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Families, Family Policy and the Sustainable Development Goals

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Christophe and Theodette hold their son Kevin, 2, while on break in a field of the Sorwathe Tea Factory where they both work — Christophe in the fields and Theodette as a caregiver — in Kinihira sector, Rulindo District, Northern Province, Rwanda (2018).

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In memoriam of Masahiro Hirao.

Foreword

This report, *Families, Family Policy and the Sustainable Development Goals* explores how the role of families, and family policies from around the world, can contribute to meeting the ambitions of the Sustainable Development Goals (SDGs). Given the key role that both families and family policies have in determining social progress, and the national and international focus on meeting the SDGs by 2030, the timing of the publication is opportune. The report summarizes reviews of evidence across six SDGs that cover poverty, health, education, gender equality, youth unemployment, and ending violence to highlight some important issues that policymakers might consider when making future policies work for families, and family policies work for the future. A key contribution of the work, given the broad scope of the SDG ambitions, has been to map how the successes of family-focused policies and programmes in one SDG have also been successful in contributing to positive outcomes in other goal areas.

The development of this report was overseen by Dominic Richardson, (UNICEF, Office of Research – Innocenti). Specific chapters were written by Esuna Dugarova (Policy Specialist at United Nations Development Programme); Daryl Higgins (Director at the Institute of Child Protection Studies, Australian Catholic University); Keiko Hirao (Professor on Family and social sustainability at Sophia University, Graduate School of Global Environmental Studies, Japan); Zitha Mokomane (Associate Professor in the Department of Sociology at the University of Pretoria, South Africa); Dominic Richardson and Despina Karamperidou (UNICEF Office of Research – Innocenti); and, Mihaela Robila (Professor of Human Development and Family Science at Queens College, City University of New York, United States of America). Research support has been provided by Victor Cebotari, Sabbiana Cunsolo, and Despina Karamperidou (UNICEF, Office of Research – Innocenti).

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CHAPTER 1.

KEY FINDINGS ON FAMILIES, FAMILY POLICY AND THE SUSTAINABLE DEVELOPMENT GOALS

Chapter 1. Key findings on families, family policy and the Sustainable Development Goals

1.1. Introduction

Family policies are a mainstay of national public policies and the most meaningful vehicle for governments to influence the standard of living of future generations. Family policies have an important part to play in meeting many of the targets that will contribute to achieving the global ambitions of the Sustainable Development Goals (SDGs).

Recognizing the role of families as an elementary unit of society, governments worldwide are increasingly enacting family policies, including conditional and unconditional cash transfers, child allowances, maternity and parental leave, and preschool education and care policies. How such policies, and their specific designs, can be leveraged to meet the SDGs is the focus of this study. Findings show that the many advantages of well-designed, family-focused policy include: poverty reduction; employment; gender equality; child protection; and improvements in health and education outcomes.

This chapter summarizes the evidence across six SDGs that cover poverty, health, education, gender equality, youth unemployment and ending violence (*see Box 1.1 for an outline of the main report contents*). The work draws on evaluations of family policy and family-focused programming across these SDGs, and concludes by highlighting important issues that policymakers may consider to ensure that future policies work for families – and that family policies work for the future.

1.1.1. What are the Sustainable Development Goals?

The SDGs are a suite of globally defined social progress indicators. The aim of the SDGs is to set global ambitions for sustainable social progress to be achieved across 17 dimensions and 169 targets by 2030, whilst leaving no one behind.

As the Millennium Development Goals (MDGs) did before, the SDGs place a strong focus on traditional social progress targets such the eradication of poverty and promotion of health and education. Unlike the MDG framework of social goals, the SDGs involve goals and targets that require both national and concerted international action, and include measures related to the environment, peace and sustainable growth. Moreover, the SDG framework covers all countries – both rich and poor – and includes targets related to social/public service provision and investment requirements for achieving the goals.

1.1.2. Why look at the role of families?

There are many reasons to focus on the role of families and family policy in meeting the SDGs, including the existing focus on family in most welfare policies across the globe, and the fact that the family is regarded as the natural and elementary unit of all modern societies. This social and political reality makes understanding the family's contribution to the social progress and development goals of the SDG framework central to finding the most effective routes to achieving those goals, within the confines of existing public policy mechanisms.

As the former United Nations Secretary-General Ban Ki-moon stated in a 2010 report, "At the international level the family is appreciated but not prioritized in development efforts. The very contribution of families to the achievement of development goals continues to be largely overlooked, while there seems to be a consensus on the fact that, so far, the stability and cohesiveness of communities and societies largely rest on the strength of the family. In effect, the very achievement of development goals depends on how well families are empowered to contribute to the achievement of those goals. Thus, policies focusing on improving the well-being of families are certain to benefit development." (Report of the United Nations Secretary-General, 2010, A/66/62–E/2011/4, p. 4.)

Box 1.1. What to expect in this report

The findings described in this chapter are distilled from the following six chapters of the report, which focus on goals related to poverty, health, education, gender equality, employment, and ending violence.

Each chapter provides detailed evidence on the selection of targets within the goal in question and the state of existing data to operationalize these targets across the globe, and presents the best available data. Each then describes a review process that identifies experimental studies that explore the links between family-focused policies, services or programmes and the achievement of these targets. Each review identifies and records attributes of policies and practices to help summarize what works and where. These attributes include: Who is enacting the intervention? At what level? For whom? How are they doing it? How is evaluated? What are the results?

These summaries of globally sourced evidence on family interventions include only high-quality studies that are conceptually and methodologically coherent and employ scientifically valid approaches to evaluation. Where available, the summaries include reflections on family attributes (at the household or national level) that have an impact on the effectiveness of the interventions. Where relevant, the summaries also look at regional variations – that is, differences in family structures and practices and in socio-demographic and socio-economic profiles across countries, which may be relevant to policy effectiveness.

The report is organized as follows: This synthesis report constitutes Chapter 1. Chapter 2 reviews the data and family policy effects on the SDG Goal 1: End poverty in all its forms everywhere; Chapter 3 covers Goal 3: Ensure healthy lives and promote well-being for all at all ages; Chapter 4, covers Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; Chapter 5, covers Goal 5: Achieve gender equality and empower all women and girls; Chapter 6, covers Goal 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all – specifically youth employment; And Chapter 7, on Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

This report highlights how the role of the family, and policies for families, can contribute to the achievement of the SDGs, and amplifies the call for policymakers, practitioners and the general public to act on the evidence.

This study also responds to the more recent charge from former Secretary-General Ban Ki-moon in his report, Celebration of the twentieth anniversary of the International Year of the Family in 2014, "Governments, in partnership with relevant stakeholders, should support data collection and research on family issues and the impact of public policy on families and invest in family-oriented policy and programme design, implementation and evaluation", (Report of the United Nations Secretary-General, 2014, A/70/61–E/2015/3, p. 16.)

Specific goals of this work

To achieve these aims, a global group of family experts from Africa, Asia, Europe, Oceania and the Americas collaborated on the main report behind this synthesis study to address the following questions:

- How do family policies and programmes work to effect different social progress goals (as defined in the SDGs) in different parts of the world?
- Which family attributes at the household or national level have an impact on the effectiveness of the previously identified family interventions?
- How can the actions of both government and non-government actors support the optimization of family policies and programmes that seek to contribute to a range of social progress and development goals?

These questions will be addressed in the summary sections of this report.

SDGs selected for the study

The goals selected for review in this study cover poverty (SDG 1), health (SDG 3), education (SDG 4), gender equality (SDG 5), youth employment (SDG 8) and ending violence (SDG 16). This selection focuses on families with children or younger dependents, across the main ministerial streams of work (social protection, health, education, etc.), where public policy and private social impact efforts are well-resourced and nationally defined. Within each of the focal goals, the following targets have been selected (*see Table 1.1 and each chapter for details*).

Table 1.1. Focal goals and selected targets covered in this report

Area	Selected goal	Targets and indicators covered
Poverty	SDG 1: End poverty in all its forms everywhere	Target 1.1: By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than $1.25 a day.
		Target 1.2: By 2030, reduce at least by half, the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions.
Health	SDG 3: Ensure healthy lives and promote well-being for all at all ages	Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
		Indicator 3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease.
		Indicator 3.4.2: Suicide mortality rate.
Education	SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	Target 4.1: By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes.
		Target 4.2: By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education.
Gender equality	SDG 5: Achieve gender equality and empower all women and girls	Target 5.1: End all forms of discrimination against all women and girls everywhere.
		Target 5.4: Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family, as nationally appropriate.
Youth employment	SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment, and decent work for all	Target 8.5: By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value.
End violence	SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	Target 16.1: Significantly reduce all forms of violence and related death rates everywhere.
		Target 16.2: End abuse, exploitation, trafficking and all forms of violence against and torture of children.
		Target 16.9: By 2030, provide legal identity for all, including birth registration.

The selection of these SDGs does not mean to infer that family policy has no role in other goal areas. It is simply that some of these other goals may be less directly influenced by national- and local-level social policies and programmes where the family is the main beneficiary or point of delivery. Instead, transnational efforts and agreements (on the environment, climate change, ecosystems, water, sanitation, transnational inequality, or energy) may be the most critical contributors to the achievement of such goals. Similarly, society- or community-level interventions (on infrastructure and industrialization, city planning, global governance, or sustainable consumption) may be necessary. In each case, families will be affected and their involvement, as part of communities and societies, will be important to achieve these other goals.

Exceptions to these selection principles are the SDGs related to food security and nutrition, and within-country inequalities. These will be influenced to some degree by anti-poverty, health and education policies, and will usually be defined within health, education and social protection ministry remits. For this reason, separate chapters on these goals have not been included.

1.2. Main findings, categorized by SDG

The main findings of each chapter are introduced in consecutive subsections covering:

- global estimates of the key targets within the goal in question
- key points regarding families, family types and the focus of the goal (distinguishing issues salient to common family structures or conditions, e.g., single parents, large families, migrant families)
- how the goal links to other SDGs through the lens of the family
- the different types of family policies and programmes identified through the review, and their influence on the targets of the focal goal and other goal areas
- key recommendations drawn from the findings of the chapter.

The information presented in each subsection is informed by a data and literature review (*see Box 1.2 for methods*).

As with any literature review, it is important to note that although efforts were made to be comprehensive, the coverage of the literature is only as strong as the search terms and databases used. Second, as with any comparative study, the reviews of the evidence and the findings they convey are only indicative of the options available to policymakers. Transferability across contexts is not guaranteed, particularly where conditions of delivery (e.g., geography, affordability, coverage, payment amounts, markets, broader welfare systems, governance structures, populations) are expected to be very different.

Across all the SDGs reviewed, the role of family policy is consistently linked to improved outcomes. Mechanisms of delivery – including family participation, targeting, conditionality and coverage – matter for different goals. While most studies reviewed here were undertaken in high-income settings, available evidence from low- or middle-income settings also shows a significant effect of family policy in each goal area (with the exception of SDG 5, on gender equality, where no low-income studies were surfaced).

Box 1.2. Methods of data and literature review

Each chapter reports relevant data and literature that have been surfaced by structured searches and which have passed quality assurance reviews. This box outlines the steps taken to review and assure the quality of the data and literature that inform the study.

The **data work** for each paper refers to the development of both reference statistic(s) and chart(s) to operationalize the selected SDG target, and to report outcomes at the national level. Following the selection of targets in a group discussion among the research team, available data series were identified using the major databases – e.g., World Health Organization (WHO) statistics, United Nations Scientific, Educational and Cultural Organization (UNESCO) Institute for Statistics, World Bank World Development Indicators, Organisation for Economic Co-operation and Development (OECD) statistics, International Labour Organization (ILO) ILOSTAT resource, and SDG indicators. These data series were then reviewed for quality using reliability tests, trend data, validity checks, metadata and available documentation, and external validity checks, plus national checks where there were concerns about specific overestimates or underestimates.

In most cases, reliable and valid macrodata were available at a near-global level, and these data were presented in a map or chart, with any relevant metadata included. When global macrodata series were unavailable, short-term trends for selected countries, regional estimates or partial comparisons were used instead.

The **literature search** was planned in advance, agreed among the research team and undertaken in English. The purpose was to ensure that each researcher adopted a standard approach to capture a representative body of up-to-date evidence on how family interventions influence the SDG target of study. Search steps included:

- Selecting a date range: This is important to ensure the inclusion of reasonably recent literature, to be able to infer relevance for future planning or policy reforms. The range was dependent on the SDG target of interest (e.g., empirical literature on the effects of family policy on educational outcomes after the year 2000) and so the selected date range is explained in the literature section of each chapter.
- Selecting search engines and databases: Only respected and wide-ranging academic search engines or journal databases (e.g., Google Scholar, JSTOR) were used.
- Selecting key search terms by target: These were to be directly relevant to the SDG target of interest and include reference to family interventions, the focus of the study (e.g., family interventions for nutrition or evaluated family interventions for nutrition).
- Using keywords to refine searches: Where a long list of available articles was produced, searches could be refined further to identify evaluations or fill gaps in the review (see final point on follow-up searches).
- Following up on citations in articles: Where existing literature reviews were found, or where studies contained literature sections referencing other evaluations or reviews, citations were to be followed up at source.
- Using follow-up searches to fill gaps: Where the final review did not provide representative evidence, specific searches by region, type of intervention, etc., could be undertaken to fill gaps.

Once a dataset of references had been built, a quality assurance step was used to select literature for review. To determine whether a paper was of sufficient quality to be included, experts reviewed it against three standards:

- Conceptual coherence: Do the data used to represent the family outcomes and family policies effectively operationalize the concepts of interest? For example, in the case of SDG 5, do the data used by the author speak to gender equality? Does the narrative behind the empirical tests make sense?
- Methodological validity: Does the author use an appropriate method to test associations between action and outcomes?
- Scientific validity: Are the results of statistical/empirical tests fully and correctly interpreted in terms of the information being reported (e.g., sample sizes)?

Papers that met all three standards were included in the study.

1.2.1. SDG 1: Families, family policy and ending poverty in all its forms

Available data show that fewer people worldwide live in extreme poverty than ever before. For example, in 1990, almost 4 in 10 people were living below the international extreme poverty line of $1.90 per day.[1] In 2013, that figure had fallen to just over 1 in 10. It is worth noting, however, that despite the progress made, this smaller proportion still represents more than 767 million people.

Sub-Saharan Africa and South Asia have consistently been identified as the two centres of global poverty that need the most international support. Extreme poverty remains concentrated in these regions, with over 40 per cent of their populations classified as extremely poor (2015–2017 measurements).

Global patterns of multidimensional poverty are virtually a mirror image of the extreme poverty pattern: risks are much higher in sub-Saharan Africa, followed by South Asia, and risks are lower still in East Asia and the Pacific and in Latin America.

Families, family types and poverty risks

Across the globe, the risk of poverty has been shown to be higher in certain types of families and households. In developing countries, these include female-headed households; migrant families, particularly if the parents are low-skilled; families living in rural areas and who depend on agriculture; and families living in urban slums with very little access to basic social services (Mokomane, 2013).

In developed countries, the risk of poverty and deprivation also tends to be higher among migrant families, single-parent families and large families; families living in urban areas; families in which the education level of parents is low; and families with low work intensity (Richardson & Bradshaw, 2012).

1 Unless otherwise stated, all amounts shown are in US dollars.

Families, poverty risks and links to other SDGs

Addressing poverty in the family has positive effects on outcomes across a range of SDGs. For instance, addressing measures of poverty and multiple deprivation links to the achievement of some SDG targets by facilitating families' abilities to meet the goals related to personal subsistence (nutrition), access to services and utilities (health, education, clean water) and access to broader learning and labour markets, and offering them the possibility of having greater choice about cleaner and more sustainable living.

Importantly, poverty is also a key stressor. Family poverty can influence family functioning and stability, which can contribute to poorer mental health, well-being, and interpersonal violence.

More directly, deprivation measures and targets proposed as part of SDG 1 are not always exclusive from other stated goals and targets in the SDG framework. For instance, the global Multidimensional Poverty Index considers six indicators for standard of living, three of which are related to SDG targets – access to clean drinking water and improved sanitation (both SDG 6) and use of clean cooking fuel (SDG 7) – and through which improvements can be achieved in access to family health and in standard of living, two issues that often affect women in particular (Calderon & Kovacevic, 2015).

Types of family policy and their effects on ending poverty

Under SDG 1, and specifically the prevention and treatment of extreme income poverty and multidimensional poverty, policies that condition families to take up other services are particularly well evaluated in terms of multiple positive effects. The review undertaken for this study highlights examples from Latin America, the Caribbean, Africa and South Asia and from high-income countries such as the United States of America: Cash transfers to families have been shown to improve living conditions, lower poverty incidence, increase spending on food, increase access to education and health care, improve family investment in human capital and enhance gender equality (*see Table 1.2 and Annex Table 1.1*).

Though approaches and their effects vary widely across countries, common issues in the optimization of family social protection benefits, such as coverage and eligibility, are important factors in augmenting their effects on extreme poverty. Moreover, other factors such as the levels at which transfers are paid and the availability of complementary or conditional human services (e.g., schools, health centres) are also important for optimizing the effects of family policy interventions and meeting the multiple associated goals in the SDG framework. Table 1.2 summarizes the evidence from the review of family-focused anti-poverty policies.

Table 1.2. Summary of the family-focused anti-poverty policy effects for SDG 1 and beyond

Complementary SDG area	Specific outcomes	Summary of the evidence reviewed
SDG 1	Reduced monetary poverty or extreme poverty	Evidence shows that social protection policies paid to families are effective in reducing poverty and extreme poverty rates across a range of countries. Importantly, results show that unconditional child-focused benefits and pensions, as well as conditional cash transfers (CCTs), can all have meaningful effects on poverty reduction.
SDG 2	Consumption/living conditions	Means-tested benefits and CCTs paid to families are shown to be effective in improving positive consumption patterns and general living conditions.
SDG 3	Access to health care services	Access to health care services has been studied as part of CCT payments to families in Jamaica and Paraguay. In both cases, positive effects on preventive health checks and family health care are reported.
	Health outcomes	Health outcomes have also been studied as part of the CCT evaluations in Jamaica, Chile and New York, United States. Only in Jamaica are improved health status outcomes not shown. The South African Child Support Grant also demonstrates conclusive effects on health in the family.
SDG 4	Access to school	Like the health care access results, CCTs show positive access effects where this outcome has been tested. Unlike health care access, family child allowances have also been studied for school access, and positive effects are also shown here.
	Education outcomes	Again, as for health outcomes, the Jamaican CCT does not seem to convert access into outcomes (grade progression). Children's education outcomes are influenced positively in Chile and New York. Again, the South African grant evaluates well.
SDG 5	Gender equality	Two studies review the effects of family-focused anti-poverty policies on gender equality: one is a global review, the other is the South African Child Support Grant evaluation. Both studies conclude that cash grants are an effective family instrument for empowering women and girls.
SDG 8	Employment	The Chilean and New York CCT evaluations report improved employment outcomes for low-income families in receipt of these benefits.
SDG 10	Reduced inequality	Evidence from Southern Africa shows payments via universal pensions and means-tested child grants are both effective at reducing inequality. In both cases, these benefits are also effective in reducing poverty rates.
SDG 11	Access to housing programmes	Only the Chile Solidario evaluation looked at access to housing programmes for the family recipient of the benefit. Increased take-up of social housing programmes was shown.

Key messages: Family policy and SDG 1

- Social protection examples in this review – in the form of unconditional family and child allowances, both targeted and universal, and conditional cash transfers (CCTs) – all contribute to a reduction in poverty rates in extremely poor and less poor populations.
- Wherever these studies are evaluated for effects in consumption of and access to education and health care services, results are uniformly positive, although levels of impact vary.
- Evidence from the review suggests, however, that the step from accessing education and health care services, as provided by these family policies, to measurable education and health outcomes, has not been crossed in all instances.
- Evidence suggests that family cash benefits can be used to promote both parental employment and gender equality.
- Policymakers should bear in mind the gaps in the review and in the data and literature related to basic universal cash benefits, which, when not designed as anti-poverty policies, can: (1) act as an incentive to register or document children; (2) serve as a means to top up family investments; and (3) play a role in breaking intergenerational cycles of poverty or exclusion.
- When promoting cash transfers designed to increase access to services (conditional or otherwise), equity in coverage and quality complementary services are needed to reduce the likelihood of creating new, or entrenching existing, forms of inequality.

1.2.2. SDG 3: Families, family policy and ensuring healthy lives

Non-communicable diseases (NCDs) are chronic illnesses that are not passed from person to person. They are the cause of death of 38 million people around the world each year, three quarters (28 million) of whom live in low- and middle-income countries (World Health Organization [WHO], 2018b). The four leading causes of NCD deaths are cardiovascular disease (CVD; 17.5 million people annually), followed by cancer (8.2 million), respiratory disease (4 million) and diabetes (1.5 million) (WHO, 2018b).

Policies and costs related to NCDs are complex and substantial. Global and country-specific data indicate a wide variation in how CVD is addressed around the world and in the services that families are entitled to receive (WHO, 2017). In 2014, 9 per cent of all people over the age of 18 worldwide had diabetes (WHO, 2014). Global health expenditure on diabetes in 2015 was $673 billion, which accounted for 12 per cent of total health costs (International Diabetes Federation [IDF], 2015).

Suicide is a considerable public health problem because of its complex consequences at the family and society level. Suicide is the third leading cause of death among adolescents aged 10–19 years in the United States, with more adolescents dying of suicide than from cancer, heart disease, AIDS, birth defects and lung disease combined (WHO, 2018a).

Families, family types and health

Given the important role of lifestyle choices (e.g., diet, physical exercise) on health outcomes, the family environment (including standard of living, routines and joint lifestyle choices) can inevitably play an important role in the prevention and treatment of NCDs and in adaptation to their chronic nature. Many health behaviours are often established in childhood (Health Behaviour in School-aged Children, 2010) and carried through to adulthood. Parents and other family members can therefore act as early promotors of healthy living. Family functioning – or dysfunctionality – can play an influential role in the formation of support networks for adolescents. Families can also constitute a source of stress and depression. Finally, as illustrated elsewhere in this report, very dysfunctional families can also harbour perpetrators of domestic violence and abuse, leading to physical injury, hospitalization and suicidal ideation.

