GoB) provides routine EPI services to children less than one year of age and women of childbearing age (15-49 years). Approximately, 4 million infants are targeted each year with eight antigens – BCG, DPT, Hep-B, OPV, measles and Haemophilus Influenza type-b (Hib) vaccine. EPI has prevented an estimated 2 million deaths between 1987 and 2000, and continues to prevent approximately 200,000 deaths every year (WHO estimates). Coverage Evaluation Surveys (CES) are conducted annually to determine the antigen-wise coverage by district. Despite reasonable national coverage, there were wide gaps between the high (83.3%) and low (44.4%) coverage districts (CES 2005). The low coverage districts included hard to reach areas (Island, char2, haor3, hilly areas) and high risk populations (residents in urban slum and high-rise buildings, and migrants). Some districts were identified as chronically low performing and hence contributing to the stagnated routine immunization coverage rate at national level.

The RED approach is not a new intervention in the immunization programme. It emphasizes the local level actions that, if implemented appropriately, will contribute to increasing the coverage. RED addresses common obstacles to increasing immunization coverage such as poor quality district planning, quality of service delivery, inadequate monitoring and supervision of health workers. Empowering districts to plan, implement and monitor activities is a key feature of the strategy.

To address the issue of equitable access to immunization services and to achieve and sustain high coverage, UNICEF, since 2006, has been providing a support to the GoB in implementation of the Reach Every District (RED) strategy in 15 low performing districts.

STRATEGY AND IMPLEMENTATION

Bangladesh started implementation of RED strategy in 2004. It was further intensified in 2006 in identified low-performing districts. Based on the CES 2005, scores on child risk measures, difficult terrain and hard to reach population groups, 15 low-performing districts were identified (see Map).

The RED Micro-planning Guideline, adapted for Bangladesh with technical support from UNICEF and WHO, is the main guiding tool for micro planning. The planning process starts with a ward level analysis of performance and categorizes the priority interventions based on the

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1 The survey is conducted by the Government of Bangladesh with technical and financial support from WHO and UNICEF
2 Char means water bodies in the local language
3 Haor means small islands in the local language
problems identified. All relevant field workers (Government health and family planning workers), supervisors and local NGOs are involved in the micro-planning process. Every year, before this process, a training session for service providers at all levels is organized by EPI in a cascade manner. District Managers initially receive orientation at the national level and then they train sub-district managers and service providers. This is followed by an orientation for field worker/supervisors at the field level, conducted by sub-district managers.

The micro planning process starts from the lowest administrative unit (ward). Plans are subsequently compiled at various levels (e.g. union) up to the district level, and are monitored and reviewed quarterly. Planning is based on an analysis of problems at the ward level and interventions are prioritized based on local issues. The micro-plan process starts in October and is completed by end of November for the following year.

The selected districts were provided with funds and technical assistance to develop and implement micro-plans covering outreach services; quarterly reviews; vaccine transportation; supervision and monitoring; and other community mobilization activities. Key activities include:

• Detailed sub-district level annual micro-planning, and quarterly reviews of the micro-plan to identify key interventions to increase vaccination coverage.

• Periodic undertaking of crash programmes\(^4\) in geographically hard-to-reach areas. The plan for crash programmes is prepared at the beginning of year and is included in local microplans, and in the supervision plan.

• Strengthened supervision from national to district and local level through the development annually of a comprehensive supervision plan; the use of a supervision checklist; and an analysis of findings from supervisions.

• Monthly collection and analysis of data by EPI Headquarters at national level. Results are then fed into the district and local levels during monthly meetings.

In these 15 districts, partnerships have been formed with local NGOs and other service providers to address pockets of poor coverage; provision of vaccinators where government’s posts are vacant; extra porters for vaccine transportation in hard to reach areas; and strengthening social mobilization. The local NGOs are also involved in the micro planning process and play a complementary role especially in covering gaps in logistics and human resources by providing vehicles to transport vaccines or health workers.

PROGRESS AND RESULTS

The 2010 CES revealed a substantial and sustained increase in EPI coverage in the RED districts that largely eliminates geographical disparities. Through the implementation of the RED strategy in the 15 low performing districts, thousands of children have directly benefited;

\(^5\) Full Vaccination Coverage (FVC) rate is % of children who have received all doses of all antigens (BCG, DPT-3 doses, OPV-3 doses, HepB-3 doses and measles vaccines) at the appropriate age by 12 months of age.

Figure 1

![Figure 1](image)

The proportion of children fully immunized\(^5\) by 12 months of age increased from 52 per cent in 2005, to 69 per cent in 2007 and 76 per cent in 2010 in the targeted districts (CES; Figure 1). Coverage in these previously poor performing districts reached the national average in 2009. Figure 2 shows how these low performing districts (i.e. Full Vaccination Coverage (FVC) rate <60%) targeted through the RED strategy have increased their coverage between 2006 and 2010.

This corresponds to an additional 206,277 (24 per cent) of children of 12-23 months in these 15 districts receiving...
all antigens at the right time and the right intervals between 1996 and 2009. This averted an estimated 32,000 deaths and has significantly contributed to the reduction of inequalities in terms of morbidity and mortality among different groups.

Vitamin-A supplementation coverage in these districts also reached close to national average rates, i.e. for infants 80 per cent compared to national average of 82 per cent; children aged 12-59 months 96 per cent compared to 97 per cent; and post partum women 37 per cent, which is identical to the national rate.6

One of the key components of the RED strategy is local level planning based on problems specific to the geographical area. Culturally sensitive issues were locally addressed through the implementation of a micro-plan. This has contributed to eliminating a significant gender differential in vaccination coverage; 77.8 per cent of boys and 75 per cent of girls received all valid doses by 12 months of age in 2010.

LESSONS LEARNED
‘RED Micro-planning’ has proven to be a powerful tool for the EPI in Bangladesh to achieve the MDGs with equity. Before the RED strategy was introduced in the low performing districts, progress of the EPI coverage in the country was uneven and inequalities existed between different groups and geographical regions. There was a large gap in FVC between the highest and the lowest performing districts. Inequalities in vaccination coverage were also related to the educational and income levels of mothers. Some important lessons have been learned through the initiative including:

a. Bottleneck analysis: The RED approach helps assess bottlenecks and identify real causes of low coverage and supports appropriate corrective actions.

b. Bottom up approach: Local level planning starts from the lowest administrative level (ward), analyzes performance and prioritizes interventions based on the problems identified. Detailed demographic profiles of target groups; geographical information mapping; and detailed strategic and activity plans are developed locally and consolidated to reach every child with all antigens.

c. Local ownership: In a highly centralized country like Bangladesh, the RED micro-planning exercise enabled districts to plan, implement and monitor activities, thus contributing to enhancing local ownership and sustainability.

d. Flexible funding: The financial support to each district provided by UNICEF in addition to regular support from the GoB ranged from USD 8,000 to 25,000 per annum per district, depending on geographical location and the magnitude of local level problems. Flexibility in requesting funding and in its utilization enabled local managers to focus on gaps and to take corrective actions quickly.
POTENTIAL APPLICATION
To reduce both disparities in child health outcomes and to increase the national EPI coverage, the RED approach should be replicated in other areas with low coverage. The initial assessment is that this decentralized equity focused approach combined with flexible funding to the districts has, within a short period of time, been successful in achieving progress in maternal and newborn health. The experience from Bangladesh provides empirical evidence and builds confidence that, with political commitment and targeted programme support, achieving the MDGs with equity is possible.

NEXT STEPS
The GoB is currently implementing the RED strategy in all districts in Bangladesh. Strong ownership created through the RED strategy among local health managers has been a driving force for sustainability. In support to this, UNICEF continues to advocate for increased government funding to the district level for the implementation of the RED strategy. The lessons learned in the 15 low performing districts will be used by EPI in other districts and urban slum areas. Furthermore, building on the experience of the RED strategy, a decentralized approached is also being introduced for the first time in Bangladesh to accelerate progress in maternal and newborn health. Again the focus of this is on low performing districts.
BACKGROUND

The under five mortality rate in Djibouti is 91 per 1,000 live births (Multiple Indicator Cluster Survey- MICS3) in 2006. The situation is aggravated by high malnutrition and Acute Respiratory Infection rates among the children. These problems are closely connected to factors such as the low rate of exclusive breastfeeding, which was 1.3 per cent in 2006 (MICS). Promotion of exclusive breastfeeding was previously supported by the Baby-Friendly Hospital Initiative. A major achievement of the initiative is the training of 100 community health workers and 200 health personnel to support exclusive breastfeeding. Social mobilization approaches and the use of communication materials such as songs, spots, sketches, and traditional stories were also pursued. The 2007 National Nutrition Policy highlights the importance of exclusive breastfeeding and appropriate introduction of complementary feeding as an optimal way of feeding infants. In spite of these initiatives, the exclusive breastfeeding rate still remained low.

Against this backdrop and in support to the national policy, the Ministry of Health expressed the need to conduct a study to identify the factors linked to bottlenecks to exclusive breastfeeding. To determine the most influential people in communities (i.e. those who could serve as key actors in the communication and community mobilization strategy), a qualitative study was conducted in 2007 using semi-structured interviews. The study identified grandmothers as the most influential actors both in the family and in the community as they were the guardians of traditional values and mothers listen to them.

STRATEGY AND IMPLEMENTATION

Development of an action plan

The study in 2007 interviewed 214 people in urban and peri-urban areas including women of reproductive age with children less than two years old and key informants in the communities (e.g. ‘grandmothers’: mothers and mothers-in-law of the women; fathers of children less than two years old; leaders of women’s associations; community health workers; and religious leaders). Three factors linked to low exclusive breastfeeding rates were identified: traditional and religious values/beliefs among mothers; family and community structure and roles/influences of
Based on the results from the study, a national action plan including training, social mobilization and communication activities was designed in support to the National Nutrition Policy. A national steering committee was established with the participation of the Ministry of Health, the Ministry of Promotion, and local women's associations to implement and follow up the action plan.

Working with grandmothers
One of the key strategies of the action plan was to work with grandmothers to promote exclusive breastfeeding, complementary feeding and nutrition of pregnant and lactating mothers. This was initially implemented in the capital by 11 grandmothers from three different communities and was then extended to 156 grandmothers. A team composed of IMCI nurses and staff from the Direction of Child and Mother Health at the Ministry of Health facilitated the training in local languages. The training made extensive use of pictures because of low levels of literacy. As of September 2011, the intervention has been scaled up to the main city of each of the five regions and to two additional villages.

Trained grandmothers organize group sessions and home visits to mothers of under five children, and lactating and pregnant women. Key messages discussed relate to: nutrition of pregnant mothers; early initiation of breastfeeding (within the first hour of childbirth); the definition of exclusive breastfeeding; and complementary feeding at six months. These messages were formulated based on the findings of the qualitative study in 2007 to address bottlenecks to the exclusive breastfeeding.

Communication materials such as pictures, songs, spots, sketches, and theater shows were developed with strong participation of grandmothers. These were broadcast through national TV and radio stations. The Child and Mother Health Promotion Weeks in May and November 2009 were celebrated in the whole country and mobilized many Ministers, women's associations and religious leaders. During the ceremonies, both lactating mothers and grandmothers made testimonies on the impact of the programme.

PROGRESS AND RESULTS
In 2009, 47,962 women were reached by key messages on nutrition and breastfeeding during sensitization sessions and home visits. A total of 35,520 young mothers who participated in the group sessions were evaluated: an evaluation form assessed their knowledge level regarding nutrition of pregnant/lactating woman; advantages of exclusive breastfeeding; harmful consequences of bottle-feeding; and appropriate introduction of complementary feeding. The communication skills (clarity of messages, engaging dialogue with the participants etc.) of grandmothers were also evaluated every trimester and refresher training was provided if necessary.

In 2009, Djibouti participated in the pilot KAP survey commissioned by the UNICEF regional office to assist with the development of an evidence-based strategy for Communication for Development (C4D). The survey covered 1,110 households and 50 schools nationwide. The survey revealed that 17 per cent of children under six months were reported as being exclusively breastfed. Bottle feeding was more common in urban than rural areas (42 per cent and 23 per cent, respectively) and among children whose households are in the highest wealth quintile rather than in the lowest (56 per cent and 20 per cent respectively). In 2010, the National Nutritional SMART survey further confirmed the progress made: the rate of exclusive breastfeeding during the first six months of childbirth was 24.5 per cent (compared to 1.3 per cent in 2006), although the rate is still extremely low.

LESSONS LEARNED
This program demonstrates the importance of building a C4D intervention based on the key actors in the community and in the family. This can transmit values, influence practices positively and bring changes in social norms that previously negatively affected exclusive breastfeeding.

Furthermore a combination of communication for behavioral change at family and community level (through interpersonal and non-formal interaction with influential persons), media and other social mobilization activities could bring positive social changes.

Grandmothers have encountered challenges because the new mothers are not putting the baby to the breast within

1 Tajdourah, Obck, Ali-Sabieh, Arta, Dikhil
2 Das-bio and Mouloud

4 Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey
The first hour. Evidence shows that only 46 per cent of the newborns receive the colostrum because mothers throw away the colostrum as recommended by traditional practice (Nutritional SMART survey, 2010). To overcome this, grandmothers now follow up with pregnant mothers until delivery and are present side-by-side with the midwife at the time of the delivery to raise awareness on the importance of early breastfeeding. Evidence from the same survey also shows that much remains to be done in the area of complementary feeding: 13 per cent of children receive complementary feeding before six months and 15 per cent after 12 months.

**POTENTIAL APPLICATION**

This kind of participatory approach involving influential women in the communities can be undertaken in any location and in any setting. It requires only interpersonal communication; social mobilization within the families and the communities and engaging grandmothers to take ownership of the methodology. Media and communications activities are also required. In Djibouti, grandmothers involved in the project have been trained by the Ministry of Health in 2010 to acquire new knowledge on other areas related to women's health such as PMTCT and breast cancer. They have also been trained to develop messages linked to breastfeeding good practices, and to strengthen their communication skills.

**NEXT STEPS**

In 2011, the program aims to extend its activities to other regions outside of the main cities; to reach more people in remote areas and to promote sharing of experience across communities through testimonials. A documentary film on the role of grandmothers to promote exclusive breastfeeding and the nutrition of the young children was finalized and will be disseminated.
ABSTRACT
Gujarat is considered one of the economically developed States of India, with an annual growth rate of more than 10 per cent and a higher per capita income than the national average. Yet, progress in the social sector has not been commensurate with that in the economic sector and thus increasing disparities are of major concern. The estimated maternal mortality ratio (MMR) and the infant mortality rate continue to be high (NFHS-3, 2005-2006). Among the major reasons for high maternal mortality are a large number of home deliveries by untrained or traditional birth attendants (37 per cent), particularly in rural and remote tribal areas, and limited availability of Obstetricians/Gynecologists (Ob/Gyns) in the government system in these areas.

Taking into account the fact that a considerable number of private Ob/Gyns practice in the small towns and rural areas of Gujarat, the Government of Gujarat launched in 2005 an innovative model of Public Private Partnership – called ‘Chiranjeevi Yojana’ (Plan For a Long Life). Under the scheme, the Government contracted qualified private practitioners who have their own hospitals in rural areas. These practitioners are required to provide skilled care, free of charge, for deliveries and comprehensive Emergency Obstetric and Newborn Care (EmONC) to pregnant women and newborns belonging to families living below the poverty line. In return, the Government reimburses the doctors for delivery care including the cost of treatment of complications based on a service charge package. Following the successful pilot of the scheme in five remote districts of the State, it was scaled up to all the 25 districts across the state in January 2007. The number of Ob/Gyns registered has increased from 173 in December 2005 to 817 in 2009, and more than 384,920 deliveries have been conducted under the scheme by 2009. The Government has now extended this model of Public Private Partnership to provide pediatric care to newborns and infants as well, with over 220 private pediatricians being enrolled. This will also help in reducing neonatal and infant mortality in the State.

BACKGROUND
Gujarat is considered as one of the economically developed States of India, with a growth rate of more than 10 per cent and a higher per capita income than the national average.1 Yet, its progress in the social sector has not been commensurate with that in the economic sector. The MMR (160/100,000, 95% Confidence Interval: 110-209) and the infant mortality rate of 50/1,000 live births continue to be high (NFHS-3, 2005-2006). Among the major reasons for high maternal mortality are a low proportion of deliveries assisted by health personnel (53 per cent), particularly in rural and remote areas. This is particularly so for the economically vulnerable population who has limited access to institutional facilities and may experience economic and social hardships.

Key indicators in Maternal and Neonatal Health show that geographic inequality strongly manifests in Gujarat: nearly 80 per cent of pregnant women in urban areas and 50 per cent of pregnant women in rural areas had more than three antenatal care visits during pregnancy. In urban areas, 83 per cent of women deliver at facilities (institutional deliveries) while 50 per cent of women in rural areas give birth at home. The major driver of the inequality in the state is linked to tribal populations (with limited physical and financial access to services as well as lack of information) residing in 12 districts.

The strategy of Emergency Obstetric and Newborn care (EmONC) adopted in India under the World Bank/UNICEF assisted project called Child Survival and Safe Motherhood in 1992 focused on development of comprehensive EmONC

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1 Per capita income in Gujarat is Rs 49,030 compared to Rs 33,731 in India in 2010-2011 (CMIE, Socio-Economic Review)
centers throughout India as per the international norm of 1 per 500,000 population. However, a key constraint to progress has been failure to operationalize these referral hospitals in the government system mainly because of the non-availability of Ob/Gyn specialists in the government sector in rural areas. Taking advantage of the many private Ob/Gyn doctors practicing in the small towns and rural areas of Gujarat, in 2005, the Government piloted the Chiranjeevi Yojana (a plan for long life), using a Public Private Partnership model to contract private providers to provide delivery care to the poor and disadvantaged in rural and remote areas.

**STRATEGY AND IMPLEMENTATION**

The main objective of the project was to ensure delivery by trained skilled birth attendants through a Public Private Partnership and thus reduce maternal mortality and morbidity in the State. Another objective was to provide free services to women in rural and remote areas and reduce disparity in the access to and utilization of EmONC.

Involving the private and NGO sectors in providing health services has long been a tradition in Gujarat. The scheme was launched by the Government in collaboration with UNICEF, academic institutions and NGOs such as SEWA-Rural and GTZ to explore various options to provide skilled care at delivery and EmONC through the private sector.

Under the scheme, the Health Department of the State Government has empanelled and contracted private practitioners who have their own hospitals in rural areas. These practitioners are required to provide skilled care for deliveries and comprehensive EmONC, free of cost. In return, the Government reimburses the doctors for delivery care including the cost of treatment of complications based on a service charge package developed in consultation with the practitioners and other stakeholders. On an average, cost per delivery is US $38 (e.g. US $13 for conducting normal delivery and approx. US $104 for conducting Cesarean Section).

Private practitioners under the scheme did not receive a better payment compared to those out of the scheme since the pricing was worked out based on the costs prevalent in a private setting in rural areas, in consultation with some private Ob/Gyn doctors. A key feature of the compensation package was the creation of a monetary incentive for private practitioners not to perform unnecessary or non-medically indicated caesarian sections and other medical interventions. Normally treatment of complications such as a cesarean section costs more than a normal delivery. However, doctors are not paid an extra fee if they perform unnecessary interventions i.e. those exceeding the prevailing norm in Gujarat (7 per cent for cesarean section and 15 per cent for other complications). If this is exceeded, the government would pay a fixed amount of Rs 1795 (US $45) per delivery, irrespective of type of delivery. Antenatal Care (ANC) was not part of the package under this scheme but many women received it from the private practitioners by paying consultation fees.

The project was launched in December 2005 and it took approximately one year for the pilot to be set up in the five remote districts of Gujarat. By 2007, the pilot was extended to all 26 districts of the State. The pilot was initially launched in remote districts of the state with a population of 9.7 million (Banaskantha, Dahod, Kutch, Panchmahal and Sabarkantha). Currently no specific policies exist for private health sector regulation in Gujarat. Some quality control measures for the private sector practices are put in place by the government through the Chief District Health Officer and Quality Control Medical Officers. All the private sector doctors partnered in the Scheme are Ob/Gyns who are registered under the Indian Medical Council.

To ensure the quality of the services provided by the private sector, specific selection criteria were developed for private Ob/Gyn doctors to be enrolled in the scheme:

- must have post-graduate qualification in Obstetrics and Gynecology
- must have his/her own hospital - preferably a minimum of 15 beds with labour and operating room
- must be able to access blood in an emergency situation
- must be able to arrange for anesthetists and do emergency surgery
- facility should preferably be accredited for sterilization procedures for Family Planning

Women were informed about the services by ob/gyns contracted under the scheme in the meetings during their ANC visits. As a part of birth micro-planning exercise, the place of delivery is discussed with pregnant women and her family members. This exercise also provides different options including seeing the doctors who are contracted by the scheme.

**PROGRESS AND RESULTS**

The results of the scheme are assessed in terms of: improved availability of EmNOC through partnership with private Ob/Gyns; number of deliveries attended by skilled birth attendants; and comparisons of expected and reported maternal and neonatal deaths and estimated lives saved. In the five pilot districts, from the 173 obstetricians who had initially registered under the scheme following the launch in December 2005, the number of private practitioners who have joined the scheme has gone up from 173 in 2005 to 817 in September 2009.

The success of the Chiranjeevi Yojana has led the Government of Gujarat not only to scale it up to all 26 districts of...
the State, but also to extend the model into a new partnership with private pediatricians. This modified model provides essential newborn care during the period mothers are in the institution after delivery and also sick newborn care for those referred to these pediatricians by front line health workers and Integrated Management of Neonatal and Childhood Illness (IMNCI) workers. The extended model to newborn babies was launched in 2009 (Bal sakha scheme) and by May 2010, over 286 Paediatricians had joined the scheme. Further encouraged by the successful implementation, the model has now been extended to cover all infants of two months to one year of age. The scheme is operational for beneficiaries residing in 43 tribal blocks of 12 remote districts of Gujarat.

More than 384,920 pregnant women belonging to families living below the poverty line have benefited from the scheme. During the year 2008-2009, over 16 per cent of the total institutional deliveries were conducted by Chiranjeevi doctors in the state. This has increased to 19 per cent in 2009-2010. Among the total number of deliveries under the scheme (N=384,921) between 2008 and 2009, 67 maternal deaths were reported during delivery while the expected number of maternal deaths was 616 (estimated 549 women’s lives were saved). For Neonatal mortality, 1,384 deaths were reported during the same period compared to 8,853 as the anticipated number of neonatal deaths (7,469 neonates were saved). The cesarean section rate was 6 per cent and the rate of complicated deliveries 5.4 per cent.

The initiative was further strengthened by a robust emergency referral system which was started by the Government of Gujarat in partnership with EMRI108 during the

2. Although by definition, maternal deaths occurred during pregnancy and up to 42 days after delivery should be included when calculating the maternal mortality rate, no robust tracking mechanism of women between their discharge from hospital after delivery up to 42 days of delivery exists in Gujarat. However, maternal deaths are followed at 0, 3 and 7 days which are the recommended postnatal care visits within 10 days of delivery/births.

3. Source: Government of Gujarat

4. GVK EMRI (Emergency Management and Research Institute) is a nonprofit organization which handles medical, police and fire emergencies through the “1-0-8 Emergency Service”. This is a free service delivered through state of the art emergency call response centers that are able to dispatch over 2600 ambulances across Andhra Pradesh, Gujarat, Uttarakhand, Goa, Chennai, Rajasthan, Karnataka, Assam, Meghalaya and Madhya Pradesh.

