Session Three

Outreach to especially vulnerable children

International Symposium on Child Poverty and Development

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The State Council Leading Group Office of Poverty Alleviation and Development

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Outreach to especially vulnerable children

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Outreach to Especially Vulnerable Children

Gaspar Fajth, Regional Adviser, Social Policy
UNICEF Eastern and Southern Africa

International Symposium on Child Poverty and Development

Beijing, China on 20–22 November 2012

The Structure of the Presentation

- Especially Vulnerable Children – Basic definitions
- Especially Vulnerable Children – Why is it important to reach them?
- Identifying Especially Vulnerable Children
- Reaching out to Especially Vulnerable Children – Legislation, policies and programmes
- Two frameworks
- Takeaway messages

Especially Vulnerable Children
– basic definitions (1)

- Reminder: Children = boys and girls age 0-17
- Reminder: difference between risk and vulnerability
  - Aggregate impact = f (probability of occurrence * size of harm caused)

  - Risk = the probability that adversity (negative event) will occur (e.g. earthquake, drought, family breakdown, lack of access to service)
  - Vulnerability = poor ability to withstand adversity (negative event)
    - *Vulnerability is a manifestation of poor material and psychosocial assets (individual and/or family and/or community)*

- In terms of population impact especial vulnerability means
  - Especially high frequency of risks and/or
  - Especially devastating impact of exposure to adversity due to poor assets

Especially Vulnerable Children
– basic definitions (2)

- UNICEF definitions
  - *Children living in poverty: "* experience deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society" (state)
  - *Marginalized children*: "Children who persistently lack effective access to needed information and one or more quality basic services, and/or are subject to abuse, violence and exploitation" (status)
- All children are vulnerable – special vulnerability may arise from current conditions or past experience
  - Geographical, ethnic, family backgrounds, income, language etc. barriers
  - Past exposure to deprivation, poverty and/or abuse
  - Disadvantage could become irreversible or trigger qualitative change in status after a certain period (adult example: skills depreciation, homelessness)
- Aggregate costs to individuals and society depend on how
  - long-lasting impacts will be
  - difficult will be to heal impact

Takeaway messages (1)

- Policies could focus on preventing risks and/or on reducing vulnerability to impact (resilience)
- Exposure to poverty and other adversity is harmful through a combination of material and psychosocial effects
- Policies often oversee psychosocial effects
- We – as individuals as well as community – tend to be more vulnerable to psychosocial than to material impact (one single case of abuse can have lifelong, difficult-to-heal impact)
- Resilience means building assets (individual, community)
- Early warning, monitoring and evaluation systems could be important building blocks for resilience through timely feedback to policy and action
- Prevention and protection is often also cheaper…

Especially Vulnerable Children
- why is it important to reach them?

- Charity, solidarity
- Human rights
  - The Convention on the Rights of the Child (CRC)
  - CEDAW
  - CRPD
- Human development
  - MDGs, poverty eradication, social development (including public health)
  - Economic growth
  - Social cohesion
- Governance
  - Political stability, citizenship
  - Programme quality and efficiency

Especially Vulnerable Children
- how we can reach them?

- The short way
  - Develop an innovative model or import a programme that works elsewhere
  - Pilot and evaluate, show it works!
  - Mobilize political and financial support, scale-up programme
- The long way
  - Define the problem, including underlying and root causes
  - Provide a conceptual framework, highlight overlapping issues
  - Measure the issue
  - Debunk myths
  - Advocate, build a coalition of stakeholders
  - Consider international experience
  - Develop and implement policies and programmes
  - Monitor and assess progress, evaluate programmes
  - Make necessary adjustments in concept, strategy and implementation

Identifying Especially Vulnerable Children
– The Categorical Approach (1)

- The "small five" – hard to reach
  - Children left without parental care (1%*)
  - Street children (2%)
  - Children of migrant parents (5%)
  - Children living in slums (10%)
  - Children without adequate documents (15%)
- The "big five" – hard to deliver
  - Children with disabilities (15%)
  - Children of ethnic minorities (20%)
  - Children living in poor households (30%)
  - Children living in rural/remote areas (40%)
  - The girl child (50%)

**Note: the prevalence rates (%) are meant only to be indicative for a typical developing country; reality may differ considerably*

Identifying Especially Vulnerable Children
– The Categorical Approach (2)

The list of special vulnerability can be very long and compounding

- …
- Children with birth defects
- Orphans
- Children in public care
- Children living in female headed households
- Those living in extreme poverty
- Children who belong to groups exposed to discrimination
- Those living without road access or information access
- Children with certain medical conditions (HIV, diabetes, etc.)
- School dropouts
- Stunted and/or wasted children

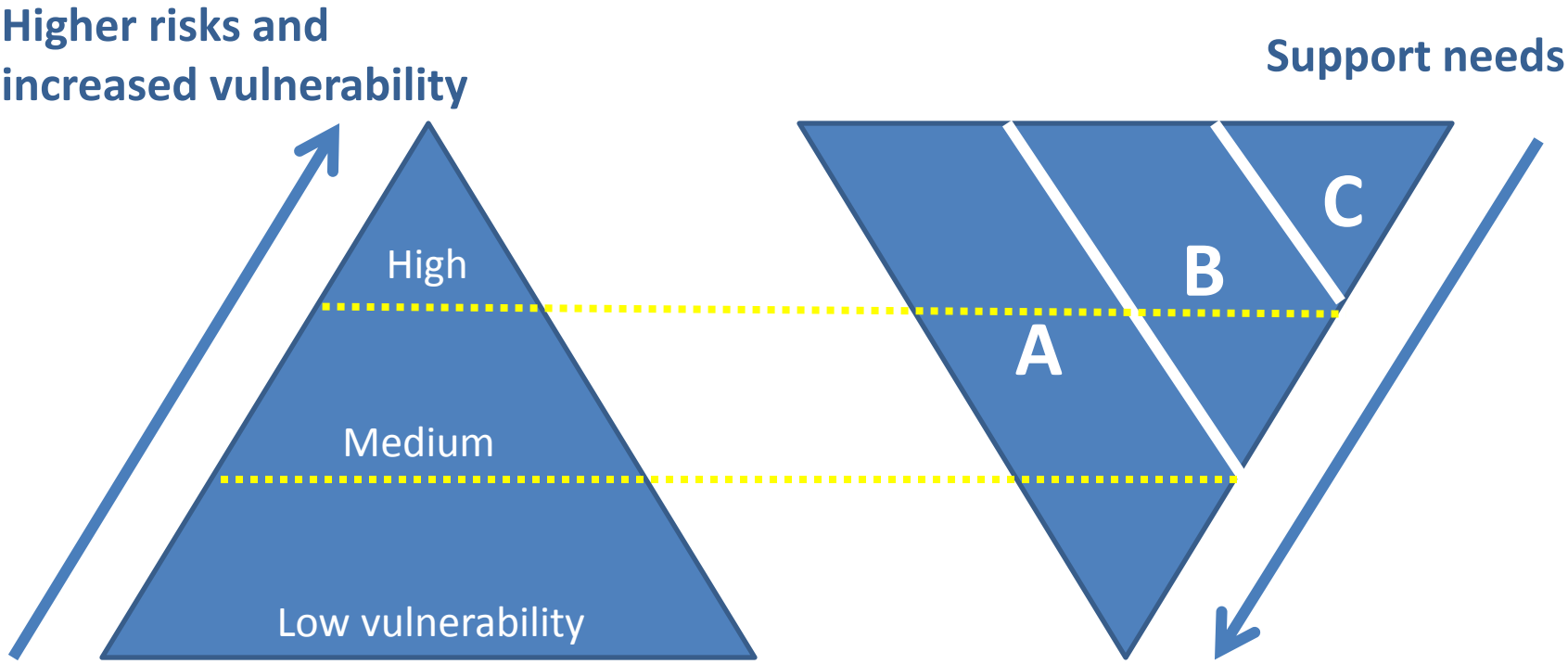
– Takeaway messages (2)

- Especially vulnerable children are not always a minority
- However, some children are always more vulnerable than others
- Focus on *multiple deprivations* and/or individual markers of disadvantage which are highly associated with vulnerability can work better than a simple categorical approach or overly broad approach
- However, overly narrow targeting can backfire in many ways
- Identifying vulnerable populations in statistical terms helps policy and programme outreach but arrangements are necessary for individual case work, grievance and correction
- Because of compounding vulnerability packages of interventions (bundled, conditioned, unconditioned) tend to work better

Reaching out to Especially Vulnerable Children
– Legislation, policies and programmes

- The importance of international and national legislation
- The importance of national development, poverty reduction strategies
- The importance of sector policies and annual public budgeting process
- The need for champions, stakeholder collaboration, civil society
- The importance of universal birth registration and having at least one universal entitlement from pregnancy and early childhood (health , nutrition, early stimulation are especially important)
- The importance of continuity in service coverage and availability of additional policy programme (affirmative action and special entitlements)

Reaching out to Especially Vulnerable Children
– The Framework of Twin Pyramids



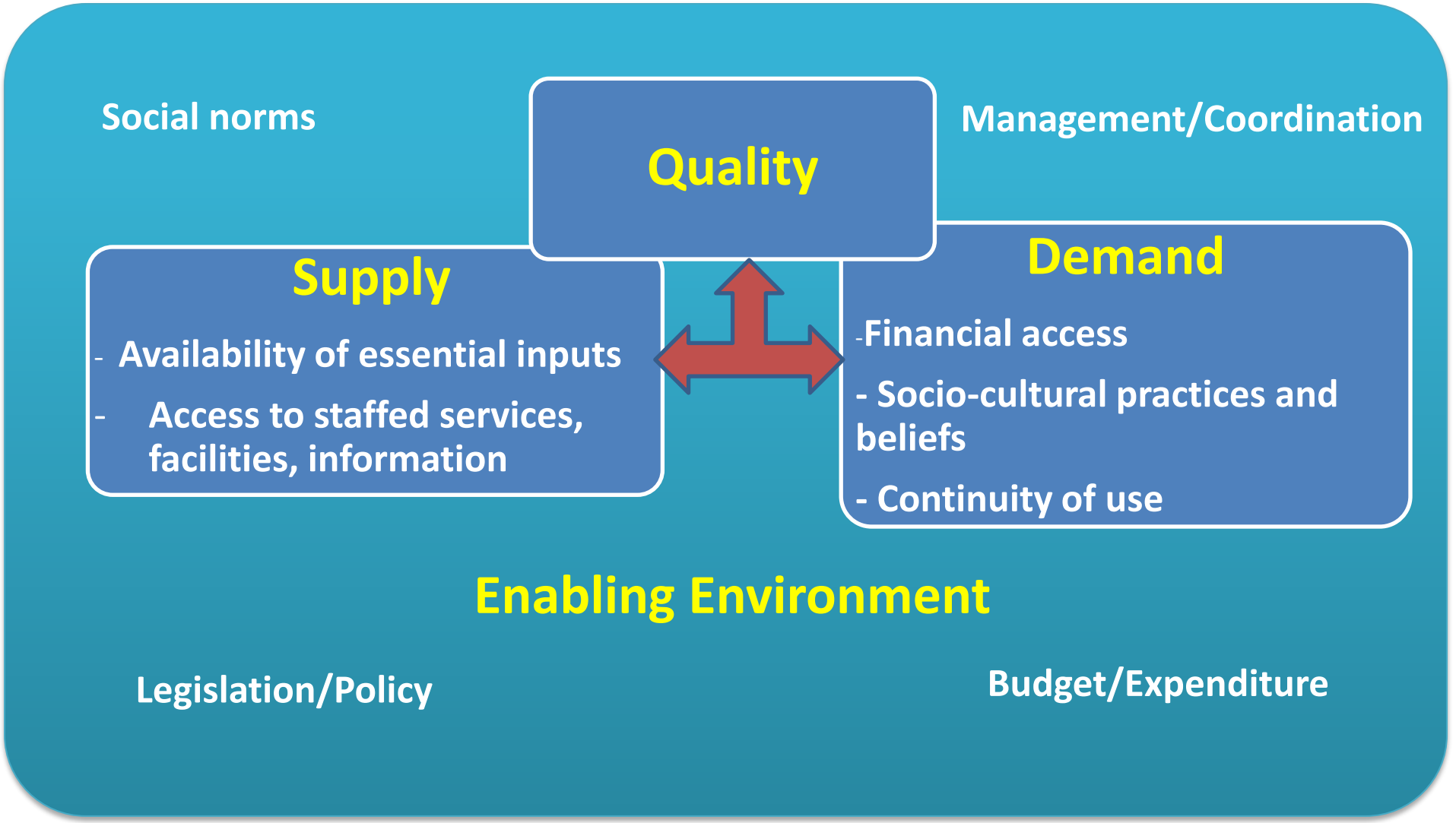
Individual, family and community assets

"A" type: universal programmes

"B" type: supportive services

"C" type: programmes targeted at the most vulnerable

Analyzing Determinants of Equity in Access and Effective Use of Services



Reaching out to Especially Vulnerable Children
– What does it take?