Families, health outcomes and links to other SDGs

The importance of the role of good health in day-to-day life in achieving personal and social progress goals across a range of domains must be underlined. Supporting healthy family environments and families that can promote healthy behaviours, or support the treatment of poor health, can contribute to achieving a range of SDGs. For example, physically and mentally healthy children are more able to learn, engage in social activity and play than those who are not. Physically healthy adults are likely to be more productive in work and meet their care responsibilities, compared with their unhealthy counterparts, and adults with good mental health have reduced risk behaviours, including risk of involvement in violent crimes.

Types of family health programmes and their effects

Treatment of NCDs and suicide risk that aims to increase knowledge of these conditions, improve family relations and promote treatment adherence and outcomes has proved effective in South Asia, East Asia, Latin America, Australia, North America and Europe (*see Table 1.3*). On occasion, clinical differences in health are not found between groups receiving family-based interventions for NCDs and those that do not receive treatment. In contrast, levels of personal support, communication and confidence, in terms of understanding and living with these conditions, improve more consistently.

The results of the randomized controlled trials (RCTs) summarized below report the outcomes for families in receipt of a family-focused treatment or programme compared with the outcomes for families who did not receive a family-focused intervention, or who received a less intensive intervention (*see Table 1.3*). Where the results are positive, they can be read as positive family or partner involvement effects (*see Annex Table 1.2 and chapter 3 of the main report for more details*).

It is worth cautioning that the studies reviewed are, in many cases, evaluations of programmes rather than national policies. This limits the applicability of the evidence for building system-wide, family-focused primary and secondary health care policies that may have broader social progress implications. For instance, family- or child-focused system-wide interventions such as immunization schemes are not covered here. Unlike national policies, programmes can be tailored and targeted to focus the impact on specific outcomes, which is likely to influence the scope of the evaluations that follow. For example, improved levels of health will undoubtedly affect the employability of some individuals, their education or training choices and, as such, their income status. The potential for these second- and third-order outcomes is not commonly investigated in the studies reviewed.

Table 1.3. Summary of the family health programme effects for SDG 3 and beyond

Complementary SDG area	Specific outcomes	Summary of the evidence reviewed
SDG 2	Nutrition/healthy eating	Notably, the nutrition and healthy eating evidence is all positive and in each case includes family or parental involvement. Education or information programmes are common in these interventions.
SDG 3	Perceived control over condition/improved knowledge	Evidence from the review suggests that nurse-led training or education programmes involving partners or family members, as well as computer-based programmes, can be effective in improving perceived control over a condition, and improving knowledge. Most studies are from the United States, but studies from Thailand and Ireland also show significant effects. Both home- and clinic-based interventions have been shown to be effective. In Sweden, a counselling with education intervention for patients and their partners had no observable effect on this outcome.
	Depression	Of the four studies reviewed for effects on depression, family-focused nurse-led education and counselling interventions were shown to be ineffective. Dietitian-led behavioural programmes and family therapy led by mental health workers were found to be effective, however.
	Self-care/adherence	Many studies show that family-based or patient–partner interventions can influence patient self-care and adherence to medical plans and practices. A broad range of practitioners are involved in these interventions. Only nurse-led education and counselling in Sweden produced null results.
	Physical health/weight loss/physical activity	Unsurprisingly, many NCD interventions have been evaluated for physical health effects. Involving either family members or partners, these are commonly effective and can result in objectively improved health statistics related to the conditions. It is in the areas of reported behavioural changes and the physical health of younger cohorts that the desired outcomes of the programmes are not consistently achieved.
	Hospitalization	Fewer individuals enrolled in a heart failure education programme with a family member were hospitalized than those receiving hospital information. Once admitted, though, time in hospital and frequency of visits were similar for both groups. Cognitive behavioural treatment for suicidal young people and their families was shown to be effective in reducing rates of hospitalization.
	Suicidal ideation/ attempts	Family interventions are almost always successful in reducing rates of suicidal ideation (only 2 of 11 interventions showed null effects). A range of therapy, behavioural and educational treatments (for family members/parents) have been shown to work.
	Mental health	Whenever mental health is measured as an outcome of a family-focused health intervention, results are positive. Professional-led exercise or therapy interventions are effective and, notably, two of the three interventions shown to positively affect the mental health of young persons with suicidal ideation involve education programmes for parents.
	Family support/parental stress	Psychological, behavioural (NCDs) and education (suicide) interventions for patients and their families/parents (sometimes at home) have been shown to increase family support.

Key messages: Family policy and SDG 3

- Comprehensive and effective family interventions should be developed based on sound theoretical frameworks to increase knowledge about the illness of study and improve family relations, treatment adherence and outcomes. Implementation of these interventions should employ multiple methods such as face-to-face interactions and the use of technology.
- Treatment of sufficient intensity and duration should be provided. An appropriate number of family-focused sessions over longer time periods, followed by spread-out reinforcements together with reminders of the importance of adherence, may help families to develop healthy patterns.
- Family interventions should be provided at different developmental stages in the lifespan. Timing interventions in childhood can teach children healthy behaviours and illness prevention to carry throughout life. Family interventions should also be provided to older adults at higher risk of suicide.
- Family life educators or family therapists should be included in the interdisciplinary teams that develop and implement family interventions. These family professionals have in-depth knowledge of family relations and dynamics.
- It is also important to promote support that can help to improve parenting skills, for healthier family functioning, and to reduce risk behaviours and risk factors related to various conditions such as diabetes, CVD, depression, anger, drug use, alcohol consumption and stress.

1.2.3. SDG 4: Families, family policy and education

Data on the proportion of children aged 3–6 years attending an early childhood education programme at the time of the most recent relevant survey are available for the global south (data are also available for high-income countries; see Organisation for Economic Co-operation and Development [OECD] Family Database, 2017). These data show that across the countries of the global south, fewer than one in two children attend preschool.

By region, income-based inequality in preschool attendance shows inconsistent patterns, with countries in Europe and Central Asia displaying the lowest regional variability. Most countries worldwide, however, have medium to high levels of inequality in attendance by income. South East Asian countries show the greatest variability by region for this indicator.

Similarly, the rates of completion for the lowest post-primary level of school vary massively across the globe. High-income countries can report net rates of over 100 per cent (i.e., more students than children of the relevant age group, as overage and underage students are included in the lower secondary system). In contrast, countries such as Chad and the Niger have overall completion rates of as low as 17 per cent and 12 per cent respectively, with completion rates for girls only of about 10 per cent.

Families, family types and education

Family policy, and families themselves, are being used as key points of intervention for promoting school attendance and learning at all stages of childhood. But while properly designed and supported family policy has the potential to be very effective in achieving these goals for children, today's family and education policies are not fit to meet the ambitions of SDG 4 without appropriate reform. Schools and childcare/preschool centres are under-attended and, in some cases, are attended by only the most privileged of children; learning outcomes are vastly unequal (UNESCO Institute for Statistics [UIS], 2017) and many family and education policies struggle to promote equitable learning outcomes.

Families, education outcomes and links to other SDGs

When families benefit from strong education policies – in ways besides meeting the SDG 4 ambitions related to participation and learning – the results for families, economies and society are readily theorized. Education for parents influences their labour market attachment, earnings, parenting practices, health choices and family functioning. For children, the same labour market effects can be expected in the longer term. Short-term health behaviours are also likely to benefit. Introducing broader social and policy reforms that encourage behavioural change for the benefits of the environment, or city planning, may also be more easily implemented in societies with higher average levels of education, helping to address environment-related SDGs. Finally, education can drive innovation and human capacities, with untold advantages for finding new routes to overcome the SDG challenges on various fronts.

Types of family policy and their effects on education

In the studies of family policy effects on education, parental employment and parental education levels moderate the effects of the policies in all regions of the world (*see Table 1.4 and Annex Table 1.3*). The same is true for the effects of family policies on the educational outcomes of families with a low socio-economic status – parent's education and employment status matters. Again, how policies are delivered (time, place, intensity, conditions) clearly matters. Evidence consistently shows that effective education systems rely on families to provide healthy home environments and additional resources to maximize state investment in human capital development.

Table 1.4. Summary of the family policy effects for SDG 4 and beyond

Complementary SDG area	Specific outcomes	Summary of the evidence reviewed
SDG 1	Earnings increments	Evidence from two quasi-experimental studies on the long-term earnings effects of maternity leave (moderated by education pathways) showed that expansion of maternity leave coverage in Germany and increased payments in Norway resulted in modest increases in earnings for children at around age 30. In the case of Norway, effects were stronger for lower-income mothers.
SDGs 3 and 4	Child development / health/language	Child development interventions delivered through family policy mechanisms are found across the board (parental leave polices, centre-based care, CCTs, family services). With the exception of parental leave policies, family policy effects are positive. Preschool has been linked to health outcomes in a global review, and inter-agency family services have been linked to language development in children in the United States.
SDG 4	Learning outcomes/ cognition	Preschool/centre-based care policies have the most consistent effects on learning outcomes. The positive results shown rarely have caveats, but effects are, on occasion, found to be greater in the short term or for low-income children. Only in Québec was a preschool policy shown to produce negative results in the cognition for four- and five-year-olds. This may be due to the low-fee, universal approach, which could have implications for quality, as well as inequality, in service provision. Parental leave policies, on the other hand, exhibit more null effects, with only the aforementioned German policy reform being linked to positive learning results. CCTs in Brazil (positive effects) and Ecuador (null effects) focus less often on child outcomes and more on participation and dropout rates.
	School participation/ dropout	The effects of family policy interventions on school participation and dropout have been repeatedly reviewed, and positively assessed in CCT cases where school attendance is a condition of benefit receipt; learning outcomes are rarely reviewed, however. There is also evidence, from both parental leave policies and preschool service studies, of the link between these family policies and increased school participation.
SDG 5	Parental care/family time	One study looked at the effects of increased job protection and maternity pay on maternal care time, which increased. Child development effects were negligible, however.
SDG 16	Social development and behaviours	Effects on children's social behaviours have been studied by preschool analysts and in the evaluation of the integration of family support in the United States. Preschool was shown to have positive effects for social development and mixed effects on social behaviour, while integrated family support helped with externalizing behaviours.

Supporting families at key points of the life course, with either services, cash benefits, leave to raise children, or integrated policies (including those with conditions), can influence the education trajectories of children. This finding provides a clear rationale for investigating the potential for tailored family support to complement education strategies in all countries, as part of meeting the SDGs.

Key messages: Family policy and SDG 4

- Although CCTs can compel families to engage with multiple social services (for schooling this works by increasing incentives for child enrolment/school attendance), there are concerns about how these services result in learning effects, how to ensure school safety in advance and how to provide equitable service coverage and quality.
- There is limited evidence that enrolment leads to learning. This could be for several reasons, including school quality; fewer resources per capita, related to increased enrolment; and enrolment without participation.
- Parental employment and parental education as mediators repeats across the policies. The differential effects of the policies for low socio-economic status families also repeat across the policies.
- Family involvement in global goals for education is a given. Many existing mechanisms are delivered via the family and, to function well, rely on families doing their part (e.g., healthy home environments, employment, education transmission).

1.2.4. SDG 5: Families, family policy and gender equality

The wage gap between women and men exists, to the detriment of women, in all countries (regardless of stage of economic development) and remains wide everywhere. According to International Labour Organization (ILO, 2017) data, 4 of the 10 worst countries in terms of gender wage gap are OECD member countries (Austria, Israel, the Netherlands, and the United Kingdom).

Women are less likely to work for pay and, where they do, are more prone to working shorter hours and working part-time (ILO, 2016a). Data from 121 countries, covering 92 per cent of total employment worldwide, show that women represent less than 40 per cent of total employment, but comprise 57 per cent of the part-time workforce (ILO, 2016a). Women are more likely to have held their jobs for less time and have experienced more career interruptions than their male counterparts.

Although there has been a general increase in women's labour force participation, the global female labour force participation rate decreased slightly (from 52.4 to 49.6 per cent) from 1995 to 2015, and women remain about 27 percentage points less likely than men to participate in the job market (ILO, 2016a).

Families, family types and gender

The interplay within families profoundly affects power relationships between women and men through the allocation of roles and responsibilities for domestic work and the upbringing of children. How women and men spend their time within the family mirrors and reproduces the differences in their access to resources outside the home, namely income and political power. Gender inequality in the public sphere is both the cause and the result of inequality in the private sphere.

At the individual level, women and men need to maintain an adequate balance between paid employment and family responsibilities. The proposed solutions to this dilemma vary between countries. The prescribed policies depend on many factors such as the country's demographic structures (e.g., fertility, mortality, mobility, availability of immigrant workers), social policies (e.g., welfare system, family structure, labour policies), labour market structure (e.g., industry composition, degree of gender segregation) and gender-role ideologies (e.g., what is deemed appropriate for women and men). Moreover, these solutions exist within a context of changing family types, including increasing rates of single-parent families (most often headed by women) in high-income settings and multi-generational households globally (as families respond to increasing housing costs and labour market demands).

Families, gender equality outcomes and links to other SDGs

SDG 5 aims to achieve gender equality not only as a fundamental human right, but also as a necessary condition for achieving peaceful, inclusive and sustainable development. Although gender equality is enshrined as a stand-alone goal in itself, it is also a cross-cutting issue deeply interlinked with many of the other SDGs, such as poverty (SDG 1), food security (SDG 2), health (SDG 3) and education (SDG 4).

For example, women still make up a high proportion of people living in income poverty (Chant, 2006) and gender equality is expected to contribute to the reduction of poverty through improvements in women's income, health, education and access to and control over land and other resources. Women play a critical role in the global food system, including in food production, preparation, consumption and distribution. During the early 2000s, while the overall proportion of the population engaged in agriculture was in decline, the percentage of females involved in agriculture increased (Food and Agriculture Organization of the United Nations [FAO], 2011). Improving educational opportunities for women has long been known to have a high social return in terms of reducing infant and child mortality and improving children's health and education (Schultz, 1995). When women have more influence over economic decisions, their families can allocate more of their income to food, health, education, children's clothing and children's nutrition (Doss, 2006, 2014).

Types of family policy and their effects on gender equality

The early years matter for gender equality, as this is the time when differences begin to appear between female and male career trajectories and demands on domestic work. Inevitably, longer and more financially generous parental leave policies, which are provided mainly to women, do not necessarily promote gender equality in the labour market, as they can encourage mothers to delay their return and thus jeopardize their career advancement over the long term (*see Table 1.5 and Annex Table 1.4*). Childcare policies that are not employment-sensitive can also have an effect here. When the costs of parental leave (whether financial or in terms of time or productivity) are met by employers, this can affect gender equality, as decisions related to hiring women can be unfairly influenced as a result.

It is important to caution that this evidence is from high-income settings, and little has been done in terms of quality evaluation in other parts of the world. Nonetheless, across all countries and settings, and despite the influence of family policies on the labour market (and labour market attachment), gender equality in the public sphere is also affected by unpaid domestic work and care work – for which policies need to be developed, particularly in light of growing elderly care needs and more single-parent households (especially female-headed households).

Despite this high-income country focus, there are global lessons to be drawn from the effects of family policies on gender equality in the labour market, in domestic work and in child rearing. The most striking of these lessons is the need to address the gender inequality inherent in the design of these family benefits.

Table 1.5. Summary of the family policy effects for SDG 5 and beyond

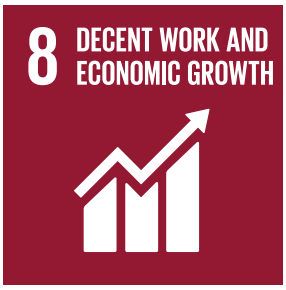
Complementary SDG area	Specific outcomes	Summary of the evidence reviewed
SDGs 1, 4, 16	Family stability	One study explored the effect of the 'daddy quota' in Iceland on family stability – specifically, the likelihood of divorce. Family stability has implications for poverty risks and child development (in both the short and long term). Results showed lower instability in cases where the 'daddy quota' is used.
SDG 3	Fertility	One study (Austria) links longer parental leave to increased fertility.
SDG 5	Maternal time with child	A Canadian study links increased mother-and-child time to longer parental leave. Changes to men's childcare burden are not reported.
	Gender equality in housework	Three daddy quota studies have looked at gender equality in housework, two of which note that fathers increase their share of housework when they have their own distinct leave entitlements. In Canada, long-term effects were observed.
	Fathers' leave time	The daddy quota in Sweden, Canada and Norway was linked (using quasi-experimental models and simple multivariate techniques) to increases in leave time taken by fathers.
	Fathers' childcare time	Perhaps in line with the evidence on the maternity benefit, of the two studies that looked at leave policies and fathers' time spent caring for children, the daddy quota intervention in Iceland had a positive effect and the parental payment increase (not the leave increase) in Germany did not register an effect.
SDGs 5 and 1	Increased wages	Almost all studies that looked at parental leave expansions and take-up found a negative or null effect on earnings. Of interest to gender equality, the use of the daddy quota in Norway is also shown to reduce men's earnings. Only an early US study on unpaid parental leave showed an earnings premium after leave was taken and the women returned to work (offsetting part of the costs related to leave, which employers and the federal government have no obligation to pay).
SDGs 5 and 8	Return to same job	One study on the effect of longer parental leave in Canada found a positive correlation with returning to the same job (although longer leave may be afforded to individuals who are expected to return to the same job).
SDGs 5, 8, 1	Mothers' labour market participation	The literature that looked at the effects on gender equality of different leave types shows similarities between the expansion of maternity leave entitlement (negative effects in the single study reviewed) and parental leave entitlement (mixed, negative and null). In Austria, the reversal of a leave extension policy resulted in increased maternal employment.
	Women's return to work after leave	In contrast, women's return to work after leave seems to be positively influenced by maternity entitlement being extended. Results for parental leave policies overall are very mixed, and include findings from Austria and Germany where entitlement extensions resulted in a more delayed return to work.
	Work preferences of mothers (commitment/ part-time work)	Work preferences of mothers have been the focus of two studies (looking at commitment to work and part-time work) that assess extensions to the leave period of parental leave policies in Germany and Canada. In both cases, a lower preference to work was found.

There is great variation in family leave policies, even between high-income countries, which is a strong indication of the lack of a single, clear consensus on how to manage the family policy portfolio in the period of birth and infancy. Poorly designed policies can establish long-term gender differences in the household, in the labour market and in longer-term welfare needs. Expansions to leave policies around the globe should therefore be sensitive to gender equitable practices – as well as a range of other factors such as labour markets, sectors and female and male educational histories – when attempting to balance, at the national level, SDG concerns such as child rearing and development, gender equality, family poverty and economic productivity.

Key messages: Family policy and SDG 5

- Longer and more financially generous parental leave policies do not necessarily promote gender equality in the labour market. They encourage mothers to delay their return to work and thus jeopardize career advancement in the long term, perpetuating the gender gap in economic rewards.
- Parental leave reserved for fathers – that is, as a benefit that is not transferable to mothers ('daddy quota') – is a promising way to encourage fathers to take leave from work, especially when this benefit is provided as a bonus period of 'take-it-or-lose-it' leave. It is very important that leave for fathers is well paid because of a strong incentive for a couple to allocate each partner's time to paid and unpaid work according to the comparative financial advantage.
- Gender equality in the public sphere can never be achieved unless unpaid domestic work and care work is shared more equally in the private sphere.
- Future family policies should pay more attention to the competing demands that they are trying to meet. They must ensure the well-being of children while making sure that equality between genders is promoted.
- It is striking to note that studies on changes to paternity leave have not evaluated the effects of the policies on women's work patterns or preferences (although they do look at gender equality in domestic work). More needs to be done to better understand the effects of family policy and recent extensions to paternity leave on gender equitable employment.

1.2.5. SDG 8: Families, family policy and youth employment



In 2016, the global youth unemployment rate stood at 13.6 per cent, with 71 million unemployed youth worldwide (ILO, 2016b). The highest youth unemployment rates by country were in some parts of sub-Saharan Africa, notably in South Africa (52.3 per cent) and Namibia (49.9 per cent); in the Middle East, notably in Oman (50.8 per cent) and Libya (48.1 per cent); and in Eastern Europe, notably in Bosnia and Herzegovina (67.6 per cent) and North Macedonia (49.5 per cent). The lowest youth unemployment rates were generally found in Western Europe, most notably in Germany (6.5 per cent) – with the exception of Greece (48.2 per cent), Spain (42.9 per cent) and Italy (38.4 per cent). South East Asia also had low youth unemployment rates, notably in Singapore (4.6 per cent) and Thailand (3.1 per cent).

Available data on the proportion of the youth population (aged 15–24 years) who are 'not in employment, education or training' (NEET) reveal very high NEET rates in the Maldives (56.4 per cent in 2010), in Trinidad and Tobago (52.5 per cent in 2013) and in Yemen (44.8 per cent in 2014). NEET data are unavailable for many parts of Africa and the Middle East, however.

According to the World Bank's World Development Indicators data (2017), the lowest NEET rates are found in Europe and Central Asia (14.6 per cent), North America (15.9 per cent) and Latin America and the Caribbean (19.3 per cent).

Families, family types and youth employment

As chapter 6 of the main report shows, differences in accessing employment opportunities are often based on family situation, household income and parental employment. This implies that policies that affect families and parental employment, along with family benefits and services, have an essential role to play in achieving SDG 8.

It is paradoxical that poorer families with fewer economic resources and a higher need for youth employment often struggle, due to poverty, to access the support they need to most effectively engage with the labour market. At an individual level, a lack of information, networks and connections (especially among youth from families with limited economic resources and social capital) creates difficulties for young people entering the workforce (ManpowerGroup, 2012). At a system level, inflexible labour markets and regulations make it difficult for young people to secure stable employment trajectories and are a major cause of youth unemployment (ILO, 2016b).