2007 with about 50 basic life support ambulances. The number of ambulances has gone up to 450 as of 2011, providing a referral transport system for medical emergencies including obstetric emergencies, fire and police. Response time is about 10-30 minutes after making the call. Although this is a separate initiative, any patient can call 108 to get a referral transport, hence complementing the services made available to pregnant women and their babies through the scheme.

Key Elements of Success

- Developing a Model of Public Private Partnership by signing Memorandum of Understandings between the State Government (Chief District Health Officer) and private Ob/Gyns or practices/hospitals to enhance access and reach of Maternal Health Services to beneficiaries in the remote and distant areas of the State.
- Private gynecologists were allowed the use of government blood banks and blood storage units for conducting caesarian sections during obstetric emergencies with minimum payment for blood screening costs.
- Ensuring delivery of pregnant women belonging to the poorer and socially excluded sections of the society by trained birth attendants free of cost. These women belonging to the poorest and most excluded population were identified though their possession of a Below Poverty Line (BPL) card.

Box 1: Considerations to be taken into when replicating

1. Regulatory measures of the private sector including a minimum requirement of skills for health workers are required.
2. Measures for quality of care assurance and monitoring should be in place.
3. Compensations have to be structured in such a way that Obs/ Gyns are motivated to provide quality obstetric care and to avoid unnecessary, not medically indicated caesarean sections due to higher compensation in case of cesarean section.
4. A robust referral system connecting the community with centers where EmONC services is in place.
5. A robust communication strategy targeting women from most disadvantaged groups informing them about availability and geographic location of services in place.
6. Long-term sustainability of the approach, particularly in fiscal terms. As a pre-exquisite of such an effort, public health bureaucracies need to reform health systems to facilitate their involvement, which needs high level of political and social commitment.
LESSONS LEARNED
The Chiranjeevi Yojana experience suggests that it saves lives and makes economic sense to harness the energies of skilled providers in the private sector at the same time as the public sector builds capacity to cater to the needs of poor women in remote and rural areas. By ensuring private health providers a minimum demand for services, the scheme has helped the health market grow in parts of rural Gujarat.

The scheme is a viable option for States where MMR is high and public health infrastructure is not fulfilling the demand, especially availability of specialists. As the scheme is implemented through an established decentralized administrative system and health care providers are local practitioners, the scheme has a high sustainability factor.

One of the key lessons of the project which can be applied in other countries is to how to identify untapped, existing resources, rather than investing a lot of resources in creating new cadres for health service delivery. The initiative demonstrates that even with limited resources in rural areas like Gujarat, it is possible to tap into existing resources and create a mechanism to provide access to health care to the most hard-to-reach women and their infants.

Challenges remain especially in those districts that have a very small number of private Ob/Gyns. Capital support has been provided to private obstetricians for setting up practice in these remote areas; they are encouraged to start a practice in these remote areas by getting advance funds to assist deliveries. There also have been efforts to improve the quality of the public health facilities in these identified poor performing areas with introduction of incentives.

Currently, Chief District Health Officer and Quality Assurance Medical officers are monitoring the work of private doctors and collecting monthly reports from all private doctors. There is a need to more rigorously evaluate the quality of care provided by private practitioners and the impact of the programme.

POTENTIAL APPLICATION
The lack of health workers in rural areas is of concern to many countries around the world. Given the significant presence of private practitioners in many countries around, they can be involved in achieving public health goals. The effort in Gujarat provides a practical experience of involving private Ob/Gyns in delivering skilled birth attendance and EmONC to poor women, where over 70 per cent seek health care from the private sector. Thus, this initiative provides a new direction to maternal health programming. Drawing on the experience in Gujarat, Box 1 provides some practical considerations to be taken into account, when similar strategy is replicated in other settings.

NEXT STEPS
- Quality monitoring - accrediting providers enrolled in the scheme
- Potential for including other services such as screening of cervix cancer, Sterilisation, HIV/AIDS screening and Prevention of Paternal to Child Transmission PPTCT services in the scheme
- Strengthening Collaboration with pediatricians (The Balsakha scheme)

RELATED LINKS
Malaria is endemic throughout eastern Indonesia with variable levels of transmission intensity and types of the parasites. In contrast to Africa where only P. falciparum is commonly encountered, mixed infections are not unusual. Generally, prevalence is highest in the more rural and remote areas outside of Java and Bali where healthcare services are often insufficient (Riskesdas, 2010, NIH R&D). While all community members are affected by malaria, particularly vulnerable groups include children under five and pregnant women. Malaria infections during pregnancy can cause severe anemia which contributes to maternal mortality and poor birth outcomes such as low birth weight, stillbirths, as well as various other deleterious effects on both child and mother.

传统的间歇性预防治疗在撒哈拉以南非洲是不适用的，由于对磺胺和磺胺-氯喹的耐药性。当前的国家政策呼吁对怀孕妇女使用青蒿素-磺胺混合治疗（ACT）以预防1季度的感染。在预防和早期识别马的病例方面，需要一个替代方案：提供长期杀虫剂处理的蚊帐（LLINs）并进行筛选，以获得首次产前和早期治疗。
STRATEGY AND IMPLEMENTATION

Facilitating collaborations
Fostering the integration of bed nets into routine and outreach services across Ministry of Health (MOH) departments was especially challenging considering the current context of decentralization in Indonesia. Integrating malaria diagnosis, treatment, and prevention into existing maternal and child health outreach strategies therefore required substantial facilitation by UNICEF to bring together MOH departments at central, provisional and district level. UNICEF and the WHO, along with key officers within the MOH who championed the benefits of integration, played critical roles in facilitating collaboration across the involved departments (malaria, maternal health, immunization) to identify mutual goals, draft a national strategy and ensure joint inputs with regards to developing operational guidelines, training materials, staff orientation, logistics systems and reporting formats for their respective programmes. Facilitation was therefore not only required across sectors but also vertically from central to provincial and district levels. Collaboration to ensure coordinated service delivery at the field level across different programme components was encouraged.

Ownership
Fostering ownership at the provincial and district levels was essential not only due to the vast and diverse nature of Indonesia, which encompasses 33 provinces and nearly 500 districts. Also decentralization has now put districts in control of their own budgetary resources, including how to deliver services. Through multiple consultations, orientation meetings, and field visits by provincial and district personnel, the strategy was initially piloted in a few districts in five provinces. The program is now expanded, with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and MOH support, to 26 provinces and over 200 districts, all located outside of Java and Bali. Support from the political authorities (bupatis) was essential not only to secure district level financial allocations, but also to raise the profile of malaria at the community level and establish it as an issue for local health and development policies and programmes.

In addition, UNICEF supported community mobilization activities in several districts, which helped increase understanding around the environmental issues involved in malaria control – some of which communities can address directly – and also their rights as citizens to effective health services, including those related to maternal and child health.

Capacity development
Midwives and nurses form the backbone of the healthcare system in Indonesia, particularly in remote areas. Although they are not present in all villages, when they are present at health posts (pustus, polindes) and health centers (puskesmas), they serve as the primary frontline providers of preventive and simple curative care for rural populations. In addition, they coordinate with health center staff and village level volunteers (kaders) to organize monthly outreach visits that combine antenatal and immunization services (posyandu). UNICEF supported the development of field level operational guidelines, training materials and job aids to assist these frontline providers and managers as they integrated the different services.

UNICEF along with personnel from across all the relevant MOH departments were involved in training of trainers at the provincial level. Following the cascade these district personnel then trained all service providers at regional and health center level within each province, which enabled the training of a greater number of providers. Participants were trained on integrated service delivery through participatory methods encompassing both theoretical and skill-based elements. This introduced the providers to malaria in pregnancy, a new area, and provided an opportunity to refresh existing competencies in antenatal and immunization. Feedback from programme implementation experiences also brought about the introduction of modules on supervision and reporting responsibilities into the training modules which are used by the MOH in training staff.

Funding
The integrated program is supported by the GFATM rounds 6 and 8 malaria grants which are supporting roll-out of the program to all malaria endemic districts outside of Java and Bali. Specifically, the Round 6 grant has been supporting roll-out in eastern Indonesia and Sumatra since 2008, while the Round 8 grant has been supporting roll-out in Kalimantan and Sulawesi since 2010. Total GFATM funding for the overall malaria program (of which the integrated program is a subset) is $168 million. Campaign-level population coverage was accomplished for Sumatra, Kalimantan and Sulawesi.
Population coverage in eastern Indonesia has been attained for some, but not all districts, due to lack of funds.

**PROGRESS AND RESULTS**

Since 2009 multiple evaluations and monitoring of the program have taken place: 1) formal evaluations via the major donor, USAID, including field visits to four provinces with participation from WHO and UNICEF (July 2010); 2) repeated routine monitoring visits by the technical working group for malaria during the period 2009-2011; and 3) a field visit by staff from UNICEF’s HQ in 2009. Methodologies varied, but all included visits to communities, interviews with health staff and visits to health facilities and warehouses at district and provincial levels, and discussion with central level malaria and maternal health staff.

A preliminary result from the evaluations indicates that bed nets have been effectively distributed to a high proportion of pregnant women and families with young children (particularly children under five). Furthermore the provision of bed nets as an incentive seems to have improved overall attendance of at least a first antenatal visit, encouraged earlier presentation for antenatal care, and increased completion of childhood immunizations. For instance, in South Halmahera district, coverage of measles vaccination increased by 10-15 per cent at post-integration compared to the baseline data, whilst in Jayapura District, a 10 per cent increase in routine ANC coverage was observed in the first year after the project was rolled out.

Women generally viewed bed nets as a desired commodity, based upon focus group discussions, even in areas where no demand creation activities have been done. In addition to prevention of malaria, they cited the reduction in nuisance mosquito bites sustained by their children as a benefit. Midwives and immunization staff reported that providing anti-malarial services were a minimal additional burden and there was the perception that the distribution of nets had led to improvements in service coverage. In places where the program has had the greatest success, there has been substantial ownership and leadership from the district health office as well as support from the district level political authorities (bupatis).

Collaboration across departments led to the development of integrated guidelines, training and job aids to ensure well-coordinated service delivery and reporting. Integration also generated synergies to the benefit of all three programs (malaria, maternal health and immunization), and addressed priorities highlighted by the Millennium Development Goals (MDGs 4, 5 and 6).

**LESSONS LEARNED**

The following key lessons learned are extracted from the above mentioned monitoring and evaluations.

In the course of integration of these programs, experience showed that policy and logistics were best left to the malaria program, while operations and monitoring were best handled by the maternal health and immunizations programs. This conclusion was jointly reached after sharing of experiences and discussion among inter-agency and governmental staff working in maternal health, immunizations, and malaria. In the areas of maternal health and immunizations, systems and personnel are available on the ground to deliver services, but they require guidance (in terms of policy) and logistics (in terms of diagnostics, Malaria drugs, and bednets) which the National Malaria Program could offer to complement the gaps.

Integrating bed net distributions into existing routine and outreach antenatal and immunization services seems to have served as an incentive to attend these services and enabled better results by improving uptake and quality of services for pregnant women and children. Integration thus accomplished mutual goals without altering programme identities, leading to greater provider and bureaucratic acceptance.

When implementing such an integrated programme, efforts are required to ensure development of training materials for new and existing staff, planning of the logistics (e.g. ACT, Rapid Diagnostic Testing for Malaria and bed net distribution) and modifying reporting and monitoring systems. The supply chain and logistics challenges in a new program located in many far-flung and remote islands take time to overcome.

An additional lesson was the importance of getting local political support in decentralized countries such as Indonesia. UNICEF field staff played a critical role in

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1. Luman et al, 2010 Ministry of Health and the US Center for Disease Control and Prevention (unpublished data)
2. Ministry of Health routine reports, 2007-2010
Challenges

Integrating incentives such as bed-net distributions increased the number of first antenatal visits and improved their timing in several districts, although it remains too early to determine whether it results in increased proportion of deliveries assisted by trained midwives. Increasing attendance to at least one ante-natal visit ensures that there is higher coverage of tetanus immunization, diagnosis and treatment of anaemia and detection of undernutrition. However, even greater benefits can be obtained through additional visits, including opportunities to detect other health problems and for counselling on the importance of midwife-assisted deliveries, exclusive breastfeeding, and postnatal visits. Realizing the full potential of the synergy obtained by bed-net distribution will require convincing mothers during the initial visit that they should return for additional visits and be delivered by a midwife rather than a traditional birth attendant.

An additional issue is the need to ensure the development of routine integrated data collection systems for better monitoring and evaluation data to demonstrate the effectiveness of the programme. This is essential not only for documenting programme effectiveness to external groups and donors but also to use the data as an advocacy tool for programme expansion. Although high quality administrative data that could be readily used to evaluate and monitor the programme was observed at local level, district-level reports vary markedly among districts. Though this in some ways an inevitable consequence of decentralization, standardization is needed. Nonetheless, many districts have improved their integrated reporting systems, and where these exist, the benefits of the integrated malaria program are clear.

A third challenge is maintaining the gains of the programme in the pilot areas. This will require a number of actions, including:

- Provision of improved supervision of staff at local and district level.
- Improvement in record keeping and data management at local and district level and careful monitoring of the results to ensure that service delivery is being optimized.
- Focus on specific indicators relevant to the programme objectives.
- Development of refresher training activities and of a flexible/portable training programme to accommodate the frequent turnover of staff.

Political commitment and sustainability represent a fourth challenge. As noted, GFATM funding has provided impetus for scale up nationally, but this funding has different effects in different districts on political and financial commitment. Some district leaders who understand the time-limited nature of this funding scheme, viewed the GFATM funding as an opportunity to build a long term program. Others, however, unfortunately, viewed the GFATM funding as an opportunity to shift health funds to other priorities, since malaria, TB and HIV/AIDS programmes are being funded. In the context of Indonesian decentralized governance—where each district receives a block grant annually to spend as it pleases—the need for sustained advocacy is constant. All parties in Jakarta, recognize the seriousness of this challenge, which, in essence, is a governance issue, and are working relentlessly via advocacy, exchange visits, and the press to ensure continued political and financial commitment.

POTENTIAL APPLICATION

The Indonesian program was discussed at length during the last Malaria in Pregnancy (MIP) Working Group meeting in Geneva, which focused on MIP in the Asian Pacific Region. A recent analysis has shown that nearly 60 per cent of pregnancies at risk for malaria infection occur in this region. Thus, the Indonesian program has potential for regional impact. To facilitate this, UNICEF has worked with the WHO, the ASEAN Secretariat, JHPIEGO, and ACT Malaria to develop a regional training network for MIP in the Asia-Pacific Region. The network leverages the political clout of ASEAN, the existing malaria training network of ACT Malaria, technical expertise in training module development and MIP at JHPIEGO to stimulate good program practice in control of MIP in Asia and the Pacific.

NEXT STEPS

Indonesia is in the process of preparing a continuation of its GFATM Round 6 proposal which, if successful, would include provisions to continue the program in eastern Indonesia for another several years. Simultaneously, UNICEF and WHO are working in concert with the MOH to convince districts and provinces to use local funding to support the program after the conclusion of the GFATM programmes. Combined, the GFATM R6 and R8 proposals are sufficient to cover all children and pregnant women living in areas of moderate and high malaria transmission living outside of Java and Bali.

ABSTRACT
Household water treatment and safe storage methods have been documented to reduce diarrhoea disease by 29 per cent in children under five. UNICEF’s office in Honduras has been working, since 2009, in partnership with Agua Pura para el Mundo to promote the use of biosand filters in rural communities in the Municipality of Las Trojes. The biosand filter is a simple, low-cost household water treatment technology. As polluted water is poured into the container and through a diffuser plate, the bacteria are removed from the water by the biomass layer which is formed on the top of the sand. As the water passes through the layers of sand, any parasites become trapped. The resulting treated water is not only improved in terms of its microbiological quality but also its aesthetic qualities including colour, taste and odour. Critical components of the project include training on operation and maintenance of the biosand filter; and hygiene promotion. The project also includes a de-worming campaign and follow-up monitoring. The experiences suggest that a biosand filter is a simple and economically accessible technology in rural Honduran communities where there is no water supply system.

BACKGROUND
Honduras has made considerable progress towards achieving the MDG water and sanitation targets. However, significant disparities in access remain between rural and urban populations; only 77 per cent of the rural population has access to improved drinking-water, compared to 95 per cent in urban areas. Access to improved sanitation presents a similar picture with coverage rates of 62 and 80 per cent in rural and urban areas respectively. Promoting appropriate household water treatment and safe storage is among UNICEF’s key interventions to reduce diarrheal disease.

Considerable experience with biosand filters has been documented, and several NGOs are currently promoting their use. Canadian NGO ‘CAWST’ estimates they have been introduced in around 70 countries with some 200,000 filters presently in use at household level. The technology is based on principles of slow sand filtration (SSF) which was first introduced in large scale water treatment facilities in Europe and North America at the beginning of the 20th century. Researchers at the University of Calgary in the 1990s adapted the SSF design to a household-scale unit. Since then several research papers have been published evaluating the biosand filters’ technical performance and health impact.

In April 2009, UNICEF initiated a partnership with NGO Agua Pura para el Mundo (APPM) to improve the quality of drinking-water and health in rural communities in the municipality of Las Trojes, Honduras. A rapid assessment of drinking-water sources revealed that many communities were obtaining their drinking water from unprotected sources or rudimentary and unsanitary water systems. Data obtained from the local health centre showed a high diarrhea rate among children 1-5 years old, especially among girls.

STRATEGY AND IMPLEMENTATION
The results of the initial drinking-water and health assessment led to a decision to introduce biosand filters in the worst affected communities in Las Trojes. The biosand filter was selected because of its track record of efficiency.
in pathogen removal, user acceptance, and ease of operation and maintenance. The biofilters would be deployed by APPM who already had extensive experience with this technology. The following steps were implemented in 27 out of the 218 communities in the municipality of Trojes.

**Base line Study**
A comprehensive baseline study was undertaken to further assess the drinking-water, sanitation, hygiene and health situation in the 27 communities identified as priority in the rapid assessment. Based on the information collected, a holistic intervention was designed consisting of biosand filters, hygiene and sanitation promotion, and de-worming.

**Connect and Promote**
Establishing a good working relationship with the local health centres was important from the beginning in order to obtain support from the government throughout the project period. Similarly efforts were made to communicate with other stakeholders including the municipality, parent associations, church groups and community boards that could also support the process especially the follow-up work.

Initial meetings were held with community leaders and members of various community-based groups and structures to explain the project objective and components. After these meetings, participants are invited to suggest a suitable demonstration house or school which might be used to explain the function, use and maintenance of a biosand filter, and installation of a demonstration latrine. The aim was to provide an example of how to establish a hygienic household environment. Demonstration events invited community members, including community leaders, to explain how the biosand filter works and promote key water, sanitation and hygiene messages. Community leaders are requested to provide a list of people interested to participate in the project and who are willing to contribute a modest amount towards the cost of the filter. Funds from the filter “sale” go back into the project.

**Train and operationalize Community Agents**
A Community Agent, selected by the community, is a local volunteer who resides in the community where the project is being implemented. Other individuals can volunteer to be potential agents, and if they fulfil the requirements they can serve in this important role. A training session is conducted with Community Agents and community members. The main objective of this training is to build the local capacity to support behaviour change around drinking-water practices, hygiene and sanitation. A training curriculum was designed that contains facilitator’s notes and tools. Community Agents are responsible for visiting homes to check how the filters are functioning and to solve problems. The visits take place two weeks after the filter has been installed. The job of Community Agents consists of keeping a record of the filter’s performance using a standardised monitoring format. Each agent is assigned to 10 households for follow up and monitoring for the first six months after filter installation.

Initially all the community agents were males as this was traditionally seen as a men’s task in rural areas of Honduras. To ensure the participation of women, female promoters were recruited to serve as the trainers to other community agents on issues related to maintenance of biosand filters and hygiene practices. These female promoters also organized daycare services during the training sessions for female community agents with children. This boosted the participation of female community agents in training: as of late 2011, 48 per cent of the community agents in Trojes are women.

**Hygiene and Sanitation Training for Teachers, Children, and Communities**
Hygiene training is a vital component the project. Health promoters train community members, teachers and school children on personal and domestic hygiene, sanitation, and on the correct use and operation of the filter including hygienic water storage and disinfection. Community volunteers trained by health promoters then take up further training activities in the communities. A celebration on Global Hand-Washing Day (October 15) is also included as part of the training and sensitization. These activities ensure the filters achieve their full impact on health.

The project engages and trains teachers to be the change agents to help students adapt healthy hygiene habits. School clubs are strengthened or formed to help students learn about
hygiene and sanitation with an emphasis on hand-washing. The students then become agents of change in their families. The training curriculum is suitable for children between the ages of five and fourteen, the age at which most children complete their primary education. The training consists of participatory methods and tools which help young children to be actively engaged in the learning experience.

With the purpose of reinforcing the knowledge transmitted during the implementation of activities, hygiene training materials for communities were developed, as well as a guide to the use of the biosand filter. The hygiene training materials disseminate key messages: hand washing, personal hygiene, home cleanliness, disinfection, storage and handling of the water for human consumption and the use and maintenance of the latrines.

Install Biosand Filters, Deliver and Distribute Plastic Bottles for safe water storage
Under the supervision of project staff, the community agent installs the filters. During installation every family receives training on the use and maintenance of the filter. Project staff visit the homes 15 days after installation to ensure that the user understands and follows the eight parameters established for the use and maintenance of the filter. The head of household receives storage bottles for collecting clean filtered water.

Follow up and monitoring
Monitoring of the project was conducted through a three step process.

1. Project staff return to the communities after installation to monitor filter effectiveness and assess the effectiveness of the education training.

2. A meeting is organized with the Community Agents to discuss any problems that have occurred during the home visits and find solutions together. If necessary, project staff will visit households with the Community Agents to resolve problems with filter use and maintenance.

3. After the project implementation, project staff conduct random surveys that measure the impact of the project and to resolve problems. Based on the results of the monitoring, trainers return to the community to provide further education and training.

Community participation
Community members are empowered through their direct involvement in the whole process of the project planning and implementation, taking their own decisions on how to improve water quality and hygiene.

PROGRESS AND RESULTS
Since January 2009 up to date, the project has achieved the following results:

• 1274 families now use biosand filters to treat their drinking-water, benefiting 5851 people of 27 communities in Trojes. 110 Community Agents were initially trained in hygiene education activities (37 women and 73 men).

• Alliances have been established with the Municipality authorities as well as the local health authorities for deworming 877 children in the 27 communities.

• A follow-up study examined several themes of the project: water quality, filter use, water storage, sanitation, hygiene, and health. Findings for each are described below.

Water quality
A well-operated filter is capable of a bacterial removal rate of 95-98 per cent. Out of the 15 filters tested, 14 were found to be performing at the 95 per cent removal level, and one filter was marginally below this performance level. Users are recommended, as per the Honduran Health Ministry guidelines, to chlorinate their filtered water to remove any remaining biological contamination.

Filter use
Of the 59 families selected from a random list, 90 per cent of them are using their filter. Of the unused filters, four have not been installed yet because the family was plan-
ning to move or reconstruct their home. Only 2 filters are unused for other reasons such as one because the family is no longer living in the house. All users reported being either satisfied or very satisfied with their filter and filtered water. Many users noted that the water’s fresh flavour and cool temperature was an improvement from their previous drinking water.

**Water Storage**
Only 45 percent of users hygienically removed filtered water from its storage container. However, these results were obtained before the water storage containers were distributed. Nevertheless, the project will reinforce training on safe water storage as part of the follow up.

**Hygiene**
In a survey of 53 people, 100% were able to name at least two out of the four key timing to wash hands. When asked how they wash their hands, 85 per cent of users spontaneously said they use soap, and had soap present. Access to soap does not seem to be a barrier to hand-washing. 92 per cent of children and 94 per cent of adults observed were wearing shoes.

