INCLUSIVE DEVELOPMENT PARTNERS

March 23, 2022

Evaluation of UNICEF Interventions Addressing Inclusion of Children with Disabilities in North Macedonia

Inception Report

Submitted by:

Inclusive Development Partners

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Acronyms

BDE	Bureau for Development of Education
CPD	Country Program Document
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil Society Organization
ECE	Early Childhood Education
EQ	Evaluation Question
ERG	Evaluation Reference Group
FGD	Focus Group Discussion
HHS	Health and Human Services
ICF	International Classification of Functioning, Disability and Health
ICF-CY	International Classification of Functioning, Disability and Health - Children and Youth
IDP	Inclusive Development Partners
IEP	Individual Education Plan
IRB	Institutional Review Board
KAP	Knowledge, Attitudes, and Practice
KII	Key Informant Interview
M-CHAT	Modified Checklist for Autism in Toddlers
MMA	Macedonian Medical Association
MOH	Ministry of Health
MoLSP	Ministry of Labor and Social Protection
NEC	National Examination Center
OECD/DAC	Organization for Economic Co-operation and Development's Development Assistance Committee
OPD	Organization of Persons with Disabilities
SDG	Sustainable Development Goal
SEC	State Education Inspectorate
SEN	Special Educational Needs
TOR	Terms of Reference
UMB	University of Massachusetts at Boston
UN	United Nations
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund

1. Introduction

Through the support of the United Nations Children's Fund (UNICEF), Inclusive Development Partners (IDP)[1] will undertake the following activity, referred to as "Evaluation of UNICEF Interventions Addressing Inclusion of Children with Disabilities in North Macedonia." To ensure this documentation is thorough, IDP will use a multimethod approach, including a comprehensive desk review and key informant interviews (KIIs), focus group discussions (FGDs), and surveys with a wide range of stakeholders. The IDP research team will collate these findings into a detailed report that documents and evaluates UNICEF North Macedonia's inclusion efforts from 2016 to 2020. The evaluation will focus on the following programmatic sectors: Social Protection, Child Protection, Education, Health and Nutrition, and Communication. IDP will also examine UNICEF's response to the COVID-19 pandemic as it relates to and intersects with inclusion programming.

Using international normative standards and best practices, IDP will also identify opportunities to grow and further the efforts already underway in North Macedonia. Throughout this process, IDP will engage various stakeholders, including ministry officials, civil society, implementing partners, and organizations of persons with disabilities (OPDs). This Inception Report provides information on the background and context of the assignment, the purpose and objective of the evaluation, scope and timeline, methodology, ethical protocols, limitations, and a work plan. IDP's current understanding of UNICEF's programming during the evaluation timeframe and the relevant legal frameworks is also included. Finally, annexes to this report include: A. Evaluation Matrix; B. Intervention Map; C. Stakeholder Map and Sample; D. Work Plan; E. Theory of Change; F. Final Report Outline; G. References; H. Desk Review Protocol; I. Normative Evaluation Frameworks; J. Informed Consent Form; K: Data Collection Instruments.

Background and Context

Highlighting inclusion of children with disabilities and introducing a disability component in all programs were integral parts of developing the 2016-2020 country program in UNICEF North Macedonia. These efforts are aligned with several Sustainable Development Goals (SDG), notably SDG 1 as it relates to the financial costs to families of children with disabilities; SDG 3 as it relates to providing equitable and quality health care to children with disabilities, including identification and habilitation/rehabilitation services; SDG 4 as it relates to providing quality inclusive education; and SDG 10 as it relates to reducing inequalities between people with and without disabilities.

At the mid-point program implementation in early 2018, UNICEF, in collaboration with the government and key partners, conducted a Light Strategic Review of their country program, resulting in a shift in the strategic direction of the program and broadening their focus from specific

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[1] Inclusive Development Partners (IDP)[1] is a unique, woman-owned small business that leverages unparalleled expertise in the field of disability rights to achieve policies, practices, and programs in corporate, governmental, and civil society sectors that ensure that international development and humanitarian aid and government services reach all members of society. Our work focuses on three key areas: 1) Policy and System Strengthening, 2) Research and Evaluation, 3) Training and Technical Capacity

groups of vulnerable children to major issues concerning all children. While this shift was considered necessary to accelerate the reforms for the social good of children given the country's readiness in light of a change in leadership, addressing the needs of children with disabilities and a commitment to inclusion remained part of UNICEF's program.

UNICEF North Macedonia's most prominent contributions toward policy reform and advocacy for the rights of children with disabilities can be summarized in the following 6 sectors. More details about each sector's programming can be found in Annex B:

1. **Social Protection:** Introduction of a new model of disability assessment based on the International Classification of Functioning, Disability and Health (ICF) and the adoption of a rights-based model of disability in the country's welfare system.
2. **Education:** The development of a legal framework and inclusive practices that support the inclusion of children with disabilities in the mainstream education system by 2023 and the transformation of "special" schools to resource centers that support the effort toward inclusion.
3. **Child Protection:** Supporting the country's effort toward deinstitutionalization and creating alternative community-based care systems for children.
4. **Health:** Enhancing the capacities of front-line healthcare workers including family doctors and patronage nurses and training them in early detection and early intervention for children with developmental disabilities.
5. **Communication:** Awareness campaigns to address the negative attitudes and perceptions of the public toward disability.
6. **COVID-19 Response:** Online individualized support for children with disabilities and their families in early intervention, early stimulation, speech therapy and psychological support.

Purpose and Objective

The purpose of this evaluation is to examine how and to what extent UNICEF North Macedonia's inclusion programming has contributed to addressing system-level bottlenecks impacting children with disabilities' access to social, health, and education services and their ability to live in caring family environments, as is their right. The objective of the evaluation is to inform UNICEF's ongoing and future programming on behalf of children with disabilities and their families. The evaluation assesses the effectiveness of the UNICEF's programs and devises a guide for any further plans or programs planning to target the inclusion of children with disabilities and their families' participation in all aspects of life. The evaluation will make note of the lessons learned and best practices, creating valuable resources of recommendations and findings of the country's progress on this front.

Scope and Timeline

The scope of this evaluation focuses on all UNICEF North Macedonia programming related to inclusion of children with disabilities during the five-year period of the 2016 to 2020 Country Program. The evaluation will primarily be national in scope and will consider UNICEF's efforts across five sectors: Education, Child Protection, Health and Nutrition, Social Protection, and Communication (these sectors are described in greater detail below in Section 6). Additionally, UNICEF provided support to families of children with disabilities during the COVID-19 pandemic in 2020, and the scope will include examination of these activities through 2020 as well. The evaluation commenced in November 2021 and will conclude in September 2022.

2. Program Summaries and Legal Frameworks

During the inception period of this evaluation, the IDP research team was able to conduct a series of introductory key informant interviews (KIIs) with the UNICEF Officers who are most closely engaged with each of the programs of interest. In the absence of program descriptions and strategy documents for some sectors, these discussions provided valuable context in support of the evaluation. Below are summaries of the five program sectors, as IDP understands them at the time of this report, based on the KIIs and review of annual reports and program documents shared to this point.

A description of the policy and legal frameworks that exist for each sector follows each program summary. These are included in light of UNICEF's participation in reform efforts and the linkages between legal frameworks and program implementation.

3.1 Social Protection

Context

According to UNICEF's 2015 Country Programme Document (CPD), allocations for social assistance programmes in North Macedonia are among the lowest in the region (1% of GDP) and the level of child allowances is inadequate to meet basic needs, with 22% and 26% of children from the poorest decile are not eligible for benefits. Since then, some improvement has taken place with the adoption of a new Law on Social Protection and the amendments to the Law on Protection of Children, through increasing the amount of the benefits as well as broadening the categories of people eligible. The budget allocated for social protection was also to certain extent increased. A determinant analysis carried out with partners showed that a key bottleneck in this area is insufficient human and financial resources allocated to the Centres for Social Work (CSWs), which administer benefits and deliver social services. The country is also in the midst of a process for decentralization of social protection (including both rights and services and their administration) from central to local government. A new model of social services was adopted and professional standards have been developed. However, mechanisms to monitor the quality and accountability of the delivery of social services remain weak.

Program Summary

UNICEF worked closely with the Ministry of Labor and Social Policy (MoLSP), the Ministry of Health (MOH) and Ministry of Education and Science (MoES) to advance a major social protection reform in order to increase cash benefits and broaden other services for marginalized children, including children with disabilities and their families. The social protection reform necessitated a shift in how disability was defined and perceived, from the medical model to the social/human rights model.

Major Implementation Focus

Expansion of social supports: Shift assessment approach from medical to social model and train stakeholders to use new tool. Establish national and regional assessment bodies, improve data management, and expand cash benefits and other social services.

A related effort was translating and adapting the International Classification of Functioning, Disability, and Health (ICF) Manual into local languages and training diverse groups of stakeholders on its concept and application. The work included capacity building sessions for civil society, including OPDs, as well as state institutions, to introduce and explain the rationale and plans for the new assessment model, and to serve as basis for piloting the model and establishing national and regional assessment bodies.

As of the end of the evaluation period in 2020, the national assessment body and two regional bodies were established and considered active, but could not fully shift to the new model for assessing children for social services until those in all 8 regions of the country are established. Assessment bodies will help to address major gaps in data availability and accuracy, and keep track of the services delivered.

Legal Framework

The social protection system in North Macedonia is regulated by the ***Law on Social Protection*** as a general law, and the ***Law on Protection of Children*** that focuses, among other things, on social protection of children. Both laws comprise a set of rights, benefits and services for persons with disabilities. They are further operationalized with a complex set of bylaws, standards and procedures and bylaws. Since 2017 until now, there have been several reforms, completed and pending, that are aiming to improve the inclusion of persons with disabilities in the society.

The ***Law on Social Protection (No.104/2019)*** organizes the overall system for administration of social protection (i.e. welfare system). It defines rights and services as well as governing bodies and service providers. The new law, adopted in 2019, embodied a significant reform in the overall social welfare system and introduced significant innovations concerning the persons and children with disabilities. The Law reformed the system of monetary rights/benefits for persons and children with disabilities. It increased their financial allocation amount[2], introduced new benefits[3]

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[2] Compensation for part-time employment for a parent of child with disability.

[3] Permanent compensation for caregivers & parents of children with disabilities.

as well as harmonized the different benefits for disabilities with one single right[4] for supporting social inclusion and equal opportunities. Moreover, the Law introduced new types of services for persons and children with disabilities such as: personal assistance for individuals with a physical disability and with total vision loss, daily centers, assisted living as well as specialized foster care in families.

Though it still refers to medical committees for assessing disability, the law paved the way for introduction of a new assessment model in accordance with the ICF. It set the legal groundwork (Art. 295) for establishment of expert bodies for assessment of the type and degree of disability, as well as correspond support services and benefits. In November 2021, the Government proposed amendments to the law concerning the new model. The amendments vest authority to conduct the functional assessments to an organizational unit within the Skopje Public Health Centre. The details are yet to be regulated with a bylaw adopted by the MoLSP , Ministry of Education and Science and Ministry of Health.

3.2 Child Protection

Context

The number of children living in institutions in North Macedonia has been continuously falling since 2008 (it dropped from 398 in 2008 to 303 in 2013, and to 18 percent from 21 percent for children under 3). Persons with disabilities represented an overwhelming majority of those living in institutions, with CWD representing 14 percent of the total number. The number of children in foster families has increased, and now represent the majority (53 per cent) of all children living in formal care. According to UNICEF's 2015 CPD, community-based services, including for CWD, have been established, but the scope and reach of the services remain insufficient due to significant remaining bottlenecks, which include lack of support programmes for families to prevent child abandonment and inadequate monitoring and supervision of the placement of children in alternative forms of care. The process of transitioning children out of institutional care was amplified with the adoption of the National Strategy for Deinstitutionalization 2018–2027, called "Timjanik". As a result, now (in 2022) there are no children in institutions in the country.

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[4] Disability welfare benefit.

Program Summary

For the past 5 years, the UNICEF's Child Protection program has been greatly focused on child-care reform and deinstitutionalization—the process of closing large scale residential institutions for children, including children with disabilities, and transitioning care back to families of origin, when possible, and strengthening the foster and kinship care system for children who cannot be reunited with their biological families. A key momentum for the reform processes was gained during a conference organized by UNICEF in 2017, that emphasized childhood development and the harms of growing up in institutional care. The conference impacted attendees and garnered support for deinstitutionalization, while the Minister of Labour and Social Policy pledged to end placement of children in large scale institutions by end of 2019.

Major Implementation Focus

Deinstitutionalization: End placement of children in large scale institutions, reunite families of origin, and strengthen the foster and kinship care system, with community -based supports ensuring children remain in their families, or in a family-based alternative..

UNICEF conducted substantial analysis to provide evidence on what needed to be done and how. UNICEF worked closely with the Ministry of Labour and Social Protection (MoLSP) in these efforts, both to support reforms in the legal framework (see below) as well as to develop standards and procedures for implementing the changes. In addition to closing residential institutions and transitioning children to families, the work of deinstitutionalization was closely tied to childcare reform, because the country needed higher quality and better regulated family-based and community-based services to provide children with disabilities and their parents/carers with additional support. Existing state-run Day Care Centers were found to generally provide a low quality of care, to a limited number of children, while their capacity could be used to provide a variety of services to a greater number of children in the community, supporting the inclusion processes. Recognizing the need to prepare the public for these shifts, to welcome children into their communities, UNICEF Child Protection and Communications teams worked closely with the MoLSP to raise awareness on the rights of children with disabilities and to promote foster care.

One challenge was the lack of specialization and support to foster families. The Center for Social Work was responsible for overseeing and protecting the interests of children, but there was a need for a separate entity to support foster families caring for the children. UNICEF worked with the MoLSP to revise the standards and procedures, focusing on the quality of care, develop a comprehensive training programme, and establish the Centers for Foster Families (CFF), which also covers kinship care. A specific training module for potential foster families of children with disabilities was developed. Through this work, UNICEF also introduced a system for monitoring the foster care provision.

Another challenge was that there were a few children from institutions being transitioned into resource centers who, for various reasons, were unable to return to their families of origin and were unable to be placed in foster or kinship care. While these children, who were mostly adolescents, were still in need of care, UNICEF supported the opening of a few small group homes. These are rented, unmarked residential homes located within communities around the country, and ultimately will exist as a temporary stop-gap measure until the children transition into adulthood and out of the child protection system, or until a family-based solution is made available.

UNICEF also supported work to transform the former institutions into hubs of community level services to provide support for children with disabilities and their families. Technical assistance for the establishment and modeling of community and home-based early intervention services, targeted parenting support programme, and enhancing the system for community-based legal empowerment for caregivers of children with disabilities was provided.

Legal Framework

The ***Law on Protection of Children (No. 23/13)*** defines the criteria and procedures for granting different types of monetary support/benefits as well as regulates the different means for protection of children such as: pre-school, vacation, recreation and other (ex. licensing, setting standards, supervision etc.). The law foresees child support for children with disabilities based on the opinion of the assessment committee. A 2018 amendment increased the value of the child support for children with disabilities by 20%. Recent proposed amendments, yet to be adopted by the legislator, intend to harmonize this law with the new model for disability assessment as well as to replace the phrase “special needs” with “disability”.

The Ministry of Labor and Social Policy is the key institution that sets the rules, policies and manages the social protection system in the country. The Centers for Social Work, established on local level, are first line responders that have significant competences in granting social benefit rights, providing social services, supervision of social service providers etc. The Institute for Social Activities is responsible for expert support to the centers as well as oversight of their work and licensing of social workers. Social service providers are group of public and private providers of social services.

The child protection system is governed by a comprehensive set of policies and laws on prevention of abuse and neglect, protection of violence against children, justice for children and care for children without parental support and children with disabilities. Child protection requires inter-sectorial approach thus this area includes policies in the areas of social protection, healthcare, education and law enforcement.

Concerning the inclusion of persons and children with disabilities, the most relevant policy is the pending process of deinstitutionalization that effectively[5] started in 2018 when the Government adopted the second National Strategy for Deinstitutionalization 2018 – 2027 “Timjanik”. This comprehensive policy document, developed with technical support by the European Union and with contributions by UNICEF and other UN agencies, included a set of measures for operationalization of the vision and the objective of the Government for transition from institutionalized social care toward family & community based social services. The Strategy is in

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[5] The first de-institutionalization strategy was adopted in 2008, but it was mostly focused on children, and the results achieved were insignificant.

line with relevant international legal instruments[6] and follows best European practices.

The policy has four objectives/pillars: a. Transformation and closure of the institutions; b. Transfer of the persons in the community; c. Providing services in the community; and d. Prevention of institutionalization. For each pillar, the Strategy foresees detailed set of activities with a timeframe. Among other things, it plans expansion of foster care, opening of small group homes and strengthening of prevention mechanisms. The policy initially planned, in the first phase of the transfer to ensure that there are no children (which was accomplished), as well as persons with disabilities (ongoing) in institutions.

The recommendation set in the Strategy concerning legislation were to great extent addressed with the adoption of the ***Law on Social Protection (No.104/2019)*** which was precondition for sustainable provision of community-based services. The law reformed the system for accreditation and licensing of service providers. It included the personal assistance as a right within the system of state funded social care. The law also provided the legal ground for greater engagement of local government in providing social services. Coordinated care (case management) was introduced as a method for work of service providers. However further effort is necessary to ensure adequate implementation of these novelties.

Overarching challenge that remains, and that should be addressed is the accepted perception that the deinstitutionalization falls solely under the social protection sector which results with lack of harmonization with the legislation and policy in the areas of health, education, housing, etc. Moreover, the laws on legal capacity and guardianship need to be reformed in line with the CRPD and there is need for effective housing policy.

The Ministry of Labor and Social Policy leads the process of deinstitutionalization with support to a certain extent by the Ministry of Education and Science and Ministry of Health. The Centers for Social Work have an active role in the transfer and oversight of the service providers. The Local government's plans, funds and implements community based social services. The service providers which can be public or private provide services to children in the group homes or in one of the other forms.

3.3 Education

Context

Prior to the policy reforms in the field of inclusive education, the process was widely opposed by the Macedonian public with only 4 percent being in favour of the policy, according to UNICEF's 2015 CPD. While the legislation supported partial educational inclusion, teachers, schools and services were not equipped to implement it effectively. To systematise inclusive education, the Republic of North Macedonia was one of the first countries to begin the process of developing in-service teacher training that is holistic in nature and based upon the bio-psycho-social model of disability as well as incorporates ICF-CY as a framework for cooperation with other sectors. This

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[6] UN Convention on the rights of persons with disabilities, Convention on the rights of the child, EU Charter on fundamental rights,

initiated the process of system-wide reform of the model of educational inclusion of children with disabilities, which was guided by the UNICEF's Country Office.