Families, youth employment and links to other SDGs

Unless youth are equipped with the support they need to succeed in education, employment and training, millions of young people risk being left behind. The private and public costs of failing to activate a significant proportion of young people globally will result in greater inefficiencies in social progress efforts across the SDGs, due to lower rates of productivity and higher rates of dependency.

In many countries, employment instability results in increased inequality in earnings, which is an underlying concern for reducing inequality within and among countries (SDG 10). Youth employment or higher education is often a bridge to independent living and economic independence, without which a significant proportion of young people must rely on the support of their family and/or the state (Smeeding & Phillips, 2002). Various factors could be responsible for this trend, including reduced economic opportunities, technological changes and the spread of globalization (Blossfeld et al., 2005; Danziger & Ratner, 2010). As well as affect

poverty concerns (SDG 1), the failure to transition to independent living can lead to mental health risks (SDG 3) and antisocial or criminal behaviour (SDG 16), (see ManpowerGroup, 2012).

Types of family policy and their effects on youth employment

For youth employment outcomes, evidence highlights the complementary effects of families with economic security and adequate resources. The evaluation evidence base is weak, however, in terms of geographic coverage of evaluations (studies come from just Mexico and the United States) and the family policies themselves are not always shown to be effective (*see Table 1.6 and section 6.4.1 of the main report*). Nevertheless, all countries are faced with the challenge of building effective school-to-work transition systems. Further studies on the role of the family in providing career advice, support during periods of unemployment, investment in youth training, and soft skills development – factors that could be readily hypothesized as determinants of youth activity – and the role for family policy are needed.

Table 1.6. Summary of the family policy effects for SDG 8 and beyond

Complementary SDG area	Specific outcomes	Summary of the evidence reviewed
SDG 5	Female labour market participation	The PROGRESA/Oportunidades CCT programme in Mexico recorded positive impacts in terms of increased work for older girls.
SDGs 1 and 8	Employment rates and earnings levels	Evidence from four studies – three of which reviewed employment and earnings levels of young people – revealed that only the Oportunidades CCT registered a 'limited' positive effect on these youth outcomes. US interventions for children leaving foster care did not register an impact.
	Intergenerational mobility	Limited positive effects on intergenerational occupational mobility were found in the evaluation of the Oportunidades CCT in Mexico.
SDG 8	Service sector employment	One study on the effects of the Oportunidades CCT registered shifts in youth employment from agricultural to non-agricultural employment.

Key messages: Family policy and SDG 8

- There is insufficient evidence on the role of the family in promoting youth activation and the school-to-work transition. This is despite multiple policies (including education, training or employment incentives) delivered via existing family benefits or in the family context, where effective family support would optimize impacts.
- While policies aimed at ensuring access to the labour market and creating decent jobs are essential, it is important to make relevant interventions to strengthen families and avoid the intergenerational transmission of weak labour market attachment.
- Helping parents to find paid work contributes not only to the economic well-being of their children, but may also positively affect young peoples' attitudes, behaviours and outcomes in the labour market.
- The 2030 Agenda for Sustainable Development provides an opportunity to incorporate youth in family policies as part of comprehensive sustainable development strategies.

1.2.6. SDG 16: Families, family policy and ending violence

Most children across the globe are exposed to violent discipline, including psychological aggression and/or physical punishment). Some 60–90 per cent of children experience violent discipline in countries where data are available (*see chapter 7 of the main report*). Notably, data coverage is incomplete and there is no way of knowing how developed countries compare with the global south. There is a dearth of data on the violent discipline of children (across all years) for countries such as Australia, Canada, New Zealand, the United Kingdom, the United States, as well as most Asia-Pacific countries and, indeed, many other European countries.

A second and more wide-ranging indicator of ending violence is intentional homicides per 100,000 people. This rate varies widely between countries, from a low of less than 1 per 100,000 (e.g., Algeria) to a high of around 30 per 100,000, depending on the year (e.g., Bahamas: 35 in 2011; El Salvador: 72 in 2011; Honduras: 93 in 2011).

Central America appears to have a concentration of homicide hot spots, but the data may include not only the extreme end of domestic/family interpersonal violence, but also extreme interpersonal violence related to drug issues.

Families, family types and ending violence

Different types of families present different levels of risk in terms of violence and ending violence. Domestic violence, and forms of violent discipline against children, occur in the family unit and are influenced by issues related to parental stress and drug and alcohol abuse (issues covered in SDG Target 3.5) and parenting practices, among other things. One clear route to preventing interpersonal violence, and towards addressing the needs of all families, is to reduce these stressors as early as possible. This means seeing families – and understanding their lives and environments as well as their knowledge of and attitudes towards parenting practices – independent of wealth or education. Poverty has long been associated with child protection issues, and in families with existing violence risks, the increased stressors of poverty may further accentuate risk. Direct causal evidence on poverty and increased violence is not forthcoming, however.

Families, ending violence, and links to other SDGs

Violence against the person is a serious violation to be addressed in its own right and it should be addressed even if positive spillovers were not so readily seen (*see summary Table 1.7*). Given the role of families and partners in perpetrating violence, it is rational to see family-based treatment, or a focus on policies to support family functioning, as key pillars to ending violence globally. Violence can occur outside the family too – in school, at work, in the local community – indeed, wherever human interaction occurs. Families also have a role here, in supporting victims of violence and setting social norms regarding the unacceptability of violence in the family and in the wider community.

Family interventions designed to lower rates of interpersonal violence and set community standards, if effective, can influence direct improvements to health (mental and physical), education, quality of local environments, and much more. One SDG supporting action would directly benefit from ending violence, SDG 4.A: Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all.

Types of family policy and their effects

Family-related policies and programmes/interventions are integral to the achievement of SDG targets related to violence prevention (*see Table 1.7 and Annex Table 1.6*). Most of the evidence regarding effective interventions comes from research in anglophone western democracies, however, with limited data from elsewhere. This means it has not been possible to draw any conclusions about geographic associations between implementation of particular types of policies, programmes or interventions and a lower rate of interpersonal violence.

Table 1.7. Summary of the family programme effects for SDG 16 and beyond

Complementary SDG areas	Specific outcomes	Summary of the evidence reviewed
SDG 3	Access to health checks	A family home visiting programme for new parents increased reporting of infant access to health checks.
	Hospitalization	Two evaluations of intensive home visiting for vulnerable parents (both prenatal and post-natal) in four settings were shown to reduce rates of hospitalization.
SDG 4	Developmental activities (e.g., reading to children) and child outcomes	Two nurse-led family home visiting services, prenatal and post-natal, showed an impact on parental development activities and child outcomes. The KiVa school-based anti-bullying intervention in Finland, which involves parents, also registered an effect on boys' outcomes related to anxiety.
SDG 16	Self-reporting of physical aggression	Reductions in self-reported physical aggression were found, again as a result of intensive nurse–family partnerships and home visiting. In contrast, a more clinical approach to treatment – involving cognitive behavioural therapy and 'gender re-education' for men – had no effects.
SDG 16	Reduced social acceptance of violence (e.g., intimate partner violence, child corporal punishment/ violent discipline)	Reduced social acceptance of violence was found to be an effect of community interventions involving women and men in Uganda. Violent discipline of children (including shouting and hitting) was not reduced in two nurse-led home visiting interventions (in the United States), but was reduced in a community version of the intervention in the Netherlands.
SDGs 16, 3, 4, 5	Decrease in experiences of violence	Empowerment plays a role in interventions that have decreased individuals' experiences of violence. In the case of intimate partner violence, home visiting and avoidance strategies result in reduced experiences. Providing micro-finance to women, along with training, has also been shown to reduce their experiences of violence. In contrast, community interventions and a single nurse-led home visiting intervention for new mothers did not register significant effects in terms of reducing domestic violence. Children in the KiVa anti-bullying programme in Finland report lower rates of victimization.
SDGs 16, 3, 4	Prevention of violent discipline of children and neglect	Of the four US studies that evaluated the impact of home visits by a nurse to new mothers, three found that the treatment reduced parental use of violent discipline. The fourth evaluation, in Hawaii, United States, did not register reductions.

Note: This table introduces the RCT evidence from chapter 7 of the main report, on ending violence. Further evidence on the effects of family-focused interventions are reported from a review of reviews covered in the chapter. Furthermore, intimate partner violence is reviewed in the main report by type – separating out forms of emotional, physical and sexual violence. Violent discipline, in terms of shouting, hitting or smacking children, is also reviewed in more detail.

The importance of settings, support and communities in addressing violence through a family policy lens is evident from the above summary. Firstly, violence is often perpetrated by a family member, partner or parent – although, in some cases, it is the involvement of parents (such as in an anti-bullying intervention) that contributes to a solution. Secondly, professional visits to the home early on in a child's life are an effective approach to identifying risk, as well as to delivering education and training interventions to optimum effect. Finally, family interventions that are delivered in a community setting (for instance, to mothers with infants) may be influential in communicating norms about family functioning and child rearing, as well as in providing some form of reciprocal monitoring. Shared norms and monitoring at a community level are likely to provide unique advantages in efforts to end violence and meet the challenge of SDG 16.

Key messages: Family policy and SDG 16

- Prevention efforts need to focus on addressing the preconditions that facilitate interpersonal violence, based on a conceptual understanding of the causal and contributing factors (such as enablers or determinants) at each level of the socioecological model (e.g., individual, family, community, society) to create and support conditions of safety (see Quadara & Wall, 2012; Walden & Wall, 2014).
- Better measurement of the prevalence of interpersonal violence globally is needed to monitor trends in the actual occurrence of victimization over the long term. Gaps in data for high-income settings are notable.
- It is important to prioritize increased relative investment in child maltreatment prevention policies and programmes such as nurse–family partnerships and home visiting for new mothers. These services can be cascaded (known as 'progressive universalism') to ensure that all children benefit, with high-need cases followed up (this is further described in OECD, 2009).
- Investment should be continued in those domestic violence prevention programmes that have been evaluated as effective, such as family-focused community interventions.
- There is an absence of jurisdiction-wide policies and programmes to address sexual violence and a lack of evidence to show what works in relation to the prevention of sexual violence towards children and adults.
- It is important to experiment with policies and programmes that can contribute to a reduction in multiple forms of victimization (starting with the drivers/risk factors and protective factors that are shared across victimization types) and invest at scale in those that show most promise.
- Meaningful and timely investment is needed in nationwide policies and programmes that directly target prevention of the full range of interpersonal violence covered by the SDGs. Too few of the well-evaluated programmes have been implemented at scale.

1.3. Synthesis of findings: Which policies work and how do they work?

This synthesis report encompasses more than 150 quality-assured family policy studies, evaluations and literature reviews. Every region of the world is covered by at least one example of a national or sub-national study, with the sole exception of the Middle East (despite including searches for Middle East studies in each literature review).

This section of the report addresses the main research questions, as outlined in section 1.1.2:

- How do family policies and programmes work to have an impact on different social progress goals (as defined in the SDGs) in different parts of the world?
- Which family attributes at the household or national level have an impact on the effectiveness of the previously identified family interventions?
- How can the actions of both government and non-government actors support the optimization of family policies and programmes that seek to contribute to a range of social progress and development goals?

Below, promising practices in family policy and programming are summarized and evidence on family attributes that determine differences in intervention effects are introduced. We then review how the various SDGs interact overall (and why this is important) and, finally, look at next steps for policymakers and other stakeholders working in this field.

1.3.1. Promising practices in family policy and programming

Evidence across the six SDGs studied in this report has shown that family-focused interventions are most often positively evaluated (this may reflect, to some degree, a publication bias towards significant results). Desired effects on family outcomes are achieved to varying degrees in most cases across all goals (youth employment perhaps being borderline).

There is no 'silver bullet' in family policy or programme design, rather aspects of different policies are shown to be effective in different settings when designed for a specific purpose. For instance, cash benefits consistently reduce poverty and decrease deprivation. Both conditional and (sometimes) unconditional transfers can encourage children's access to schools and improve health outcomes.

One ambition of this study was to uncover information about the implementation practices used in successful and unsuccessful family policies to allow inference in terms of 'quality provision'. This has been more successful in some areas than others – for instance, the chapters on health and ending violence cover programme evaluations and implementation practices. It is clear from the available evidence that implementation choices matter: Family-focused policies function differently depending on where they are hosted (home, school, community) and who is involved (professionals, family members only, online approaches). Quality in family services often means professional intervention at the family level, including home visiting and training or education packages, for example, for high-end acute treatments to end violent behaviour and for chronic health conditions.

The study does not provide data on costs of effective family-focused policies. This information may be reported elsewhere, but for the purposes of this study, it has not been possible to determine affordability of policies. That said, evidence on the impact of many of these policies on public and private outcomes, and their spillover effects in complementary goals and sectors, suggests that the ultimate benefits of family-focused public expenditure are many and varied.

1.3.2. Complementarities and consequences of family-focused policies across the SDGs

This work sought to understand complementarities and trade-offs between individual family policies aligned to specific SDGs. Table 1.8 maps examples (horizontally) of where policies designed for specific SDGs have influenced outcomes for other goals.

Light grey squares in Table 1.8 indicate studies that observed positive spill over effects of family policies from one SDG to another. These spill overs indicate opportunities for optimizing effects within and across social progress measures by integrating policy portfolios in place and over time (sequencing), increasing the effectiveness of efforts. It should be noted that efficiency gains are less easy to predict, as policy reforms can result in changes to predicted demand for the policy in the population (see OECD, 2015).

Table 1.8 highlights how family-focused interventions designed to address targets in one SDG area can spill over and influence the attainability of targets within other SDGs. Notwithstanding the limits of this review, it is also evident from Table 1.8 that these spill over effects are not uniform and can differ depending on which SDG it is that the family-focused intervention primarily addresses. Acknowledging these trade-offs allows policymakers to design family policy portfolios or prioritize family policy enactment in any of the areas studied. Moreover, although the analysis does not provide clear evidence on the sequencing or prioritization of interventions, the order of interventions clearly does matter. For instance, efforts to address employment outcomes for women will remain suboptimal while gender inequality in leave entitlements persists. Similarly, investments in learning outcomes will be less effective in areas of the world where issues of violence or insecurity have not been addressed.

It is important not to read the results reported in Table 1.8 as complete, final or fully transferable. They are indicative of what policymakers working in these specific goal areas may expect to find in terms of both direct and spill over effects of policies that exercise a family-focused approach. Inevitably, not all of the available policy evidence can be included; health system effects, for instance, have not been reviewed. Moreover, not all of the results will be transferable across countries, or fully scalable within countries in the case of pilot or programme evaluations. Instead, policymakers can use this evidence to guide their investigations regarding the case for, the design and implementation of, and the potential effects of family policy interventions.

Table 1.8. Observed SDG connections via family-focused policy and programming

Effects on >>> Policies and programming	1 NO POVERTY	3 GOOD HEALTH AND WELL-BEING	4 QUALITY EDUCATION	5 GENDER EQUALITY	8 DECENT WORK AND ECONOMIC GROWTH	16 PEACE, JUSTICE AND STRONG INSTITUTIONS
1 NO POVERTY		E.g., access to health in multiple countries, health outcomes				
3 GOOD HEALTH AND WELL-BEING						
4 QUALITY EDUCATION						
5 GENDER EQUALITY						
8 DECENT WORK AND ECONOMIC GROWTH						
16 PEACE, JUSTICE AND STRONG INSTITUTIONS						

Notes: Light grey squares denote observed positive spillover effects of an intervention from one SDG to another. Anti-poverty and health family interventions also record positive impacts on SDG 2. Anti-poverty family interventions also have positive impacts on SDGs 10 and 11.

Table 1.8 compares only the observed connections between the focal SDGs of this study. Evidence uncovered as part of the work has shown, however, that the positive impacts of family policies on SDGs 1 and 3 spill over to affect family choices related to diet, nutrition and food consumption (SDG 2) and housing and societal-level issues such as inequality outcomes (SDGs 10 and 11).

1.3.3. Strengthening the role of the family: Considerations for family policymakers and practitioners

This chapter has introduced key messages for policymakers and practitioners in each goal area. This section draws on those messages to highlight several cross-goal considerations for policymakers and stakeholders working at the global, national and programming level:

- **At a global level, more data on the family are needed.** Data to measure important aspects of the SDGs are incomplete. Work is under way to complete these datasets, with efforts by the United Nations Statistics Division, SDG indicator groups, and subgroups defined by goal (such as the Global Alliance to Monitor Learning, led by UIS). Organizations working with policymakers on this important task should underline the need for disaggregation of data by family type, child age and other family policy-relevant factors as data series develop. Moreover, data collection teams should highlight data collection priorities to operationalize the more pressing issues, such as violence, and coverage of hard-to-reach populations.
- Both international and national organizations can work (together) to **build the evidence base supporting the use of evidence-informed family policy, innovation in cross-sectoral integration, and implementation strategies**. This review shows the need for more research to meet the demand for evidence-informed responses to the SDGs. Evidence should fill gaps in evaluation evidence (e.g., on youth employment) and improve understanding of processes and planning priorities for interventions and for integrated family policy portfolios.
- National policymakers and practitioners should recognize that a family policy will not work in the same way in different countries or contexts, even if global goals are the same. This indicates a need for **evidence on scalability and transfer of family policies, particularly those policies and programmes that are well evaluated.** Comparative studies, including this one, can only provide an indication of promising practices, not a prescription for action.
- **Practitioners working with families should take note of the important role played by family professionals, early interventions and family involvement** in physical and mental health treatment. Moreover, evidence from suicidal ideation and violence treatments shows that family environments can be both the cause of, and solution to, negative social outcomes. Education and training for parents of newborns, and parents of adolescents with mental health problems, are effective approaches to dealing with serious social issues.

1.4. Summary conclusions: What is the role of families and family policy in meeting the SDGs?

This synthesis study, the culmination of the work of six geographically diverse family policy experts, has underlined the value of working for and with families to meet the SDGs. Anti-poverty, health, education, gender equality and violence prevention interventions are broadly evidenced across many countries and regions, and effective strategies for family interventions are described. Less is known about the role of family policy in youth employment. This is likely caused by a lack of quality data, rather than there being no role for the family in this goal area. Established active labour market policies, family allowances and unemployment schemes commonly include family increments and conditions – and, in so doing, implicitly accept the role of the family as part of such efforts.

Beyond the role of family policy in meeting specific goals, one clear conclusion of this work is that family policy interventions and strong families are a foundation for meeting multiple goals, even when a single policy is being used for a single purpose.

Well-designed and family-focused anti-poverty interventions have positive spill overs into education and health. Decisions about children's school or preschool attendance, for instance, will be made by parents or heads of households, and affordability will influence the choices made to some degree. Equally, family policies, when poorly designed, can have an impact on outcomes in other goal areas to the detriment of their own ambitions. The example of gender-specific parental leave polices that result in inequitable employment effects is perhaps most stark.

Overall, the accumulated evidence suggests that strong families function as supportive units, providing important resources to all members. These resources include time, money, physical resources, interpersonal care and emotional security. Policies should seek to facilitate the increased effectiveness of present social interventions and reduce benefit dependencies wherever possible.

The family is the elementary social unit. Hence the progress of families will inevitably influence the progress of the communities and societies of which they are a part. In this sense, families are enabling agents for the achievement of the SDGs. As governments and other actors in society seek to meet these goals, the role of strong families and strong family policy cannot be overlooked.

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Annex 1. Reference Tables for Policy Summaries

The following annex tables provide detailed information of the summaries in the main text and are elaborated further in the chapters that follow. Each table includes:

- **Study method and authors**. The following abbreviations are used to indicate study methods: LR=Literature review, IA=Incidence analysis, RA=Regression analysis, MM=Mixed methods, QE=Quasi-experimental study (including difference-in-difference, natural policy experiments and discontinuity analyses), RCT=Randomized controlled trial, ES=Evaluation study (other), DM=Data matching (survey and administration data), MS=Microsimulation.
- **Benefit or programme type and delivery methods**. This column records the type of policy evaluated or the main programme contents and professional lead.
- **Where?** This column lists the country or countries of study, and the national or sub-national coverage in each case.
- **For whom?** This column records the recipient of the policy or programme by the main attribute of eligibility to the service.
- **What are the results?** These columns record the effects of the policy on outcomes, as recorded in the study. The results should be read with regard to the study method. In each table:

  ++ denotes highly positive effects

  + denotes positive effects

  – denotes negative effects

  -- denotes highly negative effects

  ... denotes a null effect.

  A blank square indicates that no tests were undertaken for the specific outcome in the specific paper or report.

  Notes are flagged using asterisks and recorded below each annex table.

Annex Table 1.1. Details of the anti-poverty family policies and their effects

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?									
				Reduced monetary or extreme poverty	Consumption/living conditions	Access to health	Health outcomes	Access to school	Education outcomes	Gender equality	Employment	Reduced inequality	Access to housing programmes
IA/RA (Verme, 2004)	Social assistance benefits	Republic of Moldova	Poor and vulnerable households	+	++								
LR (Hagen-Zanker et al., 2016)		Global	Eligible families by country							+			
MM/DM (Ahmed et al., 2009)		Bangladesh (rural areas)	Ultra-poor	+									
RA (Amarante et al., 2009)		Uruguay	Children aged 0–5 years and aged 6–18 years	++				+					
MM (Levy & Ohls, 2007, 2010)	Conditional cash transfers	Jamaica	Vulnerable groups			+	…	+	…				
QE (Oliveira et al., 2007)		Brazil	Poor and extremely poor families		+								
ES/RA (Soares, Ribas & Hirata, 2008)		Paraguay (five poor districts)	Poor and moderately poor households	+		+		+					
DM (Borraz & González, 2009)		Chile	People living in conditions of extreme poverty				+		+		+*		+*
RCT (Riccio et al., 2010)		New York City, United States (poor areas)	Eligible poor families	+	+		+		+		+		

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?									
				Reduced monetary or extreme poverty	Consumption/living conditions	Access to health	Health outcomes	Access to school	Education outcomes	Gender equality	Employment	Reduced inequality	Access to housing programmes
RA (Hodges et al., 2007)	Child allowance	Mongolia	All children aged 0–17 years	++									
RA (DSD, SASSA & UNICEF, 2012)		South Africa	Poor children aged 0–17 years, means-tested for eligibility	+	+		+		+	+		+	
RA/DM (Levine et al., 2009)	Old age pensions	Namibia	All elderly people	++								+	
RA (Bello et al., 2008)		Lesotho	Older people aged 70+ with no other pension	+									
RA/MS (Dethier et al., 2011)		18 Latin American countries	Older people	+									
RA (Garroway, 2013)		India	Older persons and widows	+**									

Notes: Positive consumption refers to greater spending by beneficiary families on food, health, education and children's clothing than by non-beneficiary families. 'Vulnerable groups' refers to poor children (aged 0–17 years), poor pregnant or lactating mothers, poor pensioners (aged 65+) and destitute or poor persons with disabilities of working age. * Access to programme only, no outcome effects. ** Widows pension only. Effects: '-' negative significant association, '—' strong negative significant association, '…' null finding, '+' positive significant association, '++' strong positive significant association.

