



**Effects of the Palestinian
National Cash Transfer
Programme on children
and adolescents**

A mixed methods analysis



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Effects of the Palestinian National Cash Transfer Programme on children and adolescents:

A mixed methods analysis

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Key messages

- The Palestinian National Cash Transfer Programme (PNCTP) is well targeted to reach the poorest households in Gaza and the West Bank.
- Children benefit from its effects on household economic strengthening, especially in terms of improved health and nutrition.
- However, the PNCTP is not child-focused, and other key dimensions of children's right to social protection and a life free from poverty and vulnerability are not sufficiently addressed by the programme.
- The PNCTP could be more child-sensitive if it had stronger linkages to relevant complementary services that tackle children's broader vulnerabilities.
- Key vulnerabilities facing children that require urgent attention and could be addressed by the PNCTP include: support to complete higher secondary school and beyond; protection from violence within the family, at school and in the wider community; investment in age-appropriate recreational activities for boys and girls; and more comprehensive care for children with disabilities.

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Abbreviations

CT	Cash transfer
CCT	Conditional cash transfer
GCMHP	Gaza Community Mental Health Programme
HCYS	High Council of Youth and Sports
HDI	Human Development Index
MAP	Medical Aid for Palestinians
MDG	Millennium Development Goal
MoH	Ministry of Health
MoSA	Ministry of Social Affairs
NGO	Non-government organisations
NRA	National Rehabilitation Association
PCRf	Palestine Children’s Relief Fund
PMTF	Proxy means test formula
PNCTP	Palestinian National Cash Transfer Programme
PRCS	Palestine Red Crescent Society
SoP	State of Palestine
SPF	Social Protection Floor
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WFP	World Food Programme
WHO	World Health Organization

Executive summary

Over the past two decades, social protection programmes have been implemented in many developing countries to reduce poverty and vulnerabilities in the face of context-specific challenges such as economic crises, inequality and exclusion, and human development deficits. The multidimensional vulnerabilities experienced by poor households affect children and young people in specific ways, but their needs often remain only partially visible or even invisible to policy-makers and those designing social protection programmes and complementary interventions that tend to focus on the household unit.

This report presents findings from a mixed methods study of the effects of the Palestinian National Cash Transfer Programme (PNCTP) on children and their families, exploring impact across the four key dimensions of children's rights recognised in the United Nations Convention on the Rights of the Child (UNCRC): survival, development, protection and participation.

The situation of children in the SoP

The population of The State of Palestine (SoP) is predominantly young, with more than 40% under the age of 15. Household poverty (estimated at around 16% in the West Bank and almost 32% in Gaza) disproportionately affects children, partly because of the prevalence of larger families among the poorest, but also because of children's limited access to basic services and developmental opportunities.

Children's and adolescents' poverty status and wellbeing is, however, not only determined by their own or their household's income. It is also conditioned by the multiple dimensions of wellbeing that are closely aligned with children's rights to survival, development, protection and participation. Poverty among vulnerable households and communities in the SoP is both a cause and an outcome of an array of complex factors. Poor households often face a range of interrelated challenges, including caring for family members with physical, psychosocial and mental disabilities, chronic disease. Other common challenges include gender-based violence, stigma, discrimination, child labour and child abuse, school dropouts, domestic violence, and high-risk behaviours among young people.

Children's right to survival is compromised in a number of ways. Health shocks are a major source of household poverty. An illness or accident on the part of a parent (sometimes leading to death) triggers adverse coping strategies, with significant consequences for children: girls typically have to shoulder the domestic care burden while boys have to find work to generate income. Although child mortality rates in Palestine are relatively low due to improvements in neonatal services and prenatal care coverage, maternal mortality rates remain a cause for concern.

Child malnutrition is a persistent problem. Currently, 1 in 10 children under the age of five suffers chronic malnutrition, with the rate slightly higher in the West Bank than the Gaza Strip. Moreover, malnutrition rates are rising: between 2000 and 2010, child malnutrition in the Gaza Strip increased by 60% (over 40% nationally). Many families in both territories, but particularly in Gaza, have resorted to negative coping strategies to maintain their level of food consumption, such as reducing the number of meals eaten, eating smaller quantities, selling disposable assets, increasing levels of debt, taking children out of school, and even marrying daughters earlier while still under 17 years of age.

Access to clean water and adequate sanitation is also highly problematic, with constant fuel crises impeding safe water supply and sewage treatment. Diarrhoea is one of the most common illnesses among Gaza's refugee children, and clinics treating refugees in the Gaza Strip report a recent increase in cases of typhoid fever and watery diarrhoea in children under three.

Children's right to development is also severely constrained. Despite some important recent achievements (full gender equity in enrolment in basic education, and near universal access to basic education), the SoP's education system suffers from quality deficits and poor scholastic outcomes. In addition, violence in schools, either by

peers or by teachers, generates a negative environment for learning. Many adolescents drop out of school after completing their basic education (grade 10, roughly age 16), typically because they need to work to help support their families. But many of those interviewed also said they did not enjoy school as they often faced violence, and were not able to learn much. Children and young people (and particularly refugee children in camp environments and children living in Area C in the West Bank) also lack safe spaces for play and recreational activities.

The protracted conflict and high levels of insecurity and violence in the SoP pose particular threats to *children's right to protection*. Exposure to violence in the home and in schools (physical and psychological) directly affects children's health and wellbeing.

Palestinian children with disabilities face numerous barriers in accessing public services. For example, despite near universal access to education for most Palestinian children, more than one-third of those with a disability aged 15 years and over had never enrolled at school. Of those that did enrol, a third dropped out because services and infrastructure had not been sufficiently adapted to meet their needs. Children with disabilities find it particularly difficult to realise their right to leisure due to high transport costs, lack of adequate facilities and appropriate activities, and the fear of stigma and discrimination, which can compound their social isolation.

A clear outcome of the ongoing conflict is an increase in mental health conditions among people in the SoP, particularly children. Children exposed to high levels of trauma are more likely to report higher levels of post-traumatic stress disorder (PTSD), depression and anxiety.

Finally, children's right to participation is also constrained. The everyday problems children face severely limit their ability to exercise this right, as there are few safe spaces where they can participate. Hierarchical social norms also represent a major barrier to children's participation; girls in particular face strong restrictions on their mobility and social activities outside the home.

The Palestinian National Cash Transfer Programme (PNCTP)

The PNCTP is the SoP's flagship social protection programme, managed and administered by the Ministry of Social Affairs (MoSA). Beneficiaries are selected according to a consumption-based proxy means test formula (PMTF) that estimates the welfare of each applicant household. Eligible households receive between 750 and 1,800 new Israeli shekels (NIS) (US\$195-468) per quarter to bridge 50% of the household poverty gap. Beneficiary households are also entitled to other state-provided assistance, including health insurance, food support (in the form of dry food rations in Gaza and in isolated areas of the West Bank, and vouchers in urban areas of the West Bank), school fee waivers, and cash grants to help with one-off emergency needs.

According to MoSA, as of September 2013, 105,678 households were receiving the cash transfer (57,449 in Gaza and 48,229 in the West Bank). Given the average number of children per family, it is estimated that the total number of children living in beneficiary households is 287,794. Most of these households are classed as extremely poor.

While the PNCTP was not designed as a child-focused programme, given the large family sizes common in the SoP – particularly among poorer households – household expenses and consumption goods are often prioritised, although these include meeting children's needs, principally for food, but also clothing and schooling.

Other sources of support for vulnerable children

In addition to the PNCTP there are multiple government and non-governmental organisation (NGO) programmes that provide social protection support for children, addressing a range of vulnerabilities that cut across the four dimensions of children's rights (see above). Unfortunately, however, there is still limited communication and coordination across agencies, and no strong referral mechanism which could ensure that vulnerable children's needs are more effectively identified and addressed. For example, there is no coordination between social workers implementing the PNCTP and child protection services; yet the social workers could make referrals of suspected cases of abuse identified during the home visits they undertake (currently, these visits are mostly used to gain the information needed to determine the applicant household's PMTF score). The existing child protection network established by MoSA in 2006 would be a good forum for raising child

protection issues. But again, there are no linkages between the PNCTP and this network, nor other support services.

Another problem frequently mentioned by respondents was the discontinuation of targeted programmes for children with disabilities or other specific vulnerabilities following the 2010 launch of the PNCTP, which resulted from the merger of a number of smaller fragmented programmes. While the PNCTP has generally been welcomed, as some families are receiving more cash income due to the changes, other families have suffered from the loss of valuable in-kind support. This includes equipment (e.g. provision and maintenance of wheelchairs and hearing aids) and personal care items (including diapers and sanitary towels), as well as access to therapeutic services. The merger of the different strands of support in 2010 was not focused on addressing child-specific vulnerabilities; as a result, some of these were indirectly deprioritised at a programming level.

Conceptual framework for the study

The study is underpinned by a conceptual framework that draws on Devereux and Sabates-Wheeler's (2004) transformative social protection framework, which emphasises that to meaningfully empower poor and vulnerable populations, an interrelated system of social protection programming is critical, combining protective, preventive, promotive and transformative elements. **Protective** social protection aims to alleviate the worst of economic and social deprivation by safeguarding household income and consumption. Cash transfers and humanitarian relief fall into this category. **Preventive** social protection, such as health insurance, is designed to reduce household vulnerability by mitigating the impact of shocks. **Promotive** social protection seeks to strengthen vulnerable people's agency by bolstering their capacity for productive activities through the provision of assets or subsidies. Finally, **transformative** social protection addresses the power imbalances which create or sustain the economic and social vulnerabilities that disadvantage individuals and groups based on one or more of their social identities (including gender, religion, ethnicity, race, class, or disability).

Child-sensitive social protection adds an additional aspect to this analytical framework, in that it highlights the unique set of intersecting risks and vulnerabilities that characterise childhood. Child poverty differs from adult poverty in that it has distinct causes and effects. Poverty affects children more acutely than adults because of their vulnerability due to age and dependency, and can cause lifelong cognitive and physical damage, leading to permanent disadvantages that in turn perpetuate the cycle of poverty across generations. However, understanding child-sensitive social protection also means understanding that for children, who are uniquely dependent on the adults in their environment, social vulnerability is especially important. These relational dimensions mean that it is critical for social protection to not only target child-specific vulnerabilities but also support the caregivers, families, households, and communities who, because they are responsible for protecting and nurturing children, must be protected and nurtured themselves.

Study methodology

The study used a mixed methods approach to assess the effects of the PNCTP on children and their families. Cross-sectional quantitative data were collected from an intervention and a comparison group alongside qualitative data from a purposive sample of individuals and groups (including adolescents and adults) using participatory methods. In Gaza, qualitative data collection was carried out in the following sites: Jabalia and Beit Hanoun in the north, which included some rural areas; and Gaza City, including a refugee camp setting (Beach camp), a primarily urban context. Qualitative data in the West Bank were collected in Jericho district and Jordan Valley to include a sample of urban, rural, refugee and Bedouin beneficiaries. The five villages where research was conducted were Alnwe'ma, Aldyouk, Al-Jiftlik, Alouja and Anata.

Data were then triangulated to give a layered analysis. Data collection was sequenced, with quantitative data collected first so that preliminary findings could inform the design of the qualitative data collection instruments and sample, enabling the study team to explore in much more depth the effects of the programme and its complementary social services on children, their caregivers and families.

Key findings

Overall, our findings reveal that the PNCTP is not sufficiently child-sensitive to fully address children's poverty from a multidimensional perspective. While the programme contributes to children's right to survival, its effects on children's rights to development, protection and participation are less evident. Moreover, many caregivers commented that they had to choose how they allocated their limited household resources, including the cash transfer, between providing for their children and servicing debts incurred to cover basic expenses.

Children's right to survival:

For those who need to access health services, the health insurance component of the PNCTP was considered its most important element, because without it, they might not have been able to get necessary treatment or surgeries (including those accessed abroad), or would have had to incur significant debt to pay for these services. However, health insurance does not cover some of the recurrent (everyday) costs involved in caring for children with disabilities (such as diapers and the maintenance costs of specialised equipment/ assistive devices), or treatment for specific illnesses. Paying for these items meant families often had to go without other basic items given their limited incomes. Many respondents also expressed concerns about the high cost of medicines and equipment, which are often a common source of debt. Although the health insurance covers a package of basic medicines, these are often out of stock at government hospitals so patients need to purchase them privately, partly using the cash transfer. Where families cannot afford to pay for repair and maintenance of their child's hearing aid or wheelchair (for example), this further limits the child's prospects of attending school or taking part in any activities outside the home.

The research paid particular attention to the impact of the PNCTP on children with disabilities. In line with the quantitative findings, families interviewed for the qualitative component emphasised that the unmet needs of children with disabilities represent a significant economic and psychosocial burden on families. While PNCTP beneficiaries are entitled to health insurance, there were mixed views about how adequate this was for meeting the needs of children with disabilities. Overall, families with children with disabilities felt that the cash transfer had helped them, mainly through the entitlement to health insurance; the cash transfer itself had also helped, enabling them to pay for goods and services for the disabled family member, which they had previously found it very difficult to afford. However, although these families receive equipment for their children with disabilities – such as wheel chair or hearing aids – no provision are made for what are generally expensive maintenance costs such as new wheels or new batteries etc. which they then cannot afford, making it difficult to use the equipment. Additionally, the expenses generated by these households tend to be greater, limiting the purchasing power of the cash transfer.

In relation to nutrition, the cash transfer has enabled beneficiary households to buy larger quantities and a greater variety of more nutritious food – particularly animal proteins – which has played an important part in improving the nutritional status of children in beneficiary households. For example, some respondents noted that they can now buy meat, chicken, fruits and vegetables (either once per payment cycle, or more regularly). Indeed, adolescents in the study highlighted this as a particularly positive outcome of the programme for them, as they value having a more varied diet and food they enjoy eating.

While housing and living conditions are a significant element in determining children's wellbeing, the cash transfer amount is too low to enable families to make significant improvements to their housing conditions. However, respondents used the transfer to help pay for water and energy costs, which would otherwise have been unaffordable. In Gaza in particular, beneficiaries were less at risk of having their power cut because of payment than the comparison group.

Children's right to development:

The cash transfer was reported to have made a mixed contribution to children's access to education. The main contribution of the PNCTP to education is the exemption of school fees, which although typically low, can be a barrier for very poor households. Nevertheless, some beneficiary caregivers reported poor coordination between MoSA and the education authorities, which meant that supporting documentation often failed to arrive in time for enrolment, forcing households to pay (even if the fee was subsequently refunded).

Additional barriers, however, are the indirect and opportunity costs of schooling. For some families, the extra cash provided through the transfer was enough to enable children to continue to attend school by allowing them to pay for transport, books, uniforms and school bags. But for the poorest households, the small amount of the cash transfer was not enough to cover school expenses after other expenses (food and health care) had been prioritised. For the poorest households, the opportunity costs for adolescents (particularly boys who are better able to find paid work outside the household) are also important. When beneficiary households were asked what difference the cash transfer had made to their or their families' lives, only a small minority who were previously working mentioned that children had been able to stop working and start going to school again. This may, however, be partly due to the very small amount of the transfer; it is not sufficient to substitute for a younger member of the family working to provide additional income for the family.

The PNCTP has had some effect on children's capacity to enjoy recreational activities – such as summer camps which require the payment of transport costs – within the constraints of the local environment. A few caregivers also reported being able to buy toys or other 'treats', but most households used the transfer to cover other more basic and urgent needs.

Still, children continue to have very limited recreational time and opportunities and limited resources with which to enjoy these. An important gender dimension was uncovered in relation to children's ability to enjoy recreational activities: boys and girls both expressed the view that girls faced a more difficult situation, given the limits to their mobility outside the home imposed by restrictive social norms.

Children's right to protection:

Quantitative data suggest that the PNCTP does not have a significant effect in reducing violence at the household, community or school levels. Quantitative and qualitative findings showed that violence is widely practised – by children and adolescents themselves, their parents, teachers, and service providers. Qualitative interviews did, however, indicate that the cash transfer has had some impact in terms of reducing intra-household violence, partly reflecting lower stress levels due to a slight easing of financial pressures on the household head.

Violence in schools was widely reported and generally accepted as the norm, especially in relation to how teachers discipline children from poor households. Although there are counselling staff in some schools, some children talked of not being able to trust that their problems would remain confidential, and only in a few cases were teachers identified as sources of support. School violence was in fact one of the main reasons reported by adolescents for not attending or dropping out of school, which goes against one of the aims of the PNCTP – to support children's continuation in school.

On child labour, the quantitative and qualitative data produced some contradictory findings. The quantitative data suggest that the number of boys working outside the household is relatively low (particularly in Gaza), while the qualitative component indicates that a number of children – even those from beneficiary families – are working; boys tend to do paid work outside the home while girls support activities in the home (and, in rural areas, also do agricultural work).

In terms of children's mental health and emotional wellbeing, despite the heavy psychosocial burden on poor households in the SoP – particularly those with children with physical or mental disabilities – access to psychosocial support and counselling is very limited, and the services that do exist are of poor quality. Support from informal sources that people used to rely on (such as extended family and neighbours) is no longer forthcoming, because of the extent of hardships facing families in the SoP.

While many children who are experiencing mental and emotional health problems live in beneficiary households, the lack of outreach by social workers who visit these households on a semi-regular basis, and the limited information about the support services available, mean they are not receiving the support they need. School counsellors are available (in state schools and those run by the United Nations Relief and Works Agency (UNRWA) for refugee children). But there are too few of them (one counsellor for approximately 1,000 pupils) and most have had insufficient training to deal with children's psychosocial problems. Overall, the cash transfer appears to have had limited impact in addressing children and adolescents' psychosocial vulnerabilities.

In general terms, the findings also indicate that children's safety was being jeopardised by the fact that a considerable percentage of children were often left without any kind of supervision for several hours of the day.

Children's right to participation:

The context of poverty in the SoP and hierarchical cultural norms have combined to limit children's opportunities to participate in family decisions or in schools, and even their awareness of their rights. Participation and decision-making are also highly gendered, being the realm of men and young boys rather than women and young girls.

Children and adolescents – particularly children with a disability – spoke of their frustration at their limited opportunities to participate in everyday life, including going out to meet friends and generally socialising with their peers.

Finally, there was little evidence of efforts to involve children from beneficiary households in programme governance, including participation in the community forums that support targeting decisions and grievance redress.

Implications for policy and programming to strengthen the impact of the PNCTP on children's lives

The PNCTP contributes positively to children's right to survival; it helps households cope with economic hardship and meet children's basic needs, such as buying more nutritious food, paying some school- and health-related costs and, importantly, contributing to household debt repayment, which is a major source of stress in Gaza and the West Bank. The provision of health insurance as a complementary entitlement for beneficiaries means that households with people (including children) who have a disability or severe or chronic illness are able to cover some of the economic costs related to their care – support that is greatly valued by the families concerned. As such, the PNCTP contributes to meeting many essential household needs that affect children directly, and contributes to improving their emotional and mental wellbeing in an extremely pressured and challenging situation. The PNCTP is thus an important programme, valued by beneficiaries, and as such one which should continue with greater support and investment in order to strengthen and improve it, particularly with regard to its impacts on the lives of children and adolescents living in poverty and with multiple vulnerabilities.

The PNCTP however would have greater impact on children's lives and wellbeing if it were more closely linked to other complementary programmes that address the multidimensional nature of poverty and vulnerability and its specific impacts on children. Specifically, programme managers should consider implementing the following measures.

- ***Streamline social workers' caseload and role:*** Social workers should engage with all members of beneficiary families, not just parents, so that they can identify children's needs and make appropriate referrals. To do this, **they need additional training and a reduction in caseloads to a manageable level**, with sufficient time allocated to each family for regular follow-up. Social workers need to clearly understand that their role includes identifying the physical and emotional wellbeing of children and young people in beneficiary households and referring them to the appropriate services. The PNCTP could also consider using volunteers as 'community facilitators' to provide routine follow-up (other social protection programmes have used community facilitators to good effect – often recruiting women on a voluntary basis, who are based in and therefore trusted by the community). This could fulfil the dual objective of improving regular communication between the programme and beneficiaries, and providing local women with a rare opportunity to develop skills. Their remit should include meeting the needs of individual family members with specific vulnerabilities, as well as the wellbeing of the household as a whole.
- ***Invest in capacity-building:*** MoSA should provide training for social workers in children's rights to survival, development, protection and participation, as part of a broader cultural shift away from a policing approach to the programme (concerned with identifying 'undeserving' beneficiaries) to a supportive, rights-based approach. PNCTP social workers also need to develop specialist skills – for example, in issues facing

children living with disabilities; children coping with extreme psychosocial stress; children struggling with low school performance/literacy issues; children at risk of abuse, exploitation and harm; children with post-traumatic stress disorder; children with violence/anger management issues; and issues facing children from marginalised communities such as the Bedouin. **Training for social workers needs to be followed through with regular performance monitoring of individual staff as well as directorates to reinforce the principles of child-sensitive programming.**

- **Strengthen capacity of other government staff interacting with children, and strengthen referral systems:** Given that the PNCTP aims to reduce household poverty and vulnerability, meeting the needs of children – who face specific challenges and are fundamental to breaking the cycle of poverty – should take a multidimensional approach. With this purpose, teachers need training in non-violent forms of discipline so that they can respect children’s rights, and improve school performance and pupils’ motivation. The role of school counsellors also needs to be reassessed, as they are not the confidantes they should be for vulnerable children. Counsellors could be based in health centres as well as schools to reach children who are out of school. MoSA could use its strong links with the ministries of education and health to explore opportunities for coordinated capacity-building and learning processes, as well as for strengthening cross-sectoral referral systems to support the most vulnerable children.
- **Address gender-specific vulnerabilities:** Because girls are more socially isolated than boys, the need for gender-segregated safe spaces is acute, particularly in Gaza, given the influence of prevailing religious norms. Girls would benefit from being able to regularly discuss issues affecting their lives with girls in similar situations (along the lines of the focus group discussions undertaken for this research), mediated by an independent third party. Practical support is also needed: given that girls are more likely to be called on by their parents to help shoulder family care burdens, provision of respite care – such as community-based crèches or centres to care for people with disabilities – could potentially help girls to better manage their educational and domestic care responsibilities/duties, and, in the case of older adolescents, facilitate access to additional employment opportunities.
- For caregivers, while cash transfer programmes that target women as beneficiaries (such as those in Latin America) are thought to have an important but limited empowering effect on women at the intra-household level, evidence from this study and other recent PNCTP evaluations¹ suggests that women are often subject to strong social control by male members of the extended family, even when they are not financially dependent on them. Thus, while targeting women as beneficiaries may have some impact on increasing child-sensitive spending, this would be limited by their inability to control or make decisions over the use of resources. Arguably, it would be more important to **provide fora for women to regularly meet with other women and discuss issues of importance to them and their families**, thereby breaking down the social isolation and some of the psychosocial stresses that the qualitative findings indicated were pervasive among programme participants, enabling to provide better care and support to their children.
- **Develop a broader and better tailored package of comprehensive child-sensitive social protection services:** Although a package of services already exists as part of the PNCTP, additional complementary services should be considered to maximise the programme’s impact on the intersecting social and economic vulnerabilities facing children. Areas that need to be specifically addressed include: psychosocial counselling; awareness-raising about gender-based violence and related support services; child protection services; support for children with disabilities; low-cost recreational activities for girls and boys in the poorest households who are unable to access existing ones; awareness-raising about longer-term effects/risks of early marriage; subsidised transport; vocational counselling; awareness-raising about the risks of child labour and children’s right to education; and housing renovation support. While it is clearly not MoSA’s remit to provide all these services, it could play a key coordination role through its beneficiary database and the outreach role of social workers, ensuring good provision of information about available services to the poorest and most vulnerable families with children. Social workers could meet regularly with community providers (including non-government and faith-based organisations) to understand what services are currently available, and discuss referral options when they visit beneficiary households.

¹ See Jones and Shaheen, 2012; Pavanello and Hamad, 2012

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- ***Improve communication of MoSA's mandate:*** In order for MoSA to play an effective coordination role, it needs to improve its communication mechanisms – with beneficiaries and non-beneficiaries – explaining its role, the characteristics of the PNCTP (including targeting criteria and benefit levels), the services it offers, its procedures, and the rationale for any reforms. It should invest in a communications strategy to achieve coherence in its information dissemination and messaging.
 - ***Ensure the provision of disability-specific support:*** The PNCTP needs to do more to address the specific needs of children with disabilities; at present, there is no guarantee that their needs will be prioritised over the (often pressing) needs of other adult family members. There is also a need for regular monitoring of impact, as well as training for social workers to specialise in disability care issues to provide the multi-layered support needed by children living with disabilities, and their families.
 - ***Expand coverage and improve quality of psychosocial services:*** Given the important number of individuals in beneficiary households – including children and adolescents – experiencing mental and emotional health issues that hinder their ability to pursue a pathway out of poverty with the help of the PNCTP, there is an urgent need for MoSA to link to specialist institutions and undertake a referral system for families and children in need. (In Area C of the West Bank, a regular mobile service should be introduced so that the programme can reach out and identify vulnerable households rather than expect people to attend the directorate, given the travel distance and expense involved.) Given the limited number of social workers in the SoP, community health centres will need to play a key role, so good coordination between MoSA and the Ministry of Health will be important. The introduction of community facilitators (proposed earlier) could also help in identifying families and individuals in need of specialist psychosocial support.
 - ***Link beneficiaries to technical and vocational training for adolescent girls / boys and youth:*** Improving the quality of education and providing alternative forms of higher education such as technical and vocational training might enable adolescent boys and girls from beneficiary households to earn an income to support themselves and help their families. Given the limited scope for young people to gain formal sector jobs in the SoP, it is also necessary to promote entrepreneurship by fostering ideas for setting up innovative small businesses.
 - ***Work with parents from vulnerable and extremely poor households to improve parenting skills and behaviour towards children:*** MoSA, through social workers or community facilitators, could do more at the family and community levels to raise parents' awareness on issues related to positive parenting, gender equality, non-violent discipline, and the challenges facing adolescents. It could organise community discussion sessions to sensitise parents to children's rights and needs, thereby encouraging positive parenting practices (such as appropriate disciplining), as well as healthy social behaviour, such as taking children out for entertainment or recreational purposes. In this way, lower levels of stress and improved emotional wellbeing of children in the poorest households could contribute to children and adolescents being better able to find a pathway out of extreme poverty.

1 Introduction

Developing countries have increasingly adopted social protection strategies designed to reduce poverty and vulnerabilities in the face of challenges such as shifting demographic trends, inequality and exclusion, individual or household-level shocks (such as serious illness or death of a family member), and systemic shocks (including economic crises). The multidimensional vulnerabilities experienced by poor households affect children in specific ways, and it is therefore imperative that social protection policies and programming are sensitive to these impacts, given the wide-ranging consequences of childhood deprivation for individuals, families and communities throughout the life-course and also across generations (Jones and Holmes, 2010).

Social protection can be responsive to children's needs by promoting their wellbeing and helping to reduce their vulnerabilities. Global evidence has shown that social protection can strengthen the capacity of families to care for their children and can remove barriers to accessing services, while reaching those who are most vulnerable (Fiszbein and Schady, 2009). As such, it can contribute to more equitable outcomes within and between communities as well as to a fairer distribution of resources within the household (Devereux and Sabates-Wheeler, 2004). More importantly, child-sensitive social protection can help children fulfil their rights and achieve their development potential (Handa et al., 2010).

In fact, the United Nations Convention on the Rights of the Child (UNCRC) (1989) states that children have a right to social security, including social insurance, and to an adequate standard of living. In order for social protection systems to be child-sensitive, even if they are not targeted at children, they need to be responsive to the multiple and interrelated vulnerabilities faced by children and their families (UNICEF, 2013). In this sense, two approaches to social protection programming are critically important to address children's broader vulnerabilities: a lifecycle approach, which recognises children's vulnerabilities at different ages, from early childhood to adolescence; and an intergenerational approach, which recognises the critical role of caregivers in children's lives (ibid.; Barrientos and Jong, 2004).

Global evidence has shown that investing in social protection can enhance children's development and wellbeing, as well as having benefits that last long beyond childhood, increasing individuals' productivity as adults and contributing to breaking the intergenerational cycle of poverty. More recently – in addition to looking at the impacts of social protection on health, education and nutrition, for example – greater attention is being paid to how social protection can affect child protection outcomes (Barrientos et al., 2013; Kaplan and Jones, 2013; Jones, 2009).

One type of social protection instrument in particular – cash transfers – is generally aimed at relieving the worst aspects of poverty through improving income security, increasing beneficiaries' access to basic services, increasing consumption and, in some cases, even promoting asset accumulation. However, on their own, cash transfers are not sufficient to address the multiple vulnerabilities children face in relation to realising their fundamental rights to survival, development, protection and participation. To enable children to realise these rights, there is a need for better integrated complementary social protection programming such as health insurance, psychosocial support and fee waivers, and strong coordination across agencies and social service providers.

This report presents findings from a mixed methods study of the effects of the Palestinian National Cash Transfer Programme (PNCTP) on children (including adolescents) and their families, looking closely at how the cash transfer and complementary services affect the lives of children and their families. The evidence presented here seeks to inform decision-makers in the State of Palestine (SoP) as to how the PNCTP can be more effectively integrated with other elements of its social protection policy to maximise its ability to meet children's developmental needs and fulfil their rights, particularly focusing on the most vulnerable children and their families. There is an urgent need to make the PNCTP more child-sensitive, given that over 40% of the population are under 15 years of age (PCBS, 2012a).

Poverty among vulnerable households and communities in the SoP is both a cause and an outcome of an array of complex interactions of political, economic, health, psychological, and social conditions. Vulnerable people have limited resources with which to meet their basic needs, and limited labour and other capacities to cope with challenges. Poor households often suffer from a range of challenges that include physical, psychosocial and mental disabilities, chronic disease, gender-based violence, stigma, discrimination, child labour and child abuse, school dropouts, domestic violence, and high-risk behaviours among young people. Given these multi-layered challenges, strategies to help people exit from poverty and hardship require a comprehensive, inter-sectoral and holistic approach that responds to the different needs of different members of the household, including children. Thus, this report contends that in this context, a cash transfer programme targeted at extremely poor households would have a greater impact on children's lives' if it were more closely linked to other complementary programmes that address the multidimensional nature of poverty and vulnerability experienced not only by poor households in general but also by children and adolescents in particular.

