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From the editor-in-chief

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Dear Readers of Childhood in Africa,

In times like these I remember the words of Lester Brown, World Watch Institute founder and MacArthur Fellowship laureate, “the worst thing we can do about Africa is to lose hope.” Hope pushed us to found the Institute for the African Child at Ohio University and this journal. And compounding our difficulties in publishing an issue of Childhood in Africa, it remains the only scholarly and accessible journal of its kind on this topic.

This special issue of Childhood in Africa, “Social Justice for Children and Youth in East Africa,” was guest edited by Dr. Kristen Cheney and Dr. Auma Okwany of the International Institute of Social Studies in the Netherlands. Their patience as I worked to get this issue to press is only exceeded by their commitment to these crucial issues in child protection and welfare in East Africa. I am grateful to them for this important contribution.

We have also included a special report, Socio-cultural determinants for the adoption of essential family practices in Madagascar (2016), in this issue. We hope our readers find it useful.

On behalf of our editorial team, I apologize for the irregularity of this journal. The Institute for the African Child will soon be 20 years old- my baby has had a challenging youth- and we need to find ways to sustain it through to adulthood. Your ideas for funding and sponsoring this journal would be received with great thanks. We hope you find this special issue useful.

Sincerely,

Steve Howard

Founder
Institute for the African Child and editor,
Childhood in Africa
Director
Center for International Studies
Professor
Scripps College of Communication,
Ohio University

howard@ohio.edu

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Socio-cultural determinants for the adoption of essential family practices in **Madagascar**

Introduction: Toward social justice for children and youth in East Africa

Kristen Cheney, PhD
Senior Lecturer of Children and Youth Studies
International Institute of Social Studies, Erasmus University Rotterdam
The Hague, Netherlands
Tel: +31704260575
Email: cheney@iss.nl

Auma Okwany, PhD
Assistant Professor of Social Policy
International Institute of Social Studies, Erasmus University Rotterdam
The Hague Netherlands
Tel: +31704260578
Email: okwany@iss.nl

In East Africa, despite having established the right of every child to education, an adolescent girl is excluded from school once she is found to be pregnant. In prisons, young children are virtually incarcerated in constrained care spaces by virtue of the fact that their mothers are imprisoned. Meanwhile, a court rules that a child who is not in fact an orphan should be adopted by foreigners simply because the foreigners are perceived as having more (financial) resources.

These examples, drawn from some of the empirical studies in this special issue on social justice for children in East Africa, demonstrate the persistent vulnerability of children and youth and the undermining of their rights and wellbeing. Moreover, though there is abundant rhetoric around children's participation rights, in actuality, young people's vulnerability too often becomes an excuse for disallowing children's meaningful participation in research, policy, and interventions meant to increase their wellbeing. While instruments such as the United Nation Convention on the Rights of the Child (UNCRC) and the African Charter on the Welfare and Rights of the Child (ACWRC) provide a resource for children's citizenship, economic poverty and marginalizing social forces continually jeopardize these rights and accentuate the social vulnerability of young people. Adult prejudices and assumptions about children's capabilities continue to shape the dominant discourses of vulnerability in social policy institutions, preventing meaningful participation of young people in decisions that affect them (Cheney 2010). Protection is often used as an excuse for excluding young people, when in fact participation can be protective (Powell and Smith 2009). These prevailing assumptions and power relations are a critical feature of institutional deficits and systemic weaknesses in East Africa, and they contribute to the marginalization of young people in social institutions, as well as in social policy and interventions.

The articles in this volume therefore

describe instances in which this happens, while also considering ways to overcome such challenges. The authors in this special issue address the institutional and systemic weaknesses in social institutions that often serve to entrench and reproduce the vulnerabilities of young people rather than mitigate them. These child/youth issues emerged from a broader project on social justice.

Background of the Special Issue

This special issue is one of several research outputs of a five-year project called "Mainstreaming and Strengthening the Social Component in the Justice, Law and Order Sector (JLOS) in Uganda." The project was implemented by the International Institute of Social Studies in the Netherlands in close cooperation and to the benefit of the Nzamisi Training Institute of Social Development (NTISD) in Mpigi, Uganda. The project also involved various Justice Law and Order Sector (JLOS) institutions in Uganda, including policy staff of the national police, judiciary, probation and prison systems. Activities included the establishment of a Center for Social Justice at Nsamizi Training Institute, and a Diploma program in Social Justice. Within a few short years after the opening of the Center, it had trained 240 JLOS professionals through the Social Justice Diploma program.

The project was funded by the Dutch development cooperation program, The Netherlands Initiative for Capacity Development in Higher Education (NICHE). The NICHE program was based on the belief that "by sustainably strengthening higher education and technical and vocation education and training (TVET) capacity in partner countries, it contributes to economic development and poverty reduction."

In addition, the project, which was successfully completed in May of 2015, had a sustainability component of building the research and publishing capacity of the Nsamizi academic staff and JLOS sector partners to provide an evidence base for various social justice claims. The first collaborative research output was an edited volume, Challenging Social Exclusion: Multi-Sectoral Approaches to Realising Social Justice in East Africa (Hintjens et al. 2015). This special issue is the second.

Because so many NTISD researchers were interested in issues to do with social justice for children and youth, a main aim of this special issue became to help build the research and publishing capacity of emerging East African scholars on childhood and youth issues. By pairing emergent scholars who have direct experience and empirical data on the lives of children in East Africa with more established academics and practitioners of social justice for children, we could produce the articles herein and help disseminate the results of research that might not otherwise be published. It is our hope that it will also influence regional and comparative perspectives of and practices in the Eastern Africa region around the important issues raised. We also hope it will further discussion of how to move past the impasse of normative children's rights discourses toward a social justice frame.

Pushing the Boundaries of Children's Rights in East Africa

Many volumes discuss children's rights, but they tend to become circular in their argumentation, pointing out that children's rights are violated by certain persistent deprivations and/or lack of access to education, etc. without ameliorating the said deprivations or gaining children the needed access. They typically end with renewed calls to guarantee the fulfillment of children's rights.

According to Imoh (2014), despite the strong human rights framework for the protection and promotion of children's rights in Africa provided

by the adoption of both the UNCRC and the ACRWC, more than 25 years later, the impact of these instruments on the lived experiences of children remains limited. Indeed, the studies in this special issue show that there are still serious constraints in enforcing the rights of many children and youth in national and local contexts in East Africa.

Despite the visibility of rights discourses at the grassroots level in the region, empirical studies demonstrate the shortcomings in implementation in a number of significant ways. Okwany and Ebrahim (2015) trouble the totalizing tendencies of the dominant rights narrative, which often marginalizes local narratives of childhood and care. The normative assumptions and conceptions of childhood that undergird children's rights discourses tend to reify childhood by targeting children and marginalizing adults as well as the interdependent and reciprocal family collective systems within which caregiving is nested. In doing so, they disrupt intergenerational relations in households and in communities across many contexts (Abebe and Tafera 2014; Cheney 2014; Norman 2014). For example, Cheney (2014) notes that the foregrounding of protection over participation rights by interventions targeting vulnerable orphans in Uganda infantilized and disempowered these children, while in South Africa, frustrated adults who were by-passed in efforts to 'empower children' felt that the state was co-parenting without their consultation or buy-in (Norman 2014). Okwany and Ebrahim (2015) note that such practices not only constitute epistemological injustice but also obscure a focus on contextual approaches to care provisioning and research in Africa.

Toward Social Justice for Children

By shifting the lens to social justice, which Hanson and Nieuwenhuys define as "the shared normative beliefs that make rights appear legitimate for those who struggle to get them recognized" (2013, 6), we highlight the underlying structural and cultural barriers that act as obstructions to the attainment of social justice, redressing issues of past injustice, learning lessons from them, and moving forward more equitably. Achieving social justice is thus not only about redistribution of resources and addressing structural disadvantage, but it also requires an integrative policy approach that enables a recognition and inclusion of context – and all voices within that context. As Nieuwenhuys (2013, 7) rightly points out, this necessarily involves taking the child as a social 'being' and a "more comprehensive understanding of children's agency." To this we add the dimension of a child as 'belonging' in the social context characterized by the distributive and communal system of care in many communities in Africa as constituting a network of social relations in which young people's experiences are embedded. As argued by Boyden and Dercon (2012, 34), even "Human-capital models offer a powerful, politically persuasive framework for policy development, but they must be understood as additional to, and not alternative to, more fundamental principles of social justice. Here it is important to uphold the foundation principle for investment in human development… this applies even if economic development depends more on some groups than others." A social justice approach to childhood thus aims to transform the larger society by underlining the importance of seeing children and youth in relation to not only the family and community environment but also the broader socioeconomic, cultural, and political context of which they are a part (Bivens et al 2009; Tikly 2010). The social justice approach also leaves scope for alternative and critical perspectives because it is based on the principles of inclusivity,

democracy, and relevancy (Tikly and Barrett 2011).

We therefore argue for the need to examine how unjust social policy institutions and relationships can give rise to forms of inequality in which some groups are positioned as subordinate to others through processes of social exclusion and political marginalization (Kabeer 2008; Adesina 2010; Hytten and Bettez 2011). For children and youth, this requires a focus on age and unequal generational power relations in engagement within social networks and institutions in which their voices are often muted or silenced. We thus take a social justice approach in this special issue as an important standpoint from which to challenge inequitable, systemic, generational relations because, as noted by Tikly and Barrett (2011), social justice provides a fuller rationale for a policy focus on social equity and inclusion than does a children's rights-based framework. Indeed, as Nieuwenhuys (2008, 8) argues, "…the UNCRC…is in fact too modest a proposal that fails to meet minimal criteria of social justice." If childhood studies is to move beyond such normative boundaries, Alanen (2011, 150) claims that "…making explicit the normative foundations of childhood research requires that we also address a number of normative issues concerning the practices and arrangements 'out there', and specify in what particular respects and for what specific reasons they are problematic. It also asks us to specify what constitutes a good, or at least a better life for children...". Our call for a move toward social justice for children in East Africa is one more step in that direction.

Our social justice approach draws on Nancy Fraser's three-dimensional model of social justice – recognition, redistribution and representation – for addressing social exclusion and disadvantage (Fraser 2003; Fraser 2008). Fraser's recognitive justice focuses attention on the diversity of cultural and social differences and we view this "difference-friendly" world (2003, 7) as important for challenging the way young people are often framed in social relations. Too often, this positioning – while often regarding children as valued members of society – actually contributes to their 'political voicelessness' and constrained citizenship. The representative dimension of justice accords all social actors equal voice and active participation in social institutions while the redistributive dimension of social justice relates to equitable (re)allocation of material resources but also knowledge and skills. Besides the institutionalized processes and obstacles which, according to Fraser, exclude and prevent equal participation in social life, we heed Tikly and Barrett's (2011, 6) cautionary advice on the importance of paying attention to discourses which can have their own constitutive effects on what can and cannot be said, who can speak and with what authority, and how individual and group identities are defined. The notion of representative justice is very useful in promoting living rights for all, with an emphasis on groups like children and youth who are subject to accentuated marginalization.

In this Issue

In this issue, we provide several contextual accounts that push the boundaries of new approaches to social justice for children in a couple of important ways:

1. **Social justice for children who come into contact with the justice, law, and order system**

A number of articles in the volume deal with the predicaments of certain types of children who become subject to JLOS implementation in sometimes very problematic ways. This is especially true for very young children. For example, Muhangi et al's article argues that though prisons acknowledge infants' rights to stay with

their mothers and its importance for their development, they fail to provide adequately for children's care while their mothers are imprisoned. The reliance on charitable organizations to provide this care means that the ethos underpinning early childhood care and education is charitable humanitarianism and is not necessarily based on rights or social justice principles.

In cases of intercountry adoption (ICA), which has risen dramatically in Uganda in recent years due to the discovery of a legal loophole, the courts have used their discretionary power ostensibly to promote 'the best interests of the child' as provided for in the UNCRC. However, Namubiru Mukasa and Cheney argue that the courts' determinations in ICA cases have been largely based on very immediate perceived material needs of children, thus neglecting other rights such as those to an identity, family, and nation. They argue for a social justice approach that will take a longer and broader view of social justice for adopted children, their families, and their communities.

Similarly, Musisi and Ochen's article investigates the state of formal and informal foster care in Uganda. They conclude that there is a need for review of the regulations that currently guide foster care practice in order to enhance the integrity of the foster care system and provide for more just policy implementation.

2. **Adolescent sexual and reproductive health and rights (ASRHR)**

Another theme that emerged in discussions of social justice for young people in East Africa was the issue of ASRHR. Katende and Opollo's article explored the state of access to contraceptives by adolescents and determined that current policy regimes tend to be restrictive rather than promoting adolescent access to contraceptives. Further, access for certain groups of adolescents were more or less restricted by service providers depending on age, school enrolment, and marital status – having dire consequences for their sexual and reproductive health and rights.

Relatedly, Okwany and Kamusiime point out that despite rhetoric about the right to education – especially for girls – the prevalence of pregnancy-related exclusion in education frames pregnant and parenting students as 'non - child' or 'non-youth' by virtue of having gotten pregnant. The ineffective education sector policy in Kenya and the lack of a policy altogether in Uganda mean that pregnant girls and young mothers are not seen as having children's rights or being protected anymore. They conclude by highlighting non-normative ideologies and alternative praxis that offer promising pathways for social justice by challenging the unjust constructions of student mothers in education policy and practice.

In many ways, these injustices point to the need to involve more young people in the production of knowledge about their own ASRHR. Foregrounding the experiences and perspectives of young people is important because children and youth are in fact the experts in their own experiences, thoughts, and needs (Cheney 2011). Ngutuku and Okwany therefore explore the ethical implications of increasing youth participation in sexuality education research. Through their experiences of working with youth peer researchers as co-producers of knowledge about ASRHR, they found that the concept of "a youth researcher" positioned within specific expert discourses may be unsettling to certain actors and policy makers, and thus such tensions and contradictions must be constantly negotiated.

Through these themes, we hope to point the way toward broader discussion of ensuring social justice for children in East Africa and beyond – both in social policy and research.

Finally, we dedicate this publication to our late friend and colleague Arthur Muhangi. He was a champion for children and a promising young East African scholar who was taken from us all too soon.

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Innocent prisoners: Early childhood care and development of young children living with their mothers in prison in Uganda and Kenya

Arthur Muhangi
Nsamizi Training Institute of Social Development
P.O. Box 149, Mpigi District, Uganda.

Aurelia Munene
Nascent Research and Development Organization
P.O Box 2697 00200, Nairobi Kenya.
Tel: +254 708363571
Email: aureliamunene@gmail.com

Bernadete Naggayi Ssibetya
Nsamizi Training Institute of Social Development
P.O. Box 149, Mpigi District, Uganda.
Tel: +256772515095
Email: berna.naggayi@yahoo.com

The late Arthur Muhangi was a lecturer and coordinator of the research component of the Justice Law and Order project at Nsamizi Training Institute for Social Development (NTISD) in Uganda. He had extensive experience in social development research, and policy and how they influence development outcomes for children and youth in development in the East African region. He published articles and co-authored a book in these research areas. He is remembered for initiating and designing the curriculum for the diploma course in Children, Youth and Development at NTISD. Arthur had a MA in Human Resource Planning and Development from the Institute of Applied Manpower Research, Delhi, India; and two post-graduate diplomas from the International Institute of Social Studies of Erasmus University Rotterdam.

Aurelia M. Munene is a Senior Research Associate at Nascent Research and Development Organization. Her research interests center on linking policy, practice and theory in social development with a key focus on outcomes for children and youth in marginalized contexts. Her research interests are in the areas of: early childhood development, health care, psychosocial support, sexual and reproductive health and wellbeing, and social protection. She has a published journal article and is currently working on two book chapters, which have been accepted for publication. She has an MA in Development Studies from the International Institute of Social Studies of Erasmus University Rotterdam, a diploma in Community Health Nursing from Kenya Medical Training College and she is also a 2015 CODESRIA Laureate.

Bernadete Naggayi Ssibetya is a lecturer in public relations, social development, child protection, and research at Nsamizi Training Institute of Social Development. She is active in the promotion of social justice programs for the institute as part of its outreach and social responsibility. She has an MA in Sustainable Peace and Conflict Management from Uganda Martyrs University; and a post-graduate diploma in Children, Youth and Development from the International Institute of Social Studies in The Hague, Netherlands.

Abstract

The early childhood development phase presents a critical foundation for a child's growth. A mother's incarceration has a significant impact on the wellbeing of young children accompanying their mothers to prison and those born in prison. The inadequate conditions of prisons in Uganda and Kenya means that for pregnant inmates and those who are mothers, retributive justice is often achieved at the expense of early childhood care and development for their young children. As such, infants whose mothers are incarcerated are 'crimes invisible' victims and the poor care environments in prison means that they face an even harsher sentence than their parents do. In this paper, we examine the care context for young children living with their mothers in Luzira Prison in Kampala-Uganda and Langata Women's Prison in Nairobi-Kenya. Data was collected through focus group discussions and key informant interviews with incarcerated mothers and both state prison officials and non-state staff of organizations partnering with the prisons to provide childcare. Using a social justice framework, our findings reveal constrains and inadequacies in care provisioning for young children as they disengage with family, enter, live in, exit prison and reintegrate within families. These inadequacies have significant impact on the cognitive, physical, emotional and social wellbeing of young children. We highlight the implications for policy and advocacy for holistic care and development of young children of inmates, and we argue for supportive strategies that ensure a balance between justice without compromising the care, and citizenship rights of these children.

Introduction

Early Childhood Care and Development (ECCD) is a critical phase in every child's formative years and beyond. It spans the period between zero to eight years of age. The ECCD phase incorporates the whole range of activities that promote holistic care, development and socialization of children including nutrition, education, health, psychosocial and emotional development and (Irwin, Siddiqi and Hertzman 2007; UNESCO 2006, 2015), and the most lasting effects on child learning, health and development comes from improvements in the capacity of parents and caregivers to provide support to their children (Myers, 1999). Childhood is conceptualized in this study as a social construct, which constitutes the varied experiences of children taking place in diverse contexts. One such context where children are nurtured and socialized is with their incarcerated mothers in prisons. The institutional and legal frameworks enshrined within specific laws in each country structure care for young children in prison. The laws allow for children in their early years to accompany their mothers to prison or that babies born in prison live with their mother up to a certain age. In this study, we take a critical look at this care space in two women prisons in Uganda and Kenya where children accompany and live with their mothers in prison. We examine their care trajectories as they enter or are born in, live and exit prison. Through the

caregiving experiences of mothers, prison officers, state child protection officers and non-governmental organizations' staff, we expose the challenges and opportunities of holistic early childhood development. We conclude by highlighting the implications for securing justice in their caregiving.

The prison environment in Luzira prison in Uganda and Langata prison in Kenya is not physically and institutionally structured to adequately support holistic development of children in their early years. This is due to the constrained space for care giving attributable to the framing of incarcerated women as convicts and not mothers despite the fact that those who are pregnant or who have infants are allowed to parent in prison. Caregiving is constrained in the overcrowded, punitive prison space contributing to the significant physical, mental and social vulnerability of young children who are highly care dependent often on their mothers and other caregivers for their holistic wellbeing. Thus, the environment of care giving within prison has a direct effect on the lives of these children. The lack of state provisioning for children living in these prisons means that non-state actors step in to fill the care-giving needs. However, we note that their involvement is fragmented, has a limited outreach and is largely charitable.

We utilized the social justice framework to expose the glaring constrained childcare care processes. We contend that despite the rhetoric around protective rights with both countries adapting the UN Charter on the Rights of the Child (UNCRC) and the regional African Charter on the Welfare and Rights of the Child (ACWRC) as well as the National domestication of these instruments by both countries, in practice, there is a problematic homogenizing of childhood and caregiving. Consequently, the uniform application of laws without considering children's differentiated contexts and diverse needs means the situation of young children living with their mothers in prisons are largely invisible victims of the criminal justice system. We therefore highlight this neglect and the imperative of promoting equity and quality care of these right holders by supporting policies and practices that promote their holistic wellbeing.

The paper is organized as follows: after this introduction we contextualize the phenomenon of young children living in prison by highlighting the limits of the care provisioning for them in both countries. We emphasize the need to recognize the heterogeneity of childhood thus contextually situated care and interventions for specific groups such as young children living in prisons. This is followed by a discussion of the methodology used to collect data as well as the conceptual lens of the social justice framework utilized to guide data analysis. The presentation of study findings shows these children's vulnerabilities as they enter, live in and exit the prison space. We conclude by discussing implications for responsive policy in affording children living in prison contextually situated quality early care and development.

Contextualizing Early Child Caregiving behind Bars

The number of infants and young children accompanying their mothers to prison increases with the increasing rate of crime among women and according to (Tajuba 2013) four out of ten imprisoned women are mothers of babies and young children. Whether or not young children should live with their mothers in prison is a contested issue. Proponents, argue that although these young children could be left in the care of family members or friends, it is in their best interest to be with their mothers because there is need for bonding and attachment (Jbara 2012; Shonkoff and Phillips 2000). Opponents counter this by arguing that prisons are unsafe for raising children because

the physical space is inappropriate and poses several challenges to young children especially in respect to their freedom of movement (Alejos 2005). The challenges faced by these children in prisons vary with proximity and their number (Tajuba 2013).

In this study, we view the experiences of these children beyond this dichotomous debate. Instead, we posit that for the optimal promotion of the right to care of young children of incarcerated mothers, there is need to take into account the fluid and complex context in which each child is located. This is because children entering prisons hail from diverse family types for example: married or single parent families and some have siblings or capable and engaged extended families. Though the socio-economic status ranges, most come from poor households and the availability or willingness of extended family to provide support is variable. A heterogeneous perspective is thus important to ensure that the rights of these children are addressed on a case-by-case basis.

In both countries, the specific Prison Acts spell out the care arrangements of children in prison with their mothers. Section 30 of the Kenya Prison Act 2013, subsection 4 stipulates that a child may accompany the mother to prison:

> "…Subject to such conditions as may be prescribed, the infant child of a female prisoner may be received into prison with its mother and may be supplied with clothing and necessaries at public expense. Provided that such a child shall only be permitted to remain in prison until it attains the age of four years or until arrangements for its proper care outside prison are concluded, whichever shall be the earlier." (Kenya Prisons Act Revised 2012 Cap 90).

In Uganda, the Prison Act 2006 under section 59 subsections 2, 4 and 5 provide for the child to accompany the mother to prison:

> "…Subject to such conditions as may be prescribed a female prisoner may be admitted into prison custody with her infant. An infant referred to in subsection (2) shall be supplied clothing and other necessities of life by the State until the infant attains the age of 18 months in which case the officer in charge shall, on being satisfied that there is a relative or friend of the infant able and willing to support it, cause the infant to be handed over to the relative or friend. Where there is no relative or friend who is able and willing to support the infant, the Commissioner General may, subject to the relevant laws, entrust the care of the infant to the welfare or probation authority (Uganda Prison Act 2006).

Despite these legal provisions, there is no specific policy for children living with their mothers in prisons in most countries (Abbott and Sapsford 2012). Luzira Women's Prison for instance, currently operates in line with the National Council for Children Statute (1996), the Penal Code Act, the Local Governments Act (1997), Prisons Act (2006) and the National Orphans and Other Children Policy (NOP) to ensure early childhood care and development of the babies in its custody. However, in both countries, glaring policy gaps persist due to lack of clarity on the mechanisms of attaining specific entitlements for children in prison with their mothers. These policy ambiguities function to promote and sustain inequalities and exclusion of these children from attaining their holistic rights. This negates the inclusive interventions irrespective of age, class, gender and ethnicity embedded within a social justice framework (Ayers, Quinn and Stovall 2009).

Theoretical Lens

We adapted the social justice framework, which enables an analysis of the experiences of children who live with their mothers in prisons.

The main argument advanced in this framework is that all people have a right to basic human dignity and to have their basic economic needs met (Levy and Sidel 2006 529). These entitlements extend to children living in prison in their earliest formative years. We are in agreement with (Sayed and Soudien 2003 10) who propose that responsive discussions on social justice need to be preceded by an analysis of how inclusion and exclusionary processes occur and are sustained for a particular group. The concept of social justice also emphasize ideals of equitable (re)distribution of services that society needs to uphold to enhance wellbeing. It also allows us to deepen our analysis by providing a lens through which we can interrogate the processes of exclusion that are institutionally sanctioned or structurally propagated and how they constrain care spaces thus the rights of these children as posited by (Ayers et al., 2009). Thus, the framework enables us to focus our attention on the systems that produce and reproduce inequality and provide a roadmap through which to transform them. We examined the policy gaps and practices affecting children living with their mothers in prison and we draw on the analysis to highlight implications for protective caregiving systems that are responsive to the wellbeing of these children.

Methodology

We adopted a qualitative approach so as to understand the subjective meanings of the experiences of child caregiving and support in prison through the narratives of young children's caregivers. The study sites are the two main women's prisons, both of which are located in the capital cities of Nairobi and Kampala. We utilized qualitative methods including focus group discussions, in depth interviews and observations. We also carried out in depth interviews with 17 pregnant mothers and mothers with children in prison as well as the 6 prison officers, 2 children's officers and 3 staff from NEST Kenya and Family of Africa in Uganda which are non-state actors working collaboratively with the state in these child care spaces. Data was recorded through note taking and tape recording. Field notes were transcribed and organized for ease of analysis. Data was analyzed through reflexive thematic analysis. We obtained ethical clearance on multiple levels first with the Kenya Prison headquarters and consent from the study participants. We accommodated the mothers' preference for providing verbal consent. The consent spelt out the purpose of the study, and provided assurances of anonymity, confidentiality, non-coerced involvement. We have also maintained anonymity of the caregivers interviewed upon their request by using pseudonyms.

Study findings: Imprisoned motherhood and childcare

Studies conducted on experiences of children who accompany their mothers to prison have often investigated the life of the child while in prison only. Other critical aspects of their lives before and after are not explored or mentioned. One example is the US department of State report 2014. The overemphasis of children's experiences while in prison obscures the examination of important structural intertwining factors that inhibit the achievement of holistic rights and care for these children within the prison and after. There is also a dearth of studies on child caregiving in prison in the region. In order to adequately examine the experiences of children growing up in prison, we studied their care under three specific trajectories: children disengaging from the familiar settings and family networks, entry into the prison space and living there and finally re-engaging with the family and community. We are aware that there are children who are born in these spaces and thus

their trajectories may differ from the others. We examined their life trajectories in prison through the social justice framework by analyzing caregiving and the multiple caregivers with whom a child comes into contact with as they negotiate their prison journey. This allowed us to examine their role, limitations and resources (or lack thereof) that these care givers have so as to constrain or facilitate the attainment of rights for these children.

Disengaging from familiar settings and entry into the prison

A child who accompanies a mother to prison often undergoes a process of disengagement from familiar setting and the other family members like fathers, siblings, and friends among others as revealed in the study. More findings revealed that this is a process, which is often sudden, and the child is often unaware of what is happening and their assent or views are not sought. The state children officer revealed that there is often minimal preparation for children accompanying their mothers. For example preparation on where they are going and what prison implicates for their life and their social networks is often lacking. We contend that this bias can be traced in the dominant perspective on childhood where children are viewed as objects or spectators of care. Yet as emphasized by (Ebrahim 2010, 17) even young children are social actors who construct meanings about their experiences. This is consistent with the argument made by (Pufall and Unsworth 2004) that children are active agents and meaning makers about their lives and experiences. Mothers with children in prison noted that younger children below 1 year might only notice minimal differences in environments and thus adapt faster than older children above 2 years. We argue that this sudden disengagement without much regard to the agency of the child may have moderate to lasting impacts on the child's social and emotional wellbeing. This may often pass unnoticed since there are limited specialized follow up within the prison and without. From a justice perspective where the rights of the child are situated at the center of all interventions, we submit that the processes of disengagement need to be premised on quality caregiving for the child. We heed to the call by (Pence and Nsamenang 2008) to challenge the uniform application of the law without considering the multiplicity of contexts that these children belong to hence the likelihood of obstructing their rights.

In addition, the prison space is characterized by its own rules and regulations, meant to modify or stimulate appropriate behavior among imprisoned persons and this inadvertently includes children who are in these spaces as revealed by a prison officer who noted:

> *Sometimes children panic when they come to the facility, they realize it is not the normal life they are used to, and their reaction depends on their background (Prison officer, Langata Women Prison).*

The entry of a child into prison is legally sanctioned as the child joins the mother in prison through a court order and the children's officer follows-up with a committal order. The mother is the only parent who is permitted by law to stay with the child in prison. The rationale of the focus on the mother as a nurturer is a factor of the dominant attachment theory, which naturalizes motherhood and proposes that maternal presence and nurturing is paramount for children positive development than the father (Woodhead 2006,10). Even when the father of the child expresses the need and has capacity to take care of the child outside prison, this wish is often not legally granted as revealed during data collection in the study. Indeed it is important to heed to the argument by (Okwany et al. 2011, 58) that measures of attachment, which only focus on how well a child is attached to one primary

caregiver, often their mother, misses out on the distributed care system that has adapted beyond blood relations to include neighbours and friends and which could be important for creating a care network for children whose mothers are incarcerated.

Living in prison

Experiences of children living in prisons in this study were limited to the narratives of adults who are primary care givers. This is a key limitation in the study and we call for studies that are based on the articulated experiences and perspectives of caregivers in prison to access the actual voices of children who accompany their mothers to prison and the meanings they give to their experiences while there. The narratives, collected from caregivers, provided a glimpse of the lives of these children and areas where redress for their rights can be enhanced. Children living in prison are subjected to the stark prison conditions and 'imprisoned care' because of their dependent care on their mothers. They thus have to adhere to confined daily routines and patterns like waking up, sleeping, family visiting routines, feeding times with similar diet and confined movements.

In terms of basic service provisioning, the prison act obliges the prisons to provide access to free state basic medical care, nutrition as well as specialized care for children who have special needs like HIV/AIDS or other chronic illnesses. Additionally, children in their first years of life up to six months receive close attention from their mothers who should receive maternity leave and be exempted from prison duties and responsibilities. However, these requirements are not necessarily met in implementation due to financial constraints and systemic inadequacies. Importantly, the lives of these children are rendered invisible by the minimal documentation available about them. For example, there are no files or records beyond their registration numbers. The reason given is that the prisons' mandate is mainly is to manage the female prisoners and not the children. Therefore, the children in prison remain unseen within the prison system and wider child protection system. This exacerbates their inequality and makes it difficult to demand for the protection of their rights.

In Uganda, the study findings are specific to Luzira Women Prison but can be used to understand the prison environment in other parts of the country. The 2013 US Department of State Report noted that the 'Uganda Prison Service was not allocated funds to accommodate pregnant women and mothers with infants'. This implied that the prison has to improvise for the children. For example buying food which most times is not rich in relevant nutrients affects their health. On the other hand, the Langata Women Prison has a welfare department, which caters for both the welfare needs of the mother and the child. For example it caters for health care needs, nutrition, entertainment and facilitates communication between prisoners, their family and nongovernmental organization for any additional support. The welfare office is responsible for admission of children into the prison and they arrange for orientation for both the child and mother in the prison. They also engage in the assessment of any caring needs the mother may have and assistance is provided as needed but if often constrained by limited resources.

Data collected for this study revealed that prison is also a space where socialization of the child takes place with different caregivers. It is a foundational space where cognitive, social, emotional and physical aspects of health and wellbeing of these children are enhanced or inhibited. New relationships are created with fellow children as well as with female prisoners and officers. Children are exposed to diverse social

cultural values and practices some of which might be negative.

Experiences of mothers living with their children revealed mixed feelings in Prison as the views below reveal:

> *The shortage of stable serikali (state) supply of basic services for example water makes it more difficult for those who have children in prison than those without and this affects the care given to the children who have increased risk of diarrheal diseases (Female prisoner, Esta).*

Some of the mothers also felt that the prison environment negatively influenced their children's lives and the children had learnt negative behaviors as one mother noted:

> *I wish my child can leave this prison. They should leave at three years of age or below. He has picked up so many bad behaviors from the female prisoners here. He is better at home with the others. I don't know what to do with him (Female prisoner, Ada).*

A contrasting view from two mothers revealed how the children becomes a props for attracting benefits:

> *… Having a child in this prison is good because one is more visible to donors and well-wishers (Female prisoner, Dina).*
>
> *Children in prison often attract visitors and this is the way through which these children meet some of their needs like having different food, milk, toys and clothes among others (Female Prisoner, Fatuma).*

Amongst studies conducted on children in prison limited literature exists on the notions presented above. However, we locate these notions of supposedly positive prison experiences for children within a growing critique in social protection and social justice discussions. We draw on a study conducted in Nyanza and Western Kenya on social protection by non-state actors (Okwany and Ngutuku Forthcoming 2016) which reveals that often non state actors who fill in the lacuna left by limited state provisioning dispense rights as charity and not entitlements. This creates a sense of gratitude among recipients (citizens) and to avoid losing these benefits, they adopt a passive, non-judgmental, grateful pose hence weakening what the authors call their "bottom up accountability" opportunities. Therefore these notions were expressed in light of limited basic provisioning for children within and without the prison by the state. For example Langata Women's Prison in Kenya is one of the few prisons, which receives more donor support and aid than other prisons in Kenya. We assert that this form of accessing rights for children is a less transformative model since the interventions are limited, infrequent and fragmented and charitable. This narrows the spaces where caregivers and children can claim for their rightful entitlements and seek social justice.

Additionally, our findings also reveal that Langata women prisons benefited in 2013 from non-state support through a donation that led to the establishment of a day care center within the facility. The facility hosts 45 children who were in prison with their mothers at the time of the study. The day care was a space where children aged 1-3 years engaged in unguided play and spent the rest of the day as their mothers were working. The children are taken care of by two or three mothers and supervised by female prison officers who have undergone early childhood training. Those above three years attend a nursery school in the facility, which is attended by the officer's children as well. However, it is noteworthy that Langata prison is the only prison in Kenya with a day care center. In other prisons the children spent the day in the wards. This has the potential for providing a model for how to provide quality early care for children in prison with their mothers.

Luzira women's prison is the oldest in Uganda and has some advantages over the others such as Oyam prison in the North. Its strategic location and accessibility within the capital city Kampala makes it easier to receive more attention from different actors. It is thus comparatively more equipped with the necessary facilities for young children above two years of age. Data from key informant interviews revealed that Luzira women's prison has the highest number of children under its care. The prison owns a farm that provides food like vegetables and cows that provide milk for the babies while Uganda prison services caters for the nutrition and health needs of all inmates including the children. However, there are still insufficient efforts to ensure child protection in the prison for example the limited establishments of preventive measures like specialized medical care and structures (Mudoola 2012). This implies that the chances of ill health among the babies and young children in prison are very high and could result in poor nutrition conditions like malnourishment or obesity and ill health including asthma, ear infections and eczema as well as allergic reactions which could be mistaken for minor upsets in the absence of specialized medical structures (Mahan and Escott-Stump 2004). At the time of the study, no significant cases of ill health as a result of malnutrition were identified among the babies and young children but examples were cited. We therefore submit that despite legal provisions in the Prison acts there is no concomitant provisioning of resources to make the prison space adequately adapted to host children.

Exit from prison and reintegration

The process of the child exiting the prison reveals how the weak and limited options of care arrangements intersect with age, material deprivation and social stigma to influence the life of a child who has been in prison. During this time, the child often leaves the mother in prison and is reintegrated with their family or an alternative system of care if family care is not available. The Children Department's role becomes most visible at the prison exit phase. Their officers utilize a child`s right framework as provided by the law to inform the exit phase. Children's officers apply to the children's court and the child is released and the re-integration process begins. The local children's officer conducts a home assessment prior to release to ensure the family is ready and able to take in the child. Alternative care may be sought from non-state owned children homes since state run children's homes have limited capacity. Organizations like NEST in Kenya host children of imprisoned mothers who are above four years, providing short term rescue and shelter before reintegration of the child. Also children are taken care of within the family care structures whereby sibling tracing is done and the child rejoins them. Often this phase may have substantial repercussions on the child's wellbeing in positive, negative or neutral ways. Data from interviews with the children's officer revealed that there is a heavy social stigma attached to imprisonment for adults in general, but over and above the shame of having their mothers incarcerated, these children have to also contend with possible rejection by their family. The officer noted:

> *Once the children leave the prison environment they communicate differently because they have interacted a lot with prisoners and prison officers. They call all adults madam. Some use very abusive language or are violent or have difficulty concentrating. These changes become too much to bear for some caregivers and they refuse stay with the child (Senior child protection officer Nairobi).*

Also preparations of children before they exit the prison is minimal and children are once again disengaged from their mothers whom they were used to in prison and taken to another system of care. Moreover, there are limited mental health or child counselors available to support the child before and during this transition. This sudden process has been seen to cause great anxiety and trauma to most children according to the officer. Interview data revealed that reactions among children during exit range from: excitement to leave the prison, anxiety and fear of detaching from the mother because there is no adequate preparation for the exit. Findings also revealed that most children find it difficult to adjust to a non-prison environment once they are reintegrated.

Based on these findings, we concur with (Sayed and Soudien 2003,10) that an "interlocking framework" is useful in highlighting the multiple intersecting factors that produce and reproduce inequity among children living in prisons. For example we have revealed how age, gender, discursive childcare practices, formal and informal institutional norms, interact with fluid social, economic and political contexts to shape the experiences of these children. This line of thinking shifts our argument from a normative stance of identifying problems within the prison as a care space. We instead frame the lived experiences of these children as emerging from complex interactions between the micro, meso and macro caring contexts and requires an integrated policy approach.

Conclusion

In this study we have revealed the ECCD trajectories of young children who live with their mothers in prison and we have unveiled gaps, resources and opportunities for enhancing their holistic rights and a socially just approach for these children as they disengage from familiar setting, live, exit prison and reintegrate. We have utilized the social justice framework to underscore the glaring inequalities and processes of exclusion compounding the lives of these children. We have demonstrated that both countries do not have specific policies and strategies on how the holistic entitlements of these children will be met. The brief mention of these children in the Prison Acts without tangible integrated policies and actions is not sufficient to address their ECCD rights. Langata and Luzira women prisons present better services for children due to their visibility being located in the capital cities and ability to attract non-state intervention support. This is problematic because these services are not replicated in the other more remote and under-resourced prisons. Additionally, the charity philosophy underpinning non-state provisioning does not transform the lives of these children in their various trajectories in and out of prison. Thus has implications for responsive policy, and we contend that equitable and just caregiving for these children can best be met if their lived experience is taken into consideration in designing protective services. A coordinated state ECCD policy framework must include a recognition of the heterogeneity of childhood and caregiving including the specific needs, rights and wellbeing of children living in prison with their mothers by taking account of diverse household and extended family capacity and the fluid socio cultural and economic spaces they occupy. The embedded formal and informal institutional inequalities and silences require vertical and horizontal dialogue among the range of care providers including parents/caregivers and both state and non-state actors in formulating transformative early care and development policy action to maximize optimal outcomes for young children living in prison with their mothers.