Annex Table 1.2. Details of the family health programmes and their effects

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?								
				Nutrition/healthy eating	Perceived control over condition/improved knowledge*	Depression	Self-care/adherence	Physical health/weight loss*/ physical activity**	Hospitalization	Suicidal ideation/attempts	Mental health	Family support/parental stress
RCT (Ågren et al., 2012)	Nurse-led counselling and education	Sweden	Patients and partners		+	…	…					
RCT (Dunbar et al., 2013)	Nurse/dietitian-led education and support interventions	United States	Patients and family members	+				+				
RCT (Harrington et al., 2010)	Exercise instructor-led exercise and education	United Kingdom	Patients and family members					+			+	
RCT (Liljeroos et al., 2015)	Nurse-led counselling and education	Sweden	Patients and partners		…	…						
RCT (Löfvenmark et al., 2012)	Multi-professional-led tailored education programme	Sweden	Patients and family members		++				+*			

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?								
				Nutrition/healthy eating	Perceived control over condition/improved knowledge*	Depression	Self-care/adherence	Physical health/weight loss*/ physical activity**	Hospitalization	Suicidal ideation/attempts	Mental health	Family support/parental stress
RCT (Aggarwal, Liao & Mosca, 2010)	Health educator-led education and recommendations on diet and exercise	United States	Patients and family members					+**				
RCT (Duncan et al., 2016)	Trained health promoter-led, family-centred intervention and advice	New Zealand	Patients and family members	+				+,+*				
RCT (Reid et al., 2014)	Health educator-led, family-focused healthy behaviour counselling	Canada	Patients and family members	+				…,+**				
RCT (García-Huidobro et al., 2011)	Facilitator/clinician-led family counselling intervention and home visits	Chile	Patients and family members					+				

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?								
				Nutrition/healthy eating	Perceived control over condition/improved knowledge*	Depression	Self-care/adherence	Physical health/weight loss*/ physical activity**	Hospitalization	Suicidal ideation/attempts	Mental health	Family support/parental stress
RCT (Keogh et al., 2011)	Health psychologist-led psychological family intervention at home	Ireland	Patients and family members		+			+,+**			+	+
RCT (Samuel-Hodge et al., 2017)	Dietitian-led, family-centred behavioural weight loss intervention	United States	Patients and partners			+	+	+,+**				+
RCT (Trief et al., 2016)	Dietitian-led couples behaviour change intervention	United States	Patients and partners					…				
RCT (Wichit et al., 2017)	Nurse-led, family-oriented self-management programme	Thailand	Patients and family members		+		+					

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?								
				Nutrition/healthy eating	Perceived control over condition/improved knowledge*	Depression	Self-care/adherence	Physical health/weight loss*/ physical activity**	Hospitalization	Suicidal ideation/attempts	Mental health	Family support/parental stress
RCT (Doherty et al., 2013)	Internet-based, self-directed Teen Positive Parenting Programme	United Kingdom	Patients (11–17 years) and parents		+							…
RCT (Ellis et al., 2012)	Therapist-led family education and routine interventions	United States	146 adolescents				+	+				
RCT (Ellis et al., 2017)	Computer-delivered motivational sessions	United States	Patients (11–14 years) and primary caregivers		+		+					
RCT (Harris et al., 2015)	Clinician-led behavioural family systems therapy	United States	Patients (12–18 years) and caregivers				++	+				
RCT (Holmes et al., 2014)	Trained facilitator-led family teamwork coping skills programme	United States	Patients (11–14 years) and family members					+				

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?								
				Nutrition/healthy eating	Perceived control over condition/improved knowledge*	Depression	Self-care/adherence	Physical health/weight loss*/ physical activity**	Hospitalization	Suicidal ideation/attempts	Mental health	Family support/parental stress
RCT (Katz et al., 2014)	Trained facilitator-led, family-focused psycho-educational interventions	United States	Patients (8–16 years) and family members					…				+
RCT (Kichler et al., 2013)	Psychologist-led, family-based group therapy sessions	United States	Patients (13–17 years) and parents				+	…				
RCT (Nansel et al., 2012)	Health adviser-led behavioural intervention	United States	Patients and family members				+					+
RCT (Nansel et al., 2015)	Trained facilitator-led child and parent in-clinic session	United States	Patients and parents	+				…				
RCT (Asarnow et al., 2011)	Clinician-led adolescent and family crisis therapy	United States	Patients (10–18 years) and family members							…		

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?								
				Nutrition/healthy eating	Perceived control over condition/improved knowledge*	Depression	Self-care/adherence	Physical health/weight loss*/ physical activity**	Hospitalization	Suicidal ideation/attempts	Mental health	Family support/parental stress
RCT (Connell et al., 2016)	Trained facilitator-led family check-up/ school-based prevention programmes	United States	Grade 6 students and family members							++		
RCT (Cross et al., 2011)	Trained facilitator-led parent/teacher behavioural programme	United States	School staff and parents		+					+		
RCT (de Groot et al., 2010)	Psychiatric nurse-led grief therapy sessions	Netherlands	Families bereaved by suicide							+		
RCT (Diamond et al., 2010)	Therapist-led attachment-based family therapy	United States	Patients (12–17 years) and family members							+		
RCT (Esposito-Smythers et al., 2011)	Multi-professional-led intervention with cognitive behavioural treatment	United States	Patients and family members				+		+	+	+	

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?								
				Nutrition/healthy eating	Perceived control over condition/improved knowledge*	Depression	Self-care/adherence	Physical health/weight loss*/ physical activity**	Hospitalization	Suicidal ideation/attempts	Mental health	Family support/parental stress
RCT (Gewitz et al., 2016)	Trained facilitator-led positive parenting training	United States	Patients and family members		+					+	+	
RCT (Hooven et al., 2012)	School nurse- or counsellor-led suicide prevention intervention	United States	Patients and parents							+		
RCT (Pineda & Dadds, 2013)	Family/mental health worker-led, psycho-educational programme for parents	Australia	Patients and parents							+	+	+
RCT (Rossouw & Fonagy, 2012)	Mental health worker-led family therapy	United Kingdom	Patients and family members			+				+		
RCT (Vidot et al., 2016)	Trained facilitator-led parenting skills programme sessions	United States	Grade 8 students and primary caregivers							…		+

Notes: Effects: '-' negative significant association, '—' strong negative significant association, '…' null finding, '+' positive significant association, '++' strong positive significant association. When an association is marked with an *, see column title.

Annex Table 1.3. Details of the family policies and their education effects

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?					
				Earnings increments	Child development/ health*/language **	Learning outcomes/ cognition	School participation/ dropout	Parental care/family time	Social development and behaviours
QE (Carneiro et al., 2011)	Increased paid and unpaid maternity leave	Norway, state level	Eligible mothers	+			…		
QE (Dustmann & Schönberg, 2012)	Expansions in maternity leave coverage in Germany	Germany, state level	Eligible mothers	+		+	+		
QE (Rasmussen, 2010)	Increased birth-related parental leave	Denmark, state level	Eligible mothers			…			
RA (Liu & Skans, 2010)	Increases to parental leave	Sweden, state level	Eligible mothers			…			
QE (Dahl et al., 2016)	Expansions of paid maternity leave	Norway, state level	Eligible mothers			…			
QE (Baker & Milligan, 2010)	Increase in duration of job-protected, paid maternity leave	Canada, federal and provincial levels	Eligible mothers		…			+	
LR (Barnett, 1995)	Research synthesis (36 studies): Early childhood development (ECD) services and low-income families	Global scope	Preschool children			+st	+lt		
LR (Currie, 2001)	Research synthesis: Preschool programmes and cognitive development	United States mainly	Preschool children			+	+		
LR (Anderson et al., 2003)	Research synthesis: ECD programmes and education outcomes (achievement, language, cognition, etc.)	Global scope	Preschool children			++	++		

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?					
				Earnings increments	Child development/ health*/language **	Learning outcomes/ cognition	School participation/ dropout	Parental care/family time	Social development and behaviours
LR (Pianta, 2009)	Research synthesis: Evidence studies of ECD and preschool programmes	Global scope	Preschool children		++	++			…
LR (Nores & Barnett, 2010)	Research synthesis: International evidence on the benefits of early childhood intervention	Global scope (23 countries)	Preschool children		++*	++			++
LR (Burger, 2010)	Research synthesis: Effects of multiple preschool programmes on cognitive development	Global scope	Preschool children			+			
LR (Camilli et al., 2010)	Meta-analysis of preschool interventions on cognitive outcomes	Global scope	Preschool children			+			
RA (Dodge et al., 2016)	North Carolina's Smart Start and More at Four programmes	North Carolina, United States, state level	Smart Start: preschool children; More at Four: high-risk preschoolers			++	+		
RA (Dumas & Lefranc, 2010)	Expansion of preschool enrolment	France, state level	All preschool children			++	++		
RA (Graces et al., 2002)	Head Start: An early public intervention programme for disadvantaged preschool children	United States, federal and local administration	Preschool children at risk of poverty and social exclusion				+		+
QE (Lefebvre et al., 2008)	A low-fee universal childcare policy in Québec	Québec, Canada, provincial level	All preschool children			-	…		

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?					
				Earnings increments	Child development/ health*/language **	Learning outcomes/ cognition	School participation/ dropout	Parental care/family time	Social development and behaviours
RCT (Lowell et al., 2011)	Child FIRST (Child and Family Interagency, Resource, Support, and Training)	Bridgeport, Connecticut, United States	Vulnerable children, prenatal to 6 years of age		+**				+
LR (Rawlings & Rubio, 2005)	Literature review of evaluation results for multiple conditional cash transfer (CCT) programmes aimed at improving schooling outcomes	Colombia, Honduras, Jamaica, Mexico, Nicaragua and Turkey	Poor households				+		
LR (Adato & Bassett, 2009)	Literature review of the assessments of 20 cash transfer programmes: 10 unconditional cash transfer (UCT) and 10 CCT programmes	Africa, Latin America, Asia	Vulnerable children and families				+		
LR (Baird et al., 2014)	Review of 75 reports that cover 35 CCT and UCT programmes aimed at improving education outcomes	Global scope	Vulnerable children and families				+		
QE (Attanasio et al., 2010)	Familias en Acción CCT programme	Rural parts of Colombia, municipality level	Poor households with children aged 7–17 years				+		
QE (Baez & Camacho, 2011)	Familias en Acción CCT programme	Rural parts of Colombia, municipality level	Poor households with children aged 7–17 years				+		
RCT/QE (Gitter & Barham, 2009)	Red de Protección Social	Nicaragua, regional level	Poor households				+		

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?					
				Earnings increments	Child development/ health*/language **	Learning outcomes/ cognition	School participation/ dropout	Parental care/family time	Social development and behaviours
RA (Glewwe & Kassouf, 2012)	Bolsa Escola (later renamed Bolsa Família) programme, which began in 1995	Brazil, municipality level	Poor households			+	+		
RCT (Macours et al., 2012)	Atención a Crisis	Rural Nicaragua, communities in six municipalities	Poor households		++				
QE (Ponce & Bedi, 2010)	Bono de Desarrollo Humano	Ecuador	Poor households			…			
QE (Oosterbeek, Ponce & Schady, 2008)	Bono de Desarrollo Humano	Ecuador	Poor households				+		

Notes: Effects: 'st' short-term effects, 'lt' long-term effects, '-' negative significant association, '—' strong negative significant association, '…' null finding, '+' positive significant association, '++' strong positive significant association. When an association is marked with an *, see column title.

Annex Table 1.4. Details of the gender-specific family policy effects

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?										
				Family stability (divorce risk)	Fertility	Mother's time with child	Gender equality in housework	Father's leave	Father's childcare time	Increased wages	Return to same job	Mother's labour market participation (in the first year*)	Mother's return to work after leave (delayed*)	Work preferences of mothers (commitment/part-time work)
QE (Kluve & Tamm, 2013)	Parental leave (increased payment)	Germany, East and West	Parents						…			-*	+	
QE (Gangl & Ziefle, 2015)	Parental leave (extension of leave period)	Germany, East and West	Parents										-*	-
RA (Hofferth & Curtin, 2003)	Parental leave (unpaid, job-protected leave)	United States, federal government	Parents							…			+	
QE (Schönberg, Uta & Ludsteck, 2014)	Maternity leave (expansions in coverage)	Germany	Mothers									-	+	
QE (Lalive et al., 2014)	Parental leave (various reforms: increased leave, job protection and increased payments)	Austria	Parents										-*	
QE (Lalive & Zweimueller, 2009)	Parental leave (increased leave)	Austria	Parents			+				-		-	-	

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?										
				Family stability (divorce risk)	Fertility	Mother's time with child	Gender equality in housework	Father's leave	Father's childcare time	Increased wages	Return to same job	Mother's labour market participation (in the first year*)	Mother's return to work after leave (delayed*)	Work preferences of mothers (commitment/part-time work)
RA (Waldfogel, 1998)	Parental leave (legislation)	United States and United Kingdom, national level	Parents							+				
QE (Baum, 2003)	Parental leave (legislation)	United States	Parents							…		…		
RA (Baker & Milligan, 2008)	Parental leave (expansions in length)	Canada, provincial level	Parents				+				+			-
QE (Hondralis, 2017)	Parental leave (longer entitlement and payment)	Australia	Parents										+	
RA (Rønsen & Kitterød, 2015)	Paternal leave (introduction of 'daddy quota')	Norway, national level	Parents										…	
QE (Schönberg & Ludsteck, 2014)	Parental leave (expansion of job protection period, and maternity benefit expansions)	Germany	Parents									…		
QE (Kotsadam & Finseraas, 2011)	Paternal leave (daddy quota in Norway)	Norway, national level	Fathers				+							

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?										
				Family stability (divorce risk)	Fertility	Mother's time with child	Gender equality in housework	Father's leave	Father's childcare time	Increased wages	Return to same job	Mother's labour market participation (in the first year*)	Mother's return to work after leave (delayed*)	Work preferences of mothers (commitment/part-time work)
QE (Ekberg, Eriksson & Friebel, 2013)	Paternal leave ('daddy month')	Sweden, national level	Fathers				…	+		…				
RA (Patnaik, 2018)	Paternal leave (daddy quota)	Canada, provincial level	fathers				+lt	+						
QE (Rege & Solli, 2013)	Paternal leave (daddy quota)	Norway, national level	Fathers					+		-				
QE (Steingrimsdottir & Vardardottir, 2015)	Paternal leave (daddy quota)	Iceland	Fathers		+				+					

Notes: Effects: 'st' short-term effects, 'lt' long-term effects, '-' negative significant association, '—' strong negative significant association, '…' null finding, '+' positive significant association, '++' strong positive significant association. When an association is marked with an *, see column title.

Annex Table 1.5. Details of the family policies and their youth employment effects

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?				
				Employment rates	Earnings levels	Service sector	Intergenerational mobility	Female labour market participation
ES (Zinn & Courtney, 2015)	Employment assistance programme	Eligible young people aged 16 years and older in foster care	United States, national level	…	…			
ES of administrative data/RA (Stewart et al., 2014)	Welfare support	Eligible young people transitioned out of foster care	United States, state level	…	…			
QE (Behrman et al., 2011)	PROGRESA/Oportunidades conditional cash transfer (CCT) programme	Families with children	Mexico			+		+
RA (Rodríguez-Oreggia & Freije, 2012)	PROGRESA/Oportunidades CCT programme	Young people aged 14–24 years	Mexico, rural areas	+	+		+	

Notes: Effects: '-' negative significant association, '—' strong negative significant association, '…' null finding, '+' positive significant association, '++' strong positive significant association.

Annex Table 1.6. Details of the family anti-violence programmes and their effects

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?						
				Access to health checks	Hospitalization	Developmental activities (e.g., reading to children) and child outcomes	Self-reporting of physical aggression	Reduced social acceptance of violence	Decrease in experience of IPV	Prevention of violent discipline of children and neglect
RCT (Abramsky et al., 2014)	Community intervention to prevent violence against women and reduce HIV risk, led by the Centre for Domestic Violence Prevention	Two areas in Kampala, Uganda	Adults under 50 years of age who had lived in the area for at least one year					+	…	
RCT (Alexander et al., 2010)	Therapist-led cognitive behavioural therapy with gender re-education community mobilization intervention to prevent violence against women and reduce HIV risk behaviours	Montgomery County, Maryland, United States	Adult male clients referred to the Abused Persons Program				…			
RCT (Duggan et al., 2004)	Home visitor-led Healthy Start Program for family functioning; cognitive behavioural therapy with gender re-education	Oahu, Hawaii, United States	Families assessed as 'at risk' of child abuse at the time of their child's birth							…

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?						
				Access to health checks	Hospitalization	Developmental activities (e.g., reading to children) and child outcomes	Self-reporting of physical aggression	Reduced social acceptance of violence	Decrease in experience of IPV	Prevention of violent discipline of children and neglect
RCT (DuMont et al., 2011)	Healthy Families New York (HFNY) intensive home visitation programme, with home visits are conducted by family support workers	New York, United States	HFNY evaluation included young women who were randomly assigned to the intervention or to a control group prior to the birth of their first child, as well as older women who entered the study after the birth of their first child or a subsequent child				+			+
RCT (Fergusson, Boden & Horwood, 2013)	Early start programme of intensive home visiting to families facing multiple challenges, led by family support workers with qualifications in nursing, teaching or allied disciplines	Christchurch, New Zealand	Families		+		+			
RCT (Green et al., 2014)	Healthy Families Oregon home visiting programme, led by programme staff	Oregon, United States	New parents assessed to be at risk	+		+		…		

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?						
				Access to health checks	Hospitalization	Developmental activities (e.g., reading to children) and child outcomes	Self-reporting of physical aggression	Reduced social acceptance of violence	Decrease in experience of IPV	Prevention of violent discipline of children and neglect
RCT (Kiely et al., 2010)	Intervention for intimate partner violence, emphasizing safety behaviours and led by specially trained social workers or psychologists	Washington, D.C., United States	Pregnant women aged 18 years or over, at 28 weeks pregnant or less						+	
RCT (LeCroy & Krysik, 2011)	Healthy Families Arizona: Services and home visiting intervention for intimate partner violence, emphasizing safety behaviours and led by home visitors	Arizona, United States	Families					…		+
RCT (Mejdoubi et al., 2013)	Strong Communities for Children: A multi-year comprehensive community-based initiative to prevent child maltreatment and improve children's safety, involving nurse-led prenatal and post-natal home visits	Netherlands	Low-educated women, under 25 years of age and pregnant with first child					+		

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?						
				Access to health checks	Hospitalization	Developmental activities (e.g., reading to children) and child outcomes	Self-reporting of physical aggression	Reduced social acceptance of violence	Decrease in experience of IPV	Prevention of violent discipline of children and neglect
RCT (Olds, 2002)	Nurse-led prenatal and post-natal home visiting programmes	New York, Tennessee and Colorado, United States	Women who have had no previous live births; each programme has focused recruitment on low-income, unmarried and adolescent women		+					+
RCT (Olds et al., 2007)	Nurse-led prenatal and infancy home visits as part of a public system of obstetric and paediatric care	Memphis, Tennessee, United States	Women who have had no previous live births, with risk-aligned socio-economic characteristics			+			…	
RCT (Pronyk et al., 2006)	Micro-finance loans combined with training (provided by micro-finance services and trainers)	Rural Limpopo province, South Africa	Women residing in villages						+	
RCT (Sharps et al., 2016)	Domestic Violence Enhanced Home Visitation Program: Prenatal and post-natal home visits by community health nurses	Multiple sites, United States	English-speaking pregnant women aged 14 years or older, with a low income, from prenatal home visiting programmes						+	

Study method and authors	Benefit or programme type and delivery methods	Where?	For whom?	What are the results?	
				Prevention of violent discipline of children and neglect	
				Decrease in experience of IPV	+
				Reduced social acceptance of violence	
				Self-reporting of physical aggression	
				Developmental activities (e.g., reading to children) and child outcomes	+ (boys)
				Hospitalization	
				Access to health checks	
RCT (Williford et al., 2012)	KiVa programme: A school-wide intervention with curricula and activities against bullying, which include parents and teachers as well as students	Finland	Students in late elementary (Grades 4–6) and middle school (Grades 7–9)		

Notes: Effects: '-' negative significant association, '—' strong negative significant association, '…' null finding, '+' positive significant association, '++' strong positive significant association.

CHAPTER 2.

SUSTAINABLE DEVELOPMENT GOAL 1: END POVERTY IN ALL ITS FORMS EVERYWHERE

Chapter 2. Sustainable Development Goal 1: End poverty in all its forms everywhere

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2.1. Introduction

Poverty is a persistent global challenge and commitments to reduce it have been a recurring theme in international development goals. Perhaps the most notable instrument in this regard is the Millennium Development Goals (MDGs) that were set by the United Nations to guide the global development agenda from 2000 to 2015.