This study analyses the challenges faced by poor households with children in the SoP, paying particular attention to those who have additional vulnerabilities, such as having a family member with a disability or chronic illness, or belonging to a marginalised group such as the Bedouin. It explores how income poverty links to and is exacerbated by a range of other vulnerabilities, such as being unable to afford sufficient food to give children a nutritious diet, increased family stress related to a deteriorating economic and security environment, significant exposure to health shocks, adverse coping strategies, and the ongoing conflict with Israel, among other factors. Data show that the PNCTP – which provides access to food, health insurance and fee waivers, as well as emergency assistance – plays an important role in addressing some of these vulnerabilities. However, the study also provides evidence to suggest that while the PNCTP has evolved into an integrated social protection system, there are still important gaps in the provision of integrated services. These gaps urgently need to be filled or strengthened if the programme is to adequately respond to the multiple dimensions of children's vulnerability across the four key rights areas, which can not only be gender specific but can also change during the different stages of a child's life cycle.

The report is structured as follows: Section 2 provides the analytical framework for the study, outlining what is meant by child-sensitive social protection and how it can help protect children's rights. Section 3 provides a contextual overview of the situation in Palestine, describing the situation of children with respect to their rights to survival, development, protection and participation. It also considers the social protection mechanisms in place in the SoP, with particular attention to the PNCTP. Section 4 gives details of the mixed methods approach used for this study. Sections 5-8 present the detailed study findings. Each section begins with an analysis of the findings in relation to the vulnerabilities faced by children and adolescents across the four key dimensions of children's rights, then explores how the PNCTP has contributed to addressing these vulnerabilities, as well as highlighting any gaps or issues that are still not being sufficiently addressed. Finally, Section 9 presents the study's conclusions and provides detailed policy and programme recommendations as to how social protection programming in the SoP (and the PNCTP in particular) can be made more child-sensitive and responsive.

2 Analytical framework

2.1 Defining social protection

While social protection is still an ‘evolving discourse’ (Cook and Kabeer, 2009), UNICEF’s Social Protection Strategic Framework broadly defines it as ‘the set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation’ (UNICEF, 2012a).² Social protection has long been embedded in higher-income countries with robust social policy frameworks; but it is now increasingly being seen as a core function of development policy as lower-income countries seek not only to reduce poverty in the short term, but to meet the Millennium Development Goals (MDGs) and foster long-term equitable growth by

Components of social protection

- Social transfers (e.g. cash or in-kind transfers)
- Programmes to ensure access to services (e.g. fee waivers or social health insurance)
- Social support and care services (e.g. specialised services for children with disabilities, children victimised by violence, abandoned children)
- Legislation and policy reform to ensure equity and non-discrimination (e.g. national child rights legislation)

(Source: UNICEF, 2012a)

strengthening the resilience of individuals, households and communities (e.g. Barrientos and Hulme, 2008). This is reflected in the fact that proponents of social protection have recently established the Social Protection Floor (SPF) Initiative, which aims to ensure that nationally determined benefits are made universally available and that ‘over the life cycle, all in need have access to essential health care and basic income security’ (ILO, 2013).

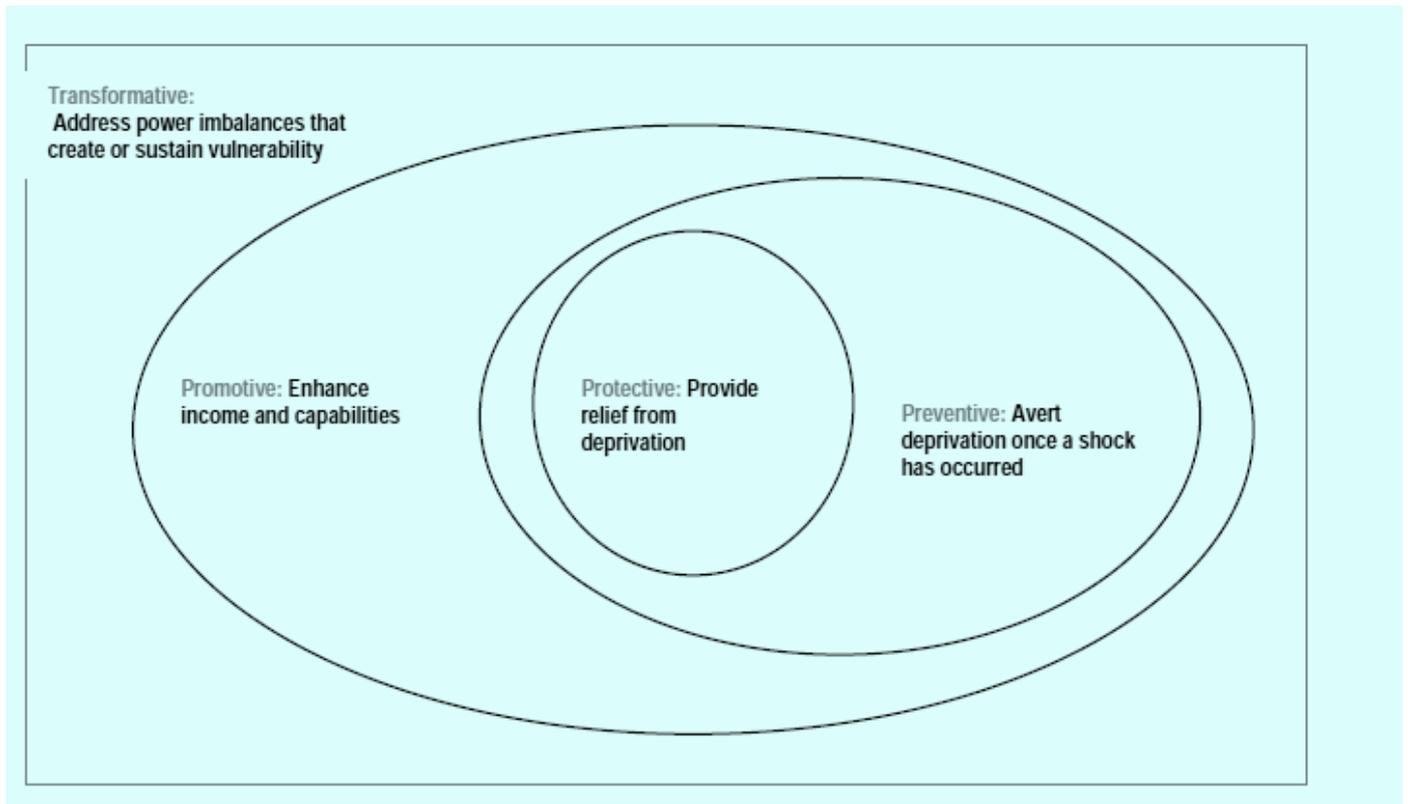
Social protection can be conceptualised as four interrelated categories of approaches (Devereux and Sabates-Wheeler, 2004); while some social protection instruments fall into just one of these four categories, some might be more comprehensive and can fall into more than one category (see Figure 1). **Protective** social protection aims to alleviate the worst of economic and social deprivation by safeguarding household income and consumption. Cash transfers and humanitarian relief fall into this category. **Preventive** social protection, such as health insurance, is designed to reduce household vulnerability by mitigating the impact of shocks. **Promotive** social protection seeks ‘to strengthen the agency of vulnerable people’ by bolstering their capacity for productive activities through the provision of assets or (usually agricultural) subsidies (GSDRC, 2013). Finally, **transformative** social protection addresses the power imbalances which create or sustain the economic and social vulnerabilities that disadvantage individuals and groups based on one or more of their social identities (including gender, religion, ethnicity, race, class, or disability). A transformative approach generally involves an integrated strategy that can include a number of inter-linked programmes (Devereux and Sabates-Wheeler, 2004).

In addition to specific programmes, a well-rounded social protection strategy or approach should ideally include certain features: it should ensure strong coordination between providers (government and non-government); it should promote citizen participation by providing accessible and robust information about social protection entitlements that allow citizens to make informed decisions; and it should promote greater accountability by creating opportunities for providers and beneficiaries to interact to discuss key programme practices and impacts (Samuels and Jones, 2013). This means that a robust social protection system should be integrated, which – according to UNICEF (2012)’s definition – means that it would:

² See also Kaplan and Jones, 2013; Handa et al., 2010

- address social as well as economic vulnerabilities
- provide a comprehensive set of interventions based on needs and context
- go beyond risk management interventions and safety nets to integrate responses to structural as well as shock-related vulnerabilities
- facilitate a multi-sector approach and coordination
- coordinate with appropriate supply-side investments to enhance availability and quality of services.

Figure 1: Social protection aims for economic justice, equity and investment in people



(Source: UNICEF, 2008)

2.2 Conceptualising child-sensitive social protection

Child-sensitive social protection adds an additional aspect to this analytical framework, in that it highlights the unique set of intersecting risks and vulnerabilities that characterise childhood (UNICEF, 2012a).³ Child poverty differs from adult poverty in that it has different causes and effects. The impact of poverty during childhood can have detrimental effects that are often irreversible. Poverty affects children more acutely than adults because of their vulnerability due to age and dependency. Poverty in childhood can cause lifelong cognitive and physical damage, leading to permanent disadvantages that in turn perpetuate the cycle of poverty across generations (UNICEF, 2011a). This in part stems from the existence of ‘critical windows’, such as the 1,000-day post-conception period in which malnutrition leaves children’s cognitive capacities permanently limited (Save the Children, 2012).

However, understanding child-sensitive social protection also means understanding that for children, who are uniquely dependent on the adults in their environment, ‘social vulnerability is especially important’ (UNICEF, 2008).⁴

³ See also Jones and Holmes, 2010

⁴ See also Roelen and Sabates-Wheeler, 2012; UNICEF, 2013

Child-sensitive social protection is therefore both multidimensional and responsive to changes during a child's life cycle, which shape the different needs of children at different ages (Kaplan and Jones, 2013). It is particularly important for social protection to provide support from the earliest possible stage to effectively address deprivation and disparities. Child-sensitive social protection is also fundamentally intergenerational and relational, and is aimed not only at children but also at the caregivers, families, households, and communities who, because they are responsible for protecting and nurturing children, must be protected and nurtured themselves (UNICEF, 2012). As Sabates-Wheeler et al. (2009) note, this means that child-sensitive social protection must pay particular attention to the positioning of women vis-à-vis their role as primary caregiver, given the dynamics of intra-household decision-making and resource allocation patterns. Finally, child-sensitive social protection recognises that due to longstanding cultural and legal traditions, children 'remain a highly invisible population with a lack of voice who are hard to reach' and who are 'by and large represented by the weakest ministries in government' (Roelen and Sabates-Wheeler, 2012: 296).

While growing demands for social protection in general, and child-sensitive social protection in particular, can be understood from a rights-based approach (Jones and Sumner, 2011), it can also be seen 'as an investment rather than a mere welfare or protective measure' (Roelen and Sabates-Wheeler, 2012). Not only does it help children reach their full potential, with lifetime benefits for the recipients themselves and the broader economy through higher long-term productivity, but it can also stimulate local markets and demand for social services through its impact in alleviating poverty (UNICEF, 2012a).

Child-sensitive social protection does not necessarily involve any particular set of inputs (Roelen and Sabates-Wheeler, 2012). Indeed, as Holmes and Akinrimisi (2012: 6) argue, it can involve any type of social protection measure, regardless of whether children are even explicitly targeted, as long as it 'helps to build a protective environment for children'. In the past decade or so, social transfers, defined by UNICEF (2012: 39) as 'predictable direct transfers to individuals or households, both in-kind and in cash, to protect them from the impacts of shocks and support the accumulation of human, financial and productive assets', have become one of the most favoured forms of child-sensitive social protection (Devereux et al., 2013).⁵ As Barrientos et al. (2013) note, transfers sometimes involve nothing other than cash or in-kind support for poor or vulnerable groups of people, such as children, people with disabilities, or older people. They are often part of a broader programme that encourages the accumulation of assets, such as the Philippines' Pantawid Pamilyang Pilipino Program, which provides transfers to parents as long as they fulfil certain conditions related to their children's nutrition, health and education. More rarely, transfers are part of a broader package of support services ranging from housing to counselling, as in the case of Chile's Solidario programme. Regardless of the overall approach, as Devereux et al. (2013: 5) note, 'the rapidly growing numbers of social protection programmes being designed and implemented across the world testify to the momentum and confidence around these interventions'.

Box 1: Social protection and children's rights

- Child-sensitive social protection (CSSP) directly addresses children's **right to survival** by guaranteeing household income as well as improving access to services ranging from health care and supplementary nutrition to sanitation.
- Children's **right to development** is also well addressed by CSSP, as it recognises the physical and emotional care that children require as well as prioritises their needs for education and recreation.
- CSSP also stretches to accommodate children's **right to protection**. In the more traditional understanding of the concept, it reduces the stress that can lead to child abuse and the reliance on adverse coping strategies that jeopardise children's current and future wellbeing, such as child labour, child marriage, distress migration, and violence against children. In the emerging systems approach to child protection, CSSP helps create 'an enabling environment for children where they grow, develop and feel safe, and where risks they face are addressed' (Barrientos et al., 2013: 3). This can include provision of identification documents and measures to reduce reliance on institutionalised forms of care, as well as specialised care for children with disabilities.

⁵ See also Barrientos et al., 2013; Molyneux, 2007

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- Thus far, CSSP debates have paid very little attention to children’s **right to participation**. Streuli (2010) emphasises the importance of talking to children to get their views on how programmes affect their experiences of poverty and wellbeing. But while there are an increasing number of initiatives to integrate spaces and systems for beneficiary feedback and dialogue into programme governance and accountability mechanisms, they are all adult-focused (Samuels and Jones, 2013).

2.3 Social transfers – how child-responsive are they?

Social transfers may be unconditional (purely on the basis of identified need) or conditional (where receipt of cash is tied to meeting certain conditions that usually involve take-up of health, education or other social services). They have been linked to a variety of positive outcomes for children, who, because they are disproportionately likely to be poor, are also disproportionately likely to benefit from poverty alleviation programmes (UNICEF, 2012). For example, conditional cash transfers (CCTs) – pioneered in Latin America but found in diverse forms around the world – have been found to reduce poverty, increase school attendance, and improve vaccination rates and nutritional status (Fiszbein and Schady, 2009). Ultimately aimed not only at mitigating the impacts of poverty on childhood but at breaking the intergenerational transmission of poverty by fostering the development of human capital, CCTs have also been found to increase women’s intra-household bargaining power, which has key implications for children’s survival, development and protection (ibid.). Notably, even transfers that are not targeted at children have been found to have positive impacts on children’s lives. For example, across southern Africa, where there are a large number of skip-generation households owing to the incidence of HIV, old age pensions have resulted in better educational and nutritional outcomes for children (particularly girls) living with their recipient grandparents (Duflo, 2003).

However, while there is broad consensus that social transfers can and do improve children’s outcomes, there is increasing disagreement around the effectiveness of conditionalities. On the one hand, as UNICEF (2012) notes, there are conceptual as well as political reasons to attach conditions to transfers. In addition to making such transfers easier to justify to taxpayers, conditionalities can also encourage behaviour change in key areas (e.g. educating parents about the importance of vaccines) and begin to shift social norms (such as those that prevent girls enrolling for and completing secondary education). On the other hand, as well as the risks of fostering paternalism, adding layers of complexity and cost, and potentially increasing the burden on mothers (who usually have to fulfil the requirements), Kaplan and Jones (2013: 7) point out that conditionality is problematic in ‘contexts where a household’s eligibility ... is tied to their participation in services that are not universally available’. Given recent findings from an experimental cash transfer programme in Zomba, Malawi,⁶ in which girls receiving unconditional transfers were less likely to be married or pregnant than their peers who received conditional transfers, there continues to be significant space for debate about the positive and negative factors around conditionality (Baird et al., 2011).

‘Soft’ conditionalities, ‘which eschew a punitive approach in favour of informing families whenever possible of the need to invest more directly in their children’s well-being’ (Kaplan and Jones, 2013: 7), may ultimately represent a compromise. Evidence from Latin America suggests a causal relationship between conditionalities and beneficiaries making greater demands for state services – ultimately leading to better government funding of those services (Fiszbein and Schady, 2009).

⁶ This experimental cash transfer programme randomly assigned adolescent girls to either an unconditional cash transfer or a conditional cash transfer, to see which was most likely to keep girls in school, help them avoid early marriage, and delay the age at which they first became pregnant.

2.4 Cash transfer programming in humanitarian contexts

There is also evidence that social transfers and other social protection measures may play an important role in fragile, conflict-affected settings by preventing crises or increasing people's resilience to them, by mitigating the impacts of crises, and by supporting the 'transition from emergency response to long-term development' (UNICEF, 2012a: 87).⁷ Evaluations of the impacts of this kind of programming on children are largely limited to child labour and children's nutritional status (Harvey and Bailey, 2011), but findings suggest that CCTs are highly effective in enabling sustained and positive child protection outcomes in a range of humanitarian contexts. For example, in the post-conflict setting of Nepal, a universal, unconditional child benefit has been proposed as a 'peace dividend' that may help 'restart the economy, and at the same time help transform the society towards supporting the social rights of the poor and marginalised' (Köhler et al., 2009).

⁷ See also Barrientos and Hulme, 2008; Thompson, 2012

3 Context

The State of Palestine (SoP) is currently classified by the United Nations Development Programme (UNDP) as an area of medium human development, with an overall Human Development Index value that has slowly improved since 2003 (with the exception of a small decrease between 2006 and 2008) (UNDP Human Development Reports, 2003-2011). Despite this slow progress, the Palestinian people have been exposed to a wide range of vulnerabilities since 1948, when several hundred thousand Palestinians expelled from the newly created state of Israel took refuge in the West Bank, Gaza Strip, and surrounding Arab countries. Since then, the SoP and the Palestinian diaspora have experienced numerous internal and external clashes with Israel. These conflicts have all contributed to loss of life on both sides, and loss of land and livelihoods for Palestinians living in these territories, contributing to increased numbers of refugees and internally displaced people, weakened social networks, poor housing and sanitation, and high poverty rates, as well as large numbers of people experiencing psychological ill health and emotional difficulties (Jones and Shaheen, 2012).

Extensive internal and external barriers to mobility act as critical constraints to growth and improved welfare for Palestinians. Restrictions on the movement of goods and people within the West Bank, major constraints on the movement of goods to and from Israel, and a near total separation between the West Bank and Gaza have resulted in highly fragmented and distorted local economies (World Bank, 2011).

The quality and availability of infrastructure and essential services has deteriorated as a result of these restrictions, which have also worsened pre-existing gaps in access to health care, education, electricity, water and sanitation, and other key services. The situation has been further exacerbated by rapid population growth and damage to infrastructure during recurrent hostilities. Such conditions have led to high levels of poverty and food insecurity, particularly in Gaza (UN OCHA, 2013). According to the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA), 57% of households in Gaza are food insecure and about 80% are recipients of aid.

The poverty rate in SoP in 2011 was 25.8% (17.8% in the West Bank and 38.8% in Gaza). Data from the Palestinian Central Bureau of Statistics (PCBS) reveal that 12.9% of individuals lived in deep poverty in 2010 according to consumption patterns (7.8% in the West Bank and 21.1% in the Gaza Strip) (PCBS, 2012a). The proportion of deep poverty among households headed by women was 25% in 2010 (compared with 25.9% for men). In the West Bank, there are more female-headed households living in deep poverty than male-headed households (22.5% and 17.5% respectively), while the opposite is the case in Gaza, with 39.4% of male-headed households living in deep poverty compared with 29.7% of female-headed households (PCBS, 2013a). The SoP is also characterised by high unemployment. More than one-fifth of participants (23.9%) in the PCBS 2012 Labour Force Survey were unemployed in the first quarter of 2012 (20.1% in the West Bank and 31.5% in the Gaza Strip). The unemployment rate was higher for women (31.5%) than men (22.0%) (PCBS, 2012a).

According to a 2011 World Bank study, employment status and educational attainment are strong drivers of poverty in the West Bank and Gaza (World Bank, 2011). Still, despite these challenges and relatively high levels of income poverty, when compared to countries with similar levels of income, the SoP has delivered some important human development achievements, such as universal prenatal care coverage and gender equity in primary enrolment. However, as indicated below, there is still much to be done, particularly to improve children's wellbeing.

The Palestinian National Cash Transfer Programme (PNCTP) is being implemented in a context of high rates of poverty and unemployment, limited livelihood opportunities, protracted conflict, and serious obstacles to the provision and uptake of basic services. In the next subsection, we give a brief overview of the situation facing children in the SoP. We highlight the main vulnerabilities they experience and the challenges they face in realising their rights in this context, and outline the main programmes and services in place to help children realise their rights, with particular emphasis on social protection. This provides the backdrop for the analysis in

sections 5-8 of how effective the PNCTP and related social protection mechanisms are in terms of improving the situation of children in Gaza and the West Bank.

3.1 The situation of children in the SoP

This overview of the situation facing children in the SoP is structured around the four key dimensions of children's rights: survival, development, protection and participation.. Demographics and child poverty

According to PCBS data for 2013, the total population of the SoP is 4.42 million (2.71 million in the West Bank and 1.71 million in Gaza). Of the West Bank population, approximately 848,000 are refugees and 40,000 are of Bedouin origin (Mihlar, 2011). In Gaza, a majority of the population (66%) are refugees. In 2013, the United Nations Relief and Works Agency (UNRWA) reported that there were 741,409 registered refugees in the West Bank and 1,203,135 in the Gaza Strip (UNRWA, 2013c). Refugees face particular vulnerabilities, including higher unemployment rates and poverty levels (UNRWA, 2013d).

The population of the SoP is predominantly young, which highlights the need for a strong policy focus on children and adolescents. According to projections based on 2007 census data, 40.4% of the total population were aged 0-14 by mid-2012 (38.4% in the West Bank and 43.7% in the Gaza Strip) (PCBS, 2012a). The SoP has one of the highest fertility rates in the Arab region due to the high societal value attached to large families and in part to early marriage (Jones and Shaheen, 2012).

Household poverty disproportionately affects children, partly as a result of the prevalence of larger families as well as the impacts of poverty on children's access to developmental opportunities, including child health and education services (UNICEF, 2010). According to PCBS data from 2011, 14.5% of households in the West Bank suffered from poverty in 2011, with a higher poverty incidence among households with children, at 15.7%, compared with 10.5% for households without children. In the Gaza Strip, 32.6% of households were living in poverty in 2011, 34.6% of households with children and 21.1% of households without children (PCBS, 2011a).

3.1.1 Survival

Health, nutrition and food security

Child mortality rates in the SoP are comparable to those in upper middle-income countries, though there are some differences between the West Bank and Gaza. The infant mortality rate (0-12 months) was 20 deaths per 1,000 live births, while the child mortality rate (12 to 59 months) was 25 deaths per 1,000 live births in 2010 (PCBS, 2011a).

However, poor rates of maternal health remain a concern. There are no national studies that give reliable estimates of maternal mortality, and official estimates tend to be under-reported. However, according to a 2011 Ministry of Health (MoH) report, maternal mortality in 2010 was estimated at 32 deaths per 100,000 live births in the West Bank and 29 deaths per 100,000 live births in Gaza – a ratio comparable to neighbouring Arab countries (MoH, 2011).

Child malnutrition is a persistent problem. Currently, one in ten children under the age of five suffers chronic malnutrition, with the rate slightly higher in the West Bank (PCBS, 2011a). Malnutrition is on the rise among children under five. Between 2000 and 2010, malnutrition prevalence rose by 41.3% nationally, with a particularly high increase of 60% in the Gaza Strip, attributed to the conflict and the worsening political and socioeconomic conditions there (PCBS, 2011a).

Due to rising prices and declining incomes, many Palestinians are increasingly food insecure. Various food items are becoming prohibitively expensive, particularly for urban residents who rely on cash purchases. Many families have resorted to negative coping strategies to maintain their level of food consumption, such as reducing the number of meals consumed, eating smaller quantities of food, selling disposable assets, taking on more debt, taking children out of school, and even marrying their daughters earlier (Oxfam 2007 in O'Callaghan

et al., 2009: 34-35). A 2010 PCBS Family Survey found that increasing levels of food insecurity had contributed to a significant rise in stunting (PCBS, 2011c).

While children have access to basic health services, travel permits have significantly reduced their access to more specialised services, particularly abroad. In Gaza, roughly 1 out of every 20 children (174 of 3,949) referred abroad in 2011 for treatment missed his/her appointment due to delays in issuing the travel permit; three children died while waiting for permission to travel (Save the Children/MAP, 2012).

Water and sanitation

Water and sanitation infrastructure remain a serious health risk for Palestinian children. Constant fuel crises have impeded water supply and sewage treatment. In 2010, residents in nearly half of Gaza's municipalities were at high risk of consuming contaminated drinking water. A 2009 study suggested that 48% of Gaza's infants and children suffered from nitrate poisoning (UNEP, 2009). Ensuring a consistent supply of clean water is essential to minimise the incidence of diarrhoea and other sanitation-related diseases, which affect infants and children disproportionately. UNRWA reports that diarrhoea is one of the most common illnesses among Gaza's refugees, and as a result of contamination, cases of typhoid fever and watery diarrhoea in children under three have increased at clinics serving refugees in the Gaza Strip (Save the Children/MAP, 2012).

3.1.2 Development

Education

The reforms of the mid-1990s, the move to expand compulsory education from nine to ten years, and curriculum changes have all helped increase enrolment rates, especially for girls. As a result, full gender equity was achieved in enrolment in basic education in the SoP by 2008 (UNICEF, 2010). Access to basic education (6-12 years) is nearly universal for boys and girls in both the West Bank and Gaza Strip.

The dropout rate at the basic stage in the 2006/07 school year was 1% for male students and female students. At secondary level, the rates rose, to 3% for male students and 4% for female students. For a variety of reasons, including poor learning environments, violence, and limited extra-curricular activities, adolescents are prone to drop out after basic education (grade 10, roughly age 16). In 2007, almost 30% did not enrol in secondary school at all. The main reasons cited were the need to work to help support their families, early marriage, drug abuse, and political polarisation (UNICEF, 2010).

With regard to the quality of education provided, learning outcomes have been declining in the SoP. This can be partially explained by internal closures and other restrictions on people's movement and access, including the impact of the West Bank Barrier. Further, the blockade and restrictions on the movement of goods and people across Gaza's borders have constrained the functioning of the education system there, leading to a dearth of learning materials, and an inability to repair or expand existing educational facilities. This has also resulted in overcrowding in the facilities that do exist, further compounded by significant damage to schools resulting from the Israeli offensive on Gaza (Operation Cast Lead) that began in December 2008 and ended in January 2009. Other constraints to educational performance include, on the demand side, limited funding to employ more teachers and limited availability of text books; on the supply side, constraints include the pervasive stress and burden of violence and occupation on Palestinian children and young people (UNICEF, 2010).

Leisure

There are some organisations that aim to provide children with recreational opportunities, including in particular the Committee for Summer Camps, established in 2001 by a group of pioneers including government officials, community leaders, business owners and community-based organisations to coordinate and organise summer camps through different organisations. The committee was positioned under the umbrella of the Ministry of Youth and Sport. UNICEF, and to a lesser extent, Save the Children, supported the committee. In some years, it organised as many as 750 summer camps. In 2007 however, with the political division, the committee collapsed in Gaza. Later, in 2010, UNICEF supported the establishment of a similar committee in the West Bank, which now has eight members from different NGOs and government bodies; there is one member from Gaza. The role

of the committee is more one of coordination and providing strategic vision. In 2006, it produced a National Declaration for Summer Camps in Palestine.

For refugee children and young people, the lack of safe and appropriate spaces for play and recreational activities inside schools and camps were reported as an important limitation for the enjoyment of their right to leisure.

UNICEF 2010's analysis, *The Situation of Palestinian Children*, reported young people's main leisure activities as watching television (34%) and spending time with friends (15%), meeting in their homes, the homes of friends and relatives, places of worship, university and school clubs, on the street, at youth centres and clubs, and cafés, NGO offices, and libraries.

3.1.3 Protection

Disabilities

Over the past 15 years, the proportion of the SoP's population with some form of disability has significantly increased. Today, using a narrow definition, 1.5% of Palestinian children have a disability, with rates slightly higher for boys (1.8%) than girls (1.3%), and higher in the West Bank (1.6%) than in Gaza (1.4%). The most common cause of disability is illness, followed by congenital factors. However, a substantial proportion of disabilities are also caused by settler or Israeli Defence Force (IDF) violence. Estimates suggest that these account for 7.6% of mental health disabilities, 4.6% of physical disabilities, and 5.2% of learning disabilities (PCBS, 2011b).

Children with disabilities face numerous barriers in accessing public services. In education, for example, despite near-universal access for most Palestinians, more than one-third of those with a disability aged 15 years and over had never enrolled at school. Of those that did enrol, a further third dropped out as services were not adequately adjusted to meet their needs (PCSB, 2011b). In 2011, less than one in three schools had appropriate facilities for disabled children (PNA/UN Women, 2011). Around half of all children with mobility-related disabilities, for example, require modifications to stay in school, such as more accessible transport and specially adapted buildings, classrooms and bathrooms. Children with disabilities living in UNRWA camps are technically permitted to attend classes with non-disabled children and still benefit from services if specialists keep track of their progress; but in practice, there are few specialists in the camps, so those children are rarely able to make use of these services (UNICEF, 2010).

Children with disabilities are also often stigmatised. In some households, disability is regarded as a divine punishment which brings shame on the family. It is common for parents to keep a child with a disability at home. This stigma also translates into self-exclusion in adulthood (PCBS, 2011b). Further, children with disabilities are disproportionately vulnerable to violence, exploitation and abuse from the community and sometimes even within the family (UNICEF, 2013).

More generally, people with disabilities in the West Bank and Gaza Strip face considerable challenges to become fully integrated into their wider community, and social protection programmes are far from adequate to help achieve this goal.

Child labour

In 2010, children and young people aged 10-17 accounted for 20.4% of the total population. The Labour Force Survey of the same year shows that 3.7% of that age group were employed, although substantially more boys than girls (6.3% compared with 1.1%). The figure was also substantially higher in the West Bank than the Gaza Strip (5.7% compared with 0.6%) (PCBS, 2011b) – largely as a result of very limited work opportunities in the latter.

In the Palestinian context, child labour is regarded as one of the coping mechanisms that can help the family and the child meet their basic needs. There are no real attempts to evaluate the impact of such labour on children's social, psychological or emotional health, or their academic outcomes. In Jericho and Jordan Valley, boys and

girls work in agriculture, with the money they earn going to their father or parents; they keep little themselves. Although children working seems to help these households and allow children to feel empowered, it can also have negative impacts in terms of protection: many children risk physical abuse from their employer, work long hours, experience harassment, are less likely to attend school and more likely to drop out, and achieve lower grades. The risks and benefits of children engaging in paid work need to be evaluated more comprehensively.