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Embedding social justice in Ugandan adoption and legal guardianship cases

Sylvia Namubiru Mukasa
Advocate of the High Court of Uganda and
Executive Director, Legal Aid Service Provider's Network
Kampala Uganda
Tel +256 -312513733
Mobile +256- 772465658
Email: sylviamubiru@gmail.com

Kristen Cheney, PhD
Senior Lecturer of Children and Youth Studies
International Institute of Social Studies, Erasmus University Rotterdam
The Hague, Netherlands
Tel: +31704260575
Email: cheney@iss.nl

Sylvia Namubiru Mukasa is a Social Justice Advocate, Member of Uganda Law Society and current Executive Director of Legal Aid service Providers Network. Ms. Mukasa holds a master's degree in Development Studies: Human rights, Gender, Conflict Resolution and Social Justice Perspectives with a specialization in Human Rights from the International Institute of Social Studies. She has a bachelor's degree in Law from Makerere University; a diploma in Legal Practice from the Law Development Centre Kampala Uganda; and a diploma in Human Rights and Democratization from Copenhagen Business School. She has worked for government as a judicial officer for 5 years and has 11 years' experience with human rights-related work focusing on the rights of the poor and marginalized. Her master's thesis was on the best interest principle in international adoptions from Uganda.

Kristen Cheney's research focuses on children, youth, and international development, mainly in Eastern and Southern Africa. She has authored two books, Pillars of the Nation: Child Citizens and Uganda National Development (2007) and Crying for Our Elders: African Orphanhood in the Age of HIV/AIDS (forthcoming), both from The University of Chicago Press. She has also published numerous articles. Dr. Cheney's most recent research concerns the political economy of intercountry adoption, orphan tourism, childcare institutions, and their relationship to child protection and wellbeing. She organized the International Forum on Intercountry Adoption and Global Surrogacy in The Hague in August 2014.

Abstract

International adoptions of Ugandan children rose by 400 percent from 2010 to 2011, many under irregular and suspicious circumstances (Lumu 2014) due to a 'legal guardianship loophole' that allows prospective adoptive parents to take children under their guardianship out of the country even before a child's adoptability has been determined. Ugandan courts then lose jurisdiction because such adoptions are finalized in the adoptive country.

This article highlights the emerging social justice issues associated with these trends, as well as the irreversible damage of such actions on children's growth and development. The courts play a critical role in adoption and legal guardianship cases, using their discretionary power to promote the best interests of children and ensure their safety, survival and development. Because judicial officers are more empowered than any other authority, we argue that they must exercise this discretion with social justice in mind; a fair and transparent process of judicial decision-making that recognizes human value, children's capabilities, and wellbeing as well as treats all parties equally – regardless of their social status – is essential if children are to be protected from adoption abuses and trafficking. A watertight adoption procedure is the only means of ensuring the appropriate identification of adoptable children and guaranteeing that children are regarded as individual rights holders rather than the property of adults.

Introduction

Lack of regulation and oversight, coupled with the potential for financial gain, has accelerated the growth of an industry around inter-country adoption, where profit – rather than children's best interests – takes center stage. Uganda as part of the global economy has not been spared of this apparently profitable trade in children across borders. The processes of inter-country adoptions (ICAs) and legal guardianship (LG) in Uganda are inadequately regulated and are thus marred with unethical conduct by adoption agencies, social workers and legal practitioners. This has led to many instances where the legal adoption procedure is being circumvented in favor of legal guardianship (Namubiru 2013). This article argues that in order to prioritize the best interests of children involved in intercountry adoption, the courts must take a social justice approach when determining a child's adoptability.

The article begins by describing the recent development of ICA in Uganda and explaining the concept of social justice relation to ICA. It then examines why Ugandan courts, inadvertently or due to structural gaps, fail to uphold social justice in adoption matters. It then discusses how a social justice approach can best be embedded in ICA to ensure children's best interests in ICA.

ICA in Global, African, and Ugandan Context

Intercountry adoption has its genesis in the post-World War II era, when American soldiers returning home drew attention to children orphaned by the war in Europe. It later took a markedly distinct tack when, instead of committing resources to helping orphans within the country of origin, the solution was taken to provide them with homes elsewhere. Although adoption was originally meant for providing an heir to childless families, it has evolved over the past few decades into a method of providing a permanent loving family environment to a child (Martin 2007). According to Martin (2007), proponents believe that ICA fulfills a child's right to grow up in a family environment for millions of children in need of homes in developing and transitional-economy nations. However, critics of ICA point to inequalities between sending and receiving countries and the way children are

commoditized to meet the demands of the West (Mezmur 2010, Cheney 2014a). Breuning and Ishiyama (2009, 98) state that although adoption across borders has the potential to successfully serve the needs of orphans by providing them with permanent and loving families, it also has the potential to turn children into an "export product" motivated either by a desire to genuinely help children in need of care or to profit from such children through child trafficking (Kapstein 2003, Martin 2007, Mezmur 2010, UNICEF 2007). This commoditization of children compromises their best interest and violates a child's basic human right to grow in an atmosphere of happiness, love with awareness of their origin and identity as enshrined in the Convention on the Rights of the Child (UNCRC 1989, Smolin 2007).

The Hague Convention on Intercountry Adoption (HCIA) was promulgated to prevent such practices. Founded on the best interests of the child, this binding convention emphasizes subsidiarity, i.e. ICA as a last resort after all other alternatives to institutionalization are exhausted. Yet children's best interests are clearly not prioritized in the way most ICAs in Uganda have been conducted to date (Cantwell 2014). Unfortunately, Uganda has still not ratified the HCIA despite calls from various stakeholders to do so (UNCRC Committee 2008).

Adoption Trends in Africa

Africa is currently perceived as vulnerable to exploitative ICA practices, including child trafficking (UNCRC Committee 2008). When ICA reached its peak in 2004, UNICEF stated,

> Over the past years, the number of families from wealthy countries wanting to adopt from other countries has grown substantially. At the same time lack of regulations and oversight, particularly in the countries of origin, coupled with potential for financial gain, has spurred the growth of an industry... Abuses include the sale and abduction of children, coercion of parents and bribery as well as trafficking to individuals whose intentions are to exploit rather than care for the children. (UNICEF 2004, cited in Roby 2007, 59)

The African Child Policy Forum (ACPF) also reports that ICA in some countries in Africa, Uganda inclusive, is marred with serious procedural problems (ACPF 2012). Mezmur (2010) gives numerous examples from a number of African countries where ICA practices have earned scrutiny for illicit activities prohibited by the HCIA including falsification of documents, violation of the rule of "no initial contact" between potential adoptive families and children, improper financial gain, sidestepping stringent residency requirements, and abuse of guardianship orders. Such abuses that led to the suspension of ICA in some countries such as Liberia – and a steep reduction of ICA in others such as Ethiopia – shifted the focus to countries with less restrictive policies and protection measures like Uganda (Breuning and Ishiyama 2009, Cheney 2014a, EveryChild 2012).

Adoption and Legal Guardianship in Uganda

In Uganda today, there is a growing concern about the number of children being adopted internationally as a result of a weak child protection system (Sserwanja 2013). A prospective parent is legally required to foster for 3 years before adoption, but applicants have used legal guardianship to circumvent this requirement. In 2008, the CRC Committee (2008) expressed concern about the rising number of applications for Legal Guardianship (LG) by foreigners. The Ugandan Children Act section 46 provides that inter-country adoption may be granted to a person who is not a citizen of Uganda only in exceptional circumstances and only after s/he has stayed in Uganda and fostered the child for a period of not

less than 3 years under supervision of a probation and social welfare officer or other competent authority, with recommendation about suitability and assurance to the court that his or her country will respect the adoption order (Republic of Uganda 1998). Though LG is meant to be a temporary measure to provide children with a family environment until they can be reunited with their legal parents, prospective adopters learned in 2007 that once they attained legal guardianship of a child, a passport, and a visa, they could take them to their home countries and apply for adoption there (Court of Appeals of Uganda 2011).

The Alitubeera case of 2011 set the precedent of LG as a means of bypassing adoption law. When one-year-old Deborah Alitubeera's parents separated and her father was unable to care for her properly, local authorities placed her in a children’s home. Later, an American couple applied for LG in the High Court. The presiding judge rejected the application, saying, "If the courts were to grant the orders sought, it would inevitably lose jurisdiction over the orders made and would therefore be incapable of supervising the welfare of the child" (Court of Appeals of Uganda 2011, 2). The American couple appealed, and the Court of Appeals overturned the decision of the High Court, stating that the Judge was in error when he undermined the best interests of the child as primary consideration. They granted LG with stringent conditions, namely returning the child to Uganda for adoption proceedings and making the child retain Ugandan citizenship until 18 years of age. However, the American embassy denied Deborah a visa on grounds that the order of returning to Uganda for the process of adoption was not implementable. An application was made for review a few days later, and the Court of Appeals unanimously agreed that, “The intention of their judgment could not be fully implemented unless they deleted the conditions requiring legal guardians to come back and file applications for adoption in Uganda” (Court of Appeals of Uganda 2011, 38).

Allowing foreign legal guardians to proceed to their own country and obtain adoption orders thus effectively nullified the requirement for consent of the birthparents and opened the floodgates for LG in Uganda. The Alitubeera decision became binding on the lower courts, limiting their discretion and control over ICA in terms of follow-ups and safeguards.

As a result, Ugandan judicial officers are now regularly granting LGs to foreigners knowing that such prospective parents will finalize adoption outside the country. The Ministry of Gender, Labour and Social Development (MGLSD), which is responsible for social policy and protection of children, views the issuance of LG orders as child trafficking. However, many legal practitioners defend it as due process of the law (Kaboggoza 2013).

Further, this case, in which the court based their determination of the child’s best interest primarily on immediate material circumstances, demonstrates the politics of ICA (Breuning and Ishiyama 2009, 98) and illustrates power relations between sending and receiving countries, as well as institutional and individual power relations in ICA. The UNCRC Committee therefore recommended that Uganda stringently scrutinize applications for LG and ICA and ratify the HCIA (UNCRC 2008). Almost eight years after this recommendation, however, Uganda has not ratified the HCIA.

Adoption in Uganda: orphan rescue and the profit motive

These developments have created a very profitable ICA landscape for the middle man, with well-connected agencies being supplied by

unregulated orphanages – which are further supplied by 'finders' who go into communities to convince poverty-stricken parents to place their children in orphanages (Kaboggoza 2013). This is bolstered by a prominent orphan rescue narrative in Western countries like the US, which accounts for nearly half the world's ICAs (Cheney 2014a). Consequently, ICA is now seen as an alternative care option of first resort rather than last resort and has thus become a matter of concern in terms of social justice.

The LG loophole has spurred increased attention toward Uganda as an ICA destination. LG requests by foreign applicants rapidly increased from 2008 to 2011. Between 2010 and 2011, with the drastic reduction of ICAs in other countries like Russia and Ethiopia, the number of ICAs in Uganda increased by 400 percent (Lumu 2014), with 95 percent of children being adopted to the US under court-approved LG orders (MGLSD 2013).

Many of the children adopted through ICA actually have birth parents who have relinquished them because of social and economic challenges that make it seem as if the only choice is to give their children away with the hope that they will live a better life. Yet, even in the face of the African AIDS pandemic, research shows that 90 percent of the children who lost one or both parents were being absorbed into tradition extended-family networks (JLICA 2009; Roby et al 2013).

This sacrifice is premised on unequal opportunities, poverty, and lack of agency – and is sometimes even driven by inducement and coercion. Adoption agencies, child care institutions, and their intermediaries – who are financially benefiting from ICA – have thus orchestrated an 'orphan crisis' in Uganda, prompting even more demand from the ICA community by perpetuating an international orphan rescue mission (Mezumur 2010, Roby et al 2013, Cheney and Rotabi 2014). The desire to adopt internationally is driven by these child rescue narratives and yet a child with extended family is not automatically adoptable according to the HCIA (HCCH 1993). ICA as a business has led to the commoditization of children (Kaboggoza 2013, Davies 2011), the proliferation of orphanages (Riley 2012), and even the actual 'manufacture' of orphans (Cheney and Rotabi 2014). This shows that, rather than being altruistic, ICA is driven by demand in receiving countries rather than supply of orphans in developing countries (Cantwell 2014, Cheney 2014a).

ICA as a Threat to Social Justice for Children

Such irregularities and the use of LG for ICA have marred the process and created a child protection crisis. Roby et al (2013) note that structural barriers to socially justified ICA can exploit and oppress vulnerable children and families and threaten the integrity of social work practice – even the survival of ICA as a placement option. Structural gaps, power disparity between sending and receiving countries and families, perceptions of poverty, cultural incompetence, misconceptions about orphans and orphanages, lack of knowledge about the impact of institution-based care, and the profit motive are all driving forces behind the growing shadow of unethical ICAs evident in Uganda, which Roby et al refer to as a form of aggression (2013, 3).

The concept of 'social justice' is ultimately about fairness, beyond individual justice. According to the National Pro-bono Resource Centre, (2011, 2), "the concept of social justice involves finding the optimum balance between our joint responsibilities as a society and our responsibilities as individuals to contribute to a just society." In other words, social justice is about equity and fairness in all we do or decide for others. It "recognizes universal human value"; "emphasizes collective/state responsibility to create a system of laws to stop

people from harming each other"; guarantees "individual liberties and equality of opportunity"; and recognizes "rights and outcomes" as well as the "value of human wellbeing" (National Pro-bono Resource Centre 2011, 4-6).

Social justice is a historical and defining foundation of the global social work profession (Holscher cited in Roby et al 2013). It is thus an apt conceptual framework for discussing unethical ICA practices (Roby et al 2013).

Roby et al argue that ICA involves multiple layers of structural disparities, creating fertile ground for the seeds of social injustice. Exchange of children through ICA usually occurs between developed and developing countries and between resourced and impoverished families, and it is facilitated by multiple intermediaries who wield considerable control and power (Cheney 2014a). Within the country of origin, birth families tend to be low on the "internal status hierarchy" (Roby et al 2013, 2), usually very poor. Such unequal status undermines the tenets of social justice for those involved in ICA, especially the child and his or her birth family.

The CRC Committee feels that current Ugandan adoption practice is inconsistent with the best interest principle (CRC Committee 2008). With the lack of clear guidelines on how to proceed with legal guardianship, protection and follow-up mechanisms, and proper records for future reference, the child's best interest is left at the whims of individual court officials whose discretion is susceptible to manipulations by other competing interests such as those of adoption agents and adoptive parents. Further, Uganda's courts are giving less regard to surrounding facts, which often and easily occasion a miscarriage of justice – especially where there has been unethical conduct, such as violation of the no-contact rule as enshrined in the CRC Article 21 (UNCRC 1989) and the HCIA Article 29 (HCCH 1993), which provides that "There shall be no contact between the prospective adoptive parents and the child's parents or any other person who has care of the child" until after determination of the child's adoptability has been established. This safeguarding measure allows for the exhaustion of all domestic options, providing for independent vetting of adoptive parents as competent and eligible. Moreover, it requires free and informed consent of the child (where possible) and responsible persons, institutions and authorities, as well as eliminating possibilities of improper financial gain and inducement of families and institutions to relinquish the child.

In addition, the law is undermined when the restrictive three-year residency requirement is circumvented. The residency requirement was mainly established to allow the child to bond with his adoptive family, including would-be siblings, but it is too restrictive and is in fact inconsistent with the CRC (UNCRC 1989).

However, one court registrar who was interviewed by Namubiru (2013) regrets that courts are not fully enforcing residency requirements, only to satisfy the interests of the applicants:

> Applicants get in touch with lawyers on the Internet, fix hearing dates, fly in, and use dolls and sweets to get bonded with the children. When you probe the adoptive parents, you find that they don't know the history of the child. When you ask them to offer assistance to the children for the three years as they foster the children, they refuse – which means they don't qualify to become parents because a parent with natural love would do anything for their child irrespective of where they are living. (Namubiru 2013)

This is where the courts' tight scrutiny would add value, including a requirement for the applicant to produce their visa applications and proof of residence while in Uganda. Courts have powers to insist that the applicants first reside in Uganda, fostering the child under supervision of a probation and social welfare officer (PSWO) before they can take the child outside Uganda. To avoid an injustice, the applicants have to meet reasonable standards of stay to allow bonding as per the HCIA.

Justice Mukiibi argues that the LG process undermines the importance of adoptive parents' familiarity with Uganda's people and culture, which has been shown to be important to internationally adopted children's identity development. He says that the current process makes it easy for a "stranger" to the country to move the child abroad. This severs all connections and denies the child an opportunity to have pride in their background (Mukiibi 2013, 19-20).

Are the Courts Panaceas or Part of the Problem?

Namubiru's 2013 study of the courts' application of the best interest principle in ICA and LG cases illustrates that despite being cognizant of the best interest principle, courts have anchored their decisions mainly on the potential economic and physical wellbeing of the child, paying less attention to other aspects embedded in the principle, such as emotional, psychological, religious and cultural identity over the life course. These too are fundamental to social justice for children.

While there are exceptional situations that warrant a child being legally adopted by foreigners, the decision should not be based solely on relative poverty of the child and/or wealth of the adoptive family. The Family Court's continued issuance of LG orders while the necessary supportive monitoring mechanisms are missing; it undermines tenets of social justice and efforts to preserve the best interest of the children affected. If, however, Uganda ratified the HCIA, they would be required to establish a central authority responsible for intercountry adoption; a legal framework that eliminates financial gain and ensures that the transfer of children takes place in secure and appropriate circumstances; availability of pre-and post-adoption counseling and other supportive networks; availability of mechanisms to collect, preserve and exchange information about the situation of the child; availability of periodic evaluation reports about the experiences of ICA between the sending and receiving countries; and measures to preserve the child's identity in terms of ethnicity and religious background. By continuing to allow ICA in the absence of the above institutional and legal framework, courts have become part of the problem because they have not proactively invoked their discretionary powers to offer sufficient protection and justice to children. The situation as it is now does not guarantee the safety of children before, during and after ICA; rather, it endangers children and facilitates child trafficking (Mezmur 2010). Further, it undermines the development of an effective child protection system that supports families and communities to raise their own children (Cheney and Rotabi 2014).

To address the impact on child protection brought about by the current trends, the courts have to revisit this position and restore stringent terms as enshrined in the international instruments and the national legal framework.

How to embed social justice in ICA

The Family Court reform must place social justice at its center in order to improve the child welfare system and to ameliorate the circumstances that make poor and minority families vulnerable (Brooks and Roberts 2002). For court

reform to be meaningful, it must be informed not only by awareness of the socio-economic and racial dimensions of child welfare but also by a holistic, ecological approach to children and families. Two such approaches are family systems theory and therapeutic jurisprudence.

The family systems theory is a well-developed way of understanding how families function, and it has achieved widespread acceptance in the mental health fields of social work, psychology, and psychiatry – despite its relative lack of familiarity among judges and courts. Contrary to the legal system's emphasis on individual rights and remedies, the family systems approach views the family as a living system whose members are its interacting parts. Brooks and Roberts point out that

> A family systems approach therefore requires courts to take into consideration the whole family, broadly defined, in making decisions about a child. It also requires a court to respect the child's attachments to family members and other intimate relationships, attempt to maintain family ties wherever possible, and focus on family strengths rather than deficits. (2002, 455)

'Therapeutic jurisprudence' is the use of law as a therapeutic agent, focusing on how the law can enhance the wellbeing of those affected by it (Brooks and Roberts 2002). It calls for law scholars and practitioners to adopt other disciplines' good practices, such as using empirical data to study problems and test the effectiveness of the proposed reforms (Brooks and Roberts 2002, 456). For example, social science research can help explain increasing disparities in childcare based on social classification (e.g. race and class), describe the harm that such disparities occasion to children, and prescribe strategies. By examining how a particular law, program, or court structure might enhance or detract from the wellbeing of those affected by the law, courts can make more well-informed, socially just decisions.

Mukiibi (2013, 13-14) argues that all abandoned children are wards of court, which "… must exercise that jurisdiction in the manner in which a wise, affectionate and careful parent would act for the welfare of the child." Mukiibi adds that it is in the best interest of the child for courts to have residual powers to prevent or correct abuses by legal guardians (Mukiibi 2013, 14). The best option is therefore to grant LGs only to residents of Uganda, as provided for in the proposed Children Act amendments that have yet to be approved. This way, the courts will maintain jurisdiction and easily apply their residual powers to correct any abuses or errors.

In most African contexts including Uganda, there is rarely a total orphan because of the extended social family (Roby et al 2013). Hence, if the HCIA subsidiarity rule is followed, the vast majority of children are not in fact adoptable. Granting ICA without exercising due diligence such as exhausting locally available options and failure to keep proper records of those adopted can irreparably damage children. It is important to note that the approach of individualistic rights discourse often emphasized in adoption best interest decisions excludes the community interests; that is, children's rights are often considered in total disregard of parental rights. Further, it is well known that adoptees long for information about their origins, and that revealed cases of adoption fraud are very traumatic for adoptees (Cheney 2014b, HCCH 2008). In the wake of continued negligence in determining children's fate, Uganda will be faced with many adoptees asking about their roots and reasons why they were relinquished. A social justice approach must consider these consequences before making adoption determinations (Cantwell 2014).

Social Justice Made Possible

The whole process and design of ICA is premised on inequality in terms of resources, knowledge and bargaining power. Most Ugandans live below the poverty line, surviving on less than a dollar a day. Certainly, extreme poverty can be a crippling barrier to human potential; however, ICA as a solution to child poverty is a drastic and costly measure when other less invasive and cost-effective means can be used to assist families and promote child well-being (Smolin 2007). Interventions that access traditional mechanisms of support such as kin- and community-based efforts and, at a macro-structural level, that target poverty reduction and expand social protection to vulnerable families are being implemented with promising results (MGLSD 2013, Roby et al 2013).

While there are genuine cases of orphaned and abandoned children in need of alternative and/or permanent care, abuse of the court process has become a volatile situation fraught with structural barriers to social justice; hence, the urgent need to rethink the strategy to combat the vice from continuing to spread. Social justice for children and vulnerable birthparents should be at the center of the adoption process in order to minimize abuses and injustice. Properly conducted ICAs are still possible as a permanency option for children in need of families if a social justice approach is adopted. First, judicial officers in Uganda, as gatekeepers, facilitators and decision makers of complex and fast-changing ICA processes must accept the responsibility of upholding and promoting social justice in cases of ICA. This stand requires careful attention to what is known about ICA and the social ecology of the practice, including concerns about human rights, the family fabric, lack of regulatory and protection structures, gender inequalities, power relations and traditional family life that interfaces with market demands for healthy children (Roby et al 2013). The social justice approach looks beyond the law and procedure to critically evaluate the circumstances under which a child is placed for adoption (Save the Children 2006), considering power relations and children's rights at the core of the decision making (Cantwell 2014). It endeavors to predict the impact of the decisions made and their outcome thereafter to the future development of the child (Jonsson 2005, Cantwell 2014). It also allows for the independent voice of the child separate from those with vested interests. In cases where children are old enough, their opinion and consent should be sought, and where children are very young, the social justice approach imagines what the child would choose if s/he were old enough to make the decision (Cantwell 2014).

Concretely, courts should immediately end LGs for the purpose of ICA, sign the HCIA, and grant adoption only as a measure of last resort. The CRC already provides universal standards and the HCIA together with the Children Act as an enabling law provide further provision for protection of children's rights.

There must also be proper post-adoption follow up, such as keeping proper records with a view to preservation of family and background identity for future reference, and periodic updates from adoptive parents.

Finally, the need to change the discourse of orphan rescue is of essence because it fuels an ICA industry that is destructive to family preservation and child protection (Cheney and Rotabi 2014). Many individuals and organizations in Uganda are trying to do just that, and they deserve our support.

Postscript

In March 2016, amendments to the 1995 Children Act supported by children's rights activists were approved by Parliament. The President approved

the amendments in May 2016, signing them into law.

The amendments included limiting legal guardianship to Ugandan citizens and reducing the probationary period for completion of an adoption order – whether the applicant is domestic or foreign – from 36 months to 12 months. Children in adoption cases will also be represented by an attorney from the Attorney General's Office.

The amendments also include the establishment of an independent body that will be responsible for policy formulation, planning and implementation of child wellbeing as well as ensuring compliance to the law, safeguards and documentation for children.

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The care and support of vulnerable children by foster care families in Uganda: Lessons in social justice and social protection

Herbert David Musisi
Lecturer, Nsamizi Training Institute of Social Development
P.O Box 149 Mpigi, Uganda
Telephone: +256 702521051/+256772470337
Email: musisi.herbert@gmail.com or mdavidherbert@yahoo.com

Eric Awich Ochen, PhD
Senior Lecturer, Department of Social Work and Social Administration, Makerere University
P.O. Box 7062 Kampala Uganda
Telephone +256 772 352 887/+256 703 143316
Email: eaochen@chuss.mak.ac.ug; ericawich@yahoo.co.uk

Herbert David Musisi is a lecturer at Nsamizi Training Institute of Social Development. He coordinates the Nsamizi/REPSSI and University of KwaZulu Natal Situated Support Distance Learning certificate course on Community Based Work with Children and Youth. Herbert is a Child Protection National Trainer certified by the Ministry of Gender, Labour, and Social Development and also a member of the National Child Protection Technical Working Group that developed the Child Protection accredited curriculum in Uganda. Herbert has a Diploma in Social Work from Nsamizi, and he received a BA in Development Studies and a Post-Graduate Diploma in Social Justice at Makerere University.

Eric Awich Ochen completed his doctoral studies at the Centre for Applied Childhood Studies, University of Huddersfield, in 2011. His PhD explored the narratives of young women's experiences of the conflict and reintegration process in northern Uganda. Eric graduated with an M.Sc. in Development and Project Planning (with Distinction) from the University of Bradford in 2002 and also holds a Bachelor's Degree in Social Work and Social Administration from Makerere University (1999). Eric currently lectures at Makerere University's Department of Social Work and Social Administration. He has previously worked with Save the Children Denmark, World Vision, Gulu Support the Children Organization, and Community Development Resource Network.

Abstract

This study aimed at investigating the quality of care and services offered by foster care families in Uganda. It targeted children aged 8-15 years, guardians, social service professionals from child focused NGOs, ministry officials and police. Data was collected from duty bearers working with children within both the civil society and the local government. Our findings showed that children in foster homes face significant challenges. In many cases, children's rights and entitlements were violated and abused by members of their foster families whom foster children trust and expect to provide them with protection, care and support. Abuses included withdrawals from school and making them perform tasks that were beyond their emotional and physical development. As a result, the quality of care and support offered by foster families at times appears inadequate and does not conform to the guidelines and standards set by the Uganda's Ministry of Gender, Labour, and Social Development. The study suggests the need for greater efforts at policy implementation and review of the regulations that guide practice in order to enhance the integrity of the foster care system.

Declaration: This work has never been submitted anywhere else and is not under any consideration for submission to another journal or publishing house.

Introduction

While fostering programs aim to promote social protection and social safety nets for children in need of care and support, at times it puts children at unforeseen risk and creates new challenges. This paper argues that while many Ugandan families open up their homes to children for foster care, instances of abuse exist, especially within the informal fostering systems and in an environment where enforcement of legislation is quite weak. Thus foster care arrangements do not always provide the best environment for the children, nor do they effectively address the long-term social reintegration of fostered children. Moreover, the situational realities of some of these foster families suggest that they lack the socio-economic means and knowledge to provide and meet the needs of these children.

Our main interest is therefore to analyze foster care from a social justice perspective and assess its promise and pitfalls in terms of factors that facilitate or constrain children's access to support and to actualize their potential as they transition from childhood to adulthood. We do this partly by reflecting on the challenges of fostering within the Ugandan foster care system and considering the very aims of fostering, which are to ensure protection, care and nurturance of children in need of support. We also juxtapose formal and informal foster care arrangements to assess how the two vary in practice and outcome. Such analysis has significant implications for intervention planning, policy and practice of foster care in Uganda. It is also expected that such reflections will generate ideas and frameworks for providing a more supportive care environment for children in need.

Methodology

A quantitative questionnaire was administered to a total of 71 actors, occupying positions of responsibility with regards to children within local governments and non-governmental organizations: police in Child and Family Protection Units (CFPUs), welfare and probation officers, a prison officer and the Assistant Commissioner for Children and Youth; social workers, councilors, sociologists, development workers, lawyers, medical officers and community development officers; teachers, tutors, and inspectors of schools. The researchers also interviewed four foster families and two fostered children. For the children

consent was sought and received from the foster families that were caring for them. The respondents were purposively identified and requested to participate in the study. All respondents work in various agencies, including local government and non-governmental organizations throughout the country that specialize in activities related to child protection, government ministries and departments mandated with child welfare provision in 13 districts throughout Uganda. We also interviewed several foster families although the majority was in informal foster care. In total, 30 male and 41 female respondents were interviewed (excluding the foster families and children).

Background

Fostering and adoption of children are modern social protection interventions carried out to ensure the safety and protection of a child from difficult and situated experiences (Biehal and Parry 2010, McDonald et al 1993, Pinheiro 2006, Wilson et al 2004). Although the United Nations' Convention on the Rights of the Child (UNCRC) points out that the best place for children to develop is the family (United Nations 1989), at times children do not get the opportunity to live with kin and hence find themselves in institutional care, foster care or adoption. Fostering provides support in situations where families and biological parents are unable or unwilling to provide effective care and protection to children. Theoretically and conceptually, fostering is the bridge between children moving from their original home (family) setting to a post-permanence support situation such as adoption, return to original home, or independent life.

Uganda Bureau of Statistics (2016) estimated that 8% (1.51 million) of all children below 18 years are orphans, declining from 13% (2.77 million) in 2002 (UNICEF 2012). Culturally, when biological parents die, or when they are unable to raise their own children, such children are raised by extended family members, who provide informal, traditional foster care coordinated within the existing family system. In Uganda, the family environment includes the cultural and social norms that are very vital in shaping the proper moral growth and development of a child. According to the Children's Act Cap 59 (Republic of Uganda 2000), fostering of children can be formal or informal. Informal foster care, which is most common, involves a relative, friend or community member caring for a child on an ongoing or indefinite basis – without this arrangement being ordered by Uganda courts of law, the Social Welfare and Probation Department, or another statutory body. Informal foster care is still largely practiced by many communities in Uganda but evidence of outcomes is fragmented. In contrast, formal foster care by unrelated foster parents is ordered by a competent administrative body, judiciary or statutory body, with the supervision of welfare and probation personnel.

Studies across Africa have indicated that caring responsibilities seem to be shifting to grandparents or other relatives (Roby 2011). While this is true in Uganda, new dimensions of care and support are emerging with the informal foster care seemingly shifting from paternal to maternal relatives. In the case of HIV-positive mothers, this is reportedly due to the fact that much support for the mother already comes from her own relatives, whom the mother would prefer to have guardianship over her children in the event of her demise (Roby 2011, 16). This position is also seemingly driven by significant distrust in the paternal kin, and doubts over their abilities and commitments to fully support children.

Foster care is increasingly being seen as a better substitute for a biological family than institutional care in the light of increasing

uncertainty about the efficacy of conventional institutions and care homes. The outcomes of foster care have been the subject of some debate, however (McDonald et al 1993, Pinheiro 2006, Wilson et al 2004, Biehal and Parry 2010), particularly the prevalence of child abuse in foster homes. Indeed, according to Assistant Commissioner Children and Youth James Kabogoza, children in Ugandan foster homes face several abuses: Many times those who are cared for by their relatives because there was no signing of a formal agreement end up working as maids in a home, do heavy labour work which is not age-appropriate, are sometimes sexually harassed and/or defiled or married off at an early age, or denied inheritances, especially by those raising and caring for them.

Further, research suggests that formerly fostered children fare much worse as adults than those that did not require foster or institutional care (Browne 2009, Holland 2009, UN Office for Human Rights 2012). It is accepted that these negative outcomes might not necessarily be a product of fostering but could have been that fostered children already had some earlier situations which earmarked them for difficult adulthood, and the foster care support was not adequate to change their life courses. Wilson et al (2004) suggest that there is mixed success in foster outcomes. Noting that children prefer stability and should therefore only be moved when deemed absolutely necessary, they question whether children should be allowed to stay in care beyond 17 years, so as not to disorganize them and uproot them from their foster parent.

In discussing outcomes in foster care, Wilson et al (2004) further note that when analyzing data about the outcomes of children in care, many times distinction is not made between children in care institutions and those in foster homes, yet it should be noted that these are two different situations with differential outcomes as well. But the evidence from studies done in Europe and America suggest that children leaving care seem to face much more difficult adulthood. These include loneliness, mental health challenges, drug addiction, crime, school dropout, unemployment, debt, and failure to socially integrate and live a more settled life (MacDonald et al 1993, Browne 2009, Biehal and Parry 2010). Heckman and Masterov (2007) argued that, in spite of its limitations, foster care is an important welfare and social justice intervention because it provides the second closest experience to a natural family in that it presents opportunities for bonding and ordinary family life to the children. Studies also suggest that fostering makes it easier for siblings who have been fostered separately by different families to maintain connections and contacts (Child Welfare Information Gateway 2013).

In this paper, we reflect on the practice of child fostering in Uganda with lessons drawn from the framework of social justice and social protection. We question whether the current Ugandan foster care system effectively promotes the respect and protection of the rights of children in difficult circumstances. While we recognize the contribution that foster care provides, we also note the potential for child abuse (including deprivation from learning, physical and sexual violence) and the failure to address their socio-economic rights within the foster care environment.

Foster Care in Uganda

Policy, Practice, and Child Protection

Article 18 of the UNCRC defines parents as either legal guardians or adult persons who have the primary responsibility for the upbringing and development of a child as mandated in Article 20: “when a child is temporarily or permanently deprived of his or her family environment, s/he

must be accorded an enabling environment for his/her development" (United Nations 1989). This implies that when a child loses his or her parents, a substitute form of care should be accorded to the child.

The protection of children in Uganda is enshrined within the Constitution (The Republic of Uganda 2005), specifically Article 34, and the Children's Act Chapter 59 (The Republic of Uganda 2000). The Local Government Act also stipulates appointment of a secretary for children's affairs at all levels of governance, from national to village level. Uganda thus has one of the most elaborate frameworks and legislative blankets for the protection of children – yet abuse and neglect still represent a large percentage of recorded violations against children's rights.

How and Why Children Enter Foster Care

In Uganda, children generally enter foster care through a number of avenues. Orphanhood is the main reason that children are informally fostered. Parental child neglect and abuse – including physical, sexual and/or emotional abuse – constitute core imperatives for fostering children formally. In other areas, children who enter foster care are found abandoned, rescued, and taken to temporary institutional care, then fostered (Walakira et al, 2014). In most cases, police, social workers and local government personnel confer before a child is removed from their homes to formal foster care. However, informal foster care arrangements are mainly made by the extended family system and in some cases the local leadership structures at community levels. The Uganda National Alternative Care Framework provides for support of children who are not in a caring environment, including fostering and shorter-term institutional care (Ministry of Gender, Labour and Social Development 2011). According to the Uganda Operational Manual for Youth and Probation and Social Welfare Officers Article 43 (Ministry of Gender, Labour and Social Development 2010), a child without a parent or guardian may be fostered by a relative without formal agreement. If any other person agrees to take care of the child, an application shall be made to the District Probation and Social Welfare Officer. Informal foster care is very frequent among Ugandan communities both urban and rural, but due to the high costs of living in urban areas, it appears as if more children are informally fostered in rural areas than in urban areas. Absolute data on this issue is missing, however.

Currently, a child without a parent or guardian may be fostered by a relative without formal agreement. If any other person agrees to taking care of the child, an application shall be made to the District Probation and Social Welfare Officer. A child can be placed in an approved home under a care order with a person who is willing to care for and maintain the child, if the Probation and Social Welfare Officer and the Warden of the home decide so. The person taking over maintenance of a child is referred to as a "foster parent" and has the same responsibilities in respect of child maintenance as the natural parent. The "foster care placement rules" found in the second schedule of the Children's Act, Cap 59 (The Republic of Uganda 2000, 61-70) refer to formal foster care; while the law recognizes and encourages informal fostering of children, it is mainly in the formal foster care system that social workers and the police CFPU play a dominant role in carrying out assessment and also testifying on the capacity of the identified carer (foster care applicant) to support the child.

According to a Senior Probation and Social Welfare officer (PSWO), the PSWO carries out an assessment on the prospective formal foster parent who applies for caring for the child. The

assessment involves crosschecking the socioeconomic capacity of the prospective family, whether the environment where the child is going to be placed is conducive for raising a child, and the criminal record of the applicant. Upon the family passing the assessment criteria set by an authority [in this case the probation office], the applicant fills in the placement forms in triplicate copies. One copy is issued to the foster parents; another copy is retained at probation office, and the other is sent to the commissioner in charge of children at the Ministry of Gender Labour and Social Development (MGLSD). Then the child is given to the prospective family to be looked after for a probationary period of 3.5 years. During that period, the child is monitored at the foster home by the probation officer who gives advice and guidance on how the child must be raised.

In the event that the child's rights are in gross violation, the foster placement order is terminated; the child is withdrawn from that family and given to another family that may be willing to take care of the child as required by the law. Formal fostering, however, remains less common in Uganda, perhaps due to the heavy presence of extended family systems that embrace orphans and other vulnerable children.

The Efficiency and Effectiveness of Foster Families in Uganda

When study respondents were asked about the contributions of fostering to equity and social justice, all respondents agreed that both formal and informal foster families play a very large role in protecting vulnerable children from significant risks and other livelihood vulnerabilities. Thirty-three respondents agreed that foster families are effective and efficient, citing the following reasons: they report cases of child rights violations to authorities for legal and medical intervention purposes; they cooperate and mobilize/pool resources together for ensuring the growth and development of fostered and vulnerable children; they restore hope to those children who have lost their parents; they provide material and psychosocial support; they protect abandoned and extremely abused children; they coordinate with other family members to support abused children; they guide and teach the children good morals; they sensitize children on their rights and responsibilities; and they encourage networking and referral pathways to other service providers for further support to children; and ensuring that children are raised in a safer environment.