The first MDG focused on eradicating poverty and hunger and aimed to halve the 1990 poverty rate by 2015. This target was achieved by 2010, five years ahead of schedule, mostly thanks to poverty reduction in China and India. In 2016, the Sustainable Development Goals (SDGs) came into effect to continue guiding the development agenda until 2030. SDG 1 aims to end poverty in all its forms everywhere and focuses on key areas of poverty eradication in the world. This concerted focus on global poverty eradication can be attributed to the fact that, rather than being merely a lack of household income or the inability to meet basic needs, poverty is now accepted as being multidimensional in nature, affecting the very core of being and existence for individuals, households and families. In essence, "poverty is a denial of choices and opportunities, as well as a violation of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and clothe a family, not having a school or a clinic to go to, not having the land on which to grow one's food or a job to earn one's living, nor having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence and it often implies living in marginal or fragile environments, not having access to clean water or sanitation".[2]

It is in recognition of these and other negative effects of poverty that virtually all countries across the world have developed and implemented strategies and policies to alleviate poverty, often with a focus on the elementary unit of society – the family. In developed countries, particularly welfare states, these have typically taken the form of benefits to supplement income or the provision of complementary services for families with children (Earle, Mokomane & Heymann, 2011; Richardson & Bradshaw, 2012). In developing countries, family-focused efforts to reduce poverty have mainly taken the form of social protection strategies and policies. This approach has largely been against the background of the acknowledged role of social protection in providing short-term relief to poverty-stricken families and its long-term promotive and transformational function in addressing some of the underlying causes of intergenerational poverty (Mokomane, 2011, 2013). Indeed, in low- and middle-income countries, social protection – in the form of conditional cash transfers (CCTs) and unconditional cash transfers (UCTs) delivered to individuals and families – was found to be effective in tackling structural determinants of poverty such as income poverty, lack of education, child labour, lack of social capital, poor health and nutrition, and gender inequalities (Baird et al., 2013; Bastagli et al., 2016; Bonilla et al., 2017; de Hoop & Rosati, 2014; Manley, Gitter & Slavchevska, 2013; Natali et al., 2016; Qwusu-Addo & Cross, 2014; Owusu-Addo, Renzaho & Smith, 2018).

2 The Statement for Action to Eradicate Poverty, adopted by the Administrative Committee on Coordination in May 1998, quoted in the Report of the Independent Expert on human rights and extreme poverty (E/CN.4/1999/48), which also contains indicators for poverty and hunger. Available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G99/106/41/PDF/G9910641.pdf?OpenElement>, accessed 14 January 2020.

The aim of this chapter is to draw on recent empirical evidence to show how family policy can facilitate the attainment of SDG 1. The chapter focuses on explicit family policies, which are those deliberately designed to achieve objectives regarding the family unit and its members (Robila, 2014).

The chapter begins by highlighting the poverty reduction goals in the SDGs and how family policy fits in. Using SDG Targets 1.1 and 1.3, an overview of global levels of poverty is then provided. The concluding section presents global evidence on how family policy – specifically involving cash transfers – can contribute to the achievement of SDG 1.

2.2. Poverty in the SDGs

SDG 1 aims to end poverty in all its forms everywhere by meeting the following five outcome targets:[3]

1.1 By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than $1.25 a day.

1.2 By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions.

1.3 Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.

1.4 By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance.

1.5 By 2030, build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters.

For the purpose of this chapter, extreme poverty is measured as the poverty headcount ratio at $1.90 a day, which is essentially the proportion of the population living on less than $1.90 a day at 2011 international prices. Extreme or absolute poverty was originally defined by the United Nations (1995) as "a condition characterized by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to social services." Today, extreme poverty is based on the monetary value of a person's consumption and is thus important because it captures those most in need (Roser & Ortiz-Ospina, 2017).

3 For the full list of specific indicators for each of the targets, see: United Nations Statistics Division, *Sustainable Development Goal Indicators: Metadata repository*, available at: <https://unstats.un.org/sdgs/metadata>, accessed 14 January 2020.

2.3. A global picture of poverty

The extreme poverty indicator and data used herein are taken from the World Bank's World Development Indicators databank and are based on primary household survey data obtained from government statistical agencies and World Bank country departments.

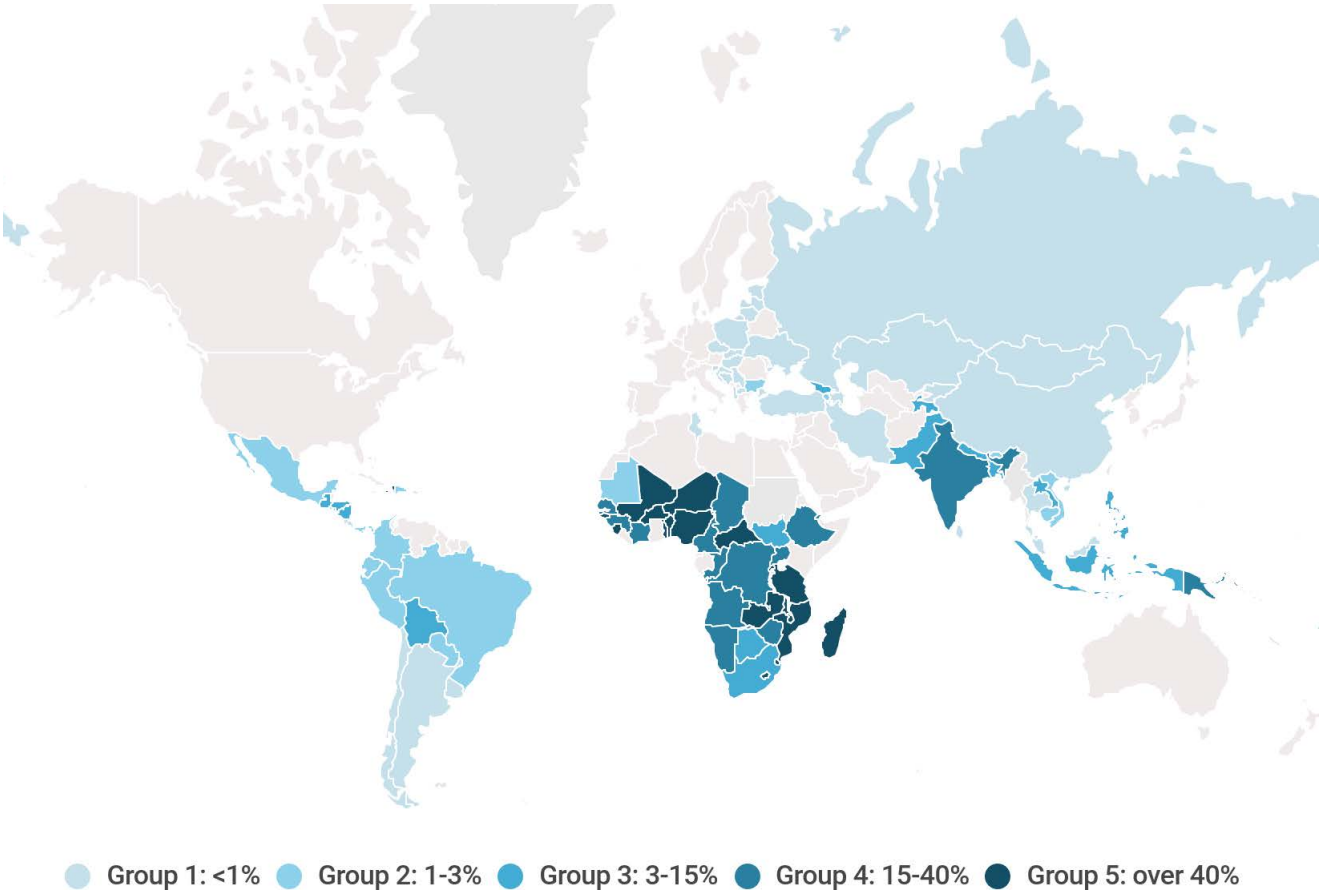
Recognizing its multidimensional nature, poverty is also explored in this chapter using the United Nations Development Programme (UNDP) Multidimensional Poverty Index (MPI), which identifies multiple deprivations at the household and individual level in health, education and standard of living. The MPI presents a comprehensive picture of people living in poverty – in terms of proportion of people in poverty and the intensity of their poverty – and permits comparisons across both countries and regions. The MPI data used in this chapter rely on two main databases that are publicly available and comparable for most developing countries: the Demographic and Health Surveys (DHS) Program database and the UNICEF Multiple Indicators Cluster Survey (MICS) database. Other non-income poverty indices were considered but not retained for this study – for example, UNICEF Multiple Overlapping Deprivation Analysis (MODA) was rejected because of its relatively limited geographical coverage in Latin America and South Asia. The global MPI provides the only comprehensive measure that is consistently available for non-income poverty in different geographical contexts.

2.3.1. Extreme poverty

Available data show that fewer people worldwide live in extreme poverty than ever before. For example, in 1990, almost 4 in 10 people were living below the international extreme poverty line of $1.90 a day (World Bank, 2016). In 2013, that figure had fallen to just over 1 in 10. It is worth noting, however, that despite the progress made, this smaller proportion still represents more than 767 million people. While this is a substantial decrease from the corresponding figure of 1.85 billion in 1990, the absolute number of people living in extreme poverty remains unacceptable and continues to be recognized as a global concern.

Sub-Saharan Africa and South Asia have consistently been identified as the two centres of global poverty that need the most international support. Map 2.1 shows that extreme poverty remains concentrated in these regions, with as many as 40 per cent of their populations classified as extremely poor in some countries. While these two regions are home to 45 per cent of all people living in a developing country context, they account for almost 70 per cent of the various dimensions of poverty.

Map 2.1. Proportion of the population living in extreme poverty 2008 to 2015 (less than USD 1.90 per day)



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Bank reports, 2015 and 2017.

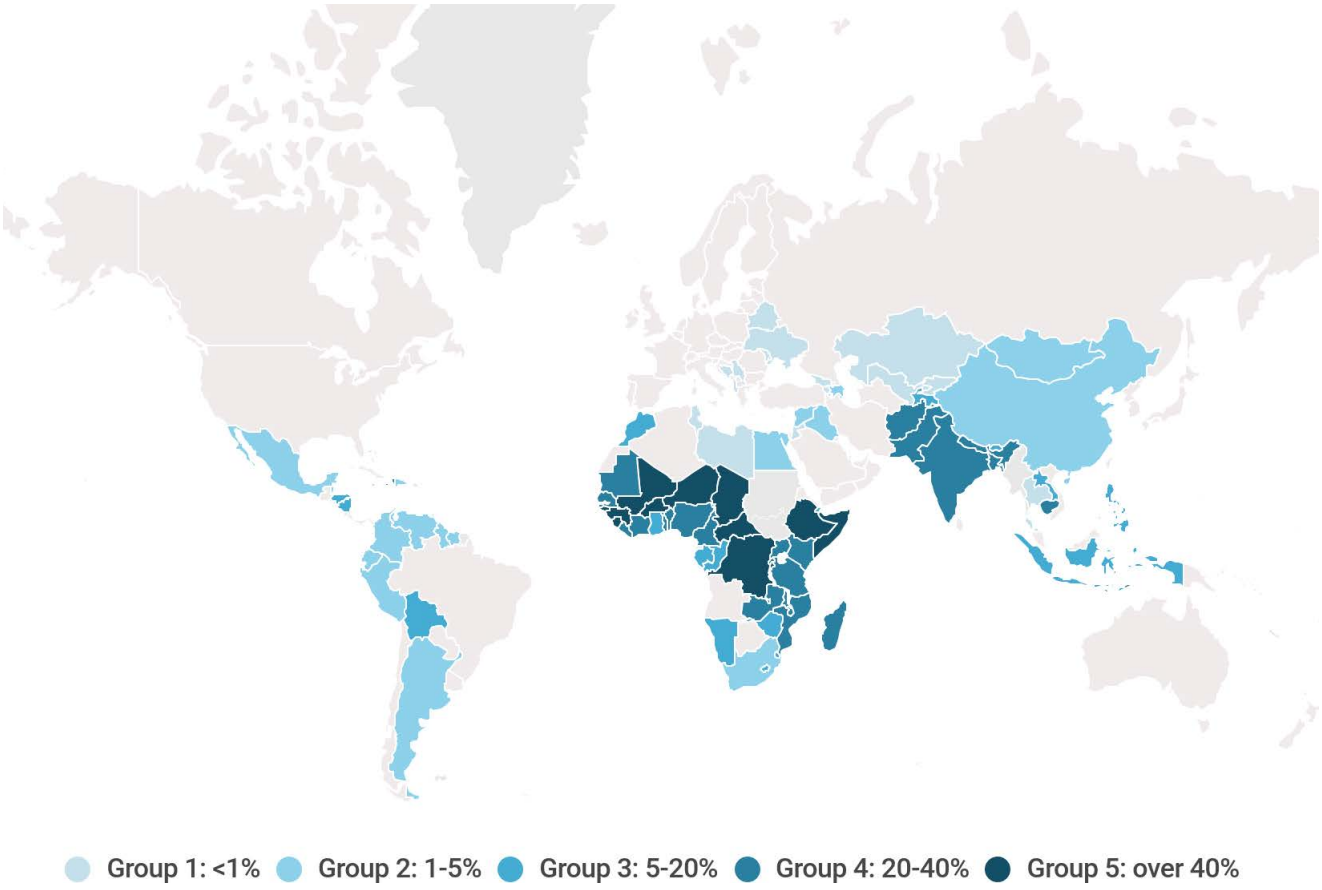
Specifically, in sub-Saharan Africa and South Asia, 75 per cent of people are income poor; 63 per cent are chronically hungry; 72 per cent of children are out of school; 75 per cent of adults are illiterate; and 86 per cent of people are living with HIV and AIDS. Furthermore, the two regions together account for more than 94 per cent of malaria deaths worldwide; for 84 per cent of under-five deaths and 86 per cent of maternal deaths globally; for 87 per cent of the global population that practises open defecation; and for 73 per cent of the world's stunted children (Sustainable Development Solutions Network, 2012).

The overall picture presented by Map 2.1 is that extreme poverty levels are much higher in developing regions, particularly in Africa and South Asia. Map 2.1 shows that extreme poverty is also high in some parts of East Asia and the Pacific, and that in Latin America and the Caribbean rates of extreme poverty vary widely. With regard to Latin America, the World Bank (2015) reports that the proportion of the region's population living in extreme poverty declined from 24.1 to 11.5 per cent in the 11-year period 2003–2013. This has been largely attributed to the expansion of social protection programmes in the region over the past decade and a half (World Bank, 2015). Additionally, it has been reported that nearly 100 million people climbed the socio-economic ladder to join the middle class in the same period, due to economic growth dynamics and job creation. Despite the region's impressive development over the past decade, some 130 million Latin Americans were still considered chronically poor in 2015 (Vakis, Rigolini & Lucchetti, 2016).

2.3.2. Multidimensional poverty

Map 2.2 presents a global picture of multidimensional poverty by country using most recent MPI data available. The overall pattern is much the same as the extreme poverty pattern: multidimensional poverty is much higher in sub-Saharan Africa and South Asia, and also affects East Asia and the Pacific as well as Latin America and the Caribbean.

Map 2.2. Levels of Multidimensional Poverty Index (MPI), 2010 specifications



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: OPHI (2020).
Notes:Multidimensional Poverty Index: Percentage of the population that is multidimensionally poor adjusted by the intensity of the deprivations. Data for around 2010. For updated data, and technical notes, see source.

Available evidence shows that of the three indicators that make up the MPI, standard of living is the largest contributor to deprivation (*see Annex Table 2.1*). The MPI considers six indicators for standard of living, three of which are related to SDG family health and standard of living targets and particularly affect women (Calderon & Kovacevic, 2015). The three indicators are:

- Access to clean drinking water (SDG Target 6.1): A household has access to clean drinking water if the water source is no more than a 30-minute walk away (round trip) and is any of the

following types: piped water, public tap, borehole or pump, protected well, or protected spring or rainwater.

- Access to improved sanitation (SDG Target 6.2): A household is considered to have access to improved sanitation if the household has some type of flush toilet or latrine, or ventilated improved pit or composting toilet, provided that it is not shared.
- Use of clean cooking fuel (SDG Target 7.1): A household that cooks with dung, charcoal or wood is considered deprived in cooking fuel.

The MPI also includes access to electricity and flooring material – a household with a dirt, sand or dung floor is considered deprived in flooring. While not directly related to the SDGs, these two indicators provide an idea of the standard of living of household members. The final indicator covers the ownership of certain consumer goods (radio, television, telephone, bicycle, motorbike, car, truck and refrigerator); if a household does not own more than one of these goods, then each person in the household is considered deprived (Calderon & Kovacevic, 2015). It is worth noting, as Calderon & Kovacevic, (2015, p. 9) posit, "Clearly, all the living standard indicators are means rather than ends; they are not direct measures of functionings" (Ibid: 9). However, the authors note a key strength of living standard indicators when compared to income measures, in particular that they are "…very closely connected to the end…they are supposed to facilitate" (Ibid).

2.4. Family policy and meeting SDG 1: A review of the evidence

The risk of monetary and multidimensional poverty has been shown to be higher in certain types of families and households. In developing countries, these include female-headed households; migrant families, particularly if the parents are low-skilled and divorced/separated for longer periods of time; families living in rural areas and dependent on agriculture; and families living in urban slums with very little access to basic social services (Cebotari, Mazzucato & Appiah, 2017; International Fund for Agricultural Development, 2017; Mokomane, 2013; Molini & Paci, 2015; UNICEF, 2015; UNICEF, 2016a). In developed countries, the risk of poverty and deprivation also tends to be higher among migrants and asylum seekers; sole parent families; families in which the education level of parents is low; families with low work intensity; and large families (Chzhen et al., 2014; Richardson & Bradshaw, 2012; UNICEF, 2016b; UNICEF, 2018).

A wide body of evidence has shown that in all such families, poverty is determined by a number of socio-economic[4] factors that can be broadly categorized as risk and vulnerability; low capabilities; inequality, exclusion and discrimination; and limited livelihood opportunities (Handley et al., 2009). At the core of these factors is a low level, or lack, of earned income due to unemployment or underemployment. In essence, many people – and hence their families – are in poverty because they are unable to find a job that pays a living wage or find any job at all. Female-headed households, for example, endure a disproportionate burden of poverty because women rarely work in traditional full-time, permanent, secure jobs (Milazzo & van de Walle, 2015; Julka & Das, 2016). Instead, they are more likely than men to work in 'vulnerable employment' – that is, categories of work that are highly precarious due to low productivity, low and highly volatile earnings, exposure to health and safety risks, and inadequate social protection, where such schemes exist (Kukrety, Oxfam & Issam Fares Institute of American University Beirut, 2016; UNICEF, 2016a). It is also often argued that although women perform nearly two thirds of the world's work, they receive only one tenth of the world's income and own only one hundredth of the world's property (Education and Training Unit, 2018). Female-headed households in many developing countries also tend to have higher dependency ratios and, overall, to be poorer than households with a present or temporarily absent male head.

4 For a review of sociopolitical-economic factors, see, for example, Handley et al. (2009).

Unemployment also affects child poverty levels – indeed, it is well-documented that in most countries, a notable proportion of those children living in poverty live in households where there are no working adults (Cancian et al., 2010; Hall & Sambu, 2017). As well as providing a regular income, an employed adult may bring to the household other benefits – including health insurance, unemployment insurance and maternity leave – that can contribute to children's health, development and education (Hall & Sambu, 2017). Children of unemployed parents are therefore more at risk of suffering the intergenerational cycle of poverty and disadvantage, and are more likely to experience educational disadvantages, are more vulnerable to unemployment and are at greater risk of later behavioural problems (Williams Shanks & Danzinger, 2011).

To the extent that an individual's needs and income potential can both change over the life course, modifying the probability of falling into poverty, it can be argued that poverty has a relevant age dimension. Like children, the elderly tend to be over-represented in poor families (Prunty, 2004; Mokomane, 2011). In developed countries, the combination of strong social security systems, well-developed capital markets and small households contributes to a high standard of living for older people. But these conditions are not replicated in many developing countries, where pension systems are weak and mostly favour the non-poor. Furthermore, the long-term formal credit market is almost non-existent, and elderly persons usually live in sizeable extended households, sharing the budget with a large number of household members, including children (Gasparini et al., 2007). Older people, particularly women, also often look after grandchildren and continue to perform unpaid domestic work for their families (Mokomane, 2011).

As money is needed to access a range of services, income poverty – which underlies much family poverty – is often closely related to poor health, reduced access to education, and physical environments that compromise personal safety (Hall & Sambu, 2017). Other personal and social costs of unemployment that are associated with insufficient income and financial hardship include: increased debt burden; homelessness and housing stress; family tensions and breakdown; increased social isolation; crime; erosion of confidence and self-esteem; and the atrophy of work skills. All of these are brought about by the erosion of the socio-economic functions of employment and tend to increase with the duration of unemployment (McClelland & Macdonald, 1999).

With many governments recognizing that a low or insufficient income is a key poverty driver in families, cash transfer programmes have increasingly become part of national poverty reduction and social protection strategies (*see Map 2.3*). Cash transfers provide a predictable and reliable source of income, which can have a significant impact on the capacity of households to meet their own needs and invest in developing their human and physical capital (Woolard & Leibrandt, 2010).

There are essentially two types of cash transfers: conditional and unconditional. The latter are effectively entitlements paid out to certain predetermined categories of individuals who are unable to work and are not covered by other social security schemes. These include people with disabilities, the chronically ill, older people without family support, and orphans and other vulnerable children (Devereux, 2006). UCTs not only provide a safety net against poverty by offering basic support to all eligible beneficiaries, but they also help families to cope with caring responsibilities, thus promoting intergenerational support (Kaseke, 2005). In developing contexts, UCTs are popular schemes for delivering and improving welfare among vulnerable segments of the population. In 2016, more than 130 low- and middle-income countries had at least one non-contributory UCT programme, with such programmes particularly visible in Africa: 40 sub-Saharan African countries had implemented a UCT by 2016, twice as many as in 2010 (Bastagli et al., 2016).