- Specific, targeted social programmes
- Feedback, participation (citizens, civil society)
- Child and gender friendly/sensitive, equity-oriented large scale human development programmes
- Inclusive economic growth
- Political prioritization

Reaching out to Especially Vulnerable Children
– Takeaway messages (3)

- The quality of services available for the general child population matters for especially vulnerable children
- Different approaches exist for inclusion – “inclusive” and “special measures”
- The “middle ground” is important
- The quality of supply matters but so does the quality of demand too
- Reaching out to especially vulnerable children goes beyond technicalities
- Political priority is essential at all levels

Thank you!

Ethnic Minority Child Poverty in Vietnam

Trinh Cong Khanh, Director of the Policy Department
Committee for Ethnic Minority of Viet Nam

International Symposium on Child Poverty and Development
Beijing, 20-22/11/2012

Outline

1- Ethnic minorities and poverty in Viet Nam

2- Multidimensional approach to child poverty

3- Ethnic minority child poverty in Viet Nam

4- Policy measures to reaching out ethnic minority children

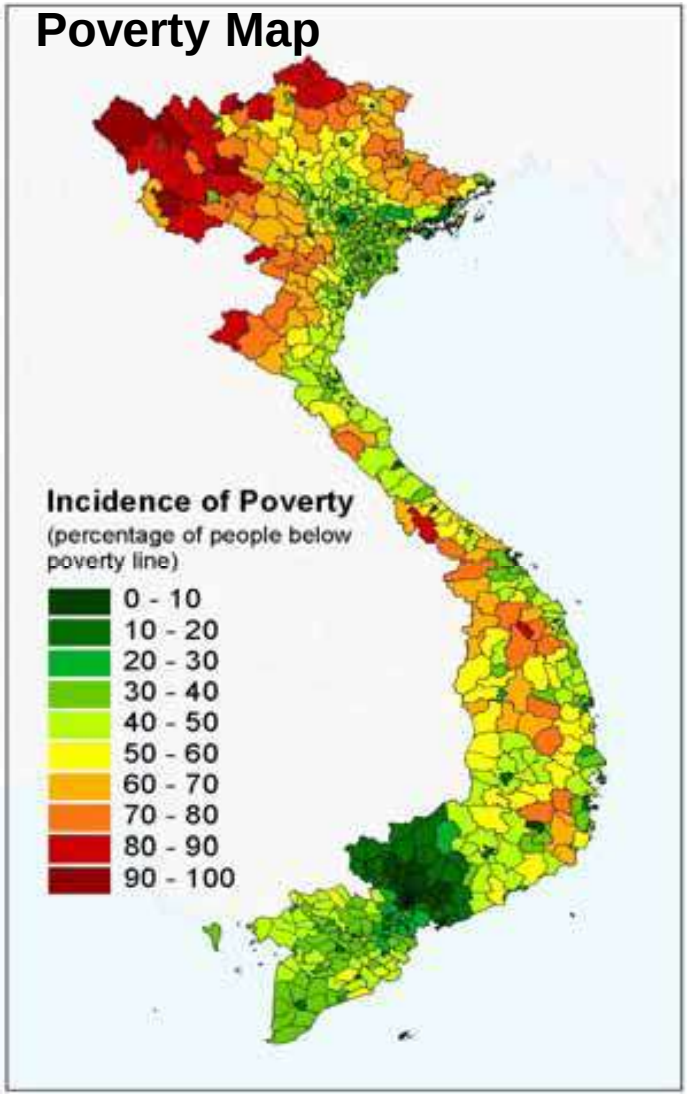
Ethnic Minorities in Vietnam

Vietnam is a multi-cultural nation with 54 different ethnic groups, among which, 53 ethnic minority groups (EM) accounts for 14% population with their distinct language and culture

75% EM reside in a scatter manner in the Northern mountainous, Central highland and border areas where frequently face with natural disasters, storms and flood and difficult transportation

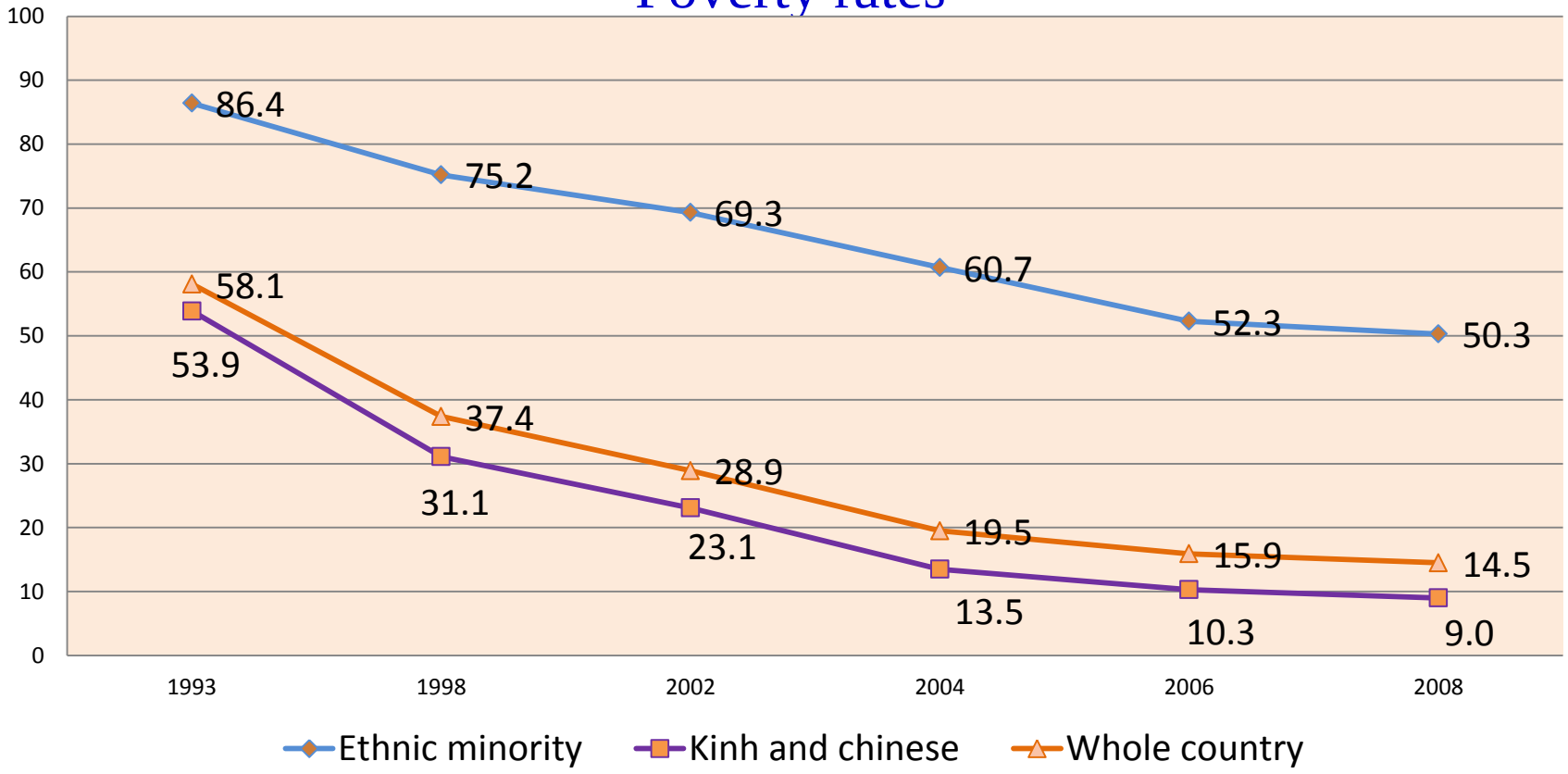
EM stays behind in economic development and gaps are increasing

EM child are disadvantaged in terms of getting accessed to basic social services such as health care, education, safe water and hygiene, etc…



Ethnic Minority Poverty

Poverty rates



- **Poverty reduction rate of EM is slower than that of Kinh/Hoa,**
- **More than ½ EM live under poverty line**
- **A consolidated figure on EM poverty in general fails to fully reflect the EM child poverty in reality**

Multidimensional approach to Child Poverty

New approach on child poverty

Monetary Poverty is just one dimension of poverty, its measures does not take into account the fact that

(i) Children are more vulnerable to poverty?

(ii) Children have different basic needs than adults (dietary, educational)?

(iii) Children depend on others' resources?

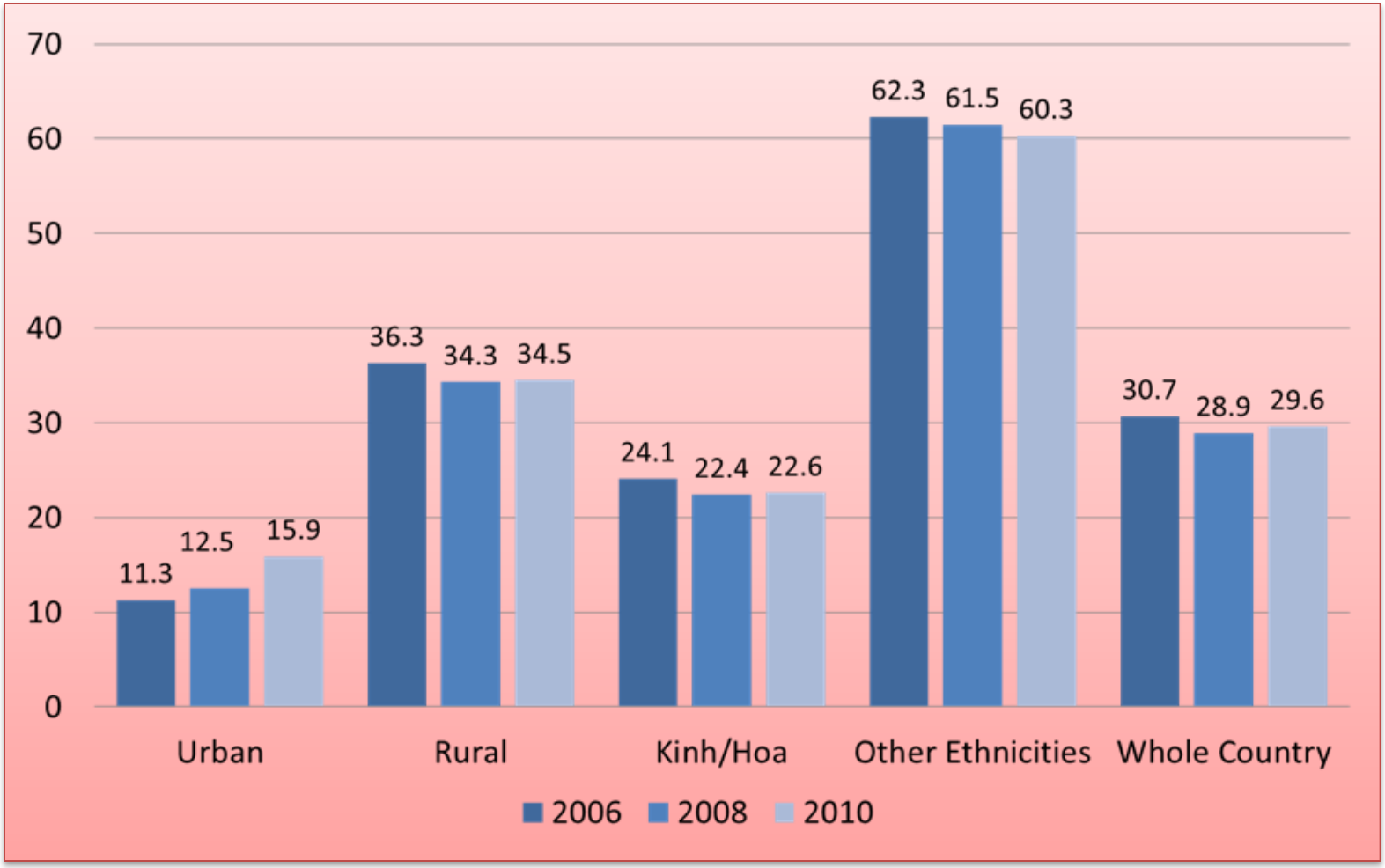
Multidimensional Child Poverty measures take into account following domains