However, a more nuanced analysis of the findings suggests that the issue of discrimination between foster and biological children remains prevalent in Ugandan foster families; a majority of foster families do not treat fostered children the same way as natural children in the home. Some respondents asserted that fostered children are often stigmatized and discriminated against by their foster parents. Some foster parents also fail to adhere to the established government fostering standards and procedures. At one of the interviews of a foster family, we noted that the child was not at their home as recorded at police and probation departments; he was staying with the foster father's mother, but the family was still providing the welfare needs of the fostered child. It was a bit difficult for the researchers to establish whether the child was enjoying his fundamental rights at the foster grandmother's home. We suspected that the child could have been sent to the grandmother to assist in doing domestic work, which is common in Uganda and fundamentally violates a child's right to be protected from exploitation.

PSWOs in Masaka and Kampala also suggested that violations of children's rights in fostering correlate with the foster parents' level of education, with more violations reported in the

homes of less-educated parents compared to those families that are fairly well educated. Usually the educated families know the consequences of the law that protect the fundamental rights of children and the implications of the foster care placement orders granted to them by the probation office. Less educated families reportedly often abuse care orders granted to them, leading to stigmatization of such children – which in the long run affects their proper emotional growth and development.

In other cases, it emerged that the failure to provide the basic necessities for the child was a product of low family income or other such incapacities. Two PSWOs confirmed that issues of indifference in low-income foster households promote child rights violations in formal foster care families. Levels of household income have necessary consequences in formal foster case in Uganda; though the state provides an enabling environment, it does not provide economic assistance to support all fostered children within foster families. Thus, the more economically endowed foster families can afford all the material needs that the child may require for proper growth and development as opposed to the poor foster families who may not be in a position to provide all of the requirements. One PSWO cited an example of a well-to-do family in central Uganda who have been able to foster three children, with the eldest now in university.

Although there have been significant efforts on the part of the State to develop legal frameworks to protect children from all forms of rights violation, children in both formal and informal foster care homes continue to face significant abuse of their rights, both subtle and overt. One interview with the head of the Family and Protection Unit at Mbale Central Police Station indicated that most reported cases of child rights violations happen in informal foster families, especially those in the rural areas. A Clinical Officer at a health center in Mbale pointed out that some cases of aggravated defilement occur in foster homes and cited a particular case of a 4-year-old girl who had been defiled by a 15-year-old boy from the same neighborhood. When respondents were asked to rank the forms of abuse/rights violations they come across in foster care situations, they mentioned physical and emotional abuse, followed by child labor; defilement and child sexual abuse and harassment. Others mentioned are child neglect and lack of identity, culture, religion, and parental love and denial of property. Thus as earlier indicated in the literature the situations in Uganda seem to be similar to experiences of fostering in Europe and America, where instances of abuse have been cited (Benedict et al 1994, Biehal and Parry 2010, Hobbs et al 1999).

Analysis of some of the views on violations of the rights of children in foster care suggests that fostered children are more vulnerable compared to other children within the same home. It could also be a symptom of deeper problems and challenges with the child care system at family, community and institutional level and its inability to ensure adequate protection to children under a dysfunctional child protection regime.

Social Justice Perspectives on Fostered Children: the case of Safina

Social justice issues in fostering can best be seen through an example of a child undergoing informal foster care. Safina [not her real name] was abandoned by her biological mother and has been fostered by a neighboring family since 2012. The biological mother was evicted when she failed to raise the rent money. While Safina's mother relocated to another house in the neighborhood, she was unable to provide food for the child. As a result, Safina was always hungry. At the insistence of her friends, Safina started eating at the

neighbor's place (the current foster family) whenever her mother did not have food. The mother was later accused of stealing a phone, so she left without telling anyone where she had gone and has not returned to take care of her biological daughter. The foster family does not know any of the child's other biological relatives, as the natural mother left no information. The foster family does not know Safina's age, but they estimate she is 10 or 11 years old. Safina is thus denied the right to a proper heritage and identity – nor is she going to school. Though Safina is given food and a house to sleep in, she has effectively become a maid who spends all her time doing housework and babysitting while other children in the home go to school, thus denying her the right to education and a future career and transformation in her livelihood options and opportunities. As Safina's foster situation is still very much informal, follow-up monitoring and support is not feasible and minimal opportunities exist to enhance Safina's access to her rights.

Three years have since passed, yet Safina's foster family has not attempted to apply for foster care placement orders as mandated by Ugandan law (Children's Act Cap 59, section 43). Their inability to apply could be explained by lack of interest to formally foster the child or even lack of information about the necessity of such a process. This is a serious violation of children's rights, and it is criminal to raise such a child without obtaining the right approvals from an authority prescribed by the law. Apart from the Police at Kyeyagalire registering the case, none of the officers has followed up on the child. The office of the Vice Chairperson, who is mandated to handle children's affairs (the Local Government Act Cap 243 and Children's Act Cap 59), is at best redundant as pertains to this function. These local authorities and the police should have taken this case up with the PSWO for further documentation but this has not been the case.

Osgood et al (2010) suggest that our childhood and adolescent experiences have significant repercussions on our transitions into adulthood – and with it the outcomes of employment, marriage and other social interactions processes and outcomes. Yet young people in care are made vulnerable through emotional stress, disability, trauma, history and other such experiences. Osgood et al (ibid) suggest that the service delivery systems could also act as a constraint to the opportunities of fostered children and young people, recognizing that youth in difficult circumstances face a multiplicity of challenges, although also served by several systems. They add that the multiplicity of the aims or missions of the system for support also complicate the young people's transition to adulthood. Other studies have also shown that when children and young people like Safina are socially excluded from the development process, the financial costs to both the country and the young people are high (Scott et al 2011).

Government Efforts and Initiatives to Promote and Strengthen Protection of Fostered Children in Uganda

The Government of Uganda has put in place several structures and institutions to ensure adherence to fostering procedures and principles. This includes the PSWOs' focal persons and Justice Law and Order structures responsible for catering for legal issues. Government has also put in place legislation and policies to ensure the development, protection and survival of children and young people more broadly. The State has also acceded to international conventions and standards that regulate issues of children rights and welfare. Ministry of Gender, Labour, and Social Development is the mother ministry responsible for

the protection of children and in charge of implementation of the National OVC Policy (2003) as well as the National Strategic Program Plan of Interventions (NSPPI) for OVCs in Uganda. The NSPPI targets critically and moderately vulnerable children, where children in foster care fall. However, this study suggests that the presence of these institutional and legislative frameworks has not prevented the rights of fostered children as well as others from being violated. It appears, therefore, that in spite of the elaborate legislative and policy environment, the community and society in general does not seem to be fully prepared or equipped to provide a high quality of informal/traditional foster care. This could possibly be explained by the dysfunctionality in the child protection regimes, the socioeconomic situation within the country and perhaps the reduction in social accountability and obligations.

The precarious economic situations of some foster families and high cost of living act as a stumbling block to effective foster care, whether formal or informal. Foster families might have limited resources, space (especially within urban centers) and inadequate understanding of the child protection and policy regimes. Though Uganda possesses a strong legislative and policy framework, the inadequacy in follow-up and dissemination of these structures appears to be one of the biggest obstacles. Limitations in policy implementation thus have a strong bearing on understanding and utilization of relevant legislation and policies. Law enforcement is also hampered by inadequate social protection development staffing, especially the probation and child welfare departments across the country. The case of Safina above is again illustrative of government inabilities to enforce legislation for children or check whether children's rights are protected within the foster care systems. Many stakeholders think that government is failing to enforce the laws available to protect children in the custody of caregivers. For example, at the district level, there is only one officer who handles welfare issues and probation work, leaving him or her with a very high caseload.

Conclusion

This study suggests that while foster care (formal or informal) is desirable due to the life challenges that some children and young people face while growing up, it is faced with a multiplicity of challenges including abuse and exploitation in foster homes. Duty bearers are aware of the challenges, but there seem to be no easy solutions as the challenges are embedded within the socio-economic and institutional realities of Ugandan society. The main implications from this study are that even as efforts are made to improve the experiences of children in formal foster care, informal foster care poses even more challenges as many times children suffer in silence. This is because of the invisibility of these cases and thus the lack of formal follow-up or monitoring to determine their situations.

Policy and Practice Recommendations

Stakeholders we interviewed raised the need to create a referral pathway for cases of physical and emotional abuse. Such cases should be referred to competent organizations; there is a need for child protection actors to strengthen networks for child protection services for a harmonized continuum of care to the communities they serve. The role of the State in strengthening child rights enforcement mechanisms and institutions, including resourcing them with adequate resources and funds, is crucial. Foster homes and institutions in Uganda must adopt a strategy of employing personnel trained in child protection from recognized public, accredited academic training institutions.

We suggest that government design and periodically review polices that govern families in

matters of growth and development of children in Uganda. Such laws must be strong enough to punish those that violate the rights of children, or make it prohibitive for children's rights to be blatantly violated. Government should introduce a mechanism for all its staff and employees to sign commitment letters so that they uphold their commitment in protecting the rights of children who are under their custody. Government must improve on its supervision and monitoring mandate in foster homes to enable effective child protection. There are several measures that can be used to address and mitigate child rights violation in Uganda, although more emphasis needs to be made by child focused agencies (inclusive of the state) on creation of awareness of issues of child rights violations to change caregivers' social attitudes over time so that they perform their role of providing alternative care much better. Similarly, efforts need to be made to strengthen community-based informal foster care to minimize rights violations.

To improve adherence to national and international foster care laws, foster parents should sign commitment agreements to ensure that they will raise the child in their custody according to the Children's Act (Cap. 59). Relevant national laws should be translated in the local language. The current study also raises the necessity of Government to register all fostered children and approved homes in Uganda and enforce implementation of existing policy, as well as linking foster parents to capacity building organizations for necessary support. It is our view that if the above recommendations are adopted, fostered children will attain fairness, equity and greater social justice in all aspect of provision of child welfare.

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The use of contraceptive in Uganda: An analysis of access and rights amongst adolescents

Alaka D. Opollo
Senior Lecturer & Research Consultant
The Management University of Africa
P. O. Box 29677-00100, Bellevue South C off Mombasa Road, Nairobi, Kenya
E: diana.opollo@gmail.com, P: +254 700001731

Moses Katende
Independent Consultant
P.O. Box 70200, Kampala, Uganda
Email: mkatendeug@yahoo.com, Tel: +256 772 958 825

Dr. Alaka D. Opollo is a Senior Lecturer & Research Consultant at the Management University of Africa in Nairobi. She obtained a BA in Psychology (2005), a Master of Science (MSSW) (2007) and PhD in Social Work (2011) from the University of Texas at Arlington (UTA). She teaches courses in gender, development, management, and research methods. Her research interests are sexual and reproductive health and program design. She has published a book entitled Modernization and Contraception in Kenya from 1998 to 2008-2009 and articles in several journals. She serves on several research committees in Kenya and the United States.

Moses Katende is an independent consultant working in the East African Region. He was a Lecturer at Nsamizi Training Institute of Social Development for 9 years. Moses has a BA in Adult and Community Education from Makerere University and a Master of Public Health from Uganda Christian University. He also has a post-graduate diploma in Children, Youth and Development from the International Institute of Social Studies of Erasmus University Rotterdam, and he received an H.J. Heinz Fellowship from the University of Pittsburgh. His research interests include sexual and reproductive health, vulnerable children, and human resources for health.

Abstract

The main objective of this article is to assess aspects of access and rights influencing contraceptive use amongst adolescents in Uganda from a social justice perspective. Specifically, the article addresses current practices and policies related to contraceptive use amongst young people according to socio-demographic characteristics. Additionally, the article addresses the awareness of young peoples' rights to access contraceptive services. A review of reproductive health programs and policies in Uganda based on an applied psychology framework were reviewed. Data collection methods used in this study included Focus-Group Discussions (FGDs), in-depth interviews and observations as well as key informant interviews. Findings indicated that the policy regimes in place appear to be more restrictive than promoting access to contraceptives by adolescents. Contraceptive use amongst adolescents was high at 46% for urban adolescents as opposed to 27 percent of adolescents residing in rural areas. Likewise, there was a significant relationship in age, marital status and contraceptive use. Adolescents who were enrolled in school faced restrictions in accessing contraceptive services as compared to their counterparts not enrolled in school. Last but not least, almost all adolescents were aware of their rights to access contraceptives and reproductive health services.

We conclude that the policy regimes on reproductive health for adolescents imposed by the government seem to be detrimental to the otherwise good intentions of the government of promoting health in this age group. Instead, the adolescents have found themselves not accessing contraceptive services because of such policies in place. Socio-demographic characteristics play a significant role as far as access to and use of contraceptives is concerned. Age and marital status, had a significant influence on access to and use of contraceptives. Likewise, being enrolled in school or not being enrolled in school also determined access to contraception services. There seems to be a concerted effort to ensure that all adolescents access the correct information about their sexual and reproductive health services.

Declaration: This manuscript has not been published and is not under consideration for publication by another journal.

Background

Contraceptive use as a preventive measure for promoting sexual and reproductive health and well-being of individuals is a social justice issue which calls for equity of opportunity between members of society, including men, women, boys and girls. However, contraceptive use in Sub-Saharan Africa is still very low, contributing to high fertility rates, including unwanted pregnancies. This can, in turn, spur high rates of abortion. Moreover, current evidence shows slow progress in expanding the use of contraceptives amongst adolescents, particularly of low socioeconomic status (Boerma et al., 2008).

While there are policies to guide and regulate contraceptive services, some tend to pose a negative influence on utilization of these services. Unwanted pregnancies, unsafe abortions, and significant challenges in accessing contraceptives endanger the health and reproductive rights of adolescents. According to Hubacher et al (2008), poor patterns of contraceptive use such as high discontinuation rates and incorrect use contribute significantly to the problem of unintended and unwanted pregnancies. This can partly be explained by restrictive policies and practices regarding contraceptive use enforced by some governments. Health advocates, however, are using human rights mechanisms to ensure that governments honor their legal commitments

to ensure access to services essential for reproductive health.

Inequity in health exists when people are unfairly deprived of the resources they need to maintain good health or protect themselves from unwanted or undesirable conditions. Shah and Chandra-Mouli (2007) argue that it is only through the equity lens that we can observe whether certain strata of the population such as the poor, young, single, rural residents and under-educated women are being deprived of the family planning resources needed to avoid unwanted pregnancies. Khalaf et al (2010) found that many young women in Jordan were not aware of the reproductive health services available to them, and there was a strong consensus about the need for information about reproductive health services. In fact, young people have a right to accurate information about sexual and reproductive health, but such is lacking in many developing countries.

In Uganda, there is a strong consensus that young people face significant challenges in accessing contraception partly due to the current policy and practice regarding contraceptive use. According to the Population Reference Bureau (2009), 49 percent of the Ugandan population was below 15 years and 20 percent was between the age of 15 and 24. Hubacher et al (2008) report that a large number of young people in Uganda are in or are soon reaching their reproductive age and thus have a potential risk of unplanned and unwanted risky sexual behaviour. They add that by 15 years of age, 11 percent of adolescents in Uganda had initiated sex and by age 19, 64 percent of young people had had their first sexual encounter.

Sexual Activity among Adolescents

Uganda has a predominantly young population with 47.3 percent being under 15 years of age (Ministry of Health 2012). According to the Uganda Bureau of Statistics (2012) young people are now starting sexual activity at a later age than in the past, though the age at sexual initiation is still early. Recent studies indicate that adolescents start having sex at an early age; the median age being 16.7 years and marriage at 17.8 years. It would appear that most of the sexual encounters in this age group are unprotected, exposing young people to unwanted pregnancies and sexually transmitted infections (STIs), including HIV/AIDS.

Sexual activity among adolescents can be either voluntary or involuntary. Young women may have sex for romance, sexual desire, economic gain, or because of coercion. The extent of autonomy young women have in relationships is difficult to ascertain. Adolescent females account for a significant proportion of maternal deaths, which are largely due to preventable causes (WHO, 2011). Unsafe abortions contribute significantly to maternal morbidity and mortality amongst adolescents. In fact, adolescents account for an estimated 2.5 million of the approximately 19 million unsafe abortions that occur annually in the developing world.

In Sub-Saharan Africa, the proportion of unintended pregnancies is approximately 25 percent or 900,000 (Guttmacher Institute, 2010). These would significantly decrease if adolescents had access to modern contraceptive methods, but many adolescents in developing countries face barriers to obtaining and using contraceptive services correctly and consistently (Chandra-Mouli et al., 2014). It is for this reason that adolescent health practitioners are lobbying for more adolescent access to contraceptives, and that this should take a rights-based approach as opposed to the current practice that espouses contraceptive access by adolescents while effectively denying them their rights.

This paper therefore examines the current practices and policies influencing contraceptive use

amongst young people; assesses variances in contraceptive use amongst young people according to socio-demographic characteristics as well as examines the awareness of young people about their rights to access contraceptive services. A case is made for the equity and rights-based access to contraceptives by adolescents who need the services. Access to contraceptive use is an aspect of social justice, where adolescents are presented with equal opportunities to access contraceptives freely without any restrictions, sanctions, or discrimination.

Data Collection Methods

The data collection methods used in this study included Focus-Group Discussions (FGDs), in-depth interviews and observations. Three FGDs of male and female adolescents aged 13-15 years old, 16-17 years old, and 18-19 years old were used. All participants aged 18 years and above signed a consent form while those below had the consent forms signed by their parents or guardians on their behalf.

Key informant interviews were conducted with policy officials in the Ministry of Education and Sports (MoES), and the Ministry of Health (MoH), as well as with other key stakeholders working with young people in the area of sexual reproductive health and rights, including Straight Talk Foundation, a non-governmental organization in Uganda. Additionally, sexual and reproductive health programs and policies in Uganda were reviewed based on an applied psychology framework. Furthermore, the study utilized reports from the National Strategic Plan on Reproductive Health, government, and the United Nations.

The inclusion criteria for participants were Ugandan adolescents within the age group of 13-19 years. Participation was voluntary, whereas exclusion criteria applied to those outside the age group, non-Ugandans and involuntary participants. The study sample included 315 respondents as indicated in Table 1 below.

Table 1: Demographic Characteristics of Participants in the Study (n=315)

Age	Number	Marital Status	Number
<16	55	Not-married	285
16-17	109	Married	30
18-19	151		
Total	**315**	**Total**	**315**
Residence	**Number**	**School Status**	**Number**
Urban	289	In-school	236
Rural	26	Out-of-school	79
Total	**315**	**Total**	**315**

Results

The following three categories according to the study objectives were used to present study findings:

1. Current policies and practices influencing contraceptive use amongst young people. The government of Uganda has well-intentioned policies in place but seems to be prohibitive where access and use of contraception by young people is concerned. It is obvious that policies and practices about adolescent sexuality are influenced by our culture, which prohibits sexual relationships let alone talking about them within certain age groups. However, as Batwala et al (2006) point out, Ugandan adolescents are living in a time of socio-cultural transition where traditional practices that formerly limited adolescents' sexual experiences are breaking down. Mass media and globalization have been far-reaching into the lifestyles of adolescents, where information about sexuality is widely available. Gone are the days when adolescents used to get sex information from aunties, uncles or community members.

The government of Uganda recognizes the importance of addressing the sexual behavior of adolescents, not only in relation to their reproductive outcomes but, more importantly, to high-risk sexual behaviors. Survey results in

Uganda have consistently indicated that young people initiate sexual activity at a relatively early age. Faced with such a reality, it is prudent that policies and practices aim at enabling adolescents' access to contraception, instead of appearing to be prohibitive (Shaw et al., 2012). Health advocates are using human rights mechanisms to ensure that governments honor their legal commitments aimed at access to services essential to their sexual and reproductive health.

2. Policies and Programmatic Activities. The Government of Uganda has put in place policies aimed at improving the sexual and reproductive health of adolescents. Through the relevant policies and laws the government recognizes and emphasizes the salience of addressing adolescent sexual and reproductive health by keeping children and adolescents in school, and increasing contraceptive use and levels of supervised delivery by trained health personnel.

National policies that have beneficial implications for adolescent sexual and reproductive health include the National Youth Policy, the National Policy on Young People and HIV/AIDS, the Affirmative Action Policy, the National Population Policy, the National Health Policy, the National Gender Policy, the draft Reproductive Health Policy, the National Reproductive Health Service Delivery Guidelines, Sexual and Reproductive Health Minimum Package for Uganda, and the National AIDS Control Policy proposals. Although some of the policies are not fully implemented yet, they could provide the basis for a supportive and conducive environment for adolescent sexual and reproductive health.

However, throughout these documents, there appears to be a systematic plan to cut out mention of access to contraceptives by adolescents, particularly those in school. Instead, emphasis appears to be on abstinence, which is good for young people, but not sufficient, especially if not all information is provided to those who cannot abstain.

We strongly argue that secondary school students be provided with information about access to and utilization of contraceptive services. Faced with the reality that many adolescents in Uganda are sexually active starting at age 13, should we continue denying those still in school the opportunity to access information and services on contraception? Are we working within their rights and hence promoting social justice for adolescents as far as accessing information and services about their reproductive health?

We should, however, not forget how lack access to and information about contraceptive use can cause adolescents to drop out of school. As one of the adolescents in one of the FGDs told us,

> *I dropped out of school because I became pregnant and my parents sent me away from home. I now live with my grandmother. Much as I knew a little about contraceptives when still in school, I never even knew how or where I could access the services. I could not go to the pharmacy because no pharmacists would sell any contraceptives to adolescents in my area. (FGD [18-19], August 2013)*

Clearly, the existing government policies about young people accessing contraceptives in some way or another influences how private operators like pharmacists approach access to contraceptives by adolescents. Pharmacists or other private operators risk being closed by the government if they are deemed to be operating outside the "law". Some adolescents are said to ask their older sisters or brothers to buy contraceptives on their behalf, meaning adolescents have learnt to skirt around the restrictions to access contraceptives at any cost.

3. Variances in contraceptive use according to social demographic characteristics. Study findings showed significant variances in contraceptive use amongst adolescents with some social demographic characteristics and no variance in contraceptive use with other social demographic characteristics.

Age

93% of surveyed adolescents below 16 years old were not using any form of contraception. Most stated that this was because they were not sexually active – but not before adding that even if they wanted, no service provider in their "right mind" will allow them to access any form of contraceptives because they are too young to engage in sexual activities. One adolescent said,

Out of curiosity we went with a friend to a pharmacy and we requested to buy condoms. The pharmacist looked at us and his response was that we should get out of his sight before he calls the police to have us arrested (FGD, 2013).

Denying adolescents contraceptives or even the correct reproductive health information will not necessarily prevent adolescents from engaging in sexual activities, but the outcome will be increased risks associated with adolescent sexual practices. For example, the MoES does not allow mention of any form of contraception when teaching sex education in secondary schools, directing that emphasis be on abstinence during this period. The MoES guidelines on sex education in schools are very clear: "do not teach aspects of contraceptive use at any level before post-secondary." Their argument has always been that introducing contraceptives to this age group will promote indiscipline and recklessness. The reality, however, is that adolescent will go ahead to engage in risky sexual behavior even without the use of contraceptives. The outcomes have always not been good, as evidenced from the high teenage pregnancies and subsequently high incidences of unsafe abortion within this age group.

Like their counterparts below 16 years old, older adolescents also go through the same ordeal when trying to access contraceptive services, where they are always reminded that they are minors. On the contrary, married adolescents indicated they access all information about contraception and the contraceptives. Some, however, indicated they do not need use of contraceptives because they have just started families and they need to have children. It should, however, be noted that the married adolescents were those in the age bracket of 18-19 years. None of the adolescents under 17 years were married in this study.

We also noted that the adolescents' accessibility to contraceptive services could be influenced by age (Yakong et al., 2010). Much as the adolescents indicated their need to access and use contraceptives, the policy guidelines undercut their desires rather than promoting them. We see this as a social justice issue, which calls for critical examination of these policies in order to make them in consistent with WHO guidelines about adolescent reproductive health.

Residence and Contraceptive use

Findings indicate that adolescents in urban areas were likely to access and consequently use contraceptive services compared with their rural counterparts. This is consistent with UBOS (2012) and Yakong et al. (2010) findings, which indicated that amongst the reproductive age group contraceptive use in urban areas was higher at 46 percent compared to 27 percent in rural areas. This study revealed a stark contrast between the availability of adolescent contraceptive services in rural and urban areas. In urban areas, there was a visible presence of adolescent friendly facilities compared to rural areas. Moreover, facilities in rural

areas were seen as dilapidated and poorly stocked. Adolescents added that personnel were unfriendly when it comes to providing adolescent services. Besides, both the provider and adolescents pointed out the limited choices of contraceptives and general lack of personnel to adequately and promptly attend to adolescent reproductive health needs as being some of the challenges they encounter.

Pillai and Gupta (2011) argue that an expansion of choices that people enjoy to improve their own welfare requires vast social institutional development over and above mere economic development. The National Adolescent Health Policy has made it very clear that success of adolescent health programs will depend on the extent to which service providers are willing adopt new skills and attitudes towards adolescent-inclusive health. Another health care provider had this to say:

> *"As a mother, I would feel really bad if I discover my adolescent daughter is using contraceptives, but as a service provider, the regulations are clear. We should serve them equally" (Key Informant Interview, August 2013).*

The quality of services and their utilization by adolescents depends a great deal on both the technical competence and attitudes of providers. This assertion is supported by the Ministry of Health (2008), who add that providers play critical roles in efforts to improve access to adolescent health care. One adolescent had this say in an FGD:

> *"One time I visited the health facility in the rural area to enquire how to use condoms, but the nurse asked a lot of questions and some were embarrassing. Instead of serving me, I was being questioned about my moral behavior. I vowed never to go back to those health facilities" (FGD 18-19, August, 2013).*

When asked what they do then in case they need contraceptives, their response was that those with money can buy them from private drug stores, while a good number do not use any. This cannot be celebrated as good news because according to UBOS (2012), about 5.4% of adolescent males aged 15-19 years have had more than one sexual partner in the last twelve months. The results can include increased cases of unsafe abortions and worse, death. Again, adolescents in rural areas indicated they cannot spend their meager income on a 'luxury' such as contraceptives at the expense of other basic needs like clothing (Hall et al., 2012). It has been argued that adolescents' low social status will leave them with limited choices about the decisions they make regarding their sexual and reproductive health rights. Creanga et al (2011) and Da'souza et al (2011) emphasize that as much as global health rights have improved considerably over the last four decades, the health status and rights of the poor everywhere compares unfavorably with more affluent sectors of society.

A dominant argument made in regional literature is that rural residents tend to lag behind as far as access to sexual and reproductive health services is concerned. This, it is argued, is attributed to the fact that the distribution of such services tend to be limited in rural areas, but this does not necessarily imply that services are well distributed in urban areas, especially in developing countries. In rural areas, most adolescents can only afford to get reproductive health services from government-aided health facilities, which are largely free. The problem is that the health care practitioners may chase adolescents away if practitioners deem them not ready to utilize contraceptives.

This is not helped by the fact that in rural areas, culture dictates it a taboo for an adolescent to walk into a health care facility and ask for contraceptive services. However, both rural and urban adolescents faced similar challenges in accessing contraceptive services. Both pointed out that in most cases when they seek services, they are judged and feel intimidated by some providers, and this tends to deter them from going back if they require the services. Other challenges pointed out included lack of privacy and receiving the silent treatment. One adolescent had this to say about privacy:

> *"When you visit the health facility, there is no private place where you could feel comfortable sharing your problems with the health care provider. Faced with such a situation, you end up leaving without getting the services needed" (FGD, August 2013).*

Another from urban area said,

> *"When you arrive at the health facility, the look the health care provider gives you indicates that you are doing something wrong. This makes you feel shy and intimidated to say exactly what you are there for" (FGD, August 2013).*

Marital Status and Contraceptive use

Ninety percent of the adolescents surveyed were not married. As with previous variables, the majority of the unmarried adolescents were not using any form of contraception due to being denied the services because they were considered too young. The married adolescents, on the other hand, could access contraceptive services if they wanted, but they indicated that they had just started families, hence their non-utilization of contraceptives. A health care provider pointed out that government policy is that all married couples should freely access contraceptive services without being discriminated against. This was supported by married adolescents or those who have been pregnant before, who noted that once the health care providers know that you are a married adolescent, they will provide you with all the support you need as far as accessing contraceptive services is concerned. The only exception, one adolescent added is "when the adolescent is not known to be married." To prove his/her marital status, the adolescent has to show up with his/her spouse or with a baby; this will accelerate access to contraception services from the health care providers.

In- versus out-of-school contraceptive use

Findings indicated that 19 percent of adolescents enrolled in school were using contraception while 56 percent of out-of-school adolescents were using or had access to contraceptives. This also depended on age. For example, 74 percent of adolescents enrolled in school aged 18-19 years used contraception compared to those below 18 years. In short, more out-of-school adolescents were using contraception as compared to their counterparts still enrolled in school. These findings are congruent with a related study conducted in rural southwestern Uganda by Batwala et al (2006). Adolescents enrolled in school pointed out that no one talks to them about contraceptives in schools, because of what they understand is a gag order by the Ministry of Education guidelines. When asked how they came to know about contraceptives, they said they read about them in magazines, from peers, and on television, amongst other sources.

Findings indicated that an adolescent who was out of school and married was likely to use contraceptives compared to adolescent enrolled in school and those who were unmarried. According to related studies, contraceptive use among sexually active adolescents is low in rural areas as compared to their counterparts in urban areas.

This study never examined contraceptive use by adolescents in rural areas who are enrolled in school versus those out-of schools.

Awareness of adolescents about their rights to access contraceptive services

Almost all adolescents exhibited knowledge about contraception and almost all adolescents were able to list at least one method of contraception, condom use being prominent. These findings are consistent with UBOS (2011). Batwala et al (2006) report a near universal awareness about family planning amongst young people. In contrast, even adolescents who indicated they were sexually active had not used any kind of contraception and this cut across the socio-demographic characteristics. Again, a significant number of adolescents were not very conversant about their rights to access contraceptives, let alone knowing that contraceptive use is a key element in adolescent reproductive rights.

Many indicated the need for awareness activities to enable them to understand their rights as far as accessing contraceptives is concerned. At present, they argued, most adolescents will either be cowed away or not demand for such services when they actually do not know the extent of their rights. A few adolescents pointed out that the community does not approve of them using contraception, much as they would wish to. This kind of belief by community members is much more predominant in rural areas, but not lacking in urban areas, either. This, according to the adolescents can be interpreted as trampling on their rights to access contraception. One adolescent in the FGD said,

> *"I was forced to marry my current partner because he made me pregnant. I am currently using contraception because the health care providers told me to do so and I want to go back to school" (female respondent, FGD, August 2013).*

This is emphasized by a report on reproductive health, which states that adolescent pregnancy is most often not the result of deliberate choice, but rather the absence of choices and circumstances beyond the control of adolescents (UNFPA, 2013). This adolescent actually never asked for the contraception herself but the health care providers advised her, and this was after she reportedly confided to one of the service providers that she wished to go back to school. Someone else had to vouch for her rights to access and utilize contraceptives. UNFPA (2013), reports that 70,000 girls aged 10 to 19 die each year from complications during pregnancy and childbirth, this being attributed amongst other things to a lack of contraceptive advice. It is safe to say that the 7.3 million under-18 adolescents who get pregnant every year in developing countries can only be addressed by changing the social attitudes of various players.

By contrast, a small number of respondents in the FGDs were of the view that as much as adolescents had a right to access information about contraceptives, they should wait until they get married for them to start advocating for the rights to access the services. When we put it to them that it is their right to access the services, some seemed to be resigned to the fact that government regulations – especially those adolescents enrolled in school – tend to be restrictive and prohibitive rather than enabling towards adolescents accessing information about contraception.

Still, adolescents were able to criticize the services and facilities, labeling them inadequate to poor in some instances. They particularly pointed out that privacy in most of the health facilities is lacking, especially in rural areas. An adolescent would practically be expected to share her/his

concerns with the health care provider in the vicinity of other clients. This, to them is a deterrent in itself, and many adolescents would actually walk away without saying a word. Talking to adolescents under conditions where they cannot be heard by others promotes privacy and improves communication. To them, this indicates better quality of services, which they can embrace.

Policymakers have persistently argued that letting adolescents enrolled in school access information about contraception will make them become sexually active, thus the need to deny them such information. Instead, this seems to be counterproductive, as many studies have consistently indicated that many adolescents are getting the information about contraception from other sources, which may have incorrect information. The policymakers in Uganda are resistant to this and continue to insist that no such information should be given in any primary or secondary schools.

There was no significant difference in awareness about reproductive health rights between adolescents out of school and those enrolled in school in urban areas. This is apparently attributed to the fact that urban adolescents would access such information from various sources, including social and mass media, peers, family, and teachers. Social and mass media is more easily accessible in urban areas than rural areas. In Ghana, mass media is a key site for disseminating information on health related aspects including adolescent sexual and reproductive health (Aikins et al., 2010). This is not any different from the Ugandan situation. Newspaper articles and pullouts appear regularly in magazines, and their content specifically targets the adolescents both enrolled in and out of school. These pullouts are provided free of charge to schools. Again, the content is regulated to ensure that information on contraceptive use is not so pronounced. On the other hand, the out-of-school adolescents who are married would get such information readily from the health care facilities in addition to other sources such as social and mass media, just like their counterparts in school.

Conclusion

The need to increase contraceptive access and use in the developing world, including Uganda, cannot be overemphasized. There is a need to define how much information on contraceptives adolescents should be exposed to. These decisions should be made bearing in mind the rights of adolescents to access and use contraception, which is necessary in the promotion of their sexual and reproductive health.

Uganda has policies and regulations in place to enable adolescents' access to sexual and reproductive health services and information; however, when analyzed, these policies appear to be more prohibitive than promotive of adolescents' rights and access to contraceptive use. We argue that such policies should aim at enabling rather than restricting and prohibiting access to contraception by adolescents, especially those still enrolled in schools.

Socio-demographic characteristics play a significant role as far as access to and use of contraceptives is concerned. Age and marital status have a significant influence on access and use of contraceptives. Likewise, being in or out of school also determines access to contraception, with adolescents enrolled in school reporting restrictions to access the services, let alone receiving information in school. As much as the adolescent sexual and reproductive health policy advocates for mainstreaming of adolescent reproductive health information into the school curriculum, information on contraceptive use has been carefully avoided until post-secondary level. Anyone who

contravenes these guidelines stands to face punitive measures, and risks having their activities within the country suspended or terminated altogether.

Adolescents in rural areas are more disadvantaged than their urban counterparts as far as contraceptive access and use. It is in the rural areas where cultural prohibition is still entrenched within the community; therefore, adolescents in rural areas face hurdles to access contraceptives. This may be because they are considered to be too young to demand for such services. The outcome has not been good, either; as such, adolescents have abandoned the services but not the risky sexual activities.

There was almost universal awareness of knowledge about contraception amongst the adolescents, although significantly fewer adolescents were aware of their access to and use of contraceptives. Knowledge about rights also depended on the socio-demographic factors, which included marital status, enrollment in or drop out of school, and residence in rural or urban areas.

We argue that access to and use of contraceptives by adolescents in Uganda must take a rights-based approach using a social justice lens. This is contrary to the current regime of policies that seem to promote the access when their actual intentions are to effectively prohibit or stop adolescents' access to sexual and reproductive health services.

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Foregrounding the tensions and silences in education policies for student-mothers in Uganda and Kenya

Auma Okwany, PhD
International Institute of Social Studies, Erasmus University Rotterdam
The Hague, Netherlands
Tel: +31704260575
Email: okwany@iss.nl

Annah Kamusiime
Bugema University - Lecturer
P.O Box 6529, Kampala-Uganda
Tel: +256701302328,
Email: annahkamusiime@yahoo.co.uk

Auma Okwany (PhD) teaches Social Policy at the International Institute of Social Studies (ISS) of Erasmus University Rotterdam in the Netherlands. Her research interests center on the relationship between policy, practice and theory in childhood and youth issues in development from a critical perspective. Her most recent research focuses on social protection to enhance the citizenship rights of vulnerable children and includes a forthcoming volume, which she edited. She is lead author of The Role of Local Knowledge and Culture in Childcare in Africa: A sociological study of several ethnic groups in Kenya and Uganda (2011) Edwin Mellen Press. She has published numerous articles and is currently co-editing a volume on Early Childhood Care and Education in Africa and another on Girls' Education in East Africa.

Annah Kamusiime is a Lecturer at Bugema University in Uganda. She was previously a Lecturer at Nsamizi Training Institute for Social Development. She has over ten years' experience in social development research and practice. Her research interest are in the areas of sexual and reproductive health issues, social protection, early childhood development, education and community development and how these intersect with gender and other identities like age, social class and space (locale) to influence development outcomes for children and youth. She has published in these areas. She holds an MA degree in women and gender studies from Makerere University Kampala, and a post graduate certificate in research and writing from the Center for Basic Research, Uganda. She is also a CODESRIA Laureate (2015).

Abstract

Early pregnancy and motherhood contribute to the high rates of school dropout for girls in Kenya and Uganda. Pregnancy contributes to an estimated 59 percent of all school dropouts in Uganda, while in Kenya, there is an estimated 13,000 pregnancy related dropouts each year. Adolescent pregnancy is therefore a significant aspect of exclusion of girls in education. This scenario persists despite the existence of policies and action aimed at protecting education for pregnant and parenting students. In Uganda, while there is no explicit policy on pregnant/parenting students, there are several government guidelines, and “good will” pronouncements, which stipulate that girls should return to school after giving birth. In contrast, Kenya has a school Re-Entry policy for pregnant and parenting students, the National School Health Policy and Guidelines, as well as guidelines within the Kenya Gender and Education Policy 2007. We review these formal/informal policies in both countries within a social justice and social constructivist framework to tease out the overt and covert silences, tensions and (in)actions of the policy regimes. This is supplemented by primary data collected through interviews with student mothers and other stakeholders including parents, head/teachers and state officials. Findings reveal that the policies reinforce and perpetuate the normative constructions that stigmatize pregnant girls and student mothers. They are also silent on structural challenges such as lack of child support and poverty within the household. We highlight emerging non-normative ideology and discourses of ability that provide possibilities for socially just policies to protect education for student mothers.

Declaration: This manuscript has not been published and is not under consideration for publication by another journal.