Program Summary

In the Education sector, UNICEF supported the government in developing a new Primary Education Law, which included provisions related to inclusion of children with disabilities in mainstream schools (see Section X for more details about the legal framework). UNICEF established a working group and held regular sessions with the Ministry of Education and Science (MoES) and experts to advocate for certain clauses to be included in the law. The work was a joint effort with civil society organizations (CSOs), OPDs, the Bureau for Development of Education (BDE), local experts, and two outside consultants. These consultants—one from Portugal and one from Serbia—were invited due to their respective country's progress toward realizing CRPD in their education systems.

Major Implementation Focus

Integration and inclusion: Transform special schools into resource centers in support of inclusive mainstream schools. Train educators to form school-based inclusion teams and provide more differentiated and individualized instructional support to students with disabilities.

To support implementation of the new law, UNICEF developed a teacher training package to prepare teachers to better support the learning needs of children with disabilities already included in their classrooms, through more individualized and differentiated instructional practices, as well as to receive children who had previously been learning in segregated settings (special schools). Approximately 30 teachers and other school support personnel from the 31 project schools received a three-day training on educational inclusion, and UNICEF provided trainees with toolkit to guide inclusive instruction. This approach enabled schools to create inclusive education teams, so that there would be a bigger pool of school personnel with an understanding of inclusive education. Inclusion teams are now mandatory per the new law, and are to include 7 members, including two teachers, a social worker, and a psychologist.

In addition to primary schools, UNICEF included a few kindergartens as part of the model study, and supported the establishment of inclusive teams. Special schools were converted into Resource Centers that support mainstream schools to include children with disabilities.

While perceptions are slowly changing, these teacher training efforts were found to be challenging because many educators were resistant to the idea of inclusive education. In addition, the Faculty of Special Education and other education faculties were skeptical as to whether full inclusion was better than what they saw as specialized targeted support within the special schools, despite the fact that the latter was, in effect, segregation.

Legal Framework

The primary education system in North Macedonia is regulated by the ***Law on Primary Education (No. 161/19).*** Students with disabilities are defined in the Law as part of the larger group of students with special educational needs (SEN), and include 'students with permanent physical, mental, intellectual or sensory impairments, and when interaction with various societal barriers, their full and effective participation in the society in an equal basis with others is impeded'. (Art. 35).

Inclusive education (Art. 11) is elaborated on a conceptual level as entailing: changes and adjustments to the content, structures and teaching strategies; accommodating the infrastructure, individualized support, curriculum to students' individual needs; and ensuring the enjoyment or realization of all human rights and freedoms of students with disabilities on an equal basis with others.

Inclusion teams (Art. 16) are provisioned to be established in schools, responsible for the inclusion policies and practices of the entire school and inclusion team for a student that works according to an individual educational plan or modified curriculum. The **individual education plan** (IEP) or modified curriculum is provisioned to be designed for students with disabilities (Art. 30, par. 7-10) in cooperation with other teachers and professional associates who participate in the student's educational process. They entail: adaptation of learning results, introduction of specific activities and methods, as well as programs for development of special skills are designed for certain categories of students with disabilities.

Types of support for students with disability (Art. 19) are elaborated to include: educational assistant, personal assistant, adequate professional support from the center for supported learning, inclusion team and assistive technology according to recommendation of a professional body for assessment and in compliance with the individual educational plan or the modified program.

The Law provides for the transformation of so-called **special schools into primary schools with a resource center** (Art. 17) which use their material and human resources to provide professional support to students with disabilities, teaching staff, professional associates, parents/guardians and the inclusion team of other primary schools. The Law (Art. 18) and the Concept for Inclusive Education also provide for the transformation of the mainstream schools with special classes into Centres for Learning Support for students with disabilities .

Related laws, bylaws and policy documents include:

- **Law on Teachers and School Support Staff (161/19).** In line with the documents on professional competences and standards for teachers and school support staff, this law regulates the professional competences which, among others, include: responsiveness to students' needs and methods of working with students with special educational needs.
- **Rulebook on the normative, description of competences and working assignments of educational and personal assistants.** This rulebook outlines the educational requirements, working hours, and types of assignments per different areas of personal and educational assistants. (Based on Art. 19, Par. 6 of the Law)
- **Rulebook on the manner of requesting and selection of educational/personal assistant.** This regulates the procedure for requesting, selecting and assigning assistants to schools and students with disabilities, financially covered by the national Budget. (Based on Art. 19, Par. 4 of the Law)

- **Rulebook on the manner of assessment of students with disabilities.** This regulates the specific expectations for assessing the educational achievements of students with disabilities in terms of: planning, selection of methods, selection and development of instruments and procedures, use of assessment, etc. (Based on Art. 139 of the Law)
- **Concept for inclusive education** (Bureau for Development of Education, 2020). This document refers to all types of SEN students, including students with disabilities and provides in-depth overview of the: approaches of building an inclusive school climate; early identification and interventions; roles and responsibilities of education stakeholders; preconditions for inclusive education; differentiation, IEP and modified curriculum, roles of primary schools with resource center and centers for learning support, teacher professional development.
- **Concept for primary education** (Ministry of Education and Science, 2020). Inclusiveness (in the wider sense of inclusion and completion of education by all children, preventing discrimination on all grounds and enabling realization of everyone's potential) is one of the three main pillars of the conceptual framework.
- **Indicators for school evaluation** (State Education Inspectorate, 2019). This outlines how the specific legal requirements for students with disabilities are translated into the school evaluation indicators, such as: developed IEPs, identifying and supporting students with disabilities, enabling conditions for education, etc. with detailed descriptors and sources of information.

The **Ministry of Education and Science** is the primary institution for developing education policies, with sectors responsible for primary, secondary and tertiary education. In addition, several main organs operate within the system. The **Bureau for Development of Education (BDE)** is responsible for developing curricula, teacher professional development and educational research. The **State Education Inspectorate (SEC)** is the key quality-assurance organ, which conducts the school evaluations and each primary and secondary school is evaluated every three years. The **National Examination Center (NEC)** is responsible for the national and international student assessments and the certification of school principals. The vast majority of primary and secondary schools are publicly owned.

3.4 Health and Nutrition

Context

Children with disabilities face numerous barriers to inclusion from early ages, some even from birth. Early detection and intervention services could alleviate some of the barriers faced by CWD. However, they are limited in scope and coverage, with home-visiting services representing an untapped potential to address these gaps. While the medical model continues to be used for assessing children with disabilities, protocols have been revised, with UNICEF support, to bring them in line with the CRPD. Despite the efforts, the health protection of children with disabilities remains the weakest link in the system, with the least sustainable policy reforms. According to the latest Situational Analysis on the Rights of Persons with Disabilities in the Republic of North Macedonia (2021), the provision of primary, secondary and tertiary health care is not fully accessible and available to persons with disabilities, including children. Access to health services is still largely based on the medical model of disability and there is a lack of specialized health services, and programs and services for prevention, early detection, diagnosis, early treatment and rehabilitation of children and adults with disabilities. Moreover, disability is not part of the criteria when preparing and providing programs for professional training in the field of public health.

Program Summary

In the Health and Nutrition sector, through its "Learning Together" program, UNICEF focused on increasing the knowledge and capacity of family doctors and patronage nurses to directly support children with disabilities and their families. Previously, family doctors—who represent a family's first contact with the health system—treated disability as a medical diagnosis rather than using the social model of disability that is based on functionality, and habitually referred families to tertiary clinics and physicians who specialize in disabilities. Similarly, patronage nurses lacked the necessary skills to identify and support families of children with disabilities in the early days and weeks after childbirth.

Major Implementation Focus

Increase family doctor and nurse capacity: Train family doctors and patronage nurses to identify developmental delays and disabilities early, provide direct support, and refer to specialists only when necessary.

To address these needs, UNICEF worked closely with the MOH and the Macedonian Medical Association (MMA) to develop a series of training modules for family doctors, focused on early detection and early intervention to support different types of disabilities. The modules included training on how to use the ICF tool and the Modified Checklist for Autism in Toddlers (M-CHAT) tool. The training opportunity proved to be very popular, and 350 doctors (22% of the eligible workforce) received training between 2018 and 2020. Trained doctors reported that they were making far fewer unnecessary referrals, and the assessment protocols have become a standard practice as well as being added to the medical school curriculum.

For patronage nurses, UNICEF was able to support training of the entire workforce. Modules included guidance on how to identify children with possible developmental delays or disabilities, when to make referrals, and ways they can help families provide needed supports to their children, ranging from physical and emotional to cognitive and social supports.

Legal Framework

The Law on Health Protection (43/12) regulates the issues related to the system and the organization of health care and the performance of the health activity, guaranteed rights and identified needs and interests of the state in the provision of health care, health institutions, employment, rights and duties, responsibility, evaluation, termination of employment, protection and decision-making on the rights and obligations of healthcare professionals and healthcare associates, quality and safety in healthcare, chambers and professional associations, advertising of the health activity, the performance of the health activity in emergency conditions and performance supervision of the health activity.

Equity/fairness in healthcare is provisioned as one of the main principles, realized by prohibiting discrimination in the indication of health care in relation to race, gender, age, nationality, social origin, religion, political or other belief, property status, culture, language, type of illness, mental or physical disability (Art. 9). **Health treatment and medical rehabilitation of adults, children and young people with special needs** is outlined as one of the assignments of primary level health activity (Art. 30).

Several proposed amendments to the Law on Health Protection have been submitted to parliament and are not yet adopted. These include, among other things, the introduction of a new health activity that will enable the implementation of the new assessment model for additional educational, health and social support of a child or young person (ICF) (Art. 6).

Article 73 is amended to read that the public health institution Health Center Skopje, in addition to the activities of a health center for the area for which it was established, may also perform an activity exclusively for functional assessment of children and youth with affected health status up to 26 years, at its headquarters and in internal organizational units, as well as on the territory of the Republic of North Macedonia in the expert teams for functional assessment of children and youth with affected health status up to 26 years in Strumica, Stip, Veles, Bitola, Gostivar, Ohrid and Kumanovo.

The Law on Health Insurance (25/00) regulates the health insurance of citizens, their rights and health insurance obligations, as well as the manner of health insurance implementation. **An exemption from (financial) participation** (Art. 34) is provisioned for children with special needs, according to the regulations for social protection.

Several proposed amendments to the Law on Health Insurance have been submitted to parliament and are not yet adopted. The amendments entail terminological adjustments in line with the ICF and the laws on social protection and child protection (in procedure), as well as the new Model for additional educational, health and social support of a child or young person in line with the ICF.

In particular, the terms ‘child with developmental difficulties’ and with ‘special needs’ are proposed to be changed to ‘children with disabilities.’ Article 9 which regulates basic health services is supplemented with an additional service: functional assessment of children and young people up to 26 years. Article 10, which regulates health services not covered by mandatory health insurance exempts the exams required by the insured person if they are related to functional assessment of children and young people with disability performed by a relevant health institution.

The **Ministry of Health** is the main policy-making institution, which mainly acts through its organ - **Institute of Public Health, responsible for** preparing national programs, analyzing health-related data, conducting research and training in the frames of public health, etc. The health institutions are organized on a primary, secondary and tertiary level. The **primary level** includes **Health Centers** which provide preventive health services, as well as first-level health care. The service providers in these institutions include general family doctors, gynecologists and dentists, as well as immunization teams which are available for all citizens. They also include the patronage (home visit) services which are offered to elderly and disabled persons, as well as pregnant women and mothers of newborns. The primary health providers refer the patients to the secondary and tertiary levels when this is assessed as needed. The **secondary level** includes geographically dispersed network of general, specialist, clinical hospitals and university hospitals. **Tertiary health care** is provided at the university clinics in the capital – Skopje. The majority of hospitals are publicly owned.

3.5 Communication

As the sectors described above began to work in their respective areas of advocacy and implementation on behalf of children with disabilities, the UNICEF country office recognized a need to support these efforts through strategic, ongoing, and cross-sectoral communication aimed at the North Macedonian public.

To guide the design of this and other efforts, in 2014 UNICEF conducted a Knowledge, Attitudes, and Practice (KAP) study ahead of the start of the new Country Program. This study allowed UNICEF to collect baseline data related to public perceptions about disability and inclusion that could inform a communications strategy as well as provide useful insights for the individual sectors.

Major Implementation Focus

Influence and improve public perception of disability: Align communication campaign with programming across other sectors to shift public understanding of disability and lay conceptual foundation for receiving children with disabilities, and their families, into local communities.

Source: https://www.unicef.org/northmacedonia/be-fair-childhood-without-barriers

The Communication team focused on raising public awareness of the environmental, social and institutional barriers that prevent children with disabilities from participating and functioning across sectors to promote a shift from the medical model to a social/human rights model. UNICEF developed a multifaceted and multi-year national communications campaign titled [Be Fair – For a Childhood Without Barriers] to change the perception from disability to 'this' ability, i.e. focus on what people with disabilities can do and how children with disabilities can achieve their potential when barriers are removed. The UNICEF team believed that it was important that the communication and the programming happen together so that the changes taking place in the country as a result of the program could be reflected and promoted in the communication efforts to help change the public perception and belief that system wide change is possible.

The communications strategy included engaging local media and celebrities, and UNICEF produced dozens of high-quality, short, and accessible videos and signage. Videos illustrated areas of civic life that are more or less accessible to people with disabilities. They also showed common phrases in Macedonian sign language, and profiled individuals with disabilities who have achieved success in a range of careers. UNICEF also prioritized involving OPDs in the communications efforts, and worked to increase the capacity of OPDs so they could continue to be involved.

A follow-up KAP study in 2017 showed that the strategy successfully led to positive shifts in public perception—although more in some areas than in others. There was great public support for the de-institutionalization movement and a shift from 4% to 24% in support for inclusive education, however more efforts are needed to build public support for schools. While data from the KAP survey showed a big shift in opinions towards inclusion, there was still a prevailing belief that children with disabilities would receive better support in special schools. This belief tends to be framed in terms of there not being enough human and technical capacity to allow for integration of children with disabilities in mainstream schools.

While as of the end of the evaluation period (2020) there remained work to do with regard to perceptions about inclusive education—both among the general public (including families of children without disabilities) as well as among educators—the communications effort contributed importantly to driving policy changes, including the new law on primary education, deinstitutionalization reform, and scaling up change in the assessment model.

3. Methodology

As discussed in the original technical proposal, IDP will build upon its successful implementation of large-scale evaluations by utilizing a multi-method approach that blends participatory quantitative and qualitative methods and relies on the revised Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC) evaluation criteria[7] appropriate for the inclusion of the voices of diverse stakeholder groups.

The CPD for 2016-2020 provides a results framework with the following indicators and targets relating specifically to children with disabilities:

- Young child wellbeing indicator:
    - % of home-visiting nurses with adequate skills related to child health, nutrition and development, including on early detection and intervention for children with disabilities. 2020 target: 100%.
- Equitable and inclusive quality early learning and education indicators:
    - % of girls and boys (with disabilities) aged 3- 5 enrolled in ECE. No target in CPD.
    - # of children with disabilities in primary education. No target in CPD.
    - % of KAP survey respondents above age 15 supporting inclusion of children with disabilities in regular schools. 2020 target: 40%.
- Social protection indicator:
    - % of boys and girls identified as having a disability using the International

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[7] OECD/DAC Network on Development Evaluation (2019). *Better Criteria for Better Evaluation*. *Revised Evaluation Criteria Definitions and Principles for Use*. DCD/DAC (2019) 58/FINAL, p.8, accessible at: http://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf.

    - Classification of Functioning, Disability and Health – Children and Youth (ICF-CY) assessment. 2020 target: 90%, with equal ethnic and gender distribution.
- Child rights monitoring indicator[8]:
    - National Human Rights Institutions supported by UNICEF do quality monitoring on child rights.

However, baseline information and targets are missing for several indicators and the CPD lacked an overall theory of change outlining the assumptions underlining how UNICEF's efforts to focus support for children with disabilities could lead to positive outcomes within and across sectors. A "Think Piece" developed during the planning stages of the 2016-2020 Country Programme provided information for to create a reconstructed theory of change, which is included in Annex E.

It is important to situate the evaluation within a global normative framework based on the principles of the Convention on the Rights of Persons with Disabilities (CRPD), including progressive realization[9], and the 2030 Agenda for Sustainable Development. To this end, and because of the limitations within UNICEF's results framework and theory of change described above, IDP has developed normative frameworks for each sector of the evaluation (see Annex I) that will serve as an evidence base for evaluating UNICEF's inclusion programming.[10] While the theory of change will not be the primary framework for the evaluation, IDP will use the evaluation findings to test the theory of change and recommend possible adjustments for UNICEF to consider going forward.

IDP's methodological approach will also be broadly guided by contribution analysis, an approach for inferring causality in real-life program evaluations, to create a contribution story (Mayne, 2008)[11]. This approach will allow the evaluators to assess UNICEF's role and contribution to program outputs and outcomes. Questions to be explored through this lens include: Have UNICEF's contributions to the program/sector influenced the observed result(s)? Why have the results occurred? What role did UNICEF play? Is it reasonable to conclude that UNICEF's contribution to the program has made a difference? What conditions are needed to make this type of programming succeed?

The evaluation questions are listed below and can also be found in an Evaluation Matrix in Annex A which includes indicators, data sources, and IDP's proposed changes to the evaluation

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[8] Two indicators that were originally included to measure child rights monitoring were found to be irrelevant due to lack of alignment with program efforts (in the case of an indicator tied to EMIS) and overly broad as well as outdated (in the case of an indicator referencing progress in the area of accessing education). The current indicator was inserted to replace the prior two indicators in December 2020.

[9] According to Article 4, Section 2 of the CRPD, "Each State must take measures to realize economic, social and cultural rights progressively, using the greatest amount of available resources to do so. This obligation, commonly referred to as progressive realization, acknowledges that it often takes time to realize many of these rights fully, for example, when social-security or health-care systems must be created or improved". This evaluation will incorporate the view of progressive realization as a pathway approach to inclusion for children with disabilities.

[10] Normative frameworks are for social protection, child protection, education, healthcare, and communication. The evaluation rubric for communication is embedded in the rubrics for the other four sectors.

[11] Mayne, J. The Institutional Learning and Change (ILAC) Initiative, (2008). *Contribution analysis: An approach to exploring cause and effect.*

questions from the TOR.