**Health**
In six communities monitored from 2009 and 2010, an average of 81 per cent of users say their family’s health is better since using the filter. Although, this is anecdotal rather than epidemiological evidence, it suggests that families will continue to use the filter if they perceive there are tangible health benefits.

Based on the results of the follow up study, the project appears to be functioning well overall. Almost all families are using their filter and most are operating it correctly. Most source water in these communities is highly contaminated but the filters are generally performing well. Compared to other communities, water storage practices in the communities where the project has been implemented are excellent given that the project includes distribution of water storage containers and hygiene training. Community agents are successfully solving problems that users bring to them, though they are overlooking some operational problems, such as doing filter maintenance too often which disturbs the biolayer of the filter.

**INNOVATION**
Biosand filters have been proven to be effective in rural Honduran communities where there is no water supply system, and the community depends on water from unsafe water sources. The technology is simple and economically accessible because it does not require high maintenance cost, and requires no electricity to operate. This project applied a holistic approach combining household water treatment and safe storage with a hygiene education component. People living in isolated villages gained access to safe drinking water, and the knowledge to adopt more hygienic behaviours for a healthier life. The positive experience gained from the project suggests that the same technology can be applied to other regions of the country, especially to isolated communities where it is difficult to provide piped water to each household.

**NEXT STEPS**
Subject to funding availability, the project will be extended to all the communities in Trojes and the ethnical groups called **Misquitos**, the majority of which are excluded from the water and sanitation services, in the Gracias a Dios Department (the north east of Honduras).
ABSTRACT
Over 140 million Indians lack access to an improved drinking water source while 67 per cent of Indians use no drinking water treatment practice (WHO-UNICEF Joint Monitoring Programme, 2010). In addition, over 600 million people are open defecating in India and this, alongside poor levels of operation and maintenance of water sources, is leading to a high risk of water contamination. Orissa, located in the eastern coastal area of India, has a population of almost 40 million. It is among the poorest and least developed States in the country. Since 2007, UNICEF has worked to build State policy and to strengthen systems on water quality improvement in Orissa and has conducted a district-level water analysis in Koraput, one of the 30 Districts of the Orissa State. The project has made significant progress in policy, capacity development and strengthened water quality monitoring system through leveraging and building on government systems, structures and resources. Two key lessons were learnt with regard to moving forward UNICEF’s agenda for ‘upstream’ work and capacity building in the Water, Sanitation and Hygiene (WASH) sector. First, there is an increasing need to strategically target areas within government systems that UNICEF’s support can tap into in order to maximize the impact in this area. Secondly work in system strengthening is a continuous process which simultaneously requires different approaches including learning platforms, training, hosting learning visits, and review processes. In 2011 UNICEF, together with the government, continues the work on water quality monitoring; development of guidelines on safety of water sources at village level; and encouraging open dialogue with communities on water quality challenges.

BACKGROUND
Water and Sanitation (including excreta disposal; safe and adequate water supply coupled with good hygienic practices) is a key intervention in preventing under-nutrition and a high disease burden among children. Water quality surveillance, linked with corrective action, is an important element within this area. Orissa is one of the least developed states in India and has poor WASH service provision. The Infant Mortality Rate in Orissa is significantly higher than the Indian average (respectively 65 and 50 per 1,000 live births) and the State is ranked 30th out of the 35 States in terms of a child health and nutrition index. Moreover, 66 per cent of the population in Orissa is below the poverty line while the national average is 37 per cent (2001 Indian Census).

In 2007, to better understand chemical and microbiological water quality, UNICEF supported the Multi-District Assessment of Water Safety (M-DAWS) project in 12 states, including Orissa. The assessment found that nationally approximately one third of water samples tested showed microbial contamination while for the Koraput District in Orissa, it was found that 70 per cent of water samples were contaminated by Faecal Streptococci.

STRATEGY AND IMPLEMENTATION
In 2007, based on the findings from the M-DAWS, initial discussions around building evidence on water quality issues started with the Government of Orissa. The Rural Water Supply and Sanitation (RWSS) section of the Orissa Rural Development Department and UNICEF had a series of consultations to identify existing resources, systems and structures, and any gaps and areas of improvement for improved water quality and safety in Orissa. As a result, the following four major action points were derived and implemented between 2008 and 2011.

1. Drafting state level policy: National guidelines for implementation of a water quality monitoring programme had been in place, but there was a need to develop state-specific guidelines and to institutionalize...
the decentralized water quality monitoring and surveillance programme.

2. **Ensuring adequate laboratory facilities**: This required an assessment of the status of the 32 District Level Laboratories (DLLs), their infrastructure, facilities, knowledge management and communication facilities and an examination of the adequacy of the existing water testing facilities.

3. **Creating appropriate institutional mechanisms at the state, district and local levels**. For example, a water quality discussion platform was created to facilitate government and non-government actors getting together to discuss challenges in water quality management and how to take these forward. The other mechanism discussed with the Government of Orissa was strengthening Operation and Maintenance (O&M) of water infrastructure, for which UNICEF produced a policy paper, which was shared with the State government. In addition, UNICEF is advocating for creating a *state-level task force on water quality* to oversee the progress towards strengthening the monitoring of water quality in the state.

4. **Implementing a regular rural water quality-monitoring programme** that is managed and overseen by the Rural Development Department with support from the Panchayat Raj (Local Government) Department and the Health Department. Based on the water quality analysis results, water safety plans and responses were developed at village level, with support from the village water and sanitation committees and locally elected leaders.

Through consultations with the government and other partners, it was also found that the primary support required was assistance from an expert (a laboratory technician) who could provide technical guidance on quality assessment of water. UNICEF supported the hiring of a technical expert who visited all districts in the state and evaluated the District-specific needs in water quality improvement.

**Capacity building.**

UNICEF piloted the project in Koraput District. This involved significant capacity building and system strengthening support to the local RWSS Department. The capacity building component involved two levels:

1. **Junior Laboratory Assistants (JLA) of all the DLLs** undertook a six day refresher course on the standard laboratory water testing methodology in the State Referral Institute. They were trained on laboratory testing and hands on use of field test kits including field demonstration, as well as receiving further training at the ISO-certified laboratory of the Tamil Nadu Water
Supply and Drainage (TWAD) Board, Chennai, on other water quality issues.

2. Self-Employed Mechanics (SEM)\(^2\) training on water quality was done by the JLAs, A key first step of capacity development by the District administration in Koraput was to fill the 122 vacant SEM posts while UNICEF created a specific SEM manual and organized an intensive training of all 390 SEMs in the District. The manual was shared with RWSS at State level as a reference tool for SEM training in other Districts.

Monitoring
UNICEF has been assisting the Government of Orissa to ensure that systematic procedures for data management and mapping are in place to identify problematic water sources and follow-up to improve them at all levels. The first such step was a comprehensive review of the entire water quality monitoring data. This review\(^3\) examined all water quality sampling results collected and entered into the Government’s on-line monitoring system.

PROGRESS AND RESULTS
Despite continuous efforts, improvements do not bear results instantly. Initial water screening at the village level in 2009 mentioned above showed that 18 per cent of 60,000 samples collected from 30 districts did not meet acceptable water quality standards. Another key finding of this review was that weaknesses still existed at various levels of the water quality program, especially at community level on awareness of water quality issues and on initiating corrective action to reduce contamination risk at water sources. In addition, more precise analysis carried out by DLLs on over 100,000 samples showed that 43 per cent were above permissible limits. The project continues as of this write-up (December 2011), focusing especially on sustaining support to implement corrective actions linked to the risks identified in the water quality surveillance program.

State-specific guidelines on Water Safety were developed in 2008 and disseminated to the sub-divisions for imple-

\(^2\) Village level workers who maintain water sources such as wells, bores and piped water schemes. They receive some remuneration from the government to maintain the village level water sources but normally have other jobs.

understand the capacity already in place and the limitations still being faced.

System strengthening and capacity building cannot be achieved overnight. Rather this is a continuous process that involves constant consultation, re-evaluation and application of measures for improvement. Many different approaches can simultaneously drive advocacy and systems strengthening – learning platforms, training, hosting learning visits, review processes etc.

Government often requires technical guidance to utilize public funds that may otherwise remain unallocated or unspent. In the case of the water quality monitoring system, UNICEF’s support of Rs. 100,000 (approximately USD 2,500) allowed the state to leverage Rs. 10 million (USD 250,000) of public funds and to plan for water quality monitoring and management, including upgrading, operating and maintaining laboratories.

Importance of building a clear understanding of the conceptual framework in terms of the cycle of responsibilities and actions required in a water quality monitoring and surveillance program (see Figure 1). It was found that when the cycle is broken at any point then the intervention is not sustained and the impact is lost.

The need to form partnerships with key stakeholders around sensitive areas such as water quality management, where UNICEF and/or Government alone cannot make the required difference. This also requires involvement of civil society and academia. To this end in April 2010 UNICEF organized a joint platform forum on water quality which was held in Bhubaneswar, the capital of Orissa. This involved Government, civil society and academia (local, national and international). The meeting report finalized with support from international experts on water produced a series of key recommendations for action which supported earlier evaluation findings.

**POTENTIAL APPLICATION**

This project in Orissa was designed based on experiences from West Bengal, India, where a similar decentralized process for improvement of the water quality monitoring system took place several years ago. The Orissa team studied elements of the West Bengal experience and took on board lessons learned, such as the need for clear definition of roles and responsibilities of state, district, and local governance bodies. The experiences Orissa described above can be applied to other states within the country or in other countries that promote decentralization.

Furthermore, the project in Orissa and other States in India has contributed to raising the profile of Water Quality issues in the country. This is demonstrated by an increased government investment in water quality improvement. As UNICEF moves ‘upstream’ from programme implementation to influencing policy and providing technical assistance, there is an increasing need for field offices to identify areas where UNICEF support can leverage government resources and fill gaps. This is especially so in India, or in other middle-income and rapid economic growth countries where financial resources are less of a constraint than in the past.

**NEXT STEPS**

The analyses of water quality sampling results to date indicate that the system still needs considerable strengthening if Orissa is to have a systematic water quality monitoring program in place with routine follow-up mechanisms. UNICEF continues to work on capacity building of water quality monitoring, including developing training modules for the newly-formed Block Resource Centres that will work on water and sanitation issues at Block level. This work consists of building capacity around implementing simple guidelines for village committees that help them examine ways to reduce contamination risks around their water sources. Work is also on-going in promoting increased inter-departmental collaboration, not only on water quality but also on sanitation and hand washing promotion. There is an immense need to continue encouraging open dialogue on water quality challenges to help build an evidence-based understanding of the problem and to identify the most appropriate ways to support the Government to address this.

**RELATED LINKS**

Knowledge Community of Children in India.
http://www.kcci.org.in/

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In 2008 Cyclone Nargis extensively damaged or destroyed 40 per cent of sanitation facilities and 57 per cent of existing health facilities in the Ayeyarwady Delta, the cyclone affected area (Post-Nargis Joint Assessment). More than 12 months after the Cyclone, the sanitary conditions in this area continued to be extremely challenging, especially in remote villages. Villagers were struggling to receive support and continued to stay in make-shift dwellings and in poor sanitary conditions.

UNICEF for the first time worked together with the Myanmar Theatrical Association (MTA) and traditional folk theatre groups known as Zat to help promote ‘4Clean’ messages (Clean Hands, Clean Latrine, Clean Food, and Clean Water) in cyclone-affected areas through edutainment performances. It was also the first time for MTA and Zat groups to be involved in a humanitarian project.

The project reached approximately 70,000 people in 54 hard-to-reach villages in Labutta township. Pre- and post-assessment of the intervention demonstrates that the edutainment through Zat created an enabling environment for behavioral change around 4Clean messages, both at individual and community levels. For example, Zat being a well-established and popular group provided an advantage in capturing audience attention. Edutainment performances were delivered in an interactive way, which allowed audiences to ask questions and discuss key messages and the content of the shows. Even after the performances, these messages continued to be discussed in the communities. The assessment, however, shows that to move further in the direction of behavior change and to sustain impact, the performances need to be followed up with more interpersonal activities using multiple communication channels. Building a stronger linkage between the edutainment intervention and programmatic service delivery in WASH or health education in the intervention areas is also important.

In May 2008 Cyclone Nargis extensively damaged or destroyed 40 per cent of sanitation facilities and 57 per cent of existing health facilities in the Ayeyarwady Delta, the cyclone affected area (Post-Nargis Joint Assessment). More than 12 months after the Cyclone, the sanitary conditions in this area continued to be extremely challenging, especially in remote villages. Since 2009, as a part of the larger WASH facility rehabilitation programme, UNICEF has worked together with traditional folk theatre groups known as Zat to help promote the ‘4Clean’ messages in the cyclone-affected areas. In an acute emergency situation, together with provision of water and sanitation facilities, promoting simple hygiene and sanitation messages that can be easily followed could help save lives if an appropriate communication channel is chosen. In order to reach vulnerable populations in rural areas, messages need to be entertaining and simple enough to keep audiences’ interest and to contribute to their behavioral change.

UNICEF’s direct partner was the MTA, the umbrella organization for all active Zat groups in the Delta region. Zat groups are very influential because they are popular and respected for their visual performances. They are capable of drawing large crowds, and their performances allow for flexibility and interactivity. The MTA assisted UNICEF in selecting five Zat groups, based on the specific criteria sought for the implementation of this project (e.g. a certain level of capacity per group; motivation to participate in humanitarian projects; and knowledge about the target
areas and their cultural context). Throughout the project, the MTA worked with UNICEF in coordinating these five media and folk groups as well as in attaining the necessary cooperation from local authorities through its Delta focal point based in Labutta.

UNICEF developed questionnaires for pre- and post-assessments. The qualitative and quantitative research was conducted with households through interviews, complemented by focus group discussions in randomly selected 15 intervention and 15 control villages. Fifteen villages of similar profiles were selected for each of the groups. One group received the edutainment messages while the other did not. A multiple stage cluster sampling method was used to first identify villages and then select households in each of the villages by random sampling. Household interviews were conducted and complemented by participatory focus group discussions.

**Planning**

Based on the findings from the pre-assessment, entertainment education was selected as a method which is appropriate to move people to the subsequent stage. The results from the assessment informed on language, ethnicities, cultural practices, geographical locations, socio-economic status, access to and preference of communication channels – particularly of interpersonal communication and edutainment. These provided a strong foundation to plan and fine-tune details in the actual performances, monitoring visits and the post-assessment that followed.

**Workshop**

In May 2009, a five-day workshop on concept and script development was conducted with key members of each of the five Zat groups and the MTA. They learned about ‘4Clean’ messages (Clean Hand, Clean Latrine, Clean Food, and Clean Water) and Water, Sanitation and Hygiene (WASH) interventions in Labutta. Scripts for dance, comedy, song and drama parts of the Zat performance were produced promoting the UNICEF messages in a variety of entertaining ways. Following the initial training, another five day training and performance rehearsal workshop was held in August 2009.

**Roadshow**

Within a month of the implementation, the five Zat groups organized roadshows in 54 remote villages in Labutta under the supervision of the MTA. They conducted two performances in each village featuring the scripts developed to promote 4Clean messages and using the skills learned during the workshop. The 4Clean messages were inserted in between Zat traditional entertainment programs (e.g. romantic and social dramas) that carried on throughout the night. In addition, each performance began with a short interactive session during which Information, Education and Communication (IEC) materials were distributed.

The evaluation design adopted the ‘Stages of Change’ model (Figure 1) as a theoretical basis for the communication and edutainment intervention. Specifically, post-assessment aimed to assess: 1) exposure to campaign messages; 2) awareness and Knowledge on 4Clean messages; 3) intention to adopt behavior; and 4) behavioral changes. It was, however, recognized that exposure to the edutainment performances followed by interpersonal communication themselves may not be sufficient or adequate to bring about lasting behavioral changes. Pre-assessment revealed that majority of the population assessed were in the pre-contemplation stage, or barely aware of the problems around sanitation and hygiene following Cyclone Nargis, yet without having formed a clear intent for action. The hypothesis was that the edutainment could achieve a powerful ‘intent for change’ by adopting the practices that would ultimately lead to a behavioral change which is the contemplation stage in the ‘Stages of Change’ theory.

**PROGRESS AND RESULTS**

All performances were completed in December 2009 and a post-assessment took place between February and March 2010. Key findings from the assessment are the following:

- Overall, awareness of 4cleans has increased from 11 per cent (pre-assessment) to 47 per cent (post-assess-
ment) of households in the intervention areas and 9 per cent to 13 per cent in the control areas.

- Caregivers’ knowledge on how to treat drinking water in the intervention areas has increased from 48 per cent to 64 per cent; whereas in the control area, there was a drop in the knowledge level.

- Significantly, compared to the control villages, many people in the intervention villages shifted from ‘no-intention-to-adopt’ behaviour to ‘pre-contemplation’ stage, and in the intervention villages, an even larger shift was observed to a ‘contemplation’ stage – which is a step just before adopting behaviour change.

- Measured by direct observations and demonstrations by household members, appropriate hand washing behaviour increased from 16 per cent to 37 per cent of households in the intervention areas, whereas the increase was not significant in the control villages (from 17 per cent to 20 per cent). Effective water treatment at the household level has increased from 19 per cent to 76 per cent in the intervention villages, in comparison to 14 per cent to 40 per cent among the control villages.

- 64 per cent in the intervention areas identified the Zat performances as their source of information for 4Cleans messages, while only 13 per cent in the control area mentioned secondary or other sources. More than 80 per cent of audiences preferred UNICEF sponsored Zat edutainment shows in comparison to other entertainment.

Thirty-six (36) per cent of audiences rated the edutainment performance as ‘very good’ and 63 per cent as ‘good’ while only 1 per cent rated it ‘average’. Anecdotal evidence also shows that people truly enjoyed the shows and reported that being able to witness the performance itself by a renowned group was a life-time event for many of them. Key hygiene messages were understood and recalled easily after each of the performances.

This being their first humanitarian project, the expert performers initially had limited capacity to convey health messages. However, they managed to overcome this challenge through high levels of commitment and motivation and support from UNICEF in opening up a new way of helping the communities while entertaining them. Being socially responsible added a significant sense of efficacy to the groups’ planning, learning and actions.

A one-day review with Zat groups and MTA upon completion of the tour showed that Zat group members had not only adopted the 4Cleans key behaviors in their own lives but were also committed to continue promoting them in their regular performances – without UNICEF support. The organizational; logistical; financial and management skills of MTA were also strengthened in the course of this project.

The Minister of Culture expressed his deep satisfaction with the project, thus further strengthening collaboration. UNICEF has received requests by government counterparts to conduct more performances in additional areas.

LESSONS LEARNED

Upon the completion of the planned roadshows (December 2009), a review meeting was organized with MTA and Zat groups to assess progress. The following lessons were identified.

Edutainment played a major role in motivating communities to adopt 4Cleans behavior through creating an enabling environment for behavioral change at individual; social; and community levels. For a sustainable behavior change, however, this intervention should be followed up and reinforced with interpersonal communication, using a multi-channel approach (e.g. use of IEC materials, mass media and video parlours at the community level). The villages were selected based on WASH project areas so that the edutainment could support other programmatic
interventions. However, linkages could be improved further by reducing the gap between hygiene promotion and service delivery in emergency response programmes, for example, by distributing soap and hygiene supplies shortly before or after performances. Close coordination with NGOs and other organizations implementing WASH and health education interventions in the targeted areas is required to better synchronize them with the edutainment.

The edutainment shows through Zat can have the best outcome when sufficient lead time is planned for concept and script development; planning and preparation of performances; and logistics such as obtaining permission from local authorities to visit the field. In this project the Ministry of Culture, as the line ministry for Myanmar Theatrical Association, was involved in granting permission for organizing performances in 100 villages. When replicating this intervention, involvement of multi-sectoral governmental ministries and departments including the Ministry of Health in the process is required. Involving concerned ministries will no doubt give the initiative more weight in the national scene, although it is also likely to complicate coordination efforts and lengthen the preparation and permission phase.

Advocacy with local authorities has proven to be very useful in multiple ways. Local authorities should be engaged early on and consulted on the selection of performance venues and to obtain accurate data on demography in each area. During the project, frequent visits were made to inform them on process and progress. Local religious leaders were engaged in advocacy because of their influence in the community. Many of them own the largest pieces of lands that may be used for staging the performances.

Logistic and technical details are important for quality and to ensure a wider outreach for the performances. The quality of scripts can be improved by drawing from experience from the first round of performances and by reducing the number of scripts to be developed. Village locations where performances take place should be visited in advance to determine travel routes and the best possible clusters to reach the maximum number of audiences across villages. This activity could be combined with pre-assessment visits.

POTENTIAL APPLICATION
This project has high potential for replication and can be adapted in a variety of ways. For example, the number of participating Zat groups and/or the number of performances could be increased to reach more communities and cover a broader geographic area. Different branches of the MTA are spread out throughout Myanmar, so the coverage area can be tailored to the need. In addition key messages could be changed to cover other sectors using those from ‘Facts for Life’ (e.g. Education, HIV/AIDS prevention, etc) once they are pre-tested for suitability in local context.

NEXT STEPS
Replication of the edutainment approach through Zat groups to promote six key family practice messages of ‘Fact for Life’ is under consideration as a C4D initiative for UNICEF’s new programme cycle. Before replicating the approach, however, the effectiveness and appropriateness of the Zat medium for promoting these messages, and sustainability in terms of behavioral change must be re-assessed. Also, combining edutainment with other interventions such as interpersonal communication methods needs to be considered to create maximum impact and reinforcement. The other issue to be considered is the process of preparation and coordination with multiple line ministries, which could be a lengthy process.

RELATED LINKS
- Facts for Life www.factsforlifeglobal.org/
CHAPTER II
BASIC EDUCATION AND GENDER EQUALITY
ABSTRACT

Until the end of 1990s, special boarding schools were the option for children with special education needs to access formal education in Armenia. This system reinforced the prevailing medical approach to disability as well as societal stereotypes of people with disabilities. The Ministry of Education and Science (MoES) has committed to increasing access of children with special education needs to inclusive schools. During the last decade, UNICEF has supported the government’s effort to achieve inclusive education through a variety of programmes, in partnership with local and international NGOs. Currently 81 schools are officially recognized as ‘inclusive’ by MoES, providing education to over 1,700 children with special education needs through adjustments in teaching/learning methods; physical learning environment; teacher education and recruitment of multidisciplinary special education teams.

The initial bottom-up approaches of capacity building of civil society organizations; community sensitization and school-level pilots were gradually complemented with advocacy towards policy level changes with an aim of strengthening systems to accommodate inclusive education. The MoES, in coordination with stakeholders, is now supporting the expansion of inclusive education through a process of policy revision and systemic reforms, and piloting an alternative funding system. Drawing on the results from an external evaluation of inclusive education policies and programmes in 2009, this case study reviews the implementation of the Inclusive Education programmes in Armenia since 2006, highlights key impacts and shares lessons learned for future programming and application to other settings.

BACKGROUND

In the mid-1990s in a post-Soviet context, special boarding schools were the single option for children with special education needs to access formal education. This has resulted in a medical approach to disability and societal stereotyping of people (including children) with disabilities, reinforcing exclusion. During the last 10 years, the MoES of Armenia has focused on increasing access for children with special education needs to their community schools.

UNESCO defines ‘Inclusion’ in the education context as a process of addressing and responding to the diversity of needs of all learners through increasing participation in learning, culture and communities, and reducing exclusion within and from education. It involves changes and modifications in content; approaches; structures and strategies; a common vision which covering all children of the appropriate age range and a conviction that it is the responsibility of the regular system to educate all children. ‘Inclusiveness’ is also one of the main principles of the ‘Child Friendly Schools Approach.’