Introduction

Despite a significant global decline in adolescent pregnancy rates over the past couple of decades, sub-Saharan Africa retains the highest adolescent pregnancy rates worldwide (UNFPA 2013). According to Birungi et al. (2015) in most countries in the sub-region, nearly all adolescent girls who have ever been pregnant are out of school. Normative attitudes and policies mean that early pregnancy in many countries leads to interrupted periods of learning and high rates of exclusion in education for girls. Thus despite the quantitative gains made in education in both Kenya and Uganda after the re-institution of tuition-free primary education and subsidized secondary education, gendered exclusion persists for girls, and pregnancy related drop-out constitutes a significant constraint to the elimination of gender disparities in education. In this paper, we contend that enabling student mothers to remain in school and continue with their studies after delivery not only protects their right to education but also promotes their capability enhancement. As noted by UNICEF (2014), when all children have access to a quality education rooted in human rights and gender equality, it creates a ripple effect of opportunity that influences generations to come.

Our starting point in this research is a concern with the insufficient attention paid in policy and research to intersecting gendered norms in school, communities and households, which facilitate girls' dropout, including pregnancy related exclusion. We concur with Unterhalter (2013, 77) who troubles this lack of attention by highlighting how dominant education policy (including those of UNESCO and World Bank) and academic literature often frame dropout, more as a problem of schools failing as learning institutions and less as an outcome of the connections between gendered communities and schools. We underscore the need

for understanding the complexity of gender and power relations at the household, community and state levels to explain the constraints to schooling for student mothers (see Wekesa 2011).

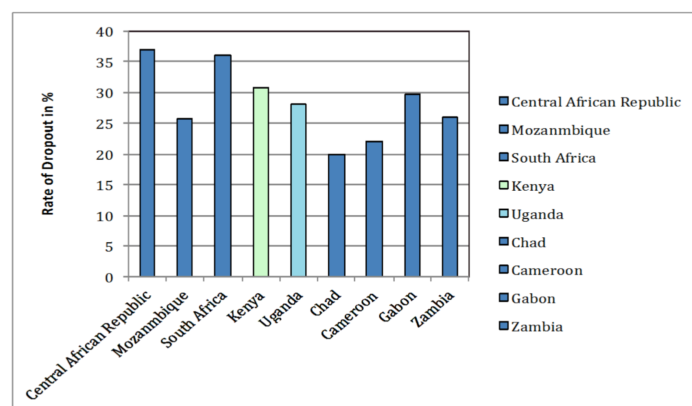
We review education policy documents for early pregnancy and motherhood, in articulation with primary data collected from pregnant and parenting students and other stakeholders to bring to the fore the gaps, silences and tensions in the policy framework in Kenya and Uganda. We highlight the gendered and structural forms of exclusion and how they intersect in everyday injustices of school culture and community as experienced and articulated by pregnant and parenting students. We show that the underlying gender inequity and injustice are complex and are a function of the negative and pathologizing constructions of young motherhood in policy, discourse and practice. We assert that these negative constructions of student mothers are entrenched in the policy regime in place in Kenya and the 'goodwill' pronouncements in silent policy in Uganda. We show that policy and practice is thus punitive and is about control of young bodies rather than protective and transformative in addressing student mothers' intersecting risks and vulnerabilities as both mothers and young people.

The paper is organized as follows. In the next section, we contextualize pregnancy related dropout in Kenya and Uganda as well as the education sector policies. The theoretical framing is followed by an overview of the methodology used in the study. We present the key findings starting with an overview of the policy environment followed by our examination of the silences, policy gaps and tensions in the policy regime in articulation with the voices and experiences of student mothers and selected stakeholders from both countries. We conclude by highlighting emerging glimpses of non-normative praxis and discourses of ability, which have significant implications, for supportive and protective policy and action that should be inclusive of the girls' voices and lived experiences to address the disabling intersecting gendered norms in school and communities.

Early pregnancy, motherhood and school dropout in Kenya and Uganda

Teenage pregnancy and motherhood contribute to increased school dropout for girls in Kenya and Uganda. As shown in Figure 1 below, both countries are among the top five countries in Africa with the highest rate of pregnancy related school dropout (Kenya ranks fourth and Uganda fifth).

Figure 1: Countries with Highest Pregnancy related Dropout in Africa



Source: ICF International (2012)

In Kenya, the 2008-2009 Kenya Demographic Health Survey (DHS) (Macro International Inc., 2012) indicates that the percentage of teenage girls who have begun child bearing ranges from 2.1% at 15 years of age to 36.2% at 19 years of age. Similarly, in Uganda, 24% of adolescent girls become pregnant before 19 years of age (UDHS 2011). Furthermore, the figure is higher (45%) for uneducated girls than (16%) for girls who have completed secondary school (UBOS and Macro International Inc. 2011). Out of 12 factors driving school drop-out for girls in Uganda, pregnancy is the highest factor accounting for 59%

of drop out (Republic of Uganda 2012, 14). Despite the significant loss of educational opportunities, which severely limit the life chances of many African girls, health issues associated with early pregnancy (including unsafe abortion, maternal mortality, obstetrics fistulae) tend to eclipse education-related effects (Birungi et al. 2015, 4). Pregnancy-related exclusion is a significant factor accounting for persistent gender disparities, inequity and exclusion in education in both countries and has long term impacts on young mothers' life chances.

Education Policies for Student Mothers

Education sector policies that deal with pregnant and parenting students are broadly categorized as expulsion policies, re-entry policies and continuation policies (Chilisa 2002, 24). In many African countries, expulsion policies both written and unwritten, were predominant in the post independence period (a holdover from colonial and missionary education); and today still remain the response to schoolgirl pregnancy in Mali, Nigeria, Tanzania, Togo and Zanzibar (ibid). Continuation policies are the most progressive in that they promote girls' right to education by providing for uninterrupted learning during pregnancy and immediate return to school after delivery as practiced in countries like Burkina Faso, Cameroon, and Chile (Chilisa 2002; Mundial 2007). Kenya is among countries including South Africa, Malawi, Zambia and Namibia that have re-entry policies, which provide for pregnant girls to re-enter school after delivery. Uganda has no official policy but has guidelines and 'goodwill' pronouncements designed to protect education for pregnant and parenting students. In this paper, we examine the silences and tensions in these policy regimes in guiding education for pregnant and parenting students.

Theoretical Lens

We examine these issues within a constructivist and social justice framework. A constructivist framework enables us to tease out the social construction of pregnancy and young motherhood in the socio cultural-context and in policy. Our main focus is on the intersecting gender norms and discourses in the school culture and in communities including households and their influence on policy. Indeed, according to Mettler and Soss (2004, 44) mass opinion and behavior are politically constructed outcomes that arise through the interaction of institutions, organizations, policies, and actors. This is consistent with the construction of policy and power is a negotiated discursive space of people, communities and ideological positions as they form and inform policy discourses (Ball 2006). We also draw on Tikly and Barret's (2011) social justice perspective for examining education quality with a focus on the dimension of inclusion and capability enhancement. For student mothers, this means examining the institutional and socio-cultural factors shaping their exclusion and inclusion in education and which constrain or enable their capability development.

Methodology

This study was based on a review of secondary research including the 1994 Kenya School Re-entry Policy and guidelines and the 2009 National School Health Policy and Guidelines; the 'goodwill pronouncements and circular in Uganda; as well as academic literature, empirical studies and reports on teenage pregnancy and student mothers in the two countries specifically and the region broadly. Qualitative interviews with a selected number of pregnant and parenting students enriched the study by highlighting their voices and providing insights on their subjective experiences and perspectives. We purposively selected a total of 12 student mothers located

within sites of a project that is targeting girls out of school between the ages of 15-18 years old to reengage with school in a rural context in Kenya and an urban poor context in Uganda. Four had returned to school after disengaging for between one to two and a half years; two were pregnant and had been expelled from school and of the six who were not in school one had completed school while five had not been able to re-engage with school. We also interviewed 3 head teachers, held one focus group with parents and four key informant interviews with state officials in each country. Data was analyzed through reflexive thematic analysis. We obtained formal ethical clearance and consent from study participants including assent from student mothers and assurances of anonymity, confidentiality, and voluntary participation.

The Policy Environment in Kenya and Uganda

The right to education for student mothers is enshrined in various international instruments that Uganda and Kenya have ratified including the regional African Charter on The Rights and Welfare of the Child (ACWRC). Article 11(6) of the ACRWC stipulates that, "state parties shall take all appropriate measures to ensure that children who become pregnant before completing their education shall have an opportunity to continue with their education." Uganda does not have a formal national policy in education to guide action in protecting pregnant and parenting students. In this policy vacuum, the Ministry of Education and Sports (MoES) in collaboration with development partners rely on a patchwork of initiatives viz.; good will pronouncements and circulars sent to schools to encourage school administrators to allow girls (especially candidates) to sit for final exams and through radio programmes and school visitations they raise awareness about the importance of protecting the education of student mothers (Republic of Uganda 2013:19). In contrast, the policy regime protecting the education of young mothers in Kenya is contained in the Return to School Policy 1994 and associated Guidelines 1998; the 2009 National School Health Policy and Guidelines (GoK 2009), the 2007 Gender and Education Policy, (GoK 2007) and the Basic Education Act 2014.

Despite these policies and efforts in both countries, the exclusion of student mothers in education remains high and pregnancy often signals the end of schooling for most girls (Ahikire and Madanda 2011; Lloyd and Mensch 2008; Muganda-Oyando and Omondi, 2008; Republic of Uganda, 2012). This is because the disabling gendered ideology which structure student mothers' exclusion is attributable to the major gaps and inherent weaknesses in implementation of the policy in Kenya and the patchwork of initiatives in Uganda. We examine these gaps and tease out the overt and covert silences, tensions and (in)actions within the policy regimes that underlie the high pregnancy related exclusion.

Negotiating Ideologies of Exclusion in Policy

I became pregnant at the beginning of my second year of secondary school and was asked to leave school, in my fifth month of pregnancy to 'prepare to have the baby.' I was sad to leave school but also relieved because the stigma and discrimination was too much. Some teachers called me 'the immoral one,' 'the bad girl,' and some students laughed at me and taunted me saying I was now a 'mama' and should not be with young people in school. "I wondered, was I not young anymore?" Only one teacher, my friends and my mother encouraged me. My father was angry and tried to compel the married man who had forced me to have sex with him, to marry me as a second wife. He gave my father some money (I do not know how much) and he moved away with his

family, I was happy. My father and some relatives still wanted me to get married to avoid the shame but my mother refused. I stayed home for two years and this year my mother was able to get some money to pay my fees and she sent me to rejoin school and live with my grandparents in this village. My grandmother looks after my child when I am in school. (Apio, 17 year- old student mother Kenya)

My elder sister got pregnant and was expelled from high school when I was in primary six and fourteen years old. My parents were so furious and forced me to leave school lest I also get pregnant like my sister. After being out of school for one year, I got a boyfriend and I was pregnant that same year. Now they want me to get married but I really want to go back to school. (Jane, 16 year-old student mother, Uganda)

These vignettes highlight the harsh reality for most pregnant or parenting students whose lives are pitted against a number of odds. Firstly, are the wider societal norms that hold girls as sexual gatekeepers and lets men get way with their "sexual escapades" while drawing from the repertoire of norms in society is a discursive school system, which categorizes girls as students and non-students. Additionally, the liminal status of "student" is incompatible with the term "mother" and so pregnant teens are sent home from school to the private space of home, where mothering should take place. Student mothers endure taunts and bullying from peers and teachers in school because as "mothers" they are in the "wrong" place. This is oblivious of a school re-entry policy in Kenya or "goodwill pronouncements" in Uganda that provide for student mothers to stay in school while pregnant and resume schooling after delivery. The practical burden of these young girls bringing up children with limited or no material support is another challenge and psychological weight that they have to grapple with even as they seek to have their voices heard. We examine the capacity of the policy regime in addressing these intersecting issues.

Schooling for these girls is greatly influenced by the web of generational power relations interacting with gendered social norms. Young people's subordinate positioning in social relations (which is accentuated for females), means that most girls do not have a choice in sexual decision-making and sex is often not negotiated or consensual. Indeed, sexual coercion is a significant component of adolescent sexual experience in developing countries (Erulkar 2004; Hewett et al., 2004; Jeejebhoy and Bott 2003; Lloyd and Mensch 2008). This is consistent with our findings which, while not representative, are indicative because out of the 12 girls interviewed, only two had become pregnant through uninformed sexual exploration with boys in their age group, while ten were coerced into having sex or were victims of sexual violence. The pervasive construction in policy and practice of girls as 'sexual gatekeepers' who only have to say no, locate problems in young people ignoring the complex interplay between social-economic structures, and power relations in the social context within which individual and interpersonal sexual practices and behaviors are embedded. In sharp contrast, manhood in various communities is defined in terms of the ability of a male to exercise his virility even if it is by using some form of force.

Navigating Disengagement and Re-engagement

Re-entry policies necessitate disengagement with schooling and allow for re-engagement after a specified period of compulsory leave during pregnancy and lactation (Chilisa 2002). In Kenya, while the National School Health

Policy (2009) stipulates that pregnant students should be allowed to remain in school for as long as possible, the Return to School Policy 1994 and the Return to School Policy Guidelines 1998 provide for pregnant students to disengage from school for delivery and re-engage with schooling 'when appropriate.' However, the policy and guidelines are silent and unclear on specifying at what stage dis-engagement and re-engagement should occur and how or who defines what is 'appropriate.'

In Uganda, there is no official policy governing schooling for these students but there are "goodwill pronouncements" and directives to school administrators to 'create an enabling environment for all pupils and students registered to sit their final national examinations irrespective of pregnancy and breastfeeding MoES Circular (2009). However, the directive is silent about other pregnant and parenting students who are not sitting for their national examinations. According to MoES (2013, 19), the Government in conjunction with United Nations Girls Education Initiative (UNGEI) have been raising awareness through radio talk shows, school visitations on the importance of allowing student mothers in school. The Uganda National School Health Policy, which is still in draft form, states that pregnant students should continue with education after they have delivered. However, there are no guidelines to specify at what point the girls would re-engage with the school system and how this should be implemented. According to FAWEU (2011), most people are not even aware of this policy provision.

The lack of a formal, coherent and inclusive policy in Uganda and the policy gaps and silences in Kenya leave a vacuum within which implementation is left to the discretion of school governing bodies, teachers and communities and their normative views and norms on adolescent sexuality drive action. In Uganda, this means that many girls are expelled immediately their pregnancy is discovered (FAWEU 2011, 3). In Kenya, the policy framework officially protects pregnant students from expulsion. As noted by a key informant: "students and their parents/ caregivers can appeal to the local education office to compel schools to re-admit them if they are expelled due to pregnancy" (Local education officer, Kenya). However, the lack of official communication on how to implement the guidelines makes the policy weak and inconsistent. Most families and students from poor households, are either unaware of the policy or lack information, support and voice to utilize it to hold schools to account. Our findings reveal that re-entry is not an event but is a process and navigating this process is a veritable 'obstacle course' riddled with policy silences and contradictions and governed by marginalizing gendered ideologies and discourses.

While there has been a decrease in overt expulsion in Kenya, numerous recent studies (Waitiri 2011; Wanyama and Simatwa 2011; Wekesa 2011; Omanchwa 2012) corroborate our findings that expulsion is covert, subtle and pregnant and parenting students are unofficially "forced" to leave school because of the stigma, discriminatory and hostile attitudes of teachers and peers as well as community and even family members who frame them as deviant and wanton. Our findings are also consistent with studies, which show that pregnant and parenting students are less likely to re-engage with schooling after disengaging (Chevalier and Viitanen 2003; Unterhalter 2012; Pillow, 2004; Wekesa 2011). According to Chilisa, (2002, 22) re-entry policies constitute a subtle form of violence on student mothers because the re-engagement process is embedded in ideologies of exclusion. We contend that the policy regimes in both countries fail to engage with these gendered

ideologies within which early pregnancy and motherhood are located.

Moral and Contamination Discourses and Exclusion

Our findings reveal that pre-marital sex and teenage pregnancy are viewed as a violation of moral principles, and conventional moralizing socialization. Yet the stigma and silence surrounding youth sexuality and reproductive health and the lack of adequate protective sexuality education in both countries leave adolescents uninformed or ill-informed about sexuality and the risks associated with unprotected sexual activity (including pregnancy, sexually transmitted infections (STIs) and HIV/AIDS). It also fails to protect them from sexual violence. Policies and action on sexuality in both countries are more focused on controlling girls' bodies and their perceived 'dangerous sexuality.' In Uganda and Kenya, female students undergo mandatory pregnancy tests and girls who are pregnant are often forced to leave the school signaling the beginning of their educational exclusion.

In Uganda, there is no formal national policy and educational institutions have a policy at the school level. In Kenya, the National School Health Policy and Guidelines provide for regular 'voluntary' pregnancy tests for girls ostensibly to identify pregnant girls and set off action to assist them to continue learning for as long as possible. However, in most girls' boarding schools, the tests are mandatory in nature. In her study of testing in secondary boarding schools in Kenya, Olum (2011, 27) notes that in reality the tests often serve as a disciplinary and surveillance technique thus reinforcing gender norms and constructions that frame adolescent girls' sexual activity (evidenced by girls' pregnant bodies) as deviant and an expression of their 'dangerous sexuality.' The testing violates the sexual and reproductive health rights of adolescent girls by limiting their freedom to choice, rights to education and privacy (ibid, 38).

Schools are key institutions of socialization and often perpetuate and reinforce the gendered ideologies in society. Our findings reveal that re-engaging with school for student mothers involves navigating the negative discourses that construct pregnant and parenting students as 'immoral'; 'sinners'; 'bad girls'; no longer young thus 'mama' (in a derogatory way). According to FAWEU (2011, 6) similar terms such as "waste" (of resources), "a curse", "a bad omen" locate the problem in the girls who often bear sole responsibility for the pregnancy and who are also viewed as academically unworthy and unfit. This contamination discourse is present in households as well. Study participants in Uganda noted that some parents and communities perpetuated the discourse of pregnant adolescents contaminating 'innocent' often, younger siblings and other girls. This is encapsulated in a proverb from the Bakiga ethnic group in Western Uganda: "omuhara kw'atwara, ajumisa akashozi koona," meaning that when one girl gets pregnant on one hill, all the other girls are contaminated, thus her peers are deemed 'immoral' by association jeopardizing their chances for getting a good suitor. Pregnant students are thus judged to be immoral with the potential to set off an epidemic of immoral and promiscuous behavior.

One study participant said that when she rejoined school after delivery, they were three student mothers in her class and one of the teachers would taunt them by sniffing the air and asking, 'Is that milk (breast milk) that I smell?" Another study participant who was pregnant and in school narrated how she would be taunted on her way to school by some community members who would shout out, "Why are you still going to school? You will corrupt those young innocent girls in

in school! You are a woman now not a child." Mulongo (2006) notes the same discourses operational on pregnant adolescents in her study of young single mothers and she quotes one who said; "I was seen as this local weed which is an 'irritant' and parents did not want me to associate with their daughters lest I influence them negatively. This constant taunting makes some girls to internalize the norms and quit school in complicity as noted by one out of student mother in Uganda, "I left school as I was not ready to face the taunts and the shaming when the teachers announced at assembly that I was the next "muyaye" (highly immoral person). Another young mother feared to re-engage as she was sure she would be told, "This is not a school for mothers, it is a school for girls and boys." This is consistent with a young mother who left school and noted: "Nobody told me not to go back to school, it was a choice between 'breastfeeding' and the "pen" and now that I was a mother, I chose breastfeeding (ibid 2006, 33). In her study in Botswana, Chilisa (2002) similarly notes that many girls do not re-engage with schooling due to fear of ridicule, intimidation, social branding and harassment by the school community.

These findings reveal that schooling is a challenge for pregnant and parenting students because school is a discursive and covertly violent environment where invisible marginalization takes place in both advertent and inadvertent ways. This is because teenage motherhood ruptures the universally held norms of motherhood because sex and motherhood is the preserve of adults and should be confined in the private sphere of the home (Mulongo 2006; Wekesa 2011; Pillow 2006). Pregnant and parenting students are thus perceived as having a "contaminating" effect on the morals of other "innocent girls." This discourse drives the social stigma in the choice to re-admit and retain student mothers. Indeed in their study, Simatwa and Wanyama (2011) note that the reticence of schools to admit student mothers was because teachers were wary of being seen as condoning 'immorality' and their institution being viewed as a 'maternity school.' The branding, name-calling and stigma is present in the community and in households as well.

The constant harassment and taunts make school a hostile space for student mothers and according to Wekesa (2011,33), has psychological impacts including low self-esteem. Both the re-entry guidelines and the gender and education policy in Kenya are silent on the steps to be taken against those who perpetrate covert violence (harassment and stigma on the learners particularly professionals). Discouraging stigma is only vaguely alluded to in the re-entry guidelines in Kenya, which stipulate ambiguously that the "school fraternity should behave as if nothing happened" (Return to School Policy Guidelines 1998). We contend that the well-meaning intentions of these policies are belied by the lack of guidelines to address the stigma that accompanies pregnant and parenting students. All study participants also noted that their pregnancy and motherhood increased financial pressure on their households that were already struggling to meet the direct costs of schooling as well as raise money for taking care of their children. The school re-entry guidelines do not address these financial constrains beyond stipulating that those who make girls pregnant should be held accountable.

Reflexive Research for Evidence Based Policy

Our findings also reveal that there is inadequate reflexive research on the subjective experiences of pregnant and parenting students negotiating the discursive gender regime and practical challenges of the school and community. Yet such empirical anchoring would form the basis of influencing potentially inclusive and

transformative policy. We assert that some of the empirical research reviewed on this topic is not reflexive and the authors are still drawing on the dominant discursive repertoire, which pathologize early pregnancy and young motherhood. The researchers use such terms such as 'the menace of teenage mothers"; "pandemic"; "immoral" and are thus complicit in the continued marginalization of student mothers, perpetuating rather than helping to challenge and change these disabling discourses. In stark contrast, more reflexive, empirical studies (see Mulongo 2006; Olum 2010; Wekesa 2011) acknowledge the challenges mothering presents for young females but importantly, they trouble the structural issues that underlie early pregnancy and motherhood and show how pregnant and parenting students experience these intersecting structural forces. In her study, Wekesa (2011, 40) presents a rich and nuanced analysis showing how gendered households are sites of decision-making, resource allocation, burdensome chores and childcare challenges intersecting with institutions in school and community to shape student mothers' voice and action in re-engaging with schooling. Such an intersectional analysis, which includes young mothers' perspectives provides for approaches that align with their lived experience within the structural forces of gendered norms and socioeconomic inequality.

Emerging non-normative praxis

> *"Most pregnant girls and student mothers experience school, communities and even their homes as hostile and exclusionary environments. I wanted to show that pregnancy and young motherhood should not be a constrain to education and that school can be a welcoming and empowering space for pregnant and parenting students." (Headteacher, Kenya)*

This sentiment was expressed by a headteacher of a girls' secondary school located within the rural study site in Kenya. She actively seeks out, admits into her school and supports pregnant and parenting students from the school community and its environs. School records show that in 2014, out of a total of 100 students in the school, 25 were pregnant and parenting students. Her stance reveals that not all education institutions and (head)teachers are uniformly hostile and exclusionary. This stance is emblematic of a small but emerging shift in enabling ideologies for addressing early pregnancy and mothering. Such efforts counter the impotence of the Return to School Policy and this headteacher can be said to have instituted an organic continuation regime that minimizes schooling interruption for students mothers who are supported to resume schooling soon after delivery. The progressive efforts include child care arrangements in a homestead adjoining the school so parenting students who do not have baby care at home, have the opportunity to breastfeed and spend time with their babies during break and lunch while receiving counseilling and support from the woman providing child care. The school is thus an inclusive space for students mothers who are living the consequences of early pregnancy and who draw on this experience to serve as credible peer educators and advocates for pregnancy prevention. The inclusive construction of young mothers as students has stimulated important conversations in the community about early pregnancy, young motherhood and schooling. This case demonstrates that school is a discursive site for contestation and change of disabling gendered ideologies in education within communities.

Such narratives of possibility and transformative discourses of ability are also evident in the resolve of student mothers who circumvent

the dominant disabling discourses and draw upon their internal resilience to endure the incivilities and systemic violence of re-engaging with an often hostile school and community environment while dealing with the practical challenges of juggling motherhood, girlhood and schooling. Indeed, in her study of student mothers and schooling in Magarini, Kenya, Wekesa (2011, 27) argues that by bringing their pregnant bodies and motherhood into the public sphere of school, young mothers who resumed schooling were contravening gendered sphere norms. She notes, that despite the delicate balance of their triple roles and the associated burdens of being daughters, mothers and students, they exercised positive agency and stayed in school amidst family economic insecurities and the marginalizing discourses pervasive in school and in their communities. We draw on this and we refer to these parenting students who re-engage with school as 'sphere-invaders' because they are actively resisting their construction as mothers and repositioning themselves as student-mothers thus reclaiming their right to education. The words of one such sphere invader in our study in Uganda captures the resiliency of student mothers' discourses of ability when she asserts:

> *You must be willing to turn a deaf ear to the insults that are thrown at you, at home, on the way to school, in the community, in school and even in class. You must know why you are back to school.*

Conclusion

In this paper we set out to highlight and trouble the significant gaps, silences and tensions in the policies and guidelines in education for student mothers in Kenya and Uganda. We contend that the gaps and silences constitute an expulsion policy in disguise because rather than addressing student mothers' specific vulnerabilities and exclusion they serve to reinforce and perpetuate them. This is because of the negative and even harmful constructions of these young females including the disabling attitudes and perceptions in educational institutions and in the community while ignoring causal structural forces.

We conclude by highlighting glimpses of non-normative agentic ideologies and discourses of ability, which support and reinforce each other and offer promising possibilities for challenging the discursive constructions of student mothers in policy and practice. These alternative discourses which require further research, provide possible pathways for developing truly inclusive socially just policy frameworks to protect the education of pregnant and parenting students in Uganda and Kenya.

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Youth as researchers: Navigating generational power issues in adolescent sexuality and reproductive health research

Elizabeth Ngutuku
PhD Researcher
International Institute of Social Studies
Erasmus University Rotterdam
P.O. Box 29776, 2502 LT The Hague Netherlands
ngutuku@gmail.com

Auma Okwany, PhD
Assistant Professor
International Institute of Social Studies, Erasmus University Rotterdam
The Hague, Netherlands
P.O. Box 29776, 2502 LT The Hague Netherlands
Tel: +31704260578
Email: okwany@iss.nl

Elizabeth Ngutuku is a PhD researcher at the International Institute of Social Studies in the Netherlands. Her doctoral research focuses on dominant framing of child Poverty in Kenya against the embodied experiences of children. Elizabeth has been the executive director of Nascent Research and Development Organization in Kenya and Uganda since 2008-2015. Her research interests are in critical studies of childhood and youth and she has undertaken various research projects in this area in Kenya, Uganda and Ethiopia. She has co-authored a book and published several articles.

Auma Okwany (PhD) teaches Social Policy at the International Institute of Social Studies (ISS) of Erasmus University Rotterdam in the Netherlands. Her research interests center on the relationship between policy, practice and theory in childhood and youth issues in development from a critical perspective. Her most recent research focuses on social protection to enhance the citizenship rights of vulnerable children and includes a forthcoming volume, which she edited. She is lead author of The Role of Local Knowledge and Culture in Childcare in Africa: A sociological study of several ethnic groups in Kenya and Uganda (2011) Edwin Mellen Press. She has published numerous articles and is currently co-editing a volume on Early Childhood Care and Education in Africa and another on Girls' Education in East Africa.

Abstract

In this paper, we reflect on the ethical issues encountered during our work with youth as researchers in a sexual and reproductive health research project in Ethiopia and Uganda. This study was carried out as the research component of a comprehensive sexuality (CSE) education project implemented by Save the Children International and their local partners in both countries. The formative research had the aim of understanding the contextual realities and gendered social norms that structure sexual behavior and practice of very young adolescents and youth in the study contexts. We examine the dilemmas and "labor" of doing research with youth within a discursive and "expert" led adolescent sexuality and reproductive health intervention regime and at the same time position the role of our "adult expert gaze." We also reflect on the research methodology we adopted of working with youth as peer researchers and the tensions in enhancing as well as accessing youth voice. We argue that while research with young people requires that researchers observe specific ethical guidelines, the concept of "a youth researcher" positioned within specific expert discourses may be unsettling and presents further quandaries. We argue that these tensions have to be constantly negotiated.

Declaration: This manuscript has not been published and is not under consideration for publication by another journal.

Introduction

In this paper, we draw on our experiences and reflect on ethical issues encountered during our work with youth as researchers in a sexual and reproductive health formative research in Ethiopia and Uganda. The study was carried out as the research component of a comprehensive sexuality (CSE) education project for young people implemented by Save the Children International and their local and International partners in both countries. The research was carried out in the bigger project areas, both urban: Kampala and Addis Ababa; and rural: Agago district of Northern Uganda and North Wollo in Ethiopia. The formative study was designed to examine the contextual realities and gendered social norms that structure youth sexual and reproductive health practice of very young adolescents and youth in the study contexts. These social norms are internalized during the socialization process that starts at home, and are reinforced in the community and within social institutions including school, religious institutions and the media.

The research was inspired by the observation that adolescent sexual health policy; practice and discourse have often laid disproportionate emphasis on individual factors situating problems in young people. In the East and Southern African region, the disproportionate framing of sexuality research within the HIV/Aids paradigm exacerbates this focus on individual level factors. Many researchers have troubled this framing, which they note is erroneously premised on linking increased risk perception with increased knowledge and individual behavior change (Kalipeni 2007; Nyanzi, et al, 2001; Ricardo et al. 2005; Taylor 2007). Our starting point in the wider study is consistent with their critique and rejection of individual-level approaches and instead we aimed to highlight the importance of situating young people within wider socio-cultural contextual realities including gender and generational relations within which individual and interpersonal sexual practices and behaviors are embedded. This is consistent with the contention by Attawell (2004) that adult-centered approaches dominating existing reproductive health services make these services less accessible to young people. These approaches are also criticized for focusing more

attention on adult centered programs and projects that are geared more toward achieving project objectives (Attawell 2004; Erulkar et al. 2005). Additionally, they ignore the voices and diversity of youth and thus fail to provide support that is based on disaggregated needs of young people.

The larger research, as a project and a process was aimed at mainstreaming generational issues and perspectives into the youth centered sexuality education project. In so doing, we expected that the data from the formative research would not only strengthen a better understanding of the context but also provide opportunities for project staff and collaborating partners to question their assumptions about the sexuality of young people; and also be reflexive about their practice and work with project stakeholders in questioning adult and 'expert' assumptions.

Against this backdrop, in this paper, we present our negotiations of ethical issues in conducting sexuality research with young people from a number of perspectives. First, we present the dilemmas of doing research with youth within a discursive and 'expert' led adolescent sexuality and reproductive health intervention/project regime. We also reflect on these processes and on our adopted research methodology that was a joint effort between young people and adult researchers. We reflect on the epistemological underpinnings of working with youth as co-researchers as well as the negotiations, reflexivities and interrogation of our 'expert' gaze as adults, academics and practitioners. This also includes a focus on the gaze by other partners who are part of the consortium implementing the CSE project. We pay specific attention to the contextual realities wherein young people experience and 'live their sexuality and reproductive health' and we examine the assumptions about sexuality and reproductive health of young people and how this context, laden with generational power relations, interacting with other axes of difference like gender and intra/intergenerational relations, influenced the research in specific ways. We present the quandaries, and often times 'unresolvable' tensions this context provided within the process of the research and how young people carefully negotiated within this structure.

The nature of this research presented specific ethical issues and dilemmas that we grappled with. We do not claim to provide a formula for how to negotiate ethical dilemmas that are presented by research aimed at enabling youth voice on sensitive issues of sexuality and reproductive health. Rather, the paper offers indications, directions and possibilities within this area and we call for a situated ethics approach (Ebrahim 2008; Christensen and Prout 2002) in working with young people as researchers. Indeed, these 'everyday ethics' stress the situated nature of ethics, with a focus on qualities of character and responsibilities attached to particular relationships, as opposed to the articulation and implementation of abstract principles and rules (Banks et al. 2013). We contend that, it is these situated ethics that will determine how we negotiate within socially constructed contexts where research with young people is embedded. This is not to argue that all ethics of working with young people as researchers are situated and based on reflexivity. Indeed, as noted by Christensen and Prout (2002) ethical issues in research with young people cannot be left solely to the discretion and idiosyncrasies of researchers in the field, rather, there has to be some framework. In this regard, we also took into consideration ethical strategies for working with young people including: confidentiality, informed consent, voluntary participation and voice.

Working with Young People as Researchers: The Rationale

The key justification of the research was that young people are actors who exercise agency and need to be given an opportunity to produce knowledge that is useful in improving their sexual and reproductive wellbeing (Izugbara 2005; Kalpeni 2007; Kirk 2007; Ricardo et al. 2005). The research aimed to generate knowledge that would position young people as owners of knowledge about their own sexuality and reproductive health. This is because very young adolescents and youth have been excluded from the production of knowledge about their sexuality. In so doing, adult assumptions about their needs and their sexuality have guided and dominated many interventions on youth sexuality. However, these adult assumptions are often counter to the lived realities of the multiplicity, relational and gendered experiences of youth. Working with young people as researchers therefore has the potential of giving them a voice in the most intimate matters of their lives. It also has the potential to destabilize adult/youth power structures in generation of knowledge but also within CSE programs (Spyrou 2011; Wang 2006; Woodgate and Leach 2010). We therefore argue that youth voice is required in ensuring that sexuality education interventions are based on needs articulated by young people, rather than those based on adult assumptions.

Secondly, most information on young people's sexuality, especially young girls, are held in confidence within well-insulated peer group and young people themselves can better penetrate these groups through peer researchers who are well positioned to establish rapport (Cheney 2011). We thus worked with youth as co-researchers to co-create knowledge with them viewing them as active social actors in the research process (Christensen and Prout 2002; Mason and Hood 2011; McDonald et al. 2011). Working with young people helped in navigating the gate keeping on sexuality of adolescents by parents, teachers, religious and community leaders as well as state officials. Importantly, these methods provided a means to enhance intergenerational dialogue and develop partnerships with these gatekeepers.

Enabling Youth Voice: Research Approach

The study was youth-led in that youth peer researchers were trained and supported to collect data from their peers and from other stakeholders. We trained a total of 56 youth researchers (male and female, in and out of school between 13 to 25 years of age). The training was a continuous process with refresher sessions and constant support from the local researchers and supervisors. Youth researchers participated in collaboratively generating and refining research questions, selection and adaptation of research tools and in data collection and analysis including reflections on findings. To obtain a broad perspective on the contextual social norms and to enhance a comparative perspective, we collected qualitative data using a range of qualitative methods including interviews, focus group discussions as well as youth-on- youth centered participatory data elicitation methods. Quantitative data was collected through a structured questionnaire that was administered to youth study participants. These tools were translated and administered in the local language in Ethiopia and Northern Uganda.

The training of youth researchers was also conducted in local language via translators in Ethiopia and in Northern Uganda. Focus was on the objective of the research, key conceptual issues, data collection processes and techniques, and ethical issues including confidentiality and informed consent. Youth researchers were supported in data collection by locally recruited coordinators and researchers. Local researchers

selected youth researchers after orientation sessions in which the objectives of the research and selection criteria were discussed with school directors, teachers and youth club coordinators in selected schools and youth related projects for out of school youth. The adult researchers then crosschecked the profiles of youth researchers against predefined criteria. Parental/caregiver consent was obtained for youth researchers. Additionally, assent to participate in the research was obtained from the youth researchers.

Generational Power Relations

Generational power relations, in this paper and within the larger context of the research place young people in subordinate positioning to adults. This positioning and relations influence the way adults engage with young people and how they perceive their agency in sexual decision-making and in reproductive health issues (Barker and Ricardo 2005; MacDonald et al. 2011; Ricardo et al. 2005; Woodgate and Leach 2010). We view these generational relations as intersecting with other axes of power including gender, tradition, 'expert' gaze and both inter and intra-generational relations. We also take a constructivist perspective in which we view youth as a social construction with social meaning so that what it means to be young is gendered, contextual and is shaped by socio-cultural, economic and political forces (Ansell 2009; Diouf 2003; Okwany Forthcoming 2016; Sommers 2012). This implies a non-deterministic influence of generational relations on youth agency in the daily micro-contexts of young people's lives. We argue that young people have agency in negotiating, resisting and shaping the meaning of youth (Christiansen et al. 2006; Durham 2006; Kelly 2000; Woodward and Wyn 1999) and they can also negotiate these generational relations.

The prevailing adult and 'expert' assumptions about the sexuality of young people influence interventions. In this paper and in the study, we trouble the dominance of this adult gaze in generational relations and how it frames and constrains youth action and voice. For example, within the web of generational power relations interacting with gendered social relations, young people are often seen as 'asexual.' Girls are also constructed as sexual gatekeepers (Fine 1988) in sexual decision making without regard to how their status as young and dependent on adults (age, gender power relations) influences this gate keeping (Okwany, Forthcoming, 2016). Additionally, how this gate keeping role influences the way boys (within the same age category) view the sexuality of girls is also an issue Barker and Ricardo (2005). Questions of which categories of young people are structured as non-youth (married or parenting youth) due to normative notions of who is an adolescent and who is not and how these norms affect/influence their sexuality are also rarely addressed in this dominant framing.

From Formal to Negotiated Consent

We grounded the research in an ethical framework. Fully cognizant of the ethical imperative for study participants to be adequately informed, beyond formal consent from parents/guardians, we adopted a situated ethics approach (Ebrahim 2008; Christensen and Sprout 2002) to ensure that youth researchers obtained both written and oral assent at the beginning of each research activity. For very young adolescents, teacher-supervisors from participating schools explained the research and its utility. We were aware of the power differentials here, and that some youth might feel compelled under these circumstances to participate without their volition. This is consistent with the caution by Hill (2005, 70) that if adult gatekeepers (like parents and teachers) give consent, then a child may not feel free to refuse to participate. Oral assent was thus reaffirmed during different parts of each

session. Both parents and youth study participants were fully informed about the research. We also held continuous meetings with peer researchers to discuss their willingness to continue with the research process and provided opportunities for them to opt out (Ebrahim 2008; Ebrahim 2011; Hill 2005; Leanen 2009; Lambert and Glaecken 2011; van Reeuwijk 2010).