1. **Relevance**

1.1 Was the design of the programmes and interventions/activities internally coherent, and adequate for producing the intended outcomes?

1.2 To what extent did the interventions address the needs of children with disabilities and their families, including any gender-specific needs?

1.3 Were relevant partners involved in the programme design, implementation and evaluation, including children with disabilities, their families and organisations of people with disabilities?

2. **Coherence**

2.1 Have UNICEF actions and interventions in different sectors been mutually reinforcing in improving inclusion of children with disabilities? And to what extent?

2.2 Have UNICEF interventions complemented any existing programme and/or policies implemented by the Government, UN agencies, or other international donors (ex. EU), thereby enhancing their effect, Or, in contrast, have they possibly undermined such programmes and/or policies?

3. **Effectiveness**

   3.1 Have the UNICEF supported programmes and interventions contributed to eliminating bottlenecks in ensuring effective inclusion of children with disabilities in the following ways?

      i. Increasing availability of supply of services and qualified human resources for their timely and effective delivery

      ii. Ensuring financial accessibility of services and setting eligibility criteria that do not cause significant exclusion errors in the access to services and cash benefits, including gender related exclusion

      iii. Changing knowledge and raising awareness about and demand for services and cash benefits

      iv. Shifting the paradigm around disability, contributing to reduced stigma and discrimination and positive social norm change

      v. Ensuring quality of social services in support of children with disabilities, their parents and families, as well as adequacy of cash benefits and entitlements.

   What factors (e.g. political, social, gender and cultural, social norms, systemic, or related to the programme and service design and implementation, professional practices) were critical for the achievement or failure of the initial objectives?

4. **Efficienc**y

   4.1 Were UNICEF programme budgets and resources (human, financial and technical) adequately used for addressing priority bottlenecks? Could we have the same programme results will less resources? (economic and technical efficiency)

5. **Impact**

   5.1 How much was UNICEF able to shift the paradigm on disability and improve the

understanding on disability?
5.2 To what extent and in which sectors did programmes/interventions make significant impact? Were there any sub-group differences (urban/rural, male/female, poor/rich, or with respect to different impairments (physical, mental, intellectual or sensory) or severity?
5.3 Was the implementation of programmes and interventions appropriately monitored and evaluated per UNICEF protocols for M&E? How were the results used?

6. **Sustainability**
   - 6.1 To what extent are UNICEF supported programmes integrated into national policies, budgets, and quality assurance mechanisms?
   - 6.2 What are the key factors that can positively or negatively influence the long-term financial sustainability of the services established?
   - 6.3 To what extent is the participation and/or support of other partners enhancing sustainability?
   - 6.4 Which lessons learned have external validity?

The below methodologies will be used for the evaluation. The evaluation team will hold bi-weekly quality assurance meetings to review data collection methods and primary data collected to ensure evaluative rigor and relevance.

Planning and Program Inquiry Meetings: To ensure that the evaluation team understands the scope of UNICEF's relevant programming, IDP's evaluators began the evaluation by holding inquiry meetings with UNICEF program officers and will hold additional meetings as necessary. These meetings will add contextual information to guide the evaluation design and methodology and will also allow the team to identify and obtain relevant documents and materials and collect contact information for individuals who should participate in data collection activities and any validation workshops. As a result of these meetings, IDP will develop domains and indicators related to each area of study and produce evaluative guidance documents to guide our normative framing of the evaluation sectors. All data collection instruments will be designed or selected to tap into the domains/areas of study and inform the final report.

Desk-based Review and Portfolio Analysis: IDP will conduct a thorough desk review, including a review of UNICEF existing documentation, evaluation reports, all relevant UNICEF program documents, academic and grey literature research and studies, government strategies, legal and policy documents, primary and secondary data reports. The desk review will follow Petticrew and Roberts'[12] method to ensure data collection continuity and facilitate the desk review. Using a rapid analysis approach, key terms and themes will be compiled and analyzed to inform common trends in documentation analyzed, which will guide the remaining areas of further inquiry and serve to triangulate with primary data collection findings.

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[12] Petticrew, M., & Roberts, H. (2006). How to appraise the studies: an introduction to assessing study quality. Systematic reviews in the social sciences: A practical guide, 125-163.

Country Mission and Data Collection: For qualitative data collection this evaluation will use a combination of purposive and snowball sampling methods to identify relevant stakeholders who have knowledge and experience in the respective areas of study. Caregivers of children with disabilities will be recruited in through OPDs. For quantitative data collection, IDP will conduct online surveys of program beneficiaries in the education sector (teachers and school support staff) and the health sector (family doctors and patronage nurses). Surveys of educators and doctors will be sent to individuals who did and who did not receive UNICEF-sponsored training, which will allow the evaluation team to examine differences across these groups. The surveys will undergo cognitive testing with individuals from the stakeholder populations prior to being conducted, and the surveys will precede interviews with members of these beneficiary groups. Surveys will be programmed with skip logic to maintain clarity and relevance. Respondents to the survey will indicate their willingness to be contacted for a follow up group discussion and participants will be selected from this list.

The sample was designed in collaboration with UNICEF and will include geographic and gender representation and is described below (a full list of stakeholders is included in Annex C along with the detailed sample):

- **Surveys**
    - Educators listed within UNICEF's Eduino programme database, which is extensive and anticipated to include school personnel who received UNICEF's in-person inclusive education (IE) training, BDE's virtual IE training, or no IE training;
    - Family doctors from the Macedonian Medical Association database, which is anticipated to include physicians who did and did not receive UNICEF's training on early detection and ICF;
    - Patronage nurses from Association of Patronage Nurses database, which is anticipated to include all nurses who received UNICEF's training (which covered 100% of patronage nurses in the country).
- **Key Informant Interviews**[13]
    - Representatives from relevant Ministries and state institutions: 6
    - Representatives from implementing partners and service providers: 9
- **Focus Group Discussions**
    - Beneficiary families
        - 1 FGD (4-6 participants) with caregivers of children with disabilities who have never been in institutional care
        - 1 FGD (4-6 participants) with caregivers of children with disabilities who have been in institutional care and now reside in kinship or foster care settings
    - Beneficiary professionals (to be selected based on survey results)
        - 1 FGD (6-8 participants) with educators who received inclusive education training

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[13] One KII/FGD for each stakeholder individual and group is planned; however, the evaluation team may ask participants for a follow up discussion if needed.

        - 1 FGD (6-8 participants) with family doctors who received UNICEF-sponsored training
        - 1 FGD (6-8 participants) with patronage nurses who received UNICEF-sponsored training
    - 1 FGD (6-8 participants) with representatives of health centers
    - 1 FGD (2-4 participants) with representatives of Assessment Bodies (national and regional)
    - 1 FGD (2-4 participants) with representatives of municipalities
- **Secondary data analysis**
    - UNICEF Monitoring and Evaluation data
    - UNICEF training evaluation data
    - UNICEF scoping or needs assessment data
    - Government beneficiary data
    - Service provider data

Interview and discussion protocols will serve as a framework, rather than a script, in that protocols will include more questions than a given interview or discussion will allow. IDP's international team will guide national-level work through virtual enumerator training of National Evaluators and virtual data collection as appropriate or necessary (e.g., telephone-based key informant interviews). Training will include guidance on using the protocols, determining which questions to ask, how to follow up and probe, and how to steer discussions back on course. The informed consent form is included in Annex J.

The data points yielded in this phase will help shed light on many of the evaluation questions and establish key findings that will be triangulated against the desk review and quantitative sources of data collection. Particular consideration in interview questions will be afforded to marginalized and doubly marginalized populations such as women and girls with disabilities. IDP's local consultants will contextualize findings, and the data collected will be reviewed by the international evaluation team to promote methodological consistency.

Data Analysis: IDP will compile and triangulate the different data sources to evaluate trends, good practices, future opportunities, and potential areas of growth in alignment with the OECD/DAC evaluation criteria[14] and sectors of the evaluation. During inception, IDP will review the principles of the OECD/DAC evaluation criteria to contextualize and determine the use of each criterion. Qualitative data will be coded using a rapid analysis approach[15]. A random sampling of reliability checks will be instituted to ensure the trustworthiness and quality of the data. The qualitative analysis will include thematic, structured coding methods to allow evaluators a large overview of the data presented in all evaluation phases. Evaluators will disaggregate data by gender to assess potential gaps between rights and opportunities for girls and boys with disabilities. Quantitative data will complement the qualitative data and can be especially helpful in examining the effectiveness of a project, though rigorous measurement of impact will be limited,

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[14] See https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

[15] See https://www.edu-links.org/resources/rapid-education-and-risk-analysis-rera-toolkit-0 for an overview of this approach in development contexts.

as described below in Section 6. Quantitative data analysis will be applied to survey data collected directly through the evaluation, but may also be applied to secondary data sources as they are available. This analysis will primarily include simple descriptive statistics and reporting frequencies Data analysis at the country and/or project/program level will differ, pending the availability of outcome-level data. Because many indicators will be measured through both quantitative and qualitative analysis, this evaluation largely uses a mixed methods approach.

Based on these findings, IDP will combine with the desk review to inform the final evaluation report. These recommendations will be shared and validated with UNICEF and relevant stakeholders, including OPDs, to ensure the input of local disability leaders and their representative organizations, consistent with Article 4 of the CRPD.

Report Development: IDP will produce a comprehensive 40-50 page report summarizing the key findings obtained through desk- and field-based data collection and analysis to outline lessons learned and strategic recommendations for future programming. IDP will also highlight key findings and recommendations through visuals and infographics.

Presentation and Validation Meeting: Consistent with our practice for all research and evaluation projects, we will share the final findings and recommendations with UNICEF and other key stakeholders for participatory validation as appropriate. A user-friendly PowerPoint Presentation will be developed and shared with the participants utilizing graphs and other infographics developed for the final evaluation report.

4. Ethical Protocols

The IDP research team will follow the United Nations Evaluation Group (UNEG) Norms and Standards as well as the UNEG Ethical Guidelines for Evaluation. Team members have completed training on research ethics through the Collaborative Institutional Training Initiative (CITI) program, and will uphold the obligations of evaluators to maintain independence, impartiality, credibility, and accountability, and disclose and avoid conflicts of interest. IDP has ethical review reliance agreements with the University of Massachusetts, Boston (UMB), which serves as IDP's Institutional Review Board (IRB) and will seek clearance for this research through UMB and/or UNICEF as needed for primary data collection. The IRB reviews human research in accordance with the U.S. Department of Health and Human Services (HHS) regulations. IDP will formally apply for ethical clearance from UNICEF before conducing primary data collection with caregivers of children with disabilities, who will be selected with support from OPDs. Informed consent to participate as well as to be audio recorded will be (separately) obtained prior to data collection from all participants and participation in the evaluation will be completely voluntary. IDP has no plans to conduct research with children. To minimize risk from COVID-19, FGDs will be held virtually when possible. All data will remain anonymous and identifying information will be redacted. Data will be stored on a secure server that is only accessible by the research team. A protection protocol and consent form are in Annex J.

5. Limitations

Key components to the success of the project will be the access to relevant literature and reports to inform review and documentation, and the cooperation of key stakeholders. It may be challenging to interview all of the necessary key informants in person or via distance due to the situation with COVID-19. In-person data collection sites may have to shift due to COVID-19 concerns. However, every effort will be made to accommodate informants' schedules, to use accessible technology, and coordinate local in-person data collection as safety permits.

Another limitation may be the lack of data related to children with disabilities from before the period of this evaluation, and in some cases, the inconsistency of current data availability. Such data includes numbers of children with disabilities (including disaggregated demographic data), numbers of program beneficiaries in different sectors, and educational performance data. This could limit the research team's ability to assess the impact of UNICEF's programming and increases the importance of qualitative data that IDP collects from stakeholders. Additionally, assessing long-term impact is unlikely to be possible due to lack of longitudinal data. This limitation was taken into consideration when proposing changes to the evaluation questions; those questions that the IDP team deemed the evaluation unlikely to answer based on data availability were dropped.

Given the interconnectedness of the reforms initiated and supported by UNICEF in North Macedonia, IDP also anticipates challenges deciphering which program inputs and sectors contributed to change, but contribution analysis will help to mitigate this limitation.

6. Evaluation Team and Work Plan

IDP's core international team will consist of the following roles and responsibilities:

Principal Investigator and Team Lead
Project Role: Inception design, methodological framing and quality assurance, data collection tool development, data analysis, ethical oversight over all evaluation activities, and dissemination of findings.

Evaluation Director
Project Role: Oversight of the evaluation team, synthesis of analyzed data into key findings and strategic recommendations, report writing, and dissemination of findings.

Monitoring and Evaluation Manager
Project Role: Supervise all M&E activities; coordinate and implement data collection, desk, and country-level analyses; analyze primary data; and support report writing.

Program Manager
Project Role: Quality assurance of the evaluation methods alongside the Principal Investigator; data collection design and implementation, coordinating country-level work; contributing to report writing; and managing the project's contract and financials.

National Evaluators (2)
Project Role: Provide an in-depth understanding of the Macedonian political and economic system and the different aspects of assessing and collecting in-country data (remotely or in-person, according to pandemic conditions).

Research Assistant
Project Role: Assist team members with meeting organization, desk research, instrument development and formatting, data analysis, and reporting, as needed.

The Team Lead, Evaluation Manager, and National Evaluators will hold biweekly quality assurance meetings to review data collection methods and primary data collected to ensure evaluative rigor and relevance. While most work will be collaboratively undertaken by the team (including desk research, instrument development, data analysis, and reporting), with internal reviews and feedback taking place in addition to reviews by UNICEF and the ERG, the two National Evaluators will conduct the majority of data collection.

The evaluation is divided into three main phases as follows:

1. **Inception**. This phase involves early meetings with UNICEF, initial desk review of documents supplied by UNICEF, development of the inception report, and forming and meeting with the ERG.

2. **Data Collection.** This phase will span three to four months and involve additional desk review, preparation for field work, and all data collection activities, including conducting KIIs, FGDs, and surveys.

3. **Analysis and Reporting.** This phase will span the final two months of the evaluation (some overlap of final data collection and initial data analysis is anticipated), and involve cleaning, analyzing, and synthesizing data; validating initial findings with stakeholders; drafting the findings report; and presenting to UNICEF, the ERG, and other stakeholders.

A detailed work plan is included in Annex D.

Annex A: Evaluation Matrix

EQ#	EVALUATION QUESTION	INDICATOR	DESK	KII	FGD	SVY	DATA ANAL-YSIS METHOD	SUGGESTED REVISION TO EQ
1	**Relevance**							
1.1	How relevant have UNICEF interventions supporting children with disabilities and their families been?	- Evidence of needs assessment data - Evidence of alignment between needs data and program design - Stakeholders perceive interventions to be relevant. FULLY/PARTIALLY/NOT	- Program documents - Needs assessment data	✓	✓	✓	MIXED	Drop; covered in 1.3.
1.2	*Was the design of the programmes and interventions/activities appropriate for achieving the intended results and outcomes?*	- Evidence of alignment between programme design and normative standards of best practice, where available - Stakeholders perceive programme designs to be appropriate. FULLY/PARTIALLY/NOT	- Program documents - Needs assessment data	✓	✓	✓	MIXED	For clarity, revise to: Was the design of the programmes and interventions/activities internally coherent, and adequate for producing the intended outcomes?
1.3	*To what extent did models and approaches to delivery correspond to and address actual needs of children with disabilities and their families, including any gender-specific needs?*	- Evidence of alignment between needs data (incl. gender) and delivery models - Country reporting on the percentage of population having personally felt discriminated against or harassed in the previous 12 months on the basis of their disability	- Program documents - Needs assessment data	✓	✓		QUAL	For clarity, revise to: To what extent did the interventions address the needs of children with disabilities and their families, including any gender-specific needs?

		- The UNICEF/Washington Group module on child functioning is used in national censuses and/or surveys - Country reports on the percentage of children with disabilities aged 1- 17 who experienced any physical punishment and/or psychological aggression by caregivers in the past month - Beneficiary families perceive alignment between intervention and actual needs. FULLY/PARTIALLY/NOT						
1.4	Were relevant partners involved in the programme design, implementation and evaluation, including children with disabilities, their families and organisations of people with disabilities?	Relevant partners, including beneficiaries, were involved in design, implementation, and evaluation. FULLY/PARTIALLY/NOT	- Documentation of participation in planning and program activities	✓	✓	✓	MIXED	No change
2	**Coherence**							
2.1	Have UNICEF actions and interventions in different sectors been mutually reinforcing in improving inclusion of children with disabilities? And to what extent?	- Evidence of alignment, cooperation, and cohesion within program plans and activities across sectors - Stakeholders perceive interventions to be mutually reinforcing of improving inclusion. FULLY/PARTIALLY/NOT	- Programme and policy documents	✓			QUAL	No change

2.2	*Have UNICEF interventions complemented any existing programme and/or policies, thereby enhancing their effect? Or, in contrast, have they possibly undermined such programmes and/or policies?*	- Evidence of complementarity or conflict across UNICEF and other existing programmes/policies. - Disability inclusive social protection instruments are in place - Stakeholders perceive interventions to enhance OR undermine existing inclusion programs or policies. FULLY/PARTIALLY/NOT	- Programme and policy documents	✓			QUAL	Expand: Have UNICEF interventions complemented any existing programme and/or policies implemented by the Government, UN agencies, or other international donors (ex. EU), thereby enhancing their effect, Or, in contrast, have they possibly undermined such programmes and/or policies?
2.3	Has there been complementarity and consistency with other **UN** actors' interventions and actions in the area of inclusion of children with disabilities? Or, in contrast, has this aspect been overseen and efforts have been duplicated?	- Evidence of complementarity or conflict across UNICEF and other existing UN programmes/policies - Stakeholders perceive interventions to be complementary or redundant with other UN inclusion interventions. FULLY/PARTIALLY/NOT	- Programme documents from other UN agencies	✓			QUAL	Drop and merge with 2.2.