CCTs, on the other hand, have the primary objective of providing short-term poverty alleviation by simultaneously maintaining consumption and promoting investments in long-term human capital development. This is done by linking the cash transfers to the demand side of service delivery and paying them subject to certain conditions being met – typically children's enrolment in and regular attendance at school, and attendance at scheduled preventive health check-ups, immunizations and other services by young children and/or pregnant or lactating women (Adato & Hoddinott, 2007; Slater 2011). While most developed countries have long-running CCTs, such programmes are less prevalent in developing contexts.

In 2015, 63 low- and middle-income countries had at least one CCT programme, up from 27 countries in 2008 (Honorati, Gentilini & Yemtsov, 2015).

Despite the differences between CCT and UCT programmes, there is evidence to suggest that both are effective tools in reaching the SDGs in different geographical contexts. A meta-analysis of more than 30,000 articles related to cash transfer programmes revealed that CCT programmes accomplish the same goals as UCT programmes in relation to health and nutrition outcomes (Manley et al., 2013). Furthermore, large-scale reviews of electronic databases and web repositories of key experts and policy organizations found that CCT and UCT programmes implemented in a variety of contexts were effective in improving key well-being outcomes such as monetary poverty; education; health and nutrition; savings, investment and production; employment; and empowerment (Bastagli et al., 2016; Owusu-Addo et al., 2018). Thus, cash transfer programmes – both conditional and unconditional – are important social protection tools that aim, among other things, to advance both national and international agendas in well-being and poverty reduction. It can be said that these efforts are in line with SDG Target 1.3: Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.

Global monitoring of child and family benefits in 2017 revealed that the benefit schemes of 117 of the 186 observed countries were anchored in national legislation (ILO, 2017). It is worth noting, however, that while many low- and middle-income countries have ingrained specific child and family benefit programmes in legislation, these programmes cover only a small proportion of the population and hence do not meet the needs of all children and families. This is particularly the case in the poorest countries of sub-Saharan Africa and in parts of Asia as well as in some Pacific countries. While many Latin American countries combine employment-related benefits with non-contributory benefits, the benefits provided in countries of sub-Saharan Africa, South Asia, and East Asia and the Pacific are not always anchored in legislation or are employment–related only (*Ibid*). The latter have limited coverage, as they are available only to waged formal sector workers who are able to contribute to social security; informal sector workers, who account for a large part of the labour force in many developing contexts, do not have access to such benefits (Mokomane, 2013; UNICEF, 2016a). Extending social benefits coverage to informal workers, through a mix of contributory and non-contributory benefits, is key to enabling the transition to a formal economy while at the same time promoting inclusion and preventing poverty (ILO, 2017).

2.4.1. Literature search and criteria for inclusion of studies in the review

This section explores the extent to which social protection programmes – and specifically non-contributory cash transfer programmes – can mitigate the impact of poverty drivers for families and vulnerable family members. It undertakes a review of the literature using sources surfaced using Google Scholar and JSTOR. The searches were performed with increasing specificity, beginning with a broad generic keyword search using the terms "family policy", "family policy interventions", "poverty", "material deprivation" and "poverty reduction". This was followed by a variety of keyword searches using different combinations of family policy type ("cash transfers", "child allowances", "old age pensions" and "disability grants"), research design ("experimental" methods, "quasi-experimental" methods and "randomized control trials (RCT)") and region ("Africa", "Asia" and "Latin America"). A further search was undertaken to source relevant citations in studies retrieved through the keyword searches.

The literature search was limited to studies written in English and published after 2007, the year that many low- and middle-income countries began to experience a boost in the implementation of, and reporting on, their cash transfer programmes (Honorati et al., 2015). Limiting the literature search to this specific time period enabled the examination of a more comparable group of cash transfer programmes.

2.4.2. Cash transfers and poverty outcomes

While it is difficult to trace the long-term impact of cash transfer programmes on broader national poverty and inequality indicators (Hujo & Gaia, 2011), there is ample evidence that CCT and UCT programmes support household consumption and lead to direct improvements in individual and household welfare (Soares, Ribas & Hirata, 2008; Adato & Bassett, 2009; Barrientos & Niño-Zarazúa, 2010).

The evidence also points to a clear link between the receipt of cash transfers and children's educational outcomes. For example, in a systematic review of the relative effectiveness of cash transfers in improving school enrolment, attendance and test scores in developing countries, Baird et al. (2013) found that CCTs and UCTs increased the likelihood of school enrolment by 41 per cent and 23 per cent respectively. The two types of transfers were also found to significantly increase children's school attendance (odds ratio of 1.65 for CCTs and 1.42 for UCTs). Notably, Baird et al. (2013, p. 7) also posit: "The effect sizes for enrollment and attendance are always larger for CCT programmes compared to UCT programmes but the difference is not significant."

Available evidence also shows that both CCTs and UCTs not only increase the uptake of health care services, but also affect intermediate determinants of health by addressing elements of material deprivation and morbidity risk (Owuso-Addo et al., 2013; Owuso-Addo & Cross, 2014; Owuso-Addo et al., 2018) and empowerment (Bonilla et al., 2017; Bastagli et al., 2016; Natali et al., 2016). This is essentially because cash transfers can increase household disposable income and purchasing power to buy better quality and more nutritious food; reduce transport costs for accessing public health care services; and reduce out-of-pocket expenditure for accessing health care services (Zhang et al., 2018). Increases in household income can also improve mental health and well-being by relieving households of stressful living conditions and concerns about meeting basic needs (Owuso-Addo et al., 2013).

In relation to savings, investment and production, Bastagli et al.'s review of cash transfer studies (2016, p. 8) concluded, "Overall, impacts on savings, and on livestock ownership and/or purchase, as well as use and/or purchase of agricultural inputs, are consistent in their direction of effect, with almost all statistically significant findings highlighting positive effects of cash transfers". Bastagli et al. (2016) also found that in over half of the studies reviewed, cash transfers did not have an impact on adult work. All of the studies on child work intensity reported statistically significant results, however, showing a clear reduction in child labour associated with cash transfers (Bastagli et al., 2016). This was noted by others such as de Hoop and Rosati (2014), who also found gender differences in this effect: boys saw a larger reduction in participation in economic activities, while there was a relatively larger reduction in girls' involvement in household chores. It has been argued that there are two main channels through which cash transfers can reduce child labour. The first is a pure income effect, in which cash transfers tend to cushion the effect of economic shocks that may lead households to use child labour as a coping strategy (de Hoop & Rosati, 2013). The second channel relates more to CCTs and their basic requirement for children's enrolment in and regular attendance at school, which essentially restricts how much time children have available to participate in income-generating activities (Bastagli et al., 2016).

In terms of women's empowerment, evidence from Bastagli et al.'s (2016) review shows that increased income from cash transfers not only reduces stress, but it also increases the decision-making power of women in beneficiary households (evidence in this study showed a protective role of increased income, but other studies have shown an opposite effect). For example, and consistent with these findings, a mixed methods evaluation of the Zambian Child Grant Programme found that women in beneficiary households made more independent and joint decisions across five domains: their own health; their own income; their partner's income; major household purchases; and family visits (Bonilla et al., 2016). Qualitatively, the evaluation found that while entrenched gender norms still limited changes in intra-household relationships, women in beneficiary households expressed increased financial empowerment and were able to retain control over the cash transfers for household investment and savings.

In line with this evidence, cash transfers are often referred to as the 'silver bullet' in the fight against poverty and inequality – a reputation that is largely based on programme evaluations in different geographical contexts (Adato & Hoddinott, 2007; Baird et al., 2013; Bastagli et al., 2016).

Despite the success of cash transfer programmes, the same evidence points to shortcomings – including disproportionate gender and in-country regional effects – in achieving a long-term impact on outcomes related to nutrition, learning and health (Baird et al., 2013; Manley et al., 2013). Many studies conclude that to achieve transformational change, cash transfer programmes must be improved with additional design components such as 'cash plus' approaches or access to basic services and support (Bonilla et al., 2017; de Hoop & Rosati, 2014).

A recent evaluation highlights the cash plus approach, which offers improvements to regular cash transfers, as a solution to address the shortcomings of existing programmes (Roelen et al., 2017). A cash plus intervention combines cash transfers with complementary types of support such as the provision of additional benefits or in-kind transfers; information or behaviour change strategies; direct access to services; and/or support to access additional services. Thus, cash plus programmes may take various forms and combine existing and external components to improve target outcomes, depending on context and pragmatic considerations.

Under the following subsections on family cash transfers, child allowances and old age pensions, this chapter reviews examples of how cash transfers can contribute towards meeting SDG 1 targets. Tables 2.1 to 2.3 then summarize the examples given in each subsection. Examples of cash plus interventions are presented as well as traditional cash transfer programmes. A focus is placed on three aspects that have been used consistently in the literature to evaluate anti-poverty programmes: coverage, targeting and poverty effectiveness (Gao & Zhai, 2012). There is also a focus on a fourth aspect, geographical diversity, to capture the diversity of contexts and variation in programme implementation. Generosity, the fifth aspect often used to evaluate anti-poverty programmes, is not explored due to a general lack of data and sparse discussion in the literature reviewed herein.

Family cash transfers

To observe the impact of family cash transfers on poverty reduction, a number of cases from different geographical contexts are presented below (*see Table 2.1 for a summary*).

In the Republic of Moldova, Verme (2008) evaluated the welfare and poverty impact of nine social assistance benefits implemented from 2001 to 2004.[5] Using data from the Moldova Household Budget Survey for 2001–2004, the evaluation results showed that the bulk of the benefits were allocated to households with monthly consumption per capita below the poverty line. The results also showed that living conditions significantly improved between 2001 and 2004, as average consumption relative to the poverty line increased from a ratio of 1.05 in 2001 to 1.53 in 2004. The poverty headcount ratio, on the other hand, declined from 63 to 34 per cent over the same period. Verme (2008) cautions, however, that when controlling for factors that were seen to have led to improved household welfare (i.e., behavioural responses, unobserved heterogeneity, endogeneity, and measurement error), the results suggested that the social assistance benefits had not contributed to improved welfare overall. The study attributes this to distorted targeting, particularly of the non-poor, as well as to the mechanism used for the self-selection of beneficiaries.

5 The nine benefits were: utilities compensation; child allowance; war veteran allowances; social allowances; death grants; Chernobyl compensations; caregiver allowances for people with disabilities; transport compensation for people with disabilities; and social assistance in the form of material benefits.

One of the best-known CCT programmes in the world is Brazil's Bolsa Família programme. Created in 2003, the programme aims to mitigate the adverse effects of poverty and break the intergenerational cycle of poverty through the provision of a monthly cash benefit to poor and extremely poor families who meet the required health and education conditions. The programme currently covers approximately one quarter of the Brazilian population (Garcia & Wong, 2016). Applying a quasi-experimental method using data from a field survey, Oliveira et al. (2007) undertook a preliminary evaluation of the programme and found that among families living in poverty, Bolsa Família beneficiary families were able to spend relatively more on food, health, education and children's clothing than non-beneficiary families. This is consistent with other reviews of the programme (e.g., Barrientos & Niño-Zarazúa, 2010) which have noted that through its provision of cash transfers, Bolsa Família has significantly reduced child poverty and helped to break the intergenerational cycle of poverty in many families.

Jamaica's Programme of Advancement through Health and Education (PATH) is a CCT that aims to achieve improved targeting of welfare benefits for the poor and to increase human capital by making receipt of the cash transfers conditional on school attendance and health care visits. PATH has two components: (1) child assistance grants, which provide health and education grants for eligible poor children aged 0–17 years on condition that they make a specified number of health clinic visits; and (2) social assistance grants, which provide cash benefits to poor pregnant or lactating mothers; to older people aged 65 years and over; and to adults aged under 65 years who are poor or destitute, or who have a disability. To evaluate the programme, Levy and Ohls (2007, 2010) combined qualitative analysis of programme implementation, tabular analysis of benefit targeting and multivariate analysis of survey data. Their results showed that the PATH coverage rate was about 20 per cent, while its targeting effectiveness was found to be better than that of other social programmes in the country. Overall, 58 per cent of PATH benefits went to the poorest quintile of the population; in other national programmes, such as the food stamp programme, the corresponding figure was only 36 per cent. The evaluation showed that, overall, PATH relieved some of the household financial pressures associated with school attendance such as the need to provide children with lunch money and pay for school transport costs. As a result, school attendance increased by about 0.5 days per month, while health care visits for children aged 0–6 years increased by approximately 38 per cent. At the same time, however, the evaluation revealed that there was no evidence that PATH was able to influence longer-term outcomes such as academic marks, grade progression and health care status.

In Paraguay, Soares et al. (2008) evaluated the pilot of the Tekoporã programme, which offers direct cash transfers to families that are: (1) classified as extremely poor, with an Index of Quality of Life (ICV) below 25, or moderately poor, with an ICV of between 25 and 40; (2) include at least one child aged 0–14 years or a pregnant woman; and (3) live within the programme's priority areas, mainly the poorest districts in the country.[6] The programme aims to reduce the potential for future poverty by: (1) breaking the intergenerational cycle of poverty through investments in children's health and education; and (2) increasing – through a family support initiative – the productive potential and social participation of households. Using an evaluation survey conducted in the five pilot districts and regression analysis, the authors noted that Tekoporã increased school attendance in beneficiary households, from 93 to 96 per cent. Furthermore, increases in the average number of health care visits by children under 5 years of age were noted, as were vaccination updates for children in moderately poor beneficiary households. Overall, the Tekoporã programme led to a 17 per cent reduction in extreme poverty in the pilot districts (from an internal level of 52 per cent), increased the per capita income in beneficiary households by between 31 and 36 per cent, and encouraged autonomous income generation among beneficiary households.

The Ingreso Ciudadano (IC) programme was the most important component of Uruguay's National Emergency Plan, implemented from April 2005 to December 2007 with the aim of reducing high poverty

6 The ICV, a non-monetary measure that ranges from 0 to 100, synthesizes several quality-of-life dimensions such as access to public services, health and education outcomes, occupation of the household head, housing condition and household assets (Soares et al, 2008).

rates and indigence in the country (Borraz & González, 2009). The programme's target population was the first quintile of households below the poverty line. According to Reuben et al. (2008), more than 75 per cent of IC beneficiary households belonged to the poorest quintile of the population. Beneficiary households received a monthly cash benefit (updated quarterly according to the Consumer Price Index) conditional upon school enrolment and attendance and regular health status control of the children of the households. Using data from Uruguay's annual national household survey and the propensity score matching procedure, Borraz and González (2009) evaluated the impact of IC, with a specific focus on school attendance, child labour and labour supply. Taking cognisance of the fact that attendance rates for children aged 8–11 years were already high, the evaluation found that the programme had no significant effect on school attendance, but that it did reduce female child labour in the capital, Montevideo, and total hours of child labour in the rest of urban Uruguay. While an examination of the programme's effectiveness in terms of poverty reduction was beyond the scope of the Borraz and González (2009) study, a review of IC and other Uruguayan social protection programmes by Reuben et al. (2008) concluded that extreme poverty rates in the country would likely have increased by 50 per cent – from 2.9 to 4.3 per cent – had IC not been implemented.

Namibia, a middle-income country in sub-Saharan Africa, stands out in the region for its long tradition of providing a universal and non-contributory pension as well as a quasi-conditional means-tested child grant. Other social cash transfers in the country include the disability pension, war veterans' subvention, child maintenance grant, special maintenance grant, foster care grant and place of safety grant. Levine et al. (2009) measured the impact of these cash transfers on poverty and inequality using data from the Namibia Household Income and Expenditure Survey and administrative data, and found that the transfers had a large effect on poverty reduction, particularly for the 'ultra-poor' where a 22 per cent reduction was noted compared with a 10 per cent reduction among the 'poor'. The transfers also reduced inequality, albeit to a limited extent. Levine et al. (2009) noted, however, a number of issues related to targeting. For example, despite the old age pension being universal, it is often more targeted at lower-income households. Among the various reasons for this are that older people tend to be concentrated in poorer households, and that the stigma and inconvenience often associated with the receipt of social assistance can discourage the relatively well off from receiving the pension. Similarly, the authors noted large inclusion and exclusion errors with regard to the child grant targeting in Namibia.

Chile Solidario is the most important anti-poverty programme in Chile. It was implemented from 2002 to 2012 and has since been transformed into the Ingreso *É*tico Familiar programme, which expends its portfolio of cash transfers to focus more on labour market and productive inclusion features (Roelen et al., 2017). Chile Solidario itself included cash plus components in its three main elements: psychosocial support, preferential access to state social services and programmes, and guaranteed access to state subsidies and to a small amount of money provided exclusively for beneficiaries.[7] A study by de la Guardia, Hojman and Larrañaga (2011) used the Chile Solidario Panel Survey and administrative data to evaluate the programme with a focus on employment and income. The authors concluded that the programme had positive effects on psychosocial welfare and on the take-up of subsidies and social programmes. There were also clear positive effects on the number and proportion of workers in the family and on the employment of the head of household. By the same token, in evaluating the short-term effects of the Chile Solidario programme, Galasso (2011) concluded that it significantly increased beneficiaries' take-up of cash assistance programmes and of social programmes for housing and employment and to improve education and health outcomes for participating households. In the short term, however, there was no evidence of improved employment or income outcomes. This was also noted by Borzutzky (2009), who concluded that Chile Solidario did not achieve its short-term poverty reduction targets. The most recent reflections on the programme, however, have noted the long-term success of the 'plus' components of Chile Solidario, namely the psychosocial support to bring vulnerable groups into the network of social services in the country (Cecchini, Robles & Vargas, 2012; Roelen et al., 2017).

7 For a more detailed description of these cash plus components, see Palma and Urzúa (2005).

Riccio et al. (2010) evaluated Opportunity NYC–Family Rewards, an experimental CCT programme aimed at helping families in New York City's most poverty-stricken communities to break the intergenerational cycle of poverty. Compared with typical CCT programmes, Family Rewards is interesting for two basic reasons: (1) it was funded by a private, non-profit agency rather than by government; and (2) it was implemented in a developed country. The evaluation showed, however, as stated by Riccio et al. (2010, p. ES-17), "the concept is feasible to implement and can make a difference in the lives of poor families in a developed country." The overall results showed that the cash payments that participant families received every two months played a major role in reducing immediate poverty and material hardships, and improved some human capital investments across the domains of children's education, family health care and parental employment.

Two recent studies from the Overseas Development Institute (ODI) reviewed the evidence of the impact of cash transfer programmes in low- and middle-income countries, with the first looking at the role of design and implementation features (Bastagli et al., 2016) and the second at the impact of programmes on women and the families they head (Hagen-Zanker et al., 2017). The two studies reviewed the evidence across six outcome areas: monetary poverty; savings, investment and production; education; health and nutrition; employment; and empowerment. The reviews covered literature spanning the years from 2000 to 2015 and their findings show positive impacts on, among others, reducing monetary poverty, increasing school attendance and improving health and employment. Against this background, the authors concluded that cash transfers can be an effective family instrument to enhance the well-being of women, girls and other household members. Indeed, the review noted that cash transfers lead to female- or male-headed households making greater investments in economic assets and increased productive investments. There does not appear to be strong support for differences in the outcomes arising from programmes targeting women, men or based on the age of the recipient. The authors also mention the role of gender-based power dynamics in the household that often influence how the cash transfer is spent. The level and duration of transfers are also important, with higher transfer levels and longer programme durations associated with larger impacts on food expenditure, savings and investments, and educational, health and nutritional outcomes.

In Bangladesh, Ahmed et al. (2009) examined the efficacy of cash transfers in enhancing the livelihoods of the ultra-poor in rural areas. The authors conducted an impact evaluation of, among others, the Food Security Vulnerable Group Development (FSVGD) programme, which targets poor women and provides them with food and cash. Drawing on qualitative and quantitative survey data from programme beneficiaries and non-beneficiaries, and using the propensity score matching method of impact evaluation, the authors noted that while the FSVGD programme reduced extreme poverty by 30 percentage points for programme participants, 61 per cent of the FSVGD households remained extremely poor. By the same token, the authors argued that although current FSVGD participants showed relatively large improvements in food security and livelihood indicators, there was little evidence that they were able to sustain these improvements after leaving the programme. Among the explanatory factors given for this were the size of the transfers and their multiplier effects on income, which are insufficient to enable most beneficiaries to move out of poverty. Irregularities in cash transfers to FSVGD participants due to administrative difficulties was identified as another factor.

Table 2.1. Summary of family cash transfer interventions and evaluations and reviews of their effects on poverty

Authors	Family intervention description (How are they doing it?)	For whom?	Where? What level?	How is it evaluated?	What are the results?
Verme (2004)	Social assistance benefits	Poor and vulnerable households	Republic of Moldova, state level	Incidence analysis; regression analysis	Benefits significantly improved living conditions and reduced poverty headcount ratio.
Oliveira et al. (2007)	Bolsa Família programme, created in 2003 to mitigate poverty through the provision of a monthly cash benefit	Poor and extremely poor families who meet the required health and education conditionalities	Jamaica, state level	Quasi-experimental method using data from a field survey	Beneficiary families spend relatively more on food, health education and children clothing than non-beneficiary families.
Levy & Ohls (2007, 2010)	PATH, a conditional cash transfer (CCT) programme that aims to achieve improved targeting of welfare benefits and to increase human capital	Poor eligible children aged 0-17 years; poor pregnant or lactating mothers; older people aged 65 years and over; adults aged under 65 years who are poor or destitute, or who have a disability	Jamaica, state level	Qualitative analysis of programme implementation; tabular analysis of benefit targeting; and multivariate analysis of survey data	Increased school attendance and preventive health checks. No evidence of effects on longer-term outcomes such as academic marks, advancement to next grade, and health care status.
Soares, Ribas & Hirata (2008)	Tekoporã CCT programme pilot	Poor and moderately poor households	Paraguay, five poor districts: Buena Vista, Abai, Santa Rosa del Aguaray, Lima and Union	Data from evaluation survey and regression analysis	Increases in school attendance and number of health care visits. Overall reduction in extreme poverty.
Borraz & González (2009)	Chile Solidario	People living in conditions of extreme poverty	Chile, state level	Chile Solidario Panel Survey and administrative data; propensity score matching procedure	Significant increase in take-up of cash assistance programmes and of social programmes for housing and employment and to improve education and health outcomes for participating households. In the short term, however, there was no evidence of improved employment or income outcomes.