In 2005, the Government adopted the concept of ‘inclusive education’ and approved the ‘Law on the Education of Persons in Need of Special Conditions for Education.’ More recently, an initiative to amend the 2009 Law on General Education has triggered an increased debate around inclusive education. Despite these policy level changes, the

1 In this document, ‘children with special education needs’ is used instead of ‘children with disabilities’ as the latter may not be inclusive of all the children whose various needs should be accommodated in order to pursue formal education. For example, physiological disability may not affect learning and access to mainstream (regular or formal) schools.

2 Guidelines for inclusion: ensuring access to education for all. UNESCO. 2005. unesdoc.unesco.org/images/0014/001402/140224e.pdf

3 For more information on Child Friendly Schools, see UNICEF’s website: http://www.unicef.org/education/index_focus_schools.html

4 In Armenia ‘Inclusive Education’ is defined as ‘education of persons in need of special conditions for education in public and professional education institutions, together with persons who do not have such needs, through provision of special conditions of education’ (Law on the Education of Persons in Need of Special Conditions for Education, 2005, Armenia MoES).
transition from the dual system inherited from the Soviet educational system was slow, and the full understanding and application of the principles of inclusive education has still not reached the central and local levels. More work is required to identify strategies for the absorption of professional and financial resources from special education to the inclusive education system. UNICEF’s office in Armenia began to support to the government with implementation of inclusive education in the mid-1990s, and has gradually shifted its strategy from grass-roots capacity development to upstream policy and advocacy work.

**STRATEGY AND IMPLEMENTATION**

**Inclusive education- strategic shift over a decade**

Between 2006 and 2008, UNICEF supported a project ‘Capacity building of inclusive schools’ in eight schools in Yerevan, the capital city, and in Tavush region. The objective of the project was to provide quality education services to students with special education needs through improvement of accessible infrastructure; development of materials and building of the methodological basis (teaching methods and didactic materials) for inclusive schools. Specifically, the project improved and supported accessibility of schools and inclusive primary education services through:

1. Professional education support services provided to 204 students with special education needs and their parents. This primarily consisted of providing consultations to teachers working in inclusive schools, developing individual education plans, and adjusting teaching methods. Resource rooms were furnished and equipped with teaching material and learning aids (e.g. audiovisual equipment and games) for children with special education needs.
2. Training of 212 teachers in eight schools on the inclusive education methodology and on needs-based education (designing education for children based on the needs of that individual child) and other support required by children with disabilities.
3. Provision of special vans to three Resource, Counseling and Training Community Centers that support students with special education needs with transportation.
4. Construction of ramps at the entrance of the school building as means of access for students with physical impairments.

Five model inclusive schools and community centers

5 Special education: education for children with special education needs in segregated institutions, with modified education curriculum or programs. All special schools in Armenia have boarding facilities.
6 MoES and Bridge of Hope were the main implementing partner of the 2006-2008 projects and a major funding was provided by VivaCell, Armenia’s largest telecommunication company.
7 Mission East is a Danish international non-governmental relief and development organization which works to help the vulnerable through humanitarian aid, development assistance, the linking of relief, rehabilitation and development and through supporting communities’ capacity to organize and assist themselves.
8 Bridge of Hope is an Armenian NGO with a mission to protect the rights and dignity of children and youth with disabilities and their families and support their social inclusion in the Republic of Armenia.

The MoES has now taken ownership of the inclusive education initiative in the country, increasing the number of inclusive schools every year. However, as of late 2011, less than 10 per cent of the country’s 1,365 public schools are recognized as ‘inclusive’ by the MoES, educating children with disabilities, and these schools are primarily located in urban areas. A total of 2,800 children with special education...
tion needs continue to study in special boarding schools, away from their homes and local communities.

System reform and advocacy
In 2009, UNICEF supported an external qualitative evaluation of the Inclusive Education policies and programmes aimed at reviewing the government’s policy regarding the provision of education for children with special needs, and identifying strengths, weaknesses and challenges in pilot inclusive education programmes. The evaluation used a qualitative methodology which included 22 semi-structured interviews and 14 site visits. The recommendations from the evaluation served as the basis for increasing the dialogue with key stakeholders concerning the policy and legal framework revision in the education sector, and supported the scaling up of the inclusive education systems wide. Inclusive education is currently included in the Mid-term Expenditure Framework (MTEF) and Education Development State Programme for 2011-2015 and a budget is allocated specifically to support the implementation of inclusive education.

Implemented in parallel to this was the promotion of de-institutionalization of children, including those with special needs, and support to the pilot reform process of social services over the last two years. Designed along with the guidelines of the Council of Europe, the reform process aims at building a model of Integrated Social Services for Armenia, such as the introduction of the professional profile of case managers, for the first time in Armenia, in the territorial offices of social services among other components. Specifically, the pilot reform process included capacity development of the Case Managers in six territories and development of regional social plans in two regions. Case Managers play a key role in identifying children with special needs (e.g. in education or health); referring them to appropriate social services and following up with them subsequently. The integration of the Case Managers in the system will allow for the provision of required social assistance to families in need of support, ensuring the social inclusion and access to appropriate services for these families. The proposal on the reform of the social services system will be presented to the Government at the beginning of 2012 for approval.

Impacts of the Inclusive Education Policies and Programmes in Armenia
The 2009 Evaluation of Inclusive Education Programmes and Policies mentioned above identified the following impact level results:

- The Inclusive Education programmes were effective for promoting social inclusion and demystifying stereotypes associated with children with disabilities. However, schools fall short in the practical implementation of quality of education due to financial, human resource and other constraints, many of which are outside of the schools’ control. Inclusive schools appeared to be operating more effectively in settings where there are existing community resource centers offering some degree of expertise on education for children with special needs which can be drawn upon for training, mentoring and networking.

- The Inclusive Schools have developed strong special education teams (including special educators, psychologists, and speech therapists), with expertise related to children with disabilities and a willingness and intent to implement inclusive practices.

- The Inclusive Education programmes in existence have been highly efficient in introducing the philosophy and goals of Education for All (EFA) and promoting the need for the de-institutionalization of children with special needs. Model schools were created as examples of a structure required for systematic reform of basic education.

LESSONS LEARNED
Based on the results of the evaluation mentioned above, and also the analysis of the experiences through supporting the Inclusive Education Programmes in Armenia, key lessons learned are:

- The practical implication of inclusive education. The experiences demonstrate the need to work on both
social norms, and behavioral and cultural changes in schools and communities in addition to advocacy at the policy level. Having children with disabilities in the same classroom as other students helps raise awareness and understanding in schools, but to be truly ‘inclusive,’ the quality of the teaching and engagement of the child on an equal basis with their peers without a disability is critical. When teachers view children with disabilities as the full responsibility of a separate special education team, they do not adjust their teaching methods to actively engage students with special needs in the learning process. This may result in a ‘classroom within a classroom’ situation where the education for children with special needs is disconnected from the rest of children although they are in the same classroom.

• **Accountability of inclusive schools.** Along with the financial and administrative accountability for children with special education needs, there should be a greater emphasis on the schools’ accountability vis-à-vis enhancing the performance of those students, based on the individual education plan or developmental targets set in relation to the child’s functional abilities. There is also a need provide an infrastructure which is conducive to teaching/learning (i.e. electricity, heating, water and sanitation); updated and sufficient textbooks and consumables; Information, Communication and Technology (ICT) tools; and assistive technology devices/support that provide a nurturing and safe environment for all children.

On the teachers’ side, it is critical to clearly define roles and responsibilities of teachers and support staff working with children with special needs, and to bridge the gaps between areas of expertise by creating collaborative exchanges between special education teams and regular teachers. Teacher preparations for Inclusive Education will require targeting both pre-service and professional development concurrently.

• **Advocacy.** Advocating for inclusive education beginning at the grassroots level with community buy-in and involvement is very important in the change process. Showcasing model schools and the success stories to demonstrate the feasibility and effectiveness of including children with disabilities are important strategies for gaining the strong support and ownership of policymakers. However, in the long run, the process of reforming one school at a time is slow and should be replaced by carefully planned system reforms. For inclusive education to become universal rather than an alternative option to special schools, the combined efforts of the government, non-governmental agencies and international donors should form one large national effort targeted at cross sectoral reforms including education, health and social services to create an enabling environment for inclusive education.

**NEXT STEPS**

UNICEF’s office in Armenia is positioning itself to further strengthen advocacy for inclusion. The efforts will focus on de-institutionalization through supporting transformation of current special boarding schools into resource centers for inclusive schools, and establishment of integrated social services to support children and their families in the community.

Building on the experiences of implementing the Inclusive Education Programmes, UNICEF is currently carrying out a survey with families or guardians of children with disabilities on their access to education, health and social services which will shed light on their access, use and satisfaction level of these services, as well as barriers to social inclusion.

The survey results will be used by the government and partners to define strategic priorities and streamline policies. The Education Development State Programme 2011-2015 stated the expansion of inclusive education and the reduction of the number of the special schools as one of programmatic directions for education development. To that end, a discussion with the MoES regarding the draft amendments to the current legislation on public education is on-going.

**RELATED LINKS**

ABSTRACT
Burundi is emerging from a prolonged period of civil conflict that left most material and financial resources as well as basic social services including education in disarray. Furthermore, the prolonged conflict left many children orphaned and vulnerable while sustaining ethnic tensions, distrust and rancor amongst the population. Despite the government’s initiative for free primary education since 2005, an estimated 137,000 children of primary school age (7-12) were out of school in 2008/2009 (Ministry of Education). In 2009, UNICEF advocacy with the Ministry of Primary and Secondary Education led to the adoption of ‘Community Dialogue’ to engage all stakeholders in identifying issues and suggesting solutions to improve school access and retention. Although this approach has been used widely in different contexts, for Burundi the challenge was to be able to mobilize community leaders within a post conflict context that was full of suspicion and tensions. The participants in the ‘Community Dialogue’, identified problems affecting access to schools in their community, drafted an action plan, and implemented it during the following three months just before the beginning of the new school year.

The initiative was evaluated positively by local administration and education decision makers in terms of identifying out-of-school children and supporting them to go (back) to school. In addition, available education data shows that four months after the Dialogue, the number of out-of-school children was reduced and the drop-out rate went down in eight out of the nine participating communities. This document focuses on the strategies of the ‘Community Dialogue’ and its contribution to the key education indicators at local level, and discusses challenges and way forwards.

BACKGROUND
Burundi is emerging from a prolonged period of civil conflict that left most material and financial resources as well as basic social services including education. Furthermore, the prolonged conflict left many children orphaned and vulnerable while sustaining ethnic tensions, distrust and rancor amongst the population. In an attempt to restore basic social services, the government declared Free Primary Education in 2005 without sufficient preparation in terms of infrastructure, teachers, materials, and institutional capacity. Though primary school enrollment skyrocketed from 59.8 in 2004/2005 to 89.7 per cent in 2008/2009, an estimated 137,000 children between 7 and 12 years old remained out of school. Continuous rancor and tensions following the conflict, dire poverty and lack of awareness of the value of education are some of the factors contributing to high repetition (34 per cent), low completion (46 per cent) or lack of access to primary school in 2008/2009.2

Burundi’s administrative structure consists of 17 provinces, 129 communes, 375 zones and 2,908 collines. In most part of the country, communities, local administrations and parents tend not to focus on their collective and individual responsibility in communities to promote and facilitate children’s school access, retention and completion. In 2009, UNICEF decided to support the Ministry of Education through the ‘Community Dialogue’ initiative to sensitize and involve community members to become the key actors in promoting school access and in creating an environment that favors children’s school retention and performance.

1 The number of out of school children was calculated based on the net enrollment (89.7 percent); the population of 7-12 years old for 2008/2009 and 2009/2010; and the net enrollment ratio (94.1 percent) (data source: Ministry of Education Annual Statistics Year Book 2008/2009 and 2009/2010).

STRATEGY AND IMPLEMENTATION

This initiative started in 2009 and in its first year, targeted 248 collines\(^3\) scattered in nine communes in the three provinces which had the lowest performance based on selected education indicators such as net enrollment rate (NER)\(^4\); disparity between school enrolled girls and boys; average number of students per classroom; and estimated number of out-of-school children of age 7-12. These were also the communes with hazardous natural or socio-economic conditions that hinder schooling (e.g. droughts and food insecurity in Kirundo and political insecurity in Bubanza). In the second year, the initiative was expanded to five provinces and replicated in an additional 552 collines in 20 communes.

Community mobilization begins with the annual global celebration of the Education for All (EFA) week in April and continues with sensitization of community leaders on their collective responsibility to ensure that their children attend and complete primary education and become better performing citizens. In 2009, UNICEF facilitated the creation of the National Commission for the EFA campaign, consisting of a team of 12 personnel from the different Departments of the Ministry and a local NGO network. The commission members served as trainers for building up local capacity for implementation of the ‘Community Dialogues’. To develop the strategy, NGOs that had employed community-based approaches as a social mobilization strategy were encouraged to share their lessons learned and good practices (e.g. selection and composition of community members). Provincial education administrators participated in the finalization of the strategy.

The EFA Commission organized a three-day workshop through which 72 participants from Provincial and Communal education offices and local administration were trained to facilitate the ‘Community Dialogue’. The training focused principally on methodologies for dialoguing in communities including how to prepare an action plan, implement it and monitor and assess it at the end of the year. These 72 facilitators then organized a three day ‘Community Dialogue’ in nine communes in July 2009, involving 772 community leaders and other participants such as parents. The members of the EFA National Commission supported the facilitation of the ‘Community Dialogue’ and also provided technical oversight during the process. The participation rate was 99 per cent (772 out of 784 community leaders invited), among which 79 per cent (609) were male and 21 per cent (163) were female, due primarily to the fact that leadership at community level is dominated by males. In 2010, an additional 1,743 community leaders were trained, and another 1,250 in 2011.

During the Dialogue at community level, the key education indicators were presented to the participants. These indicators were also compared with those from other communities and with the national average. Through a quasi-focused group discussion, participants identified problems affecting access to the school and retention in their community and also discussed possible solutions to the problems outlined. Based on the recommendations, the facilitator guided the community to identify priority actions to be taken up at the community, provincial and also national levels. Some of the priority actions identified through the ‘Community Dialogue’ include: 1) sensitize households on the importance of being literate; 2) encourage parents and adolescents to use the literacy centers; 3) help children to develop the love for education/schooling; 4) provide essential learning materials for children; and 5) collect data at colline level to have statistics of all children who are at school age. A timeline with clear responsibilities is also incorporated into the plan. These actions are implemented during the course of three months that follow the Dialogue.

Community leaders, along with school inspectors, were also responsible for collecting data on simple indicators including the number of school-age children who re/gained access to schools. Following the implementation of the action plan, community leaders participated in a reflection meeting where progress and challenges were shared, using the data collected. A monitoring mission was conducted in the fourth month of the initiation of the action plan. During this mission, a team of around six selected Commission members (national and provincial level) and community leaders organized two-day meetings to review progress in their respective target zones. Following the monitoring mission, each zone prepared a report which was consolidated at the national level by the members of the Commission for EFA and submitted to the Ministry of Education.\(^5\)

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3 Collines are the decentralized administrative level that comes after provinces, communes and zones. One colline can have 200 to 800 households.

4 Net enrollment rate (NER) in primary education is the number of children of official primary school age (according to International Standard Classification of Education 97) who are enrolled in primary education as a percentage of the total children of the official school age population.

PROGRESS AND RESULTS

The above mentioned evaluation meetings found positive changes in the level of awareness and sense of responsibility of local leaders in bringing their children to school. Exchanges with these leaders demonstrate that the communities as a collective body started acting as a “watchdog” on children’s access to and performance in schools. Specifically, the initiative showed the following results in 2009:

- EFA messages reached an estimated 160,000 households through collinal/zonal meetings, churches and house visits
- 100 per cent of school-age children were enrolled in Grade 1 in the new school year (September) in 18 out of 31 targeted zones—reported by community leaders and school inspectors
- 31 zones mobilized community members to either construct or rehabilitate a total of 84 classrooms
- As of the end of 2009, a total of 3,527 children in 31 zones and who had abandoned school were identified and returned to classrooms. Further data collection is needed to determine how much 3,527 children represent among all former drop-out/out-of-school children (% identified and returned to schools)

In addition, a comparison was made between communities in the same province where interventions took place and those where no intervention took place. Drop-out rates in the first quarter of the year based on the school registry were considered. Not only did the drop-out rates went down in 2009/2010 compared to 2008/2009 in all except one commune, but the communes where interventions took place demonstrated a sharper reduction in drop-out rates (20.5 per cent on average) from the previous year than that of communes where no intervention took place (13.2 per cent on average), as shown in Figure 1 below.

Exceptionally, in Kirundo province the drop-out rate increased in the commune where intervention took place. This is largely explained by the famine that severely hit Bugabira, one of the three communes in which interventions took place during the school year 2009/2010. A large number of farmers in this commune migrated into Rwanda or neighboring provinces and some households had to make their school-aged children work, instead of studying.

An additional effect of the ‘Community Dialogue’ was increased community participation in the Back-to-School (BTS) operation in September. UNICEF supports the BTS operation systematically and has intentionally targeted the same provinces as the Dialogue. Due to the continuous sensitization, parents, teachers, community leaders and pupils themselves actively participated in the transportation and distribution of UNICEF-supplied learning materials. This not only enhanced the level of local responsibility and ownership but also lowered overall logistics costs including transport. Results from the BTS operation in 2010 demonstrate the collective effects of the Dialogue and the BTS: the ‘Community Dialogue’ was implemented in 20 out of 43 communes (coverage of 47 per cent) in the target five provinces, while 45,622 out of 87,000 over aged children (52 per cent) who enrolled in schools were from the communes targeted by the Dialogue.

Moreover the five target provinces of the ‘Community Dialogue’ and the BTS showed an improvement in NER and in Gross Enrollment Rate (GER) (Figure 2). NER has increased by 9.9 per cent in the five provinces compared to a 7.1 per cent increase at the national level from the 2008/2009 to the 2010/2011 school year. A greater improvement was observed in GER: a 12.6 per cent rise in the five provinces compared to 6.1 per cent in the national level between 2008/2009 and 2010/2011. Disaggregated data for female pupils has followed the same trend as total pupils both for NER and GER.

These results indicate that the geographical gap in NER and GER is shrinking as five ‘lowest performing’ provinces are making faster progress than the national average. The increase in GER, however, implies that more over-aged pupils were enrolled, resulting in overcrowded classrooms with significant age gaps. This may reduce internal efficiency and quality of teaching and learning.

No significant difference was seen in repetition rate in the five target provinces compared to the national average. Furthermore the rate of repetition has marginally increased

6 Gross enrollment rate (GER) is the number of children of any age that are enrolled in primary school as a percentage of the total children of the official school age population. In countries where many children enter school late or repeat a grade the GER can exceed 100%.
7 Disaggregated data for male pupils is not yet available for 2010/2011 as of December 2011 but the same trend—a greater increase in the GER and the NER in the five provinces compared to the national level, while the repetition rate stagnated between 2008/2009 and 2009/2010, was observed.
8 Repetition rate: proportion of pupils from a cohort enrolled in a given grade at a given school-year who study in the same grade in the following school-year.
from 2008/2009 to 2010/2011 at both national level and in the five provinces.

Completion rate on the other hand has improved from 47.7 per cent in 2009/2010 to 51.3 per cent in 2010/2011 at the national level. In the five intervention provinces as well, it has increased during the same period (on average 40.6 to 45.5 per cent), though the improvement rate varied depending on the province (2.7-10.3%).

In three out of the five provinces, the rate of completion still remains below the national average in 2010/2011.

Improved access to education needs to be accompanied by quality aspects such as adequate teacher allocation and teacher training to ensure effective learning. A longitudinal study not only on access but also on quality and efficiency would further clarify the effectiveness and shortcomings of the 'Community Dialogue,' leading to improved strategies.

INNOVATION

Through the 'Community Dialogue' community leaders at the most decentralized administrative levels who would otherwise not engage with one another felt compelled to gather and diagnose the problems associated to the schooling of children in their community. They identified ways to address these problems in the Action Plan, implemented their proposal, and assessed changes resulting from their own actions. The strategy is novel and was successful for the following reasons

- Creating a space of dialogue on education where community leaders who because of their history of incessant conflicts would not dialogue or make the time to get together to talk about issues affecting their community. This in turn helped transform the EFA agenda into a common vision that these community leaders are responsible for at their community level.

- Nurturing a collective responsibility that motivates community leaders to share a common vision on education for their children, leading to taking action and monitoring the changes. No financial incentives or physical investments were provided throughout the process, but existing human resources were mobilized and communication channels were revitalized.

- 'Community Dialogue' is not a one-off event or campaign. Rather it is a dialectic process, involving negotiation and re-negotiation, building on a stratum of one activity to another in order to mobilize the community for the common good of ensuring that every child has access to a primary school and has the chance to complete it. A series of related Education activities (e.g. the Global Action Week for EFA, sensitization of communities, community advocacy and the Back-to-School campaign) were organized to enhance the collective results of the 'Community Dialogue.' The collaboration between community leaders and schools was also strengthened through these activities.

Challenges

Following an assessment of the 'Community Dialogue' in 2009, the National Commission of EFA identified challenges including: (1) weak capacity of the participants of the 'Community Dialogue' in elaborating the action plans; (2) lack of a systematic mechanism to monitor the results of the Dialogue at zonal, communal and provincial levels; (3) limited timeframe between the Dialogue and the new school year requiring a very short timeframe to implement the zonal action plans; and (4) no additional funding and logistic support provided to the EFA Commission to continue the 'Community Dialogue.'

In response, in 2010 the project stressed a more participatory approach to facilitating the Dialogue during the training of the community leaders; organized follow-up missions and

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9 Completion rate: percentage of students completing the last year of primary school. For more information on definitions of key indicators for Primary Education, see www.childinfo.org/education_methodology.html

10 Increase in completion rate for each of the five target provinces between 2009/2010 and 2010/2011 was: 10.3 per cent in Gitega, 4.6 per cent in Muyinga, 3.6 per cent in Kayanza, 3.3 per cent in Ngozi and 2.7 per cent in Kirundo province.
assessment meetings at zonal levels to ensure that the data was being collected and consolidated; and pushed back the timetable of activities to allow the maximum time possible for the implementation of action plans. The concern related to the lack of financial and logistical means was considered by the Minister of Education in 2011 where the EFA Commission prepared a budget that was dedicated to the EFA Action Week including the provision of transportation to all EFA Commission Members. Further advocacy will continue to explore the possibility of the Ministry increasing these resources such that it can extend to carrying out the ‘Community Dialogue’ exercise.

**POTENTIAL APPLICATION**

The ‘Community Dialogue’ approach empowers community leaders to take the responsibility for ensuring access to education and the protection of children’s rights. A similar approach could be a promising strategy for other geographical locations in Burundi as well as for other sectors of UNICEF interventions, and may be feasible for the following reasons:

a) Existence of different levels of administrative structures (province-commune-zone-colline);

b) compelling and participatory nature of community dialogue;

c) demonstrability of its effectiveness as goals are set by community members and results are shared.

**NEXT STEPS**

Regardless of the progress made by the ‘Community Dialogue’, persistently high repetition rate (38.4 per cent at national level and 37.3 per cent in the five target provinces in 2010/2011) and low completion rate remains problematic. An estimated 81,000 children between 7 and 12 years old were still out of school in 2010.\(^1\) Scaling up the approach of ‘Community Dialogue’ to other communes of the five target provinces is ongoing. Expected results are: to ensure capacity development in strengthening planning at decentralized level; data collection as well as monitoring; and evaluating the impact of interventions for documentation of progress made in bridging the inequity gap.

