

POLICY AND PRACTICE  
February 2011

# Equity and Reaching the Most Marginalised



## Selected Innovations and Lessons Learned from UNICEF programmes

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# In Practice

...sharing UNICEF experience and lessons learned

## Foreword

This document features nine recent innovations and lessons learned from UNICEF programmes which are illustrative examples of some of our work on equity and reaching the most marginalized. They are presented here to share the experience of UNICEF and its country-level partners in working to reach the most marginalized in order to share lessons we have learned and the good practices we have identified.

The cases highlighted in this publication are highly diverse examples – from women’s participation to deliver messages on immunization in Afghanistan to Brazil’s effort to achieve universal birth registration, lessons learned from community engagement in a rural neglected area in Uganda, and the experience from a child-friendly programme implemented in one of the poorest provinces in Vietnam.

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

Each of these pieces is a summary and 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](mailto:lessonslearned@unicef.org)).

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

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## Contents

### AFGHANISTAN

-  **Women's Courtyards: A women- to- women communication strategy for polio eradication (2009)** . . . . . 4

### BRAZIL

-  **National commitment for the eradication of under-registration of births (2009)** . . . . . 7

### BURKINA FASO

-  **Communicating for social change and civic engagement with village relays (2010)** . . . . . 10


### LESOTHO

-  **Combating child poverty in the context of HIV and AIDS: Developing a child grants programme (2009)** . . . . . 13

### MOZAMBIQUE

-  **Reaching every child with an integrated child survival package (2009)** . . . . . 17

### NEPAL

-  **School-led total sanitation (2009)** . . . . . 22


### SOUTH AFRICA

-  **Diversion for young offenders and youth development (2009)** . . . . . 25

### UGANDA

-  **Engaging communities for change in Karamoja region (2009)** . . . . . 28


### VIETNAM


-  **Integrated behaviour change communication programme: Ninh Thuan provincial child-friendly programme (2010)** . . . . . 32

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## DEFINITIONS

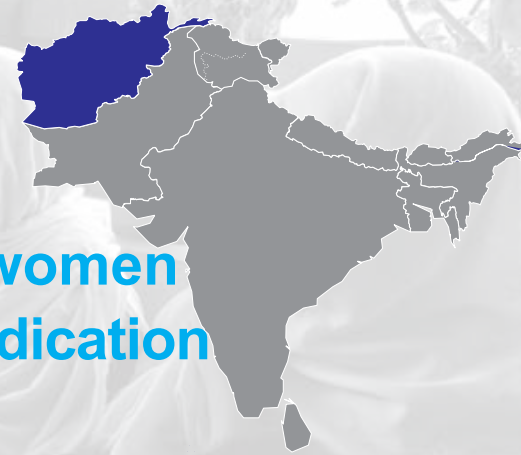
 **Innovations** are summaries of programmatic or operational innovations that have or are being implemented under UNICEF's mandate. These innovations may be pilot projects or new approaches to a standard programming model that can demonstrate initial results.

 **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.

# AFGHANISTAN

## Women's Courtyards: A women-to-women communication strategy for polio eradication (2009)



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### ABSTRACT

In Afghanistan, the high immunization coverage achieved during the National Immunization Day (NID) in early 2008 was beginning to stagnate. In the face of social and cultural barriers which inhibit women from participating in social events or even appearing in public without a burqa, the 'Women's Courtyard' programme successfully mobilized women to tackle the difficult task of ensuring 100 per cent coverage of polio drops in polio endemic areas on the border of Pakistan and Afghanistan. Based on results from surveys, women visiting neighborhoods to talk to women in their courtyards about NIDs was seen as an effective means to ensure that mothers and women are informed about NIDs and involved in the process of meeting an important milestone for their village. This strategy has contributed to both social acceptance of an inclusive approach and helped deliver a desirable result as no recurrence of polio has been noted since the inception of the strategy.

### ISSUE

In Afghanistan, the high immunization coverage achieved during the National Immunization Day in early 2008 was beginning to stagnate. One possible cause for this was too much reliance on the regular channels of communication such as radio, TV and training of teachers, mullahs, and community elders. The other factor was the over-burden of administering polio vaccine in communities by male community health workers. It became apparent that reported high immunization coverage alone could not transform communities to becoming polio-free as it would take just one or very few absentees or refusals for the virus to remain in the community. It meant that messages needed to reach inside each of the houses to ensure 100 per cent coverage of polio drops.

The reality on the ground also dictated that social and cultural sensitivity needed careful consideration when designing a communication strategy. For example, male health workers are unable to pass messages to women in the households due to the cultural norm that men do not discuss general issues with women inside the house even when related to their health. Furthermore, in order to get approval from community elders, additional work was required to encourage their involvement and understanding of the persistence of the polio virus lurking within the communities. It must also be noted that both the areas where the programme was implemented were in large semi-urban settings where no serious effort had been initiated to significantly involve women in social mobilization.

### STRATEGY AND IMPLEMENTATION

Main strategies used included:

- Obtaining support from community and religious leaders (mullahs) through dialogue and consultation.
- Refining radio and TV messages.
- Include female vaccinators in posters and banners.
- Encouraging local school girls and adolescents to become community health volunteers.
- Initiating trainings and mobilization activities prior to NID rounds. Extensive training of women took place in their courtyards. Women were consulted and encouraged to visit each household during NIDs.

All of the above strategies have contributed to community acceptance, and recurrence of polio has not been documented since the inception of 'Women's Courtyards'. There have been certain traditional elements that sometimes undermine the effectiveness of the strategy. However, the programme's momentum cannot be discounted.

### PROGRESS AND RESULTS

Since the initiation of 'Women's Courtyards', independent post-immunization surveys are beginning to show that women are able to reach all households with messaging, indicating that this could be a sustainable and reliable approach before and during NIDs. Figure 1 demonstrates that reported source of information changed over time; women's courtyard became the most popular source of information during the January 2009 NID. Table 1 shows



Door marketing by women's courtyard

that 39 per cent of interviewed households reported village women as a source of information regarding the NIDs (July 2009). Data also shows that the routine immunization coverage (DPT-3) in target areas has improved compared to the control area.

After the initial success, women's groups have been trained and mobilized to bring about behaviour changes in hygiene and sanitary practices and even produce household latrine units to be sold in the community under the WASH programme. Mother's groups are trained to assist in developing a community support network so that awareness of and access to health facilities are improved for safe deliveries even in the remote volatile districts of Nuristan. Women are trained

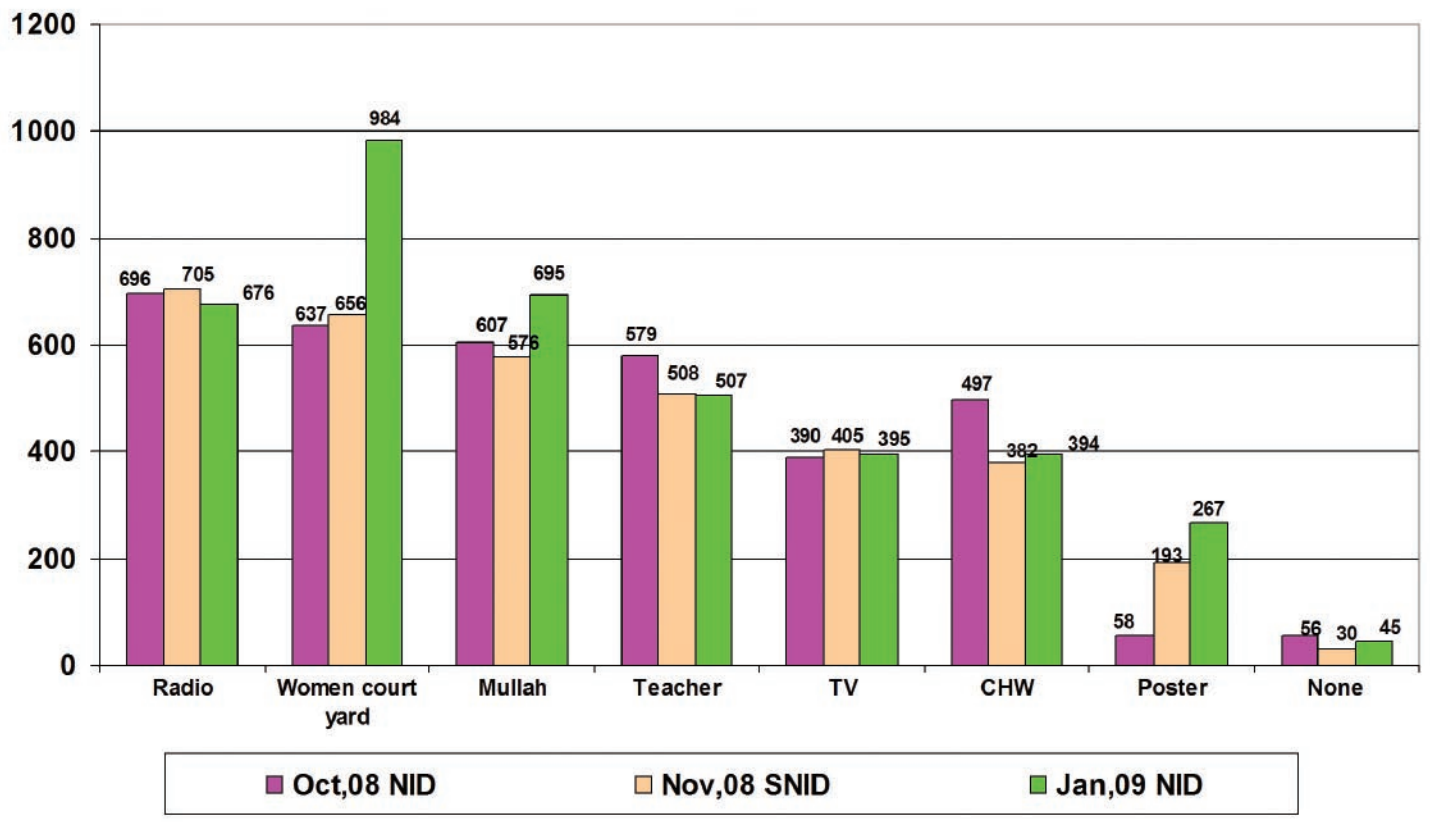


Women's courtyard training, Jalalabad assisted.

and organized into self-support groups for protection of children in partnership with Women Development Affairs and Terres Des Homme (TDH) so that families relying on income from child-labour are

During the sub-NIDs in the Eastern Region in July 2010, 350 women who were trained through the initiative were actively involved; the number of women involved in this campaign accounts for 32 per cent of the total number of community mobilizers (Figure 2).

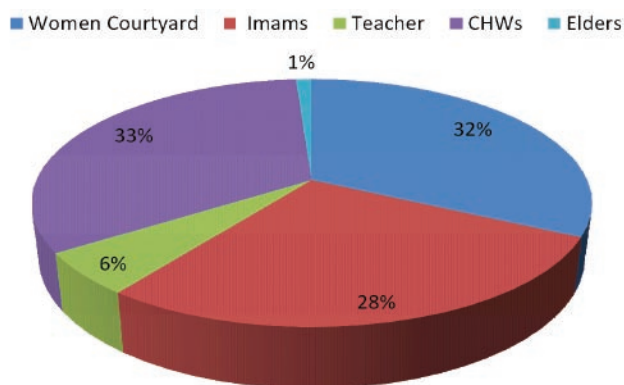
**Fig 1: Reported source of comparison PCA: Comparison of the rounds for each category Eastern region (Source: NID monthly reports Jan 2010)**



**Table 1: Micro survey on source of information via different communication channels 2,558 households interviewed July 2009 NIDs round**

Radio	TV	Teacher	Mullah	Community elder	CHW	Village woman
55%	50%	7%	7%	5%	17%	39%

**Fig 2: Community Mobilizers in Eastern Region in July SNIDs 2010**



The overall outcome of working together with community elders and leaders to support women to access the neighborhood has: (a) contributed to maintaining the high coverage during National Immunization Days (NIDs); (b) positively affected routine immunization coverage; (c) granted movement and engagement of women as community activators and leaders; and (d) allowed for the mobilization of girls and adolescents as community health workers who are trained and mobilized by the Department of Provincial Public Health.

## INNOVATION

In a context where women are forbidden to participate in social events, a culturally sensitive strategy is necessary for them to be trained and organized to facilitate social mobilization activities for other women. The non-threatening, pragmatic and practical approach adopted by the project is an effective strategy. It ensures that mothers and women are approached in their local settings and are informed and organized to support progress towards an important milestone for their village.

