
# Knowledge hub
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# Collection of best practices

## Summary of the best practice

1. Title of the best practice (e.g. name of policy, programme, project, etc.) *

SAFAL (Strengthening and facilitating ADLs in children with multiple and severe disabilities)

2. Country or countries where the practice is implemented *

India

3. Please select the **most relevant** Action Track(s) the best practice applies to *

- [x] Action Track 1. Inclusive, equitable, safe, and healthy schools
- [ ] Action Track 2. Learning and skills for life, work, and sustainable development
- [ ] Action Track 3. Teachers, teaching and the teaching profession
- [ ] Action Track 4. Digital learning and transformation
- [ ] Action Track 5. Financing of education

4. Implementation lead/partner organization(s) *

Samagra Shiksha Abhiyan Uttar Pradesh, UNICEF and Yeh Ek Soch Foundation

5. Key words (5-15 words): Please add key descriptive words around aims, modalities, target groups etc. *

Support on activities for daily living helped transition of children with severe and multiple disabilities from home based education to formal school based education

6. What makes it a best practice? *

This helped the state to understand that, last mile children, in this case children with severe and multiple disabilities, could also attend regular schools with prerequisites like ADLs. Otherwise, the state framework on homebased education remained on paper.

7. Introduction (350-400 words)
   This section should ideally provide the context of, and justification for, the practice and address the following issues:
   i) Which population was affected?
   ii) What was the problem that needed to be addressed?
   iii) Which approach was taken and what objectives were achieved? *

i) The population affected was children, between 6-14 years of age, entitled for right to education as per Right of Children to Free and Compulsory Education Act, 2009 of India and identified by state of Uttar Pradesh for transitional home based education.
ii) The state has identified more than 9,000 such children with severe and multiple disabilities. Most of these children are with cerebral palsy and speech related disabilities. These children cannot perform ADLs (activities for daily living) unless they are provided with physiotherapy and speech therapy etc. The state government does not have such facilities. Only few districts out of 75 districts have one physiotherapist but they are engaged in other activities as one physiotherapist cannot take care of so many children with severe and multiple disabilities in their respective districts. The state government has no provision for speech therapists. Hence, the children remained in their homes. They were enroled for home based education to be facilitated by special educators (supposed to take care of more than 20 such children) and the local government schools. But since these children cannot do the ADLs the schools or the special educators never took any initiative towards home based education. So, the children remained completely neglected by the state education authorities and partially neglected by the parents.
iii) UNICEF Office in Uttar Pradesh took the decision to engage physiotherapist and speech therapist in four poorest districts of the state and the country where a total of 362 such children were identified for homebased education as part of SAMARTH - the UNICEF supported government framework on disability-inclusive education. A suitable NGO partner was oriented on the issue and a team of physiotherapists and speech therapists started visiting the children and started providing ADL services after detailed assessment of children. The parents and care givers were made active partners in the process, they were oriented to provide required services to their wards in between the therapy sessions. Children of the same age from the respective neighbourhood were motivated to spend quality time with these children every day. The objective was to achieve the stated goal of SAMARTH, that is to implement a transitional home based education where transition of these children from home based education to school based education was supposed to be achieved within shortest period of time. After only seven months of intervention 82 out of 362 children started attending nearby schools regularly. This has not only motivated these children and their parents but created a very enabling environment within the homes and schools and positively impacted the teachers and other school children without disabilities.

8. Implementation (350-450 words)
   Please describe the implementation modalities or processes, where possible in relation to:
   i) What are the main activities carried out?
   ii) When and where the activities were carried out (including the start date and whether it is ongoing)?
   iii) Who were the key implementation actors and collaborators? (civil society organizations, private sector, foundations, coalitions, networks etc.)?
   iv) What were the resources needed (budget and sources) for the implementation? *

   i) The main activities carried out were - a) orientation of implementing partner, b) assessment of children, c) ADL services through therapists and parents, d) peer interactions, e) community and school interactions, f) advocacy with district and state authorities after documentations of milestones achieved.
   ii) The activities were started in four poorest districts of the state and the country - a) Bahraich, b) Balrampur, c) Gonda and Shravasti. The activities started in September 2022 and still continuing.
   iii) Yeh Ek Soch Foundation
   iv) The cost is INR 1,812 (USD 23)/child/ month considering the overall cost of the intervention.