Negotiating within a discursive context of youth Sexuality

The dominant normative motif, prevalent in the study context often frames youth as asexual. The findings of the formative research reveal a litany of discourses about youth, their sexuality and gendered definitions of (in)appropriate sexual behavior. Sexuality is a very sensitive topic, with most community members viewing it narrowly as sexual intercourse. The cultural contexts of the study set limits on young people's negotiations within social relations including with reproductive health service providers. Peer researchers were thus familiarized with the broader concept of sexuality during training sessions, which also included value clarification, and dealing with their individual norms and assumptions about sexuality. This was important because like adults, both female and male youth also draw upon the cultural, patriarchal norms, and they are active participants in perpetuating the cultural beliefs and practices. The research therefore reveals a need to engage with young people themselves as well as the gatekeepers - the adults, in pushing back the limits of this discourse and in creating a space for meaningful engagement with youth. Some youth noted that they faced quandaries as a result of their involvement with some teachers and other adults sometimes thinking that they are getting "too aware of issues of sexuality." Other youth noted that their parents were supportive of their involvement in the research as one peer researcher's story illustrates:

My father is a senior government agricultural official and we talk freely about sexuality and the importance of young people having the right information. He was very supportive of my role as a peer researcher."(Female peer researcher, rural Ethiopia)

In a few cases, youth researchers stated that though their parents consented to their participation in the research, they were uncomfortable with the content of the structured questionnaire and they had to persuade them. A peer researcher's story is illustrative:

"My father knew that I was doing research and was supportive and had even granted consent for my participation. However, when he saw the content of the questionnaires, he was very shocked and said, 'I did not know that these are things you are talking about; take these things away from my home'. I then had to talk to him and explain the role of this research and he finally relented and allowed me to continue."(Female youth peer researcher, Ethiopia).

Working with teachers as supervisors: Tensions and Norms

We worked with teachers who were supporting school clubs on sexuality education and had received training from the larger CSE project about working with young people on issues of sexual and reproductive health. We felt that they would have fewer inhibitions. While there were animated discussions by youth researchers even in the presence of teachers, in some cases, teachers still drew from the problematic discursive context and reinforced norms about youth sexual and reproductive health. For example, in Uganda, in the larger project context, there was a backlash against young people involved in sexuality programs perceived to be

encouraging youth promiscuity. Supervisors and peer researchers had to be cautious about how their role was perceived. In so doing, some teachers conformed to dominant views about youth sexuality with one teacher supervisor in Uganda noting, "I think we should not be talking about youth being sexually active. Young people should not even know that there is anything like sexual intercourse. Another teacher also drew from the discursive and gendered views of youth sexuality as pertains the sexuality of teenage mothers when he noted:

> *The issue of teenage motherhood is serious here, but we (teachers) do not have to deal with it ourselves; the students "deal" with "the offenders" [student mothers]. They taunt them and start saying things like, "I can smell a pregnant woman in the class," and often the pregnant girl cannot endure this and drops-out of school.*

We thus ensured that teachers and supervisors underwent a process of "clarifying norms" in separate sessions before they could train together with youth researchers.

The 'labour' of negotiating the 'expert' gaze in youth research

We have been critically reflexive of our 'adult', 'expert' conceptual schemes and the way they influence the research. We also encountered normative assumptions by project implementers about the capacities of young people. We cautioned ourselves against imposing our academic and 'expert' views on youth researcher during the process of research particularly in the beginning when the youth researchers were asking, "How can we really be researchers?" This is because they have long been objects of research and not 'speaking subjects' of their own embedded experience and of research (Okwany and Ebrahim 2015). We were keen to acknowledge their privileged position as generators of knowledge about themselves, while we grappled with questions about their participation and the intention of making them "researchers" in the expert and academic sense. We have been careful to simplify (without being simplistic) the academic/expert discourse used in research processes, which can be perceived by youth participants as entrenching the boundaries of us versus them. At different stages of the research and after the research, we held meetings to discuss findings and also to share the lived experience of being youth peer researchers. We also wanted to ensure that the language of research did not replace their voices.

Since the research worked within the CSE project, we also had to negotiate with the perspectives of project staff about research with youth. During the training of peer researchers, youth researchers' views about sexuality sometimes contradicted those of project implementation staff, with youth feeling that project staff had not consulted young people in some of the conceptual issues, as the exchange below illustrates:

> *Peer researcher: We should not translate family planning the way it is translated in Luganda. We feel it is wrong to include "barenness" in the conceptualization because when you present it like that it does not consider young people for whom it is not all about barenness.*
> *Staff: We were called together by the {name of organization} before the project started and we discussed different terms and came up with a glossary of words and this is the way it should be translated.*
> *Peer researcher: You mark my words. If you go with that definition to young people, let me assure you, you will be blasted.*

Youth researcher as a term is also seen as an aberration in "expert" discourses and a "misnomer" in research speak. This is because, research is perceived as an academic endeavor with certain methodologies and procedures. We have therefore been constantly "reminded" that, "this is research and not stories" that "listening to the stories of young people is "different from research." When drawing up the research design, we were tasked to explain how the organization that had commissioned the research "would gain confidence in the quality of research/data generated by youth." Adult assumptions were also evident in the caution and doubts expressed by some local project staff that young people in Ethiopia for instance, are very shy and would not talk openly about sexuality even with their peers. They were thus skeptical about our proposed strategy of working with youth as researchers. This skepticism extended to questioning the (research) capabilities of young people particularly of out of school youth including, as another international partner noted, the fact that they "did not even speak English." Our selection criteria that youth peer researchers should be "tolerant and respectful of others' ideas and behavior" for instance elicited the following comment from a staff member of a partner organization:

> "This is very subjective criteria and will be difficult to measure and there is also very little chance that you will get out of school youth who meet this criteria."

We have taken these concerns seriously by explaining our methodology of working and how we ensured validity, reliability and quality of data. It has been a 'labour' in every forum to answer questions of the "scientificity" of our methodology. In response to these questions, we clarified that we have not "ceded" to youth researchers and that "we have been in control" as facilitators and have instead been co-creators of knowledge fusing our expertise with theirs to foreground youth voice. In explaining ourselves thus, tensions and unresolved questions remain; does this accentuate our power to research about youth sexuality, define it and analyze it and does that not label young people as "non-capable researchers"? This tension remains unsolved at least for the moment.

Our reading of these concerns especially from partners implementing this project and other 'experts' has however been that, as adults, we have retained the power to talk about youth sexuality for too long, and we attribute the resistance to the 'labour' of adults dislodging from such a position. Our interactions with youth researchers throughout the research process sharply contradict prevailing adult assumptions about their research capability, as young people have been very candid and involved during training including engaging with their peers and active participated in the different aspects of the research including analysis and dissemination. Discussions with youth researchers during one data analysis workshop revealed the importance of working through peer researchers who are uniquely located as 'insiders'. One peer researcher noted: "After I completed the data collection, one of the study participants told me, "If this information was asked by an adult (say 40-year-old person), I would not have given it to them" (Out-of-school youth, Kampala). Youth researchers have also expressed emancipatory benefits from their participation in the research including their pride in gaining respect and praise from peers, teachers, parents and the community and the boosting of their self-confidence.

We have also constantly engaged in the process of looking inward as we looked outwards This entailed constant reflection on how our practice, ideas and discourses are constructing

young people and challenging our assumptions. For staff of implementing organizations, we organized a participatory inward looking workshop where we oriented stakeholders on key generational and gender issues in sexuality, including enabling and disabling aspects of social norms in policy and practice in the project contexts. Workshop participants were challenged to be reflexive and challenge their adult and normative gaze and assumptions about these issues. This process of reflexivity is continuous though interactions with some staff indicate that adult/expert norms are still framing the way youth are constructed even within the project context itself.

Moving beyond Tokenism in Youth Voice

While we argue in this paper and the broader research that youth have agency and voice, it is crucial to consider which resources they draw on for this voice and the context within which their voice is embedded. Our research indicates that the context in which this voice in located is sometimes problematic and therefore there is potential for young people and especially very young adolescents to draw from this context as they form their perspectives. In privileging the voices of young people in sexuality research, we are aware that the information they have and the views they hold may still be mediated by their context (Spyrou 2011). Our research revealed that this context is contested and discursive. As noted by Hill (2005, 63), this also means that youth voice is not unmediated. Gender reflection exercises during the training of peer researchers revealed, for instance, that young people draw from dominant notions of masculinity and femininity. In recognition of this, we have tried to go beneath the voices (Mazzei 2009) in data analysis, while trying to avoid being unduly reductionist to these youth voices.

We have accomplished this by trying to understand, probe further and engage in progressive verification of the research process and findings with peer researchers at different stages of the research. For instance, in Northern Uganda, youth study participants reported female genital cutting as a retrogressive cultural practice in the region, yet this is not a practice in the region. Discussions during analysis sessions revealed that the cultural practice was taught and discussed in school but was not practiced in the region. Similarly, young people's understanding of reproductive health needs and rights was often framed from a disease perspective. This was also attributed to the normative framing dominant in social institutions like school, households, religious institutions and in the community in young people's micro-contexts. In trying to understand voice, we have referenced the context from where such voice is drawn during the process of analysis and data presentation (Spyrou, 2011).

We have endeavored to be "responsible" with youth voice and to move beyond tokenism in voice. Working within the larger CSE project has ensured that the young researchers have an opportunity to stay engaged with the program and has also provided space for sustained engagement with issues that came out of the research in an endeavor to make their voices heard. Young people have been involved in dissemination of research findings and advocacy activities with other partners within the project, and in partnership meetings with other partners within the sexuality education consortium as well as various opportunities to work with and train other youth in different youth-centered projects. To provide a forum where youth can engage with current issues within the context of youth sexuality and reproductive health, they continue to interact and exchange ideas and information via social media including lively exchanges on the group's face book page. This has boosted young people's confidence and created

awareness among them that they can be meaningfully involved in a sustained way.

The need to have a commitment from youth peer researchers to stay on for the duration of the project cycle raised ethical issues, which researchers need to be aware of when working with youth as researchers. Working within a time-bound project, which has a specific timeline and the goal of sustaining the capacity building focus of peer researchers, it became necessary during the selection of peer researchers to encourage and select those youth who would stay within the project sites for the duration of the project cycle. However, it became clear that this requirement was problematic for some out of school youth. In Ethiopia, urban poor out of school youth are predominantly, daily laborers working as shoe shiners, construction workers, street vendors and domestic workers in the informal sector. This group is highly mobile and many are transient. Thus as one of the project partners noted in regard to this criterion:

> *'It is difficult to meet this condition specifically for out of school urban poor youth. The profile of most out of school urban poor youth is that they are highly marginalized, very poor, working for subsistence in informal livelihood ventures. e community and it will make it very difficult s office , CSE partnersion. we ialoMany of these young people are very mobile, which makes it very difficult for them to stay put. (Project Officer, CSE project)*

The partner organization also noted that such conditionalities would cause selection bias by favoring those youth who are less vulnerable. We have engaged in continuous reflection of this challenge from a political perspective and researchers working with diverse groups of youth should bear these dilemmas in mind. Given the labor mobility of some young people, would leaving out the mobile group not introduce another form of intra-generational or class distinction with some young people relatively privileged over others? How can we as adults working with youth researchers maintain our "capacity building goals" and at the same time allow the diversity of young people to live their 'normal' lives without influencing its course? We see these tensions as political and we cannot resolve them in this paper but we point to a need for awareness of such dilemmas.

We do feel that continuous engagement and involving youth in dissemination of research findings and influencing policy makers with the research outcomes is an important aspect of enhancing youth voice. We concur with Robb (2014, 248) that dissemination and engagement contribute to a series of ongoing conversations, which overlap and interact with each other throughout the research process. We feel that we have made modest attempts to 'listen deeply' to the trepidation and healthy skepticism expressed by youth researchers at the initial research training encapsulated in the words of one youth researcher who stated, "it is good you have shown interest that we young people have a voice, but I will remain skeptical until I see the outcomes of the research being implemented. This is what I would call really listening to us." (24-year-old out of school married female youth Ethiopia).

In Conclusion

In recapitulating our main thesis, we have argued in this paper that age places young people in subordinate positioning in social relations in ways that constrain their sexual and reproductive health decision-making. The larger research with young people was geared toward foregrounding and nuancing youth voice. In this paper, we have argued that working with young people in this way presents ethical dilemmas and tensions which are accentuated when working with young people as

researchers. We point to the need for researchers to be aware of these ethical concerns and tensions. We also assert that involving youth in research as co-creators of knowledge is one way of including their lived experience, voice and action for potentially inclusive understanding of their realities within the structural inequalities and discursive limitations of their lives.

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RESEARCH REPORT | 2016

Socio-cultural determinants for the adoption of essential family practices in **Madagascar**

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RESPONSIBILITIES OF RESEARCH PARTNERS

International Research Consortium	University of Antananarivo	National Institute for Statistics (INSTAT)
Literature review; design of questionnaires and research tools; training sessions for data collectors and field researchers; data analysis and report writing.	Conceptualization of study; socio-cultural context for field research; qualitative research methodology; training of field researchers; qualitative research, including focus groups, interviews, social mapping and observation; supervision of field research teams; checking and analysis of qualitative data; presentations and reports.	Design of methodology for quantitative study; development of questionnaires; training of data collectors; supervision of field data collection; collation and analysis of data.

INTERNATIONAL RESEARCH CONSORTIUM

PROJECT DIRECTOR

David H. Mould, Media Arts and Studies, Ohio University

PRINCIPAL RESEARCHERS

Andrew Carlson, Metropolitan State University, St. Paul, Minnesota
Nicola Christofides, School of Public Health, University of the Witwatersrand, Johannesburg, South Africa

CONSULTANTS

Ami Sengupta, independent researcher
Karen Greiner, independent researcher
Luke Freeman, Department of Anthropology, University College, London
Sara Nieuwoudt, Lecturer, School of Public Health, University of the Witwatersrand

RESEARCH ASSISTANT

Nicolas Loncle

REPORT DESIGN

Belen Marco Crespo

NATIONAL INSTITUTE FOR STATISTICS (INSTAT)

Heritiana Rasolofoniaina, *Senior Analyst*

Philémon Razafimanonjy, *Senior Analyst*

Jean Baptiste Tarzan Ndremutsara, *Senior Analyst*

Marius Randriamanambitsoa, *Senior Analyst*

Arsène Ravelo, *Senior Analyst*

Lina Rakotson, *Senior Analyst*

UNIVERSITY OF ANTANANARIVO

Members of Scientific Committee

Pr. Rabaovololona, Co-President of Research Consortium: Conception and design of the qualitative field study, participation in the mid-term evaluation of the study in the regions of Anosy and Atsimo Andrefana, writing of field reports after feedback.

Pr. Ralalaoherivony, CERCOM, ALSH: Conception and design of the qualitative field study, participation in the mid-term evaluation of the study in the regions of Anosy and Atsimo Andrefana, writing of field reports after feedback.

Pr. Gil Dany Andriamasitiana, Department of Sociology.

Field Research

Region	Team member	Activities
ATSIMO ANDREFANA	RAZANAMPIONONA Julie Ravakiniaina	Team leader for research in Ampanihy, Mahavatse; data collection; member of report writing team
	RANDRIAMIARISOANDRAIBE Herimanana	Ampanihy: data collection
	RAKOTOSON Lina	Belalanda, Sakaraha: data collection
	RANDRIANALY Miora	Belalanda, Ampanihy: data collection
	RAKOTOMANGA Sitraka	Mahavatse, Sakaraha: data collection
	RAZANAMPARANY Irène	Sakaraha: data collection; member of report writing team
	RASOLONIAINA Elie	Mahavatse: data collection
	RANINDRIANORO Alain	Sakaraha: data collection; member of report writing team
	Fabienne	Mahavatse: data collection
	Rasamoelina Rojo	Mahavatse, Sakaraha: data collection
	Philippe RAKOTOSON	Belalanda: data collection
	Nicolas KAMIHA	Ampanihy, Belalanda: data collection
ANALANJIROFO	SAMUEL Richard	Team leader for research in Ambohibe Vavatenina, Ampasimpotsy; data collection; member of report writing team
	RAVELONJATOVO Tantely	Team leader for research in Morafeno; data collection ; member of report writing team
	RAVALISON Mampionona	Ambohibe Vavatenina, Ampasimpotsy; data collection
	ANDRIANTSIFERANA Rado	Morafeno, Ampasimpotsy: data collection; member of report writing team
	Toto CHAPLAIN	Ambohibe Vavatenina, Ampasimpotsy: data collection
	SAMOELA Menja	Ambohibe Vavatenina; Ampasimpotsy: data collection
	VAZAHAMORA Koloina Cyrielle	Morafeno: data collection
	Annette	Morafeno, Ampasimpotsy: data collection
	Joel RAHARIJAONA	Ampasimpotsy: data collection
	Jocelyn BEMARINA	Ambohibe Vavatenina, Morafeno: data collection

Field Research

ANOSY	ANDRIANANTOANINA Rija Fenosoa	Team leader for research in Manambaro and Tsimelahy; data collection
	RAZAFIMANDIMBY Hajannie	Manambaro, Tsimelahy: data collection
	ANDRIANARISON Dheilly	Manambaro, Tsimelahy: data collection
	RAKOTOSOA Rasolo Dama Harison	Manambaro, Tsimelahy: data collection
	RANDRIAMIHAJA Jerry	Team leader for research in Tanambao and Tranomaro; data collection
	TSITIGNEA Julios	Tanambao, Tranomaro: data collection
	RABODOVOLOLONA Danie	Tanambao, Tranomaro: data collection
	RANDRIATSIMIALONA Gianna	Tanambao, Tranomaro: data collection

Data Analysis

Team member	**Activities**
RAHARINIRINA Zinaha	Coordination and organization of team activities; compilation and classification of field data; implementation of working methodology
RAKOTOARISON Fenitra Misa Nandrianina	Anosy region: organization of data by sectors, themes and research sites; categorization, coding and classification of data based on research questions
ARIMANANA Lalaina	Atsimo Andrefana region: organization of data by sectors, themes and research sites; categorization, coding and classification of data based on research questions
SAMOELA Natalyh	Analanjirofo region: organization of data by sectors, themes and research sites; categorization, coding and classification of data based on research questions
RAOELINA Soamanalina Tantely	Entry and organization of coded data in database using Atlas TI qualitative analysis software
RALANTOMANANA Mino	Entry and organization of coded data in database using Atlas TI qualitative analysis software

INTERNATIONAL REFERENCE GROUP

The researchers would like to thank the following members of the International Reference Group for their comments on the research design, data analysis and report:

Prof. Bertrand Cabedoche, President of Orbicom, global network of UNESCO chairs on communication, UNESCO chairholder on International Communication, Université Grenoble Alpes, France

Christopher Golden, PhD/MPH, Associate Director, Planetary Health Alliance, Research Scientist, Dept. of Environmental Health, Harvard T.H. Chan School of Public Health, U.S.A.

Dr. Sue Goldstein, Director, Soul City Institute for Health and Development Communication, South Africa

Dr. Richard Marcus, Professor and Director, The Global Studies Institute and the International Studies Program, California State University, Long Beach

Dr. Laetitia Nyirazinyoye, Senior Lecturer, School of Public Health, College of Medicine and Health Sciences, University of Rwanda

Dolorès Pourette, anthropologist, Institut de Recherche pour le Développement, Antananarivo, Madagascar

Dr. Thomas Tufte, Professor of Communication for Development, Roskilde University, Denmark

Dr. Patricia Wright, Distinguished Service Professor, Stony Brook University (New York), USA, Founder and Executive Director, Institute for the Conservation of Tropical Environments

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EXECUTIVE SUMMARY

Conducted in three regions of Madagascar in 2015, this study presents socio-cultural data related to 12 Essential Family Practices (EFPs).

Drawn from the programmatic areas of nutrition, health, education, protection and water/sanitation/hygiene (WASH), these practices can improve the health and well-being of women and children[1].

1. WHO/UNICEF (1998) "Vers de meilleures pratiques familiales et communautaires" (Towards better familial and community practices).

1. Pregnant and lactating mothers seek an appropriate nutrition.
2. Mothers of children aged 0-6 months practice early initiation of breast-feeding and practice exclusive breast-feeding of their infants.
3. Mothers of children aged 6-23 months provide varied and sufficient diet.
4. Pregnant women seek 4 pre-natal consultations.
5. Parents ensure vaccination of children aged 0/23 months according to the calendar.
6. Parents and caretakers of children aged 6-11 years enroll children in primary school.
7. Parents and caretakers of children aged 6-11 ensure that their children finish primary school.
8. Parents/caretakers of children aged 10-18 years disallow children to marry before the age of 18
9. Parents/caretakers of children aged 10-18 years adopt non-violent behaviours towards their children.
10. Households wash their hands with soap at critical times.
11. Households drink safe water by using an improved source or by effectively treating the water of non-improved sources.
12. Households build and use latrines.

The results of this study serve as evidence to inform the design and implementation of communication for development (C4D) interventions that support programmatic efforts, including social mobilization and community participation for the survival, development, protection and education of children in Madagascar.

The consortium collaborating on this study were the University of Antananarivo and the National Institute for Statistics (INSTAT) in Madagascar, Ohio University (USA) and the School of Public Health, University of the Witwatersrand (South Africa). The study used mixed methods, with quantitative surveys conducted in 3240 households generating the bulk of the data, complemented by insights reached through a range of qualitative techniques including interviews, focus group discussions, transect walks and community mapping. Ethics clearance for the study was received in April 2015. Instrument finalization and training on collection and analysis methods for field teams spanned the months of May-July. Qualitative and quantitative data were collected in August- September 2015, with analysis and reporting from October-December 2015.

Some of the key findings indicate that while there are opportunities for C4D to help achieve program objectives related to the 12 EFPs, there are also limitations due to bottlenecks related to supply and service-delivery[2], which communication alone cannot address.

A summary of key findings from three program-related sections of the research illustrate both opportunities and limitations for C4D's contribution to promoting EFPs:

NUTRITION

Of the survey respondents who breastfeed, 53% report giving water, and 20% give sugared water a few hours after birth. Tambavy was also mentioned by 33% of respondents who reported giving liquids within the first three days. Reasons cited in the qualitative research for supplements were the perceived insufficiency or poor nutritional quality of the maternal milk, beliefs that can be countered through effective communication.

HEALTH

The study indicates that most mothers are well informed of the benefits of vaccinations, and want to have their children vaccinated. There are few significant socio-cultural barriers to vaccination, or strong anti-vaccination feelings. Of the two main barriers cited by parents, "distance to health centers" and "missing the time when vaccinations happen," the latter provides strong potential for improvement via communication.

2. Terminology adapted from : UNICEF (2014) Formative Evaluation of UNICEF's Monitoring Results for Equity System (MoRES), p. 5

WASH

61% of survey respondents reported receiving information about potable or treated water. 98% of respondents agreed with the statement "I will use potable water because I want to keep my family in good health" but two thirds of respondents without access to potable water *did not treat* the water they collected. 68% reported that water from the river is potable and 74% that water from a spring is potable. The most important sources of information were community agents (49%), health agents (48%) and radio (40%). These forms of communication could be harnessed to raise awareness about what types of water are potable and how to treat unclean water.

For areas where the research suggests that C4D may be in a position to contribute, as with some of the data excerpts above, intervention design ideas have been proposed at the end of this report (see nine opportunities on pp. 69-80).

INTRODUCTION

This report describes and presents the key findings of a 2015 UNICEF-supported research study, conducted in three regions of Madagascar, on the socio-cultural determinants of 12 Essential Family Practices (EFPs). The purpose of the study is to provide an evidence base for programme interventions by UNICEF, the government of Madagascar and country partners, including communication for development (C4D) strategies. A more thorough understanding of barriers and motivators, including beliefs and cultural practices, key influencers and communication networks can lead to better informed and targeted interventions that contribute to measurable social and behavioural change.

The methodology for the quantitative and qualitative study was developed by a national and international research consortium, with guidance from UNICEF, a national steering committee and an international reference group. The consortium partners are:

Université d'Antananarivo (UA), Faculté de Droit, d'Economie, de Gestion et de Sociologie (DEGS), Département de Sociologie, and Faculté des Lettres et des Sciences Humaines (FLSH), par le CERCOM du Département Interdisciplinaire de la Formation Professionnelle (DIFP)

National Institute for Statistics (INSTAT), Madagascar

Ohio University, Communication and Development Studies

University of the Witwatersrand, School of Public Health

The study, building on data gathered in previous quantitative and qualitative research, was conducted in three regions—Analanjirofo in the northeast, and Atsimo Andrefana and Anosy in the South[3]. These regions are part of a larger group of seven selected based on their vulnerability in social sectors and the presence of various UNICEF programmes. Research may be conducted in four other regions at a later date.

3. As many Madagascar scholars have noted, the use of the term "the South" is problematic. Within each of the regions (including those in this study), there are significant geographic and economic distinctions between urban, coastal and rural areas, between research-rich communities, e.g. mining towns, and those that depend on subsistence agriculture, fishing or zebu-herding. Some areas are administered by local authorities; in others, political and administrative authority is mainly in the hands of traditional leaders. There are differences in religious beliefs and practices, traditional rituals, and dialects. For research to best guide programme interventions, disaggregation of data at the regional (Anosy and Atsimo Andrefana) and geographic tier levels is recommended.

The project timeline (for planning, development of methodology and questionnaires, research protocols and approvals, workshops, data collection, and data analysis) is outlined in Annex A.

This report highlights key research findings and recommendations. For reasons of space, it does not include the research instruments developed, such as the questionnaires and guides for focus group discussions and key informant interviews, descriptive statistical tables and summaries of qualitative research conducted in communities. These can be found at the project website, **https://madaresearch.wikispaces.com**

Fig 1. Study regions in Madagascar (highlighted)

CONTEXT

With worsening economic conditions and political instability, social indicators relating to the rights of children in Madagascar in almost every sector have been declining in recent years. Over 90% of households live on less than $2 per day and over a third are classified as food insecure; one in four women of reproductive age suffers from malnutrition. In the health sector, most women seek ante-natal care (ANC); however, there has been a decline in the number who complete the recommended four ANC visits, with the rate lowest in the two southern regions. The maternal mortality rate is high at 478 per 100,000 live births, with over a third of these resulting from teenage pregnancies. Most children receive some immunizations, but the number who complete the full vaccination schedule has also been declining, particularly in the South and in rural areas.

Only a little over one fourth of households nationally have access to safe water and about half use treated water. The primary barriers to accessing safe water are availability and a preference to drink water directly from the source. Handwashing practice is low with a limited number of households having soap, water supply or a designated place for handwashing. There is low awareness of the relationship between systematic handwashing and health/illness. Nationally less than three out of 100 households use improved sanitation facilities. Open defecation is widely practiced. Barriers to latrine use include the cost of building toilets, poor maintenance, cultural taboos to using and sharing toilets and low risk perception of open defecation or improper disposal of child feces.

Poverty, food insecurity and daily routines impact the nutritional status of pregnant women, mothers and children. Although almost all children are breastfed, there has been a decline in the early initiation of breastfeeding. Exclusive breastfeeding rapidly decreases by 4-5 months when nearly 70% of infants receive other fluids and complementary foods. Among children aged six months to two years, less than one quarter (22%) receive an adequate diet (according to UNICEF and WHO guidelines)—that is, both the minimum meal frequency and at least four separate food groups (dietary diversity).

Although education is compulsory from the age of six and is a national priority, Madagascar is not on track to achieving universal primary education. Approximately 1.5 million children of school-going age are currently out of school and only three out of every 10 who begin primary school complete the cycle. Factors that contribute to lower school enrolment and retention include the poor quality of public education and the need for children to engage in income generating activities to support families.

Despite opposition from some parents, child marriage remains prevalent in Madagascar, with close to half the female population aged 15-49 married before 18 years, the rate being highest in the South. Early marriage often results in teenage pregnancies and contributes to maternal mortality and morbidity. Violence against children is a major concern and, as in most other countries, is under- reported and tolerated, with most caregivers considering physical punishment necessary to raise children properly. Four out of five children aged 2-14 have experienced at least one form of violent discipline. Sexual exploitation of children including prostitution and sexual tourism has increased in recent years. The low status of children and women, normative acceptance of violence and the pervasive impunity of perpetrators allows violence against children and women to persist. These trends have been exacerbated by structural factors. Deteriorating economic conditions, both globally and nationally, have increased financial pressures on both families and individuals. Since 2005-2006, and particularly since the 2009 political crisis, government social sector capacity has declined, resulting in reduced services and lax law enforcement.

ESSENTIAL FAMILY PRACTICES

Based on these social indicators, UNICEF developed 12 Essential Family Practices (EFPs)[4]. They correspond to the programmatic objectives of the Health, Nutrition, Education, Child Protection and WASH sections of UNICEF Madagascar. The 12 EFPs are grouped under five “section umbrellas.[5]”

1 NUTRITION

Pregnant and lactating mothers seek an appropriate nutrition (EFP1-N)

Mothers of children aged 0-6 months practice early initiation of breast-feeding and practice exclusive breast-feeding of their infants (EFP2-N)

Mothers of children aged 6-23 months provide varied and sufficient diet (EFP3-N)

2 HEALTH

Pregnant women seek 4 pre-natal consultations (EFP4-H)

Mothers of children aged 0-23 months ensure their children are vaccinated according to the calendar (EFP5-H)

4. UNICEF concept note (2015), “Study of socio-cultural determinants for the adoption of key family practices in the areas of intervention of UNICEF Madagascar,” p. 1.
5. We propose a slight change to the numbering of the EFPs so that practices for nutrition are grouped together under one “section umbrella.”

3 EDUCATION

Parents and caretakers of children aged 6-11 years enroll children in primary school (EFP6-E).

Parents and caretakers of children aged 6-11 ensure that their children finish primary school (EFP7-E)

4 CHILD PROTECTION

Parents /caretakers of children aged 10-18 years disallow children to marry before the age of 18 (EFP8-P)

Parents /caretakers of children aged 10-18 years adopt non-violent behaviours towards their children (EFP9-P)

5 WASH

Households wash their hands with soap at critical times (EFP10-W)

Households drink safe water by using an improved source or by effectively treating the water of non-improved sources (EFP11-W)

Households build and use latrines (EFP12-W)

ANALYTICAL CATEGORIES AND CONCEPTS

To establish a common vocabulary for this report, we use a set of analytical categories and concepts that guide, together with the research data, the C4D recommendations. The terminology is introduced here and the concepts developed in Annex B.

SUPPLY AND DEMAND-SIDE DETERMINANTS

Constraints and bottlenecks to the uptake of a given behaviour or service can stem from "demand-side" determinants such as the lack of knowledge or motivation on the part of a community member, and can also be the result of a "supply-side" factor such as poor service, absence of supplies (e.g. vaccines or water purifiers) or lack of infrastructure (e.g. a health center). UNICEF's Monitoring for Results Equity System (MoRES)[6] provides a framework for considering the range of determinants that can enable or constrain behaviour and social change. Areas for potential bottlenecks range from 1) enabling environment (social norms, legislation/policy/political context, etc.), 2) supply, 3) quality (of service), and 4) demand. C4D can be employed in three of the four determinant areas, through advocacy, social mobilization and individual behaviour change communication. Only the area of "supply" is largely immune to communication influence.

INDIVIDUAL DECISIONS/BEHAVIOURS AND SOCIAL NORMS

When considering how to promote a given EFP, it is important to determine whether the behaviour, action or decision is within the control of the individual, or whether the action or behaviour is highly influenced by social norms. We define social norms as a system that "specifies what is acceptable and what is not in a society or group…often meant to represent a solution to the problem of attaining and maintaining social order."[7] A deeply entrenched social norm may necessitate long-duration communication formats while a one-time behaviour such as

6. Formative Evaluation, UNICEF's Monitoring Results for Equity System MoRES: From evidence to equity? (2014), p. 6

7. Stanford Encyclopedia of Philosophy, Social Norms, Section 1: Introduction

birth registration might be addressed through short-duration information-only approaches. There are thus two key questions to ask about each EFP:

> **Is the behaviour within the control of the individual or family, or is it a social norm?**
>
> **Can the behaviour be directly impacted or influenced by communication alone, or are there other barriers?**

This is illustrated by Table 1 which plots the EFPs along two axes: 1) – vertical axis: individual (or family-level) decisions and/or behaviours, or social norms, which involve the perceived opinion of others in the community; and 2) horizontal axis: how likely the EFP is to be *directly* impacted by communication (on its own), or only *indirectly* arriving at impact, because an additional material resource or factor (like geography) will affect the potential impact of a given intervention. EFPs that are both individually controlled AND directly influence-able by communication are the "lowest hanging fruit" for potential C4D impact. Tougher candidates for C4D influence are EFPs that are entrenched social norms, and/or require additional material resources (such as soap, toilet paper or supplemental food) or have material/geographic barriers (such as access to schools, or the existence of a health centre).

Fig 2. Individual decision/behaviour and direct/indirect communication impact

Individual decision/behavior

	Direct communication impact	Indirect communication impact (requires material resources)
Individual decision/behavior	EFP2-N Exclusive Breast Feeding	EFP1-N appropriate nutrition for mothers EFP3-N sufficient/varied diet 6-23 mo children EFP4-H pregnant women seek 4 CPNs EFP5-H vaccination children 0-23 months EFP6-E parents enroll 6-11 yr. children in school EFP7-E 6-11 yr. children finish primary school EFP10-W handwashing with soap, critical times EFP11-W drink safe water, treat unsafe water EFP12-W households build and uses latrines
Social norm	EFP8-P parents of 10-18 yrs. children disallow marriage for children under 18 EFP9-P parents of 10-18 yrs. children adopt non-violent behavior	EFP1-N appropriate nutrition for mother EFP3-N sufficient/varied diet 6-23 mo children

Social norm

EFP CATEGORIES

Based on the analysis presented above, the team placed each of the 12 EFPs into one of three categories

Category 1. Individual or family-level choice; C4D can directly influence (top left quadrant).

Category 2. Social norm; C4D on its own can influence, but challenges remain, since social norms often take more time and intensity, in terms of communication, to affect change (bottom left quadrant).

Category 3. C4D can only indirectly influence. There is a need for additional material resources to successfully engage in these EFPs (top right quadrant).

Further details on the analytical categories and their relationship to potential C4D interventions may be found in Annex B.

LITERATURE REVIEW

The literature review, presented (in French and English versions) at the December 2014 research methodology seminar, provided a synthesis of available research, identifying prevalence data and trends, barriers and motivators, and areas for further research for each of the EFPs. Given the wide range of EFPs, summary data sheets were compiled by sector allowing the closely related practices to be analyzed and presented together. See **https://madaresearch.wikispaces.com/Rapports**

The review was guided by the following questions:

- **What do the data indicate about the 12 EFPs nationally and in the three regions?**
- **What do the data indicate in terms of knowledge, attitudes, and behaviours as they relate to the EFPs?**
- **What do the data indicate in terms of social norms, barriers and motivators in relation to the EFPs?**
- **What do the data indicate regarding current communication practices and key influencers on the decision makers?**
- **What do the data indicate regarding the access and use of media and information communication technologies?**

The literature review included national survey data, UNICEF country programme documents, an initial desk review conducted by the University of Antananarivo and qualitative and recent anthropological studies. These data sources were complemented by peer-reviewed journal articles identified through a database search process using specific key words and inclusion criteria. The search was conducted using three main search engines: an academic one (EBSCO), one oriented to C4D and communication for social change (The Communication Initiative, CI), and a general one (Google Scholar). In summary, the review methodology consisted of:

- **Review of existing large-scale data including the MICS (Multiple Indicators Cluster Survey), EPM 2010 (Periodic Households Survey), EDS 2008-2009 (Demographic and Health Survey), and MDG 2013 (Millennium Development Goals);**

Review of anthropological study undertaken in southern Madagascar in 2011 (Le Sud: Cimetière des Projets?) and qualitative research on socio-cultural practices and actors of influence from 2013 (UNICEF Mapping Study), and other studies related to socio/cultural organizations, population behaviours, and child rights;

A thorough search of databases for peer-reviewed journal articles and published reports from national and international development agencies or research institutions;

Summary of the existing data in order to identify information gaps and potential areas for further research.

The majority of research studies conducted in Madagascar over the last quarter-century have been anthropological or ethnographic in their methodology. This is not surprising. Given the country's relative geographic isolation and cultural diversity, it offers many opportunities for research focused on traditional beliefs and practices. Quantitative studies by international and donor organizations have produced demographic data, but have not asked *why* people do or do not adopt certain attitudes and behaviours. This study is intended to help fill this gap.

Assumptions about commonality of behaviours within and across regions are easily and often made by development professionals and, sometimes, researchers. Without concrete data on the reasons or motivations for attitudes and behaviours, it is tempting to rely on existing anthropological studies which, by their disciplinary nature, tend to emphasize the role of traditional practices, religion, cultural taboos, and so on. That's what anthropologists study, and so it's what they report. We are not seeking here to debunk these studies, but simply to say that an attitude or behaviour identified as prevalent within a certain community or ethnic group should not be assumed to be widely shared, even at a district level.

Most anthropologists say that their studies are descriptive of a group of people in a particular place at a particular time, and that to generalize from their research, either to other communities or across time, is problematic. Yet, such generalizations occur. A UNICEF-sponsored report "Le Sud: Cimetière des Projets?"[8] makes broad statements about religious beliefs, social hierarchies, marriage and communication networks, among other topics, implying that such attitudes and practices are, if not universal, then at least common across all southern regions. Such conclusions are no doubt valid for some individuals or communities, but can we apply them to all of southern Madagascar?[9] The two southern regions in the study—Atsimo Andrefana and Anosy—are markedly different in history and cultural practices, and within these regions, ethnicity and culture are just two of the factors that may shape attitudes and behaviours.

8. Preliminary report, "Le Sud: Cimetière des Projets? (no author or date listed)

9. Bayer and Gostin (and others) have noted the potential stigmatizing effects in public health and communication interventions when specific "at risk" groups are "singled out" in communication campaigns. Bayer, R. and Gostin, L. (2007). *Public Health Ethics: Theory, Policy, and Practice,* Oxford

There is no broad agreement about how to define ethnic groups in Madagascar. Although government documents and maps divide the island neatly into 18 ethnic regions, ethnicity is not measured by any single criterion. Some groups are categorized on the basis of racial origin, others on primary economic activity, and others on their historical opposition to powerful kingdoms. The one constant factor in Madagascar's history is migration—both from outside and within the country, as a result of conflict or economic pressures. The result is that many communities, including several in this study such as Mahavatse and Sakaraha, are composed of people from various regions of the island. Scholars such as Richard Marcus have argued that geographic, rather than cultural distinctions, are the drivers of attitudes and behaviors; for example, a Merina living in Analanjirofo and dependent on lychee or cloves production is more likely to make decisions similar to those of Betsimisaraka neighbors than to those of highland Merina; similarly, a Betsimisaraka living on the coast of Atsimo Andrefana will follow the practices of the Vezo, an ethnic group defined almost entirely by economic activity (fishing).