Authors	Family intervention description (How are they doing it?)	For whom?	Where? What level?	How is it evaluated?	What are the results?
Levine et al. (2009)	Universal and non-contributory pension	All eligible people	Namibia, national level	Namibia Household Income and Expenditure Survey and administrative data	All cash transfers had a large effect on poverty reduction. Transfers also reduced inequality, albeit to a limited extent.
de la Guardia et al. (2011)	Chile Solidario	People living in conditions of extreme poverty	Chile, national level	Chile Solidario Panel Survey and administrative data	The programme significantly increased beneficiaries' take-up of cash assistance programmes and of social programmes for housing and employment. Though it improved education and health outcomes for participating households, it failed to reduce poverty in the short term.
Riccio et al. (2010)	Opportunity NYC–Family Rewards	Eligible poor families	New York City's most poverty-stricken communities	Randomized controlled trial	The programme reduced immediate poverty and material hardships and improved some human capital investments across the domains of children's education, family health care and parental employment.
Bastagli et al. (2016)	Cash transfers to individuals and households, with a focus on programmes design and implementation components	The review of social transfers on six outcomes: monetary poverty; education; health and nutrition; savings, investment and production; employment; and empowerment	Global	Review of research evidence published from 2000 to 2015	Cash transfers were found to: decrease poverty rates; improve education, health and nutritional outcomes; allow for savings, investment and production, including among female heads of household; reduce child labour; and empower both women and men. Higher transfer levels and a longer duration of exposure were associated with larger impacts.
Ahmed et al. (2009)	Efficacy of cash transfers in enhancing livelihoods, examined through an impact evaluation of the Food Security Vulnerable Group Development (FSVGD) programme	Ultra-poor	Rural Bangladesh	Qualitative and quantitative survey data from programme beneficiaries and non-beneficiaries, and propensity score matching method	The FSVGD programme reduced extreme poverty by 30 percentage points for programme participants, but 61% of FSVGD households remained extremely poor.

Child allowances and grants

Child allowances are cash grants paid to eligible families with children. The allowances provide a basic income floor and a cushion for families with insufficient or no income (Waldfogel, 2009). These allowances or grants can be divided into two broad approaches: (1) those that aim to *prevent* poverty by helping families to earn more; and (2) those that *reduce* the level of poverty generated by the market economy by supplementing low market incomes with other sources of cash (Plotnik, 1997). Another child-related anti-poverty strategy is the *mitigation* of the adverse effects of poverty by providing food, health care, housing, supplemental educational resources and other non-cash benefits to the poor (Plotnik, 1997).

A number of studies looking at the effects of child allowances and grants in improving the well-being of children and families in different regional contexts are identified and presented here (*for a summary, see Table 2.2*). In Mongolia, Hodges et al. (2007) evaluated the country's Child Money Programme (CMP), a CCT programme described by ILO as one of the most progressive and comprehensive in Asia (Peyron-Bista, 2016). In June 2016, the programme was offering a monthly allowance of 20,000 Mongolian tugriks, approximately $10, to all children aged 0–17 years, including children in correctional facilities and those living abroad. CMP evaluation findings from various sources confirm the progressive nature of the programme. Not only is the benefit incidence nearly twice as high in the poorest quintile of the population compared with the richest quintile (Gassmann et al., 2015), but allocation of the transfer is also pro-poor, with 34 per cent of transfers received by the poorest group (Onishi & Chuluun, 2015). Based on an analysis of Mongolia's 2014 Household Socio-Economic Survey, CMP transfers were found to significantly reduce monetary poverty. Estimates indicate that CMP contributed to a 12 per cent reduction in the poverty incidence in Mongolia and reduced its poverty gap by 21 per cent. If only children are considered, the level of poverty reduction achieved is slightly higher. CMP appears to be particularly powerful in reducing poverty in the countryside and in the western parts and the highlands of Mongolia (Tserennadmid, forthcoming). ILO (2016) attributed the programme's notable success to two of its basic components: (1) its focus on children as the main beneficiaries; and (2) its effective payment mechanism, through which the monthly benefit is paid directly, by automatic bank transfer, to eligible families. As a result, by the end of 2015, nearly 100 per cent of children aged 0–17 years received this benefit.

In Uruguay, Amarante et al. (2009) undertook an ex-ante evaluation of Asignaciones Familiares, a child allowance programme that began in 1942 but was significantly amended in 2008, following interim changes in 1999 and 2004. Under the new programme, households that have an average income per capita of below $20 and which fulfil structural poverty conditions, as per a proxy means test score, are entitled to receive the allowance for children aged 0–18 years. The aim of the programme is to contribute to poverty alleviation and to encourage school attendance, particularly for children aged 14–17 years, among whom dropout rates are high. The results of the regression analysis done by Amarante et al. (2009) show that Asignaciones Familiares increased teenage school attendance by 6 to 8 percentage points and that, overall, the programme significantly reduced extreme poverty as well as the intensity and severity of poverty. Furthermore, Uruguay's indigence incidence decreased by between 40 and 50 per cent, while the decreases in poverty intensity and severity were approximately 50 per cent and 65 per cent respectively.

In 2012, an impact evaluation of South Africa's Child Support Grant (CSG) was conducted by the Department of Social Development (DSD), the South African Social Security Agency (SASSA) and UNICEF South Africa (DSD, SASSA & UNICEF, 2012). The CSG was first introduced in 1998 and by 2012 it had evolved into a comprehensive social protection programme that each month reached over 10 million South African children under 18 years of age. The evaluation used non-experimental approaches and a single cross-sectional survey to observe the programme's impact on children. It identified the grant's positive developmental impact in promoting nutritional, educational and health outcomes for recipient children as well as in reducing poverty and improving gender outcomes and inequality among recipient households. It also emerged that receipt of the grant in the first seven years of life reduced the likelihood of children engaging in child labour outside the home later in adolescence. The effects of the South African CSG appear to be stronger for girls than for boys.

Table 2.2. Summary of child allowances and evaluations and reviews of their effects on poverty

Authors	Family intervention description (How are they doing it?)	For whom?	Where? What level?	How is it evaluated?	What are the results?
Hodges et al. (2007)	Mongolia's Child Money Programme	All children aged 0–17 years, including children in correctional facilities and those living abroad	Mongolia, state level	Analysis of the 2014 Household Socio-Economic Survey	Significantly reduced monetary poverty.
Amarante et al. (2009)	Asignaciones Familiares	Children aged 0–5 years and aged 6–18 years	Uruguay, state level	Regression analysis	Increased teenage school attendance; significantly reduced extreme poverty as well as reduced intensity and severity of poverty.
DSD, SASSA & UNICEF (2012)	South Africa's Child Support Grant	Poor children aged 0–17 years, eligible as per a proxy means test	South Africa state level	Non-experimental approaches and a single cross-sectional survey	Promotes nutritional, educational and health outcomes for the recipient children; reduces multiple indicators of poverty; promotes better gender outcomes and reduces inequality among recipient households.
Natali et al. (2016)	Zambia's Child Grant Programme	Poor female-headed households with young children (under the age of 5 years)	Three districts in Zambia: Kalabo, Kaputa and Shangombo	Data from a three-year, large-scale randomized controlled trial	Increased savings among female-headed households; increased diversification of non-farm enterprises that are traditionally operated by women.
Bonilla et al. (2017)	Zambia's Child Grant Programme	Poor female-headed households with young children (under the age of 5 years)	Three districts in Zambia: Kalabo, Kaputa and Shangombo	Four-year longitudinal cluster randomized controlled trial; in-depth interviews with women and their partners, stratified on marital status and programme participation	More sole or joint decision-making about core areas of life; increased financial empowerment of women – i.e., control over transfers for household investment and savings for emergencies. But results marked by entrenched gender norms.

Two recent impact evaluations of Zambia's Child Grant Programme (CGP) further show the effects of cash transfers on women's saving, decision-making, and participation in economic enterprises (Bonilla et al., 2017; Natali et al., 2016). The CGP is a UCT established in 2010 to target poor female-headed households with young children aged 0–5 years in three rural districts: Kalabo, Kaputa and Shangombo. Using data from a large-scale randomized controlled trial, Natali et al. (2016) found large improvements in the savings of female-headed households, especially among women who had lower decision-making power prior to the intervention. These increased savings also allowed for increased diversification of non-farm enterprises that are traditionally operated by women. In addition, Bonilla et al. (2017) observed that women in beneficiary households were likely to make more sole or joint decisions about core areas of life, although these improvements were marked by entrenched gender norms. The success of the CGP is largely credited to the programme's key design feature – that is, the transfer is unconditional and paid directly to women.

Old age pensions

Ensuring income security for people in their old age is a crucial objective among the welfare goals of modern societies. Thus, the right to income security in old age, as grounded in human rights instruments and international labour standards, includes the right to an adequate pension. Available evidence (see, for example, Barrientos & Lloyd-Sherlock, 2002; Duflo, 2003) shows that pensions can also mitigate some of the factors contributing to intergenerational poverty. For example, where sources of alternative income for younger generations are scarce, cash transfers can incentivize younger family members to live with their elders, thus creating new possibilities for intergenerational reciprocity. Furthermore, in a context of extreme poverty and household vulnerability, where it may prove difficult to reconcile cultural norms of reverence and support for elders, the pension can strengthen a household's capacity to properly care for older persons (Barrientos & Lloyd-Sherlock, 2002). Several examples of the implementation of old age pension schemes and their effects are presented below (*for a summary, see Table 2.3*).

The Government of Lesotho introduced a tax-based, non-contributory old age pension in 2004, with the aim of eliminating poverty among older persons in the population. The target group for the old age pension is older people aged 70 years and above who have no other pension benefits. Evidence from a number of studies such as Croome and Mapetla (2007) and Hagen (2008) shows that the old age pension scheme has had a positive impact on the physical and social needs of the Basotho elderly and their household members, particularly in relation to access to improved housing as well as to food and health care services. In an impact evaluation of the pension scheme, Bello et al. (2008) used logistic regression modelling and found that the pensions also played a notable role in poverty reduction. Prior to the pension scheme's implementation, 90 per cent of the sampled households were living below the poverty line, but this fell to 70 per cent following implementation; there was also a notable decrease in the average monthly poverty gap per household when older persons received a pension (Bello et al., 2008).

Dethier et al. (2011) used data from 18 Latin American countries to assess the impact of a minimum pension on old age poverty and examined the budgetary costs of such schemes using household survey data and a micro-simulation exercise. The authors concluded that a minimum pension substantially reduces poverty among the elderly in all analysed countries except Argentina, Brazil, Chile and Uruguay, where elderly poverty is already low due to existing pension systems. Furthermore, the minimum pension schemes were found to be effective in terms of incentives and spillover effects. The fiscal costs of pension schemes were found to be high but affordable in all 18 countries.

Using data from the Indian Human Development Survey, Garroway (2013) conducted an ex-post evaluation of India's National Social Assistance Programme (NSAP), with a focus on two particular NSAP schemes: the old age pension and the widow's pension. In terms of the former, apart from a minimal and not statistically significant increase in total annual income, the results were largely insignificant, which the author attributes to the diversity of recipients across income quintiles, spatial location and social group. The widow's pension,

on the other hand, led to a decline in poverty among recipients of approximately 2.7 percentage points. Considering that attempts to target poor households with old age pension benefits were ineffective, the author recommends the universalization of the scheme as a path towards improving targeting and effectiveness.

Table 2.3. Summary of old age pensions and evaluations and reviews of their effects on poverty

Authors	Family intervention description (How are they doing it?)	For whom?	Where? What level?	How is it evaluated?	What are the results?
Bello et al. (2008)	Lesotho old age pension	Older people aged 70 years and above who do not have any other pension benefits.	Lesotho, national level	Logistic regression analysis	Pensions played a notable role in poverty reduction.
Dethier et al. (2011)	Minimum pension – effects on old age poverty and its budgetary costs	Older people	18 Latin American countries	Household survey data and micro-simulation exercise	The absolute poverty reduction ranged from 2% in Brazil to 24% in Costa Rica.
Garroway (2013)	National Social Assistance Programme old age pension and widow's pension	Older persons and widows	India, national level	Indian Human Development Survey data and regression analysis	Old age pension results were inconclusive. The widow's pension led to a reduction in poverty of 2.7 percentage points.
Ardington, Case and Hosegood(2009)	South Africa's pension scheme	Men over 65 years of age and women over 60	South Africa, national level	Longitudinal modelling – comparing households and individuals before and after pension receipt and pension loss	The pension improved labour force participation among other household members, except where the recipient was an elderly female. Pension receipt also increased internal labour migration.
de Carvalho Filho (2012)	Brazil's social security reform, with a focus on the social pension scheme	Rural men aged 60 years, and rural women aged 55 years	Brazil, rural areas	Regression analysis of cross-sectional patterns of children's outcomes before and after the reform, using eligibility status as an instrument	The reform increased school enrolment for girls overall, and it reduced girls' participation in paid labour when women were the pension recipients. No significant effects were observed for boys.

Of the other relevant studies reviewed, Ardington, Case and Hosegood (2009) examined the effects of South African old age pension benefits on childcare constraints. South Africa's pension scheme provides a non-contributory, means-tested public benefit to men over 65 years of age and women over 60. For 75 per cent of South Africa's elderly population, the old age pension of 940 South African rand (equivalent to 94 euros based on an April 2008 rate) is the main source of income. The study by Ardington et al. (2009) was able to compare households and individuals before and after pension receipt and pension loss, thus controlling for a number of unobservable characteristics that relate to labour market behaviours. The results revealed that provision of cash transfers to older persons leads to increased employment among other household members. This was not found to be the case, however, for those living with a female pensioner – in such instances, the pension seems to reduce the likelihood of labour force participation by about 19 percentage points. Pension receipt also increases internal labour migration, an effect attributed to the increased resources of older persons enabling them to become self-sufficient, in turn allowing other household members to look elsewhere for work.

In Brazil, de Carvalho Filho (2012) explored the effects of the country's social pension scheme on children's labour and school enrolment. Specifically, the author looked at the effects of the 1991 social security reform that increased the minimum pension benefit and reduced the pension eligibility age in rural areas, by comparing households that became eligible to receive pension benefits following the reform with households that nearly became eligible recipients. The reform reduced the pension eligibility age for men in rural areas from 65 to 60 years and increased the minimum benefit from 50 to 100 per cent of the minimum wage. Similarly, the reform extended the pension benefits to rural female workers, excluding heads of households, and reduced the qualifying age for women from 65 to 55 years. The findings of the de Carvalho Filho (2012) study show that the reform increased school enrolment for girls overall, and also reduced their participation in paid labour, but these effects were not replicated for boys. The labour participation effects differ by the gender of the pension recipient, as only benefits received by women were associated with a reduction in girls' participation in paid labour.

2.5. Conclusions

Social protection schemes are designed and implemented with the aim of improving the well-being of the vulnerable. This review of studies on cash transfers in selected contexts reveals several key anchors for reflection. It shows that, overall, cash transfers have a strong potential to address poverty. It is quite remarkable considering the diversity of contexts and transfer types included that the review did not identify a single programme that increased deprivation among its recipients and their family/household members. On the contrary, the evidence shows that cash transfers allow families and household members to improve the margins of various outcomes, including health, nutrition, education, monetary income, child labour, empowerment, savings and employment, to name a few.

Moreover, cash transfers appear to have long-lasting effects on family welfare and provide coping strategies for families to deal with the negative effects of economic shocks and idiosyncratic events. Therefore, this review supports the idea that cash transfers have an important role to play in the long-term sustainable development of family financial status and individual well-being by facilitating efficient investments among vulnerable segments of the population.

The generation of more systematic evidence on the interplay of cash transfers and other social protection interventions is warranted, however, to fully understand the intertwined effects of cash flows and policies on family welfare. In practice, deprivation is likely to be multidimensional and social transfers are rarely implemented in isolation. This review provides evidence that social transfers may be mutually reinforcing and may relate to different well-being outcomes. Measuring the multidimensional facets of poverty and gathering data on multiple policy interventions are thus necessary steps to determine the full impact of transfers.

Nevertheless, the evidence presented in this report shows that family cash transfers are powerful policy instruments to alleviate poverty and achieve the development targets of SDG 1. Among studies reporting significant effects on the outcomes, the vast majority reflect associations in the direction that SDG 1 targets aim to achieve.

Although positive outcomes were observed in relation to the implementation of cash transfer programmes, issues related to the need for improved coverage and targeting persist. The effects of social transfers on well-being are heterogeneous across gender (of recipient and family members). There are differences in the outcomes for girls and boys who live in families targeted by cash transfer programmes. Similarly, the effects of cash transfers do not always seem to significantly improve the financial and intra-household status of female recipients, and it is likely that additional design components need to be included to produce a sustainable and transformational change.

A number of evaluations also uncovered not statistically significant effects of cash transfers on the measured outcomes. This evidence may reflect measurement error, selection bias or both. The precise nature of programmes, some of which may require longer periods of maturation for effects to manifest, may also inhibit some of the results. For instance, old age pension schemes are likely to take decades to mature, meaning that the timescale of the evaluations and reviews presented in this report could not hope to capture the full impact of such an intervention.

All this said, by examining patterns of family interventions and their effects on poverty and well-being from a global perspective, this study contributes vital evidence to support the monitoring of SDG 1. The main finding of this study, with regard to the effects of different policy interventions, lends support to the effectiveness of the impact of social transfers on SDG 1 targets and other interrelated development goals. These wide-ranging social transfer effects, although intuitive in theory and practice, have thus far been inadequately monitored across different geographical contexts. To enhance our understanding of poverty reduction in the context of the 2030 agenda, future work should continue to employ the framework applied in this study, which explores multiple cross-sectoral effects of policies and programmes, as an guide for understanding the existing evidence of change.

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Annex 2. Supporting data for Chapter 2

Annex Table 2.1. Contribution of deprivation by dimensions to overall poverty

Country	Year	Education	Health	Standard of living
Sub-Saharan Africa				
Benin	2011/2012	33.1	24.8	42.1
Burkina Faso	2010	39.0	22.5	38.5
Burundi	2010	25.0	26.3	48.8
Cameroon	2011	24.5	31.2	44.2
Central African Republic	2010	23.8	26.2	50.0
Chad	2010	32.3	22.5	45.2
Congo	2011/2012	10.6	32.8	56.6
Côte d'Ivoire	2011/2012	36.5	25.8	37.7
Democratic Republic of the Congo	2013/2014	15.6	31.0	53.4
Djibouti	2006	36.1	22.7	41.2
Ethiopia	2011	27.4	25.2	47.4
Eswatini	2010	13.7	41.0	45.3
Gabon	2012	15.2	43.8	40.9
Gambia	2013	32.9	30.9	36.2
Ghana	2011	27.7	27.1	45.2
Guinea	2012	36.6	22.8	40.6
Guinea-Bissau	2006	30.5	27.9	41.6
Kenya	2008/2009	11.2	32.4	56.4
Lesotho	2009	14.8	33.8	51.4
Liberia	2013	23.0	25.6	51.4
Madagascar	2008/2009	31.6	24.5	43.9
Malawi	2010	18.9	27.7	53.4
Mali	2012/2013	37.9	22.4	39.7
Mauritania	2011	34.5	20.3	45.3

Country	Year	Education	Health	Standard of living
Mozambique	2011	30.4	22.3	47.3
Namibia	2013	11.0	39.2	49.8
Niger	2012	35.9	24.0	40.0
Nigeria	2013	29.8	29.8	40.4
Rwanda	2010	23.8	27.2	49.0
Senegal	2014	43.6	23.1	33.4
Sierra Leone	2013	25.7	28.5	45.9
Somalia	2006	33.7	18.8	47.5
South Africa	2012	8.4	61.4	30.2
South Sudan	2010	39.3	14.3	46.3
Sudan	2010	30.4	20.7	48.9
Togo	2013/2014	26.4	28.8	44.9
Uganda	2011	18.0	30.2	51.9
United Republic of Tanzania	2010	16.9	28.2	54.9
Zambia	2013/2014	17.9	29.8	52.3
Zimbabwe	2014	10.8	34.5	54.8
South Asia				
Afghanistan	2010/2011	45.6	19.2	35.2
Bangladesh	2011	28.4	26.6	44.9
Bhutan	2010	40.3	26.3	33.4
India	2005/2006	22.7	32.5	44.8
Maldives	2009	27.8	60.2	11.9
Nepal	2011	27.3	28.2	44.5
Pakistan	2012/2013	36.2	32.3	31.6

Source: International Labour Organization. (2014). *World social protection report 2014/15: Building economic recovery, inclusive development and social justice.* ILO, Geneva. Note: Grey cells indicate largest contributing indicator by country.

Annex Table 2.2. Public social protection and health expenditure (combined) as % of GDP, 1990 and 2010 (or closest year available)

Country	1990 (or earliest year available)	2010 (or latest year available)
Sub-Saharan Africa		
Benin	1.33	4.20
Botswana	2.52 (1997)	6.59
Burkina Faso	2.44 (1995)	5.07 (2011)
Burundi	1.71	4.94
Cabo Verde	6.98 (2008)	6.87
Cameroon	2.20	2.33
Central African Republic	0.83 (2000)	2.55 (2012)
Chad	3.07 (2000)	1.31
Congo	2.20	2.79
Côte d'Ivoire	1.60	1.95 (2011)
Democratic Republic of the Congo	0.27 (2000)	3.71 (2011)
Equatorial Guinea	1.38 (2007)	2.78
Eritrea	2.16 (2000)	1.64 (2011)
Ethiopia	1.50	3.17
Eswatini	2.94 (1995)	7.32
Gambia	3.10	2.98
Ghana	2.20	5.39
Guinea	0.80	2.47
Guinea-Bissau	2.52 (2000)	5.44
Kenya	1.47	2.61 (2011)
Lesotho	7.30	8.16
Liberia	8.00	11.47 (2005)
Madagascar	1.36	2.39
Mauritania	1.00	4.87
Mauritius	4.93	9.12 (2011)
Mozambique	3.50	5.32
Namibia	3.90	7.40 (2011)
Niger	1.90	2.91
Nigeria	3.70 (2009)	2.83
Rwanda	1.90	7.31
Senegal	4.30	5.34

Country	1990 (or earliest year available)	2010 (or latest year available)
Seychelles	11.00	7.52 (2011)
Sierra Leone	1.90	2.07 (2009)
South Africa	5.97	9.79
Sudan	1.10	2.27
Togo	1.70	5.73
Uganda	0.90 (1998)	3.46 (2011)
United Republic of Tanzania	1.90	6.81
Zambia	2.30	5.46 (2011)
Zimbabwe	3.30	5.60 (2011)
South Asia		
Afghanistan	0.80	5.60 (2011)
Bangladesh	0.71	2.69 (2011)
Bhutan	3.12	4.58 (2011)
India	1.73	2.64 (2011)
Nepal	1.96	2.31 (2011)
Pakistan	1.50	1.68
Sri Lanka	5.34	3.00 (2012)

Source: International Labour Organization. (2014). *World social protection report 2014/15: Building economic recovery, inclusive development and social justice.* ILO, Geneva.