## POTENTIAL APPLICATION

The 'Women's Courtyard' approach can form the basis of a social mobilization strategy for bringing about a positive change in other programme areas as well. The strategy is especially applicable in societies where women are prohibited from participating in social events.

## NEXT STEPS

Given the initial success of the 'Women's Courtyard' approach in promoting key messages on NIDs in a socially accepted manner, UNICEF will continue to advocate the Ministry of Public Health to mainstream this approach. It has the potential to improve access to health facilities through a mother's group network and mobilization of female community health volunteers. The strategy can also

be applied to reduce the burden of death and disability among pregnant women and newborns.



## BRAZIL

# National commitment for the eradication of under-registration of births (2009)



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### ABSTRACT

In Brazil, sub-national birth registration rates in poverty-stricken northern and northeastern states have historically been low. The adoption of a comprehensive National Plan of Action complemented with public funding, political commitment and monetary incentives awarded to maternity wards per registered child led to a substantial increase in registration rates in the region. Since 2001, under the leadership of the federal government and its strategic alliances, civil society organizations, corporations and media, UNICEF has encouraged the deployment of civil registration services in public hospitals. The integration of the health sector with the civil registration authorities has been tested and improved and an online birth registration system is being piloted in the State of Pernambuco.

### ISSUE

Brazil is a country of continental dimensions (8.5 million km<sup>2</sup>), and many parts of the country, especially in the Amazon River basin (northern Brazil) and in the north-eastern part of the country, are geographically isolated. Politically, the country is a federation of 27 states and the socio-economic indicators in the northern and northeastern states are considerably below the national average, highlighting the social disparities and exclusion that these regions face.

Birth registration rates have improved steadily in Brazil over the last 12 years, partially due to UNICEF's advocacy efforts and technical assistance to the government at central, state and municipal levels. However, the situation of birth registration at the sub-national level continues to be a concern. In most of Latin America, national averages often mask sub-national pockets of poverty and exclusion, and Brazil is no exception. Birth registration rates in the northern and northeastern states of Brazil remain extremely low compared to the national average. Eight of the country's 27 states have birth registration rates below 80 per cent – three below 70 per cent (Amapá, Alagoas and Piauí) and one below 60 per cent (Roraima). Reasons for low birth registration rates in these states include difficult geographical access and presence of indigenous populations.

UNICEF-led assessments of the 2001 National Programme for the Promotion of Birth Registration imple-

mented in three states (Piauí, Ceará and Rio Grande do Norte) revealed bottlenecks. In a time span of five to seven years, the overwhelming majority of civil registration units in maternity wards had ceased to function. Several factors led to this situation, such as the high cost of maintaining a fully functioning civil registration unit within a maternity ward, the lack of awareness of existing legislation, the lack of incentives and mandate to register children, and difficult geographical access.

### STRATEGY AND IMPLEMENTATION

The objective of the project is to increase the rate of birth registration to 95 per cent in all 27 states between 2008 and 2011 through the expansion of the permanent network of civil registration and integration of civil registrars and maternity wards. The budget of the federal government in 2008 was Brazilian Real (R) \$101.6 million, distributed among various ministries. For the promotion of birth registration, the budget was R\$14.5 million of which R\$5.5 million for mobilization, R\$1 million to computerize the system, and R\$8 million for campaigns.

#### A comprehensive strategy

In 2007, UNICEF supported a strategy adopted by the Government of Brazil, entitled National Commitment for the Eradication of Under-Registration of Births and Expansion of Access to Basic Documentation (2008-2011), which establishes a holistic approach that builds upon experi-

ence gained over the previous decade. A central element of this comprehensive strategy is reinforcing the integration of the health sector (hospitals and maternity wards) and civil registration authorities at municipal and state levels. It involves governmental partners (at central, state and municipal level), civil society and other stakeholders, including the Association of Notaries and Registrars of Brazil. The priority beneficiary groups of this strategy are indigenous and rural communities and persons living in residential care institutions (children, persons with mental disabilities and the elderly). The geographical target areas are those with birth registration rates less than 75 per cent and the states in the Amazon River basin.

To fulfill the national commitment, the government has allotted public funding within the framework of a national programme called the 'Social Agenda for Birth Registration and Basic Documentation', a government plan led by the Human Rights Secretariat within the Ministry of Justice. In 2008, approximately US\$50 million (at the 2008 exchange rate) was distributed amongst the Ministries, of which approximately US\$7 million was allotted to promote birth registration.

### Implementing partners

The main partners include the federal, state and municipal governments and UNICEF. Federal government partners responsible for ministerial action/social mobilization are the Special Secretariat for Human Rights (SEDH - Coordination), the Ministry of Social Development and Fight Against Hunger, the Ministry of Justice, and the Ministry of Health.

State partners include governments at the state and municipal levels, Courts of Justice and Internal Affairs Division of Justice, and the Association of Notaries and Registrars of Brazil.

## PROGRESS AND RESULTS

In 2008, the average national birth registration rate rose to 91.1 per cent – an increase of almost 27.1 per cent since 1998 – due to significant strides made in the last decade. Birth registration rates in six states supported by UNICEF (Amazonas, Pará, Tocantins, Maranhão, Pernambuco and Alagoas) have improved by more than 20 percentage points between 2000 and 2007. Under-registration of birth in the north of the country decreased from 47.1 per cent in 2000 to 18.1 per cent in 2007. During the same period, at the national level, under-registration of birth decreased from 21.9 per cent to 12.2 per cent.

The states of the northern and northeastern regions of Brazil still have the lowest birth registration rates in the country even though they have also made the greatest improvements in these rates. This indicates the difficulties

for the universalization of these records to all Brazilians as specified under the law.

Specific results and progress made through the initiative are the following:

- UNICEF supported a revised strategy that integrated birth registration into the health sector. In addition, it helped the government define new strategies to be incorporated (e.g. capacity building for civil registrars and health care staff), develop training tools such as the '10-step Manual for Civil Registration in Maternity Wards', and explore new mechanisms for linking maternity wards and civil registrars at a lower cost.
- The initial strategy of placing civil registrars in maternity wards was replaced with a lower-cost solution of linking both institutions remotely with an online connection. This model was piloted in 2008 in the State of Pernambuco. The initial equipment cost of setting up the current on-line system in the State of Pernambuco linking 212 maternity wards with 198 civil registration offices is approximately US\$1.5 million. UNICEF is providing assistance towards the nationwide roll-out of this model.
- Research by the state government of Ceará, undertaken with UNICEF support, was instrumental in diagnosing the situation of birth registration in maternity wards both within the state and in neighboring northeastern states.
- UNICEF's efforts in the State of Maranhão – where a campaign to clear the backlog of unregistered children was launched in 2001 – has led to a sharp increase in birth registration rates. However, these improvements have stagnated, as this campaign was not complemented with more sustainable approaches.

### Key elements of success

#### Monetary incentives and revision of legislation

One of the first steps taken by the Government of Brazil towards addressing under registration was to amend existing laws. In 1999, the Ministry of Health, in partnership with the Association of Notaries and Registrars of Brazil carried out an information campaign on children's rights to birth registration. This campaign was followed by the establishment of monetary incentives for birth registration granted to both civil registrars and to health facilities:

- Law No. 10.169, established in December 2000, mandated states to create mechanisms for the monetary compensation of civil registrars at state and local level to ensure birth registration and issuance of birth certificates without charge.
- In 2002, the Ministry of Health issued a resolution which specifies that R\$5 (US\$1.72, at the 2000 exchange rate)



be allocated to the hospital of the National Health Service for each child registered by the maternity ward. The conditions of this monetary incentive include the hospital's obligation to prove that the child received his/her birth certificate prior to being discharged from the facility.

#### **Integrating birth registration into the health sector**

In addition to the monetary incentives guaranteed to hospitals per child registered, UNICEF supported the implementation of the 2001 National Programme for the Promotion of Birth Registration, consisting of placing outreach units of the notary public within maternity wards in the states with lowest birth registration rates.

#### **Combination with other priorities of the country**

Norms were established for the empowerment of the Baby-Friendly Hospital Initiative (BFHI) hospitals that are regulated in directives SAS / MS no. 756 of 16 December 2004 and no. 09 of 10 January 2008. According to the above, one of the criteria for the establishment a BFH, is to ensure that at least 70 per cent of newborns leave hospital with a civil birth registration, based on the Hospital Information System.

#### **Development of pilot projects to ensure civil registration in maternity**

Currently, the State of Pernambuco can be considered the 'model' for the creation of an online birth registration system linked to the health system, and UNICEF is providing assistance towards the nationwide roll-out of this model. In order to arrive at the current model, several pilots were developed, tested and fine-tuned. The new model enables online birth registration without the need for the presence of the civil registration office on the premises of the maternity ward or hospital. In 2008, maternity wards and hospitals were connected online with the civil registration offices.

## **LESSONS LEARNED**

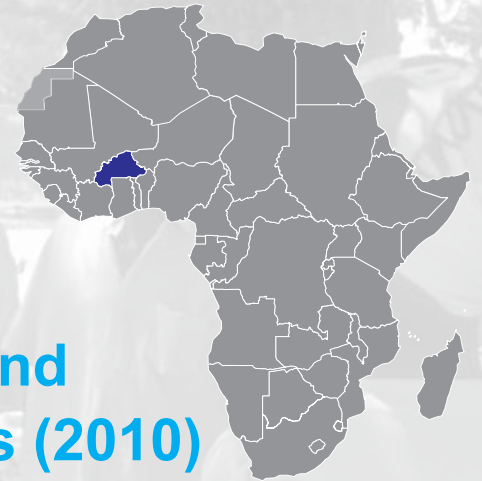
- Legal reform to ensure that birth registration is free of charge should be the first step towards improving birth registration rates. Legislation in this regard was adopted in Brazil in 1997.
- Integrating birth registration into health services requires extensive field-testing prior to creating a national 'model'. The State of Pernambuco serves as a model for the creation of an on-line birth registration system linked to the health system as it is based on testing and fine-tuning of other models.
- The Pernambuco initiative – along with other national priorities such as the Social Agenda to Reduce Inequalities and the criteria for accreditation of maternity centres as Child-Friendly Hospitals (which ensures that the newborn is registered in the maternity hospital) – is vital

to enhance efforts, add partners, and consolidate the national policy.

- Monetary incentives offered to maternity wards per registered child did not suffice to encourage maternity wards to take on the challenge of registering children. These types of incentives must be set in a framework of a comprehensive national policy, long-term budget allocations, and joint collaboration at all levels – central, state and local – between civil registration authorities and the health sector.

## BURKINA FASO

# Communicating for social change and civic engagement with village relays (2010)



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### ABSTRACT

Burkina Faso is still far from achieving the child mortality MDG target. The under-five mortality rate is 188 per 1,000 live births (2006 MICS). Nationwide, access to sanitation is exceptionally low: 13 per cent in 2006. Community-based relays that run discussions and activities around health and child rights can support communication for behavioural change for Accelerated Child Survival and Development (ACSD). During the period between 2002 and 2008, relay units were established in 1,200 villages in Burkina Faso to ensure communication activities in ACSD at the community level. A total of 6,000 community-based relays have been trained on the key family practices and organizing door-to-door talks to reach 3.6 million inhabitants. Taking into account existing structures in the community is instrumental to ensure the sustainability of communication activities. Through active involvement of relay units in villages, communication ownership at community level has been strengthened. Replication of relay units is feasible in other villages. The focus should be put on strengthening the capacity of relay units through training, provision of tools for social mobilization and materials for communication, and monitoring and evaluation.

### ISSUE

Burkina Faso is still far from achieving the child mortality MDG target. The under-five mortality rate is 188 per 1000 live births (MICS, 2006). Resurgence of vaccine preventable diseases in 2009 (15 cases of polio and more than 53,000 cases of measles) is of particular concern despite reported vaccination/ immunization coverage above 90 per cent for several years. Although the national HIV prevalence is relatively low (1.6 per cent in 2006, UNAIDS 2007), HIV infection is significantly higher in urban areas. Female Genital Mutilation (FGM) is in decline; from 77 per cent to slightly below 50 per cent in 2005,<sup>1</sup> yet activities continue to be under-funded, particularly in relation to sensitization.<sup>2</sup> One MDG target that Burkina Faso might comfortably meet is access to drinking water, which has reached 72 per cent from 34 per cent in 1990. However, the proportion of households in the poorest quintile without access to drinking water is more than twice that of the wealthiest quintile.<sup>3</sup> In relation to sanitation, access is still exceptionally low (13 per cent in 2006).