The challenge remains that enabling communities to continue carrying out the ‘Community Dialogue’ without the support of partners like UNICEF. At the end of 2009,\(^2\) School Management Committees were institutionalized as a harmonized structure in primary schools across the country. The responsibility of the committees is to ensure proper governance and management of resources, and improving the quality of teaching and learning in their schools. If operationalized, these School Management Committees may become the key structure to support extension and sustainability of the ‘Community Dialogue’ through facilitating the community’s collective responsibility towards education of their children.

The EFA Commission also plans to examine the issue of the sustainability of the ‘Community Dialogue’ in all target communes to ensure that there is continuity and the community does not lose sight of the changing contexts and the emerging challenges that children might face as they try to acquire a quality basic education.

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\(^1\) Ministry of Education, Annual Statistics Year Book 2009/2010

\(^2\) The capacities of School Management Committees are being strengthened through the Child Friendly Schools approach and other school governance strategies across the country. The Committee normally consisted of ten members: the president, the Head Master, two teacher Representatives, two Student Representatives and three community members and they are responsible for providing a conducive environment for learning and transparent management of resources in their respective schools. Each school develops an annual plan based on challenges faced by the school, ranging from provision of latrines and school furniture to the needs of additional classrooms and issues of absenteeism and repetition.
BACKGROUND

Studies in the developing world and especially in West Africa have shown that the dearth of qualified female teachers in rural schools contributes to low enrolment of female pupils.¹ In many parts of northern Nigeria, female teachers who are posted to rural schools either reject the assignment and work their way back to urban centers, or they accept the rural placement while working their way out. It was thus becoming increasingly difficult to get qualified women teachers to serve in rural schools.

There is a lack of gender parity at all levels of education in Northern Nigeria especially in four provinces (Bauchi, Katsina, Niger and Sokoto) that were classified as 'high burden states' based on UNICEF’s criteria, with the lowest figures for girls. In 2007/2008, the Gender Parity Index (GPI- ratio of girls to boys) for the four states was 0.55 in primary and 0.46 in junior secondary schools (State Ministries of Education). Moreover the number of women teachers in primary schools in these states was grossly insufficient; the proportion of female teachers with the NCE—the minimum teaching qualification for primary school level was 25 per cent in Bauchi, 23 per cent in Katsina, 37 per cent in Niger and 30 per cent in Sokoto (State Ministries

ABSTRACT

Lack of female teachers in rural primary schools could be a major cause of the gender gaps in enrolment and retention rates, especially for girls nearing puberty as they require mentoring and support from female teachers. The female teacher-training scholarship (FTTSS) award scheme is a mechanism for attracting more women into the teaching profession to serve in the rural, remote areas and reduce the gap between demand for and supply of women teachers in these communities. Introduced in 2008 through a partnership between the state and local governments, the Girls’ Education Project (GEP 2) and UNICEF, the scheme targets four northern states of Nigeria—Bauchi, Katsina, Niger and Sokoto. The primary focus is young women from marginalized areas (particularly remote rural areas) who are qualified to study for the Nigeria Certificate of Education (NCE) but would not be able to do so because of lack of funding, information and the means to make applications for admission. Selected candidates are funded through the scheme to undertake the three-year teacher-training course at the state college of education, leading to the award of the NCE. Successful candidates agree to return to their rural communities to teach in primary schools.

The scheme began in the 2008/2009 academic session with a total of 674 female candidates. As of 2011, a total of 3,246 candidates are pursuing their education under the scheme. The State and local governments have progressively increased their financial support to the scheme, from 454 students (67 per cent) in 2008/2009 to 2.598 students (80 per cent) in 2010/2011. The success of the programme has been demonstrated by high and improved retention rate of young women currently enrolled in the course. Potential candidates from both rural and urban areas are clamoring for spaces. A follow-up study is planned to assess the rate of absorption into the teaching force by the government and to follow up their impact in enrollment and retention of girls in schools in the rural areas.

¹ See for example the following studies:
of Education, 2007). In Niger State, 50 per cent of primary schools still do not have a single female teacher, and most of these schools are in the rural areas. Absence of women teachers to serve as role models in the schools and communities has contributed to girls’ low enrollment and high withdrawal rates in these states, especially in higher primary level classes when girls nearing to puberty. Against this backdrop, in 2008 the Female Teacher-Training Scholarship (FTTSS) award scheme was introduced through a partnership between the state and local governments, the GEP2 and UNICEF, targeting these four northern states.

STRATEGY AND IMPLEMENTATION

Although some form of scholarship grant scheme existed for pre-service teachers studying in the colleges of education and universities before the introduction of the FTTSS scheme, it did not specifically target women, and those from vulnerable and marginalized groups. The project team held high level discussions with government partners at both federal and state levels on the need to introduce the specially designed scheme, which targets indigenous girls from remote/rural communities. The scholarship aimed to attract young women who had reached a certain level of education and attained the minimum requirements for training, but who did not have the opportunity to continue or who were forced out due to early marriage or for cultural and religious reasons.

Community, traditional and religious leaders were informed about the scheme and subsequently advocated on its behalf through house to house campaigns to recommend adult family members that their daughters, wives and potential wives should enroll in the scheme. Criteria for selection is clearly stated and carefully monitored so that those who would be most eligible have a preference. A particular emphasis was placed on involving the community and local government authorities in selecting the candidates from the rural areas. The prospective candidate submits their application and credentials through the local education authority in their area.

A screening committee set up by the State Universal Basic Education Board (SUBEB) comprising officials from the Ministry of Education, SUBEB, local government education authorities, school-based management committees and traditional and religious leaders examines the individual applications against set selection criteria. The criteria include requirements that the candidate be indigenous to the local area; be prepared to go back to her community to serve as a teacher; and meets the minimum entry qualification for admission into the NCE programme.

The list of successful candidates is recommended for admission by SUBEB to the four state colleges of education, based on the admission requirements of each college. Successful candidates are offered admission for the three-year NCE course or in some cases (e.g. for applicants who fall short of entry requirements but who are deemed to have potential) are admitted to a pre-NCE course to support their entry into the scheme.

All FTTSS students are on a full scholarship for three years. They live in the college hostel or near the college so that they can be closely monitored and mentored. Students receive a sessional stipend of NGN 50,000.00 (USD 318) each. The allowance helps the students meet their tuition, registration, accommodation, examination fees and with their up-keep during the course. The stipends are also paid to the beneficiaries relative to their economic background to encourage applications and enrolments from the most marginalized communities. Arrangements have been made for some of the married trainees and nursing mothers to bring their babies to the college day care centers and crèches at minimal cost. This ensures that trainees would not have cause to leave lectures to take care of their babies and children, or simply drop out of college to nurse their babies.

Monitoring and evaluation

This includes monitoring both the program as well as tracking the students’ academic life and welfare. Monitoring is carried out by development and state partners and CSACEFA (a coalition of NGO’s). A scholarship committee comprising the SUBEB, the College of Education and the Ministry of Education tracks key activities of the scheme and advocates to the local government authorities (LGAs) and NGOs for commitment and sustainability. The subcommittee on the FTTSS is entrusted with the task of liaising with the colleges of education on issues related to the scholarship scheme and undertakes a quarterly verification and counseling exercise. Students sign in an attendance register once a week. Contact is also made from time to time with the course lecturers about the regular attendance of the students. Students found to be habitual absentees are advised and counseled by the teacher professional development consultant employed by the project who resides within the college to support and track performance. Any challenges noticed are raised with the college authorities for follow up. The college has in addition identified a college counselor, who handles special problems faced by the students on a day to day basis.
Sustainability and ownership
Planning and budgeting for the scheme within the State’s Education Strategic Operational Plans (SESOPs) ensures longer term sustainability. State governments have also participated actively in drawing up the criteria for admission into the scheme. Local government education authorities (LGEAs) and desk and gender officers from SUBEB interact with the FTTSS beneficiaries from time to time to address problems that the students may encounter.

At the colleges of education, as part of its structural design, the programme has been placed under the administrative umbrella of the Provost who serves as its chief coordinator and supervisor. This gives the scheme greater support from all sectors. Along with the Provost, the Deputy Provost and a FTTSS focal officer assist in monitoring, supervising and counseling services as well as overseeing the affairs of the students, ensuring their welfare and academic progress and providing the most conducive atmosphere to learn and complete the programme. The students’ performance is evaluated alongside that of all other students, however for the FTTSS students, follow up is made through the counselor and the consultant based at the college.

PROGRESS AND RESULTS
Figure 1 shows the trend of types of funding sources for the female candidates who have been on the scheme since the beginning of the project. The scheme began in the 2008/2009 academic session with a total of 674 female candidates out of which 200 students (50 per state) were sponsored under GEP2 while the governments sponsored 454 candidates\(^3\) (67 per cent). The numbers sponsored by each state differ because of budgetary considerations. The scheme also gained recognition from NGOs: Life Rehab, an NGO established by the wife of the state governor in Niger state, is sponsoring a total of 40 candidates for the school year 2008/2009 and 2010/2011.

In its second year (2009/2010 academic year), the scheme gained wider support from both state governments as well as the LGAs of one out of four states. Out of a total of 1,201 candidates admitted in the second year, the LGA supported 220 and States supported 750 students, adding the number of the government-supported students to 970 (81 per cent). In the 2010/2011 academic year, 1,472 students were newly admitted and of those, 837 were funded by states and 337 by local governments (a total of 1,174 or 80 per cent). As of late 2011, the total number of candidates under the scheme is 3,246 (excluding those who dropped out) and 80 per cent of them are funded by State or Local governments.

At the end of the first year of the programme, it was reported that the female students from the rural areas required additional support to settle down in the colleges and adjust to the college life. Additionally, some of the students were nursing mothers and had young infants, thus needed extra support. As a result of advocacy with the state government, a counselor was appointed for the students to assist them in settling down, and separate hostels were provided to nursing mothers where they could board with their nannies/relatives that helped them with childcare. These strategies appeared to contribute to the drastic reduction in the number of dropouts in subsequent years. In the first year, 54 out of 674 students (8 per cent) dropped out and 34 (5 per cent) repeated at various stages whereas in 2009/2010 and 2010/2011, the dropout rate was 0.8 per cent (10 students) and 0.2 per cent (3 students) respectively.

In terms of the change in learning environment in general, since the introduction of the scheme, the colleges of education are increasingly realizing gender parity in their own admissions and have developed realistic gender equality policies in line with the National Gender Policy. The CSACEFA (coalition of NGO’s in Nigeria) is currently independently monitoring the scheme. This follow-up study will assess the rate of absorption into the teaching force by the government and follow up their impact in enrollment and retention of girls in schools.

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\(^3\) Breakdown per state: 200, 100, 100 and 50 candidates respectively in Bauchi, Katsina, Niger and Sokoto states
INNOVATION
The main innovative elements of the scheme are following:

a) Involvement of local communities in recruitment of scholarship students from the remote rural areas. This has increased both community support for the programme and understanding on the part of stakeholders in the States, especially traditional and religious leaders, of the perceived value of education for girls. Also, in the second and third year of the training, the female students under the scheme are required to do a teaching practice for at least six weeks each year at their respective community schools as part of their training and also to advocate for girls’ education in their communities. The programme is now in high demand by potential candidates in all four states, and state governments are increasing their levels of support.

b) Partnership with all stakeholders in developing the selection criteria and process. This contributed to transparency and ownership of the scheme. The fact that some states are devolving ownership of the scheme to the local government area councils (with appreciable participation of NGOs) is a good indicator of sustainability and ownership even when the project winds up.

c) Mentoring and counseling of the female candidates provided by female staff of the colleges ensured the candidates’ welfare and contributed to their regular participation in the program. Teaching staff are also assigned to facilitate the academic performance of the girls through weekly extra lessons on communication skills supported by each college. There is also peer-to-peer coaching for students to assist each other.

d) Provision of day care facilities for candidates who are nursing mothers has provided an environment conducive to learning and has encouraged retention in the programme. In addition to special kindergartens or day care centers to accommodate babies and children of the students, college clinics have also introduced maternity services for their students.

Challenges
The scheme is not without challenges. It started rather late in its initial year. This led to new students missing some of their learning time, which affected their overall performance. This was however a learning point which led to the appointment of the counselors and in some instances to colleges organizing remedial classes to enable these students to catch up. Other challenges are shortages of hostel accommodation and the high cost of textbooks and other learning materials. Issues of accommodation, textbooks and other learning materials continue to be addressed by sponsors of the scheme. The committee has since submitted a request to the state governments on review of the scholarship fund.

Initially, though sensitization and awareness meetings were held with communities, traditional and religious leaders, the programme met with resistance and suspicion among parents, husbands and in-laws, to release their daughters or wives to enroll in a boarding school far away from their home and thus exposing them to modern culture. With continuous advocacy and sensitization meetings at the community levels, however, community members were informed of the value of girls’ education and the advantages and potential of the scheme. As a result, traditional leaders are now requesting governments to increase the funding support to the programme.

POTENTIAL APPLICATION
The programme has become a model for female teacher trainee programmes in the country. The scheme is not expensive to run, and it fills important gaps in rural areas such as the lack of women teachers; the paucity of role models for girls; weak support for girls’ education; few opportunities for higher education for women; and low employment and participation of women. These conditions exist in many states, and all states have colleges of education. Therefore, there is ample opportunity for replicating this programme nationally and in other countries with a similar setting, in order to ultimately realize universal basic education.

NEXT STEPS
Next steps include high-level advocacy to state governments and local government authorities to provide more scholarships to female trainees and to commit to employing graduates of the scheme to serve in rural schools. Advocacy is also planned to encourage implementation of the scheme in other states in northern Nigeria which have similar challenges in education. If this innovative scheme is to be taken to scale nationally to address women teacher shortages and gender parity in school enrolment, institutional and human capacities will have to be strengthened in each of the states.
CHAPTER III
HIV AND AIDS AND CHILDREN
LENNON LEARNED

UKRAINE
Personal connections to peers and outreach workers bring young sex workers into HIV services

ABSTRACT
Young women who sell sex or live on the street in Ukraine do not benefit from state health or social services, despite alarmingly high rates of HIV. Their situation is especially precarious. How do they relate to a system that rejects and blames them? International and national partners researched the plight of these young people in Ukraine, brought this data to planning councils, and subsequently pilot-tested a combined drop-in center/outreach model to bring reproductive health, HIV prevention, social welfare, and harm reduction services to them. They also advocated for a more protective legal and policy environment for this population. Through the pre-testing of the model, 117 adolescent females who had never benefited from HIV prevention services before received services between February and December of 2009. The National AIDS Programme and the State Social Services now recognize female adolescents who sell sex as an essential constituency for services. The new national AIDS law now allows adolescents aged between 14 and 18 years to have HIV testing at local AIDS centers without parental consent. One key lesson was that trust and good communication between caseworkers and young people are critical in dispelling young peoples’ mistrust of the health and social services system. Formal cooperation agreements with NGOs, the government and academic institutions guaranteed access to the various government health and social welfare services. The programme will be replicated in two more sites. Advocacy for a less punitive legislative and policy environment for young people who inject drugs, sell sex and/or live on the streets will continue.

BACKGROUND
Adolescent Female Sex Workers (A-FSWs) in Ukraine live on the fringes of society. Their exposure to health services is low and they place a low value on health-seeking behaviour. This group commonly experiences police harassment and they fear being sent to state child care institutions, which are home to far too many young Ukrainians. Moreover staggering statistics underscore their vulnerability to HIV—nearly one in five sex workers is living with HIV, and nearly one in five sex workers is considered an adolescent. Surveys conducted in 2006 provide the following insights: 15 per cent of A-FSWs report selling sex before the age of 15; 25 per cent report using condoms at the last sexual intercourse; and 19 per cent report ever having injected drugs. The overlap in risk behaviors facilitates the rapid spread of HIV among this population.

STRATEGY AND IMPLEMENTATION
Developing a model
In 2006, UNICEF and partners3 initiated research to address critical gaps in data, including prevalence of HIV among adolescent female sex workers. Keeping in mind the lack of data on adolescents living and working on the streets, the same research team carried out a behavioural survey among street-based adolescents (N=805, age 10-19, 565 boys, 240 girls) in four regions of Ukraine, and found that a considerable proportion of these girls also face a number of risks.4

A policy and legislative review within the framework of UNICEF most-at-risk adolescents (MARA) Programming, a capacity assessment among service providers, and

3 Partners are: a local NGO UNITUS; the State City Centre for Social Services for Families, Children and Youth (CSSFCY); International HIV/AIDS Alliance with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

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CHAPTER III – HIV AND AIDS AND CHILDREN
qualitative research among A-FSWs and adolescent injecting drug users in four regions rounded out the evidence base that would guide subsequent actions. This evidence was fed into strategic planning processes at the national and regional levels. Multi-sectoral planning groups, with the participation of MARA, developed strategic action plans to guide programme design and pilot testing these programmes. Structured consultations with partners and young people, as well as advocacy with policy-makers were then coordinated by UNICEF, and drop-in centres for A-FSWs, an innovative HIV intervention model, were developed and approved by local policy bodies.

Pilot phase
For the first year, planning groups opted to pilot models in four of the most HIV-affected regions of Ukraine, including the city of Mykolayiv, a city known for its particularly high incidence of HIV among young sex workers. The project employs a model of direct provision of prevention; harm reduction and social services; and referrals to government health and social services. Clients are recruited by a locally known non-governmental organization, UNITUS, on the streets and through mobile outreach clinics, a local AIDS centre, the Women’s Consultation Centre, an STI clinic and the Criminal Police for Minors. UNITUS was already running a drop-in center for adult female sex workers, and integrated the adolescent services into the existing program. Several other key partnerships between local service centers, government clinics and the implementing partners yielded further coordination of services (see Figure 1). A common anonymous coding system across referral points enabled tracing of referrals in a harmonized manner.

Monitoring and Evaluation
The London School of Hygiene and Tropical Medicine (LSHTM) provided technical support for monitoring and evaluation. Instruments were adopted based on international guidance and a research toolkit developed by LSHTM. Monitoring and Evaluation activities included direct observation; audits; review of service statistics; review of other programme documentation; satisfaction surveys with both staff and clients; and exit interviews with clients. UNITUS and its implementing partners were responsible for routine monitoring of the intervention model. UNICEF, the State CSSFCY and the Ukrainian Institute for Social Research (UISR) with its national network of researchers conducted a process and output evaluation. For the pilot phase, biological and behavioural outcomes were not measured, as they are expected to be measurable only after 3-5 years of sustained programme delivery.

The approximate programme cost is 50,000 USD for provision of basic services in one site (Nikolayev) for one year.

PROGRESS AND RESULTS
The programme is being replicated in two other regions in Ukraine. UNICEF produced the Intervention Study Report for Mykolayiv and Case Study Reports for documenting lessons learned and provided a platform for disseminating and scaling up the experience at the national level (see Related Links). Also drawing on the experiences from the pilot phase, the National Strategic Action Plan on MARA and Children Affected by HIV for 2010-2013 was drafted through a participatory stakeholders’ process and en-

The basic service package offered to A-FSWs in Mykolayiv includes:
- Outreach and drop-in services
- Information, education (including peer education), skills-building and counselling (both individual and group)
- Social services (e.g. help with documentation for social benefits) and legal advice
- Harm reduction services (Needle exchange programme) for people who inject drugs
- Provision of commodities for HIV prevention and health (condoms, lubricants, clean needles/syringes, products for personal hygiene, pregnancy tests)
- Voluntary HIV counselling and testing (VCT), including rapid testing, with referral to HIV treatment, care and support services
- Early diagnosis and treatment of sexually transmitted infections (STIs)
- Reproductive health services
- Violence prevention through counseling and referral to professional services (health, social and police) if needed

Figure 1: Overview of the implementation structure of the intervention model*


5 UNFPA and IATT on HIV and YP, 2008; WHO et al., 2004; FHI, 2000; UNAIDS et al., 2007; WHO, 2009; Adamchak et al., 2000; UNAIDS and Asian Development Bank, 2004
dorsed by the National Coordination Council on HIV/AIDS. Additional funds were leveraged from the GFATM to expand training on HIV prevention for staff working in shelters for minors (through which many MARA go through).

UNICEF Ukraine further leveraged funding from the All-Ukrainian Network of People Living With HIV (PLWH) for advocacy work on MARA. Successful advocacy led to sufficiently large samples of adolescents (aged 15+) in 2009 HIV surveillance studies among most-at-risk populations by the International HIV/AIDS Alliance; these studies provided the basis for a secondary analysis of surveillance data on MARA in 2010. Since MARA were included in the national AIDS agenda, they were also included in the GFATM proposal in 2010 as a priority group (the proposal got approval).

Key results obtained from the pilot project are following
• In total, 117 A-FSWs were served by UNITUS and its partners within the 11-month timeframe (February-December 2009) and 11 (9 per cent) were placed in state child-care institutions while receiving services.
• 49 (42 per cent) clients agreed to be tested for HIV, and 4 (10 per cent) tested positive. 46 (39 per cent) clients were tested for STIs. Two received positive tests for syphilis and nine for gonorrhea.
• Over 90 per cent of all clients interviewed (62 out of 69) through a client satisfaction survey used the services more than once. Close to 100 per cent (67 out of 69) have already recommended the project services to their peers; and 68 out of 69 clients reported overall satisfaction, including improved HIV knowledge and skills for prevention, and better access to health care.
• A-FSWs participated actively in various aspects of the HIV intervention and one girl participated as an advocate in a meeting of the Regional Coordination Council. She discussed the significance of the programme with local stakeholders. 10 A-FSWs volunteered to refer peers to services and distribute HIV prevention information.

Advocacy results
The model supported and informed advocacy work that resulted in revisions to the national AIDS Law on age of consent for testing. UNICEF commissioned a review of the national HIV/AIDS legislation and produced recommendations for change. Arguments were presented to the MoH and Parliament by UNICEF and partners during the revision process. UNICEF was an active member of the working groups established by the HIV stakeholders during the revision process.

The advocacy efforts resulted in new, more progressive HIV/AIDS legislation that includes the following new elements:
• 14-18 year olds can now receive HIV tests without parental consent and this has become a standard practice of local AIDS centres.
• A-FSWs are also now included in the National AIDS Programme and the work of State Social Services.
• Abolishment of travel restrictions for foreigners with HIV to Ukraine (was considered as human rights violation by international community before);
• Opioid substitution therapy is now endorsed as one of the key directions of the Government's policy;
• PEP (post exposure prophylaxis) introduced as a prevention method;
• Issues of confidentiality (disclosure of HIV status) are more strictly reinforced

At this stage it is too early to measure the programme’s impact on averting new infections or improving health of clients living with HIV.

LESSONS LEARNED
1. Demand for services is high because A-SFWs are a hidden population often not served by other NGO projects. Between February and July 2009, the centers had served around 100 clients, though plans were in place to only serve 50. Active recruitment came to a halt when demand far exceeded capacity.

2. Demand is seasonal. Many adolescent sex workers migrate to the south of Ukraine during the holiday seasons and summer, leading to fewer visits to the drop-in center. However, mobile phones proved helpful to keep in contact with the girls during these times, especially in case of emergency.

3. The pilot demonstrated the importance of psychological counseling, especially as related to experiences of violence and abuse, and the critical role of close communication between the A-FSWs and social workers. The personal relationship was important to ongoing client retention and support.