1. *Education*
2. *Nutrition*
3. *Health*
4. *Shelter*
5. *Safe water and hygiene*
6. *Entertainment*
7. *Protection: child labor*
8. *Social inclusion*

***Definition**: A child is considered poor when deprived from basic human needs in at least two of the above domains*

- *Poor children are not only those living in (monetary) poor households*

Multidimensional child poverty in Viet Nam by selected socio-demographic variables, 2006 – 2010



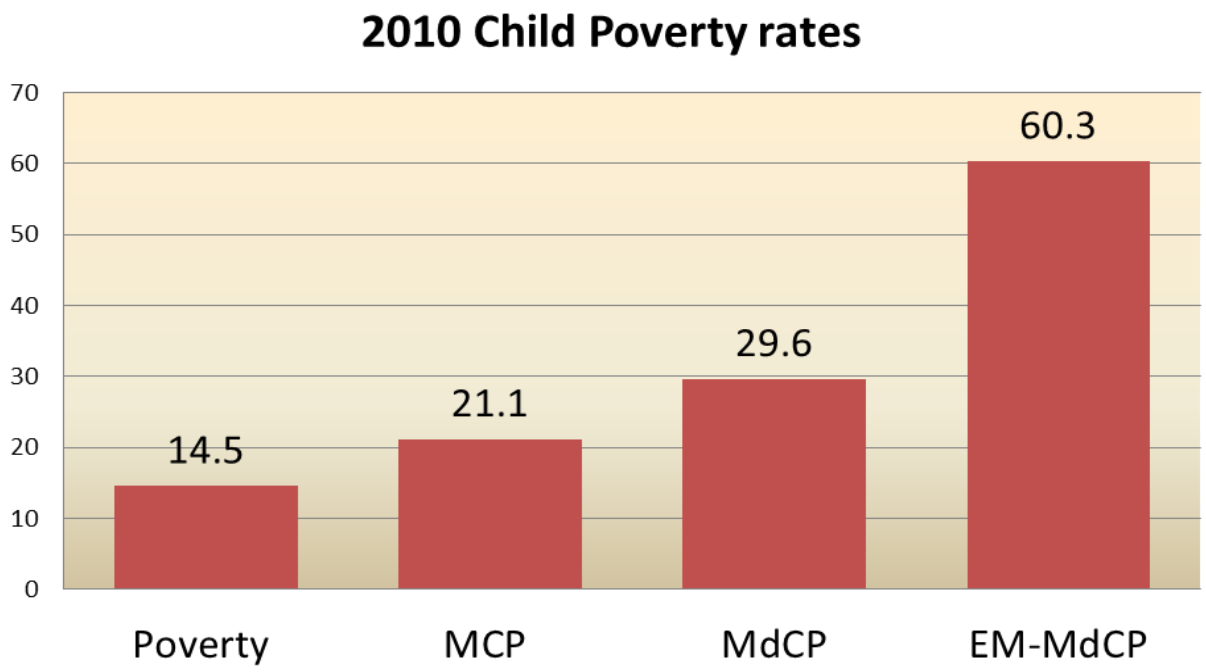
Ethnic Minority Child Poverty

Ethnic Minority Child Poverty

Figure 2: Poverty, Monetary (MCP) and multidimensional Child poverty (MdCP) and EM child poverty EM-MdCP

The EM child poverty is more highlighted.

More than 60% EM children are living under poverty line AND facing shortage of basic needs.

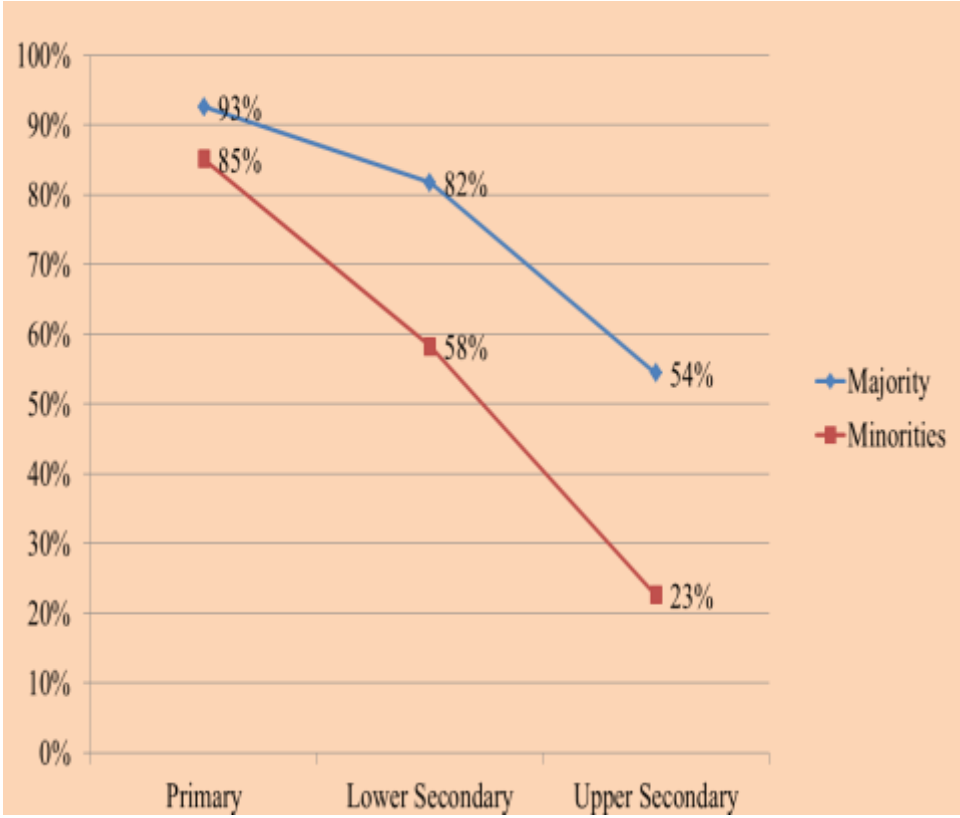


Rate of those facing at least 1 basic needs		Facing at least 2 basic needs
Mong	99,5%	97,9%
Thai	77,6%	36,6%
Tay/Muong	47%	17%
Kinh/Hoa	31,6%	8,4%

Education poverty and disparity

Net Enrolment Rates in Rural Areas, 2009
Source: 15% sample of Population and Housing Census

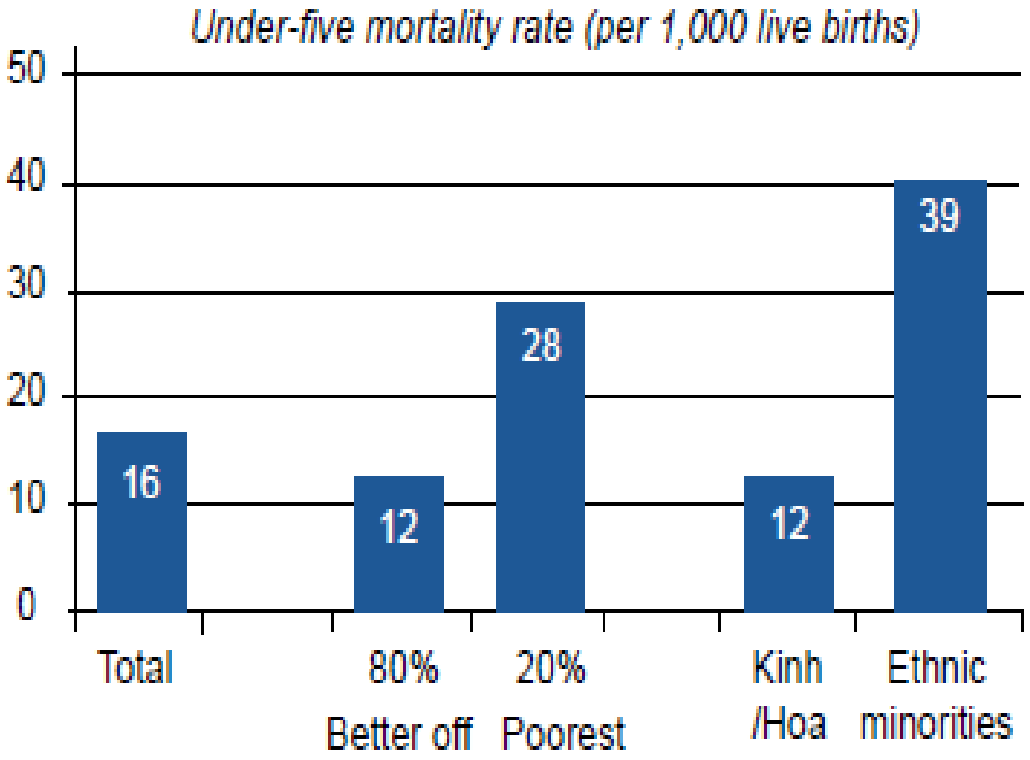
- Greater gaps between the majority and minority at higher educational levels
- EM children do not attend school at right age three times higher than the majority (27% vs. 13%);
- 17.7% EM children do not finish primary school
- 60% of EM children aged 3 to 5 were not going to kindergarten compared to that of 39% of majority children



Reasons for drop out: i) Poverty; ii) School fee, iii) child labour; iv) Language barriers; v) school far away; vi) not enough school books….

Health and Nutrition Poverty and Disparity (1)

- More than one third of EM children died before reaching the age of 5
- 58.5% EM children (age 2-4) fail to get vaccinated of 6 basic diseases
- 60.7% EM children (age 0-4) did not have health checked during 12 month round



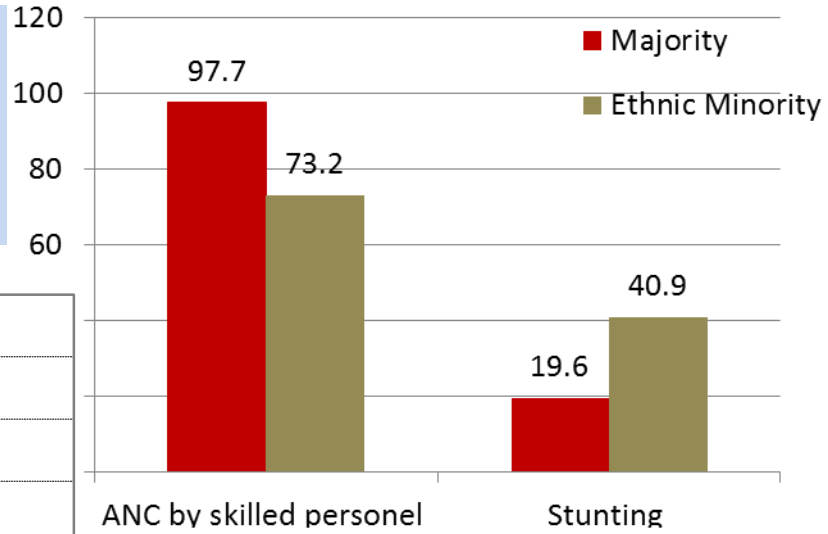
Major barriers to access and use of HC services:

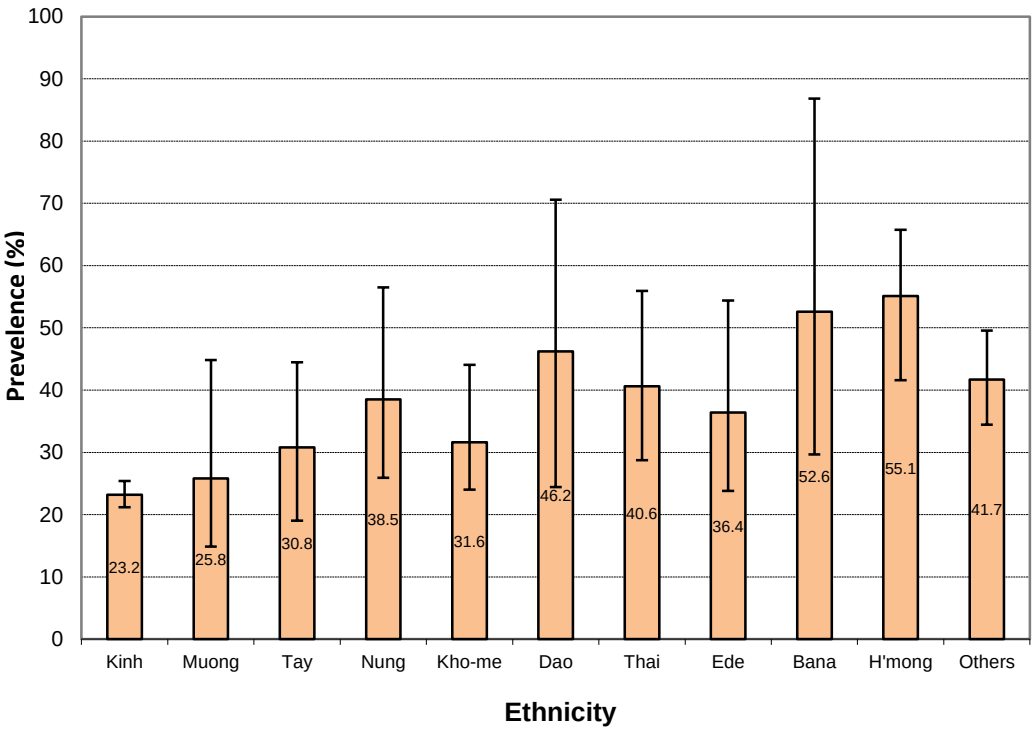
- Cost of medical treatment,
- Cultural practices and lack of awareness about consequences of not using HC services due to low educational levels etc.
- Geographical difficulties,
- Language barriers,

Health and Nutrition Poverty and Disparity (2)

Stunting rate of children under 5 years and ANC by skilled personnel

Stunting rate among EM children is twice higher than majority children



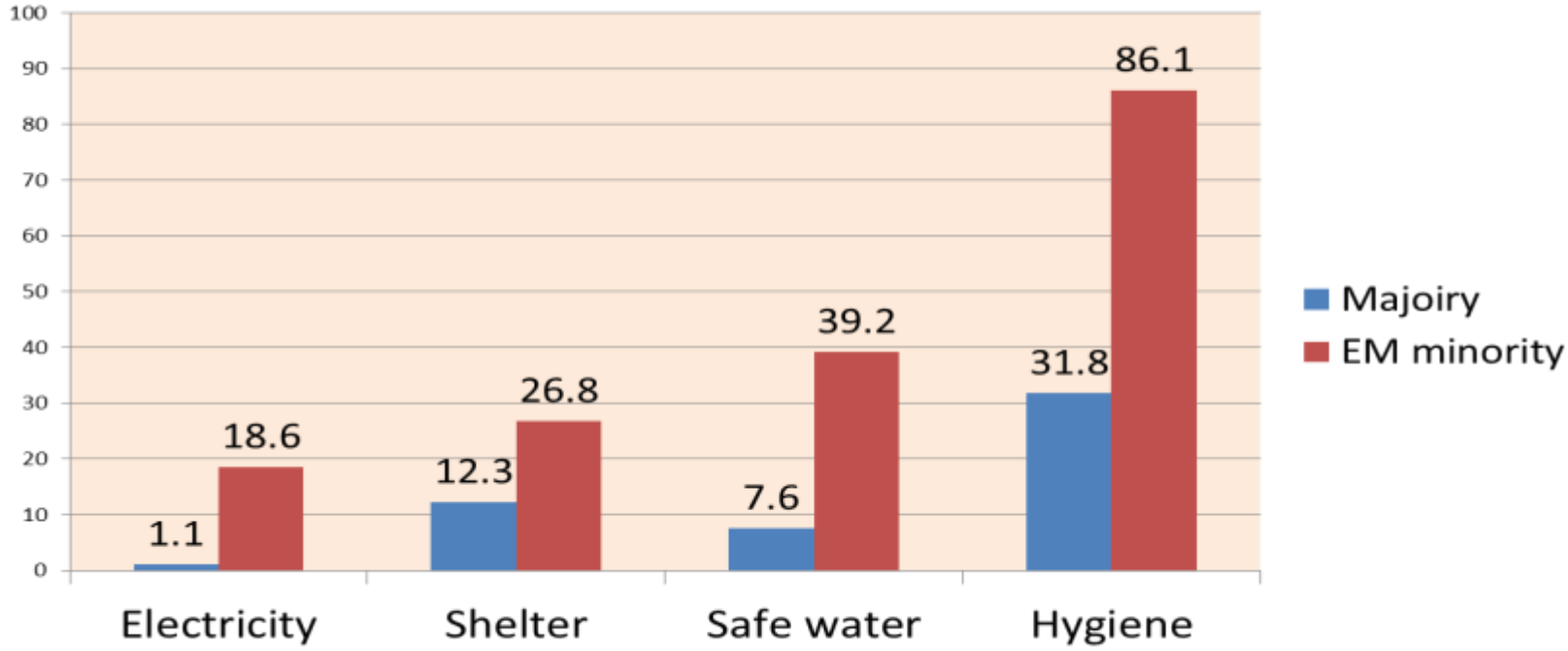


Disparities are evident for child stunting by maternal ethnicity

Source: MICS2010

Environment and living condition Poverty

Rates of children lack of access to ethnicity, shelter, clean water and sanitation



- 18.6 % EM children do not get access to electricity; ¼ households in extremely difficult areas use oil or other light sources
- More than one fourth of EM are living in temporary houses
- Still 39.2% EM children do not get access safe water; 45% households in extremely difficult areas lack of clean water for cooking and drinking
- 86.1% EM children don't have access to sanitary latrines/toilets;

Reaching out EM Children

Overall approach: Putting EM children poverty at the high level of policy agenda

- **Highest level of the political agenda** on social security: Party Resolution Nr. 15 on major social protection policies 2011-2020,with focus on improve living standards of vulnerable groups, particular EM children

- **EM human resource development strategy, 2011-2020**: putting EM children at the central of the strategy

- **Poverty reduction (PR) agenda:** multidimensional aspects of EM child poverty integrated into Resolution 80- sustainable PR (2011-2020); National target program for PR (2011-2015); Special social economic development programs in most disadvantaged and EM areas

- **Regular monitoring poverty reduction** among EM children: the nature of EM child poverty regularly identified, analyzed and integrated into the national poverty reduction reports

Some special measures: Education

- **Accessible school settings** : Hamlets/ villages classes available for pre- schools and 1-3 grades of primary education; “Semi boarding schools” for primary and secondary education;

- **Financial support** to enhance EM school attendance and continue higher education, incl. direct cash support (Decree 49), tuition fee waivers at secondary education, financial support for poor students to attend higher education

- **Support learning materials**: Free provision of learning material e.g. books, note books and other learning materials etc.

- **Promote higher education**: Develop the “EM boarding school” systems from the secondary and high schools in districts and free admission to colleagues and university of EM students,

- **Bilingual education**: Start with bilingual education for EM children to help them overcome language barriers and improve quality of learning and teaching

- **School feeding programs** in EM areas: cash support to pre-schools (aged 3-5 years) and semi-boarding schools to ensure adequate nutritious feedings and study conditions

Some special measures: Health and Nutrition

- **Upgrading commune health centers** and strengthening medical cadres in EM area
- **Free health insurance** cards ALL EM people to enhance EM accessibility to quality health care services
- **Ethnicity sensitive services**: Village health workers to support primary health care; Bare foot midwifes to support EM pregnant women, including home delivery; Mobile health team to provide immunization, growth monitoring and health checks to "unreached" children and women
- **Increased provision of health care**, incl. ANC for EM mothers and children, and regular health checks for children; roll out medical doctors to commune health centers
- **Strengthened malnutrition prevention** program: Special nutrition care for EM pregnant women, incl. free provision of supplementary micro nutrients and Vitamin A, encouraging fully 6 month breath breeding and adequate vaccination; Free provision of iodize salt, etc.

Some special measures: Social protection and living conditions

EM child sensitive social protection:

- Comprehensive cash transfers to poor families with children in EM areas to break intergenerational transmission poverty and promote human development (to be introduced)

Housing

- Program 134: Abolition of temporary houses for EM, provision of land for housing
- Extension of electricity to the remote villages/hamlets, subsidy electricity cost for poor and EM households

Safe water and sanitation

- Priorities given to address inadequate access to clean water and sanitation for EM people integrated in all poverty reduction programs, incl. Program 134, Program 135, NTP-Rural water and sanitation programs to EM and Resolution 80 and resolution 30a;
- Increased investment levels in safe water and sanitation in schools, poor households and most difficult communes in EM areas

Thank you

for your attention

Domain indicators

1. Education
Rate of children from 5-15 years old not attending school at the right age
Rate of children from 11-15 years old not completing primary education
2. Health care
Rate of children from 0-4 years old not accessing health facilities during the last 12 months
3. Shelter
Rate of children from 5-15 years old living in a household without electricity
Rate of children from 5-15 years old living in a household whose shelter does not meet standards
4. Water & sanitation
Rate of children living in a household without a sanitary latrine
Rate of children living in a household without clean water
5. Child labor (child protection)
Rate of children from 6-15 years old working
6. Social inclusion and protection
Rate of children living in households in which the head of the household is unable to work
7. Leisure
Rate of children from 0-4 that do not have any toys–Rate of children from 0-4 that do not have any books

Delivery of health service delivery to nomadic herders , Beijing, 21 November, 2012

Chimgee Dorjsuren, Chief pediatrician, Uvs province, Mongolia
Surenchimeg Vanchinkhuu, Health specialist, UNICEF, Mongolia

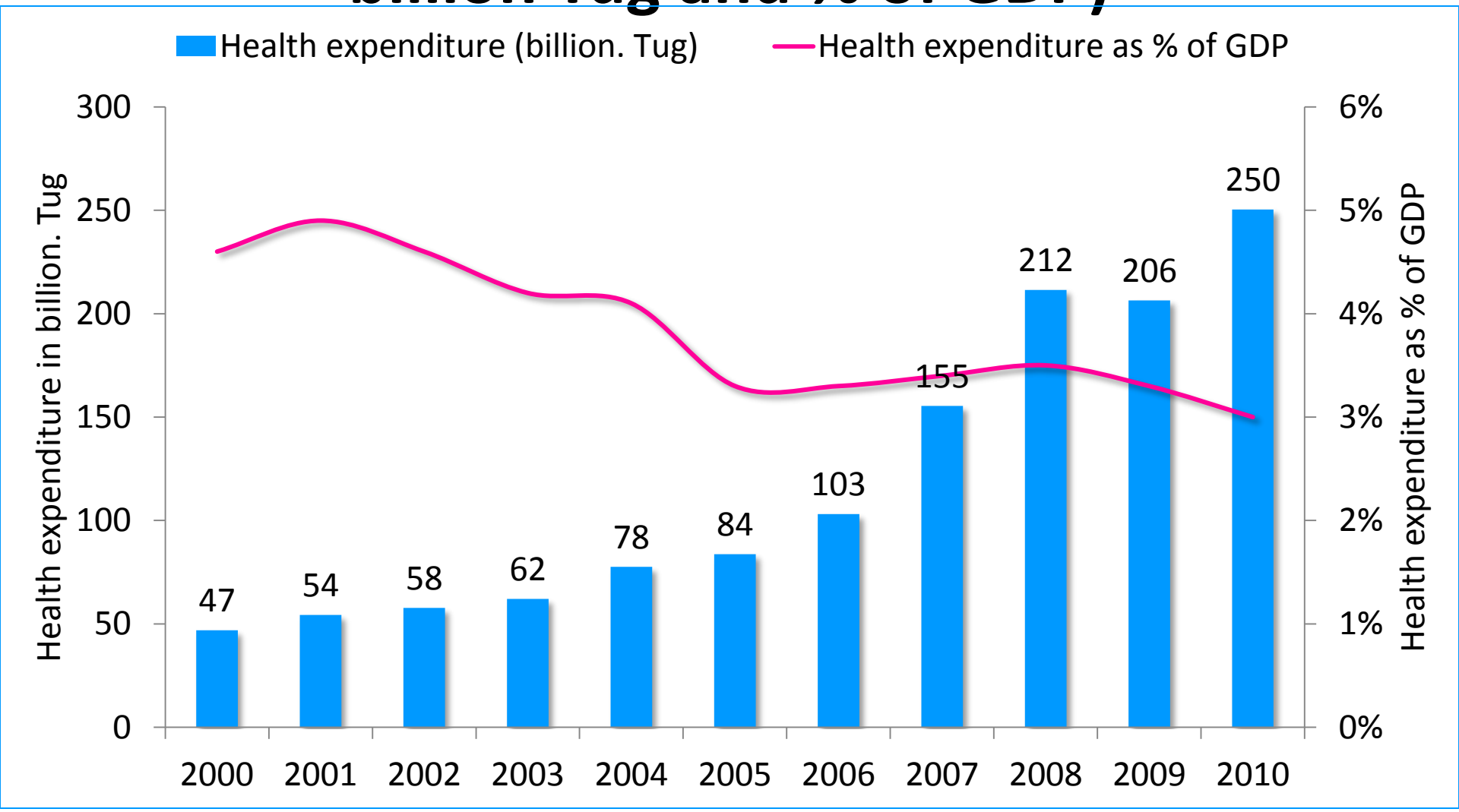
Outline of presentation

- About Mongolia, its development
- About Uvs aimag
- Delivery of basic health services
- Implementation of “Reach Every District and Soum strategy” in Uvs aimag’s poorest soums/baghs