Violence

According to the PCBS 2011 ‘Violence Survey in the Palestinian Society’, 51% of children had been exposed to violence inside the household in the past 12 months – 45.8% in the West Bank compared with 59.4% in the Gaza Strip. More than two-thirds of them (69%) were exposed to psychological violence and 34.2% to physical violence from their fathers, with 66.2% exposed to psychological violence and 34.5% to physical violence from their mothers. In addition to domestic violence, about 2 out of 100 children aged 12-17 were exposed to physical violence from the occupation forces, and 4 out of 100 were exposed to psychological violence (PCBS, 2012b).

Further, according to a 2009 study, just fewer than 6 out of 10 Gazan primary school students surveyed did not feel safe going to and from school some or most of the time due to violence related to the armed conflict (Save the Children/MAP, 2012).

Mental health / psychosocial wellbeing

A clear result of the ongoing conflict is an increase in mental health conditions, including among children. Post-traumatic stress disorder (PTSD) is a significant problem for children given their widespread exposure to violence, directly and indirectly. Children exposed to high levels of trauma are more likely to report higher levels of PTSD, emotional symptoms and neuroticism. Research has found that children’s exposure to war trauma during the most recent offensive on Gaza (Operation Pillar of Defense, in November 2012) was an important predictor of PTSD symptomatology and neuroticism (Khamis, 2013).

A recent study by UNICEF (2012b) showed that physical and emotional symptoms experienced by children and young people were associated with being exposed to or witnessing violence. There were also important associations between symptoms and feelings of fear, especially among boys. The assessment found that out of the children interviewed for the study in the five Gaza governorates: 97% reported clinging to their parents; 94% reported sleeping with their parents; 91% reported having increased sleep disturbances; 85% reported an appetite change (increase or decrease); 84% looked stunned or dazed; 77% reported crying more; 80% reported fear of loud sounds; 63% reported fearing death; 62% reported fear of being alone; 59% reported fear of injury; and 57% reported fear of leaving their house.

Another study conducted by the United Nations Population Fund (UNFPA) found that 98% of young men were having difficulty sleeping and problems with aggression, and 4 out of 10 took the prescription drug Tramadol to help them sleep and reduce anxiety. PTSD also affects parents. In 2009, PCBS data revealed that 77.8% of households surveyed in Gaza had at least one person suffering from psychological problems due to the conflict; children and adults continue to feel the prolonged effects of the conflict such as fear, insecurity, sleeping problems and high levels of stress (UNICEF, 2011).

3.1.4 Participation

A National Youth Strategy covering young people aged 13-24 years was formulated, and includes a detailed framework for adolescent participation in social and civic affairs. However, the policy was not endorsed by the High Council of Youth and Sports (HCYS) and is currently being revised. The Palestinian Child Law Article 33 also states that the ‘the child shall have the right to obtain, receive, transfer and disseminate all types of information and ideas, provided that this does not contradict with public order and morals’. This Article also obliges the state to work towards implementing and embodying this right, in accordance with its resources and capabilities (UNICEF, 2010).

There have been a number of sporadic initiatives to strengthen children’s participation, including workshops on children’s rights, and training on the United Nations Convention on the Rights of the Child (UNCRC) for staff

from government agencies and non-government organisations (NGOs). The HCYS and the ministries of education and social affairs report that they have all included the theme of children's participation in their National Strategic Plans for 2011-2013 (UNICEF, 2010). However, several factors limit children's right to participation. On the one hand, everyday constraints such as insecurity and risk of violence curb children's ability to have safe spaces for participation. On the other, hierarchical social norms represent a major barrier to children's ability to participate, with girls particularly subject to social restrictions on their mobility outside the home.

3.2 Social protection in the SoP

In 2010, the Ministry of Social Affairs (MoSA) approved its Social Protection Strategy, which identified increasing the services provided to beneficiaries living below the national poverty line as one of its priorities (World Bank, 2012). According to the strategy, the driving vision of the social protection sector is: 'A decent life for the Palestinian citizens on the path to sustainable human development in the independent Palestinian state'. The strategy's four main goals are: (1) to alleviate poverty among Palestinians; (2) to care for and enable weak and marginalised groups (including people with disabilities, older people and children, among others); (3) to form and reinforce social security in an effort to maintain an integrated social security system; and (4) to develop the legislative and institutional environments and the cooperation needed to achieve the broader objectives of the social protection sector (World Bank, 2012).

MoSA thus operates and administers social protection programmes and formulates social protection policies in both the West Bank and Gaza. It is responsible for providing assistance to poor families and marginalised groups through branch offices in each of the 16 governorates. The social protection sector includes a large group of governmental and non-governmental institutions (including charitable societies and Zakat committees), the private sector, the United Nations (UN) and other international organisations and partners (World Bank, 2012). To achieve its social protection goals, MoSA adopted definitions of the poverty line and extreme poverty line in accordance with PCBS data; it also aimed to standardise methodologies and targeting criteria between the different donors and agencies implementing social assistance programmes in the SoP (Al-Markaz, 2012). Standardising targeting criteria has so far been a slow process as different institutions have different objectives for targeting. However, a 2012 World Bank study on targeting found that the PNCTP's proxy means test formula (PMTF) correctly identified almost 70% of beneficiaries, with rates of exclusion and inclusion errors lower than other programmes that are widely considered successful (such as the *Bolsa Familia* in Brazil and *Oportunidades* in Mexico) (World Bank, 2012).

In terms of coverage and targeting, the performance of Palestinian social safety net (SSN) programmes (including those implemented by MoSA, donors and NGOs) as part of the Social Protection Strategy is among the best in the region. According to a recent World Bank study, the SoP is the only area in the region with SSN coverage above the world average, covering more than half of the poorest quintile (Silva et al., 2013). However, there is still room for improvement on other dimensions of performance, such as impact of the transfer on beneficiary households. For example, an impact evaluation of the PNCTP conducted in 2013 found that most beneficiary households were able to bridge the poverty gap to meet many but not all of their basic needs. However, it found no evidence that households were able to move out of poverty as a result of the transfer, and some households still cannot meet all their basic needs (Hackstein et al., 2013).

An important component of the Palestinian Social Protection Strategy is health insurance for the poor. PNCTP beneficiaries, and other citizens classified as poor but who might not be receiving the cash transfer, are entitled to certain complementary services, including health insurance. This is coordinated between MoSA and the Ministry of Health (MoH), which issues a health insurance card that provides free access to health care services for almost 65,000 families (including 28,000 children) in the West Bank and Gaza (MoSA, 2011, in Jones and Shaheen, 2012). Additionally, PNCTP beneficiaries and their children wishing to enrol at university can also have their tuition fees waived, although individual universities have their own policies in relation to fee waivers (PNA, 2010b).

It is important to note, however, that although children are one of the vulnerable groups identified in the Social Protection Strategy, social protection programming in the SoP is not specifically child-focused, despite children

and young people comprising a substantial proportion of the population and despite the specific challenges and vulnerabilities they face.

3.2.1 The Palestinian National Cash Transfer Programme

The Palestinian National Cash Transfer Programme (PNCTP) is MoSA's flagship social protection programme, managed and administered by the ministry. It resulted from a merger in 2010 of the two main cash transfer programmes – the European Union (EU)-funded Social Hardship Case (SHC) programme and the Social Safety Net Reform Project (SSNRP).

Beneficiaries are selected according to a consumption-based proxy means test formula (PMTF) that estimates the welfare of each applicant household (Jones and Shaheen, 2012). It was the first country in the region to target its cash transfer programme using such a formula, and has also introduced a unified payment scheme (Silva et al., 2013). Each selected household receives between 750 and 1,800 new Israeli shekels (NIS) (US\$195-468) per quarter to bridge 50% of the household poverty gap.⁸ According to data provided by MoSA to the research team for this study, as of September 2013 there were 105,678 households receiving the cash transfer – 57,449 in Gaza and 48,229 in the West Bank. Given the national average of children per family, it is estimated that the total number of children living in beneficiary households is 287,794. Almost half (45%) of these households are classified as extremely poor.

Assessments of the programme's targeting undertaken in 2012 and 2013 have found that the large majority of applicants classified as extremely poor by the programme are indeed extremely poor: more than 80% of beneficiaries are in the bottom income quintile (20%) (Silva et al., 2013). Results differ between Gaza and the West Bank, but in general, the programme is using high standard poverty indicators. The programme's targeting approach reflects its objectives of reducing the poverty gap, with its emphasis on assisting extremely poor households (Al-Markaz, 2012).

Furthermore, according to Samuels and Jones (2013), programme beneficiaries typically see the cash transfer as their right rather than a gift or charity – especially in the West Bank, where there is a strong rights-based culture fostered by a substantial NGO presence. This is critical in terms of programme governance, since parents tend to feel more empowered to advocate for themselves and their children to be included in the programme when they meet the necessary targeting criteria, or to hold authorities accountable for good implementation.

The PNCTP was not designed as a child-focused programme. As a senior MoSA official explained: *'We can't claim that MoSA has a child-focused policy, we deal with the family as a whole and there is no considerations for the child-specific conditions and needs within the family. We have in the programme 200,000 children reached by assisting their families, although we think we should treat them as an important segment of our target population.'* It is in fact the case that given the large family sizes common in the SoP – particularly among poorer households – many household expenses and consumption goods prioritise meeting children's needs, principally their schooling.

3.2.2 Other cash transfer programmes in the SoP

PNCTP beneficiary households are also entitled to other state-provided assistance, including health insurance, school fee waivers, and cash grants to help with one-off emergency needs (see Box 2).

With regard to non-state provision, UNRWA is the second largest provider of social protection in the SoP. In Gaza, UNRWA runs the Social Safety Net Programme (SSNP), which provides cash assistance to extremely poor refugee families, identified by a proxy means-tested poverty survey (UNRWA, 2011). According to a UNRWA official, 21,000 refugee families in Gaza receive a transfer of US\$150-185 per year per beneficiary household (Hamad and Pavanello, 2012). UNRWA also provides food assistance to 800,000 registered refugees. Since the inception of the PNCTP in 2010, UNRWA and MoSA have been coordinating food assistance to minimise duplication.

⁸ The poverty gap can be defined as the mean shortfall from the poverty line (counting the non-poor as having zero shortfall), expressed as a percentage of the poverty line.

PNCTP beneficiaries are also entitled to food assistance through the Assistance to Destitute Families Programme managed by WFP. In addition to this, WFP and Oxfam GB run an Urban Voucher Programme, which reaches 2,335 poor beneficiary households that were also identified using a proxy means test formula, again coordinating with UNRWA to avoid duplication (Qleibo and Bertola, 2011). The United Nations Development Programme (UNDP) runs the Deprived Families Economic Empowerment Programme (DEEP), which targets 8,669 households living below the national poverty line. DEEP offers one-off cash grants, but focuses on providing microfinance services to promote income-generating opportunities.

Other organisations (national and international), such as the Foundation for the Families of Martyrs and Wounded, the Emirates Red Crescent Society, and Islamic Relief Worldwide, provide regular financial aid for orphaned children and fatherless households. Community-based organisations such as the Salah Society in Gaza and the Human Relief Society in Hebron also provide regular assistance to orphaned households (Jones and Shaheen, 2012; Schaeublin, 2011; EU/FAO, 2007). Finally, Zakat committees provide cash grants and food to families who have lost their breadwinner due to an accident or illness, again targeting families caring for orphans. In 2009, they supported 14,850 poor orphans and 8,040 poor families, providing around US\$25-30 a month, paid every quarter (Schaeublin, 2011).

Given the breadth of vulnerabilities facing poor people in the SoP, and the limited financing available to the PNCTP and UNRWA, other programmes designed to provide a social safety net provide useful support. With the launch of the PNCTP, coordination between relief and development partners has been strengthened, although there is still a need for further improvements, not least the creation of a unified registry of beneficiaries. Coordination and collaboration – could also be improved in terms of targeting of beneficiaries and conducting needs assessments (pooling human resources where possible) – to make the range of cash transfers more efficient, and more responsive to the needs of the most vulnerable groups, particularly children.

3.2.3 Social services

The Palestinian Government is the main provider of basic social services in the West Bank, and receives significant support to fulfil this role from UNRWA and other agencies in Gaza. Existing social protection mechanisms, such as the PNCTP and health insurance, improve individuals' access to basic services.

UN agencies provide various health and education services for children, although with the exception of UNRWA, their actions are limited in scale. UNFPA provides family planning support and methods, as well as services to support individuals experiencing gender-based violence. UNICEF provides logistical support to the government for vaccines and immunisation campaigns. In education, it focuses on developing school readiness during early education, developing child-friendly schools, working on child protection, and supporting family centres and adolescent-friendly spaces.

Box 2: Complementary services currently provided to PNCTP beneficiaries

The Ministry of Social Affairs (MoSA) works with other government organisations responsible for the delivery of social assistance programmes. Civil society organisations play a vital role in assisting the poor and vulnerable groups in the West Bank and Gaza. There are more than 700 local and international charitable societies that deliver a wide range of social assistance and support services to vulnerable groups. They provide cash and in-kind assistance, vocational training, economic empowerment, loans and grants, and medical rehabilitation (PNA, 2010a). Many of the existing programmes support different dimensions of children's needs, including distribution of school bags, organisation of leisure activities, and provision of therapy for children with disabilities, among others.

However, this diverse and fragmented range of services could have an even stronger impact in reducing the specific vulnerabilities facing children and enabling them to realise their rights if the linkages between the PNCTP and other complementary services were stronger and more strategic, and if there were stronger coordination between the ministries and organisations providing assistance.

Health insurance (Ministry of Health)

Our research revealed that PNCTP beneficiaries' entitlement to health insurance is one of the most highly valued components of the programme, so continued coordination between MoSA and the Ministry of Health (MoH) is critical. Currently, health insurance is provided to almost 65,000 poor and extremely poor families. There are, however, limits to the medicines available, especially in Gaza, and the insurance scheme does not cover all equipment and maintenance-related costs (e.g. batteries for hearing aids) incurred by people living with disabilities. A national health insurance scheme that would cover all Palestinians, but particularly poor and vulnerable families, is currently under discussion (PNA, 2010).

UNRWA assistance programmes

The United Nations Relief and Works Agency (UNRWA) provides a range of services to Palestinian refugees in the West Bank and Gaza Strip. These include free health and education, including for PNCTP beneficiaries. UNRWA also provides food to families living in localities without functional markets or those who have physical constraints that prevent them accessing food.

Beneficiaries consider food assistance to be one of the most vital components of social assistance programmes, as it means they can use the money they would have spent on food to pay for other items to meet the family's basic needs. Food assistance can also help improve the nutritional status of Palestinian children (see Section 5.2).

While there is no formal coordination mechanism between MoSA and UNRWA, MoSA knows which households are registered refugees and therefore have entitlements to UNRWA assistance. Refugees do not receive cash transfers from UNRWA, however. Although it used to provide cash to poor refugees, in April 2013 UNRWA's cash grant system ended, so the only cash received by refugees is that provided through the PNCTP. Currently, PNCTP beneficiaries that are also UNRWA-registered refugees receive food rations from UNRWA, while non-refugee cash transfer beneficiaries receive food rations from the World Food Programme (WFP) through a system of coupons.

Emergency Assistance Programme

All PNCTP beneficiary households are entitled to apply for a lump-sum emergency grant from the Emergency Assistance Programme, which is independent of the cash transfer programme but also managed by MoSA. The programme targets families or individuals who incur income difficulties/shortages resulting from sudden shocks or unexpected emergencies such as destruction of their house due to military incursions. In 2010, the budget for the programme was 1 million NIS.

Support to education

PNCTP beneficiaries are also entitled to fee waivers (or a reduction in fees) for children enrolling in Palestinian Government schools and local universities (PNA, 2010a). In practice, though, our findings suggest that information about such support is not widely available and support is provided on an ad hoc rather than systematic basis. Moreover, schools and universities are not equipped to provide an inclusive education to students with disabilities (whether hearing, visual, or mental disabilities) (MoSA, 2010; MoSA, 2011).

The role of UNRWA is essential in both Gaza and the West Bank, but it has an unprecedented role in Gaza where, given the area's large share of the Palestinian refugee population, UNRWA reaches more citizens than the government does. It provides free primary and vocational education for 491,000 refugee children, even organising summer camps and school trips. It also provides a full range of essential curative and preventive medical services for refugees, with 42 primary health centres and 6 mobile health teams that reach around 13,000 patients each month in more than 150 isolated locations (UNRWA, 2013a). It also runs a rehabilitation centre for people with visual impairments and a community mental health programme, which allocates school counsellors to support the neediest children, and provides support through its safety net (UNRWA, 2013b). In Gaza, UNRWA does not formally interact with the current government, though unofficial linkages exist. This limits opportunities for learning, information exchange, and coordination of service delivery.

Finally, while the main providers of health services are the Ministry of Health, UNRWA and private providers, some NGOs also provide services, including the Palestine Red Crescent Society (PRCS), Medical Aid for Palestinians (MAP), Handicap International (HI), and the Palestine Children's Relief Fund (PCRF). NGOs support the main providers by extending services to specific populations or rendering specific services free or more accessible, particularly for vulnerable and marginalised groups. For example, MAP supports the provision of primary health care for children and rehabilitation for children with disabilities (MAP, 2013). HI provides technical support to referral centres for people living with disabilities and provides rehabilitation services in Gaza and the West Bank (HI, 2013). The PCRF helps to locate free medical care for children and runs a child sponsorship programme for children with disabilities (PCRF, 2013). Health Work Committees (HWCs) have more than 45 permanent clinics in poor and hard-to-reach areas in villages and refugee camps (Save the Children Sweden, 2011), and the Gaza Community Mental Health Programme (GCMHP) runs an occupational therapy rehabilitation (OTR) centre that provides services for people with mental illness in Gaza, targeting 15,000 adults. It also runs a community education programme to help parents support their children with psychological and behavioural problems (GCMHP, 2013). However, many NGOs operating in Gaza do not have direct contact with the government, limiting the reach of their operations.

According to the key informant interviews conducted for this study, despite the broad range of services available to support vulnerable households, there are still individuals and groups who are not receiving assistance. For example, female-headed households who have a child with a disability face particular challenges, but do not receive any assistance from their families or the wider community (key informant interview with counsellor at a centre for children with disabilities in Jericho, West Bank). This illustrates the need for the social security system to do more to reach adults and children who are falling through gaps.

3.2.4 Child-focused social assistance

Having provided an overview of the broader social protection environment in the SoP, we now briefly discuss how social assistance and social welfare mechanisms are responding to the four dimensions of children's rights as outlined at the beginning of this section (that is, whether they are child-focused) and specifically how the PNCTP addresses children's needs.

MoSA is primarily responsible for child protection systems, which include a number of specific services. Of particular importance are child protection networks (CPNs), developed to better coordinate the efforts of organisations and stakeholders working in the field of children's rights, as well as to fill the gap for a referral system and ensure follow-up. In 2006, Defence for Children International-Palestine Section (DCI-Palestine) and UNICEF developed a CPN for the West Bank, which created a functional referral system for children requiring legal and psychosocial services from several ministries and national NGOs. A helpline was concurrently established to give children access to DCI-Palestine's lawyers and social workers for legal and psychosocial consultation. In 2007, the CPN was strengthened when MoSA, in cooperation with relevant governmental agencies (health, education, labour, justice, interior/police) and NGOs, implemented the National Child Care and Protection Referral and Networking System Protocol, which defined conditions that place the child at risk of danger (violence, abuse, neglect, exploitation, incest, assault). In 2008, the CPN and helpline were subsequently transferred to MoSA, with UNICEF support. The referral system is now part of MoSA's National Strategic Plan for Child Protection from 2011-2013. MoSA also plans to expand the CPN and referral system to every district in the SoP.

There are MoSA child protection officers in each district, who have the status of a judicial officer; their mandate or jurisdiction includes ensuring that children are protected from violence, abuse and exploitation, and they also provide services for children affected by violence. The Ministry of Education (MoE) has school counsellors who support early intervention and referral services.

However, while a referral mechanism for child protection cases exists through the CPNs with the MoE counselling directors at the district level, there are no direct linkages with school counsellors or with MoSA staff implementing the PNCTP. Social workers, whose role includes visiting families in their homes to apply the proxy means test formula to assess eligibility for the PNCTP, could provide a vital link, responding or referring suspected violations of children's rights to child protection officers.

With regard to child protection services provided by UN agencies, UNICEF leads a Psychosocial Sector Working Group and a Child Protection Working Group. Through these groups and its work with partners such as MoSA and national NGOs, it focuses on building a protective environment for children, working closely with Palestinian authorities. UNICEF is also working with the Palestinian Authority to strengthen the national child protection system to prevent harm and to respond to the needs of children affected by violence in development as well as humanitarian relief contexts.

NGOs also provide a wide range of child protection services. Save the Children is the largest international organisation focusing on child protection. In partnership with local NGOs and community-based organisations, Save the Children supported the government to run a programme, funded by UNICEF, which consists of 20 family centres across Gaza, providing psychosocial, educational, health and protection services for children and their families. It runs various post-trauma rehabilitation services for ex-detainees in partnership with the Young Men's Christian Association (YMCA) and runs a child protection helpline in partnership with All the Women Together Today and Tomorrow (SAWA). A wide range of national and international NGOs, including the Palestine Red Crescent Society (PRCS), Terre des Hommes International, War Child Holland, Fakhaoora, the Treatment, Palestine Trauma Centre for Victims' Welfare, and the Rehabilitation Centre for Victims of Torture, also provide psychosocial support services for children and their families. Over 1 in 10 of the cases the torture rehabilitation centre receives are children, with a yearly increase of between 1% and 2% (Save the Children Sweden, 2011). SOS Children's Village provides shelter and support to hundreds of orphaned and abandoned children in the Gaza Strip and West Bank, and is a last port of call for the Palestinian Authority's fledgling child protection services (SOS Children's Villages, 2013; Manara Network, 2011).

Despite the multiple NGO and government programmes on child protection and child-responsive social protection services, there is still limited communication and coordination between agencies, and there is no strong referral mechanism which could ensure that vulnerable children's needs are more effectively identified and addressed. In addition, and perhaps of greater concern, is the fact that specific actions to address the needs of vulnerable children seemed to be working more effectively before the launch of the PNCTP; at that time, the focus of social protection turned to tackling poverty at the level of the family and household, detracting attention away from programming to address child-specific vulnerabilities, including in areas such as disability. Key informants interviewed in Gaza and the West Bank mentioned that this had resulted in a change in the service delivery model.

4 Methodology

The objective of this study was to explore the most critical dimensions of poverty and vulnerability faced by children and adolescents in the SoP – recognising that these might be different for boys and girls and children of different ages – and to analyse the extent to which the Palestinian National Cash Transfer Programme (PNCTP) and its complementary services are addressing the issues identified.

The study was carried out using a mixed methods approach, with primary collection of cross-sectional quantitative data and qualitative data from individuals and groups (including adolescents and adults) using participatory methods. The aim of the quantitative method used was to explore causality and obtain more generalisable findings across the population group sampled, while the qualitative and participatory methodologies enabled the study team to elicit a more in-depth analysis of any changes in children's lives as a result of the programme. The data collected were triangulated to produce a layered analysis, enabling us to explore in greater depth the effects of the programme and its complementary social services on children, their caregivers and their families.

In order to inform the instruments, the team first developed a set of indicators, in consultation with UNICEF, to explore the situation across the different dimensions of children's wellbeing (education, health, nutrition, protection, violence, etc). The quantitative survey was made up of questions drawn from a range of tools. It included questions from surveys used for studies of child wellbeing such as a Multiple Indicator Cluster Survey (MICS), from household questionnaires that have been used by members of the team for the evaluation of other cash transfer programmes, and from internationally known instruments, such as the Strengths and Difficulties Questionnaire (used with adolescents). It also included some questions developed by the team specifically to explore some of the indicators identified. The qualitative and participatory tools drew on instruments that have been used by the ODI team in social protection research and evaluations, and in participatory research with adolescents. Some of the tools for participatory research – such as ranking exercises – are based on internationally validated instruments. The aim was to have a number of instruments to enable data triangulation and a deeper process of analysis (research instruments can be found in Appendix 3). The mixed methods approach involved sequenced data collection: quantitative data were collected first so that preliminary findings could inform the design of the qualitative data collection instruments and sample, in order to explore some of the questions that emerged from the quantitative analysis in greater depth.

Care was exercised to ensure that the principles of research ethics were respected and, as some of the research was undertaken directly with children, that child protection standards – which were part of the training with enumerators – were strictly adhered to.⁹

⁹ The Modified International Code of Ethics Principles (1975), known as the Declaration of Helsinki, were followed and an official letter of approval to conduct the research was obtained from the Helsinki Committee Gaza Strip. In addition, every participant received a complete explanation of the research, was aware that participation was optional, and gave their consent. Permission to take notes and tape record the interviews was formally obtained.

4.1 Quantitative data collection

Quantitative data collection took place between April and May 2013. The quantitative component followed a quasi-experimental design to examine the situation of cash transfer recipients (the intervention group) compared with non-beneficiary households (the comparison group). The eligibility criteria for the intervention group followed MoSA's proxy means test formula (PMTF),¹⁰ and included households that are extremely or severely poor, with a low score on the PMTF, and which have been receiving the transfer for at least two years. For the comparison group, in the case of Gaza it comprised households that had very similar PMTF scores to the intervention group at the time of the household status assessment, but were on the waiting list for the PNCTP, so had not yet received the cash transfer. Because the PMTF scores include a range of background characteristics, these two groups are seen as comparable. In the case of the West Bank, households in the comparison group did not quite meet the eligibility criteria for the programme because their PMTF score was just above the threshold, although it also included households classified under the category of 'deep poverty' with respect to the national poverty line. This meant that the comparison between groups in the West Bank was more difficult because of slightly greater differences in background characteristics.

The cross-sectional study design, with an intervention and comparison group, yielded the data needed to compare study groups at 'a point in time'. The analysis did not use a discontinuity approach, as had originally been planned, due to problems with some of the variables in the study's database. As such, a difference in means approach was seen as the best option to compare groups (for full details of the quantitative methodology, see Appendix 1). The strength of this approach is that using a comparison group enabled us to estimate the counterfactual – the differences between households that do not receive the transfer and the intervention group (PNCTP beneficiaries). This approach was somewhat limited by the fact that approximately 12% of the non-beneficiaries and households on the waiting list on MoSA's database who were sampled had received the transfer in the past, so were not a true 'comparison' group, and were therefore excluded from the analysis. Furthermore, in the sites selected in the West Bank, there were insufficient households in the originally designed comparison group, which meant that a slightly different group (which was therefore less comparable with the intervention group) had to be selected. The survey samples for the West Bank and Gaza were thus different, and are described in Table 1.

¹⁰ The PMTF ascertains household welfare status by looking at household consumption and composition and setting a threshold for extreme poverty with a cut-off point of 6.39 or below. 6.39 is the cut off for severe poverty which is 590 NIS for a family composed from one person monthly. It is the point which determines eligibility (below severe poverty line) and based on that the amount of cash is determined based on the number of household members up to a certain threshold (18,000 NIS quarterly). Households with 6.41 (602 NIS per a family composed of one member) are not eligible although they don't vary too much but this is the formula. The difference between the two points (6.39 and 6.41) is limited (590 and 602 consecutively).

Cash assistance is provided to extremely poor families to bridge the gap between the estimated level of consumption determined through the PMTF and the extreme poverty line, and is calculated as a total consumption score through a multiple regression analysis on the basis of the PMTF, which comprises 34 proxy variables measuring different aspects of consumption. The regression model has been built on the basis of indicators used in the 2007 National Household Consumption Survey. Variables include geographic variables, demographic variables, health variables, economic variables, household-related variables, and having durable assets). 54% of variables reflect poverty directly.

Table 1: Selection of intervention and comparison groups

PNCTP beneficiaries (according to 2 selection criteria)	Intervention group	Non-beneficiary Households	Comparison group
Households experiencing one or more of the following vulnerabilities: female-headed household, 1 or more household members aged 65+, or members who are chronically ill, disabled, or orphaned PMTF score between 6.39 and 6.56 (that is, above the threshold to be classed as extreme poor, but still classed as 'severely poor')		Households not classed as extremely poor (i.e, above the PMTF threshold of 6.39) and not facing any of the vulnerabilities that would make them eligible to receive the PNCTP	Comparison group in the West Bank: Households with PMTF score of just above 6.39 but below 6.56, so classed as severely poor (but not extremely poor). These households did not experience any of the vulnerabilities that would make them eligible to receive the PNCTP, so will not receive the cash transfer
Households living in extreme poverty, classed as having a PMTF score of 6.39 or less	Intervention groups in the West Bank and Gaza selected to comply with extreme poverty criteria	Households classed as extremely poor but still on PNCTP waiting list	Comparison group in Gaza: Households with a PMTF score of 6.39 or below (so classed as extremely poor), and thus on the PNCTP waiting list. Expected to start receiving the cash transfer from June 2013

The survey sample size was representative of both beneficiaries and non-beneficiaries, with 1,200 households: 300 intervention households and 300 comparison households in each of the two territories, although the sample size was limited given budgetary constraints. In addition, a sub-sample of 200 adolescents was selected using a systematic random technique (an adolescent from every third household surveyed), and interviewed using a specially designed questionnaire (Appendix 2).

Quantitative data were collected through a survey of randomly selected households. Interviewers sought to speak to the female caregiver or female household head, as they are generally more involved in child care and could provide the team with better information about children and adolescents in the household. More details regarding the sampling and fieldwork process can be found in Appendix 1.

For the quantitative survey in Gaza, interviews were held with caregivers, mainly female (96% and 97% for the intervention and comparison groups respectively). Piloting was initially conducted with 22 households and resulted in further modifications to the tool. The research team decided to increase the sample size to ensure greater representativeness, so 641 households were visited – 315 in the intervention group and 326 in the comparison group, in addition to the 200 adolescent interviews (100 from each group). A team of 11 trained data collectors conducted the interviews. The response rate was over 95% among intervention and comparison groups.

In the West Bank, the survey interviewed 322 caregivers from the intervention group and 294 caregivers from the comparison group, in addition to 180 adolescents (88 from the intervention group and 92 from the comparison group). The household response rate was 98% among the intervention group and 89% among the comparison group. Piloting of the tools and guidelines was done in three areas in the West Bank: Qalandia camp, Ein-Areek village, and Betunia (semi-urban). During piloting, 11¹¹ households were interviewed. A total

¹¹ The pilot did not require more than 11 households to test their clarity, relevance, interview time, recording, completing transcripts and other aspects of field testing. The same instruments were also tested and clarified by Gaza pilot (24 families participated). Additional piloting was not possible given budgetary constraints.

of 16 field researchers were recruited from different districts to conduct the survey. Households were distributed over 37 sites across 11 governorates.