This study classified each region into four tiers, based primarily on geographical location (urban, coastal, sub-coastal and interior). Even within these tiers there are significant economic disparities, particularly between resource-rich communities where mining has boosted the secondary economy, and resource-poor communities that continue to rely primarily on subsistence agriculture or fishing. In general, more goods and services are available in research-rich areas; for example, private schools have been established in areas where there is comparatively greater wealth.

Just as problematic are statements, most often based on the views of local government officials and religious leaders, that characterize a region or district in certain ways. One study analyzed for the literature review featured sweeping statements about regions and their populations. In Analanjirofo, people were described as conservative, clinging to traditional practices, concerned only with their basic daily needs and not willing to exert extra effort to improve their lives, incapable of participating in their own development, waiting for the welfare state to solve all their problems, and motivated only by material and/or financial gain.[10] Such statements are based on limited data—views expressed in interviews and focus group discussions—and risk stigmatizing an entire region, portraying its population as either victims of environment and traditions or as incapable of becoming partners in development.

10. «Culture du moindre effort/manque de motivation et de volonté » Mapping de la région Analanjirofo (2013), p. 4

Although such generalizations are still current in some government and development circles, they have been rejected by most scholars in the social sciences and humanities as "false homogeneous categories, static, deterministic and discriminatory."[11] Communication approaches that position cultural beliefs as resources rather than barriers[12] can help tailor interventions to local contexts, with community participation, in ways that do not run the risk of stigmatizing groups.

11. Quoted in Livian, Y.-F. (2011), « Pour en finir avec Hosfstede. Renouveler les recherches en management interculturel », Communication à la première conférence annuelle Atlas/Afmi, *Les défis du management international à l'aube du XXIe siècle*, ESCP Europe et Université Paris Dauphine, Paris, 26-27 Mai, http://hal.archives-ouvertes.fr/docs/00/64/35/93/PDF/Pour_en_finir_avec_Hofstede.pdf Also, Cabedoche, B., "Education for intercultural journalism for excellence and reference centers in Africa. An academic contribution to political and critical reflection of UNESCO, "pp. 163-192, in Racha Mezrioui, Zainab Touati (Eds.), *Media and digital technologies. identity constructions and interculturalities*, Tunis and Paris: L'Harmattan, 2016 (Coll. Socio-anthropology of the Mediterranean worlds.)

12. Airhihenbuwa, C. (1995). *Health and Culture: Beyond the Western Paradigm*. Sage Publications

KEY FINDINGS OF LITERATURE REVIEW BY SECTOR

HEALTH

The EDS 2009 reports that 55% of children aged 1-12 months are fully vaccinated as per the recommended schedule. In the 12-23 months age group, nearly two- thirds of children (62 %) received all EPI vaccines, i.e., one dose of BCG, three doses of DPT, three doses of polio and one dose of measles. Data reflects higher coverage in urban areas (81%) compared to rural areas (60%). The MICS 2012, conducted in four regions in the South report that among children aged 12-23 months, 64% were vaccinated against TB and under 50% for polio, DPT and measles. The EDS and MICS rates are higher than those reported in the UNICEF Situation Analysis which indicates a decline in the percentage of children fully vaccinated from 47% in 2003 to 38% in 2012 (SitAn 2014). The discrepancy may be partly explained by the age group studied.

Almost nine out of 10 women in Madagascar receive antenatal care (ANC) by trained health personnel; however there has been a sharp decline in the number who complete the recommended four ANC visits. Less than half of pregnant women complete all four ANC visits.

Maternal mortality is high at 478 per 100,000 live births and over a third of these result from teenage pregnancies (UNICEF CPD, 2014). Access to and quality of health care services remain low. This is further compounded by socio-cultural barriers and a preference for traditional healers and remedies.

NUTRITION

Maternal nutrition and dietary practices have intergenerational consequences, affecting both mother and child. Widespread poverty and low food security pose serious barriers to achieving adequate and diverse diets. Over 90% of households live on less than $2 per day and over one third are classified as food insecure (ENSOMD 2012). Furthermore, 27% of women of reproductive age suffer from malnutrition (SitAn 2014).

Breastfeeding is near universal in Madagascar with almost all children breastfed (98%). Around two-thirds of the children (66%) are breastfed within one hour of birth. Data indicate a decline in early initiation of breastfeeding from 72% in 2008 to 66% in 2013 (SitAn 2014). According to the DHS 2009, about half of children under six months (51%) are exclusively breastfed. Exclusive breastfeeding is higher in the first two months and then rapidly decreases; at 4-5 months almost 70% of infants are receiving other fluids and complementary foods. The median duration of breastfeeding is estimated at 21.9 months and that of exclusive breastfeeding 2.3 months (DHS 2009). There is high variability in breastfeeding rates depending on the place of residence. The mother's educational level and births attended by a health provider or at a health facility appear to have a positive influence on

breastfeeding (EDS, 2009). The rates are lower in the South where 26.6 % practice exclusive breastfeeding for less than six months and 45.5% practice early initiation (MICS 2012).

In Madagascar, the National Nutrition Policy (2004) follows the WHO and UNICEF guidelines for infant and young child feeding (IYCF) which recommends exclusive breastfeeding for the first six months of life followed by the introduction of complementary foods rich in nutrients with continued breastfeeding until the age of two. According to the EDS (2009), 87% of infants in the 6-23 month age group are fed according to the recommendations. Furthermore, among children 6-35 months, 79% had consumed foods rich in vitamin A and 46% iron-rich foods. Food consumption increases with age (from 53% at 6-8 months to 81% at 12-17-months and 87% at 24-35 months); however, non-breastfed children (86%) are fed more frequently than breastfed children (75 %). For instance, 58% of breastfed children consumed fruits and vegetables rich in vitamin A, compared to 63% of those not breastfed, and 41 % of breastfed children consumed foods such as meat, fish, poultry and eggs compared to 53% of non-breastfed. A very small percentage of children consume cheese, yogurt or other dairy products irrespective of whether they are breastfed or not.

According to the MICS, among children aged 6 to 23 months, regardless of the status of breastfeeding, over one third received at least four different food groups (38%) and more than half (68%) received the minimum meal frequency. Less than a quarter (22%) of the children received adequate food, which is defined as receiving both the minimum number of calories per day and food from at least four separate food groups (dietary diversity).

WASH

A little over one fourth of households nationally have access to an improved source of water and almost half (49%) use treated water (EDS, 2009). In the South access is considerably lower at 26% and less than a fifth of households use treated water (16.3%) (MICS, 2013). The primary barriers to accessing safe water are availability and the preference to drink water directly from the source. Boiling water is not a common practice. According to the SitAn, 57% of people who have access to water system supply still drink surface water and only 28% of public primary schools have safe drinking water points (24% in rural areas vs. 57% in urban areas). Geographical and income- based disparities exist, with lower access in rural areas and among lower income groups.

The systematic and repetitive practice of handwashing is low with a limited number of households having soap, water supply or a designated place for handwashing. Indicators of handwashing at critical times are not included in the surveys reviewed. Data suggests low awareness of the relationship between handwashing and health/illness.

Nationally less than three out of 100 households use improved sanitation facilities (EDS, 2009). The Joint Monitoring Programme (JMP 2013) reports an increase in access to sanitation from 8% to 14% from 1990 to 2011. Access is higher in urban than in rural areas. 69% of people lacking access to improved sanitation live in rural areas, as are 84% of people who defecate in the open (JMP 2013). Open defecation is widely practiced, with 39% of the population, roughly 8.4 million people, defecating in the open (SitAn, 2014). In the South less than 2% use improved sanitation facilities and only about 4% practice hygienic disposal of child feces (MICS 2012). Latrine use is deterred by the cost of building toilets, the cost and reluctance to use toilet paper and other artificial products, poor maintenance, cultural taboos to using and sharing toilets among family members, and low risk perception of open defecation or improper disposal of child feces.

EDUCATION

Although education is compulsory from the age of six and is a national priority, Madagascar is no longer on track to achieving universal primary education (MDG 2). According to the MDG Survey 2012, the net primary enrolment rate is 69%, a considerable decline from 83% in 2005. Approximately 1.5 million children of school-going age are currently out of school and only three out of every 10 children who begin primary school complete the cycle (UNICEF CPD, 2014). More than three-quarters (78%) of the population have completed primary schooling, and about one third (31%) have completed secondary schooling (EDS 2009). There is gender parity in primary schooling with the ratio of girls being slightly higher than boys. Income levels and place of residence impact education indicators.

Factors that contribute to lower school enrolment and retention include poor quality of public education, low perception of the value of education among parents, the need for children to engage in income generating activities to support families, and language difficulties (the use of Malagasy as an official working language, French, local dialects and the French-Malagasy mix).

CHILD PROTECTION

Child marriage is prevalent in Madagascar, with close to half the female population aged 15-49 married before the age of 18, the number being higher in the South (65%). About 12% of the female population report marriage before 15 years of age. Early marriage often results in teenage pregnancies and contributes to maternal mortality and morbidity. As of 2012, 37% of women aged 15 to 19 years reported having started their reproductive life (UNICEF CPD). Males tend to marry later than females. Especially in rural areas, parents arrange marriages for their children, often at a very early age and sometimes even at birth. Early marriage can result in economic gain, preserve kinship ties or perpetuate the family lineage, or even build alliances between villages.

Violence against children is a major concern and, as in most other countries, is under-reported and tolerated. The MICS reports that over 80% of children (2-14 years) have experienced at least one form of violent discipline. Twenty percent of children were subjected to severe physical punishment and 64% to physical punishment. The majority of caregivers (71%) consider physical punishment necessary to raise children properly. According to the MDG survey 2013, among adolescent girls (aged 15 to 19), 14 % experienced sexual violence and 15% experienced physical violence. The Special Rapporteur on the Sale of Children, Child Prostitution and Child Pornography reported increases in sexual exploitation of children including prostitution and sexual tourism since the onset of Madagascar's political crisis (CPD, 2014).

Such data need to be treated with caution because definitions of "violence," "discipline: and "sexual exploitation" can be subjective, and thus less than reliable as a basis for strategies and programme interventions. For researchers, it is difficult to separate global trends in human trafficking and sexual exploitation from national or indigenous practices. Although economic pressures and lack of law enforcement may be factors on both levels, the involuntary servitude of minors, sometimes given legitimacy through the *dina* (social contract), has long been a socio-cultural coping strategy in Madagascar.

Over a quarter of women (aged 15-49) consider it justifiable for a man to beat his wife/partner if she neglects the children (EDS, 2009). This attitude towards domestic violence is slightly more pronounced among women in the capital city, Antananarivo (25% compared to 19% in rural areas) and among those under 30 (20 % compared to 17% among ages 45-49). According to the MICS, 37% of women consider it justifiable for their husband/partner to beat them for a reason (such as neglecting the children, arguing with their husband or refusing sex). Surprisingly, this attitude is more prevalent among women in urban areas, those with at least secondary education and belonging to the highest wealth quintile. The low status of children and women, normative acceptance of violence and the pervasive impunity of perpetrators allows violence against children and women to persist.

METHODOLOGY

RESEARCH METHODS

RESEARCH QUESTIONS

The study addresses research questions (RQs):

RQ1

What are the socio-cultural determinants of attitudes and behaviours relating to each of the EFPs, and how do they differ by region, strata, gender, education level and other socio-demographic characteristics? What are the barriers, bottlenecks and opportunities?

RQ2

Who are the key actors and/or sources of influence and networks in relation to the EFPs?

RQ3

Which communication channels/media are available and trusted in relation to the EFPs?

STUDY DESIGN

The mixed methods study consisted of quantitative surveys, with socio-demographic questions, conducted in randomly selected communities in the three regions, corresponding to geographic strata, by the National Institute for Statistics (INSTAT). The University of Antananarivo (UA) conducted qualitative research in 12 communities (four communities per region).

QUANTITATIVE DESIGN

INSTAT, which has partnered with UNICEF on previous research, was selected to implement the quantitative research study.

TARGET POPULATION

There were two respondent groups:

> **Pregnant women and mothers of children under two--questionnaire on maternal and infant health and nutrition (EFPs 1, 2, 3, 4 and 5);**

Parents and caregivers of school-aged children (6 – 18)—questionnaire on education and child protection (EFPs 6, 7, 8 and 9).

Both questionnaires included a preliminary section on socio-demographic characteristics, type of dwelling, the economic status of the family, media use, and water, hygiene and sanitation (EFPs 10, 11 and 12).

SAMPLING

To assure representivity at the regional level, each region was divided into strata based on geographic criteria: urban, coastal, sub-coastal, and interior. Enumerator Areas (EAs) from the preliminary mapping of the third General Census of Population and Housing (RGPH3) of Madagascar provided the basis for the quantitative survey. Because the EAs were defined in 2009 and changes could have occurred in terms of the number of households and borders, an update was conducted before data collection began. EAs were randomly selected from each stratum based on population size/number of households. The calculated sample size and the expectation of non-responses yielded a total of 115 EAs across the three regions.

Determining the sample size depends on several parameters, including: the degree of accuracy, the required level of representivity, and budget and logistical constraints. On the basis of these parameters, the minimum size of the sample required for each target area of the study was adjusted. The most commonly used formula for calculating the sample size in the context of a quantitative survey by cluster is as follows:

$$n = \frac{z^2 * p(1-p) * g}{m^2}$$

where n: sample size; **z**: confidence level (1.96 corresponds to a 95% confidence interval); **p**: expected prevalence; **g**: group effect; **m**: margin of error desired (set at 0.05).

Databases from previous surveys allowed INSTAT to calculate the sample size from this formula. The vaccination rate indicator among children aged 12-23 months was used to deduce the sample size by region.

Based on the calculations, the following sample sizes for each region were determined.

Table 1: Preliminary sample sizes (by region)

Regions	Households	Pregnant Women and Mothers of Children < 2	Parents and Care-givers of School-Aged Children
ANALANJIROFO	1 068	534	534
ATSIMO ANDREFANA	1 132	566	566
ANOSY	1 058	529	529
TOTAL	**3 258**	**1629**	**1629**

As indicated above, each region was divided into four strata. Within each stratum, the EAs were randomly selected, as were the households within each EA.

The sample was stratified and drawn in two stages. The first stage corresponded to the EAs, which were defined in the preliminary mapping (RGPH3), as described above. It is worth noting that in each stratum for the sample, the number of EAs drawn was dependent on the total number of EAs in the strata. That is to say that the sampling of EAs was proportional to the number of EAs, rather than the number of households or the population size.

For the second stage of sampling, 15 households among all eligible households were randomly and systematically sampled from each EA. In order to be able to conduct this second degree of sampling, all households in each EA were enumerated prior to the sampling.

This enumeration process yielded two lists: one containing households with pregnant women/mothers of children less than 2 years, and one with parents and caregivers of children aged 6 to 18. From each list, 15 households were chosen at random. In addition, it was verified that each list contained different households. If that was not the case, then the geographically closest enumerated household to the sampled household was used to replace the duplicate. This was the definitive sample list for each EA taken to the field by the team to locate the sampled households. The actual size of the sample is as follows:

Table 2: Final sample sizes by region

Regions	Households	Pregnant Women and Mothers of Children < 2	Parents and Care-givers of School-Aged Children
ANALANJIROFO	1020	510	510
ATSIMO ANDREFANA	1170	585	585
ANOSY	1050	525	525
TOTAL	**3240**	**1620**	**1620**

TEAM TRAINING AND SURVEY PRE-TEST

A five-day workshop was held at Fenerive Est in Analanjirofo in May 2015 for data collection team leaders, UNICEF staff and members of the research consortium. Final changes were made to the French-language versions of the questionnaires and they were then translated into Malagasy. The workshop reviewed interviewing techniques and procedures for completing questionnaires and logging households visited. After the workshop, the questionnaires were pre-tested in communities near Fenerive Est and final adjustments made. Each data collection team consisted of a team leader, a controller and two researchers. The leader was responsible for training team members.

ETHICAL CONSIDERATIONS

In April 2015, the entire study protocol and the research instruments and tools were approved by the Human Subjects Research Board (HSRB) at Metropolitan State University, a subcontractor to the international team. Principal researchers were trained in ethical conduct regarding the inclusion of human subjects in research prior to starting the project.

DATA COLLECTION

Data collection began on August 9, 2015, and ended on September 22. As indicated above, each region was divided into four strata. Surveys were administered to individuals (not to households), and no substitution was permitted (i.e., there was only one survey administered per household and the respondent was chosen a priori by the enumerator team). A protocol for informed consent was followed. The data collection was supervised and monitored by the national technical team.

Table 3. Results of interviews with pregnant women and mothers of children under two years: number of households selected, occupied, and interviews successfully completed

Results	Urban	Coastal	Sub-coastal	Interior	Analanji-rofo	Atsimo andrefana	Anosy	Total
Selected	105	540	510	465	510	585	525	1620
Occupied (or identified)	104	523	500	455	496	572	514	1582
Interviews completed	104	515	492	454	488	569	508	1565
Response rate (%)	100.0	98.5	98.4	99.8	98.4	99.5	98.8	98.9

Table 4. Results of interviews with parents and caregivers of school-aged children (6 – 18): number of households selected, occupied, and interviews successfully completed

Results	Urban	Coastal	Sub-coastal	Interior	Analanji-rofo	Atsimo andrefana	Anosy	Total
Selected	105	540	510	465	510	585	525	1620
Occupied (or identified)	103	524	498	461	504	568	514	1586
Interviews completed	103	522	496	460	502	566	513	1581

DATA ENTRY

Once the required number of surveys was administered, INSTAT transcribed the data from the paper questionnaires into an exportable format. This process included creation of a dictionary, development of the data entry template, creation of a data entry application in CSPro, development of control and coherence mechanisms, and the testing of the process with completed questionnaires.

TRAINING OF DATA ENTRY OPERATORS

The quality and reliability of statistics depends not only on the data collected but the correct use of the data capture software. A three-day workshop was held in Antananarivo to train staff on the Data Entry Application CSPro, a software package used for data entry in accordance with the questionnaire structure and to check the consistency of the recorded data. This workshop also covered coding procedures for some questions in the questionnaires.

DATA CAPTURE, CLEANING AND TABULATION OF RESULTS

Following the training, data from the questionnaires was entered to generate databases. This was followed by data cleaning to identify inconsistencies and missing data. In August 2015, a three-day workshop was held at the University of Witwatersrand in Johannesburg to plan the next steps in the process of data analysis. At the workshop, INSTAT representatives and the Ohio/Wits team agreed on the variables to be used to produce descriptive tables of the results.

QUALITATIVE DESIGN

Qualitative research was conducted by six five-person teams, with two teams were assigned to each of the three regions selected for the study. Four communities corresponding to the geographic strata used for the quantitative survey were selected in each of the three regions.[13] To maintain the integrity of the research, none of the communities selected on a random basis for the quantitative study were included in the qualitative study. Each team spent two weeks in a community, collecting data through a range of qualitative research techniques including community mapping, transect walks, individual interviews, focus group discussions, and participant observation.

Table 5 lists the communities, with brief profiles. More extensive descriptions of each community can be found at the research project website: **https://madaresearch.wikispaces.com/rapports**

13. Three sites initially selected in Analanjirofo had to be substituted at the last moment by communities with similar socio-demographic profiles. The rainy season left the road between Sonierana Ivongo and Maroantsetra impassable. After a meeting at the regional Prefecture, the local authorities advised against the choice of Maroantsetra and Mananara as research sites because of security problems arising from the election campaign and the trafficking of rosewood.

Table 5. List of qualitative research sites

Region	Research site	Stratum	Principal economic activities	Notes
Analanjirofo	Ambohibe, Vavatenina district	Interior	Agriculture and cash crops (cloves, lychees, bananas, coffee), livestock raising and fishing	Substitute research site
Analanjirofo	Ambinany, Soanierana Ivongo district	Sub-coastal	Agriculture and cash crops (cloves, lychees, bananas, coffee), livestock raising and fishing	Substitute research site
Analanjirofo	Manakatafana	Coastal	On RN 5 and bank of Manakatafa-na River. Landing for commercial fishing and wholesale market.	Substitute research site
Analanjirofo	Morafeno, Fenerive Est	Urban	Small businesses, fishing, agri-culture, markets; transportation center	
Anosy	Tranomaro	Interior	Mining, seasonal agriculture (rice, cassava, maize, potatoes)	
Anosy	Tsimelahy, Tolagnaro district	Sub-coastal	Hunting and gathering (depen-dence on nature), agriculture (rice, cassava, sweet potato and corn); tourism	
Anosy	Manambaro	Coastal	On RN 13 (Antananarivo-Fort Dauphin); market and transport center, mining	
Anosy	Tanambao, Tolagnaro district	Urban	Commercial and transport center; fishing, agriculture	
Atsimo Andrefana	Ampanihy	Interior	Agriculture--rice and livestock (zebu and pigs), mohair rugs, jewelry	Migrant population; ethnic mix
Atsimo Andrefana	Sakaraha	Sub-coastal	Sapphire mining and selling; seasonal -agriculture (rice, cas-sava, maize, potatoes) and cash crops (coffee, sugar cane, cotton); ecotourism	Migrant population; ethnic mix
Atsimo Andrefana	Belalanda	Coastal	Agriculture (potatoes, cassava), fishing, daily market	
Atsimo Andrefana	Mahavatse	Urban	Poor quarter of Toliara; fishing, small shops, markets, transport	Migrant population

The teams posed questions designed to capture the complexity of perspectives and experiences relating to the EFPs by meeting with a range of community members—from mothers, parents, grandparents and other members of the extended family to government officials, traditional leaders, teachers, health workers, traditional healers, religious leaders, media professionals, NGO staff, farmers and fishermen—and to people of all ages. In doing so, they noted communication networks and direct and indirect sources of influence on attitudes and behaviours. Field notes, transcripts, photographs and other research materials were uploaded to a document management site (Dropbox). The research data were analyzed using Atlas.ti software to identify themes and tendencies.

LIMITATIONS OF RESEARCH

The quantitative research study was designed to be representative at the regional level, so it is not possible to draw national or district-level conclusions. The qualitative research would have yielded more focused data if it had been conducted *after* the quantitative surveys were administered, and a preliminary data analysis completed, as envisaged in the original research design. Unfortunately, external factors delayed the training of data collectors and, thus, the administration of the surveys. Most notably, the period of *kere* (drought and food shortages) in the South in early 2015 made it impossible, from both logistical and ethical perspectives, to conduct field research. As a result, the quantitative and qualitative studies were conducted almost simultaneously in August and September. The result was that the UA teams went into the field with no guidance from a quantitative analysis about which issues needed further investigation.

Because a total of 15 days was budgeted for research in each community, it was impossible to visit remote communities, where a return trip could take up to eight days. The election campaign period and security issues also restricted the research process. As noted above, three communities originally selected in Analanjirofo had to be substituted because of difficulty of access or potential physical danger to researchers. For a description of research challenges in the field, see « Expériences des équipes de recherche sur le terrain » at **https://madaresearch.wikispaces.com/Rapports**

A three-day workshop on using Atlas.ti qualitative analysis software was held in September, and licenses purchased for university computers. The broad scope of the research and the multiple techniques (focus groups, informal group discussions, key informant interviews, observation, field notes and photographs) required the creation of a large number of coding categories, but it was still a challenge to classify more than 2,000 items and then identify key themes related to socio-cultural determinants, communication channels and influencers.

The final limitation (although also a potential benefit) is the large amount of data. The preliminary data and analysis from INSTAT (including methodology, tables and graphs) runs to more than 160 pages, see **https://madaresearch.wikispaces.com/Rapports** Although INSTAT and Ohio/Wits agreed on variables to be analyzed at the August workshop, conducting a factoral analysis on all of them would take considerable effort and time; similarly, UA, using Atlas.ti qualitative analysis software, has not been able to analyze all the data collected. UA has compiled tables of qualitative research for each of the EFPs, see **https://madaresearch.wikispaces.com/Rapports** More data can be analyzed to meet specific needs by the sections, or by UNICEF's government and civil society partners.

GENERAL FINDINGS

RQ1: What are the socio-cultural determinants of attitudes and behaviours relating to each of the EFPs, and how do they differ by region, strata, gender, education level and other socio-demographic characteristics? What are the barriers, bottlenecks and opportunities?

The study indicates that traditional practices and social norms may have been over-emphasized as barriers to attitude and behaviour change. Given the choice, most women would prefer to complete four pre-natal check-ups (CPNs), give birth in a medical facility and have their children vaccinated. Some cultural practices, e.g. consumption of Tambavy, the ritual for disposal of the umbilical cord, and Mifana (confinement or obligatory rest after childbirth), remain strong, but in many cases the barriers relate to supply, distance and cost of services rather than to cultural beliefs or tradition. Similarly, attitudes to education are based on a rational assessment of family needs; parents may believe in the potential value of education and at the same time be dissatisfied with the quality of education available.

In **WASH**, the connections between sanitation, clean water and health are now well understood by people living in rural areas. Both the quantitative and qualitative studies indicate that soap for handwashing may be considered an unnecessary expense. The low use of community latrines is frequently the result of lack of buy-in by communities. In the construction phase, the emphasis is usually on technical issues (location, access, materials) rather than on behaviour change and ownership by rural people who may have a low level of confidence in institutional actors. The location of latrines is not a matter of free choice because local socio-spatial traditions, collectively endorsed by the community, dictate where activities take place in a village, and stakeholders, including traditional and religious leaders, need to be consulted. Latrines may also be seen as the preserve of rich people or those who can buy toilet paper while poor people rely on nature (which is free) and go "in the forest."

There are two types of basic **health** centers in Madagascar Centre Santé de Base (CSB) I and II. CSB IIs are managed by a doctor and paramedical staff and CSB Is are managed by a paramedical staff and aides. Distribution of funds and medications by government to CSBs is uneven. CSB Is, in particular, vary widely in the quality and regularity of service, and commitment of staff. Some medical personnel spend part of their time on home visits to private clients, receiving parallel payment for services and reducing their time spent at the CSB.

In some communities, health services are perceived as inaccessible or not available. They provide prescriptions and technical services such as "mandatory" vaccinations but do not provide a caring environment or patient monitoring and follow-up. As a result, medical personnel, while often considered qualified and trustworthy, may also be regarded as bureaucratic, cold and inaccessible, failing to explain diagnoses or treatments to patients, and suspected of withholding health information. Requiring advance payment for medical services exacerbates this negative perception,

particularly because health facilities broadly proclaim that health care is available to all. By contrast, traditional healers offer installment payments.

The research suggests that **education** is a strong priority for most parents/caregivers, despite barriers including distance from home to school, cost of education (school supplies, clothing and personal items for students) as a proportion of regular rural household expenses, and quality of instruction. Expectations regarding school and the reasons for education are many and varied; for example, competencies (ability to read, write, count and communicate), status, economic and parental pride. Children's education is not viewed as an end in itself but as part of a household or family strategy and thus related to other EFPs. Concrete and immediate household needs, e.g. zebu herding in rural areas, caring for younger children in urban areas, take precedence over children's schooling, and keeping children out of school to perform tasks necessary for family functioning is considered normal, because they are contributing to family life and taking responsibility.

The institution of school and the educational staff are sometimes viewed in contradictory ways. The rural population may have a low opinion of the FRAMs and local teachers recruited and paid for by parents because of frequent absenteeism[14] , poor qualifications (usually without formal teacher training and either having only a bachelor's degree or not even that qualification), lack of experience and lack of supervision or quality inspection. At the same time, education itself is regarded positively because it promises a better future for children and upward social mobility, especially by mothers who take pride in their children.

In regards to **child protection**, rural respondents indicated subjective notions of age. In their view, physiological development and sexual maturity are more important than the legal definition of a child or adult. To prevent young girls from falling into prostitution, early marriage offers one solution to keep the child at home. This results in the girl dropping out of school and leads to condemnation by institutions outside the community. The paradox is that while early marriage is prevalent in many communities most respondents in the quantitative study said they were opposed to early marriage. This raises the question of whether it is an entrenched social norm (and thus difficult to change) or simply a practice which can be abandoned given changed conditions. On the other hand, in all rural communities, rites of passage are still considered necessary to the social fabric.

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14. There are two types of teachers in Madagascar—those trained and paid by the government and the Fikambanan'ny Ray Amandrenin'ny Mpianatra (FRAM), who are hired on contract by the local parent-student association. The FRAM are less qualified and often have to seek other work to supplement their meager salaries; that may mean taking a day or more to walk to and from an urban area for work.

RQ2: Who are the key actors and/or sources of influence and networks in relation to the EFPs?

In the quantitative study, respondents were asked to identify their sources of information related to the EFPs, and to list the members of their family or community that were most influential (multiple answers were allowed). The results in Table 6 can be broken down by region or strata, if needed.

Table 6: Key actors and sources of influence

Sector	Issue	Most influential	Per cent*
Education	Source of information	School director/teacher Radio 34% Chief of fokontany Community agent	47 34 30 16
Education	Who encourages education of children?	Chief of fokontany School director/teacher	60 58
Education	Who in family talks about school?	Mother Father	67 60
Education	Who decides on education?	Father Mother Both parents	35 21 32
Child protection	Who do you talk to about child abuse?	No one Partner/spouse Another member of family	35 31 10
Child protection	Source of information about transactional sex	Radio Neighbors Community agent	36 34 15
Child protection	Source of information on legality of sexual relations	Radio Members of family/friends	45 29
Child protection	Who can prevent sexual exploitation?	Parents Community leaders Teachers Religious leaders	86 33 26 15
Child protection	Source of information about early marriage	Members of family/friends Radio Community leaders	70 47 20
Health	Source of information about nutrition during pregnancy	Midwife Health agent Family Community agent	47 47 40 30

Health	Conduct of pregnancy (family members)	Mother/father Spouse Sister/brother	54 41 16
Health	Conduct of pregnancy (community)	No one Neighbors Health personnel Community agent	42 33 23 15
Health	Who advised you to take tambavy?	Mother/father Traditional healer Myself	44 42 30
Health	Who advised you to reduce amount you ate during pregnancy?	Myself Health personnel Mother/father	47 41 40
Health	Source of information on where to deliver	No one Neighbors Health personnel	48 30 20
Health	Source of information on vaccination	Health workers, meetings Community agents Family members Radio	55 52 25 25
Health	Who decides about vaccinations for child?	Mother Both parents	66 22
Nutrition	Who advised you to give colostrum?	Mother Midwife Traditional healer Health agent	32 22 14 11
Nutrition	Who advised you to breastfeed?	Mother Midwife Health agent Traditional healer	54 25 17 12
Nutrition	Source of information in feeding baby	Community agent Family Midwife Health agent	40 38 37 37
Nutrition	Source of information on foods not to eat during pregnancy	Health personnel Traditional healer	47 28
WASH	Source of information about clean water	Community agent Health agent Radio	49 48 40
WASH	Source of information about handwashing	Health agent Community agent Radio	52 47 40
WASH	Source of information about latrines	Community agent Health agent Radio	49 40 36

*Multiple responses allowed

To summarize, the quantitative research indicates that:

Parents and family members are key sources of information/influencers on education, early marriage, pregnancy, vaccinations and nutrition.

Radio is the only frequently-mentioned mass medium[15] providing information on education, child protection and WASH, with less influence for respondents on topics related to nutrition and health.

Community agents are key sources of information/influencers on clean water, hand-washing, latrines and infant nutrition, but less influential on other EFPs. Some respondents in the qualitative research claimed that community agents focused their energies on national campaigns, but were not as active outside campaign periods.

Health agents are key sources of information/influencers on clean water, hand-washing, and latrines, and on some issues in health and nutrition.

School directors/teachers and chiefs of fokontany are key sources of information/influencers on education (but not on other EFPs). Although latrine use in schools is compulsory, enforcement of the rules is lax with school officials sometimes not venturing beyond the classrooms.

15. Scholars of mass media often caution against attributing too much power to any given channel. Oft cited is Bernard Cohen, who wrote that the media (press) “may not be successful much of the time in telling people what to think, but it is stunningly successful in telling its readers what to think about.” Bernard C. Cohen, The Press and Foreign Policy, Princeton, Princeton University Press, 1963, p. 13.

Traditional healers have influence on nutrition (including consumption of *tambavy*) and tradition is cited as an important reason for not eating certain foods. However, traditional healers are not as important as other sources/influences in health.

Across the sectors, mothers-in-law, religious leaders, traditional leaders (*tangalamena*), NGOs, television, print media and posters are identified by few respondents as sources of information or influence.

The qualitative research suggests that women in villages are often members of informal groups. In some communities the most important women are the sisters and wives of the clan chiefs, the pastor's wife (for moral authority), the traditional birth attendant or midwife and the female traditional healer. The research also indicates that religious and traditional leaders, although they lack the monopoly on in influence that has sometimes been attributed to them, still wield influence in communities and need to be included in decision-making. The maternal uncle, who according to some anthropological studies has historically played an important role in areas such as education and marriage decisions, was rarely cited, indicating a declining influence. The qualitative research indicates that the *tonton* (uncle), a word used by young people to describe an older male who becomes a "social godparent," remains influential. For various motives, the *tonton* offers to help young people, especially those who are living away from home for education or work.

COMMUNITY-LEVEL COMMUNICATION NETWORKS

The qualitative research identified locations where people gather, and which provide opportunities for group-based communication. Such locations are determined by geographic strata (urban or rural), region, season or day of the week. In other words, the time and place of the intervention needs to be adjusted to the daily or weekly rhythms of the community. For example, in Mahavatse, a *bidonville* in Toliara (Atsimo Andrefana), people gather in markets and at water points at various times; however, the major event of the day that brings out many people is the return of the fishing fleet in the late afternoon or early evening.

Markets offer opportunities for group communication, e.g. through PA systems or megaphones, and also for circulation of simple print materials. Among the communication channels listed by the team in Tsimelahy (a sub-coastal region in Anosy) was the *sirikliaira*, a circular distributed on market day. Sample announcement: "Réunion sur la rivière Tarantsy (points d'eau) = approvisionnement en eau de Tsimelahy" [Meeting about the Tarantsy River (water collection points)—water supply for Tsimelahy].

Additional meeting points for potential "intercept" interventions:

Water collection points (points d'eau), communal pumps (bornes fontaines), or at river banks for women and young girls;

The homes of local leaders, influencers or people of importance

Churches, schools, health centers, community festivals such as the *tsarboraha* in Analanjirofo or the *havoria* in the South;

For young people: neighborhood video/CD stores/stalls, video games and Internet cafes, night clubs, karaoke bars, *jiromena* and other scheduled or more occasional social events from Thursday evening to Sunday.

Some respondents in the qualitative research stated that the ***jiromena***, karaoke bars, community dances and other youth-oriented social events (some of them sponsored by communes or villages) contribute to transactional sex and drug and alcohol abuse. However, they are the places where young people gather, and so offer opportunities for C4D interventions. Rather than condemn them, we should be thinking about how music, dance and peer interaction can provide opportunities for promoting EFPs.

The qualitative research indicates the importance of localizing communication, and identifies some specific linguistic practices. An example from the team in Tsimelahy (Anosy): « Takasiry (famille) c'est le moment ou les enfants peuvent partager les connaissances acquises à l'école (ou dans le champ avec d'autres enfants) sous forme de devinette. » [Family time is the moment when the children can share knowledge gained at school (or in the fields with other children) in the form of a riddle.]

RQ3: Which communication channels/media are available and trusted in relation to the EFPs?

MASS AND TRADITIONAL MEDIA

At the national level, the MDGs study (2013) reports that 43% of women aged 15-49 *are not exposed to any form of media* even at least once a week. There is only a slight difference among generations, but there is a significant difference between urban and rural areas. Media exposure varies with the level of education. Radio is the most common medium among women (49%), followed by television (23%). Only 18% of women read a newspaper at least once a week. Similarly, 38% of men (aged 15-49) are not exposed to any media, even at least once a week. Again, there is little disparity based on age, but significant differences between urban and rural areas. As with women, media access and exposure increases with higher levels of edu-

cation and income. Once again, radio is the most common medium of information, followed by television and then print media. The socio-demographic data gathered for the 2015 study broadly support the results of the 2013 MDG study, indicating that many people, especially those in rural areas, are not reached by media (radio, television or newspaper). Almost two out of three (62.3%) pregnant women and mothers with children under two years old and more than half of parents/caretakers of children aged 6-11 (52.7%) reported that they are not exposed to any media at least once a week.

Given low literacy levels and lack of electricity in rural areas, radio is the principal medium. One third of pregnant women/mothers and 43.5% of parents/caretakers listen to radio at least once a week. Geographical disparities exist with more than 70% from both respondent groups in interior strata stating that they have no media access. In Anosy and Atsimo Andrefana, mothers of children under the age of two and parents/caretakers with children aged 6-18 were more likely to report "no access whatsoever" to media than in Analanjirofo. However, even in that region nearly one third of parents/caretakers also reported having no media access.

Media access also varies by education level. Almost nine out of 10 mothers (86.1%) with no education had no media access, compared to only 29.7% for those with a secondary education; for parents/caretakers, the rates were 78% and 20% respectively. Age and marital status had no significant impact on media access.

Previous media studies by UA indicate that national billboard or poster campaigns on social issues that use technical or pejorative language do not reflect the experience of rural communities and are usually ineffective in changing attitudes and behaviours.

MOBILE PHONES AND INTERNET

Use of mobile phones is growing, but still only one in four respondents in the quantitative survey reported having access. For pregnant women and mothers with children under the age of two, 24% reported that there was a phone in their home; 86% of them said they had access to it. For parents/caregivers of children aged 6-11, the rates were 27% and 96% respectively, and for both groups, there was no significant difference across regions. The qualitative research indicates that in some rural areas, the phone, like other communications media such as a newspaper or radio, is often shared, at least with the extended family if not the community; although the purchase of the phone is a private transaction, its use is communal. Because of the lack of electricity, a new part-time occupation, the "chargeur de telephone" (using a car battery or solar panel), is also emerging.