3	**Effectiveness**							
3.1	Have the UNICEF supported programmes and interventions contributed to eliminating bottlenecks in ensuring effective inclusion of children with disabilities in the following ways? i. Increasing availability of supply of services and qualified human resources for their timely and effective delivery ii. Ensuring financial accessibility of services and setting eligibility criteria that do not cause significant exclusion errors in the access to services and cash benefits, including gender related exclusion iii. Changing knowledge and raising awareness about and demand for services and cash benefits iv. Shifting the paradigm around disability, contributing to reduced stigma and discrimination and positive social norm change v. Ensuring quality of social services in support of children with disabilities, their parents and families, as well as adequacy of cash benefits and entitlements.	Documentation and/or stakeholder perception of elimination of bottlenecks as a result of programme interventions. FULLY/PARTIALLY/NOT for each sub-indicator: i. Availability of timely and effective service and human resource supply is increased ii. Services are financially accessible and eligibility criteria do not cause significant exclusion errors iii. Knowledge/awareness and demand for services and cash benefits is increased iv. Stigma and discrimination are reduced and positive social norm change is increased v. Quality and adequacy of services, benefits, and entitlements is ensured	- Data or other documentation of service delivery timelines, exclusion errors, applications for services - KAP study data	✓	✓	✓	MIXED	No change

3.2	What are the key benefits for children and their caregivers from the implemented programmes and interventions/activities? To the extent possible—subject to availability of relevant data—determine if different groups (based on gender, ethnicity, socio-economic profile, urban-rural residence, and type of impairment) are benefitting to the same extent?	- List of key benefits for beneficiaries (children and caregivers) based on rights defined by the CRPD and outlined in CRPD General Comment documents. Key potential benefits will initially be identified through the document review and validated through KIIs and FGDs. - Evidence of access to and outcomes from health, social protection, child protection, and education services, disaggregated by gender, ethnicity, socio-economic profile, urban-rural residence, and type of disability (as data allows)	- Programme documents, incl. M&E data - Existing data on access and outcomes	✓	✓	✓	MIXED	Drop. Covered in 3.1.
3.3	What factors (e.g. political, social, gender and cultural, social norms, systemic, or related to the programme and service design and implementation, professional practices) were critical for the achievement or failure of the initial objectives?	List of factors that contributed to the achievement or failure of programme objectives, based on evidence-based normative framework for what advances/hinders inclusion and realization of CRPD. Factors will initially be identified through the document review and validated through KIIs and FGDs.	- Policy and programme documents, incl. M&E data	✓	✓		MIXED	No change

3.4	How effective were the capacity building activities?	Level of effectiveness of capacity building activities. FULLY/PARTIALLY/NOT - Existing Training Data (secondary documentation) - Stakeholder perceptions - Documented changes in primary doctor or nurse identification and referrals (secondary data) - Documented changes in inclusive instruction at schools (increase in IEPs) (secondary data)	- Training data - Identification data - Referral data - IEP data	✓	✓	✓	MIXED	No change
3.5	Was coordination between the different sectors and sectoral programmes effective and did it contribute to planned outcomes?	Documentation and/or stakeholder perception that coordination across sectors/programmes was effective in contributing to planned outcomes. FULLY/PARTIALLY/NOT	Programme documents	✓			QUAL	Drop; covered in 2.1
3.6	What is UNICEF's comparative advantage with other **UN** actors, programmes and interventions?	Documentation or perception of ways that UNICEF has a comparative advantage over other UN actors, programmes and interventions	Programme documents from UNICEF and other UN agencies	✓			QUAL	Drop; covered in 2.2
3.7	What are the synergies between UNICEF's programmes and other **UN** actors, programmes and interventions? What synergies have been created?	Documented evidence of synergies with other UN actors, programmes and interventions (validated through KIIs).	Programme documents from UNICEF and other UN agencies					Drop; covered in 3.2

3.8	What worked and what did not work to reduce inequities (in child outcomes, access to and utilisation of essential service, etc.)? What are reasons for this?	Documentation and stakeholder perceptions of what worked/did not work to reduce inequalities, including reasons.	- Programme documents, incl. M&E data, KAP studies	✓	✓		QUAL	Drop; covered in 3.1, 3.3
4	**Efficiency**							
4.1	Were programmes implemented according to initial timeline?	Documentation and/or stakeholder reporting that programmes were implemented according to initial timeline. YES/NO	- Programme documents, including work plans and progress reports	✓			MIXED	Drop unless work plans and timelines exist and can be shared.
4.2	Were UNICEF programme budgets and resources (human, financial and technical) adequately used for addressing priority bottlenecks? Could we have the same programme results will less resources? (economic and technical efficiency)	1. Documentation of identified bottlenecks at programme start 2. Stakeholders report that UNICEF programme budgets and resources (human, financial and technical) were adequately used for addressing priority bottlenecks. YES/NO 3. Stakeholders perceive that the same results could have been achieved with less resources. YES/NO		✓		✓	MIXED	No change
4.3	Were needs of children with disabilities and their families/caregivers clearly assessed?	Documentation (as available) indicates and beneficiaries (children with disabilities and their families) perceive their needs to have been clearly assessed. FULLY/PARTIALLY/NOT	- Programme documents, including work plans and progress reports	✓			MIXED	Drop; covered in 1.3

5	**Impact**							
5.1	To what extent have the programmes and interventions contributed to long-term positive changes in wellbeing of children with disabilities?	Documentation (as available) indicates and stakeholders perceive positive changes in wellbeing of children with disabilities resulting from programme interventions. FULLY/PARTIALLY/NOT	- Programme documents, incl. M&E data	✓	✓	✓	MIXED	Drop; too early to evaluate long-term change
5.2	How much was UNICEF able to shift the paradigm on disability and improve the understanding on disability?	Documentation (as available) and/or stakeholder perception of shifts in paradigm and improvements in understanding of disability. FULLY/PARTIALLY/NOT	- Programme documents, incl. M&E data, KAP studies	✓	✓	✓	MIXED	No change
5.3	To what extent and in which sectors did programmes/ interventions make significant impact? Were there any sub-group differences (urban/rural, male/female, poor/rich, or with respect to different impairments (physical, mental, intellectual or sensory) or severity?	Documentation (as available) and/or stakeholder perception of significant impact (as defined by sources), including differences in impact on various subgroups.	- Programme documents, incl. M&E data, KAP studies	✓	✓		MIXED	No change
5.4	*Was the implementation of programmes and interventions appropriately monitored and evaluated? How were the results used?*	1. Programme implementation was appropriately monitored and evaluated. YES/NO 2. Documentation (as available) and/or stakeholder perception of how M&E results were used.	M&E plans and reporting	✓			MIXED	For clarity, revise to: Was the implementation of programmes and interventions appropriately monitored and evaluated *per UNICEF protocols for M&E*? How were the results used?

6	**Sustainability:** To what extent did the UNICEF programs ensure the ongoing control and ownership of other actors?							
6.1	*Are legal, institutional/administrative and financial mechanisms established to ensure monitoring and evaluation as well as sustainability of programme results (policies, strategies, services)? Are conditions established to ensure quality of the services (service standards, training, supervision mechanisms, beneficiary grievance and redress mechanisms, etc.)?*	- Documented inclusion of UNICEF programmes in national policies and budgets. - Existence of disability inclusive interventions in the overall humanitarian intervention plan. - Disability inclusive social protection instruments are in place - The UNICEF/Washington Group module on child functioning is used in national censuses and/or surveys FULLY/PARTIALLY/NOT	Government policies, plans, plans	✓			MIXED	Simplify to: Are UNICEF supported programmes integrated into national policies, budgets, and quality assurance mechanisms?
6.2	What are the key factors that can positively or negatively influence the long-term financial sustainability of the services established?	List of key factors influencing long-term financial stability of services established. Key potential factors will initially be identified through the document review and validated through KIIs and FGDs.		✓	✓		QUAL	No change
6.3	To what extent is the participation and/or support of other partners enhancing sustainability?	Stakeholders perceive participation and/or support of other partners to enhance sustainability. FULLY/PARTIALLY/NOT		✓			QUAL	No change
6.4	Which lessons learned have external validity?	ERG validation of lessons learned.			✓		QUAL	No change

Annex B: Intervention Map

Sector	**Geographic coverage and Target Population**	**Key Stakeholders**	**Budget (disability allocation)**	**CPD Objectives/Planned results**	**Activities**
Education	Nationwide; Children with disabilities	1. EeNET 2. Schools, teachers, school staff, 3. Parents 4. Bureau of Education Development 5. Ministry of Education and Science 6. State Education Inspectorate	$2,449,741	By 2020, an increased number of marginalized boys and girls are included in quality, inclusive and multicultural early learning and education. Target: 40% of KAP survey respondents above age 15 support inclusion of children with disabilities in regular schools (baseline 4%) Target: "TBD" number of children with disabilities in primary education. (no baseline)	1. In-service training modules developed on IE and disseminated 2. Modules piloted in 17 primary schools and 10 Kindergartens 3. Training for trainers on IE 4. Workshop on "Capacity building of school inclusive teams on approaches and strategies related to differentiated learning and individualized instruction in an inclusive classroom" 5. Conducting a baseline study on the situation before the implementation of the Programme-Inclusive Education for the marginalised children 6. Training of trainer modules developed in a participatory event 7.Adoption of the decree on the proclamation of the law on primary education including articles on IE

Sector	**Geographic coverage and Target Population**	**Key Stakeholders**	**Budget (disability allocation)**	**CPD Objectives/Planned results**	**Activities**
Health	Nationwide; Children with disabilities	1. Patronage nurses 2. Health care professionals	$2,101.00	By 2020, an increased number of young girls and boys, including Roma and children with disabilities, who access and benefit from quality, integrated and inclusive health care. Target: 100% of home-visiting nurses with adequate skills related to child health, nutrition and development, including on early detection and intervention for children with disabilities. (no baseline)	In-service training modules + guides for patronage nurses and family doctors for monitoring and supporting child development

Sector	Geographic coverage and Target Population	Key Stakeholders	Budget (disability allocation)	CPD Objectives/Planned results	Activities
Social Protection	Nationwide (Regional focus for assessment bodies); Children with disabilities	1. Ministry of Labour and Social Policy 2. Social workers 3. Families of children with disabilities	$39,824	By end of 2020, an increased number of girls, boys and their families benefit from integrated and child-sensitive social protection services and transfers that address poverty, deprivation and social exclusion. Target: 90% of girls and boys identified as having a disability using the ICF-CY assessment (baseline 0%)	1.Translation of ICF to Macedonian 2. Creating technical assistance for Government in building capacities of disability assessment based on ICF by conducting a series of tasks: desk revies, field visit, training modules, training and reporting 3. Hiring a consultant to support UNICEF in creating a training of trainers 4.Introduction of a new Centers for Social Work system for collecting data on children with disabilities

Sector	Geographic coverage and Target Population	Key Stakeholders	Budget (disability allocation)	CPD Objectives/Planned results	Activities
Child Protection	Nationwide; Children with disabilities in institutions	1. Ministry of Labour and Social Policy 2. Day Care Center Working Groups 3. Families of children with disabilities	$191,546	*Not in CPD*	1. Desk review of international best practices for alternative/family /community care for children with disabilities and proposal for policy and practical change 2. Transition of institutions and reunification of children with families 3. Development of foster/kinship care system for children with disabilities coming out of institutional care, including revision of the standards and training materials, and introduction of support centres for foster carers 4. Conversion of institutions into resource centers and community support services

Sector	**Geographic coverage and Target Population**	**Key Stakeholders**	**Budget (disability allocation)**	**CPD Objectives/Planned results**	**Activities**
Communication	Nationwide; General population of North Macedonia	1.The MK government (incl. Policy makers, MPs, Ministries of Health, Education, Labour and Social Policy 2.Practitioners/Public service providers in health, education and social protection 3.OPDs 4. Media 5. Parents of children with disabilities 6. Children with disabilities 7. Children without disabilities	Unknown	*From Disability Communication Strategy:* Objective 1: Create a broad coalition to drive social change. Objective 2: Increase awareness among the general public and key decision makers of the rights of children with disabilities. Objective 3: Build the capacity of rights holders (children with disabilities and their families) so that they can become agents of change. Objective 4: Increase the number of citizens who have higher expectations of children with disabilities, and see them as having the same potential as children without disabilities	Establish a team of disability spokespersons, including parents, teachers, experts, DPOs; Establish partnerships with CSO/DPOs to oversee the development and implementation of education materials on the UNCRPD to supplement existing primary school curricular. Develop a social media campaign using info-graphics based on key findings of the KABP study; Develop partnerships and plan to organize high profile TV debates on topics related to inclusion; Organize meeting with editors and journalists together with young people with disabilities – spokespersons – to sensitize media professionals about the way media report about people with disabilities. Activate talks “It’s About Ability” with people with disabilities to demonstrate how they have overcome barriers and are participating in society, as well as with parents and educators

Annex C: Stakeholder Map and Sample

Stakeholder	Representation	# of participants	KII	Survey	FGD	ED	SP	Health	CP
Representative from the Ombudsman's Office	National	1	x			x	x	x	x
Representative from Min. of Education	National	1	x			x			
Representative from BDE	National	1	x			x			
Representative of the Min. of Labour and Social Policy	National	1	x				x		x
Representative of Ministry of Health	National	1	x					x	
Representative of the Commission for Protection from Discrimination	National	1	x			x	x	x	x
Representative of Open the Windows	National	1	x			x	x		
Representative of the Resource Center for Parents of Children with Disabilities	National	1	x			x	x	x	x
Representative of Centers for Social Work	National	1	x				x		x
Representative of Macedonian Helsinki Committee	National	1	x						x
Representative from MCEC	National	1	x			x			

Stakeholder	Representation	# of participants	KII	Survey	FGD	ED	SP	Health	CP
Representative of Association of Special Educators	National	1	x			x	x		
Representative of Institute for Social Activities	National	1	x				x		x
Representatives of other UN agencies	National	1 to 2	x			x	x	x	x
Parents/Legal guardians of CWD	National	1 FGD, 4-6 participants			x	x	x	x	x
Representatives from schools	Regional	Survey: Eduino prog. participants, FGD: 6-8 participants		x	x	x			
Representative(s) of Macedonian Medical Association	Regional	Survey: census; FGD: 6-8 participants		x	x			x	
Representative(s) of Association of Patronage Nurses	Regional	Survey: census; FGD: 6-8 participants		x	x			x	
Representative(s) of Health Centers	National	1 FGD, 6-8 participants			x			x	
Parents/foster families of CWD from institutional settings	National	1 FGD, 4-6 participants			x	x	x	x	x
Representatives of Assessment bodies for functional assessment	Regional	1 FGD, 6-8 participants			x			x	x
Representatives of municipalities	Regional	1 FGD, 6-8 participants			x	x	x	x	x

Annex D: Work Plan

	2021			2022								
	10	11	12	1	2	3	4	5	6	7	8	9
INCEPTION (LOE: Team Lead = 13, Team = 8 per person)												
Planning and Start-Up												
Initial planning and inquiry calls with UNICEF	■	■										
Internal IDP team start-up meetings	■	■										
Desk Review												
Compiling existing documentation, evaluation reports, all relevant UNICEF project and programme documents, researches and studies; government strategies and policy documents, primary and secondary data reports	■	■										
Develop desk review protocols (evaluation domains and indicators) for data analysis	■	■										
Validate resources with UNICEF and team and final definition of scope of evaluation	■	■										
Review and code materials and documentation using a rapid analysis approach	■	■										
Inception Report												
Inception Call		■										
Conduct KIIs with UNICEF sector leads (not in original workplan)		■										
Construct Theory of Change		■	■									
Summarize initial findings against the evaluation questions from desk review		■	■									
Draft methodological approach for evaluation				■								
Draft data collection instruments and research protocols				■	■							
Refine evaluation questions and develop evaluation matrix				■	■							
Review research ethics				■	■							
Revise final budget (if necessary)				■	■							
Draft structure for final report				■	■							
Draft Inception Report				■	■							
Submit Draft Inception Report				■	■							
UNICEF review of Inception Report				■	■							
Submit Final Inception Report (20pgs)						■						
Meet with Evaluation Reference Group to Review Inception						■						
DATA COLLECTION (LOE: Team Lead = 12, Team = 18 per person)												
Gather additional documentation and evidence (additional desk review)						■	■	■	■			
Train enumerators						■	■					
Collect data through KIIs, FGDs, and/or Surveys								■	■	■		
Draft and present initial analysis										■		
ANALYSIS AND REPORTING (LOE: Team Lead = 9, Team = 9 per person)												
Data Analysis												
Compile all sources of data and evidence										■	■	
Analyze and synthesize data										■	■	
Validate findings with relevant stakeholders											■	
Report Writing												
Submit draft evaluation report											■	
UNICEF review of Evaluation Report for validation											■	
Review evaluation report											■	
Submit Final Evaluation Report (40-50pgs)											■	■
Prepare and present findings												
Develop PPT presentation of the evaluation, main findings, recommendations, and conclusion											■	■
Present PPT											■	■

Annex E: Theory of Change

If

Positive social norms relating to children with disabilities improve	Stigma and discrimination towards children with disabilities is reduced Social pressure to keep children with disabilities at home is reduced Understanding of the value of pre-school is increased
Policies, legal frameworks, and funding for inclusion of children with disabilities improves	Implementation and enforcement of legislation is increased Funding for policy implementation is increased Secondary legislation is increased
Institutional management and coordination in support of children with disabilities and their families improves	Inter-sectoral cooperation is increased Child rights monitoring systems are strengthened Availability of disaggregated data is increased
Supply and quality of commodities and staff in support of children with disabilities and their families improves	Outreach and community-based services, including access, are increased Costs associated with access to services are reduced Number and distribution of qualified & experienced staff is increased Presence of quality standards is increased
Support for cultural practices of and utilization of services by families of children with disabilities improves	Awareness of available benefits and services is increased Administrative barriers to accessing benefits and services are reduced Parenting skills are improved

Then **The rights of children with disabilities will be progressively realized**

Rights of children with disabilities are progressively realized and implemented in accordance with the CRC and CRPD

They have minimum standard of living and quality health, education and protection services delivered by functioning institutions

Their families care for, protect, nurture and support them

The community respects and promotes their rights and wellbeing

Annex F: Final Report Outline

A proposed outline for the final report is below. As a structural element that will serve to show how services and implementation intersect, IDP will trace the case of an illustrative child with a disability as they experience the various systems (programs, services, and impacts of policies, laws, awareness). This can include their family, service providers, etc. Textboxes throughout the report will detail this story.

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  Program Background and Key Information
1.3. Evaluation Purpose and Methodology
  Evaluation Objectives and Scope
  Evaluation Criteria and Framework
  Methodology
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PART 2. EVALUATION FINDINGS
2.1 Relevance
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2.5 Impact
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2.7 Lessons learned
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PART 3. CONCLUSIONS AND RECOMMENDATIONS
3.1 Conclusions
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ANNEXES
Annex 1: List of Documents Reviewed
Annex 2: List of Key Informants
Annex 3: Surveys
Annex 4: In-Depth Interview Guides
Annex 5: Focus Group Discussion Guides

Annex G: References

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Annex H: Desk Review Protocol

1. Overview

IDP will conduct a thorough desk review to understand the context of UNICEF North Macedonia's efforts to support and advance inclusion of children with disabilities in the country. The desk review will contribute to answering the evaluation questions as well as inform the development of data collection plans and instruments.