1 Excision Reduction Review 1990-2006, CNLPE

2 Information from the Country Office Annual Report 2009, UNICEF Burkina Faso

3 The Situation of Childhood Poverty, UNICEF 2010

### STRATEGY AND IMPLEMENTATION

The experience of Communication for Development (C4D) interventions using relay units in Burkina Faso dates back to 2002. At the beginning, they dealt with themes including child trafficking, FGM, girls' education, and PMTCT. Most recently, community-based relays have been identified as a key for supporting communication for behavioural change for ACSD and are included in the African Regional Strategy. Their role is promoting the key family practices for ACSD in communities. Based on this strategic shift, the National Communication Plan was developed under the leadership of the Ministry of Health (MoH).

The main Communication for Development (C4D) strategies in this project are based on:

- Advocacy for policy and administrative decision makers, traditional and religious leaders to ensure their commitment.
- Social mobilization to involve groups and associations in recommended actions.
- Communication for behaviour change that is directed towards individuals, families, communities and populations.
- Capacity building of stakeholders to implement communication activities through training and support tools and materials.
- Monitoring and assessment for performance measures (studies, surveys, research).

In the context of the UNICEF-Burkina Faso Country Programme and under the National Communication Plan developed by MoH, relay units were established in 1,200 villages to ensure communication activities in ACSD at the community level. Each of these units is made up of five relays, including three men and two women.

Relay units were trained in running talks and activities linked with various themes such as: maternal and child health, HIV/AIDS/PMTCT, girls' education, child trafficking and the worst forms of labor, FGM/cutting, hygiene and sanitation. Equipped with UNICEF-provided bikes and information and social mobilization material, these community-based relays travel from village to village, house to house to inform, raise awareness of and engage in dialogue on key behavioural messages within the community.

Community participation is a central priority in this project. Families, communities and populations are regarded as agents of their own development. To do this, they are involved in all communication activities in the field. The fact that communities are willing to exchange and dialogue on issues related to maternal and child health, HIV/AIDS, education, child protection has helped raise awareness and strengthen the ownership of the activities.

The multi-media approach is applied through the integration of interpersonal communication channels (such as door-to-door talks, forum theater, video projection, and town criers) and media channels targeting communities (rural radio, community radio and television).

## PROGRESS AND RESULTS

Between 2002 and 2008, 1,200 relay units have been put in place in 1200 villages and 6,000 community-based relays have been organizing door-to-door talks in villages. A total of 3.6 million inhabitants in 1,200 villages have been reached by the relay units through door to door sensitization activities. Relay units are also ensuring the monitoring of FGM, girls' education, and child trafficking in their communities. Evaluating behavioural change at community level is difficult and time consuming. However, data below from the situation analysis of children suggests potential impacts of the project.

### PMTCT

In one of the medical districts of Bobo-Dioulasso, the second town located at the west of Burkina Faso where communication activities were implemented, the rate of HIV/AIDS test acceptance of pregnant mothers increased from 35 per cent in 2005 to 66 per cent in 2006.

### Girls' education

'Positive Emergency' Campaign and sensitization activities carried out by local radio and relay units contributed

to the increase in the gross enrolment rate of girls; it has increased by 8.6 points from 73.2 per cent (2006-2007) to 81.8 per cent (2007-2008).

### Birth registration

Sensitizing on birth registration increased family and community understanding of this child right. Birth certificates are becoming more and more common: the rate of birth registration of children under five increased from 33 per cent in 2003 to 64 per cent in 2006 (MICS 2006).

### FGM/cutting

The practice of excision has progressively decreased, from 49.5 per cent in 1996 to 28.1 per cent in 2006. It should be noted that communication actions have largely contributed to raising awareness and knowledge on the risk related to FGM among population. According to the study on FGM/cutting assessment 1990-2006 carried out by CNLPE (the national committee in charge of fight against FGM/cutting), at least 81 per cent of the surveyed population knew the risks related to the practice of the excision.

## LESSONS LEARNED

**Active involvement of relay units in villages in the project has helped to strengthen communication ownership at community level.** This is a crucial step from the viewpoint of sustaining outreach activities. Indeed, the dynamics of behaviour change and social change can be accelerated with real involvement and participation of communities, families and populations. This involves taking into account communication through outreach activities and approaches to develop different issues pertaining to various programmes (health and nutrition, HIV/AIDS, education, protection, hygiene sanitation).

The structure of the community is reflected in the communication plan as a key to helping strengthen the results on communication outreach in the villages. **Taking into account existing structures in the community is instrumental to ensure the sustainability of communication activities.** Members of the relay units are chosen on the basis of their engagement for development of the village where they live. It is a practice that follows traditional village structures and which strengthens its credibility.

**The concept of 'volunteerism' is extremely important at the level of the relay unit.** They receive no pay but the provision of a bicycle is an incentive that motivates them as it contributes to their recognition and pride.

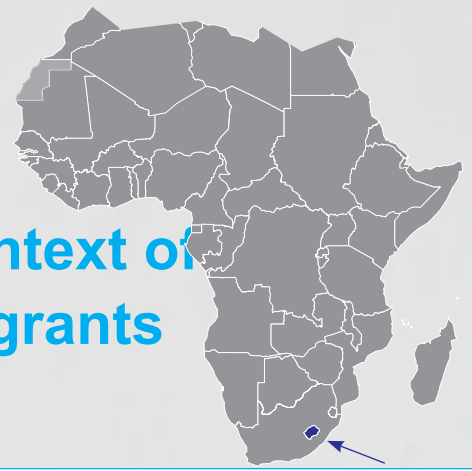
Replication of relay units is feasible in all villages. Indeed, many villages are now interested in introducing relay units. However, the **focus should be put on strengthening the capacity of relay units** through training, provision of tools, materials, image panels, and monitoring and evaluation.

**The results in terms of behaviour change are complex and should be defined over the long-term. Changing social norms in villages is even more of a challenge.**

This is why the results in terms of communication behaviour should be analyzed in terms of trends. There is the need to strengthen monitoring in the field of communication through local structures and local entities (associations, relay nuclei, groups, etc.).

## **NEXT STEPS**

- Promote the collaboration between relay units and the focal point of the regional Directorate of Women Promotion in order to strengthen women's participation in the EFP outreach.
- Engage schools by providing information and raising awareness of students through teachers in order to promote peer education in villages.
- A Knowledge, Attitude and Practice (KAP) survey is planned in 2010, focusing on the six key family practices (exclusive breastfeeding, utilization of impregnated mosquito nets, handwashing, utilisation of ORS, adequate complementary feeding, and PMTCT). Along with the KAP survey, a study to assess the best communication channels in the community (e.g. local and community radios, relay units, women's and youth associations for sensitization) will be conducted. This study will evaluate the strategy using relay units by identifying weaknesses and recommendations for improvement.



## LESOTHO

# Combating child poverty in the context of HIV and AIDS: Developing a child grants programme (2009)

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### ABSTRACT

In March 2007, UNICEF entered into a partnership with the European Union (EU) to support the Government of Lesotho's (GoL) efforts in addressing the challenges posed by the increasing number of orphans and vulnerable children (OVC) in the context of poverty and HIV/AIDS. The key strategies adopted included the strengthening of social welfare systems and establishing mechanisms for delivering a Social Cash Transfer programme to reach OVC. In April 2009, the Department of Social Welfare (DSW) with technical assistance from UNICEF and financial support from the EU launched the first payment under the Lesotho Child Grant Programme (CGP). The CGP aims at supplementing the income of poor households caring for OVC, including child-headed households, with a cash grant disbursed quarterly. The focus was on developing an integrated child and gender social protection system for the country based on the social cash transfer model. The CGP is currently being piloted in three community councils in three districts. To date, around 1,250 households, or approximately 3,300 OVC are covered by the programme. The current pilot will be expanded to a total of 15 community councils by 2011. There have been numerous challenges in the process, since the CGP was a very new and complex intervention. The main lesson learned is that before one embarks on such an intervention it is critical to carry out a detailed analysis of institutional arrangements, related structures, technical capacity, required resources and coordination and delivery mechanisms.

### ISSUE

Lesotho has the third highest HIV prevalence rate (23.2 percent) in the world compounded by extreme poverty (56.6 percent living on US\$2/day) and acute food insecurity. Children remain at the epicenter of the HIV epidemic with constantly increasing numbers of OVC (221,000 orphans out of a 1.9 million population).

When the project was initially started in March 2007, it was envisaged that much of the support for OVC at the community level would be provided through existing or newly formed caregiver groups, which would be supported and strengthened. In addition, the basic needs of OVC would be addressed through the disbursement of small grants to these children through school structures and caregiver groups. However, due to a number of challenges including the difficulty in understanding the 'small grants' component and the limited capacity at various levels, both in GoL and UNICEF, not much was achieved until mid 2008.

### STRATEGY AND IMPLEMENTATION

A comprehensive study was carried out to redesign the component of small grants into a robust social cash transfer programme, as an entry point to the broader child and gender-sensitive social protection system. The CGP was initially implemented by the DSW in three pilot communities – Matelile (Mafeteng district), Semonkong (Maseru district), and Lebakeng (Qacha's Nek district).

The pilot communities were selected on the basis of their accessibility to basic services such as health clinics, schools, water and sanitation, etc. The first pilot area is readily accessible to public services; the second is more challenging while the third area is remote and difficult to access. This project design intended to test different models to suit the different conditions in the country.

The following strategy was adopted:

- Development of a detailed implementation plan highlighting the critical assumptions.

- Dissemination of key information among major stakeholders with conscious efforts to build rapport.
- Design and implementation of a comprehensive public information campaign focusing on decision makers, opinion leaders, general public as well as potential programme beneficiaries.
- Creation of a core team of staff to ensure programme implementation in the pilot areas.
- Design and implementation of a capacity building plan to transfer basic skills to the newly recruited staff as well as the community structures.
- Provision of mentoring and monitoring support.

### Iterative approach

In the absence of the minimum requirements to implement the CGP, a trial and error or iterative approach was used. This means while the basic design was being completed, activities were also being implemented. The iterative approach allows for a more dynamic development of tools during the pilot so that by the end of the pilot year, all elements will be ready for national expansion. In this approach the design, implementation and MIS development will take place in a more combined fashion; instruments and processes will be defined, tested and adjusted at each stage. This approach has also been used for similar pilot programmes in Kenya and Tanzania.

The iterative approach allows for faster implementation as well as more fully developed tools and processes ready for national expansion at the end of the pilot. The trial and error implementation strategy was a good option for the CGP expansion given the tight timeframes currently associated with it. This would allow all required tools, systems and capacity building to be completed under the pilot to be ready for national expansion by the end of 2011.

### Targeting

To be considered as eligible households for CGP, households need to fulfill two basic criteria. A family must live in the pilot community for at least 12 months prior to the start of the programme and must have at least one child under the age of 18 permanently living in the household. However, the final selection of the households considers a number of additional indicators, including poverty.

Poverty status, using data from the Bureau of Statistics, is used to establish household targeting indicators and a multi-stage community targeting system is used to identify poor and vulnerable households. The mechanism of targeting is the following:

- The Auxiliary District Welfare Officer will make home visits to verify information contained in application forms.
- Based on its familiarity with households in the village, a

Village Verification Committee will also assist in verifying information provided by applicants. The committee will rank households according to level of vulnerability.

- A list of eligible households will be prepared by the Village Verification Committee and posted in public spaces in the community for two weeks.
- Community members will get an opportunity to make adjustment to the list through the Community Appeals and Complaints Committee within the two-week period
- The final list of eligible households will be signed by the Village Chief and the District Child Welfare Officer and posted in villages with information on the dates, times and places for enrolment.

### Social mobilisation

The CGP is supported by an extensive community development component through social mobilization with inbuilt family education/ awareness. The focus is on social and behavioural change. The households are also sensitized in the use of money for children's benefit such as investing in their education, health, nutrition and overall well-being. Attention is paid to the development of local management system, facilitating case management as well as referrals. Since this programme is developed for OVC in the context of and affected by HIV and AIDS, special attention is paid to child protection issues and how they can be addressed at the local level since services vary among village, community council and district levels.

### Trial and error approach

Due to capacity constraints and the constant political pressure, the overall design parameters could not be finalized before rolling out the CGP. To accelerate implementation and show quick results a Fast Track Approach (FTA) was introduced. The FTA, which concentrated all efforts on one pilot site, proved to be very effective.