9. Results – outputs and outcomes (250-350 words)
   To the extent possible, please reply to the questions below:
   i) How was the practice identified as transformative? (e.g., impact on policies, impact on management processes, impact on delivery arrangements or education monitoring, impact on teachers, learners and beneficiary communities etc.);
   ii) What were the concrete results achieved with regard to outputs and outcomes?
   iii) Has an assessment of the practice been carried out? If yes, what were the results? *

   i) The practice was transformative as documentation on results half way through the intervention convinced the education department that they must have strong collaboration with the health department and also allocate their own resources. It also became obvious that the ambitious transitional home based education will remain only on paper if ADL services are not provided. This was also transformative for the families, communities and the schools. The families never believed that their children will be able to walk or speak let alone ever go to schools. Most of these families are extremely poor families and in many cases both the parents work throughout the day to earn a living. They have also started giving time for their children. The communities were also inspired. Their attitude towards these children changed. They started identifying more such children who were not identified by the local schools and started requesting services. The schools were most reluctant vis-à-vis these children attending schools. They were apprehensive of many counts. But once the children started attending schools they felt inspired and motivated. The other school children (without disabilities) also developed excellent positive approach towards these children.
   ii) 82 out of 362 children with severe and multiple disabilities started attending schools regularly. Another 70 children will be ready for attending schools by November 2022.
   iii) No. We have only done documentation of the milestones achieved.

10. Lessons learnt (300 words)

To the extent possible, please reply to the following questions:
i) What were the key triggers for transformation?
ii) What worked really well – what facilitated this?
iii) What did not work – why did it not work? *

i) The key triggers were - a) aiming for the high hanging fruits, b) creating example which would motivate all, c) having a motivated team of therapists who were willing to visit remote villages and provide ADL services, d) engaging parents right from the beginning and e) community dialogues and engaging peers for interaction and play with the targeted children.
ii) What worked well - a) engaging parents, b) engaging peers, c) continuous dialogue with neighbourhood schools, d) regular feedback to parents, schools and district administration, e) setting examples within the communities and schools and above all f) creating evidence for the state to take further steps.
iii) Apart from ALD there are issues related to child protection, social security and addiction related challenges. We have started working on the child protection and social protection related issues in convergence with related government departments UNICEF Child Protection unit in the state. However, some parents introduced tobacco and sleeping pills to their wards before we started our intervention. As a result around 30 out of 362 targeted children are addicted now. We are not able to take any concrete steps towards this as we do not have professional counselors or facilities in the districts.

11. Conclusions (250 words)

Please describe why may this intervention be considered a “best practice”.
What recommendations can be made for those intending to adopt the documented “best practice” or how can it help people working on the same issue(s)? *

This was pilot to help advocacy with state government so that the state create adequate provisions for ADL services for these last mile children and achieve its own goal of transitional home based education. UNICEF supported the state government to develop the framework on disability-inclusive education. Here is an example where an UNICEF led pilot helped the state government to understand the gaps they have vis-à-vis implementation framework. This also helped how little support could be beneficial to the last mile children. This also helped in understanding that percolation of benefits happens to all when we aim for the 'high hanging fruits' - in this case, the home, community and school environments became inclusive.
The recommendation will be to - a) have continuous dialogue with the state right from designing stage, b) be explicit about the ground level challenges with the professionals being engaged, c) set goals for every children after assessment, d) engage parents and peers, e) make local schools your partners. the recommendation will also be to continuously documenting the results for every milestones achieved and sharing the same with the stakeholders - with the parents, with school teachers, district authorities and certainly with the state education department. The last recommendation will be to work towards convergence between department of education, health, nutrition, disabilities and social welfare both at district and state level.

12. Further reading
    Please provide a list and URLs of key reference documents for additional information on the “best practice” for those who may be interested in knowing how the results benefited the beneficiary group/s. *

    One can watch this short video documentation: https://unicef-my.sharepoint.com/:v:/g/personal/rpatra_unicef_org/EU4AFnws35xFhMBJlc-hmsABbPvam8pCaF67Mkwsb534Hw?e=HWzTCF