4.2 Qualitative data collection

Qualitative data collection was carried out between June and July 2013 in two distinct and purposefully selected districts/localities in each of the two territories. Since resources for the qualitative component were limited, it was only possible to conduct research in four to five localities in each territory. As such, these were purposefully selected to meet several objectives: (1) including populations in and out of camps, as well as poverty pockets in each territory; (2) including urban and rural/semi-rural localities; (3) in the West Bank, to ensure that particularly vulnerable populations, such as the Bedouin, were reached; (4) complying with accessibility and safety criteria for the team; (5) avoiding sites that had already been researched as part of a separate study of beneficiary perceptions of cash transfers (Jones and Shaheen, 2013; Hamad and Pavqnello, 2012).

Respondents in each site were selected randomly from MoSA's database of beneficiaries, guided by criteria that had been identified after analysing preliminary findings from the quantitative survey. These included age (with a specific focus on adolescents), gender (with a balanced number of girls and boys interviewed through small group discussions and individual interviews), and a greater number of adult women interviewed in focus group discussions, as they are the main caregivers for children and young people. We also purposefully selected children with particular vulnerabilities for the in-depth interviews and observations in order to better understand how the cash transfer affects their lives. These dimensions of vulnerability included: area of residency (refugees and non-refugees); presence of specific conditions such as disability or violence in the household; and, in the case of the West Bank, belonging to a marginalised group (Bedouin).

A mix of qualitative and participatory tools was used to capture different types of information from different groups and individuals, including: small group discussions with adolescents (boys and girls separately and as a mixed group); semi-structured in-depth interviews with a selection of adolescents using participatory methods, and then separate interviews with some of their caregivers (mainly mothers); and observations with children facing particular vulnerabilities (this included time spent in their homes, interviewing the children, their mothers and fathers, siblings, and also key service providers). A number of key informant interviews (see Appendix 2) were conducted in each territory at the national and local levels. Qualitative instruments were piloted and revised before being used in the fieldwork. The number and range of respondents interviewed in each territory, using a variety of different techniques and approaches, was sufficient to obtain in-depth and triangulated information about the impacts of the cash transfer on children's lives.

To ensure reliability and validity of the data, a training workshop was provided to the research teams for the quantitative and qualitative components to review, understand and finalise the study tools and guidelines. Teams in both territories implemented a standardised approach to selecting and interviewing participants across both the quantitative and the qualitative work. Participants' responses and interviewers' notes were checked daily for accuracy and verified through quality control measures.

4.3 Gaza

In Gaza, qualitative data collection was carried out in the following sites: Jabalia and Beit Hanoun in the north, which included some rural areas; and Gaza City, including a refugee camp setting (Beach camp), a primarily urban context. A team of four local researchers collected the qualitative data. In total, 89 beneficiaries were interviewed, including 71 children and 18 adults (see Table 2).

Table 2: Qualitative research conducted in Gaza

Type of instrument	Population	Total participants
Small group discussions with adolescents benefiting from PNCTP (11-17 years)	12 in total, in the following groups: males, females, refugees, non-refugees, camp residents, non-camp residents, younger (11-14) and older children (15-17)	71 adolescents, 54 female and 17 male
In-depth interviews with children	Children benefiting from PNCTP aged 11-17, 4 with disabilities or exposure to abuse and violence, in order to capture the most vulnerable	10
Observations/case studies with children with disabilities	Children with disabilities, and their caregivers, health care providers, teachers and counsellors at school	2 households; at least 3 repeat home visits
In-depth interviews with caregivers	Caregivers of interviewed children (mothers)	5
Focus group discussions with adults	Two groups of 7 caregivers of adolescents interviewed	14 adults in total
Key informant interviews at national and district levels	Government officials, representatives of local NGOs and UN agencies, social workers, teachers and health care providers	11

4.4 West Bank

Qualitative data in the West Bank were collected in Jericho district and Jordan Valley to include a sample of urban, rural, refugee and Bedouin beneficiaries. The five villages where research was conducted were Alnwe'ma, Aldyouk, Al-Jiftlik, Alouja and Anata. A total of 84 beneficiaries were interviewed (see Table 3).

Table 3: Qualitative research conducted in the West Bank

Type of instrument	Population	Total participants
Small group discussions with adolescents benefiting from PNCTP (11-17 years)	12 in total, in the following groups: males, females, refugees, non-refugees, camp residents, non-camp residents, Bedouin, younger (11-14) and older children (15-17)	38 adolescents, 20 female and 18 male (5 group discussions just with boys/6 just with girls/and 1 mixed)
In-depth interviews with children	8 interviews with children benefiting from PNCTP aged 11-17, 4 with disabilities or exposure to abuse and violence. in order to capture the most vulnerable	8 (5 girls, 3 boys)
In-depth interviews with caregivers	Caregivers of interviewed children (mothers)	15
Focus group discussions with adults	2 groups of 8 female caregivers of adolescents interviewed in two localities	16
Observations/case studies with children with disabilities	Bedouin children with disabilities and their caregivers, health care providers	2 households

Type of instrument	Population	Total participants
Key informant interviews at national and district levels	Government officials, representatives of local NGOs and UN agencies, social workers, teachers and health care providers	5

4.5 Data analysis

The quantitative data were entered, cleaned and analysed using SPSS 20 and SAS 9.1. Univariate and bivariate statistics were produced for all variables, based on a set of indicators informed by a review of secondary literature on child-sensitive cash transfer programming.

Qualitative interviews were double-recorded then transcribed, reviewed and thematically coded. To facilitate the coding process, a two-day in-depth debriefing workshop was held in each location to discuss emerging findings and key themes. Subsequently, the transcripts were coded using a thematic coding structure, and findings were first aggregated by instrument and then collectively across all instruments.

Quantitative and qualitative data were then triangulated and analysed to produce the findings presented in sections 5-8.

4.6 Limitations

The main limitations faced by this study included the following:

- A lack of baseline data to ascertain the effects of the cash transfer on specific groups of vulnerable children. Given that it was not possible to use a discontinuity approach, this would have been necessary to have for a more accurate quantitative analysis of PNCTP effects.
- The presence of multiple extraneous variables, including receiving social assistance from other programmes.
- Accessibility and costs of the fieldwork in the context of a limited budget, which limited the size of the sample in both territories, although the sample design still complied with the law of large numbers and was significant.
- The analysis of the effects of the PNCTP was somewhat limited by the fact that approximately 12% of non-beneficiaries and households on the waiting list had received the transfer in the past, and were subsequently excluded from the analysis.
- Resource constraints for the study meant that there was a limit in the time that could be dedicated to the econometric analysis.

5 Effects of the PNCTP on children and their households: child survival

We now present the findings from our quantitative and qualitative research. In line with our analytical framework, the next four sections examine the impact of the PNCTP in terms of addressing children’s rights to survival, development, protection and participation. We focus on the extent to which the PNCTP has succeeded in addressing children’s vulnerabilities, concerns, needs and priorities, highlighting critical gaps that emerged. Each subsection begins with a short explanation of the key rights issues and challenges involved, before going on to describe our findings in detail.

In order to frame these findings it is important to emphasise a crucial point that was repeatedly made by key informants: while the PNCTP’s focus on reaching the poorest households is welcome, since its launch in 2010 (following the merger of a number of smaller fragmented programmes), other programmes targeting children with disabilities or other vulnerabilities have been discontinued. So while poor families may be receiving more cash income now, other valuable in-kind support has been reduced – both in terms of equipment (e.g. provision and maintenance of wheelchairs and hearing aids) and personal care materials (including diapers and sanitary towels) as well as therapeutic services. The merger process was not focused on addressing child-specific (as opposed to household-level) vulnerabilities, and as a result, some of these were indirectly deprioritised at a programming level. This is not to say that MoSA offers no child-related vertical programmes; family and childhood as well as disability-related services still exist, but they are severely under-staffed and under-resourced compared with the level of needs, as indicated by our respondents’ comments and also by the statistics on the prevalence of physical and mental disabilities. For example, in Gaza, MoSA’s family and childhood division has only 13 staff, and in the West Bank, 37 social workers and 10 management staff, while there are just six disability counsellors to cover all five Gaza governorates. Moreover, key informants suggested that these programmes almost function independently, with minimal coordination and integration with the PNCTP or other complementary services.

To preface the analysis in this section, Table 4 presents the main demographic characteristics of households included in the quantitative survey. Characteristics of those participating in the qualitative research have already been described in Table 3, in the previous section.

Table 4: Household demographics

	West Bank		Effect	Gaza Strip		
	Interventio n n=322	Compariso n n=294		Interventio n n=315	Compariso n n=326	Effect P-value
Household respondent						
Mean age	50 yrs	46 yrs	**	45 yrs	43 yrs	*
Age group (%)						
18-24 years	2	3		4	10	
24-45 years	34	45		40	47	
45-64 years	43	39	**	48	37	
65+ years	21	13		7	6	
Gender (female) (%)	78	76		96	97	
Refugee (registered) (%)	26	28		74	64	*
Marital status (%)						

Single	12	8		7	4	
Married	56	73		66	79	
Divorced / separated	7	5		5	5	
Widowed	24	14	**	22	12	**
Households (mean per hh)						
Number of people (mean)	4.9	5.8		7.3	6.8	
Number of children (mean)	2.5	2.6		3.4	3.2	
% of HH with female household head	41.7	14.8	***	23.8	13.8	

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P -value for two group test of proportions

5.1 Health

Article 24 of the UNCRC states that children have the right to the best health care possible, to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. Further, according to Article 22 of the Palestinian Child Law, *‘the child shall have the right to obtain the highest attainable standards of free health services, while taking into account the Health Law and its relevant applicable regulations’*.

Here, we explore how children in Palestine are faring with regard to the fulfilment of their right to survival, particularly access to adequate health care, food, and living conditions (housing, access to electricity, water and sanitation), and how social protection and particularly the PNCTP is contributing to achieving children’s right to survival. We also look at how ill-health of family members can have a strong impact on children’s (particularly girls) lives as they are often tasked to be the main caregivers. It also erodes family income, with adverse consequences on the family’s economic stability in the short and long term. The purpose of the initial overview of the health situation of children is to better understand how the PNCTP is affecting this important area of children’s lives, and what aspects could be better addressed.

There is significant evidence in the literature to indicate that ill-health is one of the most serious economic ‘shocks’ that households face. In addition to the pain and distress suffered by the affected person and their caregivers (who are often children, and particularly girls), illness can have a wide range of adverse impacts on the household and its individual members (Lucas and Bloom, 2006; CPRC, 2009). Major illness is widely acknowledged as a frequent cause of household impoverishment, due both to the inability of a key income-earner to continue working and the significant costs of caring for a sick individual, covering medicines, health care consultations, and the opportunity costs for the caregiver (World Bank, 2001). In fact, evidence suggests that poor people see health as one of their greatest concerns (Narayan et al., 2000).

In the SoP, our research verified that health shocks are a major source of household poverty, with important effects on children’s wellbeing. A number of respondents said that an illness or accident on the part of the father or mother – including some that resulted in death – had triggered adverse coping strategies with significant effects on children. Girls usually have to shoulder the domestic care burden while boys work outside the home to generate income. Adolescents interviewed in both Gaza and the West Bank – some of whom were ill themselves or had a family member who was ill or disabled – explained how health shocks had changed the trajectory of their lives, forcing them to miss school or drop out altogether, so that they can focus their time and energy on providing support to the household. As such, it was a great source of hardship, stress and sadness for them.

If my father were still alive, none of these problems would have happened, he was my supporter. My mother has been ill for the past four years. She cannot walk because she is disabled. In each passing day, her health gets worse and it is deteriorating. This makes me sad and affects my life as I take care of

her in the house and I cannot go to school. I feel there is no future for me. (In-depth interview, 16-year-old girl, Beach camp, Zaytoun, Gaza)

[My] eldest son finished his secondary education last year and joined Al-Oma university by scholarship because I cannot afford his education expenses ... He had a car accident. Most of his bones were broken, he had to wear cast for a year ... The doctors had to change his cast more than twice during that year, which I could not afford ... I had to buy it on my personal account because this kind of cast is not covered by health insurance ... Transportation expenses were too high so he had to quit school because we could not afford it anymore. He used to use motorcycle but after the accident, he could not use it anymore, so he decided to stop going to the university ... [now] he started to look for a temporary job at UN and the PA, but he found nothing. (In-depth interview with mother, refugee camp, Gaza)

There were some instances where children who needed health care reported being neglected because of the need to prioritise the health of the breadwinner or an older sibling. For example, an 11-year-old girl in Gaza City, whose illness required attention from a health worker, explained that while the Shifa hospital is nearby, ‘my mother takes my father, she can't take me because he is sick ... No, I didn't go because she didn't find the health insurance, she put a tissue to my nose and took me to a doctor later who advised that I needed a surgery, then my mother told the doctor that we don't have money.’

Caring for a family member with a disability or chronic illness

Many of the households included in this study had at least one member with a disability or chronic illness, often a child, since one of the variables in the PMTF score is the presence of a person with a disability in the household. As such, it was important to explore the effect of this on household wellbeing. Children and adolescents who experience disability spoke about their frustration at the limitations they face, particularly in relation to attending school or socialising with their peers (discussed further in the section on disability below).

Caregivers in both Gaza and the West Bank were particularly concerned about the difficulty in accessing specialised health services and treatments, and the high cost of medicines and equipment necessary for individuals with more complex illnesses and disabilities. Several of the caregivers of children with disabilities commented that purchasing diapers (nappies) was a significant, recurrent cost that was not covered by health insurance, and meant that other basic needs could not be afforded.

The other kids were born with a failed kidney ... The doctors say they should be treated in Egypt, but we have no money to send them to Egypt through Rafah. (In-depth interview with mother, refugee camp, Gaza)

Our disabled child is having convulsions because we don't have money to buy the medicine. (Female participant in focus group discussion with non-refugee caregivers, Zaytoun area, Gaza)

Haytham consumes large quantities of nappies, costing the family no less than 300 NIS each month. In addition, Haytham always needs medicines as he has different chronic diseases. We pay for these medicines as the medical insurance does not cover such costs. (Mother of a 17-year-old adolescent with a disability, observation, northern Gaza)

Health insurance and the PNCTP

In relation to the significant health challenges discussed above, respondents confirmed that for those who need to access health services, the health insurance component of the PNCTP was its most important element.

Respondents of all ages whose households had a member who was ill or disabled had a favourable view of the health insurance component of the PNCTP: they explained that without it, they might not have been able to get necessary treatment or surgeries (including abroad) or would have had to do so at an extremely high cost to their already impoverished household.

The health insurance helped my daughter undergo three surgeries in Egypt. (Female participant in focus group discussion with non-refugee caregivers, Zaytoun, Gaza)

After we received the cash transfer, it really helped us a lot with buying the diapers [nappies]. I am now dependent on MoSA's assistance to buy them for my son. Hosam would be very bothered if the diaper was dirty ... (Mother of a disabled 12-year-old boy, observation, Anata, West Bank)

Given these positive perceptions of the PNCTP's health insurance component, it is important to highlight that the quantitative data indicate a statistically significant higher rate of health insurance coverage among children in beneficiary households in the West Bank (83% compared with 72% in Gaza), given that they generally receive health insurance as a complementary benefit. In Gaza, survey data indicate that access to some form of health financing is common (above 90%) – with the United Nations Relief and Works Agency (UNRWA) providing free primary health care services to refugees, and PNCTP beneficiaries having access to health insurance, which is also used by refugees for surgical and hospital-related treatments.

Given that there is good coverage of basic health services for children (including immunisation) in Gaza and the West Bank, data from the quantitative survey indicate that there is no statistically significant difference between children's health indicators in the intervention and comparison groups or by gender. The only indicator where there is a statistically significant difference between the intervention and comparison groups is the percentage of children with respiratory illness whose caregiver had given them medicines. This suggests that children in the intervention group had more access to medical treatment and medicines: 97% compared with 83% in the West Bank, and 96% compared with 87% in Gaza (see Table 5). While the difference in the number of children without health insurance coverage in the intervention and comparison groups is small in both territories given that most households surveyed have access to some form of health insurance (either through the PNCTP, UNWRA or as support to poor households from the Ministry of Health), the difference in access to medicines has two probable explanations. First, although PNCTP beneficiary households receive free health insurance, they are required to make a co-payment to the Ministry of Health (MoH) for medicines (3 NIS for adults and 1 NIS for children for each prescription), which they can more easily afford if they are in receipt of the cash transfer. Second, since shortages of essential medicines are common (government health facilities often lack supplies, with around 40% of essential drugs at zero stock level), poor households are forced to buy medicines on the market even when they should receive them for free. In this case, the cash transfer helps them afford these medicines.

Table 5: Children's access to health insurance

	West Bank			Gaza Strip		
	Interventio n n=542	Compariso n n=699	Effect P- value	Interventio n n=1,025	Compariso n n=991	Effect P- value
Children who have health insurance (%)	83	72	**	92	90	
Health status is poor or very poor (For children, as perceived by respondent) (%)	8	7		3	3	
Children (17 year olds and under) have chronic illness (ill more than 3 months in past year) (%)	12.6	6.5	**	4.8	5.3	
Children 0-5 had respiratory infection in last 2 weeks (%) WB: n=87, 143 Gaza: n=298, 344	44	59	*	42	37.5	
Children with respiratory infection in the past 2 weeks who were given medical treatment (medicines) WB:	97	83	*	96	87	**

n=39, 82 Gaza: n=126, 129						
% of children 0 to 5 with a respiratory infection who deferred medical treatment due to costs of medicine	0	9.41	*	0	6.98	**

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for two group test of proportions

There were higher rates of children who were reported to have poor or very poor health in the West Bank than in Gaza, but the differences between the intervention and comparison groups were not statistically significant in either territory. Access to health services is easier in Gaza than in the West Bank since it is a small area with many health facilities, no checkpoints and no separation wall. Further, as a result of UNRWA’s provision of free health services to the refugee population, a greater share of the population has access to health services. In the West Bank, more children (aged 0-5) in the comparison group had reported an illness in the past month than children in the intervention group, while children in the intervention group had higher rates of chronic illness, possibly because having a chronically ill child is a qualifying criterion under the PMTF.

Qualitative findings highlighted that health insurance was particularly useful when a child had a disability or a chronic disease that required highly specialised attention, services and equipment. For example, a caregiver in Jabalia refugee camp in Gaza, whose daughter is deaf, explained that she had received a free hearing aid through the PNCTP. Similarly, among participants in a small group discussion with adolescent girls aged 11-14 in Jericho, Gaza, one girl with asthma explained that the health insurance helps her family obtain her medicine, while another girl mentioned that it makes health check-ups much more affordable.

However, respondents were still concerned about the costs of having to pay for some expensive medicines, unavailability of certain medicines, and the costs of specialised treatment for certain diseases as well as some types of equipment for people with disabilities – both of which are not covered by the PNCTP and place a huge economic burden on vulnerable households. Paying for these items is a common source of debt. The cash transfer helps, enabling the household to cover health expenses directly or to repay the debt incurred if the expense was made at a time when the cash transfer funds had already been spent. Without the transfer, families would either incur even higher levels of debt to make these purchases, or not purchase the items at all.

We still don't have money for medicines, so we use the cash to pay off debts at the pharmacy. (In-depth interview with caregiver, Gaza refugee camp)

We take money from MoSA, but we thought they would cover the treatment costs of Hosam, not that we would have to pay for it from the money they give us. (Mother of a disabled 12-year-old boy, observation, Anata, West Bank)

However, the amount of the cash transfer is frequently insufficient to cover the cost of expensive equipment or necessary medical supplies. For example, three caregivers with deaf children participating in a focus group discussion in Jabalia (all of them from beneficiary households) could not pay for the costs of repairing and maintaining their children's hearing aids, which further complicated their children’s prospects of attending school; similar problems were reported among caregivers of children who use wheelchairs.

The cash transfer must provide equipment for disabled such as glasses, hearing aids, diapers, milk and [wheel]chairs. (Girl participant in small group discussion with children with a disability, mixed gender, Gaza)

Given the high costs of private transport and the inadequacy of public transport, this was mentioned as a significant obstacle to accessing basic services such as education and health care, particularly among households with children with disabilities, who require additional mobility support.

In addition to the PNCTP, several other organisations provide some form of financial support to help vulnerable households access health services. The main provider is UNRWA which, through its clinics and health insurance, provides free coverage for refugee households in and outside of camps. NGOs and religious organisations also provide support. For example, one family with a deaf daughter said the Islamic Association

contributes 200 NIS for her care. A 16-year-old girl in Jericho with a physical disability impairing the movement of her legs mentioned that the Palestinian Red Crescent Society provides physiotherapy, but her family has to pay for the sessions and for transportation, while the Palestine Medical Relief Society provided support for surgery to her leg, which was not covered by health insurance. This highlights a key point: access to such support is not systematic for all those who require it and are entitled to it; rather, it depends on whether families are living in an area where certain organisations are working, and whether they have information about the services offered by those organisations.

Economic burdens for households with children with disabilities

In line with the quantitative findings, families interviewed for the qualitative component emphasised that these unmet needs of children with disabilities are a significant burden on families, both economically and psychosocially, suggesting serious gaps in realising a rights-based approach to meeting the needs of children with disabilities and their families.

While cash transfer beneficiaries are automatically entitled to health insurance, there were mixed views on the adequacy of the insurance coverage for children with disabilities, although respondents recognised that the cash transfer itself was useful to help cover some costs that are not covered by insurance. Some parents emphasised how important the health insurance provision was to them:

Mostly I buy my medications from cash transfer money. (Small group discussion with children with disabilities, mixed gender, Gaza City and northern Gaza)

The health insurance is important for my daughter. With this insurance we could do the surgery for one of her legs, and any time she has a disease we send her to a doctor and the health insurance covers the fees. (In-depth interview with male caregiver of a girl with a disability, West Bank)

Yet others had had less positive experiences and criticised the shortcomings of health insurance in addressing the specific needs of children with disabilities (particularly specialised equipment), and the broader targeting process:

The amount [from the cash transfer] is not enough. We buy only medicines for sister and things for home. (14-year-old boy with a disabled sister, West Bank)

We fought hundreds of fights to become beneficiaries; they lost my daughter's file, and they told me my daughter did not need any assistance. (In-depth interview with caregiver for girl with a disability, West Bank)

I use an uncomfortable wheelchair to get to my school. You can't imagine the difficulty I face to get to my school because of sand and rain. As a result, I used to get to my school late even though I get out of my home very early. (14-year-old boy, participant in small group discussion with disabled children, mixed gender, Gaza City and northern Gaza)

Still, overall, there was a sense from the qualitative responses that the cash transfer had helped the families of children with disabilities, mainly through its health insurance component but also by enabling them to pay for goods and services for the disabled family member – expenses that were previously very difficult for them to afford.

Box 3: Living with spina bifida – the triple challenge of disability, gender and poverty

Rana* is a 13-year-old adolescent girl who lives with her five siblings and parents in Gaza City, in an area called Shijaia. Her story highlights the multiple vulnerabilities facing children with disabilities in poor households in the SoP.

The relationship between Rana and her family is positive and they seem to support her in all aspects of life. Yet she faces numerous challenges. She had difficulties enrolling in school because the headteacher was reluctant to accept a disabled child. Only after successive visits by Rana's parents did the teacher accept Rana as a pupil, saying, *'I accepted her as a humanitarian case, I did a favour for you'*, rather than seeing it as his duty, as a headteacher, to fulfil the right to education for all children.

The headteacher of the school even placed conditions on Rana's attendance, such as having to use diapers (nappies), as the school had no specially adapted toilet facilities, nor would the staff be able to help her. Now that she attends school, Rana said she worries a lot if she has diarrhoea, since the diapers she uses are not reliable, and she risks being in a situation of great embarrassment.

Rana's schooling is different to the schooling her classmates receive in many ways. One of the things that concerns her most is that she misses all the information technology (IT) classes because the computer lab is located on the second floor and there is no one to help her go up. She feels that this is an important gap in her schooling. It is clear the school environment has not been adapted to meet Rana's needs or those of other children in the area who have disabilities.

When the researcher asked Rana about the best times of her life, after some thought, she answered *'When I go outdoors'*. Mottaz, Rana's brother, who is kind to her and helps her, asked her *'When we visited Al Nour resort and when I went with you to the camp of the National Rehabilitation Association (NRA), did not you feel happy that time?'* Rana remembered the events and said *'Yeah, that is right, I have enjoyed these activities because my female cousins were with me, we played and I enjoyed more when we go outdoors together.'* When recalling the worst times of her life, she said *'I feel afraid when the electricity turned off, I dislike these times while I have nothing to do, I feel bored and I could neither use the computer nor watch TV.'*

Rana lives in a clean, yet very poor home. All of the money from the cash transfer goes on buying diapers that are not regularly provided by MoSA (they are only provided when there is an external donation and they are usually of poor quality, so not well received). Rana's mother said *'We buy diapers with this cash, she needs three packets per month, and the price of each of them is NIS 150. In total, I pay NIS 450 per month buying diapers, which means in three months I need to pay NIS 1,350, while the cash transfer amount every three months is only 1,000.'*

* Names have been changed to protect identities

Source: Observation in the home of a 13-year-old girl with a disability, Shijaia, Gaza City

5.2 Nutrition

Reducing hunger and promoting food security has long been an objective of social protection policies in the developing world, particularly given the consequences for children's health and cognitive capacities (Sanfilippo et al., 2012; Gavrilovic and Jones, 2012). Household food security forms the context in which individuals can enjoy their human right to adequate food as established in international human rights law. As outlined in Section 3, chronic malnutrition is a problem that affects large numbers of children in both the West Bank and Gaza, reflecting the extremely challenging and often precarious economic situation faced by households. During the fieldwork, caregivers who were interviewed (in both territories but particularly in Gaza) expressed huge concern about their inability to meet their and their children's basic needs, and particularly mentioned the difficulties they face in obtaining enough nutritious food for the members of their households. In Gaza, the consumption of poor quality or insufficient food was one of the most important preoccupations among adult respondents. The situation was said to have become worse in the past few years with the blockade, which results in frequent food

shortages or very inflated prices, as the following quotes illustrate. Interestingly, however, limited access to food was not among the top three concerns expressed by any of the small group discussions with adolescents; the fact that parents expressed more concerns about this no doubt reflects that it is their responsibility to secure food for the family.

We had nothing to eat sometimes. We could not afford to buy vegetables or fruit. (In-depth interview with mother, Jabalia camp, Gaza)

When there is no money, we just fry bread and eat. We don't tell my father, because he will feel sad and depressed. (In-depth interview with 14-year-old girl, Jabalia camp, Gaza)

Quantitative data from the survey corroborated findings from the qualitative data, indicating that more than 70% of households with children in the West Bank and around 60% in the Gaza Strip have seen changes in their children's food consumption habits due to growing income poverty, with no significant difference in the responses between households in the intervention and comparison groups (see Table 6). This suggests that decreasing incomes and higher food prices are affecting families that are receiving the transfer as well as those that are not, although as noted below, the effects on non-beneficiaries are worse in the case of Gaza. This echoes comments made by respondents in the qualitative fieldwork, who spoke about having to buy less food and poorer quality food for their families more often in the past few years.

Table 6: Food consumption

	West Bank			Gaza Strip		
	Intervention	Comparison	Effect	Intervention	Comparison	Effect
HH=households	n=81	n=99	P-value	n=149	n=166	P-value
% HH in which girls 0-10 had to eat different food in the past 3 months (e.g. less protein) because food typically consumed was too unaffordable	72.1	75.0	-	57.06	63.09	-
% HH in which boys 0-10 had to eat different food in the past 3 months (e.g. less protein) because food typically consumed was too unaffordable	69.0	76.3	-	58.49	60.87	-
% HH in which girls 11-17 had to eat different food in the past 3 months (e.g. less protein) because food typically consumed was too unaffordable	72.2	76.3	-	63.33	57.75	-
% HH in which boys 11-17 had to eat different food in the past 3 months (e.g. less protein) because food typically consumed was too unaffordable	70.2	75.0	-	61.11	58.90	-

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for two group test of proportions

Nutritional support to households through the PNCTP

When analysing weekly food expenses, West Bank households in the comparison group had higher expenses than those in the intervention group; this is to be expected, given that (as explained in the Methodology section) the comparison group is generally better off than the intervention group. Table 7 indicates that households in the intervention group in the West Bank spent, on average, 215.28 NIS on food per week compared with 232.10 NIS spent by the comparison group. In Gaza, MoSA provides cash transfer beneficiaries with food coupons they can exchange for a food ration consisting of bags of flour, sugar, oil, rice, and sometimes tinned meat. However, the amount of food ration is not enough, nor is it adequately diversified to satisfy a household's nutritional needs. On average, however, having extra money in the form of the cash transfer enables families to buy more food to meet their needs. As Table 7 indicates, households in the intervention group in Gaza spend 193.92 NIS a week, on average, compared with 148.70 NIS for the comparison group (statistically significant difference). These quantitative data were corroborated by the qualitative findings.

Table 7: Household expenditures

	West Bank			Gaza Strip		
	Intervention	Comparison	Effect	Intervention	Comparison	Effect
	Mean	Mean	P-value	Mean	Mean	P-value
Total household food expenditures (weekly) (NIS)	215.28	232.10	~	193.93	148.70	***

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for two group test of proportions

In terms of the composition of the food consumed, although there were some statistically significant differences between groups on measures of food consumption (see Table 8), there were few meaningful differences. On average, all households consumed foods from at least five food groups in the week previous to the survey. The majority of respondents reported that their household consumed grains, roots and tubers, legumes, vegetables, milk products and fruits, all of which are important to children's nutrition, although the data do not reveal how many times a week food from each food group was consumed. Households were least likely to consume animal proteins (the priciest food group), and comparison households were less likely than intervention households to consume animal proteins. Further, fewer households in the Gaza Strip than in the West Bank consumed animal proteins.

Table 8: Household food consumption

	West Bank		Gaza Strip	
	Intervention n=322	Comparison n=294	Intervention n=315	Comparison n=326
Satisfied with water (%)	10	10	14	18
Consumed any from food group (%)				
Roots and tubers	82	84	85	83
Legumes, pulses, nuts	80	78	88	86
Vegetables	99	99	99	99
Animal protein	27	21	15	13
Milk products	82	76	70	60
Fruits	68	66	72	63
Mean number per group consumed				
Roots and tubers	1	1	1	1
Legumes, pulses, nuts	1.7	1.5	2	2
Vegetables	6	5.6	7	6

Animal protein	1	1	0.2	0.2
Milk products	2	2	1	1
Fruits	2	1	1	1
Food diversity score	5	5	5	5

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for chi-square trend across study group

Indeed, qualitative findings indicate that the cash transfer has made a useful contribution to beneficiaries' capacity to buy larger quantities of food and more nutritious food – particularly food proteins – even if only occasionally. This factor is particularly relevant in relation to improving children's nutritional status. In most cases, caregivers who were interviewed said the cash transfer enabled them to give children more diverse food, and adolescents who were interviewed also noted eating more varied food as a result of the transfer. For example, some respondents reported that they can now buy meat, chicken, fruits and vegetables once in a while – some families once per payment cycle, others more regularly – something they could do only rarely, if at all, before receiving the transfer. As a result of this greater access to food, respondents reported that the nutritional composition of their diet had improved markedly. The quotes below illustrate the challenges faced by households in providing a varied diet for their children.