All available staff was deployed in the Mathula community council of the Matelile pilot community of the Mafeteng District and extensive support was provided to them to do the community-based targeting and enrolment of eligible households. This trial and error approach enabled the CGP team to record lessons learned before rolling out to the other two pilot sites. In particular, it helped GoL to understand that immediate national expansion of CGP was not possible with the existing capacity constraints and this brought about some sense of reality among all partners,

## PROGRESS AND RESULTS

The CGP was launched in April 2009 and has to date reached 1,250 households caring for around 3,300 OVC, in the three pilot districts. The CGP is planned to expand in the three pilot districts in 2010 and to two additional districts in 2011. Anecdotal evidence gathered during field monitoring visits revealed that more than 80 per cent of the beneficiaries in households are utilizing the cash for the benefit of children meeting the costs of food, clothing, and school uniforms. In some cases the beneficiary households also made some savings and are planning to invest in a small productive enterprise.

The CGP could be an entry point to establishing a child and gender sensitive social protection system through the systemization and coordination of existing government social assistance interventions, while also building the capacity of the DSW and GoL to deliver cash transfers. The CGP strengthens the entire system through its policy and delivery; facilitating community management structures and social development and the application of institutional assessments; applying case management, referrals and monitoring simultaneously strengthening the information systems. The CGP has expressed willingness to assume the risks and investment costs for the other major social assistance programmes to be improved and coordinated, towards more effective and comprehensive social assistance in Lesotho. Hence, the CGP provides referrals and links to other complementary social assistance programmes.

### Challenges

The major challenges faced so far include: incomplete or weak systems; capacity limitations, especially at the district level, shortages of staff and an oversized workload at the DSW; a cumbersome and time-consuming targeting process not well suited to the geographical challenges posed by the terrain of much of the country. In order for the CGP to be expanded in a timely manner and to ensure efficiency and cost-effectiveness, its operations need to be systematized, capacity of the DSW built to manage the CGP, and that the CGP to be the lead project in coordinating other social safety net programmes in the country.

## LESSONS LEARNED

Before initiating a new and complex intervention such as the CGP in Lesotho, one should conduct a thorough preliminary assessment and analysis of the requirements to implement such an intervention. The preliminary assessment should include the overall implementation plan, a preparatory stage (12 to 18 months) to pilot test and complete the design as well as put in place the required systems and structures; bring on board the necessary technical exper-

tise from the onset; and continuously advocate with and sensitize the key stakeholders at all levels to promote the conducive environment. A strong communication strategy needs to be developed from the onset to share specific information with key stakeholders on critical design parameters of the programme.

When setting up a programme, special attention is required to:

- Establish a core management unit within and between the implementing partners, exclusively responsible for the programme with clear roles and responsibilities as well as required human resources with technical knowledge, skills, experience and qualifications.
- Build rapport with all stakeholders including decision makers, opinion leaders, implementing partners in order to ensure ownership and long term sustainability.
- Develop a comprehensive capacity building strategy at all levels with a detailed implementation plan (focusing on resource requirement, availability, gaps, timeframe etc).
- Build partnerships with civil society organizations who have major roles in community development, setting clear roles and responsibilities along with standard guidelines to minimize the subjectivity and bring in objectivity.
- Provide a comprehensive computer-based Management Information System(MIS) based on participatory Monitoring & Evaluation (M&E) systems.
- Develop and strengthen local management systems (such as village or community-based grassroots institutions). This should include case management and referral systems in particular for the services that are offered by other independent agencies to ensure a holistic and integrated response
- Establish linkages with similar programmes to create synergies, increase efficiency and avoid duplication.

Another valuable lesson in the Lesotho context has been the use of an iterative approach, which allows for simultaneous design and implementation. This proved very successful since it becomes more dynamic and allows both designers and implementers to learn from the process as it advances.

## NEXT STEPS

The Government of Lesotho plans to strengthen and systematize the design of the CGP so that it can rapidly be expanded to 5,000 households (reaching approximately 15,000 OVC) by October 2010, and 10, 000 households

(approximately 30, 000 OVC) by the end of 2011. According to the 2006 Demographic Health Survey (DHS) released in 2010 there are 221,403 orphans in Lesotho; however, currently there are no official figures on OVC. A situation analysis of OVC is under way and once available, should be able to provide a baseline for vulnerable children.

The national scale up of the CGP depends on the results from impact evaluation and availability of financial resources. UNICEF is working closely with the World Bank, the United Kingdom Department for International Development, Irish Aid and the EU to explore future possibilities of financial support. However, extensive high level advocacy is required in the current scenario due to the huge loss of revenues because of the financial crisis. (Lesotho lost 60 percent of its major source of revenue from the South African Customs Union (SACU)).

UNICEF is assisting the GoL and the DSW in the Ministry of Health and Social Welfare (MoHSW) with technical assistance through a consultancy. The consultancy will not only complete the technical design for CGP but will also facilitate the process of developing a child and gender sensitive social protection system and strategy for the country. This technical assistance is expected to improve the overall design and implementation at all stages of CGP expansion and synchronize other existing social safety net programmes based on the identified lessons learned. It is also expected to develop and implement solutions to address the shortcomings experienced during the first pilot phase, in terms of staff capacity, delivery systems (MIS, M&E, etc.) accountability and efficiency.

In addition, UNICEF Lesotho plans to facilitate the integration of other independent social protection initiatives, to develop a central registry system – a central database with information on all households (including those caring for children) – and to help the country to develop a comprehensive child and gender sensitive social protection system.

The following activities are planned and should be completed by the end of 2011:

1. Develop a single targeting system based on proxy means testing and community validation.
2. Develop a central registry system that will have information on all households dividing them into well off, better off, poor, very poor and destitute as per agreed indicators. Detailed information would be available about all members and can be utilized by a number of social safety net programmes.
3. Operational assessment of four other key social safety

net (SSN) programmes: the Old Age Pension Scheme, the School Feeding Programme, the OVC Bursary Scheme and the Public Assistance Scheme.

4. Develop a Management Information System for the Lesotho CGP feeding into the central registry and create simple modules for the four social safety nets.
5. Design and implement a long term impact evaluation strategy.
6. Design and implement an integrated, holistic and comprehensive approach to respond to the needs of OVC in the context of HIV/AIDS, in particular catering for the protection needs, for example, providing a platform at the grassroots level to bridge the gap between claim holders and service providers.



## MOZAMBIQUE

# Reaching every child with an integrated child survival package (2009)



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### ABSTRACT

To achieve the Millennium Development Goals (MDGs) by 2015, Mozambique is increasing its efforts to reach every child, including the hard to reach, with high impact and cost-effective health and nutrition interventions through integrated services. To accelerate the decrease in under five mortality rate (U5MR), the Ministry of Health (MoH), with technical and financial support from UNICEF, decided to prioritise two strategies in 2008. The 'Reaching Every District' (RED) approach aims to reach every child with immunisation and other components of maternal, child health and nutrition package starting with 33 districts in 2008. National 'Child Health Weeks' will be implemented twice per year to reach every child under five years of age, including those in the poorest and most remote areas, with a basic package of high-impact health and nutrition interventions. After two years of implementation, initial results show a great increase in coverage of integrated child health and nutrition package, especially through the Child Health Weeks, confirming these interventions as good strategies to accelerate progress towards MDG 4 and 5. While using the Child Health Weeks to rapidly provide wide coverage of child health interventions, routine services are being reinforced using the RED approach. The RED approach is expected to be rolled out to all districts by 2012 while the MoH plans to continue Child Health Weeks through 2012.

### ISSUE

Despite sustained reductions in child mortality, Mozambique continues to shoulder one of the heaviest burdens of under-five mortality in the world. About 138 children per 1,000 live births still die before their fifth birthday.<sup>1</sup> The majority of deaths in children under the age of five are due to a small number of common, preventable and treatable conditions, such as malaria, HIV and AIDS, acute lower respiratory infections, malnutrition, meningitis, intestinal infectious diseases, and neonatal conditions, occurring alone or in combination.<sup>2</sup>

Analysis of coverage of interventions based on the Demographic and Health Survey (DHS 2003) illustrates inequities in service delivery across the continuum of care, stressing the need to fill existing gaps, especially during delivery and the post-partum period, through the delivery of an integrated package of activities.

In Mozambique, vitamin A deficiency in children aged 6-59 months was recorded at 69 per cent in a study conducted in 2002.<sup>3</sup> During the same year, the Government of Mozambique introduced supplementation of vitamin A to children

under five years of age as a short and medium-term solution to decrease the prevalence of vitamin A deficiency in this age group. Despite this endeavour, the country has never recorded acceptable coverage rates using routine health services. Vitamin A contributes to reducing the severity of certain infectious diseases (measles, diarrhoea, acute respiratory infections), contributing to reduced U5MR.

Data from the Multiple Indicator Cluster Survey (MICS 2008) indicates progress in coverage of routine immunisation for children under the age of one for the major vaccine preventable pathologies. Eighty seven per cent of children under one received immunisation against tuberculosis, 71 and 70 per cent were completely immunised against diphtheria, pertussis, tetanus, hepatitis B and haemophilus influenza B (DTPw-HB/Hib) and poliomyelitis, respectively. Sixty four per cent of children were vaccinated against measles, which corresponds to the average rate for measles vaccination in sub-Saharan Africa. Despite these gains, children living in urban areas have a higher probability of being vaccinated than those in rural areas. Fifty five per cent of children aged 12-23 months in rural areas received all the vaccines in comparison with 74 per cent of

children living in urban areas. Eleven per cent of children in rural areas received no vaccines compared to four per cent in urban areas.

With only several years left to 2015, the target year for achieving the MDG, Mozambique is making special efforts to accelerate access and reach every child, including the hard to reach with high impact and cost-effective interventions through integrated services. Inequities between the poor and the rich, the urban and rural dwellers need to be addressed. To reach the MDG 4 target for Mozambique by 2015, the annual pace of decline of U5MR must accelerate from 3.3 per cent observed between 1990 and 2006 to an estimated 6.3 per cent every year.<sup>4</sup> The task is enormous but not insurmountable.

## STRATEGY AND IMPLEMENTATION

The two main strategies adopted by the MoH to improve access to immunisation and other maternal and child survival interventions are the Reaching Every District approach and the Child Health Weeks.

**Reaching Every District (RED)** focuses on building the capacity of districts, health facilities, health workers and communities to address major obstacles to improving immunisation and other maternal and child survival services. In 2008, the MoH decided to prioritise a phased approach starting with 33 districts where the five components of RED are being introduced and monitored. A scale-up plan (Figure 1) was also identified aiming to roll out the approach to the 144 districts of the country by 2012. This approach, once implemented to scale, will enable districts to improve access and utilisation of immunisation services and create a platform for the integration of maternal and child survival interventions with immunisation services.

Reinforcing routine services is a proven way to increase coverage of high-impact child and nutrition interventions. However, obtaining results through this mechanism requires time. While reinforcing routine services, campaign style interventions are needed to improve and sustain gains in child survival. Both interventions – routine services and campaigns – should be conducted simultaneously.

**National Child Health Weeks** are designed to deliver a package of cost-effective health and nutrition interventions to children under-five years of age, using a campaign approach that reaches even the most remote areas of a country. This strategy is viewed as a mechanism to reduce child morbidity and mortality by increasing the coverage of key high-impact maternal and child health and nutrition interventions with the underlying aim of making progress towards MDG 4.<sup>6</sup> Since 2008, the Government of Mozambique, with technical and financial assistance from UNICEF, has implemented twice-yearly national Child Health Weeks.

Since 2008, four rounds of national Child Health Weeks have been implemented in Mozambique with a package of activities described in Table 1.

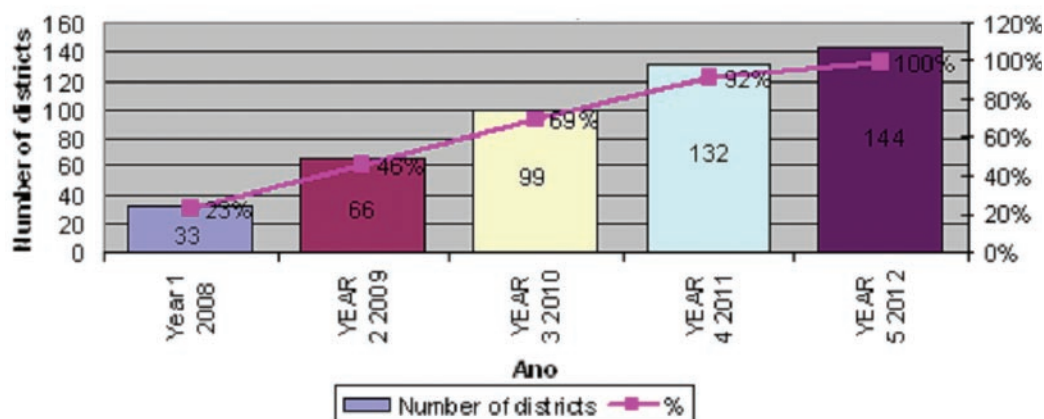
After two rounds of Child Health Weeks, provinces are fully trained to conduct micro-planning and implementation with little direct assistance from central level.