2. Sources

IPD will collect the below relevant information from program documents, academic journals, ministry policies and documents, and grey literature. Documents include policies related to inclusion, sector plans/strategies, process flows, standard operating procedures, program reports, journal articles, news articles, and other relevant sources related to inclusion. This review will also include global and regional declarations and frameworks on inclusion and international and regional comparative models of good practice. IDP will also collect relevant documents through interviews and review these as needed.

3. Codes for Desk Review and Data Collection/Analysis

In addition to coding for the evaluative criteria (Relevance, Coherence, Efficiency, Effectiveness, Impact, and Sustainability), IDP has developed the following codes and descriptions to be used to ensure consistent data collection methods when recording data. If the original resource is in Macedonian, the team will provide a summary of the information in English.

Name	Description
1. Government	
International commitments	Information on the ratification of key frameworks such as the CRPD, CRC, Marrakesh, etc. This may include key information from Government official reports and parallel reports submitted by civil society
National laws	Anything that is general or sector specific that relates to children with disabilities
Government collaboration	The role of various members of government ministries and the national and local level in implementation of reforms, institutional support through laws, policies, and funding, intersectoral collaboration
Budget	Information about the process of funding inclusive services in this sector, from donor or government sources, including how funding decisions are made.
2. Social Protection	
Data and prevalence	Information about data that exists or does not exist for beneficiaries in this sector, including prevalence rates. Other codes include: *definition, data collection*
Social services	Relevant information about how the different social service

	agencies/providers in North Macedonia are addressing inclusion through the social sector reform Subcodes: *cash allowance, cash benefits*
International Classification of Functioning, Disability and Health (ICF)	Mention of the process of implementing the ICF classification system, including translation and training on ICF, administration procedures, partnerships for implementation, and data collection and management
COVID-19	Anything related to UNICEF MK's response to COVID-19 as it relates to work with inclusion of children with disabilities in this sector
Other	
3. Child Protection	
Data and prevalence	Information about data that exists or does not exist for beneficiaries in this sector, including prevalence rates related to children transitioned out of institutional care and services provided to families and children. Other codes include: *definition, data collection, foster care, daycare*
Deinstitutionalization	Information about the closure of institutions and shift of staff and facilities to resource centers
Foster/Kinship care	Information about the development of a foster/kinship care system, including training for social workers and families
Daycare	Information about reforming or establishing daycare centers for children with disabilities no longer living in institutions
Community Engagement	Information related to raising awareness and garnering local community support for deinstitutionalization
COVID-19	Anything related to UNICEF MK's response to COVID-19 as it relates to work with inclusion of children with disabilities in this sector
Other	
4. Education	
Data and prevalence	Information about data that exists or does not exist for beneficiaries in this sector, including prevalence rates for the number of children with disabilities in various types of schools. Other codes include: *definition, data collection*
Eligibility for special education services	How students with disabilities are identified within the North Macedonian context and how they are approved as eligible for special education/inclusive education services. Subcodes: *hearing screening, vision screening, testing, learning disability, intellectual disability*
Human capital	The skills, knowledge, and experience within the system that will facilitate effective inclusive education. Subcodes: *general teacher training, inclusive teacher training, special education, classroom supports*

Curriculum	Inclusive curriculum is where a child’s right to access and participate in learning is anticipated, acknowledged, and taken into account. Subcodes: *Access, IEP, transportation, differentiation*
Assessment	How students with disabilities are assessed to capture academic progress. Subcodes: *accommodations, learning outcomes*
Assistive technology	How assistive technology (AT) is used. AT is any item, piece of equipment, software program, or product that increases, maintains, or improves the functional capabilities of a person with a disability. Subcodes: *AT type, AT training, AT budget*
COVID-19	Anything related to UNICEF MK’s response to COVID-19 as it relates to work with inclusion of children with disabilities in this sector
Other	
5. Health and Nutrition	
Budget	Information about the process of funding inclusive services in this sector, from donor or government sources, including how funding decisions are made.
Data and prevalence	Information about data that exists or does not exist for beneficiaries in this sector, including prevalence rates for the number of children with disabilities in various types of schools. Other codes include: *definition, data collection*
Healthcare providers	Information about types of healthcare providers who predominantly work with children with disabilities
Provider training	Information about training provided to healthcare professionals, including family doctors and nurses
Screening and identification tools	Information related to the types of assessment tools that were adopted, piloted, or designed to support the screening and identification of children with disabilities
COVID-19	Anything related to UNICEF MK’s response to COVID-19 as it relates to work with inclusion of children with disabilities in this sector
Other	
6. Communication	
Cultural beliefs	Cultural attitudes or beliefs on disability that may be held by the communities within North Macedonia. Additional cultural beliefs that may have an impact on students with disabilities accessing services. Shifts from the medical to social model of disability.
Parent attitudes	Research or information on the attitudes of parents of children with and without disabilities towards living/childcare situations, healthcare, and education, including possible discriminatory

	views, stigmas, etc., views on where or how they should live and be educated.
Professional attitudes	Research or information on social service, teacher, or health care provider attitudes toward students with disabilities, including possible discriminatory views, stigmas, etc.
KAP Study	UNICEF implemented a KAP stuff to measure shifts in public perception. Code for mentions of use of the KAP study in larger program documents and KIIs.
OPD Engagement	UNICEF partnered with or built capacity of OPDs as part of its communication campaign. Code for mentions of OPD consultation, capacity building, etc.
COVID-19	Anything related to UNICEF MK's response to COVID-19 as it relates to work with inclusion of children with disabilities in this sector
Other	

Annex I: Normative Frameworks

Inclusive Education for Children with Disabilities

Article 24 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) mandates that learners with disabilities receive quality inclusive education (United Nations, 2006). Inclusive education is a term that describes a learning environment wherein students with disabilities are educated in age-appropriate, local school classrooms with their peers without disabilities to the fullest extent possible. Inclusive education is not only about 'placing' children with disabilities in mainstream schools; it also concerns education systems themselves. It requires an adaptation of the general education system to apply a universal design to education that ensures that everyone can access education. Specifically, inclusive education means mainstream education systems respond to the needs of all children, rather than the creation of separate systems to serve some children. General Comment Number 4, developed by the CRPD Committee with the support of international organizations of persons with disabilities (OPDs) and other stakeholders in the field of education, provides additional details on how inclusive education can be achieved. There are several areas related to inclusive education addressed in General Comment Number 4 and this document highlights the areas of inclusive education that most directly relate to the context of North Macedonia

1 Background on Inclusive Education

Global Situation of Barriers to Inclusive Education:

Laws and Policies

- Many laws worldwide do not guarantee the rights of children with disabilities to receive an education in an inclusive setting. In fact, some countries inclusive education policies only allow for students with perceived "mild" disabilities to receive an inclusive education while others are relegated to only receiving segregated education (Hayes and Bulat, 2017).

Inclusive Education Finance

- Inclusive education is underfunded worldwide and especially in low and middle- income countries which impedes countries' ability to bridge the gap between inclusive education policy and practice (Open Society Foundation, 2017; Meijer and Watkins, 2019). Providing learners with disabilities educational supports and special education services in an inclusive setting can be approximately two to four times more expensive than educating learners without disabilities (Evans, 2004). However, research shows the educating learners with disabilities in segregated schools increased expenses by approximately 20% (Evans, 2004).

Access to Inclusive Education

- Children with disabilities not only have challenges accessing inclusive education but many children with disabilities are excluded from all forms of formal education. One study by the United Nations Children's Fund (UNICEF) in 15 countries found that 85% of children with disabilities who were out of school have never attended school (Mizunoya et al., 2016).

Pre-Service Training for Teachers

- Where pre-service teacher training does exist, training often does not include instruction for supporting learners with disabilities in an inclusive setting (WHO, 2011). Pre-service instruction on how to support learners with education usually is only provided to special education teachers or teachers who operate in segregated schools instead of ensuring that all teachers are prepared to support inclusion (Carrol, Forlin, and Jobling, 2003)

In-Service Training for Teachers

- Teachers' in-service training often does not adequately provide the skills needed to support children with disabilities in the classroom. A UNICEF 2012 Global Survey found that 33% of teachers had never received instruction on inclusive education in either pre-service or in-service (Pinnock and Nicholis, 2012)

Teacher Attitudes

- Teachers may have negative attitudes about children with disabilities or are reluctant to have a learner with disabilities in their classroom as they do not feel they possess the skills and knowledge to support them (Crispel and Kasperski, 2019). Teachers with limited previous exposure to learners with disabilities are often concerned that they will not have adequate supports or that having a child with a disability in the classroom will drastically increase workloads. These perceptions may make teachers hesitant to embrace inclusive education (Avramidis and Brahm, 2002)

2 Evidence-Based Good Practices on Inclusive Education

Laws and Policies

- When countries ratify an international treaty, such as the CRPD, a State is legally bound to ensure that its national policies are fully compliant with the standards set forth in the various treaties. Educational laws and policies should make “the right to quality education a reality for all is an absolute priority. This cannot be achieved without strong national legal and policy frameworks that lay the foundation and conditions for the delivery and sustainability of good quality education” (UNESCO, 2014, p. 5). This guidance document reiterates that all educational policies must be fully aligned with “national constitutions, legislation and policies with international standards and provisions” (UNESCO, 2014, p. 5).
- The CRPD calls on States Parties to ensure the full realization of all human rights for all persons with disabilities, including children and obligates States Parties to eliminate all discriminatory legislative and administrative measures and practices (United Nations, 2006, Arts. 4 and 7).
- UNESCO’s Policy Guidelines for Inclusion Education state that at minimum, policies should 1) recognize inclusive education as a right; 2) identify minimum standards in relation to the right to education such as physical and communication access, early identification; adaption of the curriculum and individual student supports; 3) minimum standards to ensure that families and communities are active participants in inclusive education; 4) ensure a transition plan for children with disabilities; 5) identify stakeholders and their responsibilities; 6) provide financial resources to support inclusive education; and 7) establish a monitoring and evaluation mechanism to ensure that inclusive education is being implemented (UNESCO, 2016)
- Policies should be complemented with national strategic plans that address budget, objectives, and targets to achieve various elements of inclusive education (materials, curriculum, teacher training) and relevant data collection (WHO, 2011)

Inclusive Education Finance

- Worldwide there are three models of inclusive education financing: 1) Per capita or cost-based model (where the funding is based on the child's need and diagnosis) 2) resource or school based models (where funding is based on the estimated number of learners with disabilities that would be present in any given community or school) or 3) output based models (where funding is provided in school achievement) (Hayes and Bulat, 2017)
- Each of these funding models has its advantages and disadvantages; however, the resource- school model is often considered to be the best option for countries that do not have complex identification systems (Sharma, et al, 2015; Hayes and Bulat, 2017).
- Budget for inclusive education is typically allocated for professional development and capacity building; human resources (teachers, teacher assistants, etc.) and individualized supports (materials, technology, etc.) (Sharma and Vlcek, 2021)

Access to Education

- Access to education should not be limited based upon a learner's "degree of disability" or their disability type. Instead, it is crucial to recognize that all children, regardless of support needs, should be legally entitled to inclusive education (United Nations, 2016)
- To support quality education, there should be flexible and adapted learning such as Universal Design for Learning (UDL) (Hayes, Turnbull and Moran, 2018)
- For students who are deaf and hard of hearing, inclusion signifies being educated in a sign language-rich environment where they can directly communicate with their peers, teachers, administrators, and staff. Therefore, this may not be currently feasible in many local schools, but the selection of the schools should be done by the students and families and not by the government (World Federation of the Deaf, 2015)
- Reasonable accommodations should be provided to learners who require them. This can include access to assistive devices, accommodations for assessments (extended time, alternate locations, etc.), and accessible materials. (Hayes, Turnbull, and Moran, 2018)
- In cases where there are segregated schools, international best practice suggests meaningfully transitioning children into inclusive settings with staff from segregated schools serving as resource teachers. (Forlin and Rose, 2010; Lapham and Papikyan, 2012) This collaboration between teachers and resource teachers/centers can provide technical support and increase teacher confidence in providing inclusive education.

Pre-Service Training for Teachers

- Pre-service training for teachers should go beyond rights and awareness but provide concrete strategies (such as utilizing UDL in instruction and how to use materials to engage and support instruction) to support students with diverse needs (Hayes, Turnbull and Moran, 2018)
- Teachers should have the opportunity to engage directly with learners with disabilities during a practicum to practice what they have learned on inclusive education and gain confidence in supporting the needs of learners with disabilities (Avramidis and Norwich, 2002)
- All teachers should receive instruction on how to support the learning needs of students with disabilities in an inclusive setting with a certificate in special education for teachers who can serve as resources and support to mainstream teachers. Technical experts (who may serve various schools) in braille literacy, positive behavior support, speech, etc., should be available to teachers as needed. (UNESCO, 2003)

In-Service Training for Teachers

- All teachers should receive continuous professional development in inclusive education that goes beyond awareness raising and provide concrete strategies such as inclusive pedagogy, classroom management, family engagement, and positive behavior support that support inclusion (Forlin and Sin, 2017). In-service training can be progressively realized starting with a few key staff within the school but building to training all staff.
- In-service training should go beyond only educating teachers but all individuals within the school ecosystem, including administrators, support staff, cleaning staff, inspectors, etc. (Bai and Martin, 2015).
- In-service would be coupled with mentorship and coaching opportunities for teachers to receive continual instruction in their classrooms (USAID, 2014).
- Peer support or finding ways to share experiences with other teachers on inclusive education is an effective way for teachers to receive support and learn new practical skills (USAID, 2014).

Teacher Attitudes

- For inclusive education to be achieved, it is not enough to build awareness on inclusion and a rights-based approach, teachers require pedagogical abilities, skills and strategies that can be applied in their classroom (Loreman et al, 2014, Sharma and Sokal, 2015).
- Mainstream teachers who receive additional support services (special education teachers, teacher assistants, etc.) have more positive attitudes toward inclusive education compared to teachers without supports who are concerned about increase workload (Salovita and Schaffus, 2016).
- Teachers who have received training on UDL, have improved attitudes on inclusive education (Evmenova, 2018).

Education Evaluation Rubric

Information collected and examined through desk review, primary data collection and analysis, and secondary data analysis will be triangulated and measured against the normative standards in this rubric, which is based on the evidence described above. All scores will be justified with a narrative explanation based on the evaluation findings.

Scoring criteria:

- **None**: The programme design includes activities and outcomes related to the normative standard, but there is no evidence of even partial alignment with the standard.
- **Partial**: There is evidence that the programme contributed to some outcomes that are in alignment with the standard, but other elements are missing or not aligned. Thus, there is partial alignment.
- **Full:** There is evidence that the programme contributed to outcomes that are in full alignment with the standard.
- **NA:** The standard is not included in the programme design.

Normative standard	**Alignment (NONE/PARTIAL/FULL/NA)**
LAWS AND POLICIES	
1. All educational policies are aligned with the national constitution.	
2. All educational policies are aligned with international standards and provisions described in the CRPD.	
3. Government has eliminated all discriminatory legislative and administrative measures and practices.	
4. Policies 1) recognize inclusive education as a right; 2) identify minimum standards in relation to the right to education such as physical and communication access, early identification; adaption of the curriculum and individual student supports; 3) minimum standards to ensure that families and communities are active participants in inclusive education; 4) ensure a transition plan for children with disabilities; 5) identify stakeholders and their responsibilities; 6) provide financial resources to support inclusive education; and 7) establish a monitoring and evaluation mechanism to ensure that inclusive education is being implemented.	
5. Polices are complemented with national strategic plans that address budget, objectives, and targets to achieve various elements of inclusive education (materials, curriculum, teacher training) and relevant data collection.	
INCLUSIVE EDUCATION FINANCE	
1. Budget for inclusive education follows a resource or school based model (where funding is based on the estimated number of learners with disabilities that would be present in any given community or school).	

2. Budget for inclusive education is allocated for professional development and capacity building; human resources (teachers, teacher assistants, etc.) and individualized supports (materials, technology, etc.)	
ACCESS TO EDUCATION	
1. Access is not limited based upon a learner's “degree of disability” or their disability type.	
2. The curriculum allows for flexible and adapted learning.	
3. Students who are deaf and hard of hearing are able to be educated in a sign language-rich environment where they can directly communicate with their peers, teachers, administrators, and staff. Students/families select the school, not the government.	
4. Reasonable accommodations are provided to learners who require them. This includes access to assistive devices, accommodations for assessments (extended time, alternate locations, etc.), and accessible materials.	
5. Children in segregated schools are transitioned into inclusive settings with staff from segregated schools serving as resource teachers.	
PRE-SERVICE TRAINING FOR TEACHERS	
1. Pre-service training for teachers goes beyond rights and awareness and provides concrete strategies (such as utilizing UDL in instruction and how to use materials to engage and support instruction) to support students with diverse needs.	
2. Teachers in training have practicum experiences to engage directly with learners with disabilities and practice what they have learned on inclusive education and gain confidence in supporting the needs of learners with disabilities.	
3. All teachers receive instruction on how to support the learning needs of students with disabilities in inclusive settings.	
4. Certificate programs are available in special education for teachers to serve as resources and support to mainstream teachers.	
5. Technical experts (who may serve various schools) in braille literacy, positive behavior support, speech, etc., are available to teachers as needed.	

IN-SERVICE TRAINING FOR TEACHERS	
1. All teachers receive continuous professional development in inclusive education that goes beyond awareness raises and provide concrete strategies such as inclusive pedagogy, classroom management, family engagement, and positive behavior support that support inclusion.	
2. In-service training can be progressively realized starting with a few key staff within the school but building to training all staff.	
3. In-service training goes beyond only educating teachers but all individuals within the school ecosystem, including administrators, support staff, cleaning staff, inspectors, etc.	
4. In-service is coupled with mentorship and coaching opportunities for teachers to receive continual instruction in their classrooms.	
5. Peer support or finding ways to share experiences with other teachers on inclusive education allows teachers to receive support and learn new practical skills.	
TEACHER ATTITUDES	
1. Mainstream teachers who receive additional support services (special education teachers, teacher assistants, etc.) have more positive attitudes toward inclusive education compared to teachers without supports who are concerned about increase workload.	
2. Teachers who have received training on UDL, have improved attitudes on inclusive education.	
COMMUNICATION	
1. Sector-specific communication is directly informed by persons with disabilities in relation to appropriate language and images.	
2. Sector-specific communication is accessible for persons with disabilities.	
3. Sector-specific communication includes a variety of disability types and features people with disabilities in active roles, with dynamic personalities, and in relationship with others.	
4. OPDs are engaged to support or disseminate communication.	
5. Sector-specific communication is targeted to sector stakeholders.	