Although lack of money makes it impossible for many families to own a mobile phone, usage will likely grow and provide opportunities for EFP-related messaging. Because interpersonal and small-group communication, in both formal and infor-

mal settings, is key to attitude and behaviour change, mobile phone use can be leveraged to reach people other than the actual users. The most cost-effective strategy may be SMS messages that target groups rather than individuals; in other words, a two-step communication approach[16] where the receiver of the SMS relays the message to community members or neighbors, serving as a "multiplier" and also translating or "localizing" the information when necessary. However, even if the digital divide is reduced by increased access to mobile technologies, some people, especially in rural areas and with low literacy, will lack the skills to take advantage of it.[17]

Internet access for the two target populations is negligible: only 1.1% of pregnant women or mothers with children under the age of two, and only 1.9% of parents/caretakers of children aged 6-11 have access. Rates are higher in urban areas and for those with more education, but still not high enough to justify investment. As with mobile phones, the "multiplier" effect may be important, with Internet users communicating to others by word-of-mouth. The quantitative survey did not include adolescents, but qualitative research indicates that Internet cafes are a popular gathering place (in urban areas and conurbations, even in rural areas, and especially on market days) for teenagers and young adults, raising the possibility of interventions around education and child protection. It should also be noted that young people combine digital media. For example, the communication channels noted by the team in Manambaro (fokontany Tsihary) in Anosy included, « radio card (possession de clé USB contenant des chansons de Barinjaka » and « téléphone foza de Telma avec lecteur MP3 (fichier audio). »

TRADITIONAL MEDIA

In general, community-based media, such as theatre or projects involving local artists and musicians, are seen as relevant and effective channels of communication because they use regional dialects and are regarded as locally originated, not imposed from the outside. These popular forms of cultural expression should be promoted locally, not through national campaigns. The qualitative study also noted that in some communities the *dalala*, a village crier (similar to a drummer in some African cultures) can serve as a communicator for health or education information. Because attitudes and behaviours are influenced by multiple communication channels, traditional media can become part of an overall communication strategy in which other networks and media are used.[18] However, the potential role of the *dalala* as a communicator was not examined in the quantitative research, so any strategy using this or other forms of traditional media would need to be based on a local assessment.

16. The "two-step" model of communication is supported by substantial (if somewhat dated) research on mass communication. See: Katz & Lazarsfeld (1955). *Personal Influence*. New York: Free Press.

17. Van Deursen, A. & van Dijk, J. (2010) 'Internet skills and the digital divide', *New Media and Society*, 13(6), 893-911.

18. De Certeau, Michel, 1980 : 62-63. L'invention du quotidien. Les arts de faire. Paris: Gallimard, 1990 [The Practice of Everyday Life, trans. Steven Rendall, Berkeley: University of California Press, 1984].

FINDINGS BY SECTOR

The section briefs address the following research question:

RQ1: What are the socio-cultural determinants of attitudes and behaviours relating to each of the EFPs, and how do they differ by region, strata, gender, education level and other socio-demographic characteristics? What are the barriers, bottlenecks and opportunities?

NUTRITION

Nutrition EFPs :

1. Pregnant and lactating mothers seek an appropriate nutrition (EFP1-N)
2. Mothers of children aged 0- 6 months practice early initiation of breast-feeding and practice exclusive breast-feeding of their infants (EFP2-N)
3. Mothers of children aged 6 - 23 months provide varied and sufficient diet (EFP3-N)

Research Results: EFP n°01: Pregnant and lactating mothers seek appropriate nutrition (EFP1-N)

Maternal nutrition and dietary customs have intergenerational consequences, affecting both the mother and child. Widespread poverty and fragile food security are the major obstacles to improving maternal nutrition, and to providing mothers an adequate and balanced diet. Many families depend on subsistence agriculture; more than 90% of households live on under US $2 per day and more than one third are classified as suffering from food insecurity (ENSOMD, 2012). With large numbers of children, many families find it impossible to adequately feed all family members. It is estimated that 27% of women of child-bearing age suffer from malnutrition (Sitan 2014). Adverse conditions—annual cyclones in Analanjirofo, drought in Anosy and Atsimo Andrefana--increase household vulnerability, and the amount and variety of foods available in most regions varies by season. The poor road network makes it difficult and expensive to transport food. The subordinate social status of women, traditional nutritional customs and taboos, and men's control over family spending contribute to the inadequate nutrition of women.

When asked if they had received information about nutrition during their pregnancy, 46% of women reported that they had. The most common sources of information were:

Midwife 47%

Health agent 47%

Family 40%

Community agents 30%

Radio 16%

Neighbors/friends 10%

Other sources (television, posters, and traditional healers) were reported at less than 10%. In the qualitative study, some respondents attributed poor nutrition habits to lack of knowledge, the absence of public nutrition centers in some districts or lack of information provided by center staff.

Almost half (48%) of pregnant women report taking *tambavy*[19] during pregnancy. 80% of these women reported doing so because it was good for their health; 44% said they were advised to take it by a parent and 42% by a traditional healer. Across the three regions, 38% of women reported eating less as their delivery date approached; about half said it was their own decision, and about 40% named a parent or health worker as the source of advice. 79% of these women reported having done so to make their delivery easier or to avoid a large baby. Qualitative data suggests that pregnant women may be eating less for an "easier delivery" to address the issue of difficult or no access to health clinics.

About one in four (22%) of women said there were foods that a pregnant woman should not eat. Asked why, 41% cited tradition; traditional healers (19%) and health personnel (17%) were also listed as influencers. In interior regions of Anosy, some reported that the jack fruit is not eaten because of a belief that its rough exterior texture could lead to the death of the baby; in Analanjirofo, some vegetables and fruits, including bananas, are not eaten for fear that they could make the baby too large, resulting in a difficult birth. In Atsimo Andrefana, which suffers from periodic droughts and high poverty levels, respondents in some urban areas reported that fruits and vegetables recommended for pregnant women were perceived as luxury items. This qualitative data about localized practices serves a reminder that C4D interventions are more effective when tailored to specific contexts.[20]

19. Tambavy does not have an exact English translation: it is a plant-based traditional medicine substance taken as a sedative or as a 'cure-all' remedy. See World Bank Working Paper (2006), Participatory Approaches to Attacking Extreme Poverty, p. 42.

20. Airhihenbuwa, C. (1995) Health and Culture: Beyond the Western Paradigm, SAGE, Thousand Oaks, CA.

Research Results: EFPn°02: Mothers of children aged 0- 6 months practice early initiation of breast-feeding and practice exclusive breast-feeding of their infants (EFP2-N)

Maternal breastfeeding is widely practiced in Madagascar with almost all children (98%) breastfed. However, this study confirms the finding of the 2013 MDGs study that immediate breastfeeding (within an hour of birth) is practiced by less than two out of three mothers. The rate has declined from 72% in 2008 (Sitan 2014). According to the EDS (2009) about half of children aged less than six months are exclusively breastfed. The rate of exclusive breastfeeding is highest in the first two months, and then rapidly drops in the 4th-5th month when almost 70% of children receive other liquids or complementary foods. Agricultural work or day labor contracts often prevent women from exclusive breastfeeding for six months. The mean duration of breastfeeding is estimated at 21.9 months, and of exclusive breastfeeding at 2.3 months.

There is considerable variation in the rate of breastfeeding by region and strata. Educational level and a birth assisted by a skilled birth attendant or at a health center seem to have a positive influence on the practice of breastfeeding (EDS 2009). Rates are lower in the South where only one in four (26.6%) practice exclusive breastfeeding for six months and 45.5% immediate breastfeeding (MICS 2012).

The majority of women are convinced of the benefits of breastfeeding their children, and almost all (99.9%) claimed to have done so. The mother (54%), midwife (25%) and health agent (17%) were the most important influencers; however, 29% said that no one advised them to breastfeed, indicating that the practice is almost universally accepted. Across the three regions, three out of four (75%) respondents reported that they gave their newborn child first milk (colostrum) on the advice of a mother (32%), midwife (22%), traditional healer (14%) or health agent (11%). This finding appears to contradict other studies (such as USAID/Mikolo, 2014)[21] which state that the advantages of colostrum are not widely known, and that it is sometimes discarded. In Atsimo-Andrefana, 52% of respondents reported giving liquids within the first three days, compared to 34% for Anosy and 15% for Analanjirofo. Liquids such as water (53% reported) and sugared water (20% reported) are introduced a few hours after birth to relieve the baby's dry throat and to help digestion. The increase in breast milk depends on the mother's body and the quality of post-birth nutrition. Tambavy was mentioned by 33% of respondents who reported giving liquids within the first three days, although only in the two southern regions (36% and 42% for Atsimo-Andrefana and Anosy, respectively).

21. USAID Mikolo Project, Formative Research Report (2014) Identification of obstacles to healthy behaviours, p. 31:"The first milk (appearance, taste) is considered bad and unclean "and can cause diarrhea."

Other reasons cited in the qualitative research for supplements include the perceived insufficiency or poor nutritional quality of the maternal milk and concerns that the energy needed to pump breast milk makes the mother, already tired from giving birth, even more tired.

The practices of first giving teas (while waiting for the milk) and at four months boiled foods (flour, maize, etc.) in the belief that the child will grow faster are still prevalent. 44% of respondents reported that they provide additional food to children under six months. Two thirds of these (68%) reported that they began giving their child additional food at four months. Of the supplements provided, the most common are: *ranombary*[22] (67%); tea (34%); rice (24%).

Research Results: EFP n°03: Mothers of children aged 6 - 23 months provide varied and sufficient diet (EFP3-N)

In Madagascar, the National Nutrition Policy (2004) follows the guidelines of WHO and UNICEF for young children's nutrition. These recommend exclusive breastfeeding in the first six months followed by the introduction of complementary foods rich in nutrients, with breastfeeding continuing until the age of two. Among children aged from 6 to 35 months, 79% had consumed food rich in vitamin A and 46% foods enriched with iron. Food consumption increases with age, but it should be noted that children who have not been breastfed are fed more frequently than those who have been. For example, 58% of breastfed children had eaten fruits and vegetables rich in vitamin A, compared to 63% of those who had not been breastfed, and 41% of breastfed children ate foods such as meat, fish, poultry and eggs, compared to 53% for non-breastfed (EDS, 2009).

According to the MICS, among children aged 6 to 23 months, regardless of whether they had been breastfed, more than one third (38%) had received at least four different food groups and two thirds (68%) the minimum frequency of meals. Less than one quarter (22%) received "sufficient" nutrition, which relates to both the minimum frequency of meals and at least four food groups (nutritional diversity).

60% of respondents said they had received information about feeding a baby; four sources were ranked almost equal—community agent (40%), family (38%), health agent (37%) and midwife (37%). Almost all (99%) respondents reported that their children aged 6 - 23 months had eaten solid, semi-solid, or other foods in the past day or night. Of these, 82% were still being breastfed. One in four (25%) reported providing four or more complementary feedings to their 6 - 23 month old child; 48% reported providing three complementary feedings, and 26% one or two. Four out of five (80%) reported that their 6 - 23 month old child had their own plate for feeding.

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22. Ranombary has several methods of preparation but typically refers to the milky water that arises from soaking rice or from the top milky liquid that sits on top of boiling rice.

While the majority of women report that they plan to breastfeed their child until at least 24 months of age, the reality is that a much smaller number actually do. In fact, the mean age at which women reported ending breastfeeding was 16 months, while the mean age at which women who had just started breastfeeding reported *planning* to stop was 24 months.

HEALTH

Health EFPs:

4. Pregnant women seek 4 pre-natal consultations (EFP4-H)[23]

5. Mothers have children aged 0- 23 months vaccinated according to the calendar (EFP5-H)

Research results: EFP n°04: Pregnant women seek 4 pre-natal consultations (EFP4-H)

The practice of CPNs is beginning to be followed in rural areas. The 2008 DHS and 2012 MDG studies indicate that about 50% of pregnant women make the recommended four or more CPNs. According to the DHS, about 27% make the first CPN within the first 4 months; about 42% come in at about 4-5 months, another 20% in the 6th-8th month of pregnancy. About 37% make 2-3 antenatal care visits; it is likely that they don't make the 4th visit because they start antenatal care too late to incorporate a 4th visit.[24]

Among family members, respondents cited the mother or father (54%) or spouse (41%) as the most influential concerning the conduct of the pregnancy; in the community, neighbors (33%) and health personnel (23%) were most influential. However, 42% said that no one in the community had had an influence on their decision-making.

The rates of completing four CPNs are lowest in the South—51% in Atsimo Andrefana and 55% in Anosy. In Analanjirofo, two thirds of pregnant women (66%) complete four CPNs. As with other EFPs, e.g. vaccination, the rates are highest in the urban areas, and lowest in the interior.

23. The UNICEF Health section requested additional data on birth/delivery (accouchement), which is provided below.

24. The qualitative research suggests that some people think the child does not exist until the fetus develops and a perceptible heartbeat is heard; in early pregnancy, the fetus is perceived as non-human, as a *biby an-kibo* (little beast of the belly) or *raha* (thing). Some respondents cited a belief that pregnant women have evil powers, leading women to hide their pregnancy until the 5th month. More research is needed to learn if such beliefs are held by a significant number of people, or are restricted to small numbers or specific communities.

Women who did not complete a CPN within the first four months of their pregnancy listed four main barriers:

Midwife 47%

Distance from the health center 21%

Too busy/no time 19%

Ignorance/unfamiliarity 17%

Other reasons included fear of the health agent (3%); following the advice of a traditional midwife (2%); too expensive to get to the health center (3%); advised against going by a family member (1%).

The qualitative research supports this analysis with respondents citing distance from the health center, the costs of travel, the absences of medical staff, and long waiting and consultation times as reasons for not seeking care. Some respondents said that they relied on traditional healers or birth attendants for care during pregnancy, because of local practice and unwillingness to spend money on health care; others stated that they did not understand the purpose of CPNs. Many respondents, however, understand and follow other pre-natal advice: 73% of women reported taking folic acid during pregnancy, for example.

Across the three regions, the practice of CPNs is closely tied to educational level and economic activity. Only 41.6% of mothers without primary education made four CPNs, whereas 61.8% of mothers who completed primary education did. Mothers working in agriculture were 12% less likely to complete four CPNs as those working in other occupations, all other factors being held equal. In Atsimo Andrefana, women who have completed some primary education are 2.6 times more likely to make four CPNs as those who have no education, and those with some secondary education 4.4 times more likely. In Analanjirofo, age and completion of some secondary education are the statistically significant factors.

A multivariate analysis shows that four factors--distance from health center, advice of a midwife, age and education--were predictive of the likelihood that a pregnant woman will report receiving four or more CPNs.

Respondents stated that community health workers, neighbors, community agents and close family members were most influential in the decision to seek CPNs. Traditional healers and birth attendants were least likely to recommend CPNs.

Research results (supplement): Birth/delivery at medical facility/health clinic

According to the MICS (2013), in the South three-quarters of maternal deaths occur during delivery. It is necessary to provide mothers with affordable, convenient access to assistance by qualified medical staff during delivery. Increasing the number of births in health facilities is important to reducing risks for the mother and her baby.

Two thirds of mothers with children under two years said they delivered at home, either in their own home (46%) or in someone else's home (20%). About one quarter said they delivered at a community health facility and 6% in a hospital. When asked who in the community advised them on where to deliver (multiple choices allowed), neighbors were cited by 30%, health personnel 20%, community agents 11%, and traditional birth attendants 11%; almost half (48%) said no one.

Of respondents who did not deliver at a health facility, 45% said it was because it was too far away, 16% said it was too expensive, and 12% said it was not necessary. In Analanjirofo, distance was the barrier cited by 62% of mothers; in the south, particularly in Atsimo Andrefana, the cost of delivery was listed as the second most important reason. These findings are supported by the qualitative research, with respondents noting a range of barriers including "the distance to travel to health centers, the frequent absence of staff and the shortage of supplies and equipment"; and "costs of delivery at a health center—travel, food, medical expenses—compared with delivery by a midwife." Fees include an obligatory "gift" to the medical staff, depending on the sex of the newborn (more for a boy than a girl).

The barriers to delivery at a medical facility appear to be structural rather than a result of custom or belief. Of respondents, 90% said they would prefer to deliver in a health facility to protect their health. Another incentive for delivery in a health center, noted in qualitative research in Toliara (Atsimo Andrefana), may be that a birth certificate is issued. With a home delivery, the mother would need to travel to an administrative office to obtain the birth certificate, involving cost and bureaucracy.

Just over one third reported that qualified medical personnel (30% nurse or qualified midwife, 5% doctor) assisted at the delivery. 11% had a trained traditional birth attendant, 31% an untrained traditional birth attendant, and 19% parents or friends.

Some traditional practices related to birth remain strong. To prevent bad spirits from interfering with the health of the child, 90% of respondents agreed with the statement that the placenta and umbilical cord should be buried. 98% said they buried the placenta, and 99% of them said they did this for traditional reasons. With the umbilical cord, 42% buried it, 35% kept it, and 22% said they did some-

thing else with it ('other'). In all regions of Madagascar, the umbilical cord is a symbolic link to place and ancestral descent, so people are careful to return it to their community in one form or another. An analysis of the Malagasy responses to the 'other' category reveals that many put it in "the place for throwing away umbilical cords" or "the ancestral lands" or buried it in the forest or rice fields. In Analanjirofo, estuaries and rivers are important places of identity and ancestral belonging, with descent groups associated with particular estuaries. In this region, most said they threw the umbilical cord in the river or in the sea or "dropped it in running water," symbolically returning it whence it came. Giving it to cattle to eat also returns the umbilical cord to the source of ancestral wealth: cattle. The anomaly was "throwing it on the rubbish heap," because this leaves it exposed.[25]

There do not appear to be bureaucratic barriers to the disposal of the placenta and umbilical cord, and the practice does not pose health risks. However, the cultural significance of the placenta and umbilical cord needs to be noted. Any public health policy that restricted the rights of families in this regard would be a disincentive to delivery in a health facility.

Research results: Essential Family Practice EFP n°05: Mothers of children aged 0- 23 months ensure their children are vaccinated according to the calendar (EFP5-H)

The study indicates that most mothers are well informed of the benefits of vaccinations, and want to have their children vaccinated. There are no significant socio-cultural barriers to vaccination, or strong anti-vaccination feelings, except among a few ethnic or religious groups. Of the two main barriers cited by parents, "distance to health centers" and "missing the time when vaccinations happen," the latter provides potential for change via communication for development. In terms of "distance," the barrier may not be physical (i.e., number of kilometers) but lack of a safe route through a forest or a bridge across a river. In all three regions, respondents said that communication by local health officials was more effective than national campaigns, and recommended that vaccinators come to villages at key times rather than only during vaccination campaigns.

The rates of complete vaccination for children vary somewhat according to the data sources. UNICEF research indicates that the percentage of children completely vaccinated declined from 47% in 2003 to 38% in 2012 (Sitan 2014). The DHS (2009) reported that 55% of children aged 1-12 months were completely vaccinated according to the recommended schedule. In the group aged 12 to 23 months, almost two thirds (62%) received all the PEV vaccines, that is one dose of BCG (the first required vaccine), three doses of DTC, three doses of polio and one dose of measles vaccine. The data indicate a higher coverage rate in urban (81%) than in rural areas (60%). The MICS (2012), conducted in four regions of the South, reported that among children aged 12 to 23 months, almost two thirds (64%) had been vaccinated against tuberculosis and less than half against polio, measles, diphtheria, tetanus and pertussis (DTC).

25. Translation and analysis of responses by anthropologist Dr. Luke Freeman of University College, London.

Independently of the vaccination calendar, there is significant variation in rates between the three regions. Analanjirofo ranks highest with 91.7% of mothers claiming their children have been vaccinated; in Anosy, the rate is 82.48%, but in Atsimo Andrefana only two out of three (64.78%) say their children have been vaccinated. Almost half (46%) of respondents presented a vaccination card to the data collector; these showed that 93% of children had been vaccinated for BCG (the first required vaccine).

The vaccination rate is lowest (60%) among mothers without any primary education or jobs outside the home. Vaccination rates increase according to the education level of the mother; for those who finished primary school, the rate is 72%, and for those who completed secondary education 85%. This correlation underlines the cross-sectoral impact of improvements in school enrollment and retention.

Vaccination rates correspond with media use. Three out of four mothers (75%) who listen to the radio at least once a week had their children vaccinated, and the rate for those who watch television or read newspapers (89%) is even higher. Media use is closely related with educational and literacy levels, so media are not an independent variable; in other words, media reach mostly those who, because of their educational level and employment status, are already more likely to vaccinate their children. Media coverage also remains limited, with only one in three mothers of children under two years listening to the radio at least once a week (the rate is higher for parents/guardians of school-age children, but still under 50%).

For those who did not choose to vaccinate their infants (19% of all respondents), the most cited reasons were the following: “Missed the time for the vaccinations” (26%); “Distance” (57%).

The practice of *Mifana* (confinement or obligatory rest for 3-6 months following birth) has been cited as a potential barrier to vaccination. The study showed a statistically significant relationship between the length of *Mifana* in weeks and the likelihood of vaccination. Those mothers who were secluded for 0 - 2 weeks were more likely to vaccinate their children than those who practiced *Mifana* for more than two weeks.

Some qualitative studies suggest that fears or taboos about needles may be barriers to vaccinations. This is not supported by the quantitative research as a widespread phenomenon. No participants who chose not to vaccinate their children reported that it was “taboo” and the number listing “fear of needle” was not significant. However, several said they perceived their child/ren to be too young for vaccination. Other reported barriers—the fear that the vaccination could lead to fever or illness, paralysis, or other complications—were also not supported by the quantitative data. There was also no data to support the perception that some people did not recognize the benefits of vaccination because they saw healthy, working people who had not been vaccinated.

It has been argued that fear of going to health centers and public offices is a barrier. This is tied to the concept of *gasigasy* and the perception that vaccines are a "*vazaha*" imposition. (In this context, "*vazaha"* refers to people of a different economic or social status, including government officials, doctors, health workers, not only foreigners). However, 96% of respondents agreed or strongly agreed with the statement "I have confidence in the advice about vaccination I receive from the health center."

There is a statistically significant relationship between the declaration of a religion[26] and the likelihood of reporting having vaccinated a child, with those declaring any religion more likely to report vaccinating the child. In addition:

Perception of risk was significantly related to non-religious status, with those stating "no religion" less likely to agree or strongly agree that their child would be at risk without vaccination.

Impact of non-vaccination on others was significantly related to non-religious status, with those stating no religion less likely to agree or strongly agree that non vaccination could make their child and others ill.

Overall, however, it appears that most mothers are aware of the benefits of vaccination, and that access and timing are the principal challenges. Most respondents reported knowing the benefits of vaccination:

94% agreed or strongly agreed that they could benefit from vaccinating their child

92% agreed or strongly agreed that not vaccinating could lead to a serious illness

88% agreed or strongly agreed that not vaccinating could lead to an illness than could cause others to become ill

Among respondents, 91% reported that they had received information about vaccination. Among these, the most frequently mentioned sources were:

Health workers, posters and meetings 55%

Family members 25%

Neighbors 19%

Community agents 52%

Radio 25%

26. Except for Adventists in Atsimo Andrefana and Anosy who oppose modern medicine.

EDUCATION

Education EFPs:

6. Parents and caretakers of children aged 6 - 11 years enroll children in primary school (EFP6-E)

7. Parents and caretakers of children aged 6 - 11 years ensure that their children finish primary school (EFP7-E)

Research Results: EFP Nos. 6 & 7: Parents and caretakers of children aged 6 - 11 years enroll children in primary school (EFP6-E); Parents and caretakers of children aged 6 - 11 years ensure that their children finish primary school (EFP7-E).

Although education is compulsory from the age of six and is a national priority, Madagascar is far from the goal of attaining universal primary education. According to the 2012 MDGs study, the net primary education enrollment rate is 69%, a substantial decline from the 2005 rate of 83%. About 1.5 million children of school age are estimated to be out of school and only three out of 10 children who start school complete primary education (UNICEF CPD, 2014). More than three quarters (78%) of the population has completed primary education, and about one third (31%) secondary education (EDS 2009). There is gender parity in primary education; in the southern regions, the enrollment ratio for girls is slightly higher than for boys. There is variation in access to education and the quality of schools and teachers. In general, education is poorest in rural areas, which depend on subsistence agriculture or zebu herding, better in urban areas with a more diversified economy and where schools are within walking distance. In towns and mining communities, private schools have been established to meet the needs of families who can afford to pay for education.

In this study, parents and guardians reported that almost two out of three (1,376/2,167—64%) children aged 6-11 were enrolled in school. There was no significant difference in the proportion of girls and boys enrolled.

Enrollment rates varied by region. In Analanjirofo, 92% of respondents reported that their children aged 6 - 11 were enrolled in the previous year; in Atsimo Andrefana this dropped to 57% and in Anosy to 53%. Of the children who are unenrolled, half (50%) are involved in domestic tasks. 38% are reported to be involved in neither domestic tasks or income generating tasks; 11% are reported to be involved in both domestic and income-generating tasks.

A central theme in several qualitative studies (including UNICEF's 2013 mapping study) is that parents do not see the value of education, and believe that completing school will make no difference to the child's or the family's future. Children are a source of labor and income to their families; education does not form part of the traditional tasks allocated to family members (domestic work, child care, working in fields, herding of zebus) and does not meet immediate needs.

This study found that the vast majority of respondents (92%) believe that their children should attend school. A small percentage, particularly in Anosy, believe that their children should assist with domestic tasks. About one sixth (13%) reported that there are cultural practices, traditions or beliefs that do not support the enrollment of children in school; these reported beliefs or traditions are more prevalent in Anosy than in the other two regions.

In regard to retention, 4% of parents/guardians reported that they had a child who had dropped out of primary school, and 6% reported that their child had missed a month or more of school in the previous year. The primary reason reported for a child missing a month or more of school was the absence of teachers (29%). There are two types of teachers in Madagascar—those trained and paid by the government and the Fikambanan'ny Ray Amandrenin'ny Mpianatra (FRAM), who are hired on contract by the local parent-student association. Government teachers are generally better qualified; they require certification and continued teacher training. However, especially since the 2009 political crisis, there have been periods when they have not been paid for months, forcing them to seek other work and making it difficult to keep them accountable. The FRAM are less qualified; however, because they are paid by the parent-student association, they are more accountable and cannot be frequently absent and keep their jobs. Understanding the dynamics of the education sector requires determining the teacher type and the strength of the parent-student association.

10% of respondents reported that girls do not attend school during their menstrual cycle. The qualitative research suggests that some school absences may be related to nutrition; some children do not eat (or do not eat enough) before coming to school and therefore are unable to concentrate.

In the case of students who were enrolled at one time but had withdrawn from school in the past year, most withdrew in class T1 or class T2; again, the rates of withdrawal were higher in the two southern regions than in Analanjirofo. Of those who dropped out, approximately 75% reported being involved in domestic work or zebu herding far from their home (also considered a domestic task). Most respondents (88%) believe that it's possible for a child who drops out to be readmitted or reintegrated. However, only 25% were aware of the possibility that a child who dropped out could retake a grade level.

Sources of information and influencers

Radio is the most important mass medium, with 43.5% of parents and guardians saying they listened to radio at least once a week. Four out of five (81%) of those who listened to radio said they had heard messages about enrollment. When asked from whom they received information regarding enrollment, respondents reported the following:

School director/teacher 53%

Radio 34%

Chief of fokontany 30%

Community agent 16%

Association FRAM 14%

The chief of the fokontany (60%), the school director/teacher (58%) and traditional leaders were also listed as the most influential in encouraging enrollment; only one in 10 respondents mentioned a religious leader. When asked about the content of discussions with these individuals, respondents reported: necessity of enrolling children (82%); advantages of enrolling children (71%). In contrast, **completing** primary school was mentioned as important by only 26% of respondents.

CHILD PROTECTION

Protection EFPs:

8. Parents /caretakers of children (10 – 18) disallow children to marry before the age of 18 (EFP8-P)

9. Parents /caretakers of children (10 – 18) adopt non-violent behaviours towards their children (EFP9-P)

Research Results: EFP No. 8: Parents /caretakers of children aged 10 – 18 years disallow children to marry before the age of 18 (EFP8-P)

Child marriage is prevalent in Madagascar, with close to half the female population aged 15-49 married before the age of 18,[27] the number being higher in the South (65%). About 12% of the female population report marriage before 15 years of age. Early marriage often results in teenage pregnancies and contributes to maternal mortality and morbidity. As of 2012, 37% of women aged 15 to 19 years reported having started their reproductive life (UNICEF CPD). Males tend to marry later than females. Typically, parents arrange marriages for their children at a very early age, sometimes even at birth. Early marriage can be a means of economic gain or persevering kinship or village ties.

The study reveals disparities between practice and attitudes. Despite the prevalence of early marriage, 77% of respondents reported that they were either "against" or "entirely against" marriage under the age of 18. Only 15% said that they would like their daughters to be married under the age of 18; 8% said that they would like their sons to be married under the age of 18.

Of course, some respondents may have been giving what they considered to be the 'right' answer to the data collectors. On the other hand, if early marriage is a deeply entrenched social norm, the fact that three out of four respondents say they are opposed to it is significant. 39% of respondents reported that there were cultural practices in their community that encouraged early marriage. In contrast, 24% reported that there were cultural practices that discouraged early marriage. Qualitative research indicates that some parents marry their daughters in adolescence to stop them from "falling into prostitution." Marriage was also mentioned by parents

27. Randriamasitiana, Gil Dany, « Le mariage (précoce) dans la société Malgache : enjeux sociaux, économiques et relationnels. » Conférence-débat « Les aspects socioculturels et juridiques des mariages des enfants et de toute autre forme d'exploitation des enfants qui s'y apparentent à Madagascar » 02 juin 2015, Antananarivo. « Le mariage n'a pas d'âge compétent. Il n'est pas rare de voir de toutes petites filles mariées à des hommes vieux. …L'adultère, s'il est constaté par le mari, entraîne une amende de bœufs pour le complice. Le mari oublie très vite l'injure faite à son honneur si les bœufs donnés sont nombreux ». Rajohnson, (1908) « Etude sur les Antanosy et les Antandroy» In *Bulletin de l'Académie Malgache*, Vol. VI, Tananarive, Imprimerie Officielle de la Colonie, p. 177 – 196, ici, p.183

as a financial opportunity or as a way of preventing the child from going far away from the village. Some respondents said that the practice is endorsed by community leaders who often themselves marry young girls.

Child marriage is most commonly practiced in the South. In Anosy, 24% of respondents reported that they would like their daughters to marry under 18; in Atsimo Andrefana the rate was 19%. Cultural practices encouraging early marriage were also more likely to be mentioned in these two regions.

The issue is complex, because there is no common definition of marriage in Malagasy society. In rural areas, relationships are marked by traditional ceremonies—from the *tampi-maso* or *tako-maso* ("covering of the eyes") when parents acknowledge the existence of a sexual relationship, to the *vodiondry* ("sheep's rump") when families are brought together and gifts, zebus or money exchanged as a social contract. In other societies, such marriages would be regarded as common-law relationships, and many are not legally recorded. Marriage can also be classified by the type of arrangement:

- **Early marriage: marriage of older men, wealthy or not, to young girls;**
- **Marriage arranged from birth or by birth (between families or lineages);**
- **Marriage with a member of the family[28] to avoid the dispersion of the family patrimony;**
- **Marriage to form economic or political alliances with other families, clans or villages; and**
- **Polygamy: forbidden by law, still practiced throughout the country, most often in rural areas.**

Almost two thirds of respondents (61%) reported having heard of the concept of early marriage. Seven out of 10 (70%) cited family members or friends as the source of information; almost half (47%) reported hearing about it on radio. Awareness of the concept was significantly associated with a wish for their children to marry at 18 or older. Almost half (46%) reported knowing about laws concerning child marriage and 50% knew that the legal age of marriage in Madagascar is 18. A relatively small percentage (10%) of respondents reported that child marriage is a form of child abuse.

28. Restricted to non-uterine members of the family, e.g. there would be no marriage between children of two sisters.

Fathers are most likely to be the decision makers regarding marriage before the age of 18; 75% of respondents reported that the father would make the decision for a son and daughter. Mothers were more likely to be involved in the case of their daughters, with 12% of respondents reporting that a mother would make the final decision on the marriage of a daughter under 18. One in three (35%) respondents reported that if a girl under 18 is asked for her hand in marriage, she does not have the right to choose her future husband.

The most frequently mentioned negative consequences of early marriage for girls were:

Difficulty in managing the family (53%)

Leaving school (48%)

Risky pregnancy (46%)

Complications in delivery (31%)

Problems with health of the mother (24%)

10% of respondents reported not knowing any negative consequences.

When asked about the most beneficial time for their children to get married, respondents reported the following:

When financially independent - 36%

When they have the capacity to support their future family - 20%

When they have completed tertiary studies - 16%

When they have adequate employment - 15%

Research Results: EFP No.9: Parents /caretakers of children aged 10 – 18 years adopt non-violent behaviours towards their children (EFP9-P)

Violence against children in Madagascar is tolerated and under reported. The MICS reports that over 80% of children (2-14 years) have experienced at least one form of violent discipline. 20% of children were subjected to severe physical punishment and 64% to physical punishment. The majority of caregivers (71%) consider physical punishment necessary to raise children properly. Asked “Who would you talk to regarding child abuse?” one in three respondents in the study said “no one,” and only 30% mentioned a spouse or partner. A few would talk to other family members, but very few respondents listed teachers, religious leaders, community or health workers, NGOs or the police, indicating the general social acceptance of the practice.

According to the MDGs study (2013), among adolescent girls (aged 15 to 19), 14 % experienced sexual violence and 15% physical violence. The Special Rapporteur on the Sale of Children, Child Prostitution and Child Pornography reported increases in sexual exploitation of children including prostitution and sexual tourism since the onset of Madagascar's political crisis (CPD, 2014).

Over a quarter of women (aged 15-49) consider it justifiable for a man to beat his wife/partner if she neglects the children (EDS, 2009). Interestingly, the predisposition towards domestic violence is higher among women in Antananarivo (25% compared to 19% in rural areas) and those under 30 (20 % compared to 17% among ages 45-49). According to the MICS, 37% of women consider it justifiable for their husband/partner to beat them for a reason (such as neglecting the children, arguing with their husband or refusing sex). Surprisingly, this attitude is more prevalent among women in urban areas, those with at least a secondary education and belonging to the highest wealth quintile. The low status of children and women, normative acceptance of violence and the pervasive impunity of perpetrators allows violence against children and women to persist.

Qualitative research attributed some responsibility to parents, noting that in some cases the perpetrator is an adult whom the parents have entrusted the care of the child without suspecting his/her bad intentions. Several studies have also noted the use of young girls as sexual presents for visitors (when a visitor is housed in the same place as a young girl, there is an implicit understanding that a sexual encounter is condoned).

Research results (supplement): Transactional sex

The study found that 45% of women in the parents/caregivers group reported having had a single instance of sexual relations with a man[29] at some point. The most frequently reported reason for doing so was for money (77%), followed by clothing (34%), food (27%), and a place to spend the night (10%). Almost half (48%) of women who reported engaging in a single instance of sexual relations did so under the age of 18.

The study found a statistically significant relationship between those who reported attending school at any time and the likelihood of reporting engaging in a single instance of sexual relations with a man. It also found a statistically significant relationship between region and the likelihood of engaging in a single instance of sex with a man for money; this was most prevalent in Anosy.

Among men, 76% reported having had a single instance of sexual relations with a woman[30]. The most commonly mentioned things men reported giving in exchange

29. The survey instrument used the term "man" (without specifying if referencing husband).
30. The survey instrument used the term "woman" (rather than wife).

for sex were money (86%), clothing (33%), food (29%), drinks and a good time (13%), and a place to sleep (13%). On the subject of transactional sex, 36% listed radio and 34% neighbors as sources of information.

In qualitative research, respondents identified night clubs, karaoke bars, *jiromena* and other social events as places where transactional sex (along with alcohol and drug use) took place. In general terms thy also blamed non-informational media such as videos and the wide availability of pornography.

Respondents to the quantitative survey reported conservative attitudes regarding their children's behaviour. 88% of respondents reported that they would not allow their daughter to go to a nightclub alone; 91% would not allow her to go to a bar with friends; 94% would not allow her to go out with an unknown man. For sons, the numbers were nearly as high: 75%, 78%, and 79% respectively, for permission to go to a nightclub, go to a bar with friends, or go out with an unknown girl/woman.

Regarding the behaviour of other children, 50% of parents who were aware of a child engaging in transactional sex reported that they would inform the child's parents; 32% said they would do nothing.

60% of parents reported that they were aware of a law that forbade transactional sex among children under the age of 18, while 96% reported that it is punishable by law; 45% listed radio as their source of information about the law, and 29% family or friends. When asked who in the community can prevent or stop sexual exploitation, more than four out of five listed parents; teachers and community leaders were also considered influential, but only 15% listed religious leaders and 2% NGOs.

WASH

WASH EFPs:

10. Households wash their hands with soap at critical times (EFP10-W)

11. Households drink safe water by using an improved source or by effectively treating the water of non-improved sources (EFP11-W)

12. Households build and use latrines. (EFP12-W)

Research Results: EFP 10: Households wash their hands with soap at critical times (PFE10-W)

Almost three out of four respondents (72%) agreed that there were moments during the day when they needed to wash their hands. While 87% of those listed "before eating" as a moment for washing hands, only 52% mentioned "after defecation." Only 17% mentioned "prior to feeding an infant" and 40% "prior to preparing food."

When asked the reasons for washing hands, 53% reported that it was to kill germs or microbes; 92% mentioned that it was for removing dirt from their hands. A smaller percentage, 23%, mentioned that "dirty hands smell/feel bad".

70% of respondents reported having received information about washing hands with soap or ash. The most important sources of information were health agents (52%), community agents (47%) and radio (40%). Two thirds (65%) said they used soap to wash their hands and 5% ash; the remaining 30% used only water or other locally available substances such as sand. One third (32%) reported that their families used soap every time they washed their hands while 68% reported using soap some of the time.

Among those who never used soap to wash their hands, more than four out of five (85%) said the primary reason was not having money to buy soap. This is supported by the qualitative research where respondents cited poverty as the main barrier. A typical comment was: "We don't have anything to eat so why should we buy soap?" However, it appears that some lacked knowledge of basic hygiene; 9% of respondents said they didn't think that it was necessary to wash with soap. The primary reason (75%) for not using ash was because it was "pas une habitude."

A quarter of respondents reported washing their children's hands less than twice a day with the majority of 67% claiming to wash their children's hands 3-5 times per day.