## PROGRESS AND RESULTS

### RED

Administrative data of some components of the child survival package delivered using the RED approach show increase in coverage. Results of the MICS 2008 show positive trends in national coverage, but no district based

Fig 1: Scale up and roll out plan for the implementation of the RED approach 2008-2012 Mozambique<sup>5</sup>



**Table 1: Package of activities per round of National Child Health Week 2008-2009**

Rounds of Child Health Week	1st round 2008 (31 March- 4 April)	2nd round 2008 (16-20 October)	1st round 2009 (18-22 May)	2nd round 2009 (17-21 November)
<b>Package</b>	vitamin A, de-worming, iodised oil in provinces, routine immunisation in HC, screening for nutrition status	vitamin A, de-worming, measles catch up campaign	vitamin A, de-worming, routine immunisation in HC, screening for nutrition status	vitamin A, de-worming, routine immunisation in HC and mobile brigades

indicators are currently available. An independent survey in the focus districts may be required for an in-depth evaluation of results.

RED has reinforced the capacity of districts to plan and implement routine child survival activities, creating a platform for integrated delivery of maternal and child survival package. Capitalising on this platform, the MoH has been developing the operational plan for the implementation of the recently approved MDG 4 and 5 strategic plans. Districts already implementing the RED approach use the Child Health Weeks as an additional opportunity to improve their skills in micro-planning, implementation, supervision and monitoring of activities. For districts not yet implementing the RED approach, the Child Health Weeks provide opportunities for training in micro-planning and implementation of outreach activities, preparing for RED approach.

### Child Health Weeks

Building on past experience and lessons learned, continuous improvement in coverage and quality of interventions

has been noted through the Child Health Week, as shown in Table 2. Simultaneously, hard-to-reach communities are systematically identified and special efforts are made to serve them.

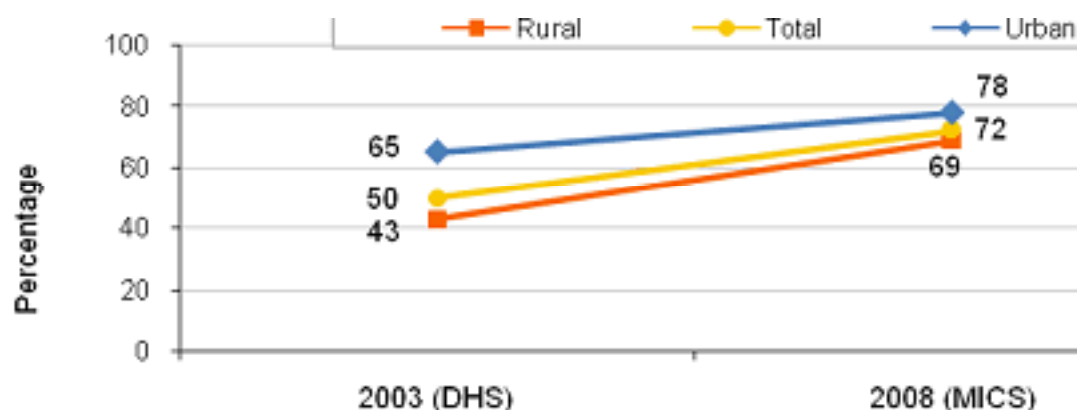
Results from the 2008 MICS confirmed a gradual improvement in vitamin A coverage when compared to data from the 2003 DHS (Figure 2). Similarly, the disparity between the urban and rural areas has reduced from 22 per cent (65 urban and 43 rural) to 9 per cent (69 rural and 78 urban) due to the concerted efforts made to reach remote areas during the national Child Health Weeks.

In addition to the routine services, exclusive breastfeeding was also promoted during the first round of the Child Health Week in 2009 through the distribution of 1,650,000 leaflets with messages on the importance of exclusive breastfeeding, often accompanied by education sessions to mothers while they were waiting for the Child Health Weeks interventions to start.

**Table 2: Results Child Health Week 2008-2009<sup>7</sup>**

Component	Target population	Coverage 1st phase 2008	Component Coverage 2nd phase 2008	Coverage 1st phase 2009	Coverage 2nd phase 2009
<b>Measles vaccine</b>	9-59 months		98.9%		
<b>Vitamin A</b>	6-59 months	83%	98.9%	100%	97%
<b>Mebendazole</b>	12-59 months	67%	94.3%	95.7%	95%
<b>LLINS Nampula Province</b>	0-59 months		100%		
<b>Iodine supplementation 4 provinces</b>	7 months -2 years	88.8%			
<b>Screening for nutrition status</b>	6-59 months	70.5%		100%	
<b>Routine immunisation</b>				Measles >85 per cent DPT3 >75 per cent compared to an average weekly coverage in 2008.	Measles >86 per cent DPT3 >76 per cent compared to an average weekly coverage in 2008.

**Fig 2: Vitamin A coverage in children under five in urban and rural areas in 2003 and 2008.**



### Challenges

Although the Child Health Weeks have been successful in achieving high coverage for a package of intervention, it must be noted that this campaign approach requires additional logistical assistance and resources to ensure that all supplies are delivered to the districts and to all health teams, especially in the most remote areas of a country. In spite of well-managed and timely preparations, last minute arrangements in sending supplies to the teams have been difficult to avoid. In addition, given the high cost of organising Child Health Weeks, results must be used for advocacy purposes to mobilise and leverage funds from other partners.

### GOOD PRACTICE

The combination of the Child Health Weeks and the strengthening of routine health services using the RED approach is paying off in Mozambique. Coverage of the basic child survival package such as vitamin A supplementation, de-worming and immunisation has been increased to thresholds that can have significant impact on child survival and can help to avert under-five mortality. Scaling up coverage of these proven child survival interventions has the potential to prevent most child deaths.<sup>9</sup> Immunisation and vitamin A supplementation – the main components of the Child Health Week package – are two of the most cost-effective public health interventions available today.<sup>9</sup>

Both approaches are also contributing in a significant way to strengthening the health system in Mozambique, reinforcing the capacity of district teams in planning, implementation, supervision and monitoring of activities, thus improving access to all eligible children – even the hard to reach – to health care.

### LESSONS LEARNED

During implementation the following lessons have been learned:

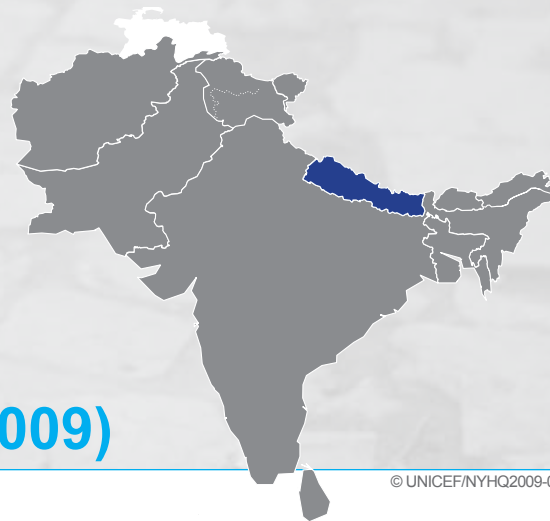
1. The RED approach has reinforced the capacity of districts to plan and implement routine child survival activities, creating a platform for integrated delivery of maternal and child survival packages. Capitalising on this platform, the MoH is building an operational plan for the implementation of the recently approved MDG 4 and 5 strategic plans. Districts already implementing the RED approach draw on the Child Health Weeks to further improve their skills in micro-planning, implementation, supervision and monitoring of health and nutrition activities; while for districts not yet implementing the RED approach, the Child Health Weeks provide opportunities for the training of district teams and the community to initiate the RED approach.
2. Implementation of the Child Health Week has also contributed to capacity building of health teams at decentralized level, thus setting up a self-sustained mechanism for the implementation of following rounds. After the first two rounds of Child Health Weeks in 2008, health teams in the provinces are fully trained to independently conduct micro-planning and implementation. Micro-planning and implementation of the third and fourth rounds of the Child Health Weeks in 2009 were conducted by provincial and district teams with minimal direct assistance from the MoH at central level.
4. Given the high cost of organizing the Child Health Weeks (US\$1.7 million per round), results should be used for advocacy purposes to mobilize and leverage funds from other partners and leveraging for more budget allocations to the health sector.

## NEXT STEPS

The RED approach will be rolled out in every district in Mozambique by 2012. An evaluation will be conducted to measure outputs obtained through the regular routine services to decide whether or not to continue Child Health Weeks. Until the complete roll out of the RED approach, Child Health Weeks will continue and will be further expanded to include other aspects of child survival such as hand washing with soap, treatment of drinking water at the point of delivery, birth registrations, and voluntary counselling and testing for HIV.

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## NEPAL

# School-Led Total Sanitation (2009)

### ABSTRACT

School Led Total Sanitation (SLTS) is a complete package for school and community sanitation and hygiene. It capitalizes on the crucial role that children can play as change agents and promoters of sanitation and hygiene in schools and communities. Developed by UNICEF and the Government of Nepal and implemented since 2006, SLTS draws on success elements from a wide range of community-based approaches to total sanitation. Through participatory approaches, motivational tools, flexibility for innovation and building ownership at the local level, SLTS is accelerating latrine coverage across Nepal.

### ISSUE

In Nepal, 54 per cent of the population defecates in the open. Some 9.1 million children under 18 live without improved sanitation, the majority of whom practice open defecation, with severe implications for the overall health of the country's children. Diarrhoea and acute respiratory infections are the leading causes of under-five mortality, with 10 million cases of diarrhoea occurring annually. Likewise, the socio-economic effects of poor sanitation are significant. The Nepal State of Sanitation Report reveals that the country continues to bear a loss of some 10 billion rupees (US\$1.33 million) each year due to loss of productive labour resulting from inadequate hygiene and sanitation. For Nepal to achieve the MDG target of halving the number of people without access to sanitation by 2015, 14,000 latrines need to be constructed each month. Nepal's challenging national context required a rapid scale-up of sanitation aimed at reaching children and communities.

### STRATEGY AND IMPLEMENTATION

UNICEF works closely with governments and other partners in more than 50 countries around the world to mainstream Community Approaches to Total Sanitation (CATS) and bring sanitation programming to scale. SLTS is one methodology under the CATS umbrella. The CATS Essential Elements are the common foundation for UNICEF sanitation programming globally. They are based on lessons learned from decades of sanitation programming and reflect UNICEF's Global Strategy for water, sanitation and hygiene (WASH). At their core, CATS rely on community

mobilization and behaviour change to improve sanitation and integrate hygiene practices. They are demand-driven and community-led, and emphasize the sustainable use of safe, affordable, user-friendly sanitation facilities. World-wide application of CATS has the potential to bring the Millennium Development Goal sanitation target 7c.

Objectives of SLTS are following:

- Eliminate open defecation through 100 per cent latrine coverage in targeted school catchment areas.
- Enhance personal, household and environmental hygiene behaviours.
- Engage children in development activities, thereby enhancing their personal and leadership skills.
- Increase ownership of schools and communities over hygiene and sanitation activities.
- Build strong school-community partnerships that enable maintenance and sustainability of hygiene and sanitation facilities.

In late 2006, UNICEF and the Government of Nepal piloted School-Led Total Sanitation (SLTS), a new community-based approach to total sanitation. Open Defecation Free (ODF) status is achieved through intensive social mobilization using participatory approaches, advocacy and institutional capacity building at school, community and district levels. SLTS builds on the achievements of UNICEF's School Sanitation and Hygiene Education (SSHE) programme, implemented in Nepal since 2000, which integrates the reward/recognition and revolving fund aspects

of the Basic Sanitation Package and incorporates the participatory tools and techniques of Community-Led Total Sanitation (CLTS), including local level tools.

SLTS begins at the school and works outward to the school catchment area, generally made up of four or five communities. SLTS works with child clubs and empowers them to put their skills to use in the community alongside community sanitation sub-committees. Together, they lead in the campaign to educate their parents and neighbors about the benefits of using improved sanitation and keeping their community clean. Key steps in the implementation to SLTS include:

- School selection and preparation in collaboration with the District Sanitation Steering Committee and local partners.
- Capacity building of stakeholders.
- Assessment of the sanitation and hygiene situation of the school catchment areas.
- 'Ignition' phase to engage community member's active participation.
- Implementation of construction of latrines at households through innovative and creative communication activities, and ODF declaration and the follow-up.