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Child Protection and Deinstitutionalization for Children with Disabilities

Worldwide, it is estimated that approximately 6 million children live in institutions as opposed to family-based care settings and a disproportionate number of these children have disabilities (Desmond et al, 2020; Human Rights Watch, 2017). Although institutions can vary greatly in their structure, size, purpose, and funding mechanism, common types include orphanages, social homes, residential care, or group homes. A prevalent belief is that children with disabilities live in institutions because they require "specialized" care; however, a breadth of research has noted the negative physical, social, cognitive, and emotional effects that institutions have on children (Berens and Nelson, 2015). The United Nations Children's Fund (UNICEF) notes that children in institutions are more likely to "experience abuse, neglect, exploitation, lack of stimulation, poor nutrition, toxic stress, and lifelong physical and psychological repercussions" (UNICEF, nd, p. 1). The impacts can be more pronounced for children with disabilities (described in this brief). This is why there are specific rights enshrined in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) to protect children from moving into institutions and to support the transition to family and community-based living, which is known as deinstitutionalization.

1. Background and Global Situation on Child Protection and Deinstitutionalization

Legal Protections

The right to family living for all children, including those with disabilities, is mandated through Articles 7 and 9 and 20 of the Convention on the Rights of the Child (CRC) and Articles 19 and 23 of the CRPD (United Nations, 1989; United Nations, 2006). Despite these mandates, and even though there are some examples of countries making the move towards deinstitutionalization (Mulheir, 2012), there are relatively few countries which have incorporated these rights in national legislation (Knapp et al, 2021).

Data Collection and Monitoring

The exact number of children, including those with disabilities, living in institutions is neither systematically counted nor monitored regularly (Goldman et al, 2020). Recent estimates suggest approximately 6 million children live in institutions (Desmond et al, 2020) and children with disabilities are often over-represented (Mulheir, 2012). It is important to note though that national records usually undercount, particularly when it comes to children with disabilities. For example, those in private institutions are often not counted at all and, in many countries, there are unregistered institutions that are either not known or not monitored (Knapp et al, 2021). Furthermore, data on the number of children living in institutions is not enough; there is a need for regular data collection on the well-being of children in institutions and those that have transitioned back to family and community-based care; however, this is also not captured on a large-scale (UNICEF, 2022).

Impact of Institutionalization on Children with Disabilities

While there are multiple types of institutions that take children with disabilities, there are several characteristics that are common across many, including lack of control over day-to-day decisions, lack of choice over whom to live with, routine activities that are often not stimulating, a high caregiver-to-resident ratio, high staff turnover, and lack of caregiver training (UN 2014; UN 2019; van IJzendoorn et al, 2011). A large body of evidence exists that demonstrates children in institutions experience stunted physical growth (van IJzendoorn et al, 2007), slower cognitive development including severe language delays (MacLean, 2003; van IJzendoorn et al, 2008), and inability to/difficulty in developing relationships with peers and adults (Vorria et al, 2003; Gunnar et al, 2000).

In addition to this, children with disabilities often face further deprivation, including physical abuse, sexual abuse, and neglect (Mulheir, 2012; Human Rights Watch, 2017). Human Rights Watch (2017) documented practices at institutions across eight countries and found evidence of children with disabilities receiving little to no education and health care, inadequate nutrition, and being subjected to inhumane practices such as being tied to beds and being physically and chemically restrained.

Family and Community-Based Care

Family and community-based caregivers play important roles in preventing (or delaying) a child's admission to an institution as they are often in the best position to advocate for and understand the strengths, needs, and preferences of the child (Knapp, 2021). However, despite this and despite the demonstrated negative effects of institutionalization for children with disabilities, many families feel as though they are unable to look after their children (due to poverty, lack of capacity, etc.) and therefore turn to institutions (Knapp et al, 2021). Globally, many families are unable to access sufficient resources to support them in raising their child with a disability at home as often governments prioritize funding for institutions rather than family-based or community support. The reluctance to fund alternative types of support for children with disabilities can be due to a number of reasons, one of which is that supporting family and community-based care takes more time to generate results (Csaky, 2009).

2. Evidence-Based Good Practices for Child Protection and Deinstitutionalization

Legal Protections

Effective protection of children with disabilities requires that national policies, legislations, and regulations support and provide resources for family and community-based care while phasing out and ultimately eliminating the role of institutions (Goldman et al, 2020). It is also crucial to pair these policies with complementary policies that address some of the root causes of why families institutionalize their children, such as policies to reduce poverty (Goldman et al, 2020). As with other disability-related work, consultations on national policies should be done in close collaboration with those directly impacted, including – but not limited to – persons with disabilities and their families.

Data Collection and Monitoring

Like many other aspects involving children with disabilities, quality data on institutions and progress towards deinstitutionalization is scant. In light of this, there are some general recommendations for monitoring current conditions and progress towards deinstitutionalization, including collecting data on the living situation of all children with disabilities (those in and out of institutions), the characteristics of institutions, and efforts and progress towards removing children from institutions and placing them with family and community-based care (UNICEF, 2022; Goldman et al, 2020). These efforts should be aligned with timely and effective reporting mechanisms for violations of policies regarding living conditions.

Establishing a Cohort of Trained Professionals and Practitioners

Efforts to deinstitutionalize must be coupled with substantial efforts to train new and existing professionals (such as social workers) to ensure, for example, the implementation of strengths-based family assessments, supportive decision-making processes that involve children and their families, and development and monitoring of care plans (Better Care Network and UNICEF, 2015; UNICEF, 2019). In low- and middle-income countries, there is often a lack of social work professionals and so, in addition to training, efforts to deinstitutionalize must include appropriation of sufficient funding to recruit, maintain, and train an acceptable staffing level.

Strengthening Family and Community-Based Care

Family and community-based carers must play a large role in the transition to deinstitutionalization. Some positive supports have been documented, including caregiver support groups and targeted training and awareness-raising activities (Brimblecombe et al, 2018). However, it is also important to recognize that long-term carers across many contexts (not just in low- and middle-income countries) can face long-term economic disadvantages, including forgone employment or education and high out-of-pocket expenses. Therefore, holistic support for carers must take into account these additional burdens (Knapp et al, 2021).

In instances where children with disabilities cannot be placed with their birth families, foster care is an alternative. The supports described above should be provided to foster care families as well as the evidence suggests that there is not enough economic support for foster care families of children with disabilities (UNICEF, 2019). It is also recommended that, particularly for children with disabilities, the foster care system establishes a careful family-assessment process, training, and ongoing monitoring (Better Care Network and UNICEF, 2015).

Developing a Continuum of Inclusive Care

In addition to strong family and community-based supports, deinstitutionalization must be coupled with a continuum of care for children with disabilities, including consistent access to inclusive education, quality healthcare, and community sensitization. When schools cannot (or refuse to) accommodate children with disabilities, institutionalization may seem like a more attractive option; therefore, the provision of inclusive education systems is critical (UNICEF, 2019). Inclusive education also plays a role in supporting the process to deinstitutionalize, enabling children with disabilities to access appropriate supports to develop cognitively and emotionally. Similar to education, health care is critical to enable children with disabilities to flourish in family-based care. Children with disabilities benefit from a range of health care supports – including specialized support – and barriers (including costs) to access those supports should be removed for children and their families (UNICEF, 2019). At the same time, families supporting the deinstitutionalization process may also require additional support (such as mental health services) to help them transition and appropriately care for their child (Goldman et al, 2020).

Child Protection Evaluation Rubric

Information collected and examined through desk review, primary data collection and analysis, and secondary data analysis will be triangulated and measured against the normative standards in this rubric, which is based on the evidence described above. All scores will be justified with a narrative explanation based on the evaluation findings.

Scoring criteria:

- **None**: The programme design includes activities and outcomes related to the normative standard, but there is no evidence of even partial alignment with the standard.
- **Partial**: There is evidence that the programme contributed to some outcomes that are in alignment with the standard, but other elements are missing or not aligned. Thus, there is partial alignment.
- **Full:** There is evidence that the programme contributed to outcomes that are in full alignment with the standard.
- **NA:** The standard is not included in the programme design.

Normative standard	**Programme Alignment (NONE/PARTIAL/FULL/NA)**
LAWS AND POLICIES	
1. National policies, legislation, and regulations support and provide resources for family and community-based care while phasing out and ultimately eliminating the role of institutions.	
2. National policies, legislation, and regulations are developed in close collaboration with OPDs and those with, or impacted by, disabilities.	
DATA AVAILABILITY	
1. Data is routinely collected on the living situation of all children with disabilities (those in and out of institutions).	
2. Data is routinely collected on the characteristics of institutions.	
3. Data is routinely collected on efforts and progress towards removing children from institutions and placing them with family and community-based care.	
4. Timely and effective reporting mechanisms are in place for violations of policies regarding living conditions	
PROGRAM DESIGN	
1. New and existing professionals (such as social workers) receive training to ensure the implementation of strengths-based family assessments, supportive decision-making processes that involve children and their families, and development and monitoring of care plans.	

2. Sufficient funding is available to recruit, maintain, and train an acceptable staffing level of social work professionals.	
3. Family and community-based carers of children with disabilities receive initial training.	
4. Family and community-based carers of children with disabilities have access to supports such as groups of other carers, targeted training on specific needs, and mental health services for carers.	
5. The foster care system establishes a careful family-assessment process, training, and ongoing monitoring of foster families caring for children with disabilities.	
6. Family and community-based carers of children with disabilities receive support to access and provide a continuum of inclusive care across the education and health sectors.	
COMMUNICATION	
6. Sector-specific communication is directly informed by persons with disabilities in relation to appropriate language and images.	
7. Sector-specific communication is accessible for persons with disabilities.	
8. Sector-specific communication includes a variety of disability types and features people with disabilities in active roles, with dynamic personalities, and in relationship with others.	
9. OPDs are engaged to support or disseminate communication.	
10. Sector-specific communication is targeted to sector stakeholders.	

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Social Protection for Children with Disabilities

Disability and poverty are closely linked. Globally, evidence suggests that persons with disabilities are more likely to experience multidimensional poverty, meaning they are often vulnerable across a range of dimensions resulting in low income, lack of education, poor living standards, inability to access quality healthcare, and disempowerment to name a few (ILO and IDA, 2019). Families raising children with disabilities face compounding challenges that can trap them in poverty, including reduced earning opportunities from having to stay home to care for their children and increased costs for specialist care, education, and childcare (UNICEF, 2019). COVID-19 has exacerbated challenges for families of children with disabilities, which underscores the need for strong social protection programs.

UNICEF defines social protection as a "set of policies and programs aimed at prevention or protecting all people against poverty, vulnerability and social exclusion, throughout their life cycles with a particular emphasis towards vulnerable groups" (UNICEF, nd). Furthermore, the United Nations stated that "the inclusion of persons with disabilities in the social protection system is not only a human rights issue, but also a crucial investment for development that States cannot afford to miss" (UN General Assembly, 2015, V. 87 p.24). Despite the strong correlation between disability and vulnerability and the global push for social protection for persons with disabilities, worldwide only 27.8% of persons with disabilities that require high support needs accessed a disability benefit (ILO, 2017). The coverage rate in middle- and low-income countries is even lower, with 18.5% of persons with severe disabilities accessing a disability benefit (Duran-Valverde et al, 2019).

Disability-inclusive social protection should take a twin-track approach: (1) improving mainstream social protection programs to integrate the needs of persons with disabilities and (2) rolling-out disability-specific and disability-targeted programs (ILO and IDA, 2019; Sammon, 2021). For these programs to effectively reach all individuals with disabilities, including children, organizations of persons with disabilities (OPDs) should be consulted in the design of laws and programs. Furthermore, there must be an effective identification and registration process as well as a transparent system to determine eligibility (Sammon, 2021).

1. Background and Global Situation on Social Protection Systems for Children with Disabilities

Social Protection Laws

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) highlights the critical role that *inclusive* social protection can play in supporting persons with disabilities (including children) to fully participate in society. The CRPD embraces a rights-based approach and emphasizes that social protection systems must, above all, advance the empowerment and inclusion of all persons with disabilities. Specifically, Articles 25, 27, and 28 recommend that States ensure that persons with disabilities have equal access to all social protection programs including poverty reduction schemes, pensions, public housing, health insurance, vocational training, and return-to-work schemes (United Nations Convention on the Rights of Persons with Disabilities, 2006).

Many countries have ratified the CRPD (except for 15) which means that those countries are legally bound to ensure their national policies and laws are compliant with the standards set forth in the CRPD. However, this does not happen consistently, and, in many instances, social protection policies fall short of including all persons with disabilities (UN General Assembly, 2015). Some countries have strong disability-specific policies, in addition to social protection policies;

however, these policies may not align, which still results in persons with disabilities having unequal access to social protection programs (UNICEF, nd).

***North Macedonia Spotlight*: Social Protection Laws for Persons with Disabilities**

Over the past several years, North Macedonia has taken steps to strengthen social protection for persons with disabilities. In 2019, North Macedonia adopted a new Law on Social Protection which increases access to programs for persons with disabilities. A sample of notable revisions in the law include the following (Mitev, 2019):

- Adjusted the Guaranteed Minimum Assistance (GMA) rates to account for households who have persons with disabilities. Previously, GMA rates were calculated for one member of the household and then adjusted, through an equivalence scale, if the household had more than one member. Now, the law provides a revised equivalence scale for households who have persons with disabilities.
- Specifically, for families with children with disabilities, the law provides for salary compensation for shorter working hours in instances where parents/guardians are caring for their child with a disability.

Despite these positive steps forward, ODPs and stakeholders have suggested that the new law has not gone far enough as it does not recognize persons with mild intellectual disabilities as beneficiaries of the new disability allowance. This example from North Macedonia highlights the complexities of legal system around social protection for children and adults with disabilities.

Data on Children with Disabilities

The development and rollout of any social protection program hinges on comprehensive and reliable data about the population it is aiming to support. When examining the global population of persons with disabilities, most estimates suggest that 15% of the population has a disability, with prevalence rates higher in developing countries (WHO, 2011). Global data on children with disabilities is more difficult to obtain and harder to generalize. This is due to several factors including, for example, cultural differences around the expectations of children's development and the use of proxy respondents in any data collection focused on children with disabilities (UNICEF, 2021).

It's not just disability prevalence rates that are important for designing and implementing social protection programs. Data on actual disability costs for children with disabilities is critical. There can be both direct and indirect costs for children with disabilities. Examples of direct costs include assistive devices, rehabilitation, increased healthcare costs, and increased transportation costs. Examples of indirect costs include parents staying at home to care for their child and forgoing some or all of their income from working (Mitra et al, 2017). Multiple factors can influence these costs and while there are several approaches that attempt to measure them, the overall consensus is that most social protection programs currently do not take into account these disability-specific costs when determining support levels (Mitra et al, 2017; UNICEF, 2019).

Types of Social Protection Programs

There are several types of social protection schemes for children with disabilities and their families, including social assistance programs, social insurance, social care services, and universal health coverage (UNICEF, nd). However, cash transfer programs (which come under social assistance) are considered one of the more common types of social protection for children and families (UNICEF, 2017). Cash transfers can be conditional or unconditional as well as targeted or universal. Overall, research on the effectiveness of cash transfer programs for children with disabilities and their families is extremely limited; however, some general observations emerge:

- Cash benefits for children and adults with disabilities are sometimes seen as controversial as there are concerns by many advocates that this approach reinforces a charity model instead of empowering individuals with disabilities (Abu Al Ghaib, 2017).
- Conditional cash transfer programs (which require households/beneficiaries to meet certain requirements in order to benefit from the program) that are not specifically targeted towards disability have faced some criticism for disadvantaging vulnerable children as caregivers may face more challenges in complying with conditions due to disability, discrimination, and other barriers (Asian Development Bank, 2008).
- There are some positive examples where targeted cash transfers to children with disabilities have been paired with additional supports, such as case management services. This twin approach has supported both children with disabilities and their families through not only economic benefits but also social benefits such as an increase in use of specialized services and a decrease in negative coping strategies by the household (UNICEF, 2019).

2. Evidence-Based Good Practices for Social Protection for Children with Disabilities

Social Protection Laws

Children with disabilities have unique characteristics (and challenges). Organizations such as UNICEF and the ILO have been working to advance social protection frameworks for children in general; however, children with disabilities must be considered in the development and review of national-level social protection laws and strategies (UNICEF, nd). Furthermore, since many countries have fragmented social protection systems (meaning there often is not one overarching/cohesive policy or law), it is important to strengthen national-level coordination mechanisms between agencies and departments that are involved in social protection programs for children with disabilities (UNICEF Syria, 2019).

Data on Children with Disabilities

Even beyond the field of social protection, the international community has long advocated for better data monitoring systems for children with disabilities. As children develop and transition to adulthood, it is important to have systems of early identification as well as regular monitoring and screening of a child’s development (WHO, 2011). Having a national registry for children with disabilities that is up to date and captures the full spectrum of disabilities can support a more efficient allocation of social protection resources (UNICEF, nd; UNICEF, 2019).

Design of Social Protection Programs

While evidence on the effectiveness of social protection programs for children with disabilities is limited, there are some recognized inclusive practices that have emerged from specific case studies as well as robust position papers from a consortium of organizations such as UNICEF, ILO, and IDA. Several of these practices and recommendations are presented below.

- **Recognize the unique costs related to disabilities:** Children with disabilities and their families face unique challenges and, more specifically, they face a different set of costs. Governments need to account for the extra costs experienced by families (such as healthcare, transportation, education, assistive devices and the variation in these costs depending on type and severity of disability) in order to establish adequate benefits and supports. Social protection benefits for this group cannot take a one-size-fits-all approach (UNICEF, nd; UNICEF, 2019).