Our situation was extremely difficult. Still now, whenever the cash transfer is over, sometimes we stay without cooking gas and father can't even go to the market to buy anything ... As soon as we receive the cash, if we are indebted to the grocery store we repay and buy new things such as a small quantity of fruit. Let me tell you honestly, now we don't eat fruits except when someone gives it to us. For instance, my father goes to the market to help his cousin who, in return, gave him 10 NIS and a watermelon. We don't buy a lot. My father brings us ordinary foods. We don't use that cash transfer money to go out or buy clothes, we use it for food. (In-depth interview with 14-year-old girl, Jabalia camp, Gaza)

Now I can afford to buy fruit and meat as well as buy the basics of our lives. (In-depth interview with mother, Gaza City)

We did not eat chicken before the cash. (Refugee widow, 37, Gaza camp)

The following account, given by a 16-year-old girl in Gaza City, illustrates a common situation in Gaza: *'My father was jobless that time because of his problems. Sometimes we didn't even have food at home. Now [after the cash transfer], he buys us fruits and gets us stuff from grocery. Before, he didn't do that and he was telling us not to go to grocery to borrow because we have no money to repay.'*

In the West Bank, food security was not such a major concern, except in extremely poor areas such as Bedouin encampments in Anata. However, respondents did indicate that they would like to be able to purchase greater quantities of good quality food, and more varied foods, to improve their families' nutritional status. In this sense, the cash transfer was similarly important in enabling families to purchase food:

They [children] become happy with the cash transfer but they ask "Today we have food, but what about tomorrow?" (Participant in focus group discussion with caregivers, Alnwe'ma, West Bank)

[CT day] is like a feast for us, everyone in my family becomes happy on this day. My father buys fruits, meat, vegetables, the refrigerator is filled, but after three days the refrigerator becomes empty. (13-year-old boy, participant in small group discussion with 11–14-year-old boys, Al-Jiftlik, West Bank)

As for the food and clothes, things were much worse before MoSA assistance. Now I can sometimes buy clothes they need, especially for the girls. As for food, we sometimes buy meat that we could not afford before MoSA assistance. (In-depth interview with mother, Al-Jiftlik Jericho, West Bank)

In both the West Bank and Gaza, some respondents mentioned that the cash transfer allowed parents to 'treat' their children once in a while with specific foods they like such as sweets, biscuits and chocolates. While this does not seem to be purchased frequently, the cash transfer seems to allow this slight flexibility in the family budget, particularly for poor (rather than the poorest) households.

Because of the voucher I was able to buy things for my children. I used to save from the cash transfer for my visit to Al Maqased hospital because my daughter was sick. Because of the coupon I can buy things they [her children] like to eat like chocolates even though it's not allowed ... But the owner of the supermarket is a very cooperative man – he allows us to select things for our children that are not part of the food voucher scheme ... (Participant in focus group discussion with caregivers, Jericho, West Bank)

With regard to other forms of support for food consumption, some refugee respondents identified food rations provided by UNRWA, while others mentioned NGOs and charitable societies such as Qamar and Al-Isra'a, which provide free fresh meals and dry food rations, particularly during Ramadan. Other organisations distributed groceries. In Oja, a Bedouin area in the West Bank, girls in a small group discussion with 11–14-year-olds spoke of a programme run by a charitable society (Al-Eslah) that used to give the children snacks every afternoon, but it was no longer running.

5.3 Housing and living conditions

Poor quality housing was reported in both territories, although the situation was especially bad in Gaza, particularly in camps, and in the semi-rural and Bedouin areas of the West Bank where research was undertaken.

In Gaza, overcrowding is a major problem, both inside and outside refugee camps, though the situation inside the camps seemed particularly dire. People's situation is exacerbated by the constant fear of losing their homes due to a missile attack or explosion, which means that families – particularly children – live with significant stress and fear.

We're in the same house with three uncles, aunt, my grandfather and his wife. That means five families in total at the same house. We were scared, my mother thought every explosion we heard was nearby, she was afraid we would end martyred. She always read Quran and tried to assure us. But we were extremely terrified. (16-year-old girl, Gaza City)

Despite respondents in the qualitative research all living in beneficiary households, they reported difficulties in accessing water and electricity because they could not always afford to pay the charges, which are a frequent source of household debt. These problems were more prominently highlighted by the quantitative data, along with other indicators of poor living conditions.

We actually sold the house in order to pay off the debt. However, my father used the money to pay the electricity and water bills. He used to delay. After selling the house we found out that water and electricity bills is more than the house price, so all the money goes for repaying bills and debts. (In-depth interview with 16-year-old girl, Beach camp, Gaza)

I can't often even meet the girls' needs. We can't pay electricity and water bills either. But after the cash, we bought fan and water heater. (In-depth interview with mother, Gaza City)

The quotes above indicate that although the cash from the transfer can provide some minimal help to improve living conditions for children in some homes (by buying a fan and a water heater), in general the small size of the transfer is not enough to help cover basic utility payments, and as a result, many households often go without basic services.

The research team observed that a few of the homes where interviews were undertaken were in precarious conditions. This was particularly the case in the two observations were undertaken in Anata village, a Bedouin area in the West Bank. Some of them had roofs made of iron sheets, with little ventilation, trapping the heat. Others were built with precarious materials and were overcrowded.

Respondents in the West Bank highlighted problems with poor quality or derelict housing, resulting in inadequate living conditions for children. A 12-year-old girl interviewed in Jericho noted that all six sisters sleep in one bedroom. She does not like the kitchen as it is not painted, and when it rains, the ceiling leaks, making the whole house dirty.

Our home is so bad. I wish that MoSA [Ministry of Social Affairs] would build a small house for us and provide us with furniture, exposed to the sun, and support us to have a computer. (13-year-old girl, Aqbat camp, Jericho, West Bank)

Similarly, a 15-year-old girl in a small group discussion in Gaza lamented that her family was too poor to provide separate sleeping arrangements for her sisters and older brother, transgressing strict norms of gender segregation; her revelation left other members of the group dismayed by her family's predicament.

There were strong complaints about poor access to water and electricity among girls and boys in small group discussions in Bedouin areas of the West Bank and in refugee camps. One girl in Ein Aldyouk, for example, explained that the MoSA money is spent in one day to pay the electricity and water bills., with one having a gravel floor and no windows, despite high temperatures, and another having no more than threadbare canvas walls and a dirt floor. Indeed, the female-headed household in the latter case was living in such hardship that during winter they resorted to squatting in an unused and unfurnished concrete block home across the paddock.

Data from the survey confirmed that overcrowding is common in both the West Bank and Gaza (see Table 9). More than 30% of households reported overcrowding (defined as having four or more people sleeping in each room) and there was no statistically significant difference between the intervention and comparison groups. This indicates problems with sufficiency of housing in both territories, but the situation is particularly problematic in Gaza where the average family size is larger. Most of the households in the West Bank have finished roofing, while the corresponding figure for the Gaza Strip is below 75%. While this is not an issue that the cash transfer can address directly, the situation nevertheless reflects the multi-layered challenges faced by children in the poorest households.

Quantitative data indicated that there are more instances of electricity being cut off due to non-payment of bills in Gaza than in the West Bank, although it should be noted that in Gaza, generalised power cuts happen every day and many households have gasoline generators, although gasoline is expensive to purchase. While the difference in this variable between intervention and comparison groups was minimal and not significant in the West Bank, it is interesting that in Gaza, the share of households who lost access to electricity due to lack of payment was close to 8 percentage points higher (statistically significant) in the comparison group (50.97% of households) than in the intervention group (42.57%)

Table 9: Housing conditions and access to services

	West Bank			Gaza Strip		
	Intervention	Comparison	Effect	Intervention	Comparison	Effect
HH=households	Mean	Mean	P-value	Mean	Mean	P-value
% of hh with more than 4 people on average per sleeping room	33.22	29.59	-	31.11	34.97	-
% of households with floor material other than earth	5.9	4.08	-	1.90	0.31	~
% of households with finished roofing	97.2	96.25	-	74.92	73.01	-
% of hh who lost access (cut off) to electricity supply as a result of lack of payment	37.17	37.58	-	42.57	50.97	~
% of hh that had their houses rehabilitated/painted/refurbished in the past 2 months	12.46	12.06	-	17.20	11.35	~

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for two group test of proportions

There was a weak statistically significant difference (17.20% compared to 11.35%) between the intervention and comparison groups in Gaza in terms of those that had been able to rehabilitate or repair their houses, while in the West Bank samples there was no evident difference. The percentage of families reported to be living in tents or marginal housing in the West Bank is near 4%. However, these data do not consider Bedouin households, since

Bedouin localities were not included in the quantitative data collection (given their remoteness and cost of including them in the sample). Still, we know from the purposely designed qualitative sample in which Bedouin households were included that they have significantly sub-standard housing.

In Gaza, only 1.2% of households reported living in marginal housing, largely because an important share of the households (74% in the intervention and 64% in the comparison group) were refugees and had access to subsidised housing. Access to electricity, sewage services, kitchens and toilets is widespread in both territories, with no statistically significant difference between the intervention and comparison groups.

In the West Bank, there was a statistically significant difference between the intervention and comparison groups in terms of households that replied that they did not have enough blankets (18% versus 5%) and mattresses (15% versus 5%) for all family members. In Gaza, 37% of homes in the intervention group and 32% in the comparison group did not have enough blankets for everyone in the household, while on average 35% of homes in the intervention and comparison groups did not have enough mattresses for everyone. In addition to levels of income poverty, this significant difference from the West Bank could also reflect the much larger average family size in Gaza.

With regard to water and sanitation, most households in Gaza have access to an improved drinking water source (approximately 93%), while in the West Bank the percentage was lower, but still above 88%. In the West Bank, the number of homes that have a toilet with piped water was statistically significantly higher in the comparison group (95.57%) than in the intervention group (88.1%), while in Gaza there was no difference between the two groups.

The percentage of households surveyed that sometimes have difficulties paying for safe drinking water in the West Bank was 72.04% for the intervention group and 78.23% for the comparison group, while in Gaza the share was lower, at 39% for the intervention group and 50% for the comparison group, with a statistically significant difference in both cases. In both areas, the comparison group is worse off than the intervention group, possibly because the cash from the transfer helped some households pay for water services.

While housing and living conditions are a significant element in determining children's wellbeing, the value of the cash transfer is too low to allow for significant modifications to housing conditions, so both the quantitative and qualitative data do not indicate major changes in this area as a result of the cash transfer, except for the few respondents that mentioned using the transfer to help them pay for water and energy charges.

5.4 Debt

Female caregivers in the West Bank and Gaza spoke about overarching financial troubles, particularly if they had become head of the household due to their husband's illness, death or abandonment. In Gaza in particular, there are few work opportunities outside the home, and those that exist are poorly paid and temporary jobs, which do not allow for household economic stability. In the West Bank there are different levels of need, with households in semi-rural areas often having less income stability than those in urban areas. The ethnic Bedouins in particular are a highly marginalised social group. Large family size (particularly in Gaza) increases consumption needs and forces caregivers to resort to negative coping strategies, particularly the accumulation of debt to bridge the basic needs gap. Few if any mothers appear to work in paid employment, and other family members (such as older brothers) contribute very little to household income (often through casual employment).

Box 4: Debt and the PNCTP

The long-term deprivations faced by poor households in Gaza and the West Bank and the large debt burdens that most households have already accumulated mean that many caregivers are forced to allocate the limited resources they receive in the form of the cash transfer between providing for their children and servicing debts, most of which are incurred in meeting children's needs, as the quotes below illustrate. **The qualitative data highlighted that the cash transfer is used principally for servicing debt and providing for basic needs.**

When it's the time of the cash transfer we end up repaying the debts and the money finished, no money enough for us. Now my father is repaying the debt gradually, there is still a large debt. My father used to buy diapers [nappies] in debt for my young sister who needs it. Now he can repay it from the cash transfer. If there is no cash transfer, then he wouldn't be able to bring the diapers. He repays the debt and then gets into more debt. My father couldn't afford the cost of pens and notebook covers, and other school items so, when we were going to school we were advised that we needed to bring these items. So my father had to purchase them through debt, he is indebted now to every grocery around; even to the library. (In-depth interview with 11-year-old girl. Jabalia camp, Gaza)

All was debt. My father used to borrow from a man, once he borrowed 200 NIS from him, he gave my brothers half shekel each and bought stuff for us. Then the money was all spent. When we received the cash transfer, we repaid debt, but the cash transfer isn't enough as my father needs medications and the transfer can't cover it all, the debt is about NIS 900 just for medications. (In-depth interview with 11-year-old girl, Gaza City)

These qualitative findings are corroborated by the quantitative data. In the West Bank, beneficiary households used the cash transfer for three main purposes: food (92%), payment of bills (64%) and payment of debt (59%). In Gaza, the cash transfer was most commonly used for food (94%), payment of debt (82%), and to buy clothing (60%).

6 Effects of the PNCTP on children and their households: development

6.1 Education

Children have the right to education under Article 28 of the UNCRC. This Article also notes that discipline in schools should respect children's dignity, and that for children to benefit from education, schools must be run in an orderly way – without the use of violence. It also underlines that young people should be encouraged to reach the highest level of education of which they are capable.

Under Article 37 of the Palestinian Child Law, '*(a) Every child shall have the right to free education and learning in public schools until the completion of secondary schooling; (b) Education is compulsory until the completion of higher basic schooling (preparatory) as a minimum. (c) The State shall take all appropriate arrangements and measures prohibit the early dropout of children from schools*'.

Social protection can have an impact on education by addressing the underlying economic and social causes that prevent children and young people attending school, and by improving the quality of the services provided to young students and their families. Receiving a cash transfer, for example, can improve enrolment levels by helping poor households to overcome the cost barriers to schooling (fees, uniforms, transport costs, books, etc). This effect can be seen both for transfers that are specifically focused on children and those that are not (Sanfilippo et al., 2012). However, although one of the aims of most child-sensitive cash transfer programmes is to promote schooling, it is important to identify the context-specific constraints preventing children and adolescents attending school so that an effective policy response (including social protection and complementary measures) can be made.

Most adolescents and caregivers interviewed for this study aspired to a full course of education for children and young people, both girls and boys. Education seems to be a top priority for most parents in the SoP. As a result, caregivers, particularly in Gaza, explained that they are willing to incur significant expenses and even debt in order to provide for the education of children under their care.

Enrolment and dropout

According to data from the quantitative survey, rates of school enrolment were generally high in the West Bank and the Gaza Strip, although in our sample, enrolment rates for the intervention and comparison groups tend to decrease with school level (from approximately 95% for girls and boys in both territories in primary to 89% in the West Bank and 84% on average in Gaza for secondary and preparatory, which is consistent with national data).

In the West Bank, the difference in enrolment between the intervention (96%) and comparison (94%) groups was small but statistically significant in primary education, but not statistically significant for secondary and preparatory schooling (table 10). In Gaza, however, the difference in enrolment rates between the two groups at secondary and preparatory levels was statistically significant, with 86.6% of adolescents in the comparison group enrolled in school compared with 82.6% of the intervention group, which could suggest that the cash transfer has not had a strong impact in terms of keeping children in school at higher levels of education. This could be explained by different factors, some of which were raised in the qualitative research. For example, a small number of mothers participating in a focus group discussion (all of them beneficiaries) explained that they had asked their children to leave school because of school-related costs before receiving the cash transfer, and they did not return to school after the family became a beneficiary. In many other cases, in both the West Bank and Gaza, the reasons cited for dropout were not cost related, but rather the result of verbal and sometimes

physical violence and abuse in school (on the part of other adolescents and teachers) and the poor quality of education. Thus, despite the PNCTP providing an important subsidy to cover school fees, the research reveals that there are other important barriers to school enrolment at higher levels of education.

Table 10: School enrolment at different levels of education, by gender

	West Bank			Gaza Strip		
	Interventio n	Compariso n	Effect P-value	Interventio n	Compariso n	Effect P-value
School attendance						
Aggregate primary school (age 6-12) WB: n=205, 296; GS: n=366, 344	96	94	~	96	97	
Aggregate preparatory and secondary school (age 13-18) WB: n=258, 283; GS: n=397, 329	88.3	89.3		82.6	86.6	~
% of girls of primary school age (6-12) currently attending school WB: n=144,136; GS: n=172, 167	95.6	96.3		97.1	97	
% of boys of primary school age (6-12) currently attending school WB: n=86, 149; GS: n=194, 177	97.7	91.3		94.8	97.2	
% of girls of preparatory school age (13-15) currently attending school WB: n= 67, 84; GS: n=96, 84	91.0	94.0	~	94.8	98.8	
% of boys of preparatory school age (13-15) currently attending school WB: n= 59, 60; GS: n= 87, 75	86.4	95		86.2	88	
% of girls of school secondary age (16-18) currently attending school WB: n= 76, 65; GS: n=107, 86	89.5	92.3		85.0	89.5	
% of boys of school secondary age (16-18) currently attending school WB: n= 52, 65; GS: n=107, 84	84.6	73.8		66.4	70.2	

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for two group test of proportions

There are also, of course, economic reasons that drive adolescents in poor households (evidenced in the intervention and comparison groups) to leave school, either to support household income or to help with domestic activities, as indicated by our qualitative data.

Many qualitative interviews identified households in which one or several children had either dropped out during the school year, had to stop attending before completing a full course of secondary education, or were not able to continue beyond secondary school. Respondents in this situation generally spoke of it with sadness and

frustration. Health shocks, unemployment or the death of an income earner were some of the main factors forcing households to take children out of school because they could not continue to pay school-related costs or because adolescents were now needed to contribute to household income. This was particularly common in Gaza, where income shocks were more frequently reported by respondents. Boys in both territories were more likely to be affected and miss out on schooling because they were better able to work outside the household for pay – partly because of social norms preventing girls from doing such work and because most job opportunities are for boys. Some girls also spoke about having to drop out of school either to care for siblings, an older member of the family, or a family member who was ill or disabled.

My daughter left school last semester because we could not sustain her needs. My daughter had asked her father to bring her a new uniform and bag but he cannot afford that, so she left school not to have to embarrass herself in front of the other girls. (Female caregiver, focus group discussion with non-refugees, Sheik Radwan area, Gaza)

My son had to work when he was a child to get money. He was working very hard to get that small amount of money – 20 NIS per day ... He came back from school then dropped his bag at home to go to work until the evening. He came back to study and some days he had no time for studying. Work affected his performance at school but he had to go to work as we have to pay the electricity and water fees in order not to be cut off. (Focus group discussion with caregivers, Alnwe'ma, West Bank)

The number of students in my class two years ago was 42, now this year 24 of them dropped out of school in order to work and help their families. (Boy participant in small group discussion with 11–14-year-olds, Al-Jiftlik, West Bank)

Quantitative data on school absence indicate that as girls and boys move up to higher levels of education, they tend to miss more days of school, perhaps reflecting the greater demands on their time and the direct opportunity costs (work outside and inside the house) that compete with their education – as indicated by the qualitative findings. The trend is similar for older adolescents in the intervention and comparison groups, as illustrated by the quotes below. Given that it is the minority of boys and girls who drop out, these adolescents might come from the very poorest households for whom the cash transfer does not have a significant impact on the decision to stay in school and forgo either direct income from work or important domestic and care activities – that is, it does not significantly increase the opportunity cost of dropping out of school. As such, even with the fee exemption resulting from the PNCTP and the small amount of the cash transfer, their households have to meet so many expenses with such a small income that they require additional resources to get by.

The level of school absences is slightly higher at all levels in the West Bank than in Gaza, perhaps because there are more income-generating opportunities there – and thus more incentives – for those that leave school. Data indicate that boys' school attendance is affected more than girls' attendance – again, possibly related to the fact that there are more income-generating opportunities for boys. For school absences, there was no statistically significant difference between the intervention and comparison groups, except for girls at preparatory level in the West Bank, where 9.2% of those in the comparison had missed 10 or more days of school compared with just 2.0% of those in the intervention group.

Specific information on school dropouts was collected from beneficiaries participating in the qualitative research, either because interviewed adolescents were dropouts themselves or because they had a sibling who had dropped out. While dropout was uncommon among participants at the primary level, it was increasingly common for adolescents at preparatory and secondary school, and particularly those from households with multiple levels of deprivation and vulnerability due, for example, to family illness, a father without work, or domestic violence, among other problems.

Father forced my brother to leave the school and try to find work. (Girl, participant in small group discussion with 11–14-year-old girls, Jabalia, Gaza)

I may drop out from school to work and secure income to my family. (Boy participant in small group discussion with 11–14-year-old boys, Gaza City)

I left the school to secure family expenses but I cannot find work. (Boy, participant in small group discussion with 11–14-year-old boys, Beit Hanoun, Gaza)

I dropped out of the school when I was in the fifth grade, now I am 15 years old. I have worked in different jobs. Sometimes I collect the metal pots and sell them to dealers. (Boy, participant in small group discussion with 11–14-year-old boys, Aqabat Jaber camp, Jericho, West Bank)

There are girls who dropped out of school to help their families in the farm. (Girl, participant in small group discussion with 15–17-year-old girls, Al-Jiftlik, West Bank)

The direct cost of school fees is not a barrier for most PNCTP beneficiaries because they are usually exempted from paying these (except where families have been unable to complete the complicated process involved in acquiring an exemption notice from the Ministry of Social Affairs). However, there are other cost barriers that make it more difficult for children and adolescents to attend school. The one most commonly cited was the high cost of public transport to distant schools; among children and adolescents in the poorest households, transport costs reduced their attendance or caused them to drop out of school altogether, as the cash transfer had to be prioritised for other household expenses. As one girl said, ‘*We do not have enough money for transportation to school*’ (participant in small group discussion with 15–17-year-old girls, Beach camp, Gaza).

Other factors that contributed to children’s poor school performance, low attendance and dropouts include discrimination and violence on the part of teachers – both of which were reported more frequently by respondents in the West Bank. While this factor is not directly relevant to the cash transfer, it was identified as an important source of child and adolescent ill-being, and undermines one of the main objectives of the PNCTP, which is to support children from poor households to continue their schooling. This is clearly a problem that should be addressed through child protection systems within schools (for example, by school counsellors prioritising it as an issue) and could be supported by social workers during their PMTF home visits, when they would try to find out if children are affected by violence in school and then refer the child to the school counsellor. Closer integration between school support systems and PNCTP social workers would begin to realise a more comprehensive vision of child protection.

Adolescents interviewed spoke about teachers giving preferential treatment to richer and ‘smarter’ pupils, so those who were struggling – usually those from poorer backgrounds who have to spend time on domestic or paid work rather than their studies – were not well supported.

In my school, because I am not as smart as my classmates, the teacher ignores me. If I do not understand, she does not repeat. But if one of the smart girls did not understand, the teacher would repeat and re-explain for her. (Girl participant in small group discussion with 11–14-year-olds, Jericho, West Bank)

They beat me when they ask me to write or read but I cannot do that, the teachers beat me and shout at me. (Girl participant in small group discussion with 11–14-year-olds, Ein Aldyouk, West Bank)

This problem is relevant to the PNCTP, because children from poor families who may be experiencing high levels of stress at home may also be experiencing violence and, in some cases, discrimination from teachers at school – even because they are programme beneficiaries. Since one of the aims of the programme is to promote children and adolescents’ school attendance (currently tackled through exemption from school fees) it is necessary for those designing the programme (and complementary measures) to understand how children from poor households can be more comprehensively supported to stay in school.

Schooling and the PNCTP

In this context of significant cost (and other) barriers to schooling for many children from poorer households, the cash transfer was reported to have made a mixed contribution. According to the qualitative data, depending on the level of household poverty, for some children the extra cash was said to be enough to enable children to continue to attend school; but for the poorest households, the level of needs was such that the small amount of the cash transfer was not necessarily enough to cover school expenses – particularly transport costs – after food and health care costs had been prioritised. Table 11 indicates the main uses of the cash transfer. In both

territories, school expenses are the fourth priority on which the cash transfer is spent. This suggests that, particularly in the case of the poorest households, the transfer does not contribute significantly to children’s schooling. Furthermore, for adolescents from extremely poor households, leaving school to go into paid work, usually at the preparatory or secondary level, is still common despite their household receiving the cash transfer, as the opportunity cost is greater – that is, the income they can contribute to the household is of greater value.

Table 11: What beneficiaries spent the cash transfer on in the past year

	West Bank	Gaza Strip
	n=322	n=315
Food (%)	92	94
Clothing (%)	43	60
Paid bills (%)	64	21
Debts (%)	59	82
Rent (%)	7	8
Educational expenditures (%)	33	47
Savings (%)	5	3
Livestock (%)	1	0.3
Investment (%)	0	0

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for chi-square trend across study group

In a context where education is not free of fee rates, except in UNRWA (primary and preparatory) schools for refugees, children from PNCTP beneficiary households are exempted from paying fees at primary, preparatory and secondary levels. While this helps with schooling costs, they still incur other school-related expenses. Additionally, PNCTP beneficiaries go through lengthy procedures and have to present multiple documents from MoSA to be exempted. Some caregivers reported poor coordination between MoSA and the school system, which meant the document supporting fee exemptions did not arrive in time, forcing households to pay the fee upfront even if it were subsequently refunded. This poor coordination was also highlighted by the Head of School Counselling at the Ministry of Education (MoE) during a key informant interview, as it undermines the PNCTP’s potential to support schooling for the most vulnerable children. A few caregivers reported using some of the cash transfer to pay for school-related costs such as transport, uniforms, bags and books, although adolescents interviewed spoke little about the transfer’s contribution to school-related payments.

The school asked us to pay 10 shekels for English books, and we paid. Then, later, they gave us the money back because we are MoSA beneficiaries. I was so happy for that. (Girl participant in small group discussion with 11–14-year-old girls, Al Qamer, Jericho, West Bank)

Some schools do not wait until we get a paper from MoSA. To me, I had to borrow 70 NIS just to register my daughter in the tenth class at school. (Female caregiver, focus group discussion with refugees, Beach camp, Gaza)

The livelihood conditions improved because we get a waiver for school fees from MoSA. Also, I became more capable of buying school uniform for my son. (Female caregiver, focus group discussion with refugees, Jabalia, Gaza)

MoSA cash transfer is good because we don’t pay school entrance fees for our children except the Tawjihi [general secondary examination] we have to pay, and we pay for school stationery needed for the children. I’m trying to cover all our needs with the 750 NIS. (Female caregiver, focus group discussion, Alnwe’ma, West Bank)

For older adolescents, as they make the transition to adulthood, vocational training opportunities are lacking. This was frequently noted in small group discussions in both territories as well as by caregivers. Fewer caregivers in the West Bank referred to university as an aspiration for their young sons and daughters than in Gaza, with more of a focus on vocational training.

Inequitable access to schools

Despite more efforts to mainstream children with disabilities into regular schools (with a twofold increase in enrolment of disabled children over the past decade), significant limitations remain. There are important gaps in terms of basic supportive infrastructure – for example, there is no public transport accessible to children and adolescents with disabilities, and private transport is unaffordable.

I dropped out from the school because the school is far away from my house, I did not have a wheelchair to use. Now I have a bicycle made from wood and it is difficult to use, it needs strong muscles. (In-depth interview with 16-year-old girl, Jericho, West Bank)

In Gaza, since both government and UNRWA schools do not provide specific support services for children with disabilities, if parents want their children to receive special education that takes into account their disabilities, they need to enrol them in private schools, the cost of which is often prohibitive.

I was unable to pay for my disabled daughter's special education ... It cost 120 NIS monthly. (Female caregiver, focus group discussion with refugees, Jabalia, northern Gaza)

Children with disabilities also face important social and logistical problems. For example, one boy noted that, while children are friendly to him in the classroom, ‘friends melt away’ after school, with no one offering to support him on his trip home, which is arduous because of the rough pavement terrain and his substandard wheelchair. Moreover, as key informants highlighted, inclusion of children with disabilities in schools is still viewed from a charitable rather than a rights-based perspective.

I like the school but I could not continue, because most of the times I used to fall down on the floor. Also the teacher in the school, when I made mistakes in class she used to twist my hand. (In-depth interview with adolescent boy with special needs, West Bank)

I like to have friends, I like to talk and sit with my classmates but they did not pay attention to me. At the school break, no one came and ate with me. Only sometimes they say ‘Good morning’. Moreover my teachers did not pay attention to me when I asked for some help in doing homework. (In-depth interview with 16-year-old girl with a physical disability, West Bank)

The teachers were not good with my daughter. Many times while she was at school the teachers did not allow her to sit at the wheelchair, they pressured her to sit on the school chair and she did not feel comfortable. The girls at the school played on the wheelchair and most times the wheelchair was not functioning well. During her time at the school she had no friends, she told me that the teachers discriminated against her and used to treat other students more favourably. (In-depth interview with mother of 16-year-old girl with a physical disability, West Bank)

6.2 Leisure

In order for children to develop fully, they must be able to exercise their right to relax and play, and to join in a wide range of cultural, artistic and other recreational activities (UN, 2010). Economic hardship, political and environmental factors – including a context of violence, mobility constraints and stress in the household – can all affect children’s capacity to exercise this right. Social protection could play a role in achieving this right through the mitigation of factors linked to economic hardship, but its focus on basic needs often means that this is overlooked. In a context such as the SoP, where depression, mental health and stress commonly affect children as well as adults, the capacity for social protection to facilitate enjoyment of this right must not be overlooked. Indeed, in all the 11 small group discussions conducted with adolescent girls and boys in Gaza, the dearth of opportunities for recreational activities was one of the top three concerns. In the West Bank, lack of access to recreation was also a key concern for 5 out of the 12 discussion groups conducted. The harsh environment in Gaza in particular thus has a significant effect on children’s ability to have (and enjoy) time and space for leisure. The following quotes illustrate how income poverty and the lack of free educational spaces contribute to children and adolescents’ deprivation:

I have not really lived my childhood like others. I find out about this reality when I watch those kids on TV. I feel a lot of pain. I spend all my life picking cucumber from the farm. (Girl participant in small group discussion with 15–17-year-old girls, Al-Jiftlik, West Bank)

I do not go on any recreational trips because we do not have money. On the day of the trip I stayed at home and told my friends that my mother didn't allow me to go. I did not tell them that we do not have money. (In-depth interview with 13-year-old refugee girl, Aqbat camp, Jericho, West Bank)

With the exception of a 13-year-old girl with a disability in Gaza City, who mentioned that she had attended a trip organised by the National Rehabilitation Association (NRA), children with disabilities find it particularly difficult to realise their right to leisure due to high transport costs, lack of adequate facilities and appropriate activities, and the fear of being ‘looked’ at. Furthermore, their households struggle to meet the costs of the individual’s other needs, which are often more pressing, so seldom have resources to spare for leisure activities.