4. Clients prefer to contact social workers on their personal cell phones rather than over hotlines. Cell phone conversations between social workers and clients were used to facilitate counseling, remind clients about appointments and treatment adherence. Clients were more comfortable discussing risk behavior over the phone than in person. However, this raises the need for a specific confidentiality policy on mobile phone use.

5. In Ukraine’s environment of highly vertical systems, provision of all essential services under one roof was impossible; formal cooperation agreements were found to improve linkages between systems, and access to multiple services by clients.
On-going administrative reform of the government is providing an opportunity to review the functions of social services and social infrastructure for children. Although the government traditionally does not contract out service deliveries to NGOs, the role of NGOs in service provision might be revisited in this process. The experience of this pilot project may be useful for this reform process in terms of clarifying the NGOs’ role as being central to service delivery and directly accessing the target population.

**POTENTIAL APPLICATION**
The model has great potential for becoming a good practice example for working with girls who are already engaging in most-at-risk behaviour, or are vulnerable to do so. The pilot project demonstrated that the MARA are a critical target group for the AIDS response in Ukraine and that it is possible to work with them, engage them and meet their needs in health, as well as other areas (primarily social and psychological needs). The experiences further suggest that HIV/STI prevention programmes with MARA can be successfully integrated into the existing health care, social services and the national AIDS response, and it is possible to sustain such service models. Issues to be considered when replicating include: continued advocacy for system reforms (to be MARA-friendly), strengthening of intersectorial cooperation and adequate budget allocation to sustain the interventions.

**NEXT STEPS**
The current phase of the MARA Project is crucial, as its main aim is to translate knowledge gained on MARA and HIV from the pilots into national action by acquiring knowledge and documenting what works with MARA. The knowledge gained here will be used to strengthen legal and policy frameworks; service providers’ capacity; monitoring and evaluation and co-ordination mechanisms for an effective response to MARA and HIV. The equity focus will be pursued in further data collection, analysis, policy and advocacy work to transform the current projects to national programmes.

Documenting experiences from the replication of the model in two other regions is underway, and reports will be available in 2012 with a further scale up plan. Results from the on-going administrative reform should be considered in formulating the scale up strategy.

While advocacy paid off and MARA were inserted into the national AIDS response in Ukraine, the limited overall response capacities and funding will restrict the scaling up of services for MARA. Consequently, the Government and UNICEF will review the National strategic HIV action plan for MARA and foresee strategies to strengthen the response to MARA for both the short and long term.

**RELATED LINKS**


Visit the UNICEF Ukraine website to view photoessays on the state of young people in the region: [www.unicef.org/ukraine/media_10515.html](http://www.unicef.org/ukraine/media_10515.html)
Zambia has an HIV prevalence of 14 per cent in adults aged 15 to 49 years with higher prevalence among women (16 per cent) compared to men (12 per cent). Perinatal and mother-to-Child Transmission (MTCT) of HIV accounts for about 10 per cent of new infections. Due to limited human and infrastructure capacity, as well as geographic access, the early infant diagnosis test results from a laboratory to a health facility took for six weeks, up to six months or never arrived at the facilities. This delay posed a significant barrier to mothers and families seeking timely access to antiretroviral therapy for their HIV-infected infants. The project Mwana, a mobile health (mHealth) initiative, aims to reduce this delay and improve children’s chances for a healthy life through the use of mobile technologies.

Implemented by the Zambian Ministry of Health (MoH) with support from UNICEF, the Zambia Centre for Applied Health Research and Development (ZCHARD)/Boston University and the Clinton Health Access Initiative (CHAI), the project went live in June 2010. It was piloted in 31 clinics in six provinces across the country and relayed more than 3,000 infant HIV test results. The project was designed to work even in rural areas with no mobile network. On average, the turnaround time of the HIV infant test results (from sample collection to result delivery to health facilities) has decreased by 50 per cent, with a greater impact in rural areas. The project is now going to be scaled up at the national level. This case study presents preliminary quantitative results from the pilot project, innovative aspects of the strategies, as well as the guiding principles for a rapid scale up identified together with the partners.

BACKGROUND
Zambia has an HIV prevalence of 14 per cent in adults aged 15 to 49 years with higher prevalence among women (16 per cent) compared to men (12 per cent). Perinatal and mother-to-Child Transmission (MTCT) of HIV accounts for about 10 per cent of new infections. Although the number of new HIV infections in children aged 0-14 years in Zambia has declined from 21,189 in 1996 to 9,196 in 2009, 50 per cent of newborns who contract the virus from their mothers die before the age of two, if no interventions are provided. These deaths contribute significantly to the national under-five mortality rate.

Survival rates are up to 73 per cent higher for HIV-positive newborns if they are diagnosed in time to begin treatment within their first 12 weeks of life. However, many children born to women with HIV are not being systematically monitored and are identified as infected with HIV only when they become very sick. Infants under the age of 18 months need an Early Infant Diagnosis (EID) Test to detect HIV through dried blood spot samples, which is different from the standard antibody test for adults and older children. Currently only three laboratories in Zambia offer this test as it requires sophisticated laboratory technique (DNA PCR). No other alternatives such as mobile laboratories are available in Zambia to facilitate geographical access to the EID, especially in rural areas.

In addition to the initial barrier of mobilizing mothers or caregivers to have their babies tested, transport of the samples and the test results, especially for rural clinics, is one of the biggest obstacles to having the test results available and initiating timely Antiretroviral Therapy (ART) for HIV-positive infants. Against this backdrop, in June 2010, the Ministry of Health (MoH), in partnership with UNICEF, CHAI and ZCHARD, launched a pilot phase of the Project Mwana.

1 Zambia Demographic and Health Survey. 2007. The latest estimated prevalence rate among adults of 15-49 years is 13.5 per cent (12.8%-14.1%) (Source: UNAIDS, 2009).
2 National AIDS Council; Zambia HIV Prevention Response and Modes of Transmission Analysis. 2009
STRATEGY AND IMPLEMENTATION

The overall goal of the project is to strengthen the quality and access to health services for mothers and infants in rural areas through using the Free and Open Source code-base, called RapidSMS. Two SMS applications were developed to facilitate communication between health facility workers and community-based agents by providing SMS messaging services free of charge. The following objectives of the project are also aligned with the national health strategies for Zambia.

1. Strengthen early infant diagnosis system by getting the test results from the laboratories to health facilities in a faster and more efficient manner using the ‘Results160’ SMS application.
2. Improve the rate of postnatal follow-up of mothers and infants and increase the number of birth registrations at clinic and community settings through community-health workers’ tracing by the ‘RemindMi’ application.

With the Results160 application, SMS messages are used to send the HIV EID test results from the labs back to staff in health facilities where the samples were collected. The results arrive on phones in smaller clinics and SMS printers in larger facilities. The system also tracks samples from the facility to the lab and displays the location of the samples on a website that provides real-time monitoring for the province and district officials. The tool has been designed to provide data to the district and province health personnel to monitor the performance of their health facilities and districts in terms of the HIV EID testing.

Through the RemindMi application, SMS messages are sent to trained Community-Based Agents, known as ‘RemindMi Agents,’ who look for infants and their caregivers to remind them to return to the health facility for 6 day, 6 week and 6 month post-natal check-ups; or special circumstances, such as laboratory results arriving at the facility. The tool also allows for facility staff to send specific patient tracing requests. The staff type the word TRACE and the mothers name and it sends a message to the RemindMi Agents to find that mother and remind her of the clinic visit. The Agents also register births using this application.

A preparatory phase started in 2009 with district level gap analysis and building local partnerships including collaboration with MoH. One of the challenges often raised in a project using RapidSMS is how to be inclusive - through providing the same access to areas with little or no mobile phone network coverage as to the rest of areas. During the preparation process, it was discovered that almost all facility staff living in rural areas with little network coverage would travel to areas with network coverage 1-3 times a week to use their phones for personal communication. As requested by the facility staff, the system was designed to work so that they could use it when they traveled to places with coverage.

To date, the project has been piloted in 13 predominantly rural districts of Zambia (see Map). A major focus of the project has been ensuring that both MoH leadership and local technical support by Zambian software developers are in place to make the project sustainable.

A monitoring and evaluation system has been built into the initiative. Quantitative analysis focuses on comparing the turnaround time of results getting from the laboratory to caregivers before and after the introduction of the SMS system. Various data sources are used for this analyses including: HIV testing registers in each clinic; pre and post SMS system data; comparison of hard copy and SMS results; discrepancy analysis between hard copy and SMS results; and messaging use patterns on the SMS server. Qualitative data was collected, coded and analyzed using a satisfaction survey of system users (health care workers) at clinics, district health clinics and laboratories.

PROGRESS AND RESULTS

Since February 2010, over 3,200 results have been sent by Result160 and over 4,500 post-natal reminders have been sent by RemindMi. An evaluation of the pilot project was conducted in 21 health facilities in two provinces by ZCHARD in 2011, looking at 710 EID results that were delivered from the laboratories to the facilities by SMS between July 2010 and February 2011. Key results from the evaluation are as follows:

3 According to the standard protocol by the Ministry of Health in Zambia.

4 Messaging use patterns provide a real-time overview that can be used to manage the project through web based alerts and reports. This means that problems can be addressed immediately instead of, for example, after an evaluation.
On average at national level, the turnaround time5 for EID results has decreased by 50 per cent compared to the baseline data. Among the provinces, the greatest improvement in the turnaround time was observed in the Southern Province (decreased by 57 per cent) which also had reliable baseline data (Figure 1). However, it has not yet been established whether the faster results leads to earlier ART access for HIV infected infants.

Rural areas with little or no network are performing better than urban areas in terms of the reduced turnaround time according to the hardcopy and SMS analysis. For example in the Luapula province, there was a 28 per cent decrease in the overall turnaround time by SMS messages compared to hardcopy, while a 46 per cent decrease (from 110 days to 60 days) was found in nine rural, ‘hard-to-reach’ facilities (Figure 2). Despite the significant improvement in the rural areas, the turnaround time needs to be further shortened to attain its ultimate or ‘golden standard’, which is no more than four weeks in the Zambian context6.

Increased volume of early infant diagnosis results arriving from the laboratory to health facilities by SMS, compared to hardcopy; in six provinces where the project was piloted, 30 per cent more results were received by SMS while many hardcopy results never arrived at the facility.

The birth registration component of the RemindMi application appeared to be well-adopted by community health workers who were trained on the system, based on anecdotal evidences. It is too early to know if SMS reminders through this application have significant impact on increasing adherence to post-natal appointments.

ZCHARD is in the process of conducting a formal evaluation and various studies, looking at its quantitative impact, the qualitative experience of stakeholders, and at outcome level indicators.

INNOVATION

Creating a system that takes advantage of software, phones, networks and SMS technology is a powerful innovation that has reduced delays in receiving EID test results, improved communication among health care providers and community volunteers, and encouraged women (and their infants) to return to the clinic for their post-natal checkups and test results. RapidSMS enabled the deployment of such a system easy and was customized to the exact needs of the Zambian health infrastructure.

One of the key innovative aspects of the project is that the system was designed to work in areas with little or no mobile phone network coverage, potentially reaching the most disadvantaged communities. The evaluation showed that those facilities without mobile network had roughly the same improvements in turnaround time as ones with full network coverage. This demonstrates that if an appropriate strategy is chosen depending on the local context, existence of the mobile phone network is not necessarily a prerequisite for implementing a RapidSMS project.

The project team reported two main challenges during the building of the RapidSMS systems: building government ownership of the project throughout the implementation of the project, even during the preparation phase, and coordination among the partners. Approaches used to overcome these challenges were to meet and strategize regularly during the pilot phase and to ensure that there was only one coordinating body (an SMS technical working group led by the MoH), one joint plan, and one common monitoring and evaluation framework. Based on the pilot experiences, key guiding principles for scaling up of the Mwana project were identified by the project team and partners in Zambia (Box 1).

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5 The turnaround time means the number of days it takes from sample collection to laboratory testing and results delivered to health facility. For more information, see: www.pathfind.org/site/DocServer/Kenya_EID.pdf?docID=10201

6 The ‘golden standard’ of 4 weeks for turnaround time is recommended by the Zambia Ministry of Health and is linked to the national protocol on the immunization schedule for children under five. Specific immunizations are given at birth, 6 weeks, 4 weeks after births, and so on. In hard-to-reach areas, this is very important as a caregiver will be asked to return 4 weeks after the birth (if the EID test was done), to have their infants obtain required immunizations (OPV2 and DPT-HepB-Hib2), as well as to collect the result of the EID of HIV test results.
POTENTIAL APPLICATION
The experiences from the Mwana project in Zambia can serve as the basis for future mHealth projects. With national mobile phone penetration growing at an unprecedented rate in Zambia, there is an enormous opportunity to scale up the project and explore the use of the platform for other areas in health such as PMTCT and nutrition which require diagnostic tests and results delivery for timely treatment. Partnerships with telecom companies and software developers put in place through the project will make scaling up efforts a matter of training. The cost of the development of the system was large upfront but with the will of the MoH to scale the system nationally, the potential health impact will be significant.

Additionally the entire system and supporting processes and materials were designed in a way to make a single package that can be easily replicated in other countries. By taking the existing code and tools and re-implementing it in other countries facing similar issues with early infant diagnosis and post natal visits, the investment made in the innovation will continue to pay off.

NEXT STEPS
Despite the significant contribution of the Mwana project to reduce turnaround time, there are still challenges linked to the timely detection of HIV among exposed infants and getting them on ART on time (as discussed in the Background section). The first obstacle is the issue of a child not being tested for HIV at all or who is brought to the test center too late to get ART on time. Once a child gets tested for HIV, other major obstacles for timely HIV detection and initiation of ART for HIV-infected infants in Zambia are logistic issues (transporting test samples from rural clinics to laboratories) and inadequate human resources at laboratories and health facilities. Beyond the issues related to testing and getting results on time to caregivers, access to paediatric ART remains a serious issue due to non-availability of pediatric ART services at a large percentage of ART sites in Zambia. RapidSMS technology is a powerful tool to help alleviate some of the obstacles; nonetheless these core challenges should be addressed through an integrated approach as the Mwana project goes to a scale.

RELATED LINKS
- Project Mwana blog spot http://projectmwana.posterous.com/

Box 1: Guiding principles for scaling up the Project Mwana (recommendations from the project team)

1. Government leadership
   - Involve the MoH from the beginning.
   - Integrate the project into long-term planning.
   - Leverage the existing national health systems and tools rather than creating your own
   - Integrate data into district reporting.

2. Locally sourcing
   - Employ a permanent local software development team.
   - Have a permanent project manager who can coordinate partners.
   - Create government-led working groups.

3. Cost control
   - Negotiate with telecom companies for scale, not pilots.
   - Utilize the phones people have rather than purchasing and supporting a national phone system.
   - Create district-level training teams.

4. Co-creation
   - Make decisions based on identified needs of the end users.
   - Create the tools with the people who are going to use them.
   - Test early and often; don’t worry about failing and stay adaptable.
   - Use open source tools that can be customized to local needs.

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7 mHealth (mobile health) is a term used for the practice of medicine and public health, supported by mobile devices
CHAPTER IV
CHILD PROTECTION FROM VIOLENCE, EXPLOITATION AND ABUSE
BACKGROUND

According to Annual Statistics Reports of the Department of Juvenile Observation and Protection, Ministry of Justice, the number of children in conflict with the law in Thailand was between 31,000 and 39,000 cases annually during 1998-2002 and sharply climbed up to 51,128 cases in 2007. Of the total juvenile cases during 1998-2007, around one third of children were charged with drug related offenses. The second highest, or around 26 percent, were offenses related to assets/properties (e.g. stealing, robbery, and damaging properties, etc.). Another 11 percent of children were charged with offenses related to life and body (e.g. physical assaults and murder, etc.). The recidivism rate has been between 11 and 19 percent in the past decade. Between 75 and 90 percent of young offenders were temporarily released within days pending investigation and court trial. The issue of post sentence confinement raised an important concern given that children normally served their sentence in an overcrowded facility and for a longer period of time. Therefore, in addition to its main goal of diversion, the FCGC also aimed to reduce the number of children in post sentence confinement. FCGC results from an acknowledgement on the part of key justice officials that a purely punitive system does not work and that children and youth have an innate capacity for reform and positive contribution. It is also based on an approach rooted in the understanding that some children come into contact with the law as a result of problems in their families and communities, including poverty and violence, which push them onto the streets and into risk-taking behavior.

STRATEGY AND IMPLEMENTATION

Conception phase

Representatives from the Thai Ministry of Justice learnt about the process of New Zealand’s Family Group Conferencing (FGC) during a training session on child-friendly procedures for abused children, organized by the New Zealand Government as part of the Good Governance Programme in 2000. It provided a good basis for the Ministry to explore its possible application in Thailand. Since 2003, on an annual average, more than 10 percent of juvenile cases country-wide are diverted from the formal justice system through FCGC every year. FCGC has become an accepted and standard practice nationally that influences opinion as to appropriate treatment of children in the justice system. The Ministry of Justice is currently looking into specific legal provisions particularly in the Juvenile and Family Court Act, which will further ensure the sustainability of FCGC implementation.

ABSTRACT

The number of children in conflict with the law in Thailand was between 31,000 and 39,000 cases annually during 1998-2002 and sharply climbed up to 51,128 cases in 2007. The main cause for these cases included drug related offences, stealing or damaging assets or properties, and physical assaults or murder. Under the leadership of the Ministry of Justice, the Family and Community Group Conferencing (FCGC) was formally introduced to Thailand in mid-2003 with UNICEF's support in recognition that the number of cases of children in conflict with the law was on the increase. The goal of FCGC is to divert children involved in low-level offenses away from the formal judicial system and to restore social harmony between the victim, child offender and the community. It also serves to reduce the number of children in post-sentence confinement.

Since 2003, on an annual average, more than 10 percent of juvenile cases country-wide are diverted from the formal justice system through FCGC every year. FCGC has become an accepted and standard practice nationally that influences opinion as to appropriate treatment of children in the justice system. The Ministry of Justice is currently looking into specific legal provisions particularly in the Juvenile and Family Court Act, which will further ensure the sustainability of FCGC implementation.
the New Zealand’s FGC as a diversion option in Thailand. Furthermore, other models for restorative justice such as Canada’s First Circle methodology and the Real Justice approach of the International Institute for Restorative Practices were also taken into consideration when developing the Thai model. Incorporating the component of ‘community’ made the model more receptive to interlocutors and the public as it is seen as a model similar to the traditional justice practice in Thailand. The Thai model has become the FCGC which was implemented in early 2003 with technical support from UNICEF.

How it works
It was crucial to put in place the standard of practice. The Ministry developed regulations and guidelines and has provided continued training to its staff in charge of FCGC. The guidelines provide information on the theoretical concepts underpinning restorative justice and the FCGC model; FCGC eligibility criteria; step-by-step guidance on the preparation and facilitation of FCGC; and required documentation. It was fortunate that Thailand has an existing legal provision to serve as the legal basis for FCGC even though the law was not intended for the purpose of instituting FCGC.

Although FCGC is not formally incorporated into Thai law, existing laws establish a framework and process that facilitate the use of this alternative response to juvenile crime. All children charged with a crime must be taken by the police to the Juvenile Observation and Protection Center (JOPC) within 24 hours of arrest. The Ministry of Justice has established a JOPC in each of the 76 provinces in the country. The JOPC Director can decide to hold such children under custody or may grant a temporary release to the care of the child’s parents or other suitable person or institution with or without bail. Children are held at the JOPC pending investigation and court trial if they have not temporarily been released. A JOPC is staffed with a team of professionals including psychologists, social workers and probation officers.

Criteria
Once a child is under the care of the JOPC, FCGC can be used if three criteria are satisfied:

1. The alleged offense is punishable by five years’ imprisonment or less
2. The director of the center believes the child is amenable to rehabilitation
3. The child understands and agrees to oversight by the director if a non-prosecution order is entered

In addition, FCGC is an option only if it is the child’s first offense, if the child is willing to admit guilt and take responsibility for the crime, and if the victim consents. Migrant and other non-Thai children are also eligible for FCGC. Participants in FCGC normally include the victim, the child offender, the parent/s and relative/s of the child, a psychologist, a social worker, one or more community representatives, the police investigator, public prosecutor and conference facilitator.

Expected outcomes
The conference will reach a consensus as to what the child offender is required to do to repair the harm. Options typically include an apology to the victim, community service, and/or restitution. Other creative agreements can include the child’s ordination as a novice Buddhist monk, the writing of an essay on why the act was wrong and what harm resulted, and a promise to stay away from certain activities or people. In addition to what the child may be required to do, the parents may also be a party to the agreement and be required to take steps to address the issues that brought the case into the system. As a part of any agreement, the child remains under the supervision of the JOPC for up to two years and is required to have periodic contact with a social worker or probation officer. Successful conferencing leads to a non-prosecution order and no criminal record.

PROGRESS AND RESULTS
Although UNICEF provided technical support during the early years, FCGC has been the Ministry of Justice’s own initiative from the onset. The FCGC continues to operate to date as the government’s programme and all of JOPCs are using FCGC to divert juvenile cases from the formal judicial system.

Between 2003 and 2010, the Ministry of Justice registered a total of 336,058 juvenile cases country-wide (annual average of 42,007 cases). Of those, more than 10 per cent (over 37,000 cases) were diverted from the formal judicial system through FCGC. The recidivism rate among the young offenders who underwent FCGC has been less than four percent on an average while the overall national average was 11-19 per cent (2003-2010).

A review of the Juvenile Justice system by Loyola University in 2007 found that FCGC has been largely responsible for the change in attitudes amongst justice system officials and communities that now promote a rehabilitative approach to juveniles in conflict with the law rather than a punitive approach. Although not yet established in the

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3 Article 63 of the Juvenile and Family Court Act, 2005
4 Ibid.
5 Article 50 of the Juvenile and Family Court Act, 2005
6 The rest of the cases (90 per cent) went through the formal judicial system.
FCGC has become an accepted and standard practice that influences opinion as to appropriate treatment of children in the justice system. All of the children interviewed by the assessment team reported satisfaction with the FCGC process, as did their parents. Although the reaction of victims was more mixed, they generally supported the process and the idea of "giving children a second chance."

The Ministry of Justice states that staff charged with the FCGC have quickly adapted to their role and mandate given that the concept of mediation is similar to Thai traditional justice. Since mid-2003 when the project was initiated, the Ministry of Justice has provided continued training to its staff (attached to the JOPC) on FCGC. The staff gained more confidence over time in handling FCGC.8

Based on the positive results, FCGC has become an accepted and standard practice that influences opinion as to appropriate treatment of children in the justice system. Although not yet established in the legal code, FCGC is being implemented nationally and all of JOPCs throughout the country continue to use FCGC to divert juvenile cases from the formal judicial system.

GOOD PRACTICE
The intervention is considered as a good practice for the following reasons:

1. Thailand based its conferencing model on three well-known restorative justice models: New Zealand’s Family Group Conference model; Canada’s First Circle methodology; and the Real Justice approach of the International Institute for Restorative Practices. It then adapted those models to incorporate traditional Thai community-based dispute resolution values and practices. FCGC reflects a hybrid process that aims to create a unique and culturally-specific form of diversion.

2. FCGC provides a formal avenue in dealing with juvenile cases without resorting to formal judicial process. At the same time, the number of children in post-sentence detention has been reduced. This results in increased capacity of juvenile justice actors in dealing with more serious cases in the system. As reported, on an annual average, more than ten percent of juvenile cases have benefitted from FCGC.