- **Carefully consider eligibility criteria:** Determining inclusive and transparent eligibility criteria is a critical component of any social protection program. Persons with disabilities can face exclusion in traditional eligibility assessments (Mitra, 2010; Palmer and Nguyen, 2012). Generally, there are two prominent ways in which this can happen. The first is that many countries rely on a medical diagnosis to determine eligibility for disability-targeted social protection programs. This is a narrow way of looking at disability and does not consider functional limitations that individuals may face (Farinha, 2021). Additionally, this approach conflicts with the rights-based approach to disability enshrined in the CRPD. The second is that in cases where social protection is not necessarily targeted to persons with disabilities but rather relies on a household's assessment against a determined "poverty threshold," people with disabilities can be left out. A determined "poverty threshold" may look at a household's income but it does not adjust or account for the additional disability costs that families of children with disabilities face (ILO and IDA, 2019). Practitioners recommend that these assessments are broadened to look at not only impairments but also environmental barriers that persons with disabilities face. Additionally, any type of threshold assessment needs to account for additional disability-related costs (ILO and IDA, 2019). This approach casts a more inclusive net and helps to ensure that children with disabilities get the support they need.
- **Cash alone is insufficient; consider "cash plus" strategies:** Children with disabilities should have access to a wide variety of supports. While cash transfer programs can provide some economic advantages to families of children with disabilities, experts recommend that this be supplemented by disability-targeted services to enable transformative support and advance the rights-based approach. Examples of other types of services that can fall under social protection schemes for children with disabilities include enabling access to formal inclusive education, specialist health (including mental health) providers, family support programs, and peer support programs (International Policy Centre for Inclusive Growth, 2018; Ullmann et al, 2021).
- **Consult with OPDs:** Active and proactive involvement of persons with disabilities is crucial for all disability-related programming. This is even stated as an obligation in Article 4.3 of the CRPD (United Nations Convention on the Rights of Persons with Disabilities, 2006). Where countries have disability-specific social protection programs, OPDs are often consulted; however, they must be included in discussions around mainstream social protection programs so that they can support policymakers to refine priorities and ensure that children with disabilities and their families are fully included (ILO and IDA, 2019). Additionally, OPDs can play a large role in raising awareness of social protection programs as often persons with disabilities do not know that programs exist or how to access them (Development Pathways, 2019; ILO and IDA, 2019).

Social Protection Evaluation Rubric

Information collected and examined through desk review, primary data collection and analysis, and secondary data analysis will be triangulated and measured against the normative standards in this rubric, which is based on the evidence described above. All scores will be justified with a narrative explanation based on the evaluation findings.

Scoring criteria:

- **None**: The programme design includes activities and outcomes related to the normative standard, but there is no evidence of even partial alignment with the standard.
- **Partial**: There is evidence that the programme contributed to some outcomes that are in alignment with the standard, but other elements are missing or not aligned. Thus, there is partial alignment.
- **Full:** There is evidence that the programme contributed to outcomes that are in full alignment with the standard.
- **NA:** The standard is not included in the programme design.

Normative standard	**Programme Alignment (NONE/PARTIAL/FULL/NA)**
LAWS AND POLICIES	
1. Children with disabilities are considered in the development and review of national-level social protection laws and strategies.	
2. Coordination mechanisms exist between agencies and departments that are involved in social protection programs for children with disabilities.	
DATA AVAILABILITY	
1. A national registry for children with disabilities exists that is up to date and captures the full spectrum of disabilities.	
2. Government accounts for the extra costs experienced by families of children with disabilities (such as healthcare, transportation, education, assistive devices and the variation in these costs depending on type and severity of disability) in order to establish adequate benefits and supports.	
PROGRAM DESIGN	
1. Eligibility criteria considers medical diagnosis of disability as well as functional limitations and environmental barriers.	
2. Families of children with disabilities are not excluded from services based on the same income calculations as people without disabilities.	
3. The program provides cash benefits plus access to services (such as access to formal inclusive education, specialist health - including mental health - providers, family support programs, and peer support programs.	

4. OPDs are included in discussions about mainstream social protection programs so that they can support policymakers to refine priorities and ensure that children with disabilities and their families are fully included.	
5. OPDs are active in raising awareness of social protection programs.	
COMMUNICATION	
11. Sector-specific communication is directly informed by persons with disabilities in relation to appropriate language and images.	
12. Sector-specific communication is accessible for persons with disabilities.	
13. Sector-specific communication includes a variety of disability types and features people with disabilities in active roles, with dynamic personalities, and in relationship with others.	
14. OPDs are engaged to support or disseminate communication.	
15. Sector-specific communication is targeted to sector stakeholders.	

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https://www.unicef.org/syria/media/5316/file/Cash%20transfer%20programme%20for%20children%20with%20disabilities%202019.pdf

Development Pathways 2019 https://www.developmentpathways.co.uk/blog/building-inclusive-social-protection-systems-for-persons-with-disabilities-in-low-and-middle-income-countries/

International Policy Centre for Inclusive Growth 2018 http://www.ipc-undp.org/pub/eng/PIF43_Social_protection_meeting_children_s_rights_and_needs.pdf

Ullmann et al 2021 https://www.unicef.org/lac/media/22406/file/No-contributory-cash-transfers.pdf

WHO 2011 – World Report on Disability

Primary Healthcare for Children with Disabilities

Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) states that persons with disabilities have a right to receive healthcare service on an equal basis as individuals without disabilities, including healthcare that is in or near their local community. Article 25 also indicates that States should “provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons” (CRPD, Art. 25b). To do this effectively, many individuals may first need to be identified as having a functional limitation or disability.

Furthermore, Article 26, on Habilitation and Rehabilitation, indicates that “comprehensive habilitation and rehabilitation services and programmes” should “begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths” (CRPD, Art. 26 1a). The World Health Organization (WHO) defines rehabilitation as “a set of interventions designed to… optimize functioning in individuals with health conditions in interaction with their environment” (WHO, 2017a). The WHO approach of focusing on the health and functional limitation over disability diagnosis is in line with the CRPD and biopsychosocial model of disability adopted by WHO, which seeks to combine the medical (e.g., providing medical support and treatment as needed and beneficial) and social (e.g., understanding the interaction between a person’s functional limitation and barriers presented in society) model of disability within healthcare.

From a healthcare perspective, in order for children with disabilities to receive the support and services available to them, they must first be accurately screened for disability. Early identification services, ideally before children reach school age, can help to connect families with social assistance, rehabilitation services, supports, and interventions that can mitigate some of the developmental delays that may occur if not addressed until later in the child’s life (Scherzer, et. al., 2012).

Background on Identification and Rehabilitation

Global Situation

The WHO estimates that 15% of the global population has a disability (WHO, 2015). This rate can vary depending on the country context, with lower income countries tending to have higher prevalence of disability in their populations due to a range of factors, including poor nutrition, conflict, violence, substance abuse, and environmental disasters, among others. Further, approximately 1 in 20 children (93 million) are estimated to have a moderate or severe disability (WHO, 2015). Yet, the available data on disability prevalence by country is inconsistent and scant, which can greatly hinder responsive policy making and service provision (WHO, 2017a).

Once a person has received a disability diagnosis, they are entitled to receive various supports, as specified by the CRPD. In 2017 the WHO convened 208 participants from numerous regions and countries to discuss the dearth of rehabilitation services available globally. The meeting resulted in a Call to Action that identified several barriers needing urgent attention. These include:

- under-prioritization by government amongst competing priorities;
- absence of rehabilitation policies and planning at national and sub-national levels;
- limited coordination between ministries of health and social affairs where both are involved in rehabilitation governance;

- non-existent or inadequate funding;
- a dearth of evidence of met and unmet rehabilitation needs;
- insufficient numbers and skills of rehabilitation professionals;
- absence of rehabilitation facilities and equipment; and
- lack of integration into health systems.

Data

When assessing for disability, there are two types of tools commonly used: screening tools and diagnostic tests. Screening tests flag the potential of a condition and indicate if a need exists for further diagnostic testing. Diagnostic tests provide "definitive information about the presence or absence of a target condition" (Trevethan, 2017, p. 1). The benefits of using screening tools are as follows: they are known to be more accessible, less time-intensive, less expensive, and place fewer demands on the healthcare system. Many high-income countries have put in place developmental monitoring protocols and standards requiring primary care pediatricians to apply simple tools at prescribed timepoints during early childhood development to flag the need for the screening of potential limitations or disabilities (Scherzer, et. al., 2012).

The screening tool most widely used within the medical setting is the International Classification of Functioning, Disability, and Health (ICF), released by the WHO in 2001. The ICF framework constitutes a shift from a medical model of disability to a social or human rights model. Yet, even information on which countries use the ICF tool, let alone the associated aggregate data on disability prevalence, is difficult to find or still emerging. Some data is available on disability prevalence through UNICEF's household-based Multiple Indicator Cluster Survey (MICS), administered to a sample of the population in 118 participating countries. MICS includes a Washington Group child functioning module (WG-CFM) for children 2 and above (UNICEF MICS).

Laws and Policies

Many countries that have ratified the CRPD fall along a continuum of realizing their commitment through enacting domestic legislation. Laws relating to healthcare, including affordable provision of health insurance, protection from discrimination from healthcare providers, and access to early identification of disability and rehabilitation services, are not universal. Though some countries have made progress, the movement towards the main purpose of the paradigm shift (i.e. treating people with disabilities as full "subjects" bearing equal rights and deserving equal respect, and not as "objects" to be managed or pitied) has been uneven (EFC, 2010).

Even where laws or policies are in place, implementation can lag behind and there might be a significant dissonance ("implementation gap") between policy and practice. The country may even have advanced disability legislation and policies on paper, but not have an effective administrative infrastructure to implement them (Lang, 2010). Moreover, the evidence shows that people with disabilities experience poorer levels of healthcare compared to the general population (WHO, 2010). UNICEF notes the substantial challenges that accompany actual implementation of the ICF after it is adopted. "It requires substantial institutional changes, including establishing multi-disciplinary assessment teams; introducing new assessment methodologies, instruments and equipment; and recruiting professionals with a distinct set of skills" (UNICEF, nd, p5).

Finance

Rehabilitation can be costly in some cases, and financial considerations vary by country context. Again, there is little evidence available for LMICs that can be used to ascertain cost-effectiveness, particularly as such calculations must factor in not only the cost of providing services, but also cost savings that come about through the resulting increases in functioning and independence. Returns on investments in rehabilitation can be seen not only in the health sector, but also in the education and labor sectors, as well as in more general measures of social and family well-being (WHO, 2017a).

Many countries across the Central and Eastern Europe region provide universal health coverage for their citizen populations, but the extent to which truly no-cost services to children with disabilities is implemented varies, with some evidence that informal out of pocket payments are sometimes expected from families of children with disabilities. Specialist rehabilitation services are also not always covered by health insurance (UNICEF, nd.).

Training of healthcare providers

Decreases in child mortality rates within many low and middle income countries (LMIC), and the subsequent reduction in the need for a heavy focus on acute life-saving medical interventions, has revealed a skills gap among health care providers. Medical training is typically focused on growth metrics and on diagnosing and treating childhood illnesses. Many healthcare professionals do not possess the training or ability to identify developmental delays and disabilities among children in their care, nor focus support on increasing functioning (Scherzer, et. al., 2012, Cieza, et. al., 2021, WHO, 2017a).

WHO notes that accessing services for children with disabilities is voluntary on the part of individuals and families, but recipients may need help to recognize and understand their needs, and should be empowered to make informed decisions (WHO, 2017). Thus, healthcare providers not only need to be trained to identify disability, make referrals, and provide appropriate care; they also need to be cognizant of their patients' rights and support them in self-advocacy.

Limited data exists on rates of access to rehabilitation services for children once they have been identified as having a disability. One systematic review in LMICs found that "access to rehabilitation services was highly variable and poorly measured…but generally shown to be low" (Bright, Wallace, and Kuper, 2018). The WHO estimates fewer than 10 rehabilitation practitioners exist per one million people in LMICs (WHO, 2017a).

Evidence-Based Good Practices on Identification and Rehabilitation

Laws and Policies

Articles 25 and 26 of the CRPD require that laws relating to healthcare must ensure that people with disabilities enjoy the highest attainable standard of health without discrimination. More specifically, laws and policies must ensure that persons with disabilities have access to a) the same range, quality, and standard of affordable healthcare that is provided to other persons and b) specific healthcare services needed because of their disability (early identification and intervention and services to minimize and prevent future disabilities). Healthcare should be accessible and physically proximate to the home or the community. Laws should ensure that identification and rehabilitation services are available and affordable, and that rehabilitation not be allocated solely for adult populations (such as in the context of returning to the workforce), but also integrated into early childhood care (WHO, 2017a). Sound laws and policies on healthcare of persons with disabilities must include the following elements: health promotion, prevention, medical care, rehabilitation and assistive devices (WHO, 2010).

Data

Countries should have in place an effective process for identifying and subsequently registering people with disabilities, as well as a transparent system to determine their eligibility for support services (Sammon, 2021). A country's national Health Information System (HIS) needs to have the capacity to include accurate information on functioning, disability status, and rehabilitation needs and provision (WHO, 2017b), including assistive devices, which is rarely included in HIS databases (UNICEF, nd). This is not only important for healthcare and rehabilitation providers, but also for policymakers who need population data to make informed decisions about policy and funding (WHO, 2015).

Finance

Funding should be provided so that healthcare providers, particularly primary care doctors and nurses and pediatricians, can receive pre-service and in-service education and training on how to identify functional limitations, developmental delays, and disabilities and provide or refer identified children with evidence-based habilitation or rehabilitation services. Universal health coverage should include standard screening and rehabilitation services as needed, with no co-pays required of families or individuals, and connections to early intervention services.

Training for Healthcare Providers

The WHO calls on nations to "train health professionals on early identification, assessment and referral of people that can benefit from rehabilitation, habilitation, support and assistance services" as part of sustainable workforce development efforts (WHO, 2015, p18). Such training should be integrated into core educational curricula for rising medical professionals, as well as provided as continuing professional development opportunities for existing healthcare providers.

Healthcare Evaluation Rubric

Information collected and examined through desk review, primary data collection and analysis, and secondary data analysis will be triangulated and measured against the normative standards in this rubric, which is based on the evidence described above. All scores will be justified with a narrative explanation based on the evaluation findings.

Scoring criteria:

- **None**: The programme design includes activities and outcomes related to the normative standard, but there is no evidence of even partial alignment with the standard.
- **Partial**: There is evidence that the programme contributed to some outcomes that are in alignment with the standard, but other elements are missing or not aligned. Thus, there is partial alignment.
- **Full:** There is evidence that the programme contributed to outcomes that are in full alignment with the standard.
- **NA:** The standard is not included in the programme design.

Normative standard	**Programme Alignment (NONE/PARTIAL/FULL/NA)**
LAWS AND POLICIES	
1. Laws and policies provide that children with disabilities have access to the same range, quality, and standard of affordable healthcare that is provided to other persons.	
2. Laws and policies provide that children with disabilities have access to specific healthcare services needed because of their disability (early identification and intervention and services to minimize and prevent future disabilities).	
3. Laws and policies provide that children with disabilities have access to rehabilitation care, if needed.	
4. Laws and policies provide that children with disabilities have access to assistive devices, if needed.	
5. Laws and policies provide that healthcare for CWD is accessible and physically proximate to the home or community.	
6. Laws and policies ensure that identification and rehabilitation services for CWD are affordable.	
DATA AVAILABILITY	
1. An established process exists for identifying and subsequently registering children with disabilities.	
2. The national Health Information System (HIS) has the capacity to include accurate information on functioning, disability status, and rehabilitation needs and provision, including assistive devices.	
PROGRAM DESIGN	

1. Pre-service training on how to identify functional limitations, developmental delays, and disabilities and provide or refer identified children with evidence-based habilitation or rehabilitation services is integrated into core educational curricula.	
2. In-service training on how to identify functional limitations, developmental delays, and disabilities and provide or refer identified children with evidence-based habilitation or rehabilitation services is provided as continuing professional development opportunities for existing healthcare providers.	
COMMUNICATION	
16. Sector-specific communication is directly informed by persons with disabilities in relation to appropriate language and images.	
17. Sector-specific communication is accessible for persons with disabilities.	
18. Sector-specific communication includes a variety of disability types and features people with disabilities in active roles, with dynamic personalities, and in relationship with others.	
19. OPDs are engaged to support or disseminate communication.	
20. Sector-specific communication is targeted to sector stakeholders.	

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Communication About Children with Disabilities

Attitudes and beliefs about children with disabilities are key determinants of social inclusion. Across different countries and contexts, negative attitudes, misconceptions, and social norms can impact the life of a child with a disability and, for example, result in poor quality (or lack of) education, difficulty in developing social bonds with peers, and challenges in obtaining healthcare (Jones, Presler-Marshall, and Stavropoulou, 2018). Social and behavior change communication can influence changes in attitudes, beliefs, behaviors, and social norms that can support full inclusion of children with disabilities. In taking a holistic approach, social and behavior change communication strategies (similar to UNICEF's Communication for Development framework) are generally built on four inter-related levels of influence: (1) individual; (2) family and peer networks; (3) community; and (4) social and structural (USAID, nd; UNICEF, 2016; CDC, nd). This approach recognizes that attitudes and practices at each of these four levels can impact children with disabilities and that approaches to promote positive changes must target multiple levels. For the purposes of this brief, three levels are discussed: (1) individual and family; (2) organizational; and (3) social and structural. Attitudes and perceptions within each level also cut across programmatic and technical areas such as education, health, social protection, etc.

Past – and in some contexts, present – models of disability have shaped how individuals, peers, communities, and society view children with disabilities, and it is important to understand these models when exploring and interrogating communication strategies to change attitudes.

Models of Disability

Charity Model: This model considers persons with disabilities as objects of charity rather than as empowered individuals. The result of this model is that individuals, peers, communities, and societies limit their responses to care and assistance.

Medical Model: This model considers persons with disabilities as having a medical condition that needs to be treated. The result of this model is that individuals, peers, communities, and societies treat persons with disabilities as if they need to be "fixed."

The CRPD has tried to shift the approach away from the charity and medical models towards the **Social Model** (UN, 2006). This model frames disability as something that is socially constructed and that societal barriers (consisting of attitudinal, physical, and information/communication) do not adequately accommodate an individual's differences. This model puts the individual at the center. While there is still a lot of work to be done to shift to the social model in all contexts, communications can play a key role in helping the shift happen.