Current development status of Mongolia, NDIC (MOED), 2012

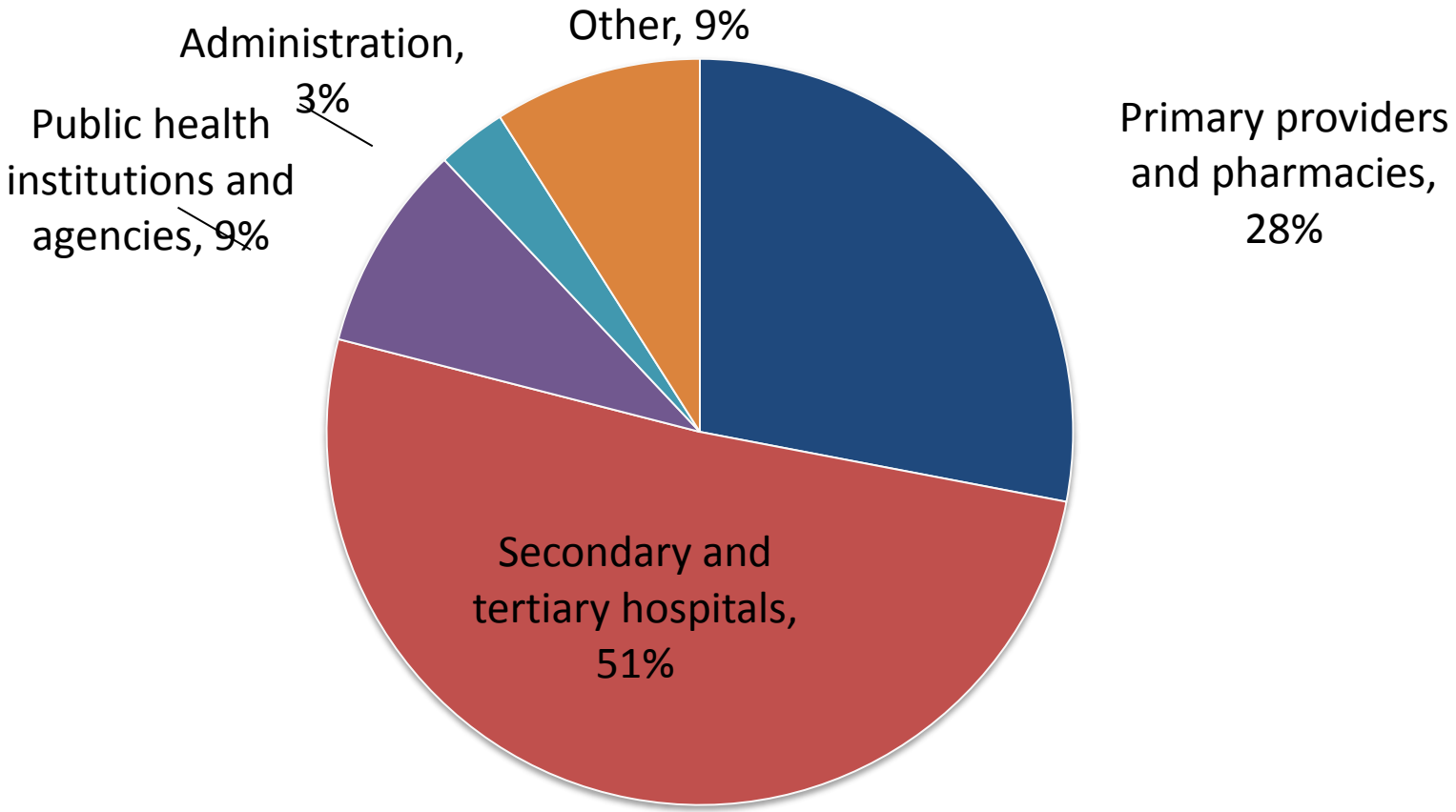
GDP per capita	•Moving from low income to lower middle income country as per WB classification.
Human Development Index	•Takes 100th place out of 169 countries, or average country. Income indicator is the lowest among HDI.
Competitiveness Index	• 96th place our 143 countries as per World Economic Forum report on World Competitiveness
Quality of Life	• Quality of life Index is 107 out of 192 countries

Total Health expenditure in Mongolia (in billion Tug and % of GDP)

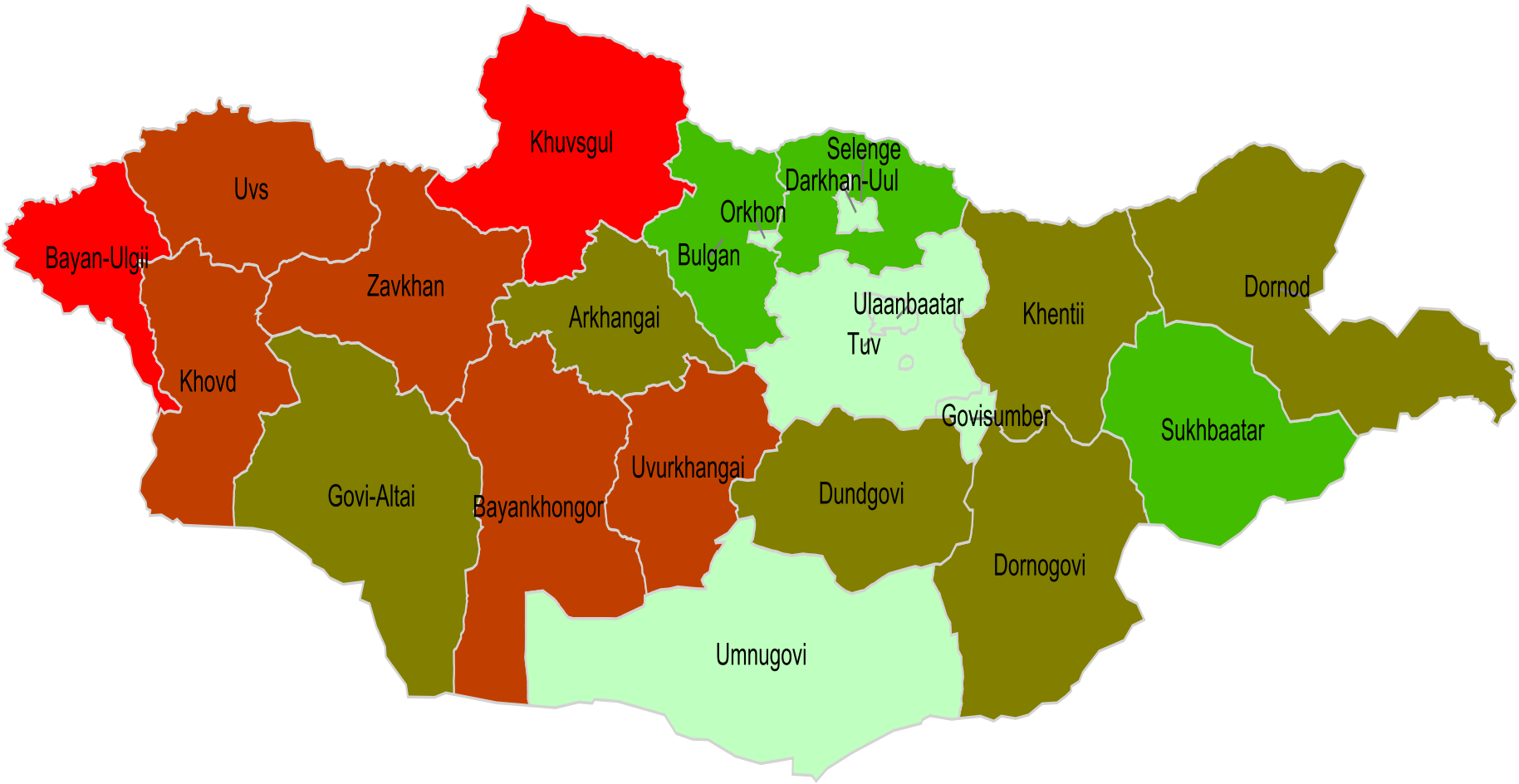


Imbalance in Health Expenditure in Health System (Mongolia)

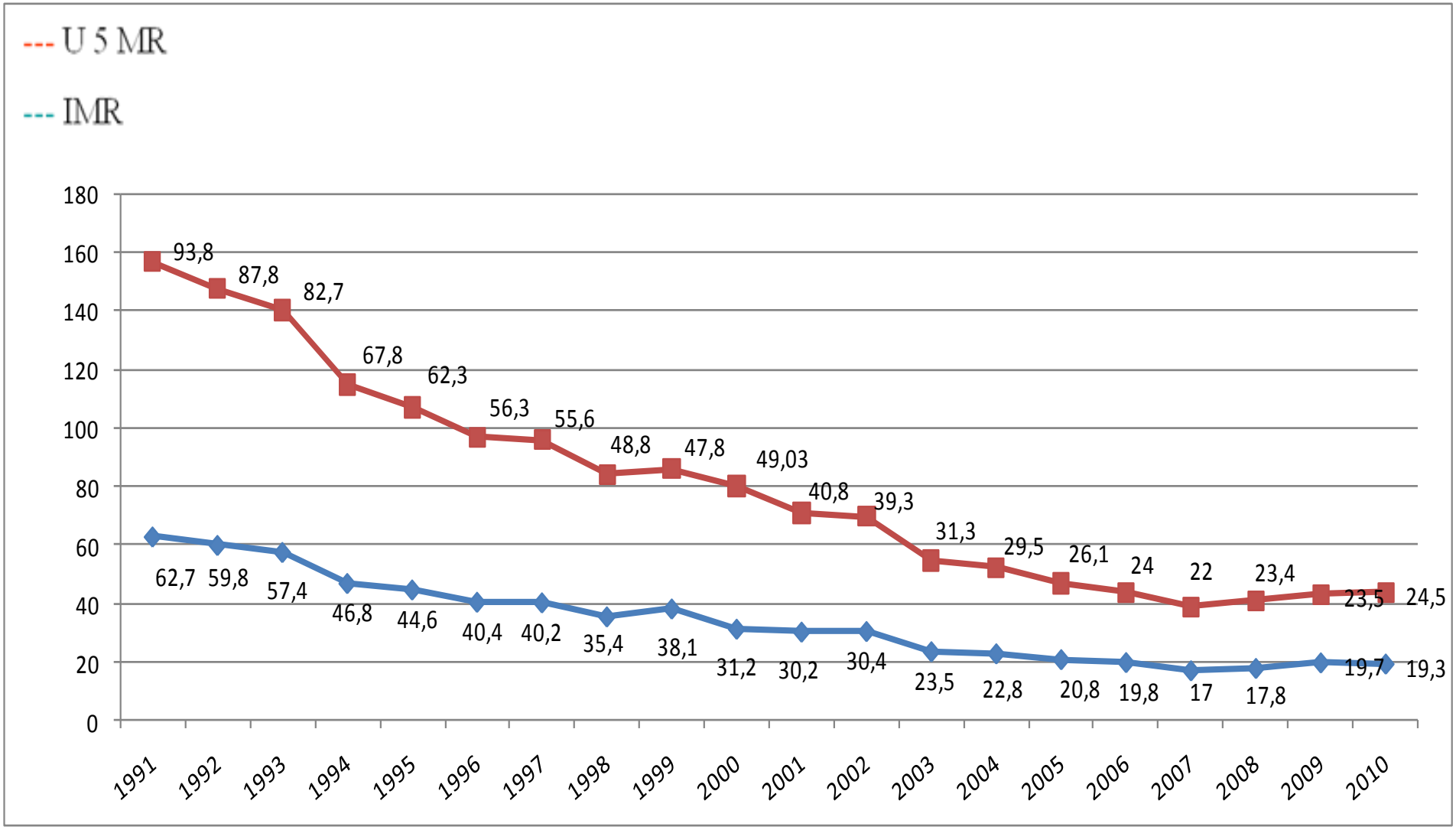
Composition of MOH Budget Allocation in Mongolia, 2006