Research Results: PFE No 11: Households drink safe water by using an improved source or by effectively treating the water of non-improved sources (PFE 11-W)

Nationwide, a little less than a quarter of households have access to a safe water source and almost one half (49%) use treated water (EDS 2009). In the southern regions, only one in four households (26%) have access to safe water and less than one sixth (16.3%) use treated water (MICS, 2013). The principal obstacles are the availability of potable water and the preference for using water directly from the source without treatment because it is perceived as potable. According to UNICEF's Situation Analysis, 57% of people who have access to a water-supply system still drink surface water, and only 28% of public primary schools have potable water points (24% in rural areas versus 57% in urban areas). There are disparities based on income level, between urban and rural areas and between ecological and climatic zones. Water supply is more reliable in the highlands and the northern coastal areas than in the south, which is subject to periodic droughts.

Approximately 40% of respondents reported that they obtained drinking, cooking or washing water from a surface source such as a river, canal, lake, or another unprotected source. An additional 20% reported that they obtained water from an unprotected well. The mean time reported to obtain water was nearly 30 minutes. Collecting water was mainly done by adult women (67%) and young women under 18 (17%). Of those with access to potable water from a protected source, 61% reported that they had no difficulty collecting it; 57% reported paying to keep the water point in working order.

The use of non-protected wells was much higher in Atsimo Andrefana (28%) than in the other two regions (14% in Analanjirofo and 18% in Anosy). However, the use of surface water (lakes, rivers, canals, etc.) was higher in Analanjirofo and Anosy, 43% and 48% respectively, compared to 30% in Atsimo Andrefana.

Overall, 98% of respondents agreed with the statement "I will use potable water because I want to keep my family in good health" and 83% with the statement "If I know that the water from the river or other unprotected source is not safe, I should stop using it for drinking in my household."

However, two thirds of respondents without access to a protected source of potable water did not treat the water they collected. Of those who did (33% or 364/1078) 86% reported that they boiled water and 18% said they added a chemical such as chlorine, Javel, or Sur'eau. The most widely reported reasons for boiling water were:

Treated water is clean - 79%

Treated water is healthy - 70%

Because my family does it - 11%

Because my neighbors do it - 11%

Because a health agent advised me to - 11%

Almost two out of three respondents (61%) reported receiving information about potable or treated water. The most important sources of information were community agents (49%), health agents (48%) and radio (40%). However, a knowledge gap remains. Overall, two out of three respondents (68%) reported that water from the river is potable and 74% that water from a spring is potable. This varied significantly by region, as indicated in the tables below.

Table 7: Responses by region to the question "Is water from the river potable?"

	Yes	No	Don't Know
Analanjirofo	59%	41%	0%
Atsimo-Andrefana	60%	39%	1%
Anosy	85%	14%	1%

Table 8: Responses by region to the question "Is water from a well potable?"

	Yes	No	Don't Know
Analanjirofo	82%	16%	2%
Atsimo-Andrefana	60%	40%	0%
Anosy	81%	17%	2%

Table 9: Responses by region to the question "Is water from a piped fountain potable?"

	Yes	No	Don't Know
Analanjirofo	72%	20%	8%
Atsimo-Andrefana	61%	28%	10%
Anosy	77%	17%	6%

On a regional level, the qualitative research indicated several threats to safe water. In Atsimo Andrefana, some well water is polluted by animal carcasses, and river and well water by bilharzia disease. In Analanjirofo, some people use well water directly without purifying it. As some villages are located on river and stream banks, they form the center of activities—for washing clothes, doing dishes, bathing, water for cooking and drinking—and these banks are also used for defecation, with some places culturally selected by the community. In some areas of dense, primary forest, bodies are not buried but left in coffins in the forests; when the body decays, the pollution is carried by rain to infect the water supply.

Research Results: EFP 12: Households build and use latrines (PFE-12W)

At the national level, access to improved sanitation facilities remains low, increasing from 8% to 14% of households from 1990 to 2011 (JMP 2013). Access is highest in urban areas; 69% of people in rural areas lack access to improved sanitation (JMP 2013). It is estimated that about 8.4 million people (39% of the population), particularly in rural areas, practice open defecation and that this is socially accepted (Sitan, 2014, MDGs, 2013). In the South, less than 2% of households have access to improved sanitation facilities (MICS 2013). Several factors discourage the use of latrines. These include: the costs of construction, inadequate maintenance, taboos against use, the sharing of toilets by male and female members of the family, low risk perception about the practice of open defecation, and improper disposal of children's feces. The situation in communities with CLTS programmes is different, with latrine use at about 50%.

Qualitative research indicates that people practice open defecation (by the sea, in forests, around the village) where people will not see them or because it is a place assigned by the community for this purpose. Some consider that doing one's business in a latrine is like doing it in the home. People do not think they are capable of building and using their own latrines, and latrines are not supported by community leaders or community agreements. Health workers and traditional chiefs are not convinced of the benefits, and do not use latrines themselves. People do not make a connection between open-air defecation and water quality with excrements carried by rainwater. Other barriers cited include lack of construction materials, unsuitable soil (sand, rocks), wood for flooring that will not be resistant to termites, lack of space for latrines (with regard to local land use and taboos). Even if latrines are available, families cannot afford toilet paper and may resort to using paper from school notebooks; by contrast, water from the river and leaves from the forest are free.

Half of the respondents (51%) reported that members of their families did not use latrines of any kind. Of those who used a latrine, 80% constructed the latrine themselves. Two thirds (64%) reported that they shared a latrine with other households. About 71% said they had received information about latrines, with the most common sources being:

Community agents - 49%

Health agents/workers - 40%

Radio - 36%

Local authorities (chief of fokontany) - 23%

Other potential sources of information (family members, traditional leaders, local organizations) were mentioned by less than 10% of respondents.

For respondents who believed that children should use a latrine, the mean age when they should start using one was four years old. Half did not think it mattered where a baby defecated, 22% thought that a baby should defecate outside the house, and 18% thought that a baby should use diapers.

80% of women reported using the family latrine when they were menstruating; 91% reported that they used a cloth during menstruation, 9% reported using disposable sanitary pads and the remaining 1% used tampons (usually a piece of fabric cut from old clothing), or something else. Most (87%) women reported washing the cloths that they used while menstruating.

C4D
OPPORTUNITIES

Programme staff and C4D unit team members are best-placed to know what number and type of communication-related interventions have occurred, and have been successful, during past programming cycles. The role of the research team has been to aggregate, analyze and synthesize large amounts of quantitative and qualitative data and then present results that provide promising opportunities for immediate or near-future action.

The nine C4D opportunities presented in this next section are highly curated, representing a best-faith effort to determine what issues found in the data, in which regions, can be addressed through C4D interventions. The proposed activities do not always address what the data reveal to be the most intractable or widespread problems. This is because C4D is not always a stand-alone solution to some types of problems (see Individual decisions/behaviours and social norms—Categories of EFPs, above, and Annex B). In this sense, a given C4D intervention idea may address a lesser problem because it has greater chances of success of being addressed through communication.

Existing research studies, most of them standardized and highly rigorous (DHS and MICS data, for example), have identified programmatic areas needing attention; these were summarized in the literature review, and key points are noted in the relevant program sections. By providing here small-scale “pilot” interventions, deliberately limited in terms of scope and investment required, the aim is to to: 1) save time for and C4D and program staff by winnowing and analyzing large amounts of existing and new data to inform the proposed ideas; and 2) design manageable interventions, positioned as experiments, with shorter durations and some suggested basic measurement indicators and/or activities, (these can be considered illustrative, as there are many ways to measure any one intervention).

1: Nutrition

Less than half (46%) of the women surveyed sought information during their pregnancy. Midwives, health agents and community agents were the most frequently cited sources of information outside of family members. This suggests that a two-pronged approach for communicating about nutrition may be fruitful:

1. For “information seekers” (those who speak to service providers) capacity strengthening and easy-to-use conversation tools for service providers could be an effective channel for reaching pregnant women. Information-seeking women could also be encouraged to share the information received among neighbors and family members.

2. For those who do not actively seek information, the “peer sharing” described above could be one source of information. Additional channels for non-seekers of information could include radio spots and short radio dramas to provide key nutritional information, and to encourage all women and men to promote nutrition with neighbors and family members expecting children. Radio was cited by 16% of respondents and family by 40%.

2A: Breastfeeding

Given that the majority of women surveyed (99.9%) are convinced of the benefits of breastfeeding, there are two areas where C4D could support nutrition. These are:

1. Stressing the benefits of *immediate* breast feeding; and

2. Highlighting the importance of *exclusive* breast feeding.

This could be done with a catchy song (radio or at health clinics), that builds on the already-adopted behaviour, and explains how children can get more immediate and longer benefits if women make the "two small changes for better health."

2B: Complementary feeding and continued breastfeeding

One way to engage mothers who have already adopted breast-feeding and who are interested in continuing good nutrition is to create opportunities for women to share tips and encouragement. The opportunities for discussion, idea-sharing and mutual support could take many forms, including cooking classes or recipe contests with low-cost supplemental nutrition options[31], weekly discussion sessions and child "check-ins," where children can be weighed, to track participation and results, and allowing mothers to see "proof of concept" that good nutrition can make a difference in their children's health. The peer engagement strategy aims to motivate and engage women to help them follow through on a plan to continue breastfeeding and good nutrition. If many women, as a group, encourage each other to actively pursue good nutrition for their children, a positive social norm can begin taking shape. As the norm catches on, those who do not do everything possible (within their economic means) to consistently provide good nutrition will begin feeling pressure to do so.

3: Health

A key piece of data guides the C4D recommendation that follows:

1) **90% of respondents said they would prefer to deliver in a health facility to protect their health.**

When a lack of financial resources limits the number of health facilities where women can give birth, or limit women's ability to access existing services, strengthening the capacity of untrained birth attendants could be a way to bridge the gap between services and clients. C4D is more often used as a tool to generate demand rather

31. Such as the locally-grown but not well known Moringa plan: http://www.zahana.org/Site_With_Pix/Moringa-in-Madagascar.html. See also, Azafady's video on Moringa as "Laoky" sauce with rice https://www.youtube.com/watch?v=WL2iL8x5DNU

than a tool to improve service delivery, but in this instance, there is a need for quality, low-cost, and mobile service – all of which can be improved by strengthening the capacity of existing resources (traditional birth attendants).

4: Vaccination

A key piece of data guides the C4D recommendation that follows:

1) 98% of respondents agreed that vaccination was important

The responses on the perceived importance of vaccination and also sources of information for vaccination cited below suggest that a health-center-based C4D activity or tools could be used to promote completion of the vaccination cycle, rather than vaccination itself, which most community members already consider beneficial.

Among respondents, 91% reported that they had received information about vaccination. Among these, the most frequently mentioned sources were:

Health workers, posters and meetings (formations sanitaire) 55%

Family members 25%

Neighbors 19%

Community agents 52%

Radio 25%

Aiming to encourage completion of health service cycles among community members who have access to health clinics and have already used their services, provides a captive audience, and represents "lower hanging fruit" than attempting to persuade those having never accessed services.

The MERCI[32] "memory helper" (aide memoire) from vaccination promotion is a good example of a simple one-page tool for health center personnel. It can serve as inspiration for developing a similar tool, made-for-Madagascar or for regions, using local terminology (see Fig. 4). Another tool, a "conversation card developed" by UNICEF Chad and Chadian government counterparts, is a job aid for health workers so that they can verbally explain the routine immunization schedule to low-literacy health-center clients (Fig. 5).

32. http://www.immunizationbasics.jsi.com/Docs/BASICS_MerciCard.pdfMoringa-in-Madagascar.html. See also, Azafady's video on Moringa as "Laoky" sauce with rice https://www.youtube.com/watch?v=WL2iL8x5DNU

Fig 3. MERCI card (USAID/Basics/DRC)

AIDE MEMOIRE POUR L'AGENT DE SANTE
COMMUNICATION AVEC LES MERES

MALADIE :	Informer la mère contre quelle maladie, elle ou son enfant ont été vaccinés
EFFETS SECONDAIRES :	Informer la mère sur les effets secondaires possibles et lui dire comment agir
RENDEZ-VOUS :	Préciser la date a laquelle elle doit revenir avec son enfant pour la prochaine vaccination
CARTE DE VACCINATION :	Recommander à la mère d'amener la carte de vaccination avec son enfant chaque fois qu'elle vient au centre de santé
IMMUNISATION COMPLETE :	Rappeler à la mère qu'une seule ou deux vaccinations ne protègent pas son enfant. Chaque enfant doit-être vacciné 5 fois avant l'âge de 12 mois.

Fig. 4: Vaccination conversation card UNICEF/Chad

These simple one-page (or postcard-sized) tools are not designed to be persuasive communication messages aiming to directly raise awareness among community members, but rather are operational communication tools that help health center personnel **remember** key points or dates[33] to share in their conversations with clients. Additional operational communication tools, already employed for vaccination promotion and drop-out prevention/reduction in Madagascar[34] could be part of a package of tools made available to select sites for testing and adaptation to local needs/contexts.

33. See data on the phenomenon of parents/caregivers "missing the time for the vaccinations" in the pages that follow.
34. For an example of use of community based immunization records, search for dropouts through the"3 card file" system, Government of Madagascar (2014), The GAVI Alliance Annual Progress Report 2013, p. 14.

Complements to the operational communication tools for health workers might also be envisioned, informed by existing resources from Madagascar. As one illustrative (and possibly widely-known) example, the "Diploma" for completion of vaccination cycle developed for the Jereo Salama Isika project (1998-2002), can serve as inspiration for community-facing communication materials that help remind parents about important vaccination and inspire them to achieve completion[35].

Fig. 5: "Diploma" for completion of vaccination cycle

5: Education

Like the recommendations related to health, this C4D recommendation for education relates to "preaching to the converted" by initially focusing on the **completion** of primary school by children already enrolled in school. Designing for this population ensures that C4D interventions will not waste resources by aiming to generate demand where there is no supply, where distance is an issue, or where local schools are not affordable for parents. By starting with those already enrolled, there is both a captive audience (we know where to find these children and educators) and a demonstrated pre-existing commitment to education. As both education-related EFPs are category 3 (requiring additional resources), a pilot intervention should begin where resources already exist to increase the potential of C4D to make a difference. Study results also support the focus on retention (rather than enrollment) for the three regions. When asked about the topics of discussions about school with educators and community leaders, respondents listed: necessity of enrolling children (82%); advantages of enrolling children (71%). Only 26% cited the importance of **completing** primary school.

35. See: USAID (2001) Jereo Salama Isika, BASICS II (2004) Madagascar Immunization Report September 2001 – April 2004, p. 25, and also BASICS II (2004) Demonstrating Communication Impact: Madagascar Case Study, p. 27 (Annex)

Specific strategies for school retention could be gathered and vetted through a participatory "crowd-sourcing" (and child-friendly) process via a **contest mechanism**. A series of contests (after prototyping the idea at one site) would be an excellent way to generate dialogue as well as locally-proposed and implemented solutions related to the completion of primary school for already-enrolled children. Community members are often viewed merely as targets of development interventions, rather than as resources or agents of change[36]. The contest mechanism flips this logic on its head by presuming that community members have good ideas and will be willing and motivated to share them – in other words, the assumption is that community members are both a resource and agents of change.

The primary benefits of the contest mechanism for generating ideas and inspiring action are five-fold:

1) A contest can generate dialogue on the topic of school retention as student teams conduct research and work collaboratively on their intervention design;

2) A contest can provoke press interest on the topic of school and can lead to "earned media" (free media coverage) on the subject, especially at the moment when winners are announced;

3) A contest will generate ideas and solutions that are rooted in local context and culture;

4) Contest submissions will provide a range of ideas (and additional research) at a fraction of the cost of a large intervention or a partnership cooperation agreement (PCA); and

5) A school-based contest invites the participation of children and adolescents, which is one of UNICEF's core commitments to children[37].

6: Child Protection

A weekly Malagasy-language radio drama (using local dialects for some characters) dedicated to issues of child protection, including but not limited to the two protection- related EFPs, to be aired on local and community radio stations.

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36. The language of "community as resources/agent" is borrowed from McLeroy et al., (2003) Community-Based Interventions American Journal of Public Health: April 2003, Vol. 93, No. 4, pp. 529-533; http://www.scenariosafrica.org/

37. UNICEF (2010) Core Commitment to Children in Humanitarian Action, See p. 7, which encourages "the participation of children, adolescents, women and affected populations, including in the analysis, design and monitoring of humanitarian programmes."

When 80 of children (2-14 years) have experienced some form of violent discipline, as is the case with Madagascar (see data in section brief), the phenomenon is not only widespread – it is a social norm. Norms are difficult to change, because of the sheer number of people agreeing with them, and also the long-standing and thus entrenched nature of most norms. A message, a poster, a 30-second public service announcement – these are all doomed to fail in the face of a social norm. The drama and emotion lacing entertainment education (EE) scripts (whether radio or TV), and the family- and peer-level dialogue they generate, show more potential.[38] For one, listeners of an EE radio novella can hear about other people's problems and arguments – they don't have to feel personally implicated. Further, a radio novella is entertaining, unlike most PSAs and pamphlets: it captures attention, and makes listeners care about the characters and what happens to them. There is a substantial amount of social science evidence and theory[39] to support EE as an effective (although not usually fast or efficient) way to promote social and behaviour change. Madagascar EE models already exist, such as Search for Common Ground's radio soap, *Vohidrazana* (Village of the Ancestors).

If deemed successful in generating dialogue and interaction on protection-related themes, the radio programme can be easily scaled up through distribution of recordings of the episodes. There is a wide range of interaction mechanisms[40] available, both low and high tech, to help amplify dialogue related to subjects raised on the radio broadcast. These include: listening clubs, call-in shows, SMS trivia quizzes or polls (via UNICEF's Rapid Pro 2.0 platform or another open-source software, like Frontline SMS), U-Report (also via Rapid Pro 2.0), and even old-fashioned letters, which can be received at stations and read on-air prior to or after broadcasts. Building in some sort of feedback loop to hear from listeners is essential for learning the valuable lessons that can help convert the intervention into a scalable, more widely broadcast program.

One of the greatest benefits of EE is the ability present a wide range of issues, to tailor scripts for language and context, and to adapt storylines on an ongoing basis – according to local formative research or program feedback. To cite examples from the study data, the radio novella could address transactional sex, under-age sex, domestic violence, corporal punishment, and also issues not cited in the data such as birth registration or child labor.

38. On the subject and impact of entertainment education, see: Pop Culture with a Purpose: Using Edutainment Media for Social Change; and Entertainment education broadcasts, social mobilization and ground delivery in Rural India.

39. See, for example, Singhal and Rogers (2002). A theoretical agenda for Entertainment Education, Communication Theory, pp. 117-135.

40. For some examples, see Frontline SMS Blog (2011) Communication for social change: How to turn a stone into a sponge (it's not magic, it's design!)

7: WASH

The WASH-related opportunity is the use advocacy to address material barriers to hygiene (soap) and health (water treatment products) in targeted areas through Corporate Social Responsibility (CSR) mechanisms[41] already existing in Madagascar[42]. While corporate donations are clearly not a sustainable source of support (they are the equivalent of giving the fish rather than teaching to fish), specific "in-kind" donations – soap from UNILEVER, for example – may help certain community members who are not the poorest-of-the-poor develop good handwashing habits and experience improvements in health that would lead to future soap purchases once in-kind donations are exhausted. One could make the argument – again using UNILEVER as an example – that today's CSR beneficiaries could be tomorrow's paying customers. The WASH section could also commit to collaborating with the strategic communication section to generate press coverage of any CSR donations, to encourage other potential corporate partners to join UNICEF in its efforts. Imagine special-edition soap with the "key moments for hand-washing" printed on the packaging, benefitting entire villages, receiving coverage in regional or national news outlets.

The cost of advocacy, in terms of time and effort, would be minimal. The key activity would be in crafting tailored pitches to CSR units in various corporations. An alternative but more time-consuming approach to advocacy is to develop CSR correspondence/appeals/proposals in collaboration with specific high-need communities, so that the art of resource mobilization is taught to communities, who can later (ideally) advocate for themselves. The benefit of a slower, participatory approach to CSR is that communities could use learned advocacy skills to also lobby the government for specific services and/or infrastructure that is lacking.

8: Investments in media

In Madagascar's current economic situation, investments in print, television and Internet would bring limited returns, reaching only a small, mostly urban audience (even with group viewing situations). As already noted, media, including community radio, cannot be considered by themselves as drivers of change because attitudes and behaviours exist in a complex and fluid environment; investments in both traditional and community media need to be carefully considered in the broader context of programme interventions.

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41. UNICEF/Madagascar (undated) : "CHILDREN ARE EVERYONE'S BUSINESS" Assessing CSR in Madagascar, states: "87% of the companies were generally in favour of engaging in CSR activities for children, in particular in school construction, WASH and fight against child labour.." (p. 1)

42. See Sumitomo Corporation CSR in Madagascar (one WASH-related project) Building relationships of trust with local communities through the Ambatovy Project (Case study 4).

Despite its partial reach, especially in rural areas and to those without education, radio offers (of all media) the best potential for C4D interventions. Over the last three years, Search for Common Ground (SFCG) has undertaken several projects using radio to promote peace and social cohesion and reduce tensions and violence, especially among young people.[43] An evaluation of the Andrew Lees Trust's *Projet Radio* (ALT/PR) in southern Madagascar showed that the initiative achieved some success in changing and enhancing knowledge and attitudes on topics including HIV/AIDS, family planning, maternal and child health, environmental issues, social and administrative issues, and gender inequality.[44] Radio also reportedly had a positive impact on the uptake of health services, enrolment in literacy classes, construction of environmentally-friendly woodstoves, tree-planting, agricultural yields, and awareness of strategies for poverty reduction through income generation and community associations. For both SFCG and ALT/PR, building partnerships with local and community stations for production, distribution and broadcast, the use of local dialects, and the blending of information and entertainment formats, such as SFCG's radio soap, *Vohidrazana* (Village of the Ancestors), have helped to make the programming engaging and relevant.

The team proposes UNICEF expand its existing partnership with SFCG and work with other agencies and NGOs to support EFP-related programming produced by local stations. Although most programming will (for reasons of cost) likely be informational in format (talk shows and call-ins), some entertainment programming (music and EE radio novellas) would likely increase reach and impact. It is also important not to consider radio in isolation; most successful C4D interventions combine radio programming with community-based activities or education. As noted in the evaluation of ALT/PR (and as SFCG has demonstrated), use of local producers and dialects is important.[45]

Because national radio has the widest reach, the team recommends UNICEF approach the government to explore how to increase and improve the quality of programming on health, nutrition, education and child protection. Qualitative research suggests that most national radio coverage is event-based, and does not examine health or social issues in depth. The team also proposes that C4D interventions using radio include a research or measurement component, whereby impact can be assessed by comparing changes in attitudes and behaviours in districts where radio was used with changes in districts where people were not exposed to radio.

43. Search for Common Ground, Madagascar Projects, https://www.sfcg.org/tag/madagascar-projects/
44. UNFPA (2012). Metcalf, L., Harford, N., & Myers, M. (2007). The contribution of radio broadcasting to the achievement of the Millennium Development Goals in Southern Madagascar.
45. UA's qualitative research includes the compilation of a glossary of dialect from communities in the three regions.

In Madagascar's current economic situation, access to radio will probably not expand quickly, especially in rural areas; therefore, interventions using radio may not reach remote areas that include the poorest and most vulnerable populations. This presents a challenge for UNICEF's equity mandate. Radio represents a relatively fast and cost-efficient way to reach urban and some rural populations, but other forms of communication (interpersonal and small-group), which reach remote populations – and so help to address issues of equity – are also more time-consuming and expensive. The recent phenomenon of circulating music or other content on secure digital (SD) cards and flash drives, or transferring content by Bluetooth ("side-loading")[46] provides an opportunity to reach areas falling outside the broadcast areas of radio stations.

One option is to try to bridge the gap between media 'haves' and 'have-nots.' This could involve providing wind-up and/or solar-powered radios to communities that lack radios. (Battery-powered radios are cheaper, but users may not be able to afford new batteries). Further study would be needed to decide how to implement such a solution, but experience from other countries indicates that the first step is to provide free or low-cost radios to public institutions, including schools and health centers. Radios could be made available at low cost to churches and other groups. However, technological support should be part of broader, community-based interventions.

The next section outlines a complement to mass media--interpersonal communication through community participation, including opinion leaders and other community members of influence.

9: Community participation

Both the quantitative and qualitative data indicate that community members in the three regions have a range of local influencers and communication channels, including events, markets and other meeting points. Data indicating that those who claim a religious affiliation are more likely to adopt positive health behaviours than those who profess to have no religion suggest that churches and other places of worship are an additional gateway where information and practical exercises to promote EFPs can be integrated.

46. Kirkley, C. (2015) "Music from cellphones," http://thepiratebook.net/music-from-cellphones/

In contrast to the opportunities presented by schools and churches, respondents express resistance to information coming from outsiders (*gasygasy*) and information that is perceived as overly technical. The implication for designers and implementers of C4D interventions is that any and all information related to EFPs should pass through a filtering and localization process, allowing community members to adapt content and inviting them to provide and circulate EFP-related information using local resources. Even a fully formulated (unchangeable) communication product such as a pre-recorded educational song can be introduced by community members themselves through local radio, blue-tooth or SD card trading ("side-loading"), or word of mouth sharing at events such as the *havoria* or *tsaboraha* and other popular gatherings. In other words, the quality and trustworthiness of the person introducing the information are just as important as the information itself.[47]

When local actors and cultural practices are viewed as a resource, rather than as a barrier, there is great potential for creating additional gateways for EFPs to supplement schools and places of worship. Approaching community members as resources, agents of change, and naturally-occurring "units of solution"[48] can be a fruitful first step for C4D and other programmatic efforts. Participation takes time, and can slow down interventions and the turn-around time for results, but community involvement has much greater potential for true ownership and sustainability.

47. Le Cardinal, G., Guyonnet, J.-F., Pouzoullic, B., 1999, 215-226, « Construire la confiance, une vertu nouvelle pour sortir du désir mimétique et de la violence », *Communication et organisation*, n° 16, 2e semestre.

48. McElroy, et al., (2003) *Community Based Interventions*, American Journal of Public Health (Vol 93, No. 4), p. 530.

FUTURE RESEARCH

1. A focused qualitative study on specific issues identified by quantitative that need further investigation (see “Limitations of Research, above).

2. A study of the relationship of health workers (vaccinators, health agents, trained midwives) to communities, and how they communicate with patients (researching service-side factors to improve their engagement with communities). This could include a study of the perceptions of pregnant women of what they consider to be a “normal” birth in order to better understand how complications are taken into account by family members, medical staff and traditional healers.

3. Human-centered design (HCD) research can be used to gain deeper understandings of existing practices related to EFPs, with WASH themes in particular providing a good starting point. HCD research includes a step for “co-creation” where community members can participate in the design process, suggesting potential solutions that are adapted to their needs and contexts.

Annex A

Project timeline and context

DATE	ACTIVITY	OUTPUTS/RESULTS
September 2014-April 2015	Planning meetings, literature review (previous research studies), work plan, methodology (*Protocol de L'Etude*), questionnaires and research protocols.	Work plan, literature review, drafts of quantitative and qualitative methodologies, draft French versions of questionnaires.
January-March 2015	Capacity building on research; compilation of research articles; research database access.	Online sessions on research topics for UA faculty and post-graduate students, website established for project documents.
April 2015	Human subjects research clearance.	Research methodology approved by Institutional Research Board, Metropolitan State University, St. Paul, USA
May 18-22, 2015	Workshop (at Fenerive Est) with INSTAT team leaders to finalize questionnaires and protocols for field data collection.	Malagasy versions of questionnaires ; *Protocol de L'Etude* revised ; questionnaire pre-test conducted.
March-July, 2015	Development of topics, methodology and tools for qualitative research study.	Synthese de la note methodologique, outlining research principles and methods, criteria for selection of field sites.
July 20-26, 2015	Qualitative research methods workshop, Toliara, for UA field research teams.	Sample data collection in districts of Toliara; protocols for field research; forms and templates for organizing and reporting qualitative data.
August 5-8, 2015	Workshop on quantitative data analysis, University of Witwatersrand.	Procedures for data entry, reporting and analysis.

DATE	ACTIVITY	OUTPUTS/RESULTS
August-September 2015	Qualitative field research in six communities in three regions.	Data (field notes, community maps, FGDs, interviews, photographs) uploaded
August 9-September 22, 2015	Quantitative data collection by 12 teams in three regions.	Target of 1,620 completed questionnaires for each group (total of 3,240) for three regions
September 21-24, 2015	Workshop on qualitative data analysis, including use of Atlas.ti software.	UA faculty/students ready to do thematic analysis.
September 5-October 31, 2015	Quantitative data capture using CSPro, data cleaning.	Data from questionnaires captured and made ready for statistical analysis
November 1-30, 2015	Analysis of quantitative and qualitative data.	Preliminary report from INSTAT on quantitative data.
November 30-December 4, 2015	Presentations to UNICEF and steering committee; research symposium	Sharing of research data; feedback for final report.
December 5-31	Multivariate analysis of quantitative data; merge with qualitative data and previous research.	First draft of final report with results and recommendations for C4D interventions
January 1-February 29, 2016	Revisions of final report based on comments from UNICEF, UA, International Reference Group and Steering Committee; translation from English to French; conference presentation on vaccination	

The original timeline for design, implementation and analysis of the research had to be adapted due to unexpected delays outside the control of the research consortium. This delay resulted in the simultaneous collection of quantitative and qualitative data, which was not ideal. When sequenced rather than simultaneous, qualitative and quantitative methods are complementary and allow for richer, deeper results.[49] If a quantitative survey, for example, comes before qualitative interviews, the qualitative portion can follow up on the quantitative results to inquire about the "why behind the what." Interviews or focus groups prior to quantitative research can also be useful for designing a more detailed and nuanced survey instrument.

49. Morgan, David (1998). Practical strategies for combining qualitative and quantitative methods: Applications for health research, *Journal of Qualitative Health Research*, pp. 362-376.

Annex B
Analytical categories and concepts

To establish a common vocabulary for this report, the team proposes a set of analytical categories and concepts.

Supply and demand-side determinants

Constraints and bottlenecks to the uptake of a given behaviour or service can stem from "demand-side" determinants such as the lack of knowledge or motivation on the part of a community member, and can also be the result of a "supply-side" factor such as poor service, absence of supplies (e.g. vaccines or water purifiers) or lack of infrastructure (e.g. a health center). For vaccination, for example, there are three essential components: vaccine (supply), vaccinator (service) and vaccinated (client). When any one of these elements is lacking, vaccination will not occur. From a C4D perspective, "generating demand" can be pursued where and when the other two elements of the vaccination equation are present. Wisely choosing the site of an intervention, so that demand is generated where services and supplies exist, ensures that communication is not wasted, and does not lead to frustration on the part of community members.

UNICEF's Monitoring for Results Equity System (MoRES)[50] provides additional terminology for considering the range of determinants that can enable or constrain behaviour and social change. Areas for potential bottlenecks range from 1) enabling environment (social norms, legislation/policy, etc.), 2) Supply, 3) quality (of service), and 4) demand. C4D can be employed to affect three of the four determinant areas, through advocacy, social mobilization and behaviour change communication –with only the area of "supply" being largely immune to communication influence.

Advocacy is often most useful on the "outer ring" of the ecological model (Fig. 2), for influencing decision makers, policies and legislation at the "enabling environment" level. **Social mobilization** can help trigger or inspire *community-level* action that is essential when problems are of a communal nature, such as sanitation (latrines) and vaccination, where individual decisions to defecate in the open or to *not* vaccinate a child for measles can have negative consequences for neighbors and the larger community.

50. Formative Evaluation, UNICEF's Monitoring Results for Equity System MoRES: From evidence to equity? (2014), p. 6

Fig. 6: Three strategies for communication for social and behavioural change.

Behaviour change communication (BCC) aims to promote change at the individual level, with community members (parents, for example) and/or service providers (vaccinators, or other health clinic staff for example). BCC works best when individuals can fully control their own actions, as with the decision to quit smoking, the act of boiling unclean drinking water, or providing respectful service to health clinic clients. When behaviours to be addressed, or actions to be promoted, are related to deeply-entrenched social norms, longer-format C4D interventions are generally more effective, especially when they generate dialogue that can gradually "chip away" at tightly held beliefs (before a norm can change, one has to be able to at least talk about it – which isn't the case for some norms related to "taboo" behaviours – like domestic violence in some countries). The difference between individual decisions/behaviours and social norms is outlined in the section that follows.

Individual decisions/behaviours and social norms

When considering how to promote a given EFP, it is important to determine whether the behaviour, action or decision to be promoted is within the control of the individual, or whether individuals perceive they have less autonomy, because the action or behaviour is highly influenced by local social norms. We define social norms as a system that "specifies what is acceptable and what is not in a society or group…often meant to represent a solution to the problem of attaining and maintaining social order." A social norm is likely in play if a community member asks themselves, with concern: "What will others in the community think if I act in this way, or make

this decision?” If I choose to stop smoking (individual decision) I may not face a social consequence but if my daughter is not married by a specific age (social norm), there may be some judgment on our family.” The difference between an individual decision and a social norm can have implications for C4D intervention designs. A deeply entrenched social norm may necessitate longer-duration communication formats, such as a multi-year radio serial drama, to generate the level of dialogue that can help chip away at norms over time. The promotion of a one-time behaviour such as birth registration, on the other hand, might be addressed through short-duration information-only approaches, via leaflets or SMS blasts. Knowing whether a C4D intervention is meant to address a behaviour or a norm can help avoid the waste of time and money that can occur when there is a mismatch between problem and approach.

Direct and indirect communication impact

Just as a deeply entrenched social norm will be more difficult to influence than an individually-controlled behaviour, some EFPs are impossible to address with communication alone, i.e., without additional material resources. For example, a communication intervention promoting proper nutrition, or hand-washing with soap, will not be effective if people are too poor to buy nutritious foods or soap. The promotion of school enrollment and retention requires that a school be open, geographically accessible, and with fees local parents can afford. Communication can have direct impact when additional resources are not required for a specific practice to be performed successfully. Exclusive breast feeding, biology permitting, is a practice most mothers can control without additional resources. Parents do not need material resources to avoid disciplining their children with violence; communication has the potential to have an impact, even if violence against children is an accepted social norm (it just may take longer when a given practice is an accepted norm). Fig 2 (page 16) plots the 12 EFPs along two axes, categorized as either within the control of the individual, or as a social norm, which is subject to the perceived judgement of others within the community. The EFPs are further categorized as being able to be directly impacted or influenced by communication alone, or as having an additional material resource or barrier affecting the possibility of action. The EFPs that are both individually controlled AND directly influence-able by communication are the “lowest hanging fruit” for potential C4D impact. Tougher candidates for immediate C4D influence are the EFPs that are entrenched social norms, and/or require additional material resources (such as soap, or supplemental food) or have material/geographic barriers (such as access to schools, or the existence of a health clinic).

Frequency of action

An additional factor that can affect the potential influence of communication is the frequency and/or regularity of action that is being promoted. An EFP which must be done once (enroll a child in school) is different, from a communication perspective, from one that needs to be done repeatedly or daily. A one-time action might be promoted through an "event-based" activity, such as an "enrollment festival", whereas something that needs to be done *daily* might require a visual prompt ("wash hands!" sticker) or repeated radio announcements and catchy phrases. With repeated practices, such as hand-washing, communication would aim to promote habits and new, positive social norms.

Checklist for where/when to proceed with a C4D intervention

Below is a set of questions – a checklist - which outlines conditions that can facilitate (or hinder) the implementation of a C4D intervention. A C4D intervention design, plan or strategy is the road map to be followed to arrive at a specific objective. This report contains several potential paths to increasing uptake of essential family practices. But the path and the roadmap alone are not sufficient to ensure successful arrival. To continue the "journey and destination" analogy, one also needs resources: the vehicle and petrol for the journey, and a driver. The vehicle may be an implementing partner (government agency or community-based organization) and the petrol could be funding or in-kind goods (like donated SMS messages). The driver is someone with sufficient technical experience to oversee and manage the journey.

Attempting 12 journeys (one for each EFP) at one time would require a great deal of resources, and the chances of success would be diminished. Beginning with a few well-equipped vehicles – or even one vehicle - is better than an entire fleet getting lost or running out of petrol short of the finish line.

The evidence base that informs the suggested recommendations is unlikely to change suddenly; and thus interventions can be timed strategically, they can be staggered, for example, to allow for sufficient resources to be gathered, and for capacity to be strengthened over time, with lessons learned along the way to be converted into ongoing improvements.

Key questions

1. Is the intervention a priority for the sections and/or country office? If yes,

2. Are there sufficient C4D support and resources (staff and funding) to help design and monitor the intervention? If yes,

3. Are there sufficient section/programme support and resources (staff and funding) to proceed with intervention? If yes,

4. Is there a partner and/or partnership agreement allowing for on-site implementation? (i.e., local "boots on the ground") **If yes, to all of the above: proceed with planning, design and implementation.**

BONUS: If there a government partner/counterpart ready and willing to collaborate (for ownership, sustainability, and local expertise/resources)

BONUS: If the intervention measurable, in terms of implementation/monitoring and impact/evaluation (for lessons to be incorporated if/when going to scale and to generating practice-based evidence) .

If "no" to any of the above, the conditions for success of the intervention may not be ideal, and thus postponement, or even abandonment, of the C4D intervention should be considered. The art of designing and implementing a C4D intervention is as much about the "when" and "whether" as it is about the "what" and "how."

Annex C
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Research report:

Socio-cultural determinants for the adoption of essential family practices in Madagascar (2016)

In 2015, researchers from Ohio University (U.S.A.), the University of the Witwatersrand (South Africa), the University of Antananarivo and the Madagascar National Institute for Statistics, with financial support from UNICEF, conducted a major baseline study in three regions—Atsimo Andrefana and Anosy in the south, and Analanjirofo on the east coast. The study focused on knowledge, attitudes, beliefs and practices in five sectors--nutrition, health, education, child protection and water/sanitation/hygiene (WASH). This was a mixed-methods study, with quantitative surveys of 3,240 households generating the bulk of the data, and field research conducted in eleven communities with interviews, focus group discussions, transect walks and community mapping. The study is intended to provide an evidence base for programme interventions by international development agencies, the government of Madagascar and NGOs, providing an understanding of barriers and motivators, including beliefs and cultural practices, key influencers and communication networks. The report indicates that while there are opportunities for communication for development (C4D) to help achieve programme objectives, there are also limitations due to bottlenecks related to supply and service delivery, which communication alone cannot address.

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