For a practitioner's guide to SLTS see 'Guidelines on School Led Total Sanitation from the Nepal Steering Committee for National Sanitation Action, Department of Water Supply and Sewerage and UNICEF, Nepal' ([www.communityledtotalsanitation.org/resource/guidelines-school-led-total-sanitation-slts](http://www.communityledtotalsanitation.org/resource/guidelines-school-led-total-sanitation-slts)).

Implementing partners are following:

- Ministry: Ministry of Physical Planning and Works/Department of Water Supply and Sewerage
- UN agencies: UN-HABITAT, WHO
- Network: Nepal Red Cross Society

## PROGRESS AND RESULTS

The SLTS approach is creating a social movement for ODF declaration that is enhancing the sense of dignity, identity and pride among local stakeholders. In addition, SLTS is sparking an outward momentum for neighbouring villages and districts to follow the ODF approach. At the policy level, it is attracting attention and support from multidisciplinary sectors including health, education, environment, social development and tourism. As of June 2009, the following outcomes had been achieved.

### On the ground

- SLTS has reached approximately 90,000 households and 500,000 people in 15 districts through 300 schools and surrounding communities.
- More than 730 child clubs, with nearly equal participa-

tion of girls and boys, are actively managing upkeep and cleanliness of toilets, classrooms and school grounds in the ongoing SSHE programme.

- Over 1,000 settlements from 250 school catchment areas, and 23 village development committee areas in 10 districts have been declared ODF. Three districts are on their way to declaring district-wide total sanitation.

### Capacity building and replication

- Over 1,000 school headmasters and teachers, 8,000 child club members and several local leaders trained on SLTS, including nearly 50 per cent women.
- District Sanitation Steering Committees have been established and trained in SLTS facilitation in 15 districts. SLTS has been replicated by Environment and Public Health Organization, Nepal Water for Health, Nepal Red Cross Society, United Nations Human Settlements Programme (UN-HABITAT), the World Health Organization (WHO) and other partners.
- Stakeholders are realizing the importance of increased coordination and integration of health, education and environmental priorities within sanitation promotion.

### Policy level

- SLTS has been incorporated in the Nepal Sanitation Master Plan, developed in 2009.
- The Government of Nepal is replicating the SLTS programme in all 75 districts.
- Targeted budget lines have been established for sanitation at the national and district levels.
- Provision of a 25 per cent additional budgetary grant to villages that become open defecation free and have a child-friendly environment and facilities.

### Key elements for success:

- **Children as leaders** Empowered children are a dynamic and ultimately powerful force for catalyzing school, family and community behaviour change around water and sanitation. SLTS takes what children learn one step further, translating their knowledge of good sanitation and hygiene practice into advocacy and action on behalf of community health.
- **Support funds and partnerships** SLTS promotes creative, non-subsidy-based, financing strategies to assist poorer people, such as loans from revolving funds, basket funds and local level cooperatives. In many school catchment areas, fifty-fifty matching funds that provide loans to households have been established by the government and donors. Child clubs and village development committees also provide other types of material

and social support to ensure that all community members are able to construct a latrine. Local level resource mobilization enhances community responsibility and ownership over the programme results. To achieve the holistic objectives of SLTS, the approach has been integrated with other initiatives, including income-generating activities; women's microcredit programmes; Dalit upliftment; and environmental programmes. These partnerships promote sustainability by reducing programme duplication and optimal use of resources.

- **Local technologies and design to achieve total sanitation for all:** Schools and communities have developed a wide range of latrine designs based on the local environment, affordability and sustainability. Local entrepreneurs have invented technologies and toilet products that are cost-effective and efficient and which are then promoted in communities. These include child- and gender-friendly latrines and latrines for children with disabilities that include facilities for hand washing with soap.
- **Prioritising the most vulnerable groups:** Total sanitation inherently requires participation by all members of the community. In the past, the exclusion of poor and disadvantaged people from sanitation programming proved a major hindrance to achieving open defecation free communities. With SLTS, vulnerable populations are prioritised.

## LESSONS LEARNED

There is opportunity for increased engagement with partners. At present there is significant variation among organizations regarding subsidies for household latrine construction; this makes building the momentum for community-led sanitation more difficult. Stronger partnerships with international NGOs and other sanitation stakeholders on the ground is one means of scaling up SLTS and promoting other community-approaches to total sanitation.

Continued support to communities is important to SLTS programme success. Changing hygiene and sanitation behaviour is complex and can take a number of years to ensure sustainability. The knowledge and skills child clubs and community members are learning through SLTS are becoming a culture which can be transferred from generation to generation. To maintain this however, regular programmes and campaign activities are required to encourage internalisation of good habits by school children and community members.

## NEXT STEPS

The Government of Nepal is currently replicating the SLTS programme in all districts in Nepal.

## REFERENCE

Field Note. UNICEF Policy and Programming in Practice. Community Approaches to Total Sanitation (CATS). UNICEF 2009. Available online at: [www.unicef.org/evaluation/files/CATS\\_field\\_note.pdf](http://www.unicef.org/evaluation/files/CATS_field_note.pdf)



Child club members of a school in Bandipur VDC, Tanahun, having a meeting with their teacher.



## SOUTH AFRICA

# Diversion for young offenders and youth development (2009)



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### ABSTRACT

The National Institute for Crime Prevention and the Reintegration of Offenders (NICRO) provides diversion programmes for young people in conflict with the law, with most participants being referred by a prosecutor. The case is withdrawn on condition that the young person completes the diversion programme. The programme aims to develop young people's potential and make young offenders accountable for their actions while encouraging them to heal the damage they have caused and learn to lead constructive and healthy lives. Most participants are between 14 and 18 years old. A special curriculum is drawn up for each participant which usually includes one or more of the following programmes: Youth Empowerment Scheme, Pre-trial Community Service, the Journey, and a Family Group Conference. In the first longitudinal study on the success of diversion, it was found that only 6.3 per cent of youth re-offended in the first year after completion of the programme. With the recent passing of the Child Justice Bill in the South African National Assembly, there will be increased demand for proven diversion models such as those provided by NICRO.

### ISSUE

Diversion programmes emerged as a direct result of problems relating to the treatment of juvenile offenders and the detention of juveniles in prisons and police cells while awaiting trial. During the apartheid period, there were large numbers of children who were involved in protest movements and civil unrest who had been placed in detention. In the immediate post-apartheid period, some 2,000 of these children were released from prison and police cells during 1992. The release of the juvenile offenders highlighted further the inadequacy of services for children in conflict with the law. The majority of the young offenders were children from disadvantaged backgrounds

Allied to the appalling conditions under which juvenile offenders were kept was the concern of very young children being kept in prison and police cells and with adults. Public outcry culminated in the establishment of the inter-ministerial committee on young people at risk. In the absence of a legislative framework, the policy recommendations of the inter-ministerial committee on young people at risk highlighted diversion programmes as an alternative to imprisonment and detention in police cells.

In 2005, an estimated 30,000 children were diverted from the criminal justice via agreements with the National

Prosecuting Authority and NGOs. The majority of cases that get diverted involve less serious offences. While this diversion programme has proved successful, the number of children in conflict with the law is increasing. One major challenge is the lack of diversion programmes, particularly in rural areas where levels of poverty are high.

Today, the current social context and high levels of crime have placed large numbers of children at risk. According to the Child Justice Alliance, out of 18 million children living in South Africa over 100,000 are arrested annually; at one point in 2006 there were 3,834 children in detention, of whom 2,729 were awaiting trial. Some 15 per cent of all crimes are attributed to children. There are no centralized statistics on children subject to pre-sentence diversion. NICRO, the largest service provider, receives around 20,000 cases annually.

The Child Justice Bill was passed by the South African National Assembly in June 2008, and is expected to be signed into law by the end of the year. The bill establishes a criminal justice process for those children accused of committing offenses, and includes a focus on procedures for individualized assessment and preliminary inquiry, diversion and restorative justice.

## STRATEGY AND IMPLEMENTATION

Upon being identified for participation by NICRO, an at-risk youth will be enrolled in one or more of the following diversion approaches:

1. The **Youth Empowerment Scheme (YES)** is a life-skills training programme that usually runs for six to eight sessions. It is the most widely used diversion option nationally. The main aim of this programme is to strengthen participants self-knowledge, help them understand how their choices and thinking affect the way they react to challenges and to promote communication and discussion about the offence.

Within this diversion programme, emphasis is not placed on the young offender but on his/her total functioning and the circumstances that caused the offending behaviour. Every young offender is assessed by a probation officer. When a decision is made to divert an offender to the YES programme, NICRO engages in a further assessment to determine and develop individual strategies.

Parents are involved in this programme are taught skills for supporting their children and dealing with the problem. This programme is undertaken in an interactive and participatory way where, in a challenging and non-threatening environment, children and their parents are free to talk about the offence, its causes, how reparation can be made and how repeat offending can be avoided. The focus of the programme is on the young offender within his or her environment and it explains:

- Rights and responsibilities
- Developmental factors impacting on behaviour
- Environmental factors impacting on behaviour

Over a period of 12 months (2004 – 2005) 4,260 youth offenders passed through this programme. After the completion of the programme, 94 per cent of the youth involved have not re-offended.

2. **Family group conferencing** is an important way to include families, victims and the offender in the mediation process. The purpose is to come to an agreement and also to prevent recidivism. The success rate of this programme is unknown.
3. **The Journey** is a two to three month intensive programme aimed at high-risk youth. An inherent part of this programme is a distinct curriculum. The programme employs information giving, group discussions and adventure therapy as facilitation methods to encourage change.

Through removing participants from high risk crime related learning environments and placing them in an experiential learning environment effective behavioural, attitudinal and skill changes are facilitated which halts the downward spiral of self-destruction. Also very critical within this programme is the process of continuity. After the completion of this programme, volunteers continue with service delivery (contact, monitoring and evaluating).

4. The **pre-trial community** service option allows youth who have committed an offence to do volunteer work at community service centres. Depending on the nature of the offence, the youth may be allocated any number of hours between 20 and 300 hours of voluntary service. The number of hours allocated is made by a probation officer. This programme allows the young offenders the opportunity to make reparation to the community he/she has offended. According to reports and within a 12 month observation period, a 95 per cent compliance rate was observed, suggesting an understanding of the damage caused to the community, and increased personal motivation and development of insight.

## PROGRESS AND RESULTS

Preliminary evidence suggests that NICRO's diversion programmes are effective in reintegrating children in conflict with the law and in preventing re-offending. In the first longitudinal study on the programmes' success, it was found that only 6.3 per cent of youth re-offended in the first year after completion of the programme. In 2007 NICRO completed the baseline measurements for a three year longitudinal impact study which will provide further information of the impact on and effectiveness of diversion on juvenile offenders and the reduction of crime.

## INNOVATION

Key innovative aspects within each programme component are as follows:

1. The **YES programme**: This programme assumes a rights-based approach to diversion with restorative elements aimed at strengthening responsibility and reconciliation between the young offender and his or her parents and includes a component on promoting empathy for the victim. In addition, the assessments for this programme inform the focus and content of interventions. While this programme is fairly structured, NICRO uses the assessment process to develop an individualised intervention strategy for each child. Young offenders who display adolescence-limited antisocial behaviour can benefit from this programme. According to NICRO, this programme absorbs 61 per cent of juvenile offenders of which fewer than 10 per cent

re-offend within a three year period following completion of the programme.

2. **Family Group Conferencing:** Only offenders who admit to the offence and agree to participate in the diversion are allowed to participate in this programme. The offence has to be the first offence committed and has to be of a minor nature. FGC are only used when the offence has occurred within a family or a friendship setting. Most offenders are between the ages of 12 and 18 and are usually children who are still at school but who come from dysfunctional family environments.
3. **The Journey:** The participants in this programme are usually high risk youth. Participants include repeat offenders and those who have committed more serious crimes. During this assessment process the strengths and weaknesses of the family as a support structure are identified. This programme allows the youth to be removed from familiar surroundings. The adventure phase of this programme consists of problem-solving courses, horse riding, and swimming. Participation in these activities is often challenging simply because most of the participants have never engaged in these kinds of activities. The last phase of this programme involves debriefing, reintegration and follow-up. The follow-up are provided in the form of group meetings to assess how plans have been put into practice and what progress has been made.
4. **Pre-trial community service:** This programme obliges the youth offender to serve a pre-determined number of hours at a community based structure in his or her free time without payment. Charges are withdrawn on condition that the service hours are completed within a stipulated time and the individual concerned has adhered to all other conditions stipulated by the court. This programme attempts to make youth offenders take responsibility for their actions and gives them an opportunity to make amends through service to the community.