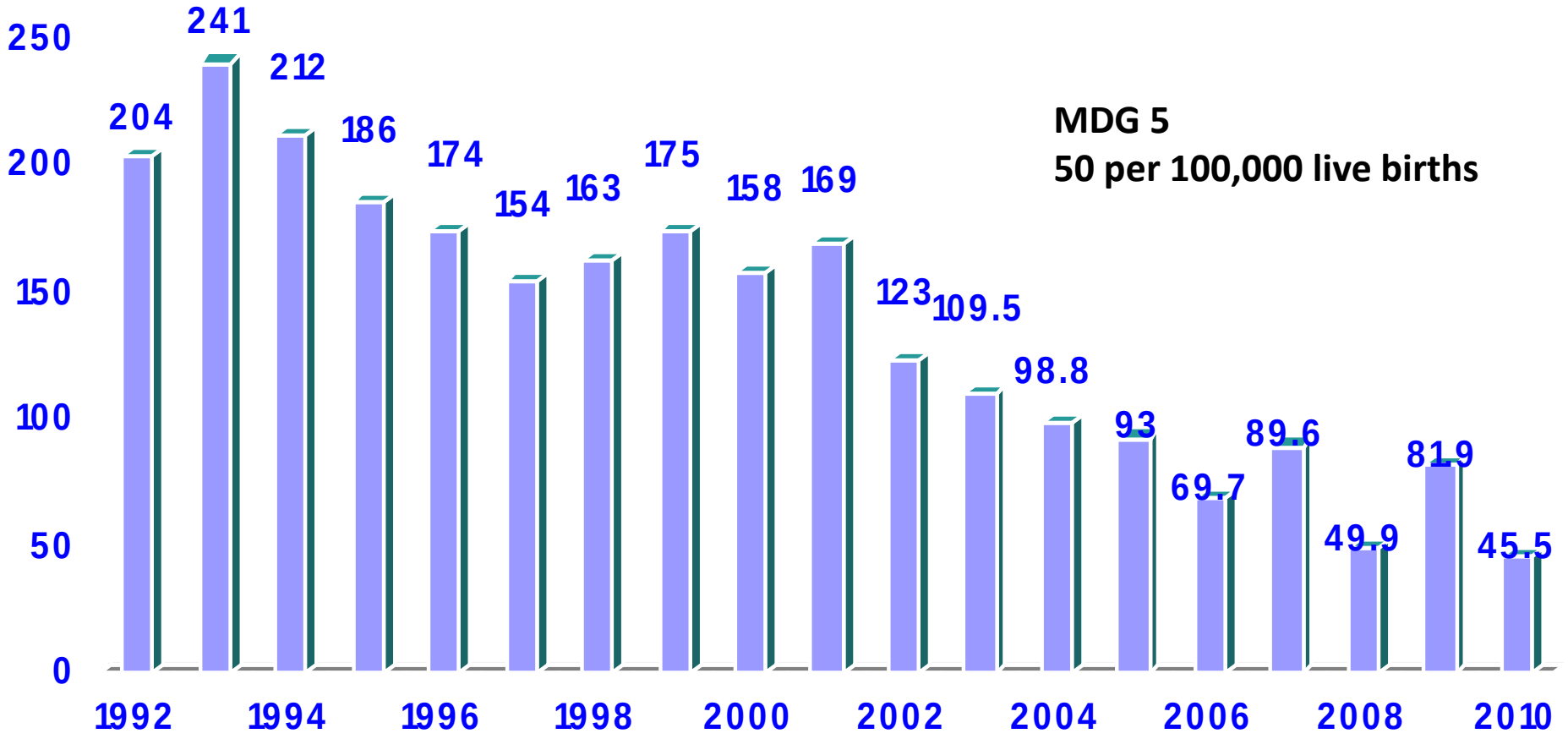
Mongolia: Local Development index



Mongolia: Under 5 and Infant Mortality, (source:National Health Statistics)

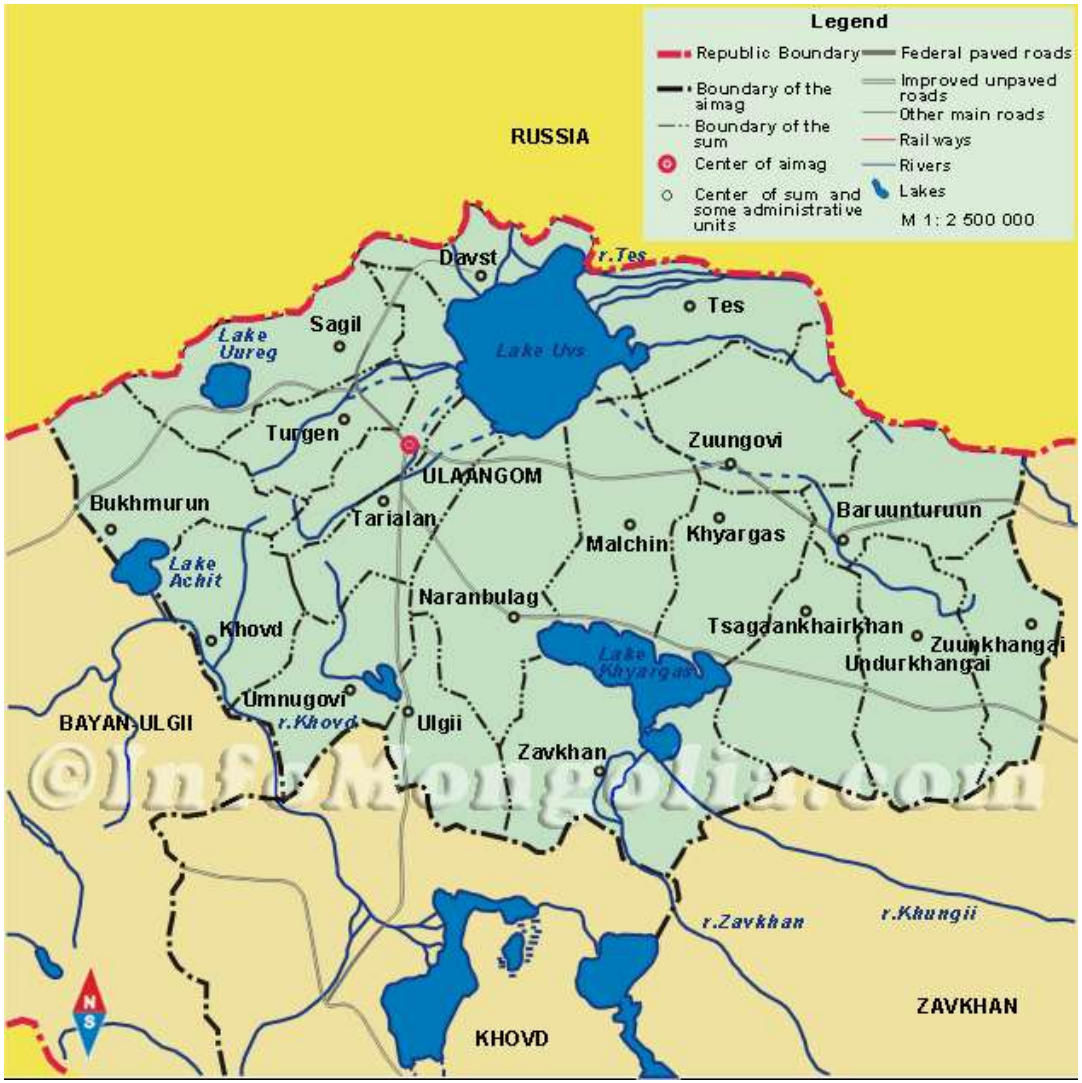


Maternal Mortality Ratio (1992-2010)

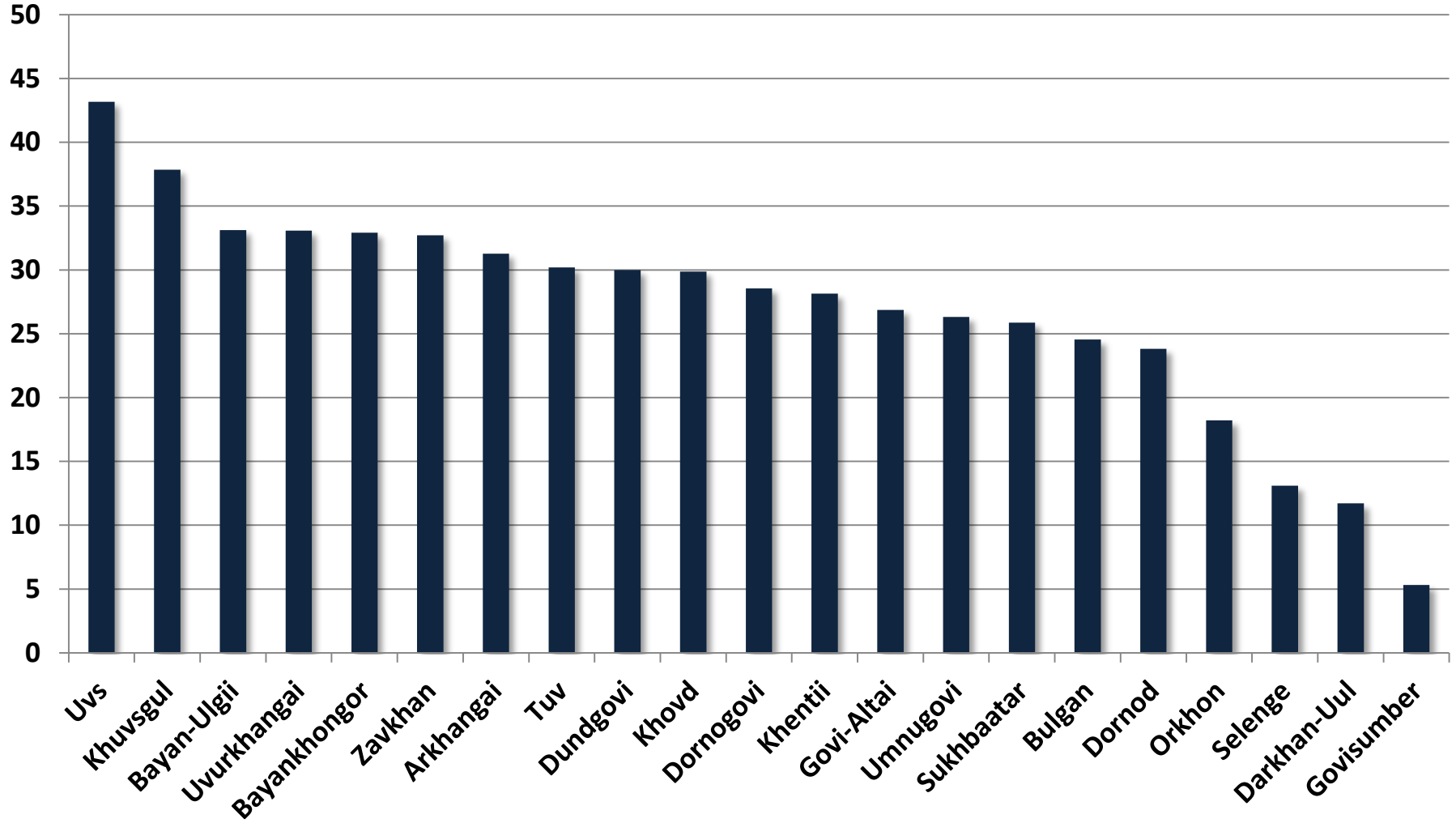


Uvs aimag

- Located in 1340 km from UB
- Total population - 74 448
- Children aged 0-16 y.o- 30872
- Multi-ethnic society consisting from Dorbet-60%, Bayad (15%), Halh (15%). Few number of Tuvans, Khotons and Kazakhs live.
- 18 soums (subprovince) and 94 baghs (lowest administrative unit)
- 64 baghs - domestic animal husbandry, main source of livelihood
- Herders – 7680 households or -50% of total



Under 5 Mortality by Provinces (2010)