Source: UN (2021)

1. Background and Global Situation on Attitudes towards Children with Disabilities

Individual and family level

Individual attitudes towards children with disabilities are often influenced by family, peer, and community attitudes. It is important to note that these attitudes can vary within countries, communities, and even within an individual family; attitudes towards persons with disabilities are largely context-driven. Looking particularly at low- and middle-income countries, many communities associate disability with incapacity, misfortune, and shame (Jones, Presler-Marshall, and Stavropoulou, 2018). In extreme examples, children with disabilities are hidden at home and denied access to education (as parents do not see the benefit of sending them to school), health care, and social interaction to name a few (Groce and Kett, 2014; Inguanzo, 2017; Rohwerder, 2018). Even in instances where parents may not harbor negative attitudes towards their children with disabilities, they often choose to keep them hidden to protect them from the prevailing negative perception and stigma that exists in their society (UN, 2016). Where children with disabilities are able to interact with peers (either in or out of a school setting), they can face negative attitudes including bullying and rude behavior (Godeau et al, 2010). This further highlights the fact that just physically being included in schools (in an inclusive setting) does not necessarily result in positive acceptance or strong peer relationships (de Boer et al, 2012).

Organizational level

Beyond individual attitudes, organizational-level attitudes can impact whether children with disabilities feel included and empowered. When discussing specifically children with disabilities, the most obvious example of organizational-level attitudes is within the education sector. Teacher attitudes towards inclusive education and the education of children with disabilities varies greatly across contexts. A review of teacher attitudes towards disability and inclusive education showed that their attitudes could vary as a function of country-level policies (e.g.: teachers may have more positive attitudes if the country has a strong inclusive education policy) and support systems within the school (Avarmidis and Norwich, 2002; Urton et al, 2014). Additionally, teacher's attitudes can vary based on type of disability. Teachers can perceive certain disabilities as harder to accommodate than others and may be more reluctant to include those students in their classroom (Jury et al, 2021).

In addition to the education sector, healthcare is another area where not only can there be negative attitudes towards persons with disabilities, but also that these attitudes can impact the quality of healthcare provided (VanPuymbrouck et al, 2020). A review of studies focused on low- and middle-income countries found that persons with disabilities reported "attitudes of healthcare staff" as a barrier to accessing healthcare. On the part of the healthcare worker, examples included lack of perceived need, lack of awareness, poor communication with the patient, and discrimination against the patient (Bright and Kuper, 2018). Additionally, healthcare providers often have limited knowledge and understanding of the rights of persons with disabilities and are therefore unable to provide them with a high standard of care (WHO, 2021; UN 2018). When persons with disabilities feel as though they cannot access quality health care (due to negative attitudes from healthcare workers), it can impact their willingness and ability to seek out medical care.

Social and structural level

The CRPD obliges governments to implement policies that enable people with disabilities to fully participate in all aspects of society so that they can achieve the fullest quality of life (UN, 2006) and so that societies can move towards the transformational social model of disability. However, globally, there is still discriminatory legislation and policies that reinforce prejudice and act as a key driver of negative attitudes towards persons with disabilities (Rohwerder, 2018). At the social and structural level, organizations of persons with disabilities (OPDs), based on their first-hand experience of attitudinal challenges and barriers, often advocate for structural-level reforms that may, or may not, result in policy changes.

Beyond individual/family and organizational attitudes towards persons with disabilities, societal and social factors can also shape attitudes. Generally, research has shown that collectivistic societies have less favorable attitudes towards persons with disabilities than individualistic societies (Benomir et al, 2016; Black et al, 2003). To combat societal misconceptions of persons with disabilities, many governments partner with organizations to (international, national, and local) to deliver communications campaigns. As stipulated in Article 8 of the CRPD, awareness-raising campaigns are critical tools that governments must use to combat stereotypes, promote the contributions of persons with disabilities, and strengthen positive relationships towards persons with disabilities (UN, 2006). Despite this mandate, there is minimal evidence on the long-term impact of disability awareness campaigns on improved attitudes and beliefs of the public (Scior et al, 2015; Fisher and Purcal, 2017).

2. Evidence-Based Good Practices for Inclusive and Equitable Communication

Misconceptions and prejudicial attitudes about disabilities are often difficult to overcome; however, targeted communication strategies can, over time, support individuals, communities, organizations, and societies to change the way they see and treat individuals with disabilities. It is important to begin each communication campaign/strategy with an understanding of the issues (e.g.: through a Knowledge, Attitudes, and Practices survey), develop inclusive and disability-sensitive communications materials, and monitor the progress and impact of the campaign/strategy (UNICEF, 2017). Some general communication tips when working with persons with disabilities can be found in the textbox, while more specific examples of good practices are found at the end of this section.

General Communication Tips when Designing Inclusive Messaging

1. **Use empowering images and language:** Consult with persons with disabilities about whether they prefer "person first" or "identity first" language and use images that show persons with disabilities as active participants. Consult with local OPDs to use context-appropriate language.
2. **Consider the medium:** Pick the most accessible medium (or mix of several) for delivering a communications message.
3. **Collaborate with OPDs and persons with disabilities:** Communication about disabilities should include people with disabilities and campaigns should embody the principle "nothing about us without us."

Source: adapted from USAID (nd) and UN (2021)

It is important to note that most of the research referenced below focuses on communication strategies that improve changes in *attitudes* towards children with disabilities. There is relatively little research on communication strategies that change *the long-term behavior* of individuals towards children with disabilities which is arguably more impactful and should be explored further.

Individual and family level

Families and communities can play an important role in shaping attitudes towards children with disabilities. They are particularly influential in low- and middle-income countries where there may be a lack of targeted support for children with disabilities (McKenzie and Muller, 2006). When parents are supported to challenge myths and misconceptions around disabilities, particularly in forums such as parent associations and community meetings (and through the use of contextually appropriate mediums such as drama, songs, and speeches), they are likely to have more positive perceptions of children with disabilities, including their own child (McConkey et al, 2016). Other communication strategies that have improved family, community, and peer attitudes towards children with disabilities have involved using radio, television, and brochures to convey messages and, in those messages, using both children with and without disabilities (UNICEF, 2007; UNICEF 2018).

Organizational

Whereas there are several examples of successful communication campaigns for children with disabilities (UNICEF 2018; UNICEF 2017), transformative communication strategies do not just have to happen at the national level, and they do not always have to be large-scale – even though evidence points to targeted in-service trainings on inclusion as having a positive impact on teachers' attitudes towards disability (UNESCO, 2009). Within the education sector, individual teachers and schools play a key role in supporting the inclusion of children with disabilities. Strategies such as providing spaces for school leaders, teachers, parents, and members of the community to come together in "inclusive education committees" to discuss challenges and priorities led to more positive attitudes around disability and increased enrollment rates (McConkey, 2010).

Within the healthcare system, there are several ways to improve the attitudes of healthcare professionals towards persons with disabilities. The WHO (2015) calls for targeted education and training of healthcare professionals (including providing the opportunity for persons with disabilities to deliver the training) and communications campaigns developed in partnership with organizations of persons with disabilities. While there is largely a lack of research on the effectiveness of these types of strategies, positive results have been reported from programs where healthcare professionals invited persons with disabilities to co-train on disability. Additionally, more exposure to persons with disabilities and their families can lead to more positive attitudes (Shakespeare et al, 2009).

Social and structural level

Laws and policies can impact attitudes and beliefs at the individual and community level. When communications and advocacy strategies result in policy changes, the reforms are often more successful in changing attitudes if there was a transparent consultation process and an accompanying communications strategy (Fisher and Purcal, 2017). OPDs can play a critical role in both developing more inclusive policies and communicating them to communities.

While communication strategies can happen at the individual system level, as described above, research suggests that approaches to changing attitudes towards children with disabilities may be more effective if all three levels are addressed simultaneously. Taking the example of inclusive education, in countries where they are (1) laws to mandate inclusive education; (2) training on disabilities; and (3) media that exposes children, families, and teachers to positive portrayals of students with disabilities, then attitudes towards children with disabilities are more likely to become more positive (Fisher and Purcal, 2017). Targeting awareness and change at multiple levels, through repeated information, can start to combat negative attitudes towards children with disabilities. However, beyond improving attitudes, real change often requires more than just a communications campaign. It requires that communication campaigns are supported, when necessary, by other resources (such as funding, technical capacity, etc). Taking the example above, with inclusive education, if the laws, training, and positive media are not accompanied by, for example, more funds for schools to purchase inclusive education resources or funds to make schools more accessible so children with disabilities can attend, then individual and community attitudes may be changed but educational outcomes for children with disabilities may not change.

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Annex J: Participant Protection Protocol and Informed Consent Form

Protection Protocol

Participant Safety:

UNICEF has contracted with Inclusive Development Partners (IDP) to conduct an Evaluation of UNICEF Interventions Addressing Inclusion of Children with Disabilities in North Macedonia. IDP has partnered with two national experts in North Macedonia to consult on the project and carry out the Focus Group Discussions (FGD). During the recruitment process, our national experts who have experience and expertise in the fields of inclusive education and law, will introduce themselves and the evaluation to the potential participants and share the informed consent form with them. This will allow the potential participants to become familiar with the evaluation and its requirements and informally consent to the process before accepting the invitation to participate in the FGD. During the FGD the facilitators will repeat the introductions of themselves and the evaluation and will obtain informed consent from the participants (regarding the study and the recording the session). The discussions will be conducted using an online platform such as Zoom. The online platform offers both convenience and security for the participants allowing them to take the call/meeting in an environment of their choosing (at home or in their office) and allows them to adhere to COVID-19 protocols of social distancing, if needed.

Data security:

After obtaining consent, the facilitators will record the discussion and take notes throughout the conversation, which they will later translate from Macedonian to English to share with the rest of the evaluation team. The translated English notes from the discussions will be shared with the rest of the team on a secure file on Dropbox that only the research team has access to. The recording and the notes will be destroyed after the end of the evaluation in September 2022.

Focus Group Discussion Informed Consent Script (Caregivers)

Consent Language: Thank you for agreeing to participate in this Focus Group Discussion related to the Evaluation of UNICEF Interventions Addressing Inclusion of Children with Disabilities in North Macedonia. The goal of this study is to provide UNICEF with information about the effectiveness of their recent inclusion programming across several sectors, and help to identify opportunities for ongoing and future work in this area.

You have been selected to participate in this study because your perspective will help us to learn more about UNICEF's inclusion programming in the child protection / social protection / health / education sector(s). Your participation is very important, but you have the right to refuse to participate in the study at any time before, during, or after the discussion process. You can skip any questions you do not want to answer.

Your relationships with the program or evaluation team will not be affected if you choose not to participate. This discussion will take approximately 60 minutes. However, we will ask if you are available for a second call if the discussion exceeds this time.

We want to ask you about questions about your family's involvement in the UNICEF-supported programs between 2016 and 2020, and hear your perspective on how various aspects of the programs were implemented as well as their impact.

If you agree to participate, the information you provide us will remain confidential and your name and personal information will not be used in any way. We do not have any money or gifts to give you for your participation, but we know that your participation may provide information that can help improve the inclusion of children with disabilities in North Macedonia. If you have any questions about the study, you may contact Valerie Karr at valerie@inclusivedevpartners.com

If you would like to talk to someone about this study, or how you feel as a result of questions asked during this interview, you can contact either of the following local researchers:

Goce Kocevski, gkocevski@myla.org.mk, +389 78 252 942

Ana Mickovska, amickovska2@yahoo.com, +389 70 783 821

Please help make our discussion confidential by not sharing anything said in the group with anyone outside the group.

Do you have any questions now?

Do you understand everything I have explained?

Do you agree to participate in this study? Yes ____ No ____

Do you agree to this discussion being recorded so that we can remember what is said?

Yes ______ No________

Key Informant Interview/Focus Group Discussion (non-Caregivers)

Consent Language: Thank you for agreeing to participate in this Key Informant Interview/Focus Group Discussion related to the Evaluation of UNICEF Interventions Addressing Inclusion of Children with Disabilities in North Macedonia. The goal of this study is to provide UNICEF with information about the effectiveness of their recent inclusion programming across several sectors, and help to identify opportunities for ongoing and future work in this area.

You have been selected to participate in this study because your perspective will help us to learn more about UNICEF's inclusion programming in the [child protection / social protection / health / education] sector(s). Your participation is very important, but you have the right to refuse to participate in the study at any time before, during, or after the discussion process. You can skip any questions you do not want to answer.

Your relationships with the program or research team will not be affected if you choose not to participate.

This discussion will take approximately 60 minutes. However, we will ask if you are available for a second call if the discussion exceeds this time.

We want to ask you about questions about your involvement in the UNICEF program [specify] between 2016 and 2020, and hear your perspective on how various aspects of the program were implemented as well as their impact.

If you agree to participate, the information you provide us will remain confidential and your name and personal information will not be used in any way. We do not have any money or gifts to give you for your participation, but we know that your participation may provide information that can help improve the inclusion of children with disabilities in North Macedonia.
If you have any questions about the study, you may contact Valerie Karr at valerie@inclusivedevpartners.com

If you would like to talk to someone about this study, or how you feel as a result of questions asked during this interview, you can contact either of the following local researchers:

Goce Kocevski, gkocevski@myla.org.mk, +389 78 252 942
Ana Mickovska, amickovska2@yahoo.com, +389 70 783 821

Please help make our discussion confidential by not sharing anything said in the group with anyone outside the group.

Do you have any questions now?

Do you understand everything I have explained?

Do you agree to participate in this study? Yes ____ No ____

Do you agree to this discussion being recorded so that we can remember what is said?

Yes ______ No________

Annex K: Data Collection Instruments

#	INSTRUMENT	FILE	#	INSTRUMENT	FILE
1	Educator Survey	Survey - Educators March2022.docx	10	Edu Sector: MK Government KII/FGD	MK Government Education
2	Family Doctor Survey	Survey - Gen. Practitioners	11	Health Sector: MK Government KII/FGD	MK Government_Healt
3	Patronage Nurse Survey	Survey - Patronage Nurses	12	CP Sector: Beneficiary Professionals KII/FGD	Beneficiary Professionals_CP
4	CP Sector: Implementing Partner KII/FGD	Implementing partner_CP	13	SP Sector: Beneficiary Professionals KII/FGD	Beneficiary Professionals_SP
5	SP Sector: Implementing Partner KII/FGD	Implementing partner_SP	14	Edu Sector: Beneficiary Professionals FGD	Beneficiary Professionals_Educ
6	Edu Sector: Implementing Partner KII/FGD	Implementing partner_Education	15	Health Sector: Beneficiary Professionals FGD	Beneficiary Professionals_Heal
7	Health Sector: Implementing Partner KII/FGD	Implementing partner_Health	16	Beneficiary Families FGD (*subject to ERB review/approval*)	Beneficiary families_March202
8	CP Sector: MK Government KII/FGD	MK Government_CP	17	Other UN Agencies KII/FGD	Other UN Agencies_March20
9	SP Sector: MK Government KII/FGD	MK Government_SP			

Annex L: Research Ethics Training Certificates

CITI PROGRAM

Completion Date 30-Sep-2021
Expiration Date 29-Sep-2024
Record ID 40322865

This is to certify that:

Valerie Karr

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Social & Behavioral Research Investigators and Key Personnel
(Curriculum Group)
Social & Behavioral Research Investigators and Key Personnel
(Course Learner Group)
3 - Refresher Course
(Stage)

Under requirements set by:

University of Massachusetts Boston

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w0b3a5c96-0ee4-411f-b49f-fae4fac5108c-40322865

CITI PROGRAM

Completion Date 27-Mar-2022
Expiration Date N/A
Record ID 48139731

This is to certify that:

Emily Kochetkova

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Responsible Conduct of Research Staff
(Curriculum Group)
Responsible Conduct of Research Staff
(Course Learner Group)
1 - RCR
(Stage)

Under requirements set by:

University of Massachusetts Boston

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w98439181-212f-495a-9cb8-a9be534802aa-48139731

Completion Date 26-Mar-2022
Expiration Date N/A
Record ID 48138116

This is to certify that:

Ana Mickovska-Raleva

Has completed the following CITI Program course:

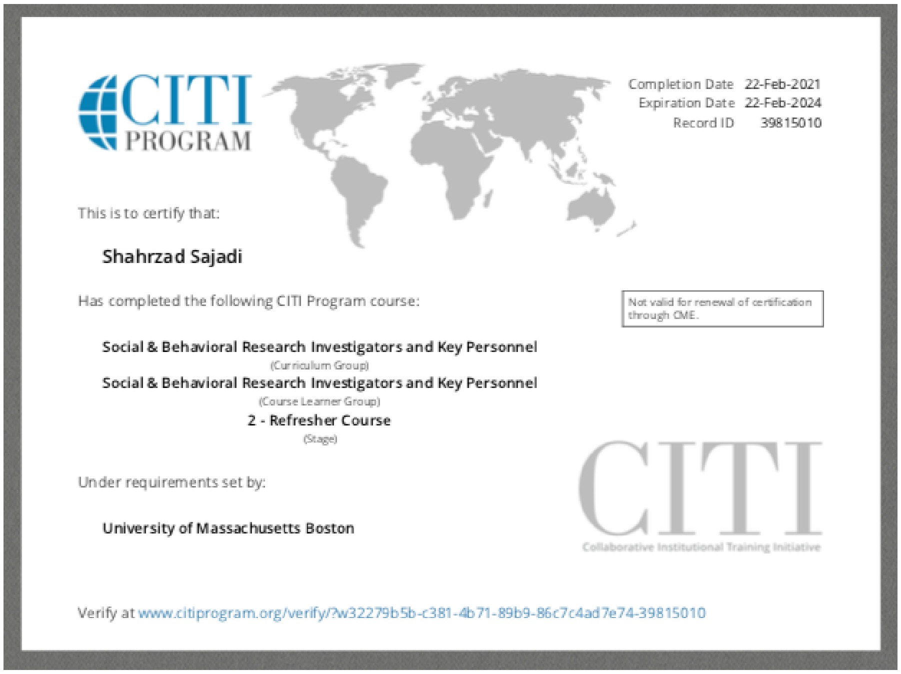
Not valid for renewal of certification through CME.

Responsible Conduct of Research Staff
(Curriculum Group)
Responsible Conduct of Research Staff
(Course Learner Group)
1 - RCR
(Stage)

Under requirements set by:

University of Massachusetts Boston

Verify at www.citiprogram.org/verify/?w5433b78e-50e1-4e9f-a653-fbf168b2c5e0-48138116



Completion Date 22-Feb-2021
Expiration Date 22-Feb-2024
Record ID 39815010

This is to certify that:

Shahrzad Sajadi

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Social & Behavioral Research Investigators and Key Personnel
(Curriculum Group)
Social & Behavioral Research Investigators and Key Personnel
(Course Learner Group)
2 - Refresher Course
(Stage)

Under requirements set by:

University of Massachusetts Boston

Verify at www.citiprogram.org/verify/?w32279b5b-c381-4b71-89b9-86c7c4ad7e74-39815010