## POTENTIAL APPLICATION

All programmes are operational throughout South Africa, and can be replicated elsewhere. The YES programme in particular is interesting as individualized strategies are designed to suit the specific needs of the young offender. In addition, it empowers both the duty bearers and claim-holders and addresses the root causes of violations. This is of critical importance within the South African context because of the high levels of poverty which are often cited as determinants of criminal activities.

## NEXT STEPS

The challenge to scaling up the diversion programme is that it is mostly operational within urban set-ups. Efforts are being made to expand this programme to rural areas. Issues to be considered for the future programming include research, training needs, staffing and volunteer needs, obtaining community and family buy-in, and cost effectiveness analysis.



## UGANDA

# Engaging communities for change in Karamoja Region (2009)

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### ABSTRACT

The Karamoja sub-region of northeastern Uganda, inhabited primarily by nomadic pastoralists, is the country's most neglected area. Regional insecurity has perpetuated extreme poverty (82 per cent of the population live below the poverty line), famine, malnutrition and myriad other health challenges in Karamoja. In February 2008, UNICEF and partner, Straight Talk Foundation (STF) launched a project 'Engaging communities: A holistic communication project for Karamoja region', a multifaceted community engagement and empowerment project. The project aimed to establish a working model for community engagement and effective participatory communication for social change within the local context. The experience of targeted and participatory development communication in a hitherto neglected region provided some cogent lessons learned to improve future development communication efforts.

### ISSUE

The Karamoja sub-region<sup>1</sup> of northeastern Uganda, inhabited primarily by nomadic pastoralists, is the country's most neglected area. Comprised of five administrative districts, Karamoja covers a vast area of approximately 27,500 km<sup>2</sup> and has a population of roughly 1.1 million. A majority of the population lives in isolated rural areas.

Regional insecurity has perpetuated extreme famine, malnutrition and myriad other health challenges in Karamoja. A recent OCHA report (October 2008) highlights serious and persistent gaps in achievement on key humanitarian and development indicators in Karamoja, showing little improvement since the 2006 Uganda DHS. With an under five mortality rate of 174 per 1,000 births, a gross enrolment rate of 34 per cent, a literacy rate of just 11 per cent, and an HIV/AIDS prevalence rate that has risen steadily over the last ten years, Karamoja is in urgent need of assistance. Furthermore a complex interplay of pervasive negative attitudes towards education and health and traditional practices may have negatively affected people's coping capacity, which has resulted in vulnerability, especially among girls and women.<sup>2</sup>

1 The Karamoja region of northeastern Uganda, comprising the districts of Nakapiripirit, as well as Abim, Kaabong, Kotido and Moroto, represents a distinct geographic, developmental and humanitarian challenge to Uganda's stability and poverty eradication ambitions, characterized by cultural factors and endemic conflict involving the agro-pastoralist Karamojong population.

2 Bhattacharyya, Manasi. 'Situation Analysis of Children in Karamoja' submitted to UNICEF, December 2008

### STRATEGY AND IMPLEMENTATION

Launched in February 2008 by UNICEF and partner STF the project aimed to establish a working model for community engagement and effective participatory communication for social change in the Karamoja context. Though the project primarily addressed young people aged 10-24, it also engaged those adults with important roles in the lives of adolescents, such as parents, teachers, and elders, to lobby for support in promoting the key project outcomes. Based on a situation analysis conducted prior to the project, the project set out to achieve five operational results:

1. Increased number of young people and adults with improved knowledge, beliefs and attitudes towards education; awareness created on the importance and benefits of education.
2. Increased number of young people aware of and able to seek Adolescent Sexual and Reproductive Health (ASRH) services in health centres and hospitals; increased information available on services.
3. Increased number of men and women knowledgeable on PMTCT services and where they are provided.
4. Increased number of people showing improved knowledge and attitudes towards prevention of HIV/AIDS.



Children photographed in and around the village of Katabole in Moruita Sub-County of northeastern Uganda, Nakapiripirit District.

5. Increased community dialogue on HIV/AIDS, child survival and development, protection and education.

To achieve these results, STF designed and implemented a package of integrated interventions using three communication channels: radio, print, and face-to-face.

#### Key components of the package

- Pre-recorded “Straight Talk” and “Parent Talk” radio programmes in Ng’akarimojong, the local language.
- The formation and ongoing support of community and school-based radio listener groups.
- The production and distribution of information, education and communication (IEC) materials with targeted messaging to promote literacy and knowledge on protection, health, and education issues.
- District-governance level advocacy meetings.
- Multi-topic face-to-face interventions, with parent dialogues.
- Teacher training – life skill learning and dialogue facilitators, and peer educator trainings at selected schools in the region.
- Distribution of 5,139 solar powered and windup battery-less ‘Blue Radio’ sets throughout the five project focus districts to help ensure widespread access to CSD, protection and HIV/AIDS information and the pre-recorded radio magazine programmes produced locally under the project.

## PROGRESS AND RESULTS

The effectiveness of the interventions was initially verified by independent research (Population Council, 2007), in which a direct positive correlation was demonstrated between exposure to STF programmes and key outcomes among youth, including safe sexual behaviour and improved knowledge and attitudes. An end-of-project assessment demonstrated a clear need to strengthen and expand the reach of the core communication efforts in Karamoja. Positively, the assessment revealed a heavy

demand from the participating population for expanded Straight Talk Foundation (STF) communication interventions. This demand for expanded local-language STF programming in the region is reiterated in a recent report commissioned by DanChurchAid and undertaken by ANPPCAN Uganda & TPO, entitled ‘Social justice amidst complex realities: the case of Pokot women and children in north eastern Uganda’. This call to meet additional demand in Karamoja region speaks to the effectiveness of the STF multi-channel, multi-media approach.

Following the initial phase of the project, the contract with STF was renewed for the same project and the region although the name of the project was changed to ‘Communication for change in Karamoja 2009-2010’. An end-of-project ‘Rapid Review’ impact evaluation of the second phase was conducted in late January and early February 2010 in the five districts of implementation: Abim, Kaabong, Kotido, Moroto, and Nakapiripirit. The focus of the exercise was to profile and assess the effectiveness of strategies employed by STF and UNICEF. The exercise was purely qualitative in nature, and aimed to learn directly from beneficiaries how effectively the project interventions facilitated the achievement of the five key operational results. In conducting the assessment, the STF team and a group of 25 local research assistants engaged with all key beneficiary groups: adolescents, Junior Journalists, peer educators, key partners (AFLI, opinion leaders, stakeholders), parents, teachers, and community-based organisations.

Overall, findings indicated a strong and positive impact of the key project interventions on strengthening knowledge, attitudes, and practices vis-à-vis education and health in Karamoja region. In addition, findings clearly show that parents and children exposed to STF programmes are more comfortable and likely to engage in parent-child dialogue on the key issues addressed under the project than those not exposed. Finally, the review identified marked improvement in and expansion of opportunities for child participation in assessing and responding to the key health, education, and protection challenges in Karamoja.

## LESSONS LEARNED

**Lesson 1: Challenges raised regarding effective radio set utilization in communities should be addressed by amending the strategies, especially following points:**

**Inadequate instruction:** Despite efforts of the distribution team to sensitize participants in the proper use and purpose of the radio sets, some respondents complained during the final assessment that they did not receive sufficient instruction. This related more to social use of the

radios than technical operation, leading to issues such as individualization and male dominance/gender bias.

**Individualization:** In line with the insufficient instructions on proper social use of radio sets, certain beneficiaries have raised concerns about individualization of community radios, whereby one or two people in a given community have claimed the radios as their own and refuse to allow others access.

**Male dominance/gender bias:** Perhaps the most serious challenge to effective radio set utilization by participating communities is male dominance of the radios and gender biases in Karamoja that prevent females from accessing the radios as often and freely as they are intended to.

**Durability of radio sets:** Radio spot-checks conducted during the final assessment of 'Engaging Communities' project revealed many radios to be damaged, with moving parts such as cranks, knobs, and solar panels broken or missing. Many other radios have become filled with dust, affecting the quality of the sound they produce.

**Lesson 2: The initiative highlighted an importance of modifying technical components of radio programming to ensure maximum access.**

**Overcoming language barriers:** It became clear in the assessment that the Pokot and Labwor communities of Karamoja do not listen to STF Ng'akarimjong language programmes as they find the language too difficult to understand.

**Poor radio signal/coverage:** Poor signal coverage came out as a barrier to accessing STF programmes for certain communities, most notably the Pokot and Labwor.



Karamojong community leader receives 'blue radio' during radio distribution carried out by Straight Talk Foundation for the 'Engaging Communities' project.

**Day and time of programmes for in-school adolescents:** The timing of "Straight Talk", a recorded radio show in Karamoja, has proved inappropriate for some in-school listening and student listeners' groups.

**Lesson 3: Sustainability of face-to-face training and dialogue should further be ensured by increasing engagement of key opinion leaders, formal and informal leaders, and marginalized groups.**

**More follow-up mechanisms for clubs and groups:** There is a need to more thoroughly engage community-based organizations (CBOs) in face-to-face activities in the region, facilitating more regular follow-up and support to STF-trained clubs and groups.

**More use of regional networks:** Though STF made a concerted effort to utilize partnerships and existing community and organization networks in the region under 'Engaging Communities', the assessment revealed a need to enhance this effort even more in order to take full advantage of the existing structures in Karamoja.

**Further engagement of women:** The assessment raised concerns about the inadequate level of engagement with women in the first phase period of the project, and revealed that striving for equal engagement of women and men in trainings and parent dialogues is not sufficient to truly involve women in achieving the project's objectives.

**Need to engage elders and opinion leaders:** Recognizing the critical cultural role of Karimjong elders and other key opinion leaders in the region in driving acceptance (or rejection) of health and development communication, STF has identified a need to engage these actors more closely in its regional activities.

## NEXT STEPS

At the GoU/UNICEF 2008 Annual Review for Karamoja, UNICEF representatives and key partners expressed a need for more active engagement of the participating populations to improve development programming and results in Karamoja. In the spirit of meeting this need, and to incorporate lessons learned, UNICEF and STF will implement a multifaceted communication project in the five Karamoja districts of Abim, Kaabong, Kotido, Moroto, and Nakapiripirit.

The project will emphasize local community and institutional capacity building for participatory communication using community radio, face-to-face communication, and targeted IEC messaging campaigns. The aim of the project is to facilitate participation and dialogue at multiple levels and across various communication channels. Importantly it



Pedo Lois, age 15, from Kasimeri Primary School, recites the poem Karamojong Child during the Karamoja Special Session for Children. Moroto. 5 Mar 2009.


will engage adolescents and key adults as duty bearers in dialogue for development. Core project activities targeting these groups includes radio programming, Junior Journalist activities, and production of a periodic newsletter for school children highlighting activities implemented under the project.

## RELATED LINKS

- Straight Talk Foundation: [www.straighttalkfoundation.org](http://www.straighttalkfoundation.org)
- Population Council, 2007. "The Straight Talk Campaign in Uganda: Impact of Mass Media Initiatives". Available at: [www.popcouncil.org](http://www.popcouncil.org)

## VIETNAM

# Integrated behaviour change communication programme: Ninh Thuan Provincial Child-Friendly Programme (2010)



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### ABSTRACT

UNICEF Viet Nam works in Ninh Thuan Province to integrate sectors and services in order to improve the awareness and change attitudes toward key children's and women's issues. The Integrated Behaviour Change Communications (IBCC) programme aims to provide a unique package of communication interventions from different sectors to ensure access to convergent social services, especially for children. The IBCC focuses on identifying key areas where change is most needed, using available evidence to define approaches, messages and channels and ensure adequate capacity to moderate and facilitate change through communication. IBCC was initiated under the framework of Provincial Child-Friendly Programme in Ninh Thuan province in late 2007. The lessons learned from Ninh Thuan will inform the IBCC approach in other provinces.

### ISSUE

Ninh Thuan is one of the poorest provinces in Viet Nam. Located in the south Central coastal region of the country, around 25 per cent of its population still lives below the international poverty line despite economic growth and steady progress in living standards. It also has significant numbers of ethnic minorities accounting for approximately 22 per cent of the total population.

Many child survival and development indicators present a dismal picture of the Ninh Thuan province compared to national averages. The infant and under-five mortality rates in this province are 36 per 1,000 and 48 per 1,000 (2005 SEDP data) respectively, compared to the national averages of 19 per 1,000 and 23 per 1,000. The malnutrition rate is as high as 30 per cent and access to safe water and sanitation stands at 45 per cent and 40 per cent, respectively (NT SEDP data).