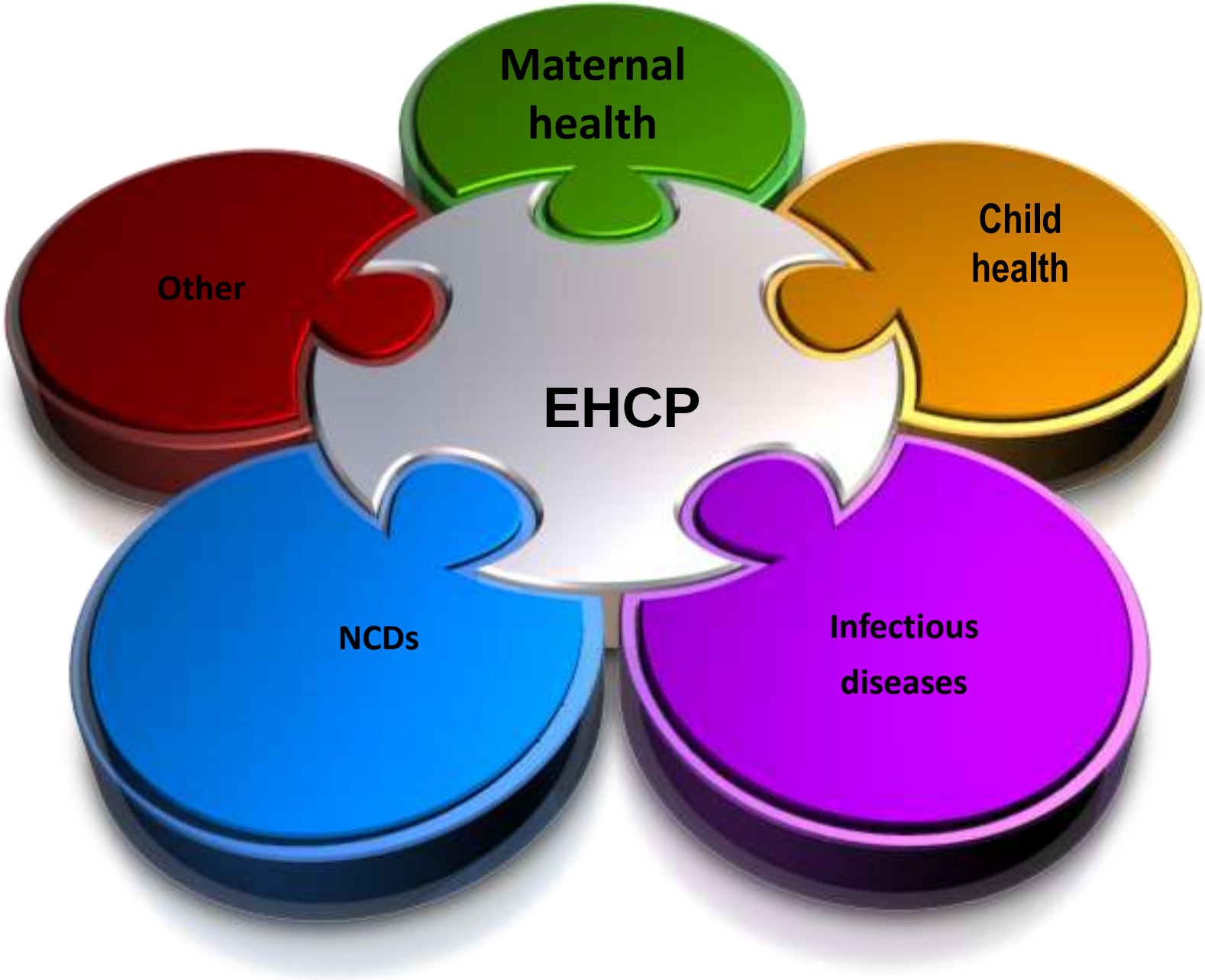


Health system structure of Uvs aimag

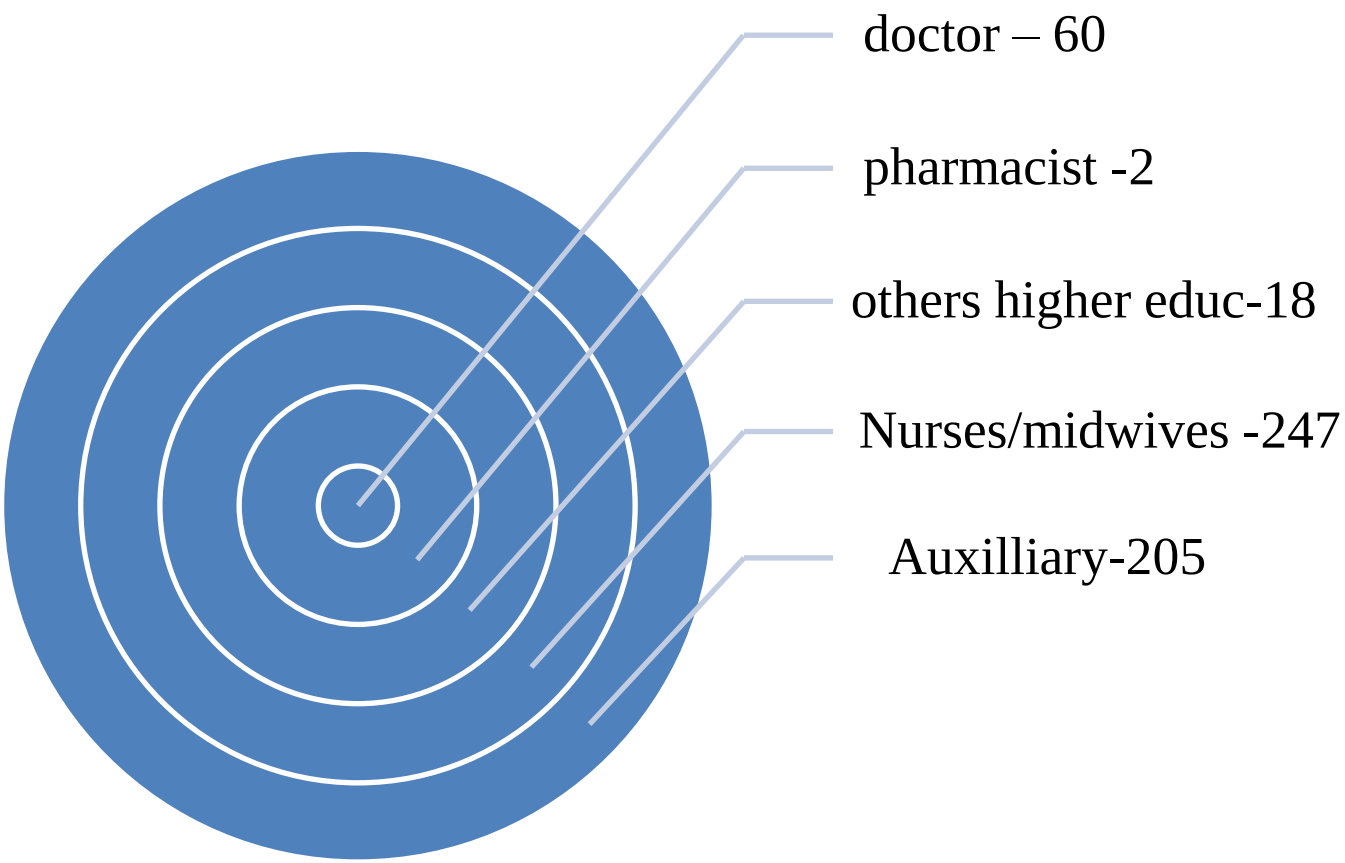
- Farest soum is located in 339 km and closest soum is in 31 km from aimag center
- Aimag center has general hospital, provides secondary level care
- Each soum has own PHC center, with 1-2 doctors and 4-6 bagh feldshers/nurses
- Average service radius for one soum doctor is 80-150 km and one bagh feldsher is 50-70 km

Nomadic culture vs outreach health service

- One herder family moves at least 4 times in a year, once in every season
- During summer/autumn herders move every 2 months depending on pasture situation
- If drought/dzud happens herders move neighbouring soum or aimag up to 4-500 km away from their home soum
- Conducts outreach immunization/GMP/ANC/Vitamins monthly to remote herders
- Bagh feldshers use motobike during summer/autumn and during winter use only horse and camel
- If herders are out of soum and aimag territoria contacts host aimag/soums' PHC center inform about high risk group particularly pregnant women and 0-5 children


Maternal health
Child health
Other
EHCP
NCDs
Infectious diseases

Human resources working in the aimag



Purpose and structure of REDS strategy implementation

To solve barriers hindering immunization coverage through improved microplanning, accessibility, supportive supervision and monitoring.

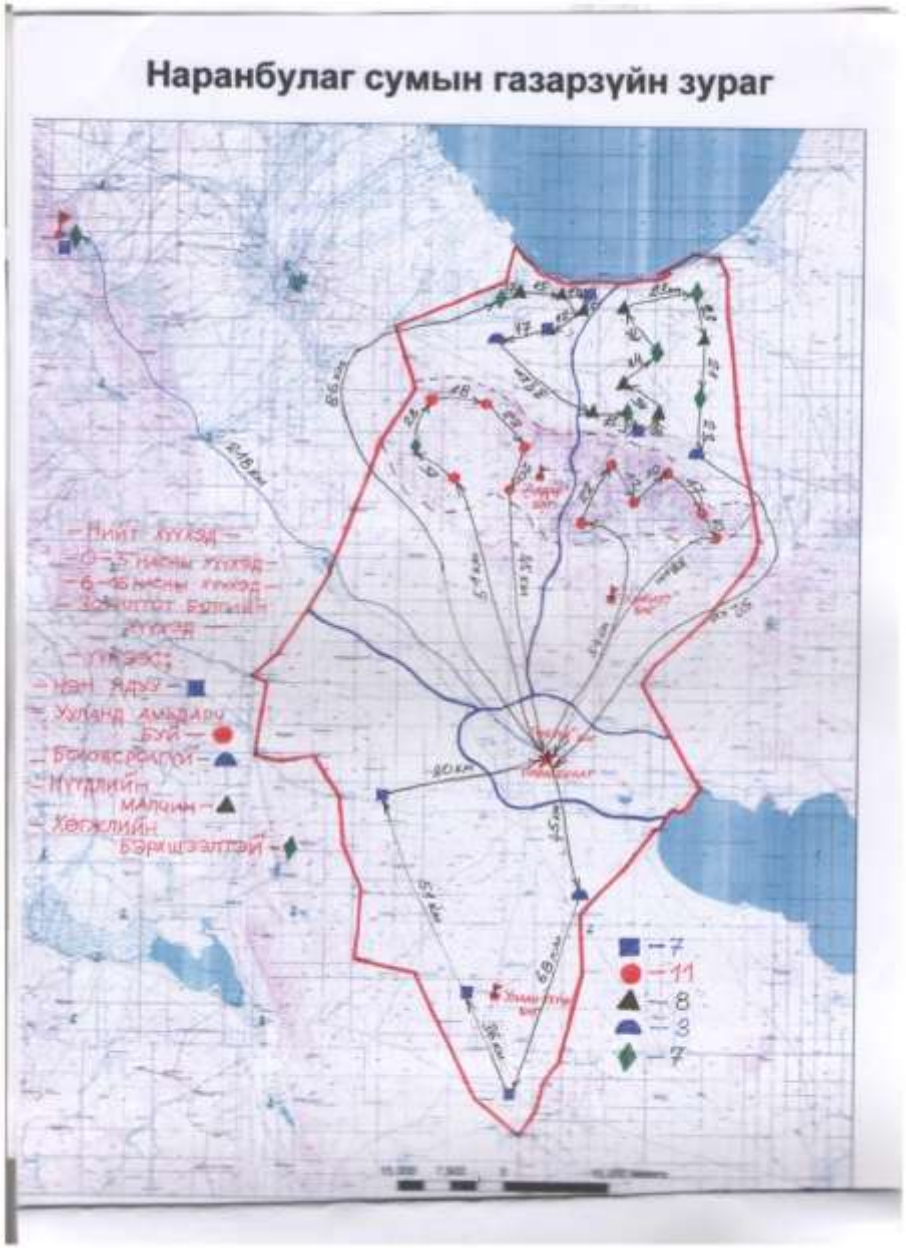
Has five key composition:

- Barrier analysis and microplanning
- Remove various barriers (health system, population and immunization system's) to immunization coverage
- To intensify immunization outreach and Supportive supervision
- Increase accessibility of basic health/social services to target population including essential commodities
- Improve quality of monitoring and evaluation, use of data in decision making and resource management