3. Successful FCGC cases resulted in non-prosecution order and no criminal records. It provides children with another chance in life without being stigmatized. FCGC provides an avenue for children and their parents to jointly and openly discuss problems and participate in the decision making that will affect their lives. It also gave the community an opportunity to provide support to children and families to cope with the problems that also affect the community. This led to the restoration of social harmony.
POTENTIAL APPLICATION
Within the country, FCGC is being replicated in the Far South of Thailand where there is an ongoing insurgency and has been adapted to both rural and urban settings. There have also been attempts to use FCGC as a diversion option at other points in the juvenile justice, such as before the charge has been pressed by police or court verdict has been passed. The Ministry of Justice has also started working with the Ministry of Education to implement the practice of FCGC in schools to help settle conflicts and maintain harmony to prevent cases from entering the judicial process.

Because it is based on traditional community systems of restoration, it has wide applicability in the Asia Pacific context where traditional community dispute resolution mechanisms are widespread as it has proven adaptable to local cultural beliefs and traditions.

NEXT STEPS
Although it has been implemented throughout the country, FCGC is largely dependent on policy and available resources of the Ministry of Justice. Having specific legal provisions particularly in the Juvenile and Family Court Act will ensure the sustainability of FCGC implementation. At the same time, criteria for FCGC should be expanded to benefit more children in conflict with the law. Offences that have higher punishment than five year imprisonment should be in the coverage of FCGC.

As described above, Ministries of Justice and Education are exploring possible use of FCGC in schools. Continued training and other capacity building for practitioners would also be crucial in safeguarding the rights of children involved in the procedure in different settings.
ABSTRACT
Recent economic growth in Cambodia has resulted in notable improvements and progress within the social sector. However, young children (aged 0-5 years old) continue to face many challenges related to health and their overall development, with low enrollment rate for the Early Childhood Education (ECE) services. Over the last seven years, the Royal Government of Cambodia (RGC) has been implementing comprehensive Early Childhood Care and Development (ECCD) Programmes to address these persistent issues among young children. In parallel to implementing different ECCD programme components, the RGC with support from UNICEF and other partners developed and adopted the first National ECCD Policy in February 2010, followed by an ECCD National Action Plan (NAP) prepared in January 2011 to effectively implement the policy. The process of developing the ECCD policy brought together representatives from different ministries and encouraged participation among all levels of government beyond sectoral boundaries. Although it is still early to assess the overall impact of the policy, some results are already evident in improved access and quality of community-based ECD programmes. Drawing on the results of UNICEF’s external evaluation of the ECD programme funded by the Government of the Netherlands, this case study is presented in two parts: Part I: key components of the ECCD programme in Cambodia and the impact level results; and Part II: strategies used in the formulation of the national ECCD policy and lessons learned from the process, as well as critical gaps that need to be filled in the future ECCD programme in Cambodia.

BACKGROUND
Cambodia’s history of conflict coupled with persistent rates of poverty, has presented significant challenges to improving the standard of living and protecting the rights of its children. However, economic expansion and investment in social sectors have brought some improvements in child health-related indicators. For example, the under-5 mortality rate has decreased from 124 to 54 per 1,000 live births between 1990 and 2010 (Cambodia Demographic and Health Survey; CDHS, 2010). While there have been improvements, serious threats to child survival remain. Malnutrition among children under five continues to be a challenge, and has not improved much in the past five years; 40 per cent of children are stunted and 11 per cent were wasted in 2010, compared to 43 and 8 percent respectively, in 2005 (CDHS, 2005/2010).

Children from the poorest families, ethnic minorities and those with disabilities are the most disadvantaged in terms of access to ECE. For instance, in the provinces that are predominantly occupied by ethnic minority groups, the ECE enrollment rate in the 2008/2009 school year was as low as 12 per cent for children aged three to five years (Ratanakiri province), whereas in other provinces, up to 40 per cent of children were enrolled (Stung Treng province). Reliable statistics on children with disabilities do not yet exist and the first inclusive preschools were just opened in October 2011. In order to address these challenges, the RGC set out the ECCD Programme\(^1\) to mobilize multiple sectors to improve health, nutrition, early learning and community participation to provide comprehensive services to young children.

\(^1\) In Cambodia, the term ‘Early Childhood Care and Development (ECCD)’ is used as equivalent to ‘Early Childhood Development (ECD)’ while ECD is more globally used within UNICEF.
PART I:
KEY PROGRAMME COMPONENTS

1.1. Strategies and Implementation

Building on existing initiatives
Implemented by the Ministry of Health, the Baby Friendly Hospital Initiative (BFHI) and the Baby Friendly Community Initiative (BFCI) focus on educating mothers and caregivers on appropriate infant and young child feeding. They target young children (0-3 years old). The Baby Friendly Initiatives complement the existing initiative, the Community-based integrated Management of Childhood Illness (C-IMCI), by adding the elements of exclusive breastfeeding and complementary feeding. The RGC has recently integrated components of the Baby Friendly Initiatives in the training manuals for the C-IMCI to ensure linkages between the two programmes. The same strategy has been incorporated into Cambodia’s National Policy on Infant and Young Child Feeding, and prioritized in the country’s 2009–2015 National Nutrition Strategy.

Early learning services for communities and families
Since 2004, three line ministries, with support from UNICEF, initiated the Community Preschool (CPS) and Home-based Programme (HBP). The CPS is a model of ECE for children aged three to five years old in communities which aims to increase enrollment, especially among the most disadvantaged children. These preschools were opened in communities where there was no state preschool, mostly in rural/remote areas, specifically targeting areas with low net enrollment rate and high repetition rates at primary schools. Trained community educators (CPS teachers) run classes for two hours a day, five days a week.

The HBP provides educational resources and opportunities for mothers. They are essentially weekly mothers’ groups that are led by a trained ‘core’ mother. Mothers’ groups and their children typically meet for one hour a week, twice a month. During the meetings, mothers receive instructions on how to promote children’s development and well-being. The HBP represents a culturally sensitive approach that respects preferences for small-group interactions and engages parents in a participatory learning process.

In support of the CPS and HBP, a Parenting Support initiative (PSI) has been in place since 2006, implemented by the Ministry of Women’s Affairs. The PSI organizes sessions run by community focal points for women and children. The sessions cover a range of topics on ECD including early child-

2 The Community-based integrated Management of Childhood Illness (C-IMCI) targets child health, safety, nutrition and early stimulation.
3 Ministry of Education, Youth and Sport (MoEYS), Ministry of Interior (MoI) and Ministry of Women’s Affairs (MoWA)

hood development stages, cognitive stimulation, nutrition and advice on health and safety issues.

Two of the community initiatives- CPS and PSI- have been implemented through existing structures at the commune level and also supports the RGC’s current strategy of decentralization which aims to guide the Commune Councils in taking responsibility for facilitating access to social services for children.

Community participation and action
A capacity assessment of the Commune Councils for Women and Children (CCWC) carried out by the Ministry of the Interior and UNICEF in 2009, found that in a short period of time, local entities became more active in contributing to the creation of an enabling and protective environment for young children and their families. Each participating partner plays a unique and vital role in realizing the achievement in ECCD at the community level. For example, several Commune Councils offered incentives to preschool educators within their communities to help promote and sustain ECCD activities. The need for construction and renovation of preschool facilities not only generated income for members of the community, but also increased their sense of contribution to and participation in ECCD. Furthermore, the programme has set a working example for decentralization of administration and oversight functions of community-based social services, which enhance the capacity of duty-bearers to provide appropriate care for young children to survive and develop to their full potential.

1.2. Impacts of the ECCD Programmes
Between 2008 and 2010, UNICEF supported a global evaluation of Early Childhood Development (ECD) programmes in 10 countries including Cambodia. The evaluation assessed the status of ECD strategies and activities, and also the factors that influenced processes towards achieving the outcomes, primarily through qualitative methods (e.g. key informants interviews), but incorporating survey data as well. The evaluation found that the programme provided an opportunity
for Cambodia to apply a comprehensive ECCD programme in selected communities. Key impact-level results obtained through the evaluation and other surveys are as follows:

**Increased enrolment rates**
The enrollment rate of children in preschools was almost doubled in the last five years: from 13.6 per cent in school year 2005/2006 to 25.5 per cent in 2010/2011 among children aged 3-5 years old, and from 27.3 to 46.2 per cent among children five years of age (See Figure 1). In 2010/2011, the enrollment rate for girls 3-5 years old was 26.3 per cent while for boys, it was 24.8 per cent. Rates of enrollment have also improved in the two predominantly ethnic minority provinces, although the gap in the enrollment rate between the national average and the Ratanakiri province appeared to be almost doubled (from 7 per cent in 2005/2006 to 13 per cent in 2009/2010: Figure 2). Further analysis on inequalities based on the disaggregated data (e.g. by poverty quintiles) is ongoing.

**Effectiveness of the community-based programmes**
From 2007 to 2010, a longitudinal study was conducted to evaluate the impact of CPS and HBP on enrollment rates and learning achievements of children once they transitioned into primary school. The study found that both CPS and HBP are equally successful in boosting school outcomes for children (e.g. correct entry age to primary school and low dropout and repetition rates) not only in the first grade, but for subsequent years as well. The results among children who attended CPS or HBP were comparable to those who went through the state preschools. This finding encouraged the government and partners to further scale up these community and home-based ECCD programmes.

**Increased coverage**
In six UNICEF-supported provinces, coverage for the C-IMCI module on breastfeeding and complementary feeding was 57 per cent in health centers and 53 per cent of villages were covered as of 2010. A qualitative evaluation of the initial implementation of the community care

of mothers and newborns package, revealed significantly higher levels of knowledge and appropriate practices in villages where the intervention took place. Little has been tracked concerning the need for and coverage of the training events focused on direct service providers and parents, particularly for services that are not delivered in a preprimary classroom or group care setting.

**Improved parental knowledge and practice**
Parents participating in focus group discussions during the UNICEF-supported evaluation reported that they learned about the importance of sending children to school as well as the importance of good hygiene practice which many parents passed on to their children. The Baby Friendly Initiatives have successfully supported an increased national rate of early breastfeeding from 35 per cent in 2005 to 65 per cent in 2010, and exclusive breastfeeding for the first 6 months from 60 per cent in 2005 to 73.5 per cent in 2010 (Cambodia DHS, 2005/2010).

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7 Arianna Zanolini for UNICEF Cambodia, ECE Longitudinal Study, 2011
PART II: FORMULATING A NATIONAL POLICY

2.1. Participatory process and strategies
Merging all of the ECCD-related efforts into one, the government initiated the development of the country’s first National Policy on ECCD in October 2008 through national consultations with various ministries and stakeholders. As a part of this process, a study tour to the Philippines was organized for core officials to learn from their experience in implementing an ECCD programme and to review relevant international policies. Following the study tour, an inter-sectoral, inter-ministerial, technical committee was established to lead the participatory process of ECCD policy development. These efforts resulted in the development of a new ECCD policy which was approved by the Council of Ministries in February 2010 (see Box 1). Following the creation of the policy, the National Action Plan is currently being finalized and approval is pending.

2.2. Lessons learned
Based on the results from the global evaluation mentioned above, the following factors that contributed to successful implementation of the ECD programme were identified and elaborated by UNICEF’s office and partners in Cambodia.

- **A long-term commitment to articulate shared goals of improving outcomes for children and families.** The development and approval of Cambodia’s National ECCD Policy has been in process since 2005, including periods of limited activity or constrained progress. Regardless, UNICEF and its partners have remained engaged in the effort throughout the process to ensure passage and enactment of the policy. Meanwhile, education- and health-specific policies and plans moved toward incorporating goals and strategies in support of ECCD. These sectoral commitments to ECCD were helpful in delineating the roles and responsibilities of individual ministries in the national policy.

- **Ability to coordinate a large-scale collaboration across government ministries at the national and subnational levels.** Participants in the ECCD policy-creation process noted that the adoption of the policy was facilitated by clarifying each ministry’s role in ECCD and placing emphasis on the idea that the coordinating ministry’s function would not impinge on the responsibilities or purview of other ministries. The policy development process was participatory, which evaluation respondents noted as an important aspect of its success and the primary reason for broad commitment to its implementation.

- **Building on existing policies where possible.** Although Cambodia had policies and practices that included sectoral ECD policies and intervention approaches, the enactment of the intersectoral National Strategic Development Plan from 2009-2013 served as the foundation for the development and approval of the National Policy on ECCD.

- **Decentralization of responsibility for ECD services.** The most successful approaches to increasing the potential for sustainability seemed to be those that brought about a sense of local ownership and responsibility for ECCD services, as well as a demand for these services among parents and other community members. For example, UNICEF Cambodia office staff and government officials reported that the decentralization of responsibility for ECCD services has increased the sense of ownership and commitment to ECCD at provincial and local levels. According to the capacity assessment conducted by the Ministry of the Interior and UNICEF in 2009, the 422 UNICEF-supported communes have demonstrated increased capacity in data use, planning and reporting, and leveraging resources for social provision through the

Box 1: Cambodia’s first national ECCD policy
Aligned with Cambodia’s National Strategic Development Plan 2009-2013, the new ECCD policy stresses the provision of integrated, holistic ECCD services for all children from conception to age six by supporting their survival, growth, development and learning. The policy underlines the importance of providing care and development services to children who are poor, disadvantaged and vulnerable. The policy also calls for cross-sector and multi-level government collaboration, aimed at building upon previous plans and strategies to improve educational development for children. It designates the Ministry of Education, Youth and Sports (MoEYS) as the coordinating agency for the policy and specifies roles and responsibilities for ECD across 11 ministries, parents and families, development partners and civil society. It is important to note that the recently approved National Social Protection Strategy for 2011-2015 supports implementation of the ECCD Policy.
decentralized planning and budgeting system. Documentation of these decentralized capacity development experiences has influenced the formulation of the 10-year National Programme for Sub-National Democratic Development 2010-2019, with clear and functional assignments to commune, district and provincial councils.

e. Need for cost analysis data. During the UNICEF-supported evaluation, respondents agreed that the data on costs would be critical to informing Cambodia’s ECCD policy implementation and that a more comprehensive costing effort that addressed all of the service approaches was needed. For example, it is essential to conduct an analysis of budget allocation and financing for ECCD services and initiatives in the country, per capita costs of ECCD services, as well as simulation of financing options. Results from these analyses will help the government plan the implementation of the ECCD policy, especially make decisions on whether and how to scale up the different components of the ECCD programmes.

POTENTIAL APPLICATION

Effective ECCD policy development and implementation requires an integrated approach. The Cambodian experience demonstrates that although it takes time and resources to build intersectoral teams with common goals and strategies, ultimately, it can lead to a harmonized, coordinated and more efficient approach that can potentially be effective in fulfilling holistic children’s rights. From an equity perspective, it is clear that the most deprived children suffer from multiple deprivations and therefore, an integrated approach has the power to address multiple and cumulative risks simultaneously.

NEXT STEPS

The next step is to support ECCD policy implementation at the local (community) level, and ensure sustainability of the results. In order to achieve this, the priority must be to provide access to comprehensive services for the most deprived children including those with disabilities/developmental delays and children from ethnic minority groups.

RELATED LINKS


8 Ministry of the Interior, UNICEF Cambodia, and VBNK. CCWC Capacity Assessment. Phnom Penh, Cambodia: UNICEF Cambodia, 2009 (The assessment was done through field visits, consultative meetings with multiple stakeholders and in-depth interviews)

BACKGROUND

The Government of China embarked on a national wide poverty reduction policy programme starting in 1986. In 2001, the Government initiated a 10 year Rural Poverty Reduction Programme, coordinated by its agency LGOP (The State Council Leading Group Office of Poverty Alleviation and Development). The Programme is currently in its second phase. The LGOP provides special funds for poverty reduction projects, focused mainly on 592 officially recognized poverty-stricken counties. Until now, this Programme has concentrated mainly on stimulating pro-poor economic development through projects that promote job creation, income generation and the development of marketable skills by the rural poor.

While the Rural Poverty Reduction Programme focused on economic development of the rural poor, investments on social development have been a lower priority. Furthermore, although China has seen great progress in poverty reduction in the past decades, child poverty has not been a focus area for the LGOP. No research had been conducted on child poverty issues. There was a need to rigorously measure and document the extent of child poverty whether through an income based or multidimensional approach. As a response to these gaps, in 2007 UNICEF’s office in China started work with LGOP on child poverty issues.

STRATEGY AND IMPLEMENTATION

The collaboration between UNICEF and LGOP led to a special focus on reducing child poverty within the national Rural Poverty Reduction Programme. Under this collaboration, UNICEF has provided support and technical assistance to the LGOP to:

1. Highlight that child poverty should be looked at as distinct from adult poverty
2. Conduct research to understand the child poverty situation in China
3. Design and pilot schemes that identify the dynamics of child poverty alleviation at the local level

Situation analysis on Child Poverty

A conceptual framework for child poverty (Figure 1) was developed, by delineating its relationship to adult poverty and the role of child-focused interventions in the larger poverty reduction programmes. Based on the conceptual framework, a situation analysis was designed and implemented together with LGOP, as a part of the UNICEF’s
The study targeted two provinces (Gansu and Hubei) which represent the Western and Central regions where development indicators for women and children lag behind compared to the Eastern part of the country. A quantitative survey was conducted with 3,301 households and in-depth case studies were developed for two selected provinces (Gansu and Hubei). In 2009, the situation analysis of child poverty was completed.

Piloting revised Rural Poverty Reduction Plans
Based on the results from the situation analysis, in 2010, initial steps were taken to incorporate child deprivation and measures into the Rural Poverty Reduction Programmes at village level. The components included nutrition, early childhood development, clean water, housing and social services for children left-behind by migrant parents. These components varied village by village, based on the local context. The selected villages are nationally defined poverty stricken areas. The programmes were then pre-tested in villages.

The pilot programmes followed a participatory approach through extensive consultations with local communities, including children, women, men, care-takers, public service providers and local officials on related components. As a first step, an assessment was undertaken to determine the extent of the existing poverty reduction programme in the selected villages, the real needs among children and how to prioritize and address them. The assessment also investigated the main challenges in tackling child poverty as identified in the situation analyses. Based on the assessment, revised village development plans were developed in each village and the budget was also reallocated from the ‘Comprehensive Development Funds’ received by the villages from the government.

Advocacy
In parallel, UNICEF invested in raising awareness of LGOP officials on child focused poverty reduction. A series of national, regional and provincial workshops were held between 2007 and 2011, addressing the difference between child and adult poverty, multi-dimensions of child poverty and main social protection measures to address child poverty. Different advocacy materials (e.g. calendars, diary and mouse pad) were developed and distributed to LGOP staff throughout the country.

As part of its continued advocacy, since 2007 UNICEF has been presenting new information and perspectives on child poverty issues at the annual UN-LGOP International Poverty Reduction Day Conference, held every October 17. In a major step toward further elevating awareness of child poverty issues in China, in May 2011 the first Child Poverty and Development Forum was held in Hangzhou, co-organized by UNICEF China and the LGOP. The forum provided valuable insights into Chinese and international experiences as inputs into the development of China’s poverty alleviation policy 2011-2020.

PROGRESS AND RESULTS
Following the approval of the relevant sector and community authorities, the new or strengthened child-focused components were included in 10 revised development plans at village level in three districts, where complementary policy measures were identified and tested on a pilot basis. In addition, pilot provinces have incorporated child poverty components into the national 10 year Rural Poverty Reduction Strategy (2011-2020) and Social Economic Development Plan (2011-2015).

By addressing multiple deprivations faced by children, a
broader and more comprehensive Rural Poverty Reduction Programme will help to ensure the survival, development and protection of the most vulnerable children in rural China. Special attention will be given to the difficulties faced by millions of ‘left-behind’ children in poor rural counties, where large-scale out-migration has left them in the care of grandparents or others. By investing more in poor rural children, it is envisaged that the Programme will improve these children’s future capabilities and thus their opportunities in adulthood, thereby helping to overcome ‘poverty traps’ and break the inter-generational transmission of poverty.

INNOVATION
As a result of this initiative, for the first time in China, child poverty has been documented and included at various levels of poverty reduction policy from national to provincial and lower levels. This experience is a successful example of policy making and implementation in a highly decentralized system, highlighting a two pronged approach. First it includes a top-down approach where the national situation analysis on child poverty – which for the first time recognized the difference between child poverty and adult poverty in China – addressed the special needs of children. This created high-level recognition of the urgent need to include children’s needs in the new ten years poverty reduction programme at the national level. This recognition was fortified by high level policy advocacy and awareness raising.

Second, a bottom-up approach used here demonstrated the effectiveness of child-focused components in rural poverty reduction programmes through implementing participatory pilot programmes in selected villages. These pilot interventions are closely monitored by the LGOP for possible replication to other villages and lessons learned from this process have shaped the national policies on poverty reduction.

POTENTIAL APPLICATION
Multidimensional Child Poverty Studies are being carried out in a large number of countries and the Global Study on Child Poverty and Disparities alone has 55 participating countries. Specifically, the experience of conducting a situation analysis (or Child Poverty Study) in China is relevant and can potentially be applied for the following purposes:

Middle income countries: Each year there is an increase in countries that graduate from low income country status to middle income status. Commonly, this graduation has little significance to the most deprived children within countries. While income averages have increased so has inequity, in fact the bulk of the world’s poor now live in middle income countries. Most UNICEF offices in middle income countries have limited budgets, hence investing in policy is cost-effective. These country offices in middle income countries have an increased opportunity to engage with governments on the issue of equity and disparities and the China child poverty process shows the relevance of UNICEF engaging in policy advocacy in middle income countries.

Equity: The child poverty initiative in China provides a practical tool to further advance the development agenda with an equity focus. By demonstrating that the most vulnerable children experience multiple deprivations, the multidimensional child poverty measure raises awareness of disparities within countries, regions, income groups, ethnic or other minorities. The presence of combined deprivations is particularly important for identifying the most vulnerable children.

National ownership: the child poverty process in China shows the importance of establishing and fostering partnerships with the most relevant government ministries and local authorities to enhance official commitment towards long term sustainability around child sensitive public policy. The Chinese government officials at different levels were involved at all stages including data collection, pilot phase and field visits. The evidence based advocacy led to increased leveraging of Government development funds for poverty alleviation at the local level and the allocation of resources to cross-cutting issues.

NEXT STEPS
Building on this breakthrough requires intensification of the pilot work which is currently underway. Additional focus is required on scaling up the poverty reduction programmes by linking grassroots pilot experiences with the implementation of the national strategy 2010-2020. Furthermore, the multidimensional nature of child poverty requires a comprehensive and cross-sectoral set of policy responses, beyond the purview of the LGOP.

Under the new 10 year national poverty reduction strategy, UNICEF is currently engaged in discussions on the establishment of a comprehensive child welfare system with a range of national counterparts. The experience from the child poverty study and the pilot rural poverty reduction programmes will provide important inputs to this work.
BACKGROUND

The International Monetary Fund (IMF) estimates that Guatemala’s economy will grow by 2.8 per cent in 2011 and 3.0 per cent in 2012, largely a result of increases in exports, foreign direct investment and remittances. This positive growth trend reflects a major turnaround from 2009 when the economy grew at a meagre rate of 0.5 per cent. While recent projections suggest that recovery is well underway in Guatemala, the economic growth has not reached all quintiles of the population. To cite just one example, the basic food basket remains above the minimum wage level. This has clear nutritional implications for vulnerable children and their families.

Although children and adolescents constitute 48 per cent of the total population in Guatemala, less than 20 per cent of the national budget is invested in this age group. Overall low taxation rates result in a modest national budget, which was just over US$7.0 billion (or 15.6 per cent of GDP). The limited budget has prevented increases in social investments and led to low educational coverage, high malnutrition levels among children and high child mortality rates, especially in rural areas and among indigenous populations. The electoral campaign in 2011 was seen as an historic opportunity to bring the issues that affect children and adolescents to the fore in national debate. Since 2008 UNICEF, the ICEFI and other partners have analysed the impact of the global economic crisis on children and adolescents, which has led to an evidence-based advocacy campaign.