According to quantitative data from the household survey (see Table 12), only a few households reported having taken their children for recreational (social/entertainment) activities in the past month – less than 25% of households in all cases, with no statistically significant difference between the intervention and comparison groups in either territory. This is low even by local standards; a recent study found that approximately 72% of caregivers in the Gaza Strip take children out on recreational activities, suggesting that income poverty is a significant barrier to exercising such positive parenting techniques (ANERA, 2012) and that children living in poverty do not have many opportunities to enjoy activities outside of school and their domestic or work responsibilities.

Table 12: Recreational activities for children

	West Bank			Gaza Strip		
	Intervention	Comparison	Effect	Intervention	Comparison	Effect
	Mean	Mean	P-value	Mean	Mean	P-value
% of households that took their children to social/ entertainment activities in the past month	17	18.1	-	26.5	24.7	-

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for two group test of proportions

Similarly, less than a quarter of households in Gaza reported that children had books or toys at home, although the corresponding figure for the West Bank was closer to 45%. The lower number in Gaza can also be linked to the embargo and the lack of access to material goods. In general, these data indicate that receiving the cash transfer does not have a statistically significant effect on accessing these types of goods.

Table 13: Access to books and toys

	West Bank			Gaza Strip		
	Intervention	Comparison	Effect	Intervention	Comparison	Effect
	Mean	Mean	P-value	Mean	Mean	P-value
% households that have books and/or toys for children aged 12 or under	46.4	42.8	-	23.5	24	-

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for two group test of proportions

These quantitative data contrast somewhat with the qualitative data, which suggest that some households – particularly in the West Bank – are able to provide their children with recreational opportunities and books/toys since receiving the cash transfer.

PNCTP enabling children to access recreation

Using the cash transfer for the purpose of providing children with recreation might be contentious for those who regard it as an entitlement aimed at meeting basic needs and reducing extreme poverty. But from a child rights perspective (which sees children’s development in a more holistic way), being able to provide entertainment opportunities for children might actually be a positive contribution to breaking the cycle of poverty, and more importantly, contributing to a more balanced state of wellbeing by reducing the depression and anxiety many children and young people experience.

According to qualitative responses, the PNCTP has had some effect on children’s capacity to enjoy additional recreation activities, within the constraints of the local environment. A few caregivers reported being able to buy toys, such as bicycles, but this was rare. Most households do not prioritise these expenditures from the cash transfer given other more urgent needs. But for those caregivers that are able to meet some of the basic needs – generally from poor rather than extremely poor households – they also find a way to purchase items or provide money for services for their children’s recreation, including for trips organised by schools, which they have to pay for.

At the day of payment me and my sister ask my father to give us pocket money to go to swim and he does, and also my sister asked him when he went to pick up the money from the bank to buy her a bicycle and he did. (Girl participant in small group discussion with 11–14-year-old girls, Ein Aldyouk, West Bank)

The situation got better after the cash transfer, because after receiving it I was able to buy things for my daughter ... I bought clothes, food, a mobile and a laptop for my daughter. (Female caregiver participant in focus group discussion, Alnwe’ma, West Bank)

After MoSA assistance I can take some of my kids to Jerusalem and can visit their friends, while before MoSA, my kids were home most of the time. (In-depth interview with mother, Al-Jiftlik, Jericho, West Bank)

There might, however, be a balance to strike here in terms of children’s wants. The increasingly commercialised context, with TV images of luxury items for children of all ages, have also sparked some newfound ‘wants’ among children, with some respondents from very poor families complaining that the cash transfer was not able to help them obtain things like ‘play stations’, smartphones or holidays abroad – something that is well beyond the scope of a basic social protection project, and perhaps something that needs to be communicated better to beneficiaries.

An important gender dimension was uncovered in relation to children’s ability to enjoy recreational activities. Boys and girls generally agreed that girls faced a more difficult situation, given the limits to their social mobility outside the home imposed by restrictive social norms.

There is discrimination in access to recreational activities in favour of boys. Boys do not need permission to stay out late and can go anywhere they like. Girls are only allowed to go to the public garden once per month. (Girl participant, small group discussion with 11–14-year-old girls, Ein Aldyouk, West Bank)

Before my husband had died, he was taking my daughters to trips. But after he died, their brother forbade them to go to any trips. (Female caregiver, focus group discussion in Alnwe’ma, West Bank)

On the other hand, however, some boys said that they were most affected by poverty because they were the ones who typically went out, and now their opportunities to do so were limited. For example, opinions from a small group discussion with 11–14-year-old boys in Aqbat, Jericho, in the West Bank, indicated that boys are more affected by problems among friends because they have more friends and spend more time outside the home;

boys have more worries about lack of money as they ‘need’ to spend more while out, including on cigarettes and parties.

Through the Committee for Summer Camps, schools in refugee camps in the West Bank often organise summer camps for children – sometimes even separately for girls and boys to encourage their participation. However, these are usually not free and therefore are unaffordable for the poorest families. Other organisations identified as providing recreational opportunities for children included the WAI-Qamar organisation, which had organised a summer camp for girls in Jericho. They also organised a photography course and private tutoring for girls. Also in Jericho, Sheikh Harb Charitable Society had distributed school bags for girls. Respondents in the small group discussion with 11–14-year-old girls in Al Qamar, Jericho, said that the fact that boys were not included in these schemes had made them feel special, since boys are generally seen as having many more opportunities to leave the house and play or work during the holidays.

6.3 Social stigma

Social stigma attached to poverty seems to be quite widespread and a source of shame, particularly for adolescents, which results in them not wanting to socialise; it also results in other children not speaking to them at school, which can have consequences for their self-esteem. For example, female caregivers in a focus group discussion in Alnwe’ma in the West Bank agreed that they could not afford new clothes for their daughters, particularly for special occasions such as weddings, so they had to borrow clothes. They felt that this affected their daughters’ self-esteem and made them feel ashamed. Several caregivers in different focus groups, as well as adolescents interviewed, mentioned not wanting to go to school if their bag or uniform was old or in a very bad condition. In general, children said that the cash transfer could be improved by including the provision of new clothes, which indicates the importance they attribute to this. Thus, there is significant social pressure on households, even the poor, to comply with social demands, putting increased pressure on children and adults alike, and exacerbating low sense of psychosocial wellbeing.

My children did not go to preschool because they wanted a new bag. (Female caregiver, focus group discussion with refugees, Jabalia camp, Gaza)

I can’t go out with friends, because of lack of money and clothes. (In-depth interview with 17-year-old male refugee, Beach camp, Gaza)

In the past, people used to respect my father because he had money, but not anymore. (Girl participant in small group discussion with 11–14-year-old girls, Gaza City)

The cash transfer has provided some minor relief in this regard, with respondents mentioning they were occasionally able to buy clothes for their children for special occasions, purchase a new school bag or uniform, or provide them with pocket money to be like other children.

We could give the kids the allowance they needed. (In-depth interview with mother, Gaza City – saying that this made children more comfortable in their social circle)

I could not buy new clothes for my sons for Eid. (Female caregiver, focus group discussion with refugees, Jabalia, Gaza – all participants concurred.)

There were mixed views among children as to whether the fact that their household was a PNCTP beneficiary brought social stigma on the family. Some were adamant that their beneficiary status did not lead to their exclusion, and that they were able to retain a sense of personal dignity.

The cash transfer helps me; it doesn’t harm me. (In-depth interview with 17-year-old boy, Jabalia, Gaza)

We don’t feel shy from receiving the cash; many people are doing the same. (Girl participant in small group discussion with 15–17-year-old girls, rural area north of Gaza)

Others, especially girls, were reluctant to admit that their families were beneficiaries for fear of peers ostracising them:

I don't feel shy because my father receives cash, we didn't do something wrong ... However, some girls would distance themselves from me if they knew we receive the cash transfer. So, I don't talk about it. When the transfer is late it makes the whole family sad. (In-depth interview with 16-year-old girl, Gaza City)

I feel shy, some people mock me when they know that we receive the cash transfer. (In-depth interview with 17-year-old male, Beach camp, Gaza)

Similarly, in the West Bank, some children expressed embarrassment and shame about their families being PNCTP beneficiaries, as the following quotes illustrate:

One time, a man said that this family is a beneficiary of MoSA, which makes me embarrassed, and that hurt me deeply. I told my mother I will give him 2,000 shekels, just so he won't talk like that about us in front of people. (In-depth interview with 17-year-old male, Jericho, West Bank)

They don't like to be associated with people like me who are poor. (In-depth interview with 12-year-old girl, Jericho, West Bank, speaking about her school friends)

7 Effects of the PNCTP on children and their households: protection

All children have the right to be protected from violence, exploitation and abuse. Child protection rights under the UNCRC ensure that children are safeguarded against all forms of abuse, neglect and exploitation, including: special care for refugee children; safeguards for children in the criminal justice system; protection for children in employment; and protection and rehabilitation for children who have suffered exploitation or abuse of any kind. Article 4 in particular commits governments of signatory states to ‘... have a responsibility to take all available measures to make sure children’s rights are respected, protected and fulfilled’. When countries ratify the Convention, they agree to review their laws relating to children. This involves assessing their social services, legal, health and educational systems, as well as levels of funding for these services. Governments are then obliged to take all necessary steps to ensure that the minimum standards set by the Convention in these areas are being met. They must help families protect children’s rights and create an environment where they can grow and reach their potential. In some instances, this may involve changing existing laws or creating new ones.

In the case of the SoP, children’s right to protection from violence, exploitation and neglect has only more recently been seen as a critical vulnerability that social protection programming should address – either directly or through linkages to complementary services. In a humanitarian or conflict-affected context, however, the importance of increasing the spotlight on protection-related vulnerabilities is enhanced. Here, we discuss the research findings that pertain to children’s protection and care, highlighting children’s voices wherever possible. More specifically, we consider children’s rights to protection from physical discipline, child labour and exploitation, from exclusion based on disability, and from psycho-emotional ill-health, inadequate parental care, and early marriage.

7.1 Physical discipline and violence

Drawing on cross-cultural analyses, Dawes et al. (2004) emphasise that in general, physical violence against children is linked to social norms and occurs less frequently in cultures where children are more positively valued and there is greater tolerance of their misbehaviour. They argue, however, that in contemporary societies, children are generally economically burdensome (particularly under the age of seven or so) and that in conditions of economic stress, the risks of violence to children increase.

According to the quantitative data analysed (table 14), inappropriate child disciplining practices were prominent among both the comparison and the intervention groups, with no significant differences, although overall, they occurred less frequently in the West Bank than in Gaza. The most commonly practised approaches were yelling and shouting (more than 60%), not allowing children to leave the house (over 40%), shocking (nearly 50%), slapping the child with a bare hand or object (45%), and using insulting language (30%). Some 11.3% of adolescents perceived it as natural for parents to use physical punishment to discipline children, with the rate higher among males (15%) and in the comparison group (7.6%).

Table 14: Forms of discipline and violence against children at home

(%) Households that used this method with any of the children in the past month	West Bank			Gaza Strip		
	Intervention	Comparison	Effect	Intervention	Comparison	Effect
	Mean	Mean	P-value	Mean	Mean	P-value
Took away privileges, forbade something (<i>name</i>) liked or did not allow him/her to leave house	54.6	49.5	-	55.0	57.9	-
Explained why (<i>name</i>)’s behaviour was wrong	81.3	78.6	-	91.1	94.5	~
Shook him/her	46.5	51.5	-	60.0	65.2	-
Shouted, yelled at or screamed at him/her	66.1	69.2	-	76.4	82.6	*
Gave him/her something else to do	47.8	48.0	-	42.7	43.7	-
Spanked, hit or slapped him/her with bare hand OR OBJECT	40.0	46.6	~	51.8	61.3	*
Called him/her dumb, lazy, or another name like that	36.8	36.0	-	42.1	48.6	~
Do you believe that in order to bring up, raise, or educate a child properly, the child needs to be physically punished? Yes	17.1	11.4	*	21.8	19.3	-

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for chi-square test

These data suggest that the PNCTP does not have a significant link to violence at the household, community and school levels. This is partly due to the fact that there are no components in the programme specifically aimed at tackling these violations of children’s rights, but might also be linked to the fact that there is no coordination between social workers implementing the programme and child protection services, who could provide support if cases of suspected violations were identified during home visits (which are currently mostly used to gain the information needed from applicants to determine the PMTF score). Quantitative and qualitative findings showed that violence is widely practised – by children themselves, their parents, teachers, and service providers. However, data in some of the categories presented in Table 14 are slightly higher than the national average. This might be because poverty increases parental stress levels, which in turn increases the likelihood of violent reactions to children’s demands; it might also be because parents in poorer households (with lower levels of education) have less awareness of positive, non-violent forms of child discipline.

Violence against children in the home

According to the qualitative data, violence is sometimes perceived as ordinary behaviour by both the victim and the perpetrator – for example, several adolescents interviewed said that it was normal for parents to beat them, and some caregivers said that it was their prerogative as children were ‘theirs’. In the case of sibling violence, at least three female respondents explained that older brothers sought to control their behaviour through physical or psychological violence. For example, during an observation conducted in the home of a 13-year-old girl with a hearing impairment in Jabalia camp, Gaza, she expressed through her caregiver that her older brother regularly

beats her when she made strange noises while trying to communicate, and that although he can use some sign language, they have a poor relationship.

My father hits me when I make mistakes and my brothers as well. Hence I try not to make problems or any mistake. (In-depth interview with 15-year-old boy, Gaza City)

Box 5: Violence against children at home, and its consequences

Rawan has a severe leg injury that resulted from an act of violence by her father. He hit her hard on the leg with a wooden stick because he did not want her to speak to people he disliked. The hospital applied a cast, but her knee was so badly damaged that she has a permanent disability.

According to Rawan's mother, Ghalia, her husband is very hot tempered and has been using physical and verbal violence against her children and her for 23 years. He has hit Ghalia with sticks and even tried to suffocate her once. She thinks the violence has to do with the fact that he wants food and cigarettes but usually has no money, which makes him very stressed. The father is particularly violent with his eldest son whom he beats in order to bring him more money.

Rawan's family are very poor. Their home is precarious and they often have no money for food, let alone school. In addition to the father only having occasional work, Ghalia was forced out of work to care for her daughter full-time, putting further financial strain on the household.

Classified as living in extreme poverty, the family were enrolled in the PNCTP, but Ghalia complains that it is her husband who receives the cash transfer and only on occasions does he share it with her or the children, spending most of it on himself. As such, she wishes the money could be assigned to her disabled daughter so that it could be used for Rawan and her siblings.

After Rawan's injury, Ghalia explained that she: *'went to MoSA office in Jericho and reported his violent acts against us, especially against my daughter, Rawan, and filed a legal case in the court against him. The only thing they did was to make him sign a commitment not to harm any of us, but he continued to be violent.'* Thus, as a result of her complaint, MoSA made Ghalia's husband commit not to hit Rawan again, or risk losing the transfer. Although he is still violent, he is less so now than before he started receiving MoSA assistance.

Rawan's mother laments: *'I wish I could help my older daughters to go back to school as we don't have the money to support their transportation to school and my husband is not in favour of sending them to school.'* However, she explained that she feels the situation is much better as a result of the cash transfer, particularly as they can sometimes purchase more food (including meat on occasions), clothes, and now have health insurance. Another important factor is that she now feels she has someone to go to in case of emergency, and if she needed to report a domestic violence incident. Her husband has been warned by MoSA that he might no longer be eligible for the transfer, which can be put under Ghalia's name if he commits an act of violence. This decreased the episodes of violence but did not stop them. However, it is important to note that it is difficult to put the cash transfer under a young disabled daughter's name under normal circumstances, only through complaints.

(Source: In-depth interview with caregiver, Bedouin area, Al-Jiftlik, West Bank)

Often, victims of violence (especially caregivers) were also perpetrators of violence, mostly against children and adolescents, and explained their behaviour in terms of excessive stress and frustration. For many caregivers and adolescents, domestic conflict was a major concern:

Honestly, my father keeps insulting my mother a lot, they fought just yesterday. I cry when I see my father insulting my mother. (In-depth interview with 16-year-old girl, Gaza City)

He [my husband] hits me a lot ... Many times we reach the point of divorce ... He used to hit my eldest son badly. I used to hit [my younger two sons] severely ... The debt was very big. (In-depth interview with mother, Al-Jiftlik, West Bank)

He [my husband] is awful. He is mad all the time and doesn't talk ... He uses a stick to hit her [a mentally disabled daughter]. (In-depth interview with mother, Gaza City)

In the case of sibling violence, it is not just older siblings beating younger siblings but also older brothers seeking to control the behaviour of their sisters. For example, one 16-year-old girl who had been forced to drop out of school to become her mother's full-time caregiver told how her brothers had applied considerable psychological pressure on her:

I don't talk to my brother about going back to school. I am not used to confronting him. I only talk to my mother about this. I told my brother about going back to school and he said that 'my school is my mother!!' ... He refuses for me to leave the house. (In-depth interview with 15-year-old girl, Beach camp, Gaza)

Although the quantitative data collected suggest no effects of the cash transfer on domestic violence, qualitative interviews indicated that the cash transfer does have some effect in the reduction of intra-household violence through decreasing levels of stress within the household. This was noted in a number of interviews with caregivers and adolescents across Gaza and the West Bank, as illustrated by the following quote:

Before joining the cash transfer, we had no hope. When my son requested anything, I shouted on him, saying 'Shut down your mouth, I don't have money'. But now we have hope. I tell him: 'When I receive the cash, I will give you what you need'. (Focus group discussion with caregivers, Jabalia camp, Gaza)

Violence in schools

Violence in schools can compound the emotional stress and ill-health experienced by children facing violence at home, as a result of economic hardship on the family, increasing children's vulnerability and reducing their resilience to the challenging situation they are living in. Additionally, as indicated by qualitative interviews, violence in schools was an important reason for school dropout and lack of motivation to attend school. This is important to consider, as it goes against one of the implicit aims of the PNCTP, which is to encourage school attendance and continuation through the exemption of school fees and occasional subsidy of school supplies.

Children and young people expressed mixed views about teachers in the individual interviews and group discussions in terms of whether they provided a source of support for impoverished or vulnerable students, whose families were more likely to be PNCTP beneficiaries. While some teachers are highly respected and do offer support, including intervening to prevent bullying, there were also a number of complaints about verbal and physical violence perpetrated by teachers.¹² Violence at the hands of teachers in schools was reported in both Gaza and the West Bank, but seemed to be widespread in the Jordan Valley research sites, and to be generally accepted as the norm, especially vis-à-vis children from poor households. Teachers often use violence as the quickest and easiest means of disciplining children, and in response to a challenging educational environment.

Violence is the easiest way of dealing with troublesome children given the huge pressure on teachers, unfriendly and intensive curriculum, crowded classes, low incentives for teachers, and relatively accepted practice of mild violence used by teachers against children in schools. (Head of School Counselling at Ministry of Education, Ramallah, West Bank)

The teacher asked my brother to come to the class blackboard. He came and she hit him, slapped him on his face, [my brother] hit his head on walls, and he told my father, then my father went to school to talk with the teacher who had hit my brother. (13-year old boy, West Bank)

I feel extremely terrified of her [the teacher]. I keep wishing that her lesson is the first of the day so then I can feel relieved it is over. She punishes us with a stick for any wrong answers ... I'm scared and my

¹² A recent study on preschool children (ANERA, 2012) showed that, of the total surveyed teachers, only 37% reported avoiding physical, verbal and emotional punishment on a daily basis. A 2013 survey on violence (PCBS, 2013b) indicates that 26.4% of children aged 6-17 are exposed to psychological violence at schools – mostly by teachers (26%) – followed by physical violence (21%). In addition, 21.4% of children have been exposed to psychological violence by their peers and 14.2% to physical violence.

grade has dropped ... But I don't like to complain. I think I will affect her livelihood – I tell myself it's a year that will come to an end. (In-depth interview with 14-year-old girl, Jabalia camp, Gaza)

In some cases, children explained that violence was used as a response to poor academic performance and resulted in high levels of frustration and humiliation among affected students:

They [the teachers] beat me when they ask me to write or read but I cannot do that, the teachers beat me and shout at me. (Participant in small group discussion with 11–14-year-old girls, West Bank)

Since I was in the second grade, I used to be beaten in school every day. Once in the first week of school, the principal called our names, took us out, and beat us. They asked for my parents, and brought them to school. When he hit me, I ran out of class – God protects you when someone wants to speak of something bad about a person, they make you feel like a garbage and humiliate you. Then the teacher came in and hit us, then the principal also hit us. The principal came to me and said 'Bring me your parents'. I picked up my bag and told him assalam alaikum [good bye] and since then I never came back to the school. (17-year-old male who dropped out of school at age 15, West Bank)

Teaching staff seem to be aware that physical violence is, in theory, not acceptable, but rely on it nevertheless. Children also acutely feel that they have no channels to turn to in order to report such abuse:

We are stuck, and when the UNRWA supervisor comes to our school, the teacher hides the stick and the principal warns us that any one talks about the school punishing students with sticks will be punished severely. (Participant in small group discussion with 11–14-year-old boys, West Bank)

The school does not understand our financial problem. At the time of paying our school tuition, they ask you to pay without allowing to listen to any excuse. As a result, I drop out of school, our bodies are not made of iron to tolerate all of these troubles. We are bored, it is enough humiliation, they beat us all the time. (Participant in small group discussion with 11–14-year-old boys, West Bank)

Victims of violence have limited access to counselling or support, and these services were reported to be generally weak. This suggests that while social safety nets in the SoP (and particularly the cash transfer) may be reducing children's economic vulnerabilities, there has been very little attention to tackling broader social vulnerabilities such as school-based violence, which could be addressed through linkages to complementary programmes and services. For instance, some children spoke about there being poor quality counsellors in schools whom they could not trust, and only in very few cases were teachers identified as sources of support. Caregivers spoke about psychological support services available from MoSA and NGOs, but pointed out that they were difficult to access. The child protection network established by MoSA in 2006 (see section 3.2.4) constitutes a good forum for raising child protection issues; however, there are no linkages between the PNCTP and this networks, nor other support services.

7.2 Work and exploitation

Many children work to help their families in ways that are neither harmful nor exploitative. However, a child rights approach emphasises that children have the right to an education and to play, and that children working – especially if they are working excessive hours or under exploitative conditions – can seriously undermine these rights. In fact, Article 32 of the UNCRC states that the government should protect children from work that is dangerous or might harm their health or their education.

The quantitative data collected indicate interesting trends in relation to children working (see Table 15). Work in and outside the household is a gendered phenomenon, with girls more likely to do domestic work for three or more hours a day than boys, in all age groups. Girls aged 15-18 are more frequently involved in regular domestic work – around 50% in the West Bank and 89% in Gaza, on average, for intervention and comparison groups, with no statistically significant difference between the two groups. Boys, on the other hand, were more frequently involved in paid work outside the home, reflecting the fact that social norms allow them more mobility. In the West Bank, the figure was 66% of boys in the intervention group and 44% in the comparison

group work (although the difference is not statistically significant), suggesting that more boys in the intervention group need to work given their level of poverty.

The corresponding figure for Gaza is very low: 2% among the intervention group and 0.8% among the comparison group. This figure contradicts the information obtained during the qualitative research, where several respondents mentioned that adolescent boys commonly worked outside the household. This difference might be explained because survey respondents were reporting ‘formal’ or contracted work, rather than informal and temporary jobs. In both territories, it was reported that most adolescents in the 15–18 age group who work in or outside the household still attend school. However, there is a statistically significant difference between the intervention group (100%) and the comparison group (80%) in the West Bank, and no difference in Gaza between the two groups (with 94% of boys and 100% of girls in that age group reporting attending school and working).

Table 15: Data on children doing work in and outside of the household

	Intervention	Comparison	Effect	Intervention	Comparison	Effect
	Mean	Mean	P-value	Mean	Mean	P-value
	Girls			Boys		
	West Bank					
% of girls / boys aged 5-14 who work outside the house more than 3 hours per day in the past 7 days	0	0		0.71	0.92	-
% of girls / boys aged 5-14 who work in household chores (including supervising siblings) more than 3 hours per day in the past 7 days	24.71	23.83	-	12.77	11.06	-
% of girls / boys aged 5-14 who are involved in child work and are currently attending school (petty trade, agriculture, etc)	-	-	-	-	.	~
% of girls / boys aged 15-18 who work outside the house more than 3 hours per day in the 7 days	0.99	0.93	-	6.09	10.75	-
% of girls / boys aged 15-18 who work in household chores (including supervising siblings) more than 3 hours per day in the past 7 days	50.4	48.5		13.4	18.2	
% of girls / boys aged 15-18 who work in household chores and are currently attending school	89.5	93.3		100	80	~
% of girls / boys aged 15-18 who are involved in child labour and are currently attending school (petty trade, agriculture, etc)	-	-		66	44	-

% of girls / boys aged 10-14 working in exploitative/ risky forms of labour (to be defined by UNICEF in case of SoP but can include: in the tunnels, transactional sex, others)	1.25	0.95	-	3.23	2.17	-
% of girls / boys aged 15-18 working in exploitative/ risky forms of labour (to be defined by UNICEF in case of SoP but can include: in the tunnels, transactional sex, others)	1.20	1.23	-	0.00	4.35	*
	Gaza					
% of girls / boys aged 5-14 who work outside the house more than 3 hours per day in the past 7 days	1.9	0.8	-	1.4	0.4	~
% of girls / boys aged 5-14 who work in household chores (including supervising siblings) more than 3 hours per day in the past 7 days	13.38	14.88	-	14.07	17.5	-
% of girls / boys aged 5-14 who are involved in child labour and are currently attending school (petty trade, agriculture, etc)	100	100	-	97.43	93.18	-
% of girls / boys aged 15-18 who work outside the house more than 3 hours per day in the past 7 days	1.4	0.9		2.0	0.8	
% of girls / boys aged 15-18 who are involved in child labour and are currently attending school (petty trade, agriculture, etc)	93.9	86.4	-	72.7	57.1	-
% of girls / boys aged 10-14 working in exploitative/ risky forms of labour (to be defined by UNICEF in case of SoP but can include: in the tunnels, transactional sex, others)	0	3.22	-	3.7	0	-
% of girls / boys aged 15-18 working in exploitative/ risky forms of labour (to be defined by UNICEF in case of SoP but can include: in the tunnels, transactional sex, others)	0	8.33	*	0	0	-

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P -value for two group test of proportions

As noted above, some of these figures are in contrast with the findings from the qualitative research, possibly because the quantitative sample was not designed to capture responses specifically from children and adolescents working, and because the questions about work were asked to caregivers responding the survey rather than to children and adolescents directly, which was done in the qualitative component. While the quantitative data suggest that the number of boys working outside the household is relatively low, particularly in Gaza, the qualitative component indicates something different. Qualitative findings indicate that children's involvement in work in the SoP – even children in families that receive the cash transfer – is quite common. At least one respondent in every small group discussion (with approximately 5 participants) said they had a sibling who was working or they were working themselves. Boys tend to be more involved in paid work outside the home while girls support activities in the home and, in rural areas, do agricultural tasks.

I want to work, to do anything, just to have money and promote the living conditions for my family. (In-depth interview with girl aged 11–14, north Gaza)

This was particularly the case when households had experienced a shock, such as the loss or illness of a family member or the main income earner. For example, a 15-year-old boy from Gaza explained that, after his father was laid off, his parents treated him differently, with negative repercussions for his education:

The way they treated me changed. They started to put pressure on me to work. They asked me to look for a job as there is no money. When I asked for my school pocket money, mother and father told me go and find a job so I was obliged to work before and after school. I hated school that time. (In-depth interview with 15-year-old boy, Gaza City)

The quantitative data did not report many children who had dropped out of school to work, though this could be because the question about the reasons for school dropout was only indirectly asked through questions on enrolment and work. Several caregivers and adolescents interviewed for the qualitative component of the research noted that children, mainly boys, had been compelled to drop out of school in order to help the household meet its living expenses.

Even after the cash transfer, my son had to leave the school to work and get money. (Refugee participant in focus group discussion with caregivers, Gaza City)

One 17-year-old male noted:

I dropped out from school when I was 14 because I had no uniform and took to work at sea ... [after father became unemployed] I saw my father staying home and never going out, I thought I would help him, and that I would try to find some work and help uplift the family's status. (In-depth interview, Beach camp, Gaza)

In the West Bank, another 17-year-old explained how he became responsible for his mother when his father died. He dropped out of school at age 15 to start a number of informal jobs to help support his family, who were experiencing economic hardship.

I dropped out of the school when I was in the fifth grade, 15 years old, and then I worked in different jobs. Nowadays, sometimes I collect the metal pots and sell them to dealers. (17-year-old male, participant in small group discussion, West Bank)

Another boy, aged 12, emphasised that he and others like him no longer see themselves as children but as income earners, contributing to their families:

We are not children, we get money and help our families ... I went to work when I was in the third grade, the first work for me was at the farm to pick vegetables. (12-year-old boy, participant in small group discussion, West Bank)

As the quantitative data indicate, there is, by contrast, very limited pressure for adolescent girls to take on paid work outside the home, mostly due to cultural constraints on their mobility. But there is a significantly higher number of girls in the older age cohort working in domestic activities. As one 11-year-old girl in the West Bank noted: *'I hate home chores because it is so hard and tiring.'*

Several girls in the qualitative sample also noted they had to shoulder a considerable work burden in caring for disabled or sick family members. As already noted, this has consequences for their schooling and other opportunities as they grow older. One 11-year-old girl noted that *'my mother does the housework and I look after my disabled sister'* (in-depth interview, Beach camp, Gaza); and a 15-year-old girl tearfully explained that she had been forced to drop out of school despite being a very good student as, following her father's death, her mother had fallen ill and become paralysed, and her brothers pressured her to abandon her education in order to care for her:

My mother has been ill for the past four years. She cannot walk because she is disabled. Each passing day, her health gets worse and it is deteriorating. This makes me sad and affects my life as I take care of her in the house and I cannot go to school ... I do all of the housework: doing laundry, washing the dishes, mopping the floor ... everything... My mother relies very much on me ... I feel there is no future for me. (In-depth interview, 15-year-old girl, Gaza City).

Both the quantitative and qualitative data did not suggest that the cash transfer makes much difference in situations where children have to work, particularly in the poorest households, where, as well as the small cash transfer, additional income is still needed to make ends meet. According to the quantitative data presented in Table 15, there are small and not significant differences between the situation of children and adolescents in the intervention and comparison groups.