In terms of reproductive health, poor infrastructure, lack of medical equipment and essential drugs and inadequate capacity of health workers are common challenges in provinces like Ninh Thuan. These challenges are compounded by the low awareness in local communities about dangerous symptoms during pregnancy and delivery, different contraceptive methods and sexually transmitted infections.

### STRATEGY AND IMPLEMENTATION

The IBCC programme aimed to increase awareness of and improve attitudes and change behaviours towards key children and women's issues among local political leaders and government officials, communities and families. In late 2007, UNICEF Viet Nam initiated the IBCC programme as part of the Ninh Thuan Child-Friendly Programme. The objective of the IBCC programme is to provide a unique package of communication interventions to ensure that the various actors, starting with the children themselves, access convergent social services. It also targets policy and decision makers and the public at large to ensure a conducive and enabling environment for implementing communication interventions for all sectors: Health and nutrition; water, sanitation and hygiene; child injury prevention; and child protection and education.

To promote change and positive development, IBCC communication interventions target people at three levels. The first is the individual level with the primary targets being children, parents and caretakers. The second is the community level, with a focus on people in the community and service providers. Third is the provincial level, which includes authorities and policy makers, to ensure strong policy and legislative support for change.

IBCC also integrates different communication channels. Research shows that interpersonal communication such



## Priorities and Roadblocks

	LESS IMPORTANT	MOST IMPORTANT
LESS CHANGEABLE (define why? = roadblocks!)	X	#2 - Area for research-based / innovative communication
MOST CHANGEABLE	#3 - Easy to implement – can work as catalyst for other areas	#1 - Immediate action – 'Quick Win'

as house visits and group meetings are most effective in realizing behaviour change, and these have been the main focus of the IBCC work in Viet Nam so far. Commune health workers and collaborators are often from the same community and thus understand the local culture and language. When visiting each household they explain the key issues with flip charts and leaflets. Monthly group meetings for pregnant women and mothers with infants are organized to raise awareness on nutrition issues as well as on the prevention of child injuries.



The first step of the IBCC planning process was a brainstorming session involving relevant UNICEF staff. From June to August 2007, focal points from different UNICEF sections held meetings to identify key issues and problem behaviours in Ninh Thuan based on available data and experiences in the region. A prioritized list of problems and behaviours was developed, taking into account the importance of the problems and the potential for behaviour change among targeted groups.

In September 2007, a planning meeting took place in Ninh Thuan involving all UNICEF focal points, the Provincial People's Committee and relevant provincial departments to identify and prioritize key issues, audiences and channels, and identify research gaps and methods. As a result



of the meeting, a set of prioritized problems was agreed upon, and a communication strategy was developed to respond to these problems.

In November 2007, UNICEF focal points and key counterparts met again to plan IBCC activities for different audiences. This time, grassroots collaborators and communicators who work in the project communes joined to learn about this new integrated approach and assisted in developing activities on the ground. An IBCC working group has been formed to implement and supervise the activities. The group is led by Department of Planning and Investment (DPI) and coordinated by the Centre for Health and Education (CHE) with participating lined departments that include: Department of Health (DOH), Preventive Medicine Centre (PMC), Provincial Centre for Clean Rural Water Supply and Environmental Sanitation (PCERWASS), Department of Education and Training (DOET), and Department of Labour, Invalids and Social Affairs (DOLISA).

At the end of 2007, a Programme Communication Officer joined UNICEF to support implementation of the IBCC in Ninh Thuan. His first assignment was to carry out a knowledge, attitudes and practices (KAP) survey with the IBCC Working Group (CHE, DOET and DOLISA staff). The field staff met with approximately 200 individuals from local communities and gathered information on safe water, health and nutrition, education and child protection.

In 2008, together with the implementation of Ninh Thuan IBCC programme, two other provinces (Dien Bien and An Giang) were prepared for the IBCC's implementation in 2009. However, at IBCC planning stage in Ninh Thuan, problem identification was done by different social sector and appeared to have some limitations for the integration of different provincial departments on IBCC implementation.

Because of lessons learned in Ninh Thuan, during the planning stage in Dien Bien and An Giang provinces, problem identification was done based on cross-cutting

disciplines of child rights – survival, development, protection and participation – not by sector. And at the next stage, each IBCC activity was designed with an approach that requires joint implementation with more than one line department. This will require more collaboration among line departments.

At the school level, in 2008, IBCC-trained teachers have developed an extracurricular activity called ‘outside of class learning time’ to focus on communicate about issues such as hand washing, children’s rights and brushing teeth. Teachers try to make the learning time more creative and fun with music, dance and singing. However, it appeared that children need more creative activities which allow them to extend beyond the one way communication environment.



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Given this challenge, a Creative Connection Pilot (CCP) was implemented from August 2009 to January 2010. The aim was to set up an after school programme in three secondary schools in Ninh Thuan that enabled teachers and pupils to creatively explore specific identified child key issues e.g. traffic accident prevention, safe water, hygiene, in after school workshops. This programme was to be in contrast to other more formal mass communications and aimed to enable local, relevant learning and communications on child safety issues. These workshops culminated in a school sharing event.

At the beginning of 2009, UNICEF established a C4D unit with five staff under Child Survival and Development programme (CSD). One of the main focus areas of the C4D unit is the IBCC programme that moves away from the traditional Information, Education and Communication (IEC) interventions towards a creative and innovative approach, evidence-based and strategic communication, as well as capacity building to ensure the integrated approach.

## PROGRESS AND RESULTS

### The IBCC two-year implementation, 2008-2009

In the beginning, local partners felt that the IBCC initiative made sense, but would be difficult to carry out. In the past, there had been different types of behaviour change communication initiatives focused on different sectors, but targeting the same audiences: caretakers of children, mothers, pregnant women and children. The current IBCC initiative provides a unique package of communication interventions that eliminates these overlaps and creates synergies.

What the IBCC initiative means in practice is best explained through some examples: health care workers used to communicate with community members about health and nutrition. With IBCC, they are expected to communicate not only health messages, but also education, child injury prevention, child protection and safe water and sanitation messages. In the mass media, TV and radio programmes used to focus on one sectoral theme related to children, but with IBCC, they provide integrated messages on several key priority issues.

The IBCC orientation workshop and several communication skills trainings took place throughout 2008. Over 400 provincial officers, health workers and school teachers participated in different types of training to build their capacity in interpersonal communication (especially listening skills), and in providing integrated messages and information on issues such as children’s rights, prenatal check-ups, safe water, and hand washing. Village leaders and grassroots collaborators from the Women’s Union, Youth Union and Farmers Union also participated in the trainings. Their voluntary assistance to the teacher and health workers brings IBCC to the local level and mobilizes the society ‘from below’.

The supports and active participation of local authorities and community networks are essential for IBCC to create an enabling environment for sustainable behaviour and social change. One-day workshops at the commune level with village leaders and representatives of the mass organizations were conducted to strengthen their involvement in IBCC and social mobilization activities in 2009. In 2010, community support group at grassroots level are expected to strengthen community involvement, e.g. community support group for breast-feeding promotion.

Mass media provides other key communication channels for disseminating key messages efficiently. In Ninh Thuan, the provincial TV and radio channels, as well as the local loud speaker system, broadcast programs 20 times a month for six months. As part of the program, IBCC packages are distributed at special events such as Viet Nam’s national Children’s Day in June 2008. A writing competition



was organized for primary and secondary school children and 1,380 essays were submitted under a theme “What can pupils do to make our lives better?” Another campaign was Breastfeeding Week in which over 840 mothers attended to learn more on the importance of breastfeeding.

The pilot of ‘Creative Connection’ was generally successful in enabling teachers to run an after school behaviour change programme using new creative, communicative classroom techniques which were by and large widely adopted in the CCP activities and which were also transferred to normal classroom timetabling.

The pilot was also successful in allowing the students’ ‘voice’ to be heard regarding the child safety themes. Most of the products at the school sharing events were clearly authentic, pupil driven works, ‘owned’ by the students and demonstrating a clear connection to child key issues.

The pilot was moderately successful in helping schools move away from the more traditional didactic message based programmes organized at local and school levels. At the heart of CCP is the need for pupils, teachers and parents to make connections in their lives both within the safety theme and with other safety themes that go deeper than simple message delivery mechanisms. The processes followed and the products produced show a move towards a more detailed exploration of subjects using non-traditional forms such as photography, mapping, sculpture, displays and hip-hop.

However, the CCP was less successful in enabling further high quality dialogue, sharing and exploration of the issues between parents, teachers and pupils especially at the school sharing events. This was largely due to the project design and the time constraint of CCP that did not allow for additional focus on teacher’s facilitation and sharing skills and dialogue building but instead focused on teaching skills development, creative process and art product making as the main building blocks.

In 2009, a network of UN agencies and NGOs was set up to share the experience on creative communication for behaviour and social change. In November, 2009, the first information sharing was conducted in UNICEF with the participation of 17 NGOs and UN agencies to exchange experiences and lesson learned on creative communication and to seek possibility of collaboration and networking.



## LESSONS LEARNED

While the establishment of a functioning IBCC working group at provincial level was essential, coordination between different line departments within the group still needs improvement. Although stakeholders have agreed to focus on children’s issues and cooperate with other departments, in reality it is still not clear how to work together. Another challenge is the issues from five sectors leading to an overloaded communication agenda for the actual implementer, and the challenge to integrate 14 key issues into plans and activities. The number of key issues/behaviours from five sectors needs to be limited, prioritized and linked together for better coordination/implementation.

Lessons learned from the IBCC Ninh Thuan initiative on maximizing the integration of provincial departments on IBCC implementation include:

1. At the first stage of the planning process, problem identification should be done based on child rights – survival, development, protection and participation – rather than by sector (health and nutrition, education, safe water and sanitation, child protection, child injury prevention, etc). At the next stage, each IBCC activity should be designed with an approach that requires joint implementation with more than one line department. This facilitates and promotes more collaboration among line departments.
2. Development of the IBCC plan by using results from the KAP survey and available data enabled an evidence-based approach and was a good start. However, there is still need to revisit and improve audience

analysis, channel analysis and IEC material assessment in order to strategically choose the best channel and tools that are needed to reach the audience.

3. Social mobilization and community-led social change (communication for social change) need to be strengthened to create a more enabling environment for sustainable social change. One-day workshops at the commune level with village leaders and representatives of the mass organizations were conducted to strengthen their involvement in IBCC and social mobilization activities in 2009. However, more activities need to be implemented to empower communities and networks to influence and reinforce social norms and cultural practices. In 2010, community support group at grassroots level are expected to strengthen community involvement, e.g. community support group for breastfeeding promotion.
4. Creative, innovative and participatory approaches to communication need to be considered for a successful behaviour change communication. Piloting a school-based approach 'Creative Connection' was successful in creating a process whereby pupil generated IBCC materials, as opposed to mass, centrally produced products, were made that had an authentic, relevant and creative local 'voice'.
5. IBCC should be strategic. It should be planned for a longer period (e.g. for the full five year duration of the country programme) instead of simply being part of the Annual Work Plan.

## POTENTIAL APPLICATION

After two years of experience with the IBCC initiative in Ninh Thuan, it appears that the IBCC approach is a good model, with clear planning stages and steps, and a process that is easy to replicate in other provinces. This approach also helped to eliminate inconsistencies and overlaps among projects in different sectors. In 2010, The IBCC programme is planned to be implemented in two other provinces.

## NEXT STEPS

At the end of 2010, an impact evaluation on IBCC programme will be implemented in Ninh Thuan. The results will serve as evidence for new CP planning as well as to advocate Vietnamese Government for IBCC model replication.

IBCC programme is planned to be implemented in two other provinces (Dien Bien, An Giang) in 2010. From the lesson learned of Ninh Thuan, these provinces have prepared well for 2010 IBCC implementation. In 2009,



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there was a planning workshop, IBCC skills training, IBCC materials package development and the establishment of a provincial IBCC working group.

At the planning stage, in Dien Bien and An Giang, the problem identification was done based on child rights – survival, development, protection and participation – rather than by sector (Health & Nutrition; Water, Sanitation & Hygiene; Child Injury Prevention; Child Protection and Education) as in Ninh Thuan to maximize the integration of different provincial departments. And each IBCC activity was designed with an approach that requires joint implementation with more than one line department.

The Creative Connection pilot has finished and the next step is to explore scale up options that reflect both the learning from the pilot project and community priorities. It is planned to scale up in Ninh Thuan and other provinces Dien Bien and An Giang.

Networking with other UN agencies and NGOs who have been implementing behaviour and social change activities in the same location will be strengthened.

**For further information on Lessons Learned and Good Practices, please contact:**

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