ABSTRACT

While there has been some recent economic growth in Guatemala, signalling a recovery from the global economic crisis, its effects on children and adolescents are not yet visible. Since 2008, UNICEF’s office in Guatemala has supported measuring the impact of the economic crisis on the most vulnerable populations, including children and adolescents, in collaboration with the Central American Institute of Fiscal Studies (ICEFI) and other partners. The analyses examined the multi-faceted aspects of the impact of the crisis, providing evidence to inform national dialogues on public policy. Based on this analysis, in October 2010, ‘Te toca’ (It’s your turn), a large multimedia advocacy and communication initiative, was launched with the aim of impacting the 2011 electoral process. Ultimately, ‘Te toca’ seeks to obtain a commitment from the new government to eradicate hunger, violence and impunity. The results of the electoral campaign will have a significant impact on the implementation of policies and actions of national and municipal public institutions beyond 2012. This case study describes the process of generating knowledge on children and adolescents in the context of the economic crisis and how the knowledge fed into formulation of policy recommendations and subsequent advocacy efforts.

STRATEGY AND IMPLEMENTATION

The analyses consisted of a review of public spending on children and adolescents, studies on the situation of children during the economic crisis, disasters and migration, and costing exercises to overcome programmatic and financial bottlenecks. Methodologies included qualitative perception studies, opinion polls and national public investment studies as well as national household surveys. Based on the results from the analyses, a series of publications were issued (see Related Links).
The Contamos series: analysis of public investment in children and adolescents

In 2009, ICEFI and UNICEF developed a methodology called ‘Contamos’ (We count) to measure national public investments in children and adolescents. The methodology differentiates direct public expenditure (e.g. on primary and secondary schools) from indirect ones (e.g. subsidies to build affordable housing) and calculates the proportion of the budget that represents the population between 0 and 17 years of age against the total population. Using this methodology, UNICEF and ICEFI published four reports known as the ¡Contamos! (or ‘We count!’) series during 2009-2011. The first two reports ¡Contamos 1! and ¡Contamos 2! analyzed the national budgets of 2010 and 2011 through a child and adolescent lens. The ¡Contamos 3! examined public spending on children and adolescents in 2009-2011, a time period when the economic crisis had a greater impact on public finances. These publications target different government institutions, the parliament, universities and research centers, and civil society, as well as other UN agencies in Guatemala.

Monitoring the situation of children and adolescents in the economic crisis

The partnership with ICEFI has also allowed monitoring of the situation of children and adolescents in relation to the economic crisis. In November 2010, UNICEF published the report, ‘The perfect storm: Impact of climate change and the economic crisis on children and adolescents’, which lists the effects of the global economic crisis, rising food prices, natural disasters due to climate change, and the loss of jobs, among others, measured by qualitative and quantitative surveys, as well as other information sources. Following this publication, in 2011, ICEFI and UNICEF conducted costing analyses to improve the country's public services in relation to children and adolescents. For example, with regard to nutrition, a costing of policy options to eradicate hunger among under-five children was undertaken, which included analysis of the causes and determinants of malnutrition and identified major bottlenecks. It further recommended the amount of the budget to be earmarked to end hunger between 2012 and 2021 (USD 154 million) and a need for a comprehensive tax reform to fund it.

Household surveys on migration

Due to the impact of the economic crisis on migration patterns, UNICEF participated in the International Organization for Migration's (IOM) surveys on migration which took place in 2009 and 2010 in Guatemala. This allowed UNICEF to access historical migration survey databases covering the 2006-2010 period. Using this information, UNICEF developed a report ‘Going North’, which analyzes the risks of migration and describes the changing profile of migrants and of Guatemalan households benefiting from the remittances. The study also discusses how violence (e.g. caused by organized crime and drug trafficking) influences and impacts the lives of Guatemalans in the context of migration, specifically highlighting the issue of the high impunity rate.

Building a large advocacy campaign

All of the above mentioned analyses formed a strong evidence base for advocacy efforts in light of the presidential, legislative, departmental and municipal elections in 2011. Starting in 2010 and continuing throughout 2011, UNICEF Guatemala has held meetings with various political parties to inform them of the situation of children and adolescents in the context of the persistent economic crisis and the policy implications.

The advocacy efforts are reinforced by the national awareness campaign ‘Te toca (It’s Your Turn)’ led by UNICEF and supported by Plan International, a NGO, and the media. Launched in 2010 and using multimedia channels and communication materials, ‘Te toca’ promotes the participation of civil society in seeking the commitment of the new government to eradicate hunger, violence and impunity. The campaign also demands that authorities identify which resources will be earmarked to address these issues and how they will be funded. The budget analysis and projections were further used to inform the incoming government authorities of some of the fiscal measures that the country needs to address in order to, for instance, reduce chronic malnutrition. To date, more than 69,000 people are following this campaign on its Facebook page where interactions and discussions with the campaign supporters is being facilitated.

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7 The rate of impunity exceeds 95 per cent of total crimes and offenses in Guatemala according to UNHCR estimates
8 [www.facebook.com/TeToca](http://www.facebook.com/TeToca)
INNOVATION
Drawing on UNICEF’s efforts to understand the impact of the economic crisis on the well-being of children and adolescents, the initiative developed a platform of knowledge and evidence based on diverse analyses and studies. Ultimately, the evidence demonstrated that children were the most affected by the crisis, and provided civil society with tools and information to participate in the social media campaign to advocate for increased investments in poor children and their families. It is important to note that although UNICEF’s logo was behind the campaign, Guatemalan nationals from different sectors actively participated in all the mass media pieces produced.

POTENTIAL APPLICATION
Economic crises and budget cuts are likely to be a recurring challenge for governments across the world. It is therefore imperative that countries consistently carry out child-sensitive public expenditure analyses in order to identify cost-effective programmes as well as options to increase fiscal space, even in times of crises, so that children and marginalized populations are safeguarded during periods of budget contractions. In the case of Guatemala, situation analyses and evidence-based policy making processes were linked to the national election campaign in 2011, which entailed a great synergy of the advocacy efforts.

NEXT STEPS
UNICEF will continue to work with ICEFI on analyzing national public investments in children and adolescents, as well as monitoring the proposed national development plan to inform and strengthen state institutions, especially those responsible for protecting children and the most vulnerable. By the end of 2011, the remaining series ¡Contamos 5-8! will be published, which will focus on the priority needs of children and adolescents in development plans to be implemented between 2012 and 2021.

In addition to the ongoing analyses being carried out, UNICEF conducted a rapid evaluation of disadvantaged municipalities to more accurately identify the location of vulnerable groups who should be prioritized in terms of public policy and budget allocations. This report will be available in December 2011 and will further support UNICEF’s policy advocacy efforts.

Given the recent change of political power, UNICEF is taking advantage of ongoing discussions to launch a new national development plan, which will impact future fiscal decisions. Within this debate, UNICEF and its partners are lobbying for the overall national budget to be increased by more than three per cent of GDP (15.2 per cent to 18.5 per cent) so that campaign promises and key child-focused
development objectives can be fulfilled. The advocacy campaign will also continue during 2012 to disseminate the results of a close monitoring of ongoing and planned social investments in children.

RELATED LINKS

Crisis, climate change, migration
The perfect storm: Impact of Climate Change and the Economic Crisis on Children and Adolescents. November 2010
Spanish (Sp): www.unicef.org.gt/1_recursos_unicefgua/publicaciones/La%20tormenta%20perfecta%20Guatemala.pdf

Migration, impunity, violence, crisis
En: www.unicef.org.gt/1_recursos_unicefgua/publicaciones/Going_North.pdf

Migration, crisis
Sp: www.unicef.org.gt/1_recursos_unicefgua/publicaciones/Cuaderno%20de%20Trabajo%20No.%2027.pdf

Budget, crisis, malnutrition, hunger
¡Contamos 4! Analysis to reduce hunger in Guatemala 2012-2021. August 2011
En: www.unicef.org.gt/1_recursos_unicefgua/publicaciones/BoletinCostoHambreENG.pdf

Budget, crisis, rights
¡Contamos 1! Analysis on the implementation of Guatemala’s national budget aimed at children and adolescents (August 2010). November 2011
Sp: www.unicef.org.gt/1_recursos_unicefgua/publicaciones/contamos_1.pdf

¡Contamos 2! Analysis of the national Budget 2011 focused on children and adolescents. November 2011
Sp: www.unicef.org.gt/1_recursos_unicefgua/publicaciones/contamos_2.pdf

Sp: www.unicef.org.gt/1_recursos_unicefgua/publicaciones/contamos_3.pdf

11 Source: ICEFI (Spanish) www.icefi.org/articles/costo-planes-de-gobierno-guatemala

Sp: www.unicef.org.gt/1_recursos_unicefgua/publicaciones/Cuaderno%20de%20Trabajo%20No28.pdf
CHAPTER VI
EMERGENCIES
BACKGROUND
Ensuring access to basic household, personal and hygiene items (often referred to as Non-Food Items or NFI) to ensure the well-being and survival of emergency-affected children and their families is an essential component of UNICEF’s Core Commitments to Children in Humanitarian Action (CCCs)\(^1\). Provision of essential household items and emergency shelter materials has been a core component of UNICEF and partners’ relief programmes for displaced, returning displaced and other disaster-affected populations since 2004.

Humanitarian NFI assistance programs have traditionally been supply-focused and undertaken largely as logistics operations consisting of procuring, moving and distributing relief items. While UNICEF’s standard DRC emergency household kit used in direct distribution programs has been designed and modified based on inputs from affected communities and is composed of the key items an average family in the DRC might need, it is still a pre-defined ‘one-size-fits-all’ package. Programmes based on direct distribution of a standard ‘kit’ often do not respond as effectively to the priority needs of households which often vary significantly depending on the individual family’s situation and local context.

Building upon existing relief programs for emergency-affected populations which include a significant NFI component, UNICEF and partners created the cash-based voucher NFI fair approach to allow beneficiaries to select goods and supplies according to their own priorities, leading to improved efficiency in NFI assistance as well as greater participation of affected populations.

STRATEGY AND IMPLEMENTATION
Objective and target: The objective of the NFI fairs is to improve the living conditions and reduce the vulnerabilities of emergency-affected families without access to basic items necessary for their survival and well-being by providing them access to such items according to personal choice. The NFI fair concept is straightforward.

Instead of receiving a standard, pre-determined package of relief supplies, families receive vouchers with different monetary values which they then use to purchase

\(^{1}\) UNICEF’s partners in the NFI Fair methodology and other cash-based relief programs have included AVSI, Caritas Développement Kindu, Concern Worldwide, CRS, IRC, NRC, and Solidarités International.
basic household and personal items at a special market or ‘fair.’ The strategy is used to assist communities affected by population displacement where an assessment of household vulnerability has revealed a critical lack of basic NFI and where an analysis of the local and regional commercial sector indicates that the fair approach will be viable.

Preparing for the fair: Depending on a market analysis of the area, the total value of the vouchers can range from $40-$100 per family, with each family receiving the same amount at any given fair. The vouchers are printed with dots representing their value in order to help illiterate beneficiaries easily identify the value of each voucher. For each fair, 40-80 participating traders are identified from local and regional markets and are provided with information from needs assessments as to which types of NFI families have said they need most. Partners also encourage producers and traders of locally-made items such as baskets, wood products, locally-made cookware, and even toys to participate. Different methods are employed by partners to ensure that prices reflect those of the local markets, where competition between vendors keeps the prices reasonable and bargaining is the norm. Vendors are allowed to bring any type of NFI they wish to sell (only food, seeds, medicine and livestock are not permitted).

Women as the family representative: The female adult in the households are registered to represent the family at the fair. This ensures that in polygamous families, all wives and their children benefit equally from assistance. Women are selected to represent the families at the fair in part because the majority of items available and purchased are linked to household activities primarily undertaken by women and girls—food preparation and storage, fetching water, cleaning clothing and utensils, and certain livelihood activities. While for slightly more than half of the families (52 per cent), women reported that they were accompanied by their husbands to the fairs, monitoring of the programme reveals that women tend to be more involved than men have been in family decisions on what to buy, although this varies significantly by province (see ‘gender equality’ under the Good Practices section below).

A typical fair day: After receiving their sheet of detachable vouchers, the registered beneficiaries enter the fairgrounds where vendors have set up their market stalls to display their wares. Beneficiaries can compare items and prices, handle the merchandise, select sizes and colors, and haggle for prices just like at a regular market. Families are free to choose from a vast array of items. Staff from partner NGOs were on site to assist women and families who may need extra help in using the vouchers. At the end of the fair day each vendor’s vouchers are tallied up; vendors are paid later on in a secure setting in cash, by check or bank transfer for the value of their vouchers. A typical fair day reaches 500-600 families and depending on the total number of families to be assisted in targeted areas, partners may organize up to five or six days of fairs for a given zone at the same fair site.

Monitoring system: After initial pilots in 2008, UNICEF and partners scaled up the number of fairs and designed an intensive monitoring system to gather information from both beneficiaries and vendors. Over 1,600 beneficiaries

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2 While ideally, organizations might want to link the total value of the vouchers a household receives to the family size, UNICEF and partners do not adjust the value of vouchers distributed according to family size for two primary reasons: 1) during humanitarian operations where the rapidity of response is among the key priorities, the time needed to register and verify household size and then tailor voucher amounts to each family could negatively impact the agility and rapidity of the response; 2) this approach is more pragmatic since it reduces the risk of fraud (families might be tempted to claim additional family members in order to receive more vouchers). Monitoring has revealed no significant complaints by families about this method.

3 Vouchers are color coded and specially stamped for the day of the fair to avoid risks of vouchers being fraudulently copied

4 A typical fair will feature dozens of different types of items ranging from clothing to foam mattresses, locally-made mortars and pestles to rubber sandals, aluminum roofing sheets to small suitcases, soap to flashlights. There are also items used to restart livelihood activities: farming tools, bicycle parts, or large cooking pots for home-based ‘restaurants.’
were surveyed as well as several hundred vendors on site at fair days and 713 households were reached in post-fair monitoring some month later. Dozens of focus group discussions were also conducted with beneficiaries and vendors, as well as lessons learned workshops with partners. The monitoring included detailed examinations of purchasing patterns – disaggregated by beneficiary type, province, and the person who represented the family at the fair; general issues of satisfaction with the method and recommendations for improvement; issues related to gender, protection and vulnerable groups; and what vendors did with their earnings. This initial monitoring was designed to examine the effectiveness of the fair method in meeting families' needs as well as feasibility questions for improving and expanding the method. NFI fairs have now become a part of regular emergency programming, and UNICEF and partners have developed modified tools and approaches to ensure continued monitoring and analysis of the approach.

**PROGRESS AND RESULTS**

Using the NFI fair approach, UNICEF and partners have reached more than 157,000 emergency-affected families or estimated 785,000 people\(^\text{5}\) between 2008 and 2011 (data as of November 2011). The fair method is now being employed by UNICEF partners in six different provinces and adapted for a variety of different beneficiary groups—including displaced persons, host families, returnees, Congolese economic migrants expelled from Angola, and victims of natural disasters.

The fair approach has a multiplier effect within the local economy by infusing cash into the local markets as opposed to sending these resources outside the country as is the case when procuring relief items from large suppliers abroad. In 2011 alone, UNICEF partners have paid out a total of more than $5 million to hundreds of local vendors allowing them to expand their capital, open new shops, hire additional employees and contribute to the recovery of the local commercial sector. Since starting the fair approach beneficiaries have purchased more than $11 million of household and personal NFI from vendors at fairs. In 2012 UNICEF plans to conduct a detailed market impact evaluation through the ARCC (Alternative Response for Communities in Crisis) initiative to better understand and map the impact of this injection of money into the local economy.

**GOOD PRACTICE**

During the period of intensive data collection, UNICEF partners surveyed 1,688 beneficiaries the day of the fairs and 713 households in post-fair monitoring in three different provinces. While UNICEF and partners are finalizing the analysis of the data from monitoring and conducting follow up research to confirm and better understand some of the initial findings, many of the preliminary results are available as of late 2011 and are used in the analysis to identify and justify the following ‘good practice’ components.

**Beneficiary preference and dignity.** The NFI fairs are grounded in the respect for the dignity and rights of the affected families as they allow them to participate directly in their own assistance. The extensive monitoring conducted by UNICEF partners has indeed revealed overwhelming preference for this approach: 97 per cent of beneficiaries report a strong preference for fairs over direct NFI distributions. Initial concerns that local suppliers might not be able to provide high quality supplies seem unfounded: 87 per cent of beneficiaries report that the quality of items available at the fairs is 'very good'; only 1 per cent said quality of items was 'not good.'

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\(^\text{5}\) Calculated by average five persons per household.
One size does not fit all. While UNICEF and partners will continue to assist emergency-affected families through direct distribution of NFI—and will sometimes combine fairs with the direct distribution of some items—the standard kit approach is based on what is often a flawed one-size-fits-all analysis of need. The fair approach recognizes that beneficiaries themselves are the best placed to decide and select what they need. The extensive data analysis has confirmed in striking ways how diverse families’ choices indeed are: among families surveyed in over 30 different fairs in three different provinces, interviewers found more than 800 distinct combinations of purchased goods. Even those families who bought the same major categories of articles with their vouchers chose to spend different amounts of money on those articles.

Gender consideration. Beneficiary choice is at the core of the fair approach, yet project implementers are sensitive to the fact that gender and power dynamics within individual households may disempower women from the decision-making processes as to what the household will purchase at the fairs. Results, however, indicated that this has not been a significant problem. As noted above, women are asked to represent their families as the ‘buyers’ during the fair. Households are also encouraged to discuss what they will buy and make consensual decisions prior to the fair day.

Post-fair monitoring surveys indicate that overall, 76 per cent of families reported that the women had been involved in the decisions on what to buy; 64 per cent indicated that men had been involved, and 28 per cent indicated that children had been involved. In two of the three provinces surveyed, women were more involved in the decision-making processes than men (see Figure 1). Analysis of items purchased during fairs reveals that on average more money is spent on items designated for women and children than men. In cases where the man represented the household because the wife was ill or otherwise unable to attend, a preliminary gender disaggregated analysis of purchasing patterns does not reveal significant differences in items bought by men and women. Nevertheless, potential risks linked to gender dynamics and household choice need to be taken into consideration when replicating this approach in new areas.

Rapidity and scale of response. Bringing large quantities of supplies into a country can be costly and slow, yet UNICEF partners can now rapidly organize fairs to reach remote areas or serve large numbers of families after massive displacements. In September 2010, for example, UNICEF partners Norwegian Refugee Council (NRC) and Solidarités International, mobilized vendors for a series of fairs reaching 13,000 newly displaced families in just a few weeks. Using standard kit distributions to meet their NFI needs would have nearly depleted all pre-positioned stock which would have several months to replace. UNICEF partners using the fair approach in North Kivu and Orientale provinces are now reporting that they can now mobilized vendors for fairs with as little as a week of lead time.

Dynamism of the commercial sector and access. Initially UNICEF believed that mobilizing vendors to travel beyond a certain radius from their centre of economic activities would be a limiting factor in terms of expanding the
fair approach beyond areas close to large commercial hubs. The experience, however, has shown that the commercial sector is far more dynamic and flexible in conflict-affected eastern DRC than initially expected. Vendors have demonstrated incredible mobility; the attraction of potential customers at a fair draws vendors from far to participate. In DRC the fair approach is also providing beneficiaries with access to a far wider array of items than using a direct cash transfer or voucher on an open market approach might offer: 65 per cent of families report that the items they purchased at the fairs are not easily available in their local shops or markets.

A recent partner activity report\(^6\) showed that 100 per cent of vendors would be interested in participating in future fairs. On average vendors reported that their earnings from a few days of NFI fairs were equivalent to their earnings from almost four months of regular activity. With this scale of potential earnings, vendors are extremely motivated to participate. In addition they are far more creative and agile in finding ways to transport large quantities of NFI supplies to fairs in hard to access areas than even the best NGO or UN logistics teams. Partners have been able to organize NFI fairs in areas where it would have been logistically nearly impossible to organize large distributions.

**POTENTIAL APPLICATION**

The potential applications and expansion of the NFI fair methodology are enormous in other emergency and post-emergency recovery situations where dynamic markets can be mobilized or re-invigorated to provide the supplies that emergency-affected families need most. The implications of the fair approach in terms of recovery and transition for both beneficiaries and participating vendors are significant.

The voucher approach can also be expanded to other sectors – including social services – in emergency and post-conflict assistance. Some of UNICEF’s partners in the DRC have experimented at having local primary schools attend the fairs so that families can use their vouchers to pay official school fees. In Orientale Province’s Ituri district one partner has teamed up with local health centers for a health care voucher pilot as well.

**NEXT STEPS**

With increasing support and enthusiasm from donors\(^7\) UNICEF has continued to expand and mainstream the fair approach in the DRC in 2011 and will continue to do so in 2012. As of 2011, over 50 per cent of all UNICEF-supported NFI assistance in the DRC is delivered through fairs. Other pilots initiated in 2011 included direct unconditional cash transfers to displaced families, programmes to test the feasibility and effectiveness of using vouchers in open markets, and a capacity building partnership with a NGO Solidarités International to train other organizations, promote learning and exchanges, and conduct additional research on market systems, the fair approach and cash-based assistance in emergencies.

As national lead in the DRC for coordination of the NFI sector,\(^8\) UNICEF will also continue training more organizations in the country in cash-based approaches and serve as a forum for discussion and learning in this area. Over 80 different international and national aid organizations have already participated in trainings and workshops on cash-based response facilitated by UNICEF and partners since 2009. Furthermore, to document and share learning on the NFI fair strategy, UNICEF plans to publish in 2012 a comprehensive study on the 2009-2011 experience and a ‘How To’ field guide on applying and using the NFI fair approach.

**RELATED LINKS**

- Cash vouchers give options to families displaced by violence in eastern DR Congo (UNICEF internet)  
  [www.unicef.org/infobycountry/drcongo_56433.html](http://www.unicef.org/infobycountry/drcongo_56433.html)
- Info Humanitaires juin 2010 (français)  
  [www.unicef.org/drcongo/french/resources_5510.html](http://www.unicef.org/drcongo/french/resources_5510.html)
- Youtube video on the use of cash-based vouchers and NFI fairs (Non-Food Item), or ‘foires NFI (UNICEF-DRC)  
  [www.youtube.com/watch?v=GJmlLcE6S8](http://www.youtube.com/watch?v=GJmlLcE6S8)
- The NGOs and Humanitarian Reform Project- Good Practice paper series (DRC)  
  [www.icva.ch/doc00004197.pdf](http://www.icva.ch/doc00004197.pdf)
- Website 'Rdc- Humanitaire: Portail d'information humanitaire pour la RDC' (French):  
  Expérience avec l'Approche ‘Cash-based Vouchers’ et Foires. Janvier 2011  
- SOKO MUZURI (nouvelle approche d’assistance aux personnes vulnérables) (Video) Janvier 2011  

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6 Report submitted by Solidarités International (one of the ARCC partners), North Kivu, 2011
7 Donors include: ECHO, USAID/OFDA, SIDA, Japan, and the DRC Humanitarian Coordinator’s Pooled Fund and United Kingdom’s Department for International Development (DfID)
8 In the DRC, UNICEF is the lead agency for the Non-Food Item and Shelter ‘Cluster.’ Clusters are coordination mechanisms dedicated to ensuring good coordination between actors in different sectors, identifying needs and gaps, and promoting best practices.
For further information on lessons learned and good practices, please contact:
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