The only relevant differences between the comparison and intervention groups in both territories concern 15–18-year-old boys who worked outside the household or in household chores for more than three hours a day. In the West Bank, 6.09% and 13.4% of boys in the intervention group worked outside the house and in household chores respectively, compared to 10.75% and 18.2% in the comparison group. The difference is four and five percentage points higher respectively in the comparison group, but these differences are not statistically significant. In the case of the West Bank, the most relevant difference is among those boys who continued in school even if they were working outside the house and on household chores. A significantly higher number in the intervention group stayed in school (100% against 80% who worked on household chores and 66% against 44% working outside the household). In Gaza, the difference between the two groups for 15–18-year-old boys working outside the house for more than three hours a day is very small and not statistically significant (2.0% in the intervention and 0.8% in the comparison group). While in Gaza, there is also an important difference with regard to those boys staying in school while working (72.7% of the intervention group compared with 57.1% of the comparison group), the difference is not only not significant, but based on a very small number of boys working outside the household; for this reason, it does not offer any generalisable findings.

Qualitative findings had richer information about children and adolescents involved in work in and outside the home. While all respondents in the qualitative sample were programme beneficiaries, many spoke about children (particularly boys) working to make an income, and when asked about what difference the cash transfer had made to their or their families' lives, only a couple mentioned that children were able to continue in school rather than working. This may be due to the very small amount of the transfer, which is only enough to cover very basic needs (health, food, repaying debts, and occasionally helping with school supplies); the value of the transfer is not sufficiently large to be able to substitute for an additional income in the family, which is generally still needed to cover household costs.

7.3 Exclusion based on disability

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006) recognises disability as an 'evolving concept' that *'results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'*.¹³ The Convention describes people with disabilities as including *'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their*

¹³ <http://daccess-dds-ny.un.org/doc/UNDOC/LTD/N06/645/30/PDF/N0664530.pdf?OpenElement>

full and effective participation in society on an equal basis with others' (United Nations General Assembly, 2006: Article 1).

Disability affects all aspects of children's lives. Children with disabilities in developing countries are more likely to die young than their counterparts in developed countries. It has also been estimated that 75% of children with mental disabilities are under the age of 10 (Sen, 1992: 255, in Harriss-White, 2003: 6). Disabled children are less likely to be sent to school, often because families believe that their disclosure will cause stigmatisation for the whole household, and also because disabled children are not seen as a worthwhile investment (Yeo and Moore, 2003: 574). Within our research, we paid particular attention to children with disabilities given the growing evidence suggesting that they are especially vulnerable to child protection deficits, including physical and sexual abuse – in their homes, their wider communities, and in the institutions charged with their care – reflecting systematic discrimination against and undervaluing of disabled children.¹⁴ Additionally, as many PNCTP beneficiary households have children with disabilities, we wanted to explore how the cash transfer is affecting them, and how social protection mechanisms can improve the type and quality of support available to this particularly vulnerable group.

Disability among children surveyed in our sample was higher among the intervention group than the comparison group (15.5% compared with 13.8% in the West Bank, and 11.28% compared with 9.5% in Gaza), and both figures are higher than the nationally reported figures (less than 3%). This might indicate, on the one hand, that the incidence of disability is higher among poorer households than in the rest of the population in the sampled districts, and that, as noted earlier, the targeting process gives particular weight to households who have a person with a disability. With regard to equipment and services for children with disabilities, the quantitative data revealed a statistically significant difference: only 20.75% of children in the intervention group and 4.29% of children in the comparison group in the West Bank (36.4% and 33.7% respectively in Gaza) who need medical devices and services to make their condition better reported having access to them, which suggests that there is considerable room for improvement in the attention provided to children with disabilities. Among the quantitative sample in the West Bank, however, the receipt of the transfer seems to have made a difference.

Support services for children with disabilities

The importance of professional support and skills in improving the lives of children with disabilities was shown in several cases. One 11-year-old boy with mental health problems in the West Bank, who now attends a community centre for people with disabilities in Jericho City, recalled that when he was attending a government school *'I used to like to go home and stay with my family because I don't like the school anymore because children used to bully me when at school and they used to make fun of me.'*

Another child noted that while they had received occasional support from a charity, it was usually temporary and thus of limited benefit:

Some physiotherapy female professionals from Al-Wefaq Association used to visit our home and give physiotherapy sessions to her, but they stopped after the end of their project. (Mother of daughter with spina bifida, during observation in Gaza City)

Finally, it is important to note that for caregivers in particular, the lack of adequate care facilities or provision of respite care services places a very heavy burden on their shoulders and precludes them from taking up income-generating opportunities. For adolescent children who care for another family member, full-time or part-time, this has negative consequences for their schooling, leading to bad performance or even dropout. This further reinforces family poverty and isolation, as the following quotes illustrate:

I have a special situation. I once was offered to do some sewing work, but I cannot leave Hosam [her disabled child]. Who would feed him, give him to drink, change his diapers? ... My husband, though, I swear, does not help with a single thing. He is inside. Sleeping! (Observation with mother of disabled child, West Bank)

¹⁴ Jones et al.'s (2012) meta-analysis of data on disability and sexual abuse found that children with disabilities were 2.9 times more likely to be sexually abused than children without disabilities; for children with a mental or intellectual disability, the risk of sexual abuse was 4.6 times greater.

The mothers who have disabled children are depressed, because the people in the society refuse to accept these cases. So women and families are very much stressed and burdened by these cases. (Key informant interview with director of community centre for people with disabilities, West Bank)

7.4 Mental health and psycho-emotional ill-health

Another clear outcome of the ongoing conflict and poverty in SoP is the deterioration in children's mental health conditions, which has not been adequately addressed by the PNCTP and complementary services. Part of this, as we have discussed elsewhere (see Jones et al., 2013) is due to the excessively high caseloads that social workers currently face, especially in Gaza. This means they simply do not have the time or resources to undertake psychosocial assessments of members of the households they work with, let alone ensure that adequate support is provided. But as mental health experts we interviewed highlighted, it also reflects a chronic under-resourcing of the mental health sector and the short-termist approach that many NGO programmes have adopted.

Children in the SoP face multifaceted psychosocial vulnerabilities, as reflected in our quantitative and qualitative findings. In-depth interviews with two adolescent boys, for example, reinforced the important negative spillover effects of poverty and family stress on schooling. A 17-year-old boy from Jabalia noted that, after his father was made redundant, his education suffered for several years owing to poor psychosocial health:

My educational level started dropping slowly, the low income affected my spirits. The situation was ok till grade 6, then in grade 7 I failed one topic, maths. In grade 8, I failed all topics. In grade 9, I failed two topics and grade 10, I passed them all. (In-depth interview with 17-year-old boy, Jabalia, Gaza)

Qualitative findings also reflected some positive effects of the cash transfer on the psychosocial status of beneficiary children. Most respondents in individual interviews who were asked about changes in the level of stress in the household reported that the transfer decreased tensions among family members, in part because of reduced material stresses, but also enabled parents to have more time with their children. The transfer enables adolescents to engage in social activities, and feel more 'equal' when some of their 'wants' (not only their basic needs) are met.

On the payment day, we feel happy. More people go to the market and traffic also increases. (Small group discussion with boys aged 15-17, Gaza City)

After the cash transfer, my son's self-confidence increases as he can get pocket money, at least 1 NIS, to go out with his friends. He goes out with his friend much more than before. (43-year-old participant in focus group discussion with caregivers, Jabalia, Gaza)

My children's psychological status improved after the cash transfer. When my son wants something, I ask him to wait till the payment day. He trusts me and becomes more confident. (Focus group discussion with caregivers, Jabalia camp, Gaza)

After the cash, we became more comfortable, we sit more with our children. (Focus group discussion with caregiver, a widow, Beach camp, Gaza)

When MoSA gives us money, my children's spirits improve because I can meet some of their needs. When I got 1,400 NIS, our life felt as if we are like rich people compared to our previous situation before the cash transfer. (In-depth interview with mother of 13-year-old girl with a disability, West Bank)

In the West Bank, several children highlighted an absence of adults (men or women) they could trust in the context of high levels of emotional stress:

After my aunt passed away, I stopped telling anyone about my personal issues. No one understands me. (In-depth interview with 13-year-old girl, West Bank)

... There are constant problems in the family. How am I supposed to study with so many troubles in the house? (In-depth interview with 13-year-old girl, Jericho City, West Bank)

Our findings indicated that despite the heavy psychosocial burden on poor households, particularly those with children with physical or mental disabilities, access to psychosocial support and counselling is very limited, and the services that do exist are of poor quality (according to key informants and service users alike). Also, referrals to other programmes and services are not effective, resulting in unmet psychosocial needs among many of the poorest families.

While some respondents noted that they used to be able to rely on informal support from extended family members and neighbours – both economical and psychosocial – increasingly, this was no longer forthcoming, as so many other families were experiencing hardship due to losing businesses or jobs and were also under significant levels of stress. Local mosques are now playing a more central role in reducing children's vulnerabilities, particularly through the provision of basic needs (such as food and clothes) and by organising trips during the summer, promoting sports, games and social gatherings for children.

Availability of counselling services

Although both government and UNRWA schools have counsellors, feedback on their role was generally not positive among girls (while boys seldom mentioned them). They were seen to be not only unhelpful, but even insulting and rude, and also untrustworthy (prone to breaking confidentiality).

The counsellor yells at us ... She doesn't like me ... Don't know why, I didn't do anything to her. I tried to talk to her once but when I went to her she asked me to leave because she wanted to talk only with the older girls, I was then in grade 5 ... She prefers some girls to others ... If she talked to us then we would turn to her, but she doesn't ... I'd talk to her, she would make things easier for me, relieve my sadness by psychological support. (In-depth interview with 16-year-old girl, West Bank)

Key informants generally corroborated these problems with school-based counselling, stressing that counsellors are inadequately trained to deal with children's psychosocial problems and there are too few of them to be effective in responding to children's needs (there is one counsellor for approximately 1,000 pupils). Efforts are currently underway within the UNRWA school system in Gaza to address these shortcomings, but no similar reforms are yet in place within government schools.

In addition to poverty-induced stressors, a significant number of respondents highlighted the chronic psychological ill-health they and their household members face owing to the ongoing conflict and widespread insecurity. In some cases, the effects of the conflict have been direct and severe, with close family members killed or injured.

About two years ago in Ramadan, my brother was injured by flying shrapnel during a bombardment. After he was injured he stopped working and lost his income. Shrapnel near the brain affected him and he now can't move his hand owing to nerve loss. He is paid 1,400 NIS from the Palestinian Injuries Association but spends most of the money buying medicine and for transportation to the hospital. He also takes some money from the cash we get from MoSA. Our house was also bombed during the last war [November 2012]. The damage was terrible. (In-depth interview with 16-year-old girl, West Bank)

During the bombing we were all at the same place ... My mother thought every explosion we heard was nearby, she was afraid we would end martyred. We were extremely terrified ... There were almost 30 family members in the same room, my grandfather used to ask us to sit in separated spots just in case a missile hit the place so that it won't kill us all ... Another time we had to flee from our house after the owner of a neighbouring building was given a one-hour ultimatum to evacuate the building. We rushed to the street petrified and phoned father, who told us to go to one of his friends' place. My youngest brother got sick. Even my sick [epileptic] brother had a seizure and my mother didn't know how to handle it ... (In-depth interview with 16-year-old girl, rural area of Gaza City)

While some people reported that they are able to turn to family members or close friends for emotional support, many indicated that there is a general expectation that people will just cope. There are a number of NGO programmes providing short-term group therapy, but there was a general sense that the support provided was not of adequate quality.

As part of the quantitative research for this study, we conducted a strengths and difficulties questionnaire (SDQ) survey¹⁵ with adolescents in both the intervention and comparison groups to gauge the types of psycho-social vulnerabilities young people are experiencing, how resilient they are in the face of these, and what types of support and resources they can draw on (see Table 15). Importantly, this component of the questionnaire aimed to identify whether there were significant differences in the SDQ scores of these two groups, which could perhaps be linked to the PNCTP. The data showed, however, that there are no significant variations in the proportion of abnormal SDQ scores between the intervention and comparison groups. Most adolescents scored 'normal', with the figure ranging from a mean value of 74% in the West Bank and 82% in Gaza. Gender differences were not statistically significant either, though more girls scored 'normal' in both territories. Similarly, there is a slightly lower proportion of abnormal SDQ scores in the intervention group (7.55%) than in the comparison group (9.18%) in Gaza, while the difference is the other way around in the West Bank, with 15.91% abnormal scores in the intervention group and 10.75% in the comparison group. However, the differences between the two groups were not statistically significant. These data could suggest that the PNCTP has no significant effect in increasing resilience and promoting a positive mental health status among beneficiary adolescents.

In terms of the hope scale, which measures an individual's belief in their ability to complete tasks and reach goals, and which we hypothesised might generate interesting data about differences between the intervention and comparison groups, the data similarly showed no significant variations. Interestingly, a substantial minority exhibited low hope scores: 40% (Gaza) and 33.3% (West Bank) of the intervention group, compared with 35% (Gaza) and 30% (West Bank) of the comparison group. The self-esteem index - where questions reflect adolescents' images/perceptions about their house, clothes, school items and work - showed no significant variations between the two groups. In the West Bank, self-esteem scores were lower overall than in Gaza, with lower scores given by the comparison group. Nevertheless, adolescents from the intervention group expressed greater hopes about their situation than those in the comparison group. Also, self-esteem scores were higher (in Gaza) among those from cash transfer beneficiary families than non-beneficiary families, but variations were not statistically significant. On the self-efficacy scale, which is used to predict ability to cope with daily stresses as well as adaptation after experiencing all kinds of traumatic life events,¹⁶ both the intervention and comparison groups scored very high (more than 90%) in both territories, with a higher proportion in the intervention group (73% in Gaza, 60% in the West Bank) than in the comparison group (68% in Gaza, 64% in the West Bank). Females also scored higher than males on the self-efficacy scale in Gaza, with a statistically significant difference (females 72%; males 69%), but there was no evident difference in scores by gender in the West Bank.¹⁷

The self-esteem index contained nine questions, with the mean score then calculated. Among the questions, having appropriate clothes was of particular concern for the intervention group and the comparison group, with 66.2% of both groups feeling ashamed of their clothes. This was also echoed in the qualitative findings, as the following quotes illustrate:

If I don't have a suitable dress, I wouldn't go to the party. (Girl participant in small group discussion with 15-17-year-olds, Gaza City)

I don't go with my cousins during feast, because they wear new clothes, but I'm not. (In-depth interview with 14-year-old girl, north Gaza)

There were some small differences between the intervention and comparison groups regarding adolescents' perceptions about gender roles, which generally reflected male-dominant perspectives. This implies little influence of the cash transfer in this regard, and is not surprising given the absence of awareness-raising components on gender roles that some cash transfer programmes (e.g. in Latin American countries and in the Philippines) have.

¹⁵ The strengths and difficulties questionnaire is a brief behavioural screening questionnaire for young people aged 3-16. There are several varieties of this tool, which is commonly used by researchers, clinicians and educationalists. In our research, we only included an SDQ for adolescent participants.

¹⁶ <http://userpage.fu-berlin.de/health/engscal.htm>

¹⁷ This is in keeping with an earlier study by Quota et al. (1995).

We can conclude that the overall psychosocial status of children benefiting from the cash transfer, particularly in Gaza, is slightly better than that of their counterparts in the comparison group; still, the cash transfer appears to have had limited impact in addressing children and adolescents' psychosocial vulnerabilities.

Aside from schools, some NGOs provide psychosocial support services, but these generally concerned recreational activities rather than professional, individualised support. In any case, awareness of such services among our sample respondents was very low, suggesting that many children with psychosocial needs are not being reached.

Table 16: Adolescents' responses by psychosocial-related variables

Variable	Group			Gender		
	Intervention n=106	Comparison n=98	P value	Male n=100	Female n=104	P value
% of adolescents with normal S&D survey score	81.13	84.69	-	79	90	-
% of adolescents with borderline S&D survey score	11.32	6.12	-	9	9	-
% of adolescents with abnormal S&D survey score	7.55	9.18	-	12	5	-
% of adolescents with high hope most of the time (29-36 points on hope scale)	20.95	22.92	-	23.23	20.59	-
% of adolescents with average hope most of the time (22-28 points on hope scale)	39.05	41.67	-	37.37	43.14	-
% of adolescents with low hope most of the time (6-21 points on hope scale)	40	35.42	-	39.39	36.27	-
% of adolescents who think they are doing pretty well (a lot, most and all of the time)	59.43	56.12	-	56	59.62	-
% of adolescents who reported making plans for future study and work	92.9	90.6	-	87.1	96.1	Less than 0.05
% of adolescent reporting that studying hard will be rewarded by a better job	98	96.8	-	96.7	98	-

Variable	Group			Gender		
	Intervention n=106	Comparison n=98	P value	Male n=100	Female n=104	P value
Sense of inclusion						
% of adolescents reporting that, when at shops/market, treated by others with fairness and with respect	94.3	87.5	-	90	92.1	-
% of adolescents reporting that adults in the community treat them worse than other children their age	20.2	15.5	-	21.4	14	-
% of adolescents reporting that other children in their class treat them with respect	89.8	95.7	-	92.2	93	-
% of adolescents reporting that other pupils in the class tease them at school	19.8	13.2	-	20.2	13.3	-
% of adolescents reporting that teachers treat them worse than other children	10.4	12	-	12.4	10.1	-
Mean self-esteem index (out of 100%)	0.73	0.68	-	0.69	0.72	-
Gender roles			-			-
% of adolescents reporting that teenage boys and girls should be treated equally in all things	74.53	78.57	-	72	80.77	Less than 0.05
% of adolescents reporting that it is ok if parents put more restrictions on teenage girls than on boys' movement outside the house	64.15	60.2	-	68	56.73	-
% of adolescents reporting that it is ok if parents expect teenage boys to do fewer household chores than teenage girls	44.34	46.94	-	55	36.54	Less than 0.01
% of adolescents reporting that it is ok if parents expect teenage boys to spend less time taking care of other family members (e.g. younger	51.89	48.98	-	50	50.96	-

Variable	Group			Gender		
	Intervention n=106	Comparison n=98	P value	Male n=100	Female n=104	P value
siblings or sick family members) than teenage girls						
% of adolescents reporting that it is ok if parents expect teenage boys rather than teenage girls to drop out of school to support family income	22.64	24.49	-	22	25	-
% of adolescents reporting that, for women, it is more important to get married than to go to college	5.66	8.16	-	10	3.85	-
Methods of discipline						
% of adolescents reporting that physical punishment is ok for adults to discipline teenagers	10.38	12.24	-	15	7.69	-
% of adolescents agreeing with adults not allowing children to go out as a method of disciplining them	32.1	33	-	31.3	33.7	-
% of adolescents reporting asking for an explanation as to why their behaviour was wrong	98.1	96.9	-	97	98.1	-
% of adolescents reporting agreeing with insulting adolescents	5.7	6.1	-	8	3	-
Benefiting from extra income						
% of adolescents reporting benefiting from additional income to the household such as cash transfer and others	88.7	63.3	Less than 0.001	76	76.9	-
% of adolescents reporting having more food from the additional money	80.7	67.7	Less than 0.05	76	75	-
% of adolescents reporting having more school items such as stationery from the additional money	62.4	41.9	Less than 0.01	52	56.3	-

Variable	Group			Gender		
	Intervention n=106	Comparison n=98	P value	Male n=100	Female n=104	P value
% of adolescents reporting having more clothes from the extra income	73.1	64.5	-	78.7	61.3	Less than 0.05
Social capital						
% of adolescents with no one to talk to about problems	8.91	9.38	-	9.18	9.09	-
% of adolescents who belong to a religious/social/sport club	27.62	21.43	-	29.29	20.19	-
% of adolescents usually invited to go out with friends	60.38	60.2	-	77	46	Less than 0.001
% of adolescents who don't go out with friends when invited because of money-related issues (not enough money, no right clothes)	21.54	15.25	-	15.59	22.41	-
% of adolescents who don't go out with friends when invited because their parents are strict	20	16.9	-	9.1	34	Less than 0.001

Key: ~ $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$; P-value for two group test of proportions

7.5 Inadequate parental care

Even accounting for the considerable variation in norms regarding acceptable childcare practices between and within different societies and cultures, children from low-income families are disproportionately more likely to receive inadequate care (Marcus, 2013).¹⁸ This was reflected in our quantitative findings in Gaza and the West Bank, which indicated that child safety is being jeopardised, with between 30% and 40% of children under 12 years of age reported to have been left without any kind of supervision for several hours of the day. This practice was also more evident among the comparison groups: while the difference between the two groups was not statistically significant, the frequency with which young children are left unsupervised suggests an issue of concern that merits further investigation.

Similarly, around a quarter of the surveyed study population do not worry about their children when leaving them alone as they believe that children can take care of themselves. Yet more than one-third of children surveyed had had some kind of accident in the year preceding the survey,¹⁹ with the rate being higher among the comparison group than the intervention group in Gaza (37.2% compared with 32.7%) but higher for the intervention group in the West Bank (30.1% compared with 26.5%), though the difference was not statistically

¹⁸ It is critical to note that the definition of 'inadequate care' focuses on broader structural problems, including poverty and inequality, rather than assuming that care deficits are a matter of wilful parental neglect.

¹⁹ Respondents were asked about the following accidents: swallowing drugs/pills/medicine; swallowing something poisonous; swallowing foreign body; falls; burns; cuts; drowning

significant in either case. This indicates that there are serious gaps in the ability of parents to provide adequate supervision and care for their children. In a context where most mothers stay at home rather than leave the home to work, this level of inadequate care might result from the domestic burdens that fall on the main caregivers, particularly given large family sizes. This resonates with reports from the Ministry of Health, which indicate that accidents are the leading cause of death among children over the age of one in Gaza (MoH, 2012).

The mean number of weekly hours parents spend focusing exclusively on their children was generally low, although higher among the intervention group than the comparison group, with strong statistically significant findings in Gaza. In the West Bank, a higher proportion of children under 12 were left without parental supervision for anywhere between one and five hours, a practice that was more evident among the comparison group.

Not more than one-third of the caregivers we surveyed were adequately informed about places that provide child protection services, with the proportion being slightly higher among the intervention group than the comparison group (especially in the West Bank). The findings suggest that there is more information about related social services available to the intervention group, with two-thirds of them reporting having access to relevant information. Knowledge about legal services is weak, suggesting that the PNCTP is not only inadequately informing beneficiaries about resources available in the community to support them in meeting their children's needs, but is also failing to facilitate linkages with other child-related programmes being implemented by MoSA and other ministries and agencies. For instance, UNICEF supported MoSA in the development of multi-sectoral child protection networks as a forum for advocating for and tackling issues around child protection, but our qualitative findings suggested that PNCTP beneficiaries had very limited knowledge of these networks. Even cash transfer beneficiaries who are visited by a social worker do not know about child protection and legal services, when this could be a relatively easy way for such information to be relayed to them. Lack of awareness about the available services restricts people's access to them and subsequently limits take-up rates.

8 Effects of the PNCTP on children and their households: participation

Children's right to participation in family and community life, and in decisions that affect their lives, has arguably received the least attention in discussions on child-sensitive social protection. In this section we explore some of the experiences of children with regard to their participation in different spheres, focusing on the type of services and support children have access to within the community that facilitates their participation in family and community decision-making. We also consider whether belonging to a PNCTP beneficiary household has had any effects in terms of building adolescents' social capital in school and in the wider community.

8.1 Decision-making within the family

A critical dimension of children's right to participation is their right to participate in decisions within the family, in line with each child's evolving capacities. However, the context of poverty in the SoP and hierarchical cultural norms around parenting have combined to limit the opportunities for the children in our sample to participate in family decisions, or even to be aware of their rights, as the following quotes highlight:

If my father beats me, I don't tell anybody. He is my father, and he can do whatever he wants. (Girl participant in small group discussion with 15–17-year-olds, Beach camp, Gaza)

Father does not care about our views, he comes home from work then goes to sleep ... And you must give him money when you work to keep him silent. (In-depth interview with 14-year-old boy, Jericho, West Bank)

Moreover, participation and decision-making seems to be highly gendered, with small group discussions with girls in the West Bank suggesting that decision-making processes were exclusively the realm of male members of the family.

In the case of the PNCTP, while many children noted that they requested small presents or treats from their parents on payment day and that many parents did their best to meet these requests, there was no strong sense that household priorities about how best to use the cash were discussed with children. So the material items received were seen as 'gifts' rather than 'rights'.

8.2 Knowledge of services and other support available to children

Being aware of and having access to support services is a critical component in ensuring that children are able to participate actively within their community. Most adolescents living in similar kinds of areas identified similar services with the same providers, typically a combination of NGOs and charitable (often religious) institutions. Mosques emerged as an important service provider of spiritual and social support as well as direct assistance (food parcels, hot meals and clothes). However, little effort has been made to leverage and coordinate this support with state provision.

It is also the case that much of the support that is potentially available to children and their families is not actually taken up because of cost barriers – both in terms of fees or transport costs (for recreational activities, for example) or stringent beneficiary criteria, such as summer camps targeted at UNRWA school students in Gaza or targeting based on social/political affiliation (*wasta*), which was mentioned by a couple of respondents. Boys

seemed to feel the lack of recreational activities particularly acutely: while they generally had more opportunities to socialise outside the home than girls, in comparison with boys from better-off households they felt relatively more disadvantaged by household income constraints. Interestingly, the small group discussions held with girls echoed these sentiments, highlighting the internalisation of gendered social norms, particularly reflected in terms of girls' restricted mobility, which limits their entire scope of activities outside the home.

In the West Bank, a significantly smaller proportion of adolescents reported belonging to social groups, the figure being higher among the intervention group. Some individuals reported one-off assistance from UNRWA and neighbours, and members of the community (interview with caregiver, Jericho). However, here too, cost barriers and family restrictions (in particular for girls) were also observed to affect adolescents' ability to take up available recreational activities.

I stay all the time at home. Sometimes I visit my friend and we talk with each other, tell each other stories, only once a month I visit her, my family does not allow us to visit friends. (13-year-old girl participant in small group discussion, West Bank)

It is also important to note that there was no evidence of any efforts invested in trying to include children in any aspects of PNCTP programme governance – including, for example, participation in the community fora that support targeting decisions and grievance redress. Part of the problem, as discussed elsewhere, is that these committees in the West Bank largely comprise of key community figures who are consulted in an individual capacity rather than as part of a dedicated and actively functioning committee (see Jones and Shaheen, 2012).

8.3 Social capital

There is growing interest within social protection policy circles around how to improve understanding of the effects of social transfers not only on raising living standards, but also on improving social relations. Theoretical linkages are increasingly being drawn between social protection and social cohesion specifically (Babajanian, 2012). Social cohesion enables citizens to enjoy a sense of stability, belonging and trust, and offers opportunities for upward social mobility. Conversely, the absence of or low social cohesion can trigger or reinforce social instability, civil conflict, and crime (OECD, 2012; DFID, 2005). The implementation of public policies, such as social protection or redistributive reforms, is often more effective in cohesive societies where politicians have more room for manoeuvre than in less cohesive societies (Easterly et al., 2006, in OECD, 2012), which has important implications for poverty reduction and inclusive growth, state-building and state legitimacy (Pavanello et al., 2013). In the case of children and adolescents, understanding the effects of cash transfers on social capital is important not only because of its implications for their developing a sense of identity (a critical part of adolescence), but also because of potential effects on their education and psychosocial wellbeing.

Among girls especially, there was a strong sense that school provided a key outlet from the confines of the home, and that those who had had to drop out because of having to care for members of their family or do other family work, and/or for financial reasons, were much more socially isolated. That said, a number of children in our sample emphasised that poverty often stood in the way of positive social relations with other children. A total of 40% of adolescents surveyed in Gaza and 24% in the West Bank reported not being invited to go out with friends. There was a statistically significant difference between adolescents in the intervention group (67.04%) and comparison group (85.86%) in the West Bank, but no difference in Gaza. The gender difference is statistically significant in both territories, however, with more adolescent boys (86.7% in the West Bank and 77% in Gaza) than girls (67.7% in the West Bank and 46% in Gaza) saying that they are usually invited to go out with friends. This difference reflects cultural restrictions on girls' mobility outside the home, which are particularly strong in Gaza.

Furthermore, more adolescents in the intervention group (20%) than the comparison group (15.5%) reported being teased by peers, with boys experiencing this more than girls (21.4% compared with 14%). As one 11-year-old girl explained:

I used to have three or four friends at the first grade. But now I have just one. I have fewer now because I have no money. My friends like the girls whose fathers work, they arranged meeting together and bring gifts and things to eat. But they don't invite me. They told me how can I join them while I can't afford to buy stuff. (In-depth interview with 11-year-old girl, Gaza City)

Similarly, a 14-year-old girl noted that social class often played a divisive role in the school environment:

I sit next to the ordinary girls at school, not the wealthy girls ... I don't like to humiliate myself ... They act arrogant and brag. There was only one [wealthy] girl who wasn't – I loved her so much, her father was a teacher but she was down to earth despite being a top student. She didn't act arrogant and dismiss other girls. (In-depth interview, Gaza City, Tufah rural area)

According to findings from the adolescent survey (see Table 15, section 7.4), in the West Bank, the chances of adolescents in the comparison group being invited to go out with friends and participate in social events were reported to be higher; only a small proportion reported not being able to go out with friends because of money-related issues, with this being double the proportion reporting the same among the intervention group. By contrast, the proportion of adolescents who had someone to talk to was less overall than in Gaza, although higher among the intervention group. There were also differences between the number of adolescents reporting belonging to a social group, the number being greater among the intervention group.

Slightly fewer adolescents reported that their teachers treat them worse than other children in the West Bank compared with Gaza, and slightly fewer adolescents in Gaza reported that they are treated with fairness and respect by others outside the home (e.g. at shops and markets).

Having discussed the effects of the PNCTP on children's rights to survival, development, protection and participation based on the findings of our qualitative and quantitative research, the final section of this report presents our conclusions and recommendations.

9 Conclusions and recommendations

9.1 Conclusions

Palestinian children and adolescents suffer from a wide range of vulnerabilities, which can have long-lasting effects on their wellbeing and their physical and psychosocial development. Many of these vulnerabilities are directly linked to poverty and economic hardship, while others are indirectly linked, triggered by other stressors within the household and community, including gender inequality, violence, lack of opportunities, and an environment of instability. These vulnerabilities are exacerbated by the protracted Israeli–Palestinian conflict and occupation. Particular groups of children are often especially vulnerable to these circumstances, including: children with disabilities; those living in families where parents are in a situation of depression or despair (often linked to unemployment); children from marginalised ethnic groups, such as the Bedouin in the West Bank; and those children and young people who are most exposed to violence and insecurity in their wider community. There are gender-specific vulnerabilities too, wherein the need for boys to earn an income to contribute to the household affects their development and the opportunities they can take up; while discriminatory social practices and attitudes have major consequences for girls’ mobility outside the home and their personal development.