Plannnig and Microplanning

- Conducted planning training on REDS strategy for 28 decision makers of selected 5 soums and 3 baghs of aimag center including social welfare, insurance, health department, registration, police, soum doctors and bagh feldshers
- Based on Minister of Health decree of April, 2011 No 154 to implement the strategy Uvs aimag Governor issued a decree to establish multisectoral working group to implement the strategy on 30 May, 2011 No A/279
- Each selected soums established soum level working groups comprising from multisectoral representatives

Microplanning and supportive supervision



- Each soum teams conducted mapping and microplanning to outreach various target groups
- Trained 60 bagh feldshers and nurses on implementation of the strategy for outreach service delivery and methods to interview with target group to identify barriers

Target population

- ❖Unregistered population
- ❖Informal miners /
- ❖ Remote herders, herders living in mountains
- ❖Poor people with no Gher/ housing
- ❖Uninsured
- ❖School drop out
- ❖Very poor
- ❖ Violence
- ❖ Disabled
- ❖ Unimmunized

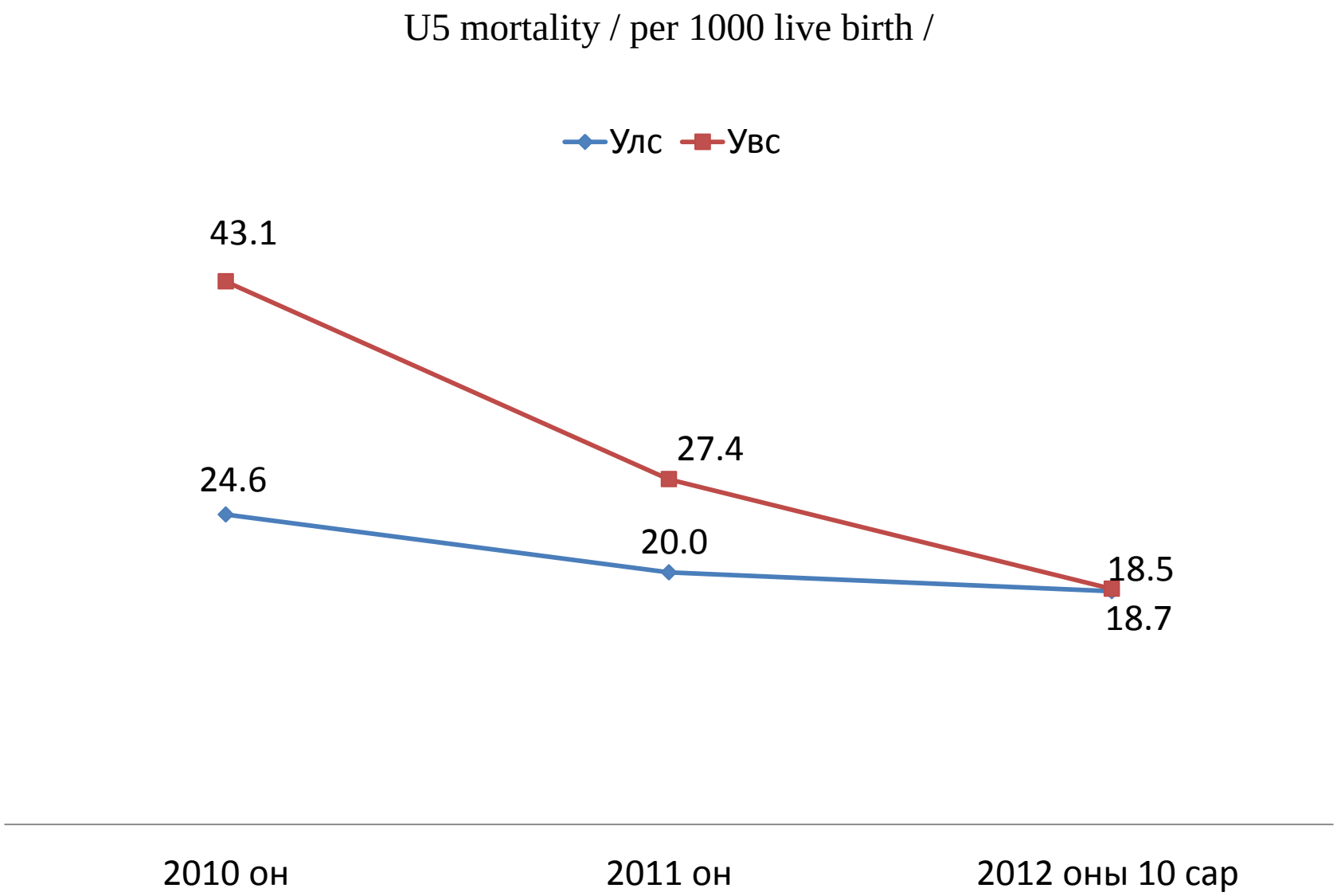
№	Selected soum/bagh	Total No of household	Population	Target household	Target population
1.	Tes soum	1298	5774	102	490
2.	Naranbulag	1062	4459	124	567
3.	Tarialan	896	4000	198	840
4.	Tsagaankhairkhan	616	2300	106	523
5.	Umnugobi	1030	4236	113	565
6.	Munkhbisrelt bagh	1562	7046	140	701
7	Kharkhiraa bagh	245	1025	28	112
8.	Khundlun bagh	186	869	17	92
9.	Total	6895	29709	828	3890

№	Target groups	Tes	Naranbulag	Tarialan	Tsagaankhairkhan	Umnugobi	Munkhbishrelt	Kharlkhiraa	Khundlun	Total	Barriers solved l
1	Children 0-5 years old	134	287	238	155	157	202	45	21	1239	IYCFC
2	Children aged 6-16 years old	10	57	17	11	10	23	5	3	136	MNCH
3	Informal miners	-	-	182	-	187	-	-		369	PHC service
4	Hard to reach herders living in mountains	127	139	285	180	87	12	23	53	906	MNCH service
5	Very poor	95	72	102	123	43	89	29	8	561	CT/FS
6	Out of school	3	2	11	2	8	-	-	-	26	23
7	Unregistered	15	-	-	50	-	382	-		447	384
8	Disabled	3				9	15		7	27	PHC
9	Unimmunized	3	2	5	2	4	2	-		18	Im

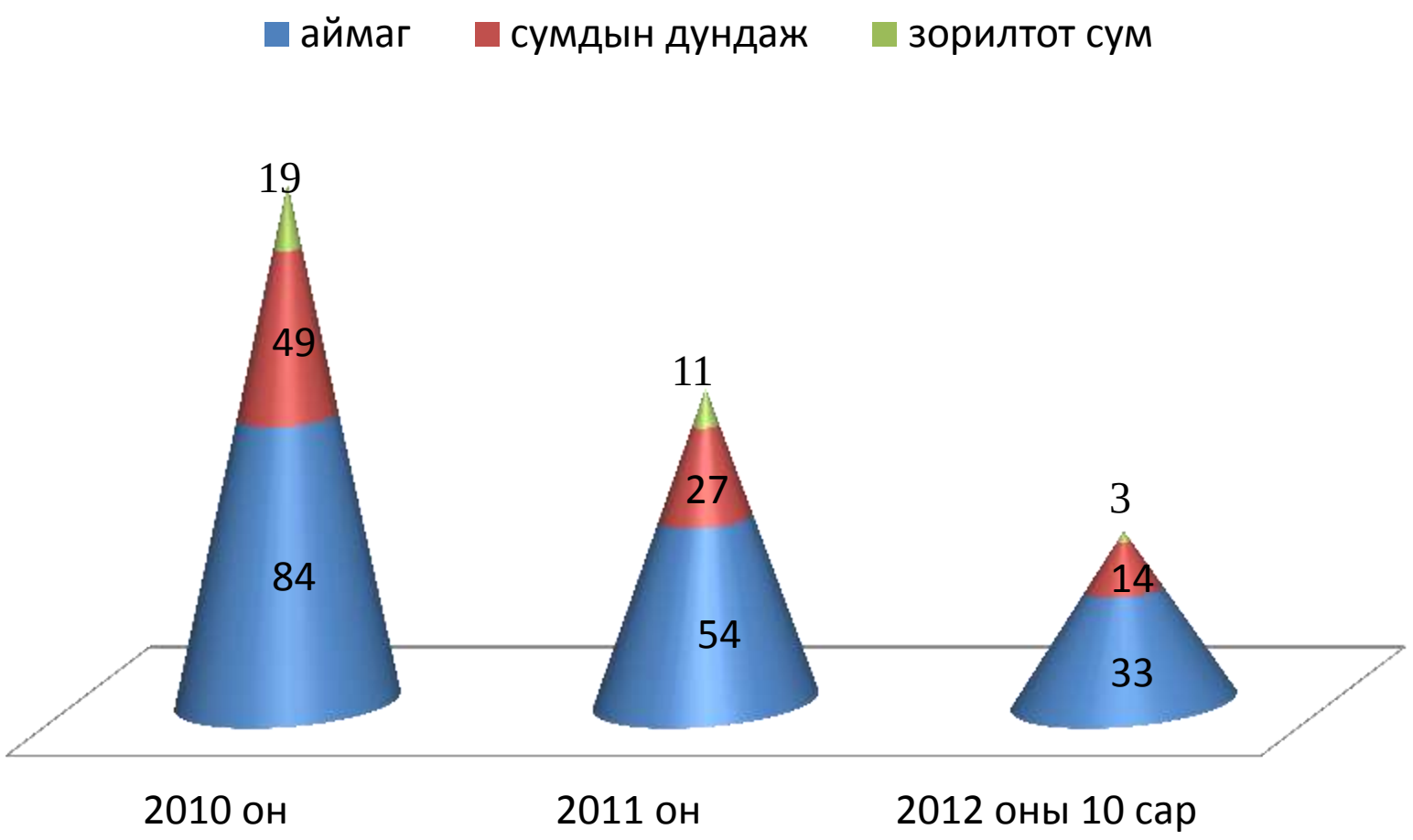
- 668 target parents received a counseling on IYCF and care, social health insurance, registration and protection.
- Essential child health medicines were given to – 367 households
- 83 citizen received new health insurance book and 225 citizen was paid health insurance premium
- CCT – 4 houseolds
- Drug subsidy to 12 citizen
- Social welfare CT – 37
- 2 elderly without care takers were given to care center
- 6 families were given Gher /mongolian dwelling/

Preventive Health services made during outreach:

- Revealed 161 pregnant mothers and 80 % of them are in the first 3 months.
- Regular ANC for – 102 pregnant mothers .
- Postnatal visit for – 32 mother and newborn .
- Distribution of MMPs for 113 pregnant and lactating mothers
- Contraceptives to 51 mothers for birth spacing
  - GMP conducted for 991 children U5, revealed malnourished 96 / 9.6%/,stunted – 53 , with rickets – 41 / 4.1% / , growth faltered 28 / 2.8% / children aged 6-24 month and received nutrition support.
  - 430 children aged 6-24 months received MMPs .
  - Vitamin A and D distributed to 185 children.
  - Catch up immunization for – 35 children.
  - Mother and child health book were given to -184 mother and children.
  - 318 children received IMCI care.


U5 mortality / per 1000 live birth /
Улс
Увс
43.1
27.4
24.6
20.0
18.5
18.7
2010 он
2011 он
2012 оны 10 сар

Number of U5 children death compared to Uvs aimag center and soums' average



Home delivery

№	Name of soums	2010	2011	Oct, 2012
1.	Naranbulag	1	0	0
2.	Umnugobi	1	0	0
3.	Tarialan	8	1	0
4.	Tes	2	2	1
5.	Tsagaankhairkhan	1	1	0

Antenatal care

№	Name of soums	2010	2011	Oct, 2012
1.	Naranbulag	76.4%	81.1%	94.3%
2.	Umnugobi	82%	84.3%	94.6%
3.	Tarialan	76.1%	92%	88.1%
4.	Tes	81.6%	85%	85.5%
5.	Tsagaankhairkhan	91.8%	97.6%	95.3%

- UNICEF provided 20,590 million MNT support, 46% was for training of grass root health workers, 8.17% spent for supportive supervision, 45.83% for outreach services
- UNICEF provided essential child health antibiotics, equipments, support for training on ENC care and use of essential equipments, growth monitoring devices, cold chain, MMPs (multiplemicronutrients) and IEC materials on IYCF. Supplementary nutrition support was provided too.

Thank you