Effects of the programme: covering general household needs

The PNCTP does, to some extent, contribute to children’s right to survival; it helps households cope with economic hardship and meet children’s basic needs, such as being able to buy more nutritious food, paying some school- and health-related costs and, importantly, contributing to household debt repayment, which is a major source of stress in Gaza and the West Bank. The provision of health insurance as a complementary entitlement for beneficiaries means that households with people (including children) who have a disability or a severe or chronic illness, are able to cover most of the economic costs related to their care – support that is greatly valued by the families concerned. As such, the PNCTP contributes to meeting many essential household needs that affect children directly, and contributes to improving their emotional and mental wellbeing in an extremely pressured and challenging situation.

However, most respondents noted that the amount of the transfer was too small to make a significant contribution to their or their children’s physical or emotional wellbeing, particularly in a context of large families and limited opportunities for the cash transfer to serve as a ‘springboard’ to other income-generating initiatives (e.g. through access to micro-credit or vocational training), or investment in higher levels of education that could make the impacts of the PNCTP more transformational. For example, limited income opportunities and low household income still push many children and adolescents from beneficiary households into work, at the cost of their education and longer-term opportunities.

Limits in addressing children’s specific needs

Our findings reveal that the PNCTP is not sufficiently child-sensitive to fully address children’s poverty from a multidimensional perspective. This largely reflects the fact that it was not designed to address the specific and wide-ranging vulnerabilities and needs of children and young people, focusing instead on the needs of target households as a whole. In terms of programme design, the wellbeing of children is understood in the context of household wellbeing; targeted support to children as individuals is not therefore regarded as necessary (except in the case of children with disabilities, who have specific requirements for which extra money is needed). While the programme is being effective in helping families meet some of children’s basic needs (both through the additional cash income it brings and other entitlements, from food aid and health insurance, to school fee waivers), **the programme and its complementary services do not provide sufficient support to meet children’s emotional and psychosocial needs** or to realise their right to protection and participation. These needs are strongest among certain groups of vulnerable children that are not fully supported by the programme. They include: children who lack adequate parental care; children who are exposed to violence in the home,

school or wider community; children with disabilities; girls, for whom the heavy restrictions on their mobility outside the home (particularly in Gaza) prevents them realising their right to education or leisure; and children from Bedouin households, who suffer social exclusion and are often unable to access basic services. These are core child protection concerns that could be effectively addressed through a more child-sensitive social protection approach that improves linkages between social protection and child protection systems.

Beneficiaries who were interviewed for this study – children and young people, and adults – almost consistently emphasised that they would be worse off without the cash transfer, and most parents were more hopeful about their children’s future because of it (as reflected in data from the quantitative survey and discussions during qualitative interviews). We can conclude therefore that while the programme contributes to children’s right to survival, its effects on children’s rights to development, protection and participation are less evident, but could be strengthened through some specific measures (see Table 16 for detailed policy recommendations designed to make the programme more relevant, effective, sustainable and child-sensitive).

One of the PNCTP’s strengths is that it is well targeted to the poorest and most vulnerable households, as confirmed by recent studies by the World Bank and European Union (Hackstein et al., 2013; World Bank, 2012a). But its overall impact on children’s lives is undermined by the fact that it does not take into consideration the complex intra-household dynamics that exist, including gender inequality, and the specific needs of children and adolescents of different ages across the four dimensions of children’s rights. As noted in our analytical framework (Section 2), cash transfer programmes are increasingly being designed to link to a range of complementary services as part of a comprehensive national ‘social protection package’ that is more effective and sustainable in meeting the needs of target beneficiaries. In this light, the PNCTP could be used as the axis for a better coordinated social protection package – one that provides more comprehensive support services for children and young people that directly address their broader vulnerabilities and needs, and creates an environment in which they could begin to realise their rights to development, protection and participation too. As part of a comprehensive social protection strategy it could focus on increasing access to child protection services, and referrals to other supportive services that could strengthen children and adolescents’ resilience and development. Beyond the provision of basic economic support – which is crucial – there is scope for integrated social protection interventions to reinforce children’s sense of inclusion and to create an environment where they have access to trusted adults and peers who can provide counselling or advice for those going through challenging circumstances whether at home, at school, or in their wider community.

Addressing children and adolescents’ priorities

The children and adolescents interviewed generally had different priorities to those of their parents or caregivers. For example, among the greatest concerns mentioned during small group discussions with adolescent girls and boys were the need for recreational spaces and activities, concerns around safety and security, violence at home and at school, illness among family members, and the lack of vocational opportunities. Household income poverty and unmet needs consistently came up in discussions with adolescents, so the ranking of adolescents’ concerns does not mean that adults’ worries about meeting children’s and their families’ basic needs as primary caregivers are not important to children. It does, however, illuminate the fact that children’s worries and needs go beyond their basic survival needs, and so programmes need to be multi-faceted to have maximum impact on the different aspects of children and young people’s lives.

The adolescents interviewed generally noted that the cash from the PNCTP is very important to them and their families. They commented that it helps them gain access to items that are important to them, including toys or games and clothes, which means they can participate in social activities and recreational activities, including school trips. Conversely, children who were not able to participate in social or recreational activities with their peers, for various reasons, felt this as a very negative aspect of their lives, which prevented them building friendships with peers or protective relationships with trusted adults.

The qualitative component of the study also found that the programme had a particularly important effect on helping poor families meet some of the additional economic costs of caring for a child with a disability, in terms of the support provided through the complementary health insurance component. However, most children and their caregivers in this situation acknowledged that the cash was still insufficient to provide for all the economic

costs involved, from regular costs (such as diapers or transport) to one-off costs (such as specially adapted equipment).

Children's views on how the programme could be improved

When asked how the programme could be improved, the most common response from children and adolescents was that the value of the cash transfer should be increased, because the amount is too low and the money is quickly spent. However, there appear to be different perceptions based on the level of poverty experienced: children from the very poorest households see the contribution made by the transfer as significant, while those from slightly better-off families see it as making only a marginal contribution.

Overall, however, children and adolescents had a very limited understanding about what the cash transfer in particular – and social protection more generally – is designed to achieve, and its limitations. In the context of the economic and material shortcomings that are common in the SoP, questions posed to children about how the PNCTP could be strengthened resulted in many answers that were well beyond the remit of any social protection programme; for example, some wanted MoSA to provide computers, bicycles, recreational activities, clothes for special occasions, and even video games. This indicates that MoSA – possibly through the social workers who are the main point of contact with beneficiary families – could do more to provide information about the rationale behind the programme and to manage household expectations about what the PNCTP can do, including how it can help families meet children's needs. This is imperative, as misperceptions about the programme can undermine its perceived usefulness among beneficiaries.

When asked how the programme could be improved, a common response among adolescents was for MoSA to either provide or refer beneficiaries to vocational training programmes. Girls, for example, said they would benefit from learning skills in areas such as sewing and hairdressing – particularly girls living in refugee camps, where livelihood opportunities are even more curtailed. Others called for scholarships to support them in the latter years of high school and especially for university. (While we are aware that some beneficiaries receive support for their children's education through fee waivers, this does not seem to be systematic, and information about eligibility and application procedures is not widely disseminated.)

These responses suggest that adolescents understand that the PNCTP is currently not a stepping stone for them to achieve economic independence – something they regard as essential for their future. Younger children, on the other hand (aged 11-14), said that they would like the PNCTP to provide support in the form of school supplies, uniforms and bags. Boys and girls in this cohort were generally still attending school, but noted the difficulties of continuing to do so when their parents could not afford essential school items. The shame this brought on the children acted as a disincentive to continue to attend school (as noted in Section 6).

Strengthening programme relevance and effectiveness by addressing intra-household dynamics

Intra-household dynamics play a key role in terms of the impact of the cash transfer on children's lives, independently of their specific needs. While most households prioritise using the transfer to help meet children's basic needs, this is not always the case. For example, a child with a physical disability in Gaza noted that her father spent most of the transfer on drugs for his personal consumption, so it brought very little benefit to her and her siblings. Similarly, a girl in the West Bank whose father was chronically ill said that there was not enough money to care for her own illness, as resources were spent on her father's health needs; another child with a disability noted that while MoSA had donated a car to her family to help her travel to a special school, the father was using the car for a taxi business and no longer had time to take her to school. Though these were not common scenarios –most caregivers confirmed that the cash transfer and much of the regular debt incurred by the family was spent on good and services benefiting children – they could be counteracted by establishing 'soft' conditions that would guarantee that children always benefit from the transfer and its complementary services.

The small size of the transfer inevitably means that the full range of vulnerable children's needs cannot be covered; as noted, adolescents often have to work, either as well as continuing in school or in place of it (dropping out). Though the programme nominally promotes schooling through fee waivers, lack of coordination with the Ministry of Education means that, in practice, many children in beneficiary households do not benefit from this intended support. Furthermore, the opportunity costs to the poorest households of children staying in

school are high, given the potential income that adolescents could contribute to family expenses. Though increasing the level of the transfer would be challenging – especially as it is already relatively high in terms of regional and global standards – there are other ways that the PNCTP could support children in staying on at school: for example, it could be used as a platform to link unemployed adults in beneficiary households with income-generating opportunities (without excluding the household from the programme), or consider ways to make adolescents’ partial involvement in paid work more compatible with school attendance and performance. (It should be noted, however, that given the protracted conflict and the very limited labour market opportunities available, the government and development partners may need to continue to invest in social protection at higher than average levels in the name of social justice.)

Strengthening the focus on social vulnerabilities

The PNCTP could do more to address children and adolescents’ social vulnerabilities, particularly through its support structures such as social workers, referral mechanisms, and the beneficiary database, as well as through providing strong linkages to complementary services. The social workers involved in implementing the programme currently struggle with unmanageable caseloads that result from having to collect data to determine applicant households’ PMTF score and monitor the accuracy of this data over time, so they are not able to fulfil their core professional role of supporting families, let alone intensify this support. In terms of value for money, since the social workers are already undertaking home visits, if more social workers were recruited they could spend more time in each household, not only to verify PMTF data but to help identify the specific needs of beneficiary family members, including their children, and making referrals to relevant support services. Better coordination among government agencies and NGOs involved in implementing social protection programmes, as well as more and better information for beneficiaries, could increase the effectiveness and efficiency of the PNCTP and its complementary programmes, particularly in terms of the extent to which they are child-sensitive and responsive to children and adolescents’ varied needs.

The importance of enhancing coordination among government, development partners and civil society actors

Despite the many local and international organisations or groups working to support children in Gaza and the West Bank, many children are still not being reached. Services currently provided by the government, NGOs, charitable and religious institutions are useful and important, but they are still unable to provide support in a comprehensive and systematic way that responds effectively to the range of challenges that children and adolescents face. This implies a strong need for greater coordination among those organisations, at different levels. It is essential to reinforce coordination, networking, information sharing, policy development, and advocacy. There needs to be a stronger evidence base about children’s vulnerability – including evidence given by children themselves – and monitoring of relevant indicators in order to inform a more adequate and effective policy and programme response.

While the PNCTP is an important policy intervention, it still operates as a humanitarian programme, rather than a developmental programme aimed at helping beneficiaries graduate out of poverty in a more permanent way. This is largely the result of a context in which there are very limited income-generation opportunities, triggering dependence on the cash transfer. As such, there is an urgent need for the government and donors to support the local economy and the livelihood options of families, particularly adolescent boys, girls and young women, including free movement of goods and people, regular supply of energy/electricity, employment opportunities, domestic industries, and a safe and secure community environment.

At the management level, the PNCTP is working independently from other programmes. The PNCTP’s management rarely considers children’s needs as distinct from household needs, principally because the household is the unit of focus for the programme. They regard children’s issues as being the responsibility of the Child and Family Division, rather than exploring how the PNCTP can specifically support children through MoSA interventions. In this light, it is vital that child protection is not seen as a complementary ‘add-on’ to social protection, but rather as an integral component of relevant social protection policies and programmes.

Our findings indicate that child-sensitive social protection could maximise the PNCTP’s impact not only on the poorest and most vulnerable children but also their families – the very same target group of the programme. Thus, better integration of the different assistance programmes implemented by MoSA is essential. The PNCTP

database is a good starting point for targeting relevant policies, and the social workers currently involved in the programme could be better supported to give the specialist inputs they are trained to provide to the families with whom they work.

In sum, the programme is both **relevant** for children, in a context of substantive challenges that render them extremely vulnerable, and **effective**, in that it helps their families to partially meet their basic needs. Income poverty and lack of sustainable income-earning opportunities are two of the major problems faced by Palestinian households, and the cash transfer contributes to raising household income. However, more complex problems that affect the trajectory of children and young people's lives, including protection, participation and development challenges, are not being sufficiently addressed by the programme or complementary initiatives. What is needed is a relevant, comprehensive social protection package that takes the full range of children's vulnerabilities into account, alongside income poverty, to deliver a more child-responsive, developmental and transformative cash transfer programme that benefits children and their families.

9.2 Policy recommendations

A number of key policy and programming recommendations emerged from our findings (see Table 16). Given that the PNCTP is national in nature, many of these apply to both Gaza and the West Bank. Where there are differences, we have specified these. It should be further noted that in the West Bank, our qualitative research was concentrated in the Jericho/Jordan Valley area, so the recommendations that are directed at MoSA and its development partners, including UNICEF, relate to the programme as it is implemented in this area more specifically.

Table 17: Recommendations to make the PNCTP and related social protection interventions more child-sensitive

Policy area	Recommendation
<p>Fostering stronger synergies between child protection and social protection systems</p>	<p>Findings reveal that poorer households are more likely to have children who require a child protection response (because, for example, in the case of children with disabilities, their families may be unable to meet their needs, or because children experiencing violence or high levels of stress will need access to psychosocial support). This suggests that better synergies are needed between social protection and child protection systems in the SoP to ensure that the social protection system is better placed to respond to or appropriately refer children identified as having significant vulnerabilities.</p>
<p>Addressing gender-specific issues</p>	<p>For caregivers, while cash transfer programmes that target women as beneficiaries (such as those in Latin America) are thought to have an important but limited empowering effect on women at the intra-household level, evidence from this study and other recent PNCTP evaluations (e.g. Jones and Shaheen, 2012) suggests that women are often subject to strong social control by male members of the extended family, even when they are not financially dependent on them. Thus, while targeting women as beneficiaries may have some impact on increasing child-sensitive spending, this would be limited by their inability to control or make decisions over the use of resources. Arguably, it would be more important to provide fora for women to regularly meet with other women and discuss issues of importance to them and their families, thereby breaking down the social isolation and some of the psychosocial stresses that the qualitative findings indicated were pervasive among programme participants, enabling to provide better care and support to their children.</p> <p>Because girls are more socially isolated than boys, the need for gender-segregated safe spaces for leisure and for participation is acute – and arguably more so in Gaza, given the conservative religious norms that determine appropriate behaviour for girls and boys. Girls noted that they would welcome opportunities to discuss issues affecting their lives with girls in similar situations (along the lines of the focus group discussions undertaken for this research), mediated by an independent third party.</p> <p>Given that girls are more likely to be called on by their parents to help shoulder family care burdens, provision of respite care – such as community-based crèches or centres to care for people with disabilities – could potentially help girls to better manage their educational and domestic care responsibilities/duties. These could also offer work opportunities for women and men who are currently unemployed.</p>
<p>Streamlining social workers’ caseload and mandate</p>	<p>The programme should strengthen social workers’ interaction with all members of beneficiary families, not just parents or caregivers, so that they can identify children’s needs. As a first step, social workers’ excessive caseloads should be reduced so that they have time to interact and engage in a meaningful way with all members of the beneficiary household, including time needed to carry out regular follow-up. Social workers also need to clearly understand that part of their role is to help ensure the physical and emotional wellbeing of children and young people in beneficiary households.</p> <p>This will require investment in more social workers, with adequate training.</p>

	<p>It is also critical to strengthen communication between social workers and beneficiary households about the aims and rationale behind the PNCTP so that beneficiaries have clear and transparent information on any changes in payments and processes relating to the programme. Communications for development (C4D) can play an important role facilitating these communications. UNICEF conceptualises C4D as a mechanism for engaging communities and listening to adults and children as they identify problems, propose solutions and act upon them. Communication for development is seen as a two-way process for sharing ideas and knowledge using a range of communication tools and approaches that empower individuals and communities to take actions to improve their lives.</p> <p>In other social protection programmes, community facilitators have been used to provide more effective routine follow-up (facilitators are people, often women, who are based in and therefore trusted by the community, and perhaps have even graduated out of the programme themselves). This role could be introduced in the PNCTP, providing the individuals concerned with an honorarium rather than a salary. It could be an effective way of improving communication and impact, and building the skillsets of women, who may never have been part of the workforce, therefore giving them a much-needed opportunity to develop skills.</p>
<p>Investing in capacity-building for other government staff interacting with children (e.g. teachers, counsellors) and strengthening referral systems</p>	<p>Given the multidimensional vulnerabilities that beneficiary children face, it is key that other professionals interacting with children – particularly social workers working for the PNCTP who visit poor and vulnerable households on a regular basis - are also provided with capacity-building opportunities, including how to refer children in need to specialist support services. Children reported experiencing very high levels of violence from teachers, so providing more training for teachers and schools in non-violent forms of discipline and child motivation would help ensure that children’s rights are respected, and would also improve school performance and motivation.</p> <p>While many of the children interviewed said there were school counsellors at their school, they were mostly not valued because they often breached children’s confidentiality, which undermined trust in the counsellor’s role. Many children, however, expressed a strong need to have trusted adults outside their families in whom they could confide; reforming and strengthening the role of counsellors (based in schools and in health centres, to reach out-of-school children) would therefore seem to be an important step forward. MoSA has strong links with the ministries of education and health, and thus there would be opportunities for coordinated capacity-building and learning processes, as well as for strengthening cross-sectoral referral systems to support the most vulnerable children.</p> <p>Gaza: Important learning could be derived from UNRWA, which is currently rolling out training of counsellors.</p>
<p>Developing a broader and better tailored package of child-sensitive social protection services</p>	<p>Globally, as well as in the SoP, there is increasing recognition that economic support (such as cash transfers) in isolation are inadequate to tackle the intersecting economic and social vulnerabilities faced by children and their families, and thus a broader package of services support/ interventions is required.</p> <p>The PNCTP is already providing some complementary support to beneficiaries (through health insurance, food aid, and tuition fee waivers or school equipment subsidies), and our findings, as well as those from other recent assessments of the PNCTP, underscore the importance of these complementary services. But they also indicate that an</p>

	<p>even broader support package is needed if meaningful and sustainable changes in the lives of the poorest and most vulnerable children are to be achieved.</p> <p>Additional complementary services that should be considered – through linkages to government and non-governmental entities, including faith-based organisations – include: psychosocial counselling; awareness-raising about gender-based violence and related support services; child protection services; disability support (see below); low-cost recreational activities for girls and boys; awareness-raising about longer-term effects/risks of early marriage; subsidised transport; vocational counselling; awareness-raising about the risks of child labour and children’s right to education; and housing renovation support.</p> <p>In the short term, these types of linkages could be facilitated through a detailed mapping of services available at directorate/governorate level and information shared through the existing centralised database/single registry system. It is not realistic to expect MoSA to provide all these services, but it could play a fundamental role as the key coordination agency, ensuring good provision of information about available services to the poorest and most vulnerable families with children. Social workers could meet regularly with community providers to understand what services are available from non-profits and religious organisations, and work with them to identify what additional support is needed, as well as how the government could most effectively contribute to realising this support.</p> <p>Social workers visiting beneficiary households could then play a more proactive role in making referrals for household members – including women, children and young people – to existing services (whether provided by government, NGOs or faith-based organisations) to better meet the needs of individual family members in addition to the household as a whole.</p> <p>In order to avoid duplication of services and maximum equity, beneficiaries could be provided with a card which provides a record of all the services they are eligible for and those for which they are not eligible. This might also help to manage expectations more effectively.</p> <p>Gaza: In Gaza, coordination with mosques, which are a key source of service provision for children and young people, would be essential in order to ensure broader coverage of multi-sectoral interventions for the most vulnerable children. Similarly, greater sharing of information and experience between MoSA and UNRWA could be beneficial, given the very wide reach of UNRWA services in Gaza.</p>
<p>Communicating MoSA’s institutional mandate and coordination, including through improvements to feedback and grievance procedures</p>	<p>Our findings indicate a strong level of distrust towards MoSA at the subnational level. If MoSA is to play an effective coordination role, it needs to improve its communication mechanisms with the broader community – beneficiaries and non-beneficiaries – about its role, the services it offers, its procedures, and reforms. It would be important for MoSA to invest in a clear communications strategy so as to provide the requisite level of coherence in the information and messaging it generates.</p>

	Trust in MoSA and the PNCTP could also be strengthened by improving feedback and grievance procedures, with greater community involvement. This could be fostered through the empowerment of strong functioning committees rather than powerful individuals who consider beneficiary cases.
Ensuring provision of disability-specific support	<p>While MoSA has successfully implemented a poverty-targeted cash transfer programme that is in line with the international ‘gold’ standard in a relatively short period of time, it should devote more attention to addressing the full range of needs of people living with disabilities, including children and adolescents.</p> <p>Respondent families with children with disabilities noted that they received more material support from the government – in terms of specialised equipment, personal care items, physiotherapy, etc – before the launch of the PNCTP. The cash support is welcome, but for impoverished households it is inadequate to meet the complex needs of children with disabilities. In addition, given that the PNCTP focuses on the household as a whole rather than its individual members, there are no guarantees that children’s needs will be prioritised over and above the often pressing needs of adult family members.</p> <p>Caregivers certainly need support given the heightened care burden involved, but there is also a need for regular monitoring to ensure that investments are benefiting children with specialised needs, as this is not necessarily the case with the current system. In the medium term, this will require more social workers who are specialists in disability care issues, who can provide the necessary multi-layered support to children living with disabilities and their families.</p>
Linking beneficiaries to technical and vocational training for adolescent girls / boys and youth	In the case of adolescent boys and girls, improving the quality of education and providing alternative forms of higher education such as technical and vocational training might enable them to earn an income to support themselves and help their families. Given the limited capacity for young people to gain formal sector jobs in the SoP context, it is also necessary to promote entrepreneurship by fostering ideas for setting up small businesses that provide alternative goods or services.
Working with parents from vulnerable and extremely poor households to improve parenting skills and behaviour towards children	<p>Inappropriate practices for disciplining children (such as yelling and shouting, shocking, slapping, and verbal abuse) were prominent among the intervention and comparison groups. It seems that there are also serious communication gaps between adolescents and their parents, which require multi-sectoral interventions.</p> <p>Through social workers or community mobilisers (such as the facilitators proposed above), and with the support of NGOs, MoSA could do more at the family and community levels to raise parents’ awareness on issues related to positive parenting, gender equality, non-violent discipline, and the challenges facing adolescents in particular. This would help parents to provide better support to their children. Holding sessions to sensitise parents to children’s rights and needs could encourage more positive parenting practices (such as appropriate disciplining), as well as healthy social behaviour, such as taking children out for entertainment or recreational purposes.</p> <p>Our findings indicated that child safety is being jeopardised by the fact that a considerable percentage of children had been left without any kind of supervision for several hours of the day. Raising parents’ awareness about child safety and the need for adequate supervision is thus essential.</p>

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Appendix 1: Details of quantitative methodology

The quantitative component was the same utilised by the EU evaluation of the PNCTP. The Overseas Development Institute (ODI) research team partnered with local staff to collect, clean and analyse the data, and the EU team contributed to the study design and analysis of data. As such, the methodology detailed in Hackstein et al (2013) is the same as the one described here.

Sampling

Sampling frame for the household survey: Utilising the MoSA database, we constructed the sampling frame for the quantitative household survey.

Sample selection: For both samples, we employed a two-stage sampling process. In the first stage, we randomly selected smaller geographical units within governorates in the West Bank and Gaza, (i.e. municipalities, localities and towns). Recognising time and budgetary limitations, as well as security conditions, it was decided to exclude areas that were too difficult and costly to reach due to checkpoints. In the second stage, the team randomly selected households within the selected municipalities or locations to participate in the study from MoSA's database of beneficiaries and non-beneficiary households to which the proxy means test formula (PMTF) had been applied. We over-sampled within categories to ensure that the sample size was reached and sufficient interviews were conducted. When we could not find households listed in the database due to problems with addresses or phone numbers, we went onto the next sampled household.

This sample design allows for an analysis of differences in poverty and wellbeing between groups based on their cash transfer programme beneficiary status as well as extreme poverty and vulnerability status.

The West Bank

In the West Bank, we used a regression discontinuity approach to select the intervention and comparison groups. The discontinuity is based on the cut-off score from the PMTF whereby those households that were eligible for the transfer were at or just below the line of 6.39. Households just above the line, up to 6.41 – but not receiving the transfer – were eligible to be selected into the comparison group. We used this approach because there were not enough waitlisted households that had PMTF scores below the cut-off that were scheduled to receive the transfer in 2013. This allowed us to have a counterfactual that was similar to the intervention group but does not receive the transfer.

The sample was selected as follows. We determined the number of intervention households that had received the transfer for at least two years. Next, we calculated the proportion of all beneficiaries per governorate. Using the overall proportion of beneficiaries per governorate, we calculated the number of beneficiaries to select to increase representativeness in those governorates. Then we did a systematic sampling of remaining localities / municipalities. We removed several localities where the sample size for the comparison group was too small (i.e. 0 or 1 household). Next, we selected a proportionate number of households per locality. Finally, we randomly selected beneficiaries from the MoSA database. The intervention group had a PMTF score of 6.39 and were in receipt of the transfer for at least two years. The comparison group had a PMTF score of between 6.39 and 6.41 and did not receive the transfer.

Interpretation of data from the West Bank

If key indicators are better in the intervention group than the comparison group, the interpretation might be that some of this difference is due to the cash transfer. If the intervention group indicators look the same as the comparison group indicators, the interpretation might be that the transfer helped elevate these households to the standard of the better-off comparison group or that there is no change in the indicator. If the intervention group indicators look worse than the comparison group indicators, the interpretation might be that there is a minimal benefit from the transfer, but not enough to help these households move to the standard that the comparison families are at.

In general, per indicator, we interpreted findings based on the type of indicator, validation of indicators from the database where possible, and triangulation with qualitative findings.

The Gaza Strip

In the Gaza Strip, we selected an intervention group of beneficiaries with a comparison group of households that received the transfer in either March or June 2013. All of these households had a PMTF score below 6.39. We used all governorates and localities in Gaza, so that no areas were excluded. For the intervention group, we determined the number of households that had received the transfer for at least two years. Next, we calculated the number of households set to receive the transfer in March or June 2013. Using the overall proportion of beneficiaries per governorate, we calculated the number of beneficiaries to select for the sample per governorate and locality, ensuring that we had enough households in the comparison group per locality. Finally, we randomly selected beneficiaries from the MoSA database. The intervention group and comparison group had a PMTF score of 6.39 or below. The intervention group received the transfer for at least two years. The comparison group had not yet received the transfer.

Interpretation of data from the Gaza Strip

If the intervention group has better indicators than the comparison group, the interpretation might be that some of this difference is due to the cash transfer. If the intervention group looks the same as the comparison group when we examine indicators, the interpretation might be that there is no change due to the transfer. We determined this based on the indicators, validation of indicators from the MoSA database where possible, and triangulation with qualitative findings.

If the intervention group indicators looked worse than the comparison group indicators, the interpretation might be that there is little if any benefit from the transfer. It could be that the comparison group is not as poor as the intervention group. Again, we can determine this based on the indicators, validation of indicators from the database where possible, and triangulation with qualitative findings.

Fieldwork and training

The ODI team, in collaboration with the consultants working on the EU-funded evaluation, developed the survey tools to communicate on sampling issues, as well as to problem-solve during fieldwork. Two questionnaires were developed, one for households and one for a sub-sample of adolescents.

In the West Bank, the field team consisted of 15 data collectors, 4 supervisors, and 9 local coordinators who helped in recruiting and identifying households. The office-based team in the West Bank consisted of the principal researcher, a local principal researcher, a data manager, and 4 data entry people. In Gaza, the field team consisted of the principal researcher, a local principal researcher, 12 data collectors and 2 supervisors.

In the West Bank, the initial training was conducted over three days in order to become familiar with the survey tools, and to pilot and finalise them. Subsequently, there were two days of training with the final instrument,

which included practice interviews, ethical training, recruiting subjects and other topics. In the Gaza Strip, the team conducted a five-day training to cover all of the aforementioned topics.

The number of households interviewed per day per interviewer varied by location. On average, each data collector interviewed three households each day. The average length of interviews was two hours per household, ranging from between 1.5 hours and 3 hours per interview.

For some localities, the data collection was entered concurrently in order to complete the data entry on time. For the remaining localities, data entry began after the completion of data collection. Data entry took on average 20 minutes per interview. The in-country data cleaning process was then completed. The data were sent to the ODI and EU teams for further cleaning and statistical analysis.

Appendix 2: Key informants interviewed

West Bank

1. Daoud Aldeek, Assistant Deputy Minister of MOSA
2. Reema Kilani, Head of the School counselling at the Ministry of Education (MoED) and link person between MoED and MoSA
3. Counsellor in health directorate in Jericho, Department of Mental Health
4. Husam Qree'at-Head of the village council-New'meh-Jericho district
5. Director of the Community Center for the Disabled
6. Social worker, Community Center for the Disabled
7. Director of MoSA Jericho-Jericho City

Gaza

1. Eman Adwan, Director of family and childhood program-MOSA
2. Awni Abu Harbeed, Director general of disability-MOSA-
3. Kamal Abu Qamar, Director of the National Society for rehabilitation
4. Riyad Bitar, Director of CT program-MOSA
5. Social worker-MOSA, Northern Governorate
6. Ayed Abu Haloob, Dr Khitam Abu Hamad, Director of Terre Des Hommes Gaza-Child protection network
7. Dr Sami Owida, Child psychiatry , Gaza community mental health program
8. Dr Bassam Zaggout-NGO disability expert
9. Reham Agha, Social worker Family and childhood program-MOSA
10. Dr Safa Naser, UNICEF-Child protection
11. Said El Ostaz, Director of the North Office for MOSA



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Cover image: A 14-year-old Bedouin girl walks near her home in Jefflek, a rural area north of Jericho, in Palestine © Rebecca Reid/ODI 2013

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