CHAPTER 3.

FAMILIES AND SUSTAINABLE DEVELOPMENT GOAL 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES

Chapter 3. Families and Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages

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3.1. Introduction

A wealth of research has documented the links between family functioning and health outcomes (e.g., Dunbar et al., 2013; Trief et al., 2016). For instance, the quality of family life – specifically, marital/spousal relations and parent–child interactions – has important influences on health promotion and illness progression (e.g., Vedanthan et al., 2016). Marital relationship quality has been found to be related to better health and lower cardiovascular reactivity during marital conflict (Robles et al., 2014), while poor marital quality, characterized by a decreasing rate of positive partner exchanges and an increasing rate of negative interactions, has been associated with an increased prevalence of diabetes in men (Whisman et al., 2014). Moreover, multiple family interventions to provide support in coping with different illnesses have been developed and evaluated over the years (Shields et al., 2012).

To explore how families and family policy can contribute to the achievement of SDG 3, this chapter examines family interventions for cardiovascular disease (CVD) and diabetes, the two leading causes of death by non-communicable diseases (NCDs), and suicide, an indicator of mental health.

Several electronic social sciences databases (PsychInfo, Google Scholar and JSTOR) were searched for relevant literature published in the period 2010–2017, with 2010 selected because previous reviews on family interventions and health conducted searches up until this year (e.g., Shields et al., 2012). Searches selected only peer-reviewed journals written in English, and only randomized controlled trials (RCTs) were included in this literature review due to their more rigorous design; pilot studies were excluded, even if randomized. Only interventions extended to family members (e.g., partner/spouse, parents, children) were considered.

The terms used for the searches included the following keywords and phrases, employed in various combinations: "family interventions", "randomized control trials (RCT)", "meta-analysis of family interventions", "reviews of family interventions", "evaluations of family interventions"; "non-communicable disease (NCD)" and name of the illnesses: "cardiovascular disease" and "diabetes"; "psychological interventions", "mental health", "suicide"; "family policies", "policies for health"; "Africa", "Asia". Examples include "randomized family interventions for cardiovascular disease", "family policies and health", "policies for diabetes" and "policies for cardiovascular disease". In addition, article references were checked for further studies that could potentially meet the literature review criteria.

Following a brief introduction to health in the SDGs, and details of the focus of this chapter, sections 3.3.1 and 3.3.2 provide reviews of family interventions for NCDs, with a focus on CVD and diabetes. Section 3.3.3 discusses family interventions for suicide, an indicator of mental health. Section 3.4 offers conclusions and recommendations for future research, practice and policy.

3.2 Health in the SDGs

SDG 3 aims to ensure healthy lives and promote well-being for all at all ages. Its nine targets cover: maternal mortality; infant and young child mortality; health epidemics; premature mortality from NCDs, and mental health; substance abuse; traffic accidents; sexual and reproductive health care services; universal health care coverage; and deaths related to pollution. This chapter focuses solely on Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. The indicators in focus are:

3.4.1. Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease

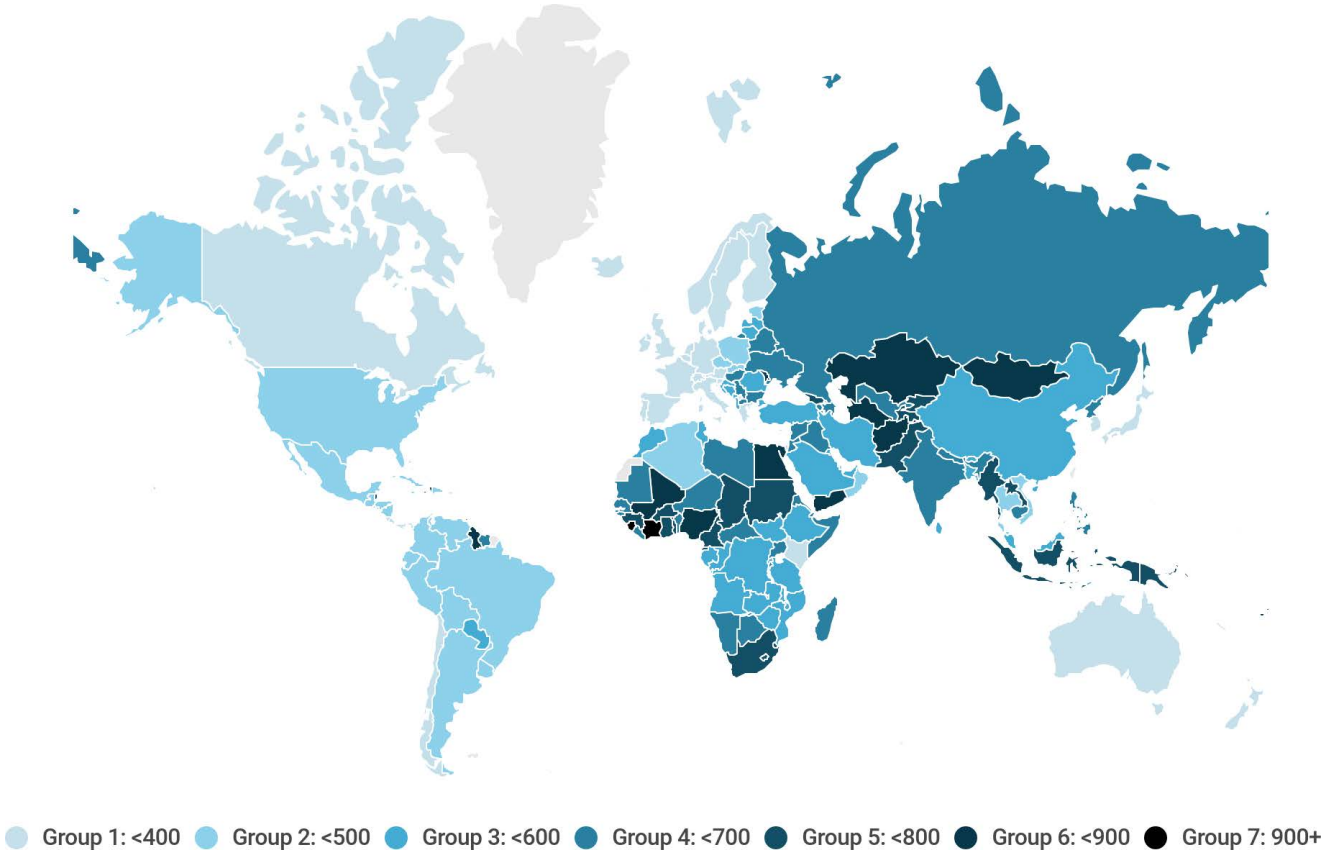
3.4.2. Suicide mortality rate

Target 3.4 has been selected for this chapter because there is evidence that family involvement has the potential to make positive contributions to health promotion. Given that individuals live within family systems, involving families in developing and maintaining healthy lifestyles – through good family relationships, healthy diets and physical exercise and avoidance of harmful practices (e.g., smoking, alcohol abuse) – is essential in ensuring individual well-being. This is also significant for children, who have a chance to learn lifelong healthy practices within their families. Families are also important in providing instrumental and emotional support when illness has developed, to ensure the patient's adaptation to illness, treatment adherence and a good prognosis and evolution of the illness.

3.3. Family interventions for non-communicable diseases

NCDs are chronic illnesses that are not passed from person to person. Each year, they cause the death of 38 million people around the world, three quarters (28 million) of which take place in low- and middle-income countries (WHO, 2018b). The four leading causes of death from NCDs are: CVD (17.5 million deaths annually), followed by cancer (8.2 million), respiratory disease (4 million) and diabetes (1.5 million) (WHO, 2018b) (*see Map 3.1*).

Map 3.1. Deaths from non-communicable diseases, 2015



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Health Organization. (2017). *Global Health Observatory*. Available at: <www.who.int/gho/en>, accessed 14 January 2020. Note: Colour-coded mortality rates are per 100,000 of the population.

To address the burden of NCDs worldwide, the 66th World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (resolution WHA66.10). This provides a platform for different governmental and non-governmental stakeholders to work together in attaining various health-related goals, including a 25 per cent reduction in premature mortality from NCDs by 2025 (WHO, 2013).

The WHO Global Action Plan follows on from the United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (resolution A/RES/66/2), which underlined the responsibility of governments to address the challenges of NCDs and the importance of international cooperation in achieving their prevention and control.

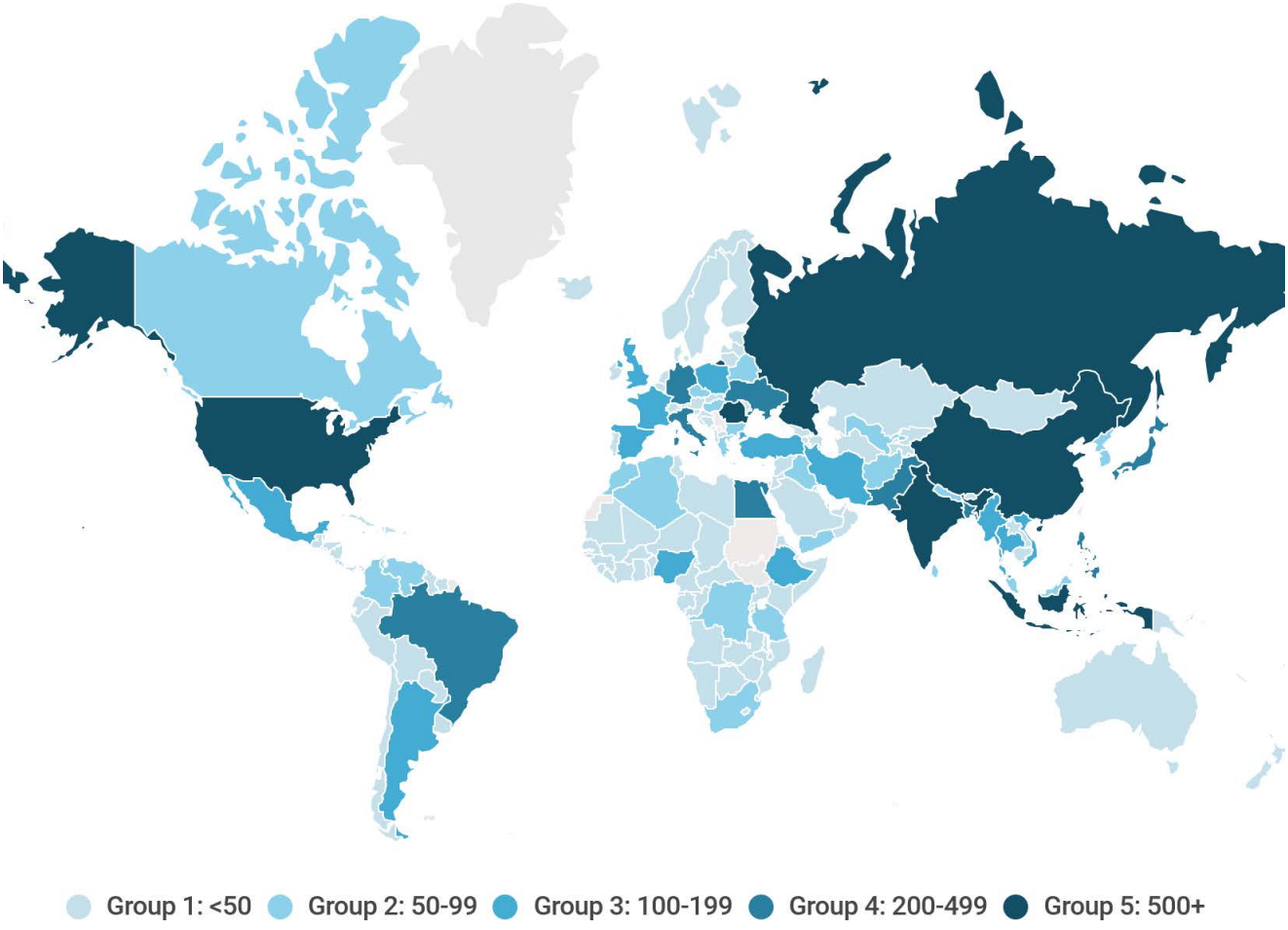
NCDs, in particular CVD and diabetes, share similar risk factors such as obesity, high blood pressure, physical inactivity and salt intake and are thus susceptible to similar interventions. They are preventable illnesses and healthy changes in lifestyle have the potential to bring about positive outcomes, preventing or delaying their emergence. Such changes are more effective if they are implemented at the family level, with family members participating together in healthy behaviours, such as a healthy diet, physical exercise and supportive behaviours, which can contribute to illness prevention or adaptation to disease and treatment adherence.

The following sections provide an examination of family interventions and policies for CVD, the leading cause of death in the world (*see section 3.3.1*) and diabetes, one of the most expensive illnesses to treat (*see section 3.3.2*). Each section begins by providing background information about the illness and its impact on families, continues with a review of the interventions and ends with a review of existing family policies and programmes to address the illness.

3.3.1. Family interventions for cardiovascular disease

CVD is the leading cause of death in the world. Global and country-specific data indicate that there is wide variation in how CVD is addressed around the world and the services to which families are entitled and use (WHO, 2017) (*see Map 3.2*).

Map 3.2. Deaths from cardiovascular disease, all persons, 2015



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Health Organization, Department of Information, Evidence and Research. (2017). Note: Colour-coded mortality rates are per 100,000 of the population.

CVD encompasses several conditions, including high blood pressure, coronary heart disease, cardiac arrest and ischaemic heart disease. Given the chronic nature of CVD and the importance of lifestyle (diet, physical exercise) in its prevention and treatment, social context – particularly family context – plays an important role in adaptation to the disease. Although CVD is rare in childhood and adolescence, the risk factors that accelerate its development begin in childhood and are related to genetics (e.g., family history) and lifestyle (e.g., obesity, physical inactivity) (Daniels, Pratt & Hayman, 2011). Thus, spousal support, marital quality and quality of parenting are significant in setting the stage for healthy behaviours and effective mechanisms for coping with this illness.

Family interventions for CVD

The review of RCTs of interventions for CVD (2010–2017) that involved family members (e.g., partner/spouse, parents of patients) revealed a limited number of studies (eight articles based on seven RCTs) conducted in Canada (Reid et al., 2014), New Zealand (Duncan et al., 2016), Sweden (Ågren et al., 2012; Liljeroos et al., 2015; Löfvenmark et al., 2013), the United Kingdom (Harrington et al., 2010) and the United States (Aggarwal, Liao & Mosca, 2010; Dunbar et al., 2013) (*see Table 3.1*).

The interventions targeted patients with heart failure (Ågren et al., 2012; Dunbar et al., 2013; Liljeroos et al., 2015) and stroke survivors (Harrington et al., 2010). Three interventions focused on family members of patients with CVD and educating and counselling them on preventive techniques and reducing the risk of developing the illness, involving a healthy diet and weight management, regular physical exercise and smoking cessation (Aggarwal et al., 2010; Duncan et al., 2016; Reid et al., 2014). All of the interventions focused on adults and some specifically involved the patient's partner (Ågren et al., 2012; Liljeroos et al., 2015), while others invited family members in general to participate (Duncan et al., 2016; Harrington et al., 2010).

Family interventions targeting patients with CVD

The goals of the interventions for patients with CVD and their families were to strengthen knowledge about the illness, enhance their perceived control, improve physical and mental functions (Liljeroos et al., 2015), increase self-sufficiency (Ågren et al., 2012; Liljeroos et al., 2015), increase knowledge about a healthy diet and physical exercise, reduce obesity and cardiovascular risk (Aggarwal et al., 2010; Duncan et al., 2016), reduce dietary sodium intake and improve medication adherence (Dunbar et al., 2013).

Techniques used in the interventions included psycho-educational support (Ågren et al., 2012; Liljeroos et al., 2015; Löfvenmark et al., 2013), counselling (Reid et al., 2014), group psycho-education and training sessions (Dunbar et al., 2013), family support groups (Löfvenmark et al., 2013), follow-up phone calls (Dunbar et al., 2013) and family partnerships focused on improving family communication through applied exercises such as role playing (Dunbar et al., 2013; Stamp et al., 2016). The interventions had been grounded in different theoretical frameworks, including the health promotion model (Liljeroos et al., 2015), cognitive behavioural theory (Ågren et al., 2012) and self-determination theory (Dunbar et al., 2013).

In terms of the modalities for implementation, most of the interventions provided a combination of face-to-face interactions, educational materials and technology (Ågren et al., 2012; Liljeroos et al., 2015). In some instances, face-to-face meetings between the health educator, patients and their partners were followed up with reinforcement phone calls (Liljeroos et al., 2015; Reid et al., 2014) or computer-based education (Ågren et al., 2012). Combinations of dyad sessions and group sessions of patient–family partnerships were also used to promote sharing and role-play exercises (Dunbar et al., 2013; Löfvenmark et al., 2013). Settings for the intervention implementation varied from home-based (Duncan et al., 2016; Liljeroos et al., 2015) to community centres (Harrington et al., 2010) to clinics or hospital rooms (Liljeroos et al., 2015; Löfvenmark et al., 2013).

Table 3.1. Family interventions for patients with cardiovascular disease (all RCTs)

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Ågren et al. (2012)	Psycho-education: three modules of face-to-face counselling, and computer-based education, to assist dyads to develop problem-solving skills. Follow-up at 3 and 12 months. Cognitive behavioural strategies to support dyads in modifying factors that contribute to physical and emotional distress.	Nurse	155 patients with chronic heart failure, in patient–caregiver dyads (usual care n=71; intervention n=84)	Sweden	Significant differences in patients' perceived control over the cardiac condition after 3 months, but not after 12 months; no effect for the caregivers. No differences over time in dyads' quality of life and depression, in patients' self-care behaviours and in partners' caregiver burden.
Dunbar et al. (2013)	Education and Support Interventions to Improve Self Care [ENSPIRE] clinical trial: to test a heart failure patient–family partnership intervention (FPI) to reduce dietary sodium (Na) and improve medication adherence (MA) compared with a patient–family education intervention (PFE) and usual care (UC).	PFE sessions: master's-level trained nurse; registered dietitian. FPI: master's-level trained nurse	Patients with heart failure, in patient–family member dyads (n=117)	United States	FPI and PFE reduced urinary Na at 4 months. Dietary Na decreased from baseline to 4 months, with both PFE and FPI lower than UC. More subjects adherent to Na intake at 8 months in FPI and PFE than in UC. Both FPI and PFE increased heart failure knowledge following the intervention. Dietary Na intake, but not MA, was improved by FPI and PFE.
Harrington et al. (2010)	Community-based intervention for stroke survivors to improve integration and well-being; included exercise and education twice weekly for 8 weeks.	Volunteers and qualified exercise instructors	243 stroke survivors and family members	United Kingdom	Intervention improved physical integration, which was maintained at the one-year follow-up, and promoted greater improvement in the psychological domain at 6 months.
Liljeroos et al. (2015)	Psycho-educational intervention: support for heart failure patient–partner dyads to maintain and strengthen the dyads' physical and mental functions and perceived control.	Nurse-led programme of three sessions in patients' home or in clinic, with telephone follow-up	155 patient–partner dyads	Sweden	Intervention had no effect on health, depressive symptoms or perceived control among the patient–partner dyads at 24 months.

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Löfvenmark et al. (2013)	The same RCT evaluated (Löfvenmark et al., 2011) the impact of the intervention on knowledge and patients' health care utilization. Intervention group (IG) received heart failure education programme; control group (CG) received information according to standard hospital routines.	Cardiologist, nurse, dietitian, physiothera-pist, social worker	128 family members of patients with heart failure	Sweden	Knowledge on heart failure increased significantly more in IG, and knowledge was maintained at third assessment. Readmission at least once for 17 patients in IG compared with 28 patients in CG. No differences in frequency of readmissions or number of days hospitalized.

Those implementing the interventions were mostly trained health professionals (Duncan et al., 2016), including nurses specifically (Ågren et al., 2012; Liljeroos et al., 2015). The intervention examined in Harrington et al.'s (2010) study included trained volunteer workers. In some instances, the implementation was conducted by trained health promoters, with no details given regarding the level of expertise (undergraduate or postgraduate degree), exact field or level of training (degree or training sessions). For example, in Reid et al.'s (2014) study, the health educators implementing the intervention received two days of training in counselling and were observed by an experienced therapist, who provided feedback on their performance. Such training may be insufficient and may have an impact on the effectiveness of the intervention. An example of a multidisciplinary team is given in Löfvenmark et al.'s (2013) evaluation of a multi-professional programme for patients living with heart failure and their family members, which involved a cardiologist, nurse, dietitian and social worker. Developing multidisciplinary teams to work with patients with CVD enables an extensive range of skills and expertise to be employed to dispense effective treatments to meet such patients' complex needs.

The results of the interventions indicate improvements among patients and their families in knowledge about the illness and increased commitment to healthy lifestyle changes – including a healthy diet, weight management and physical exercise – but not a significant direct impact on health. Most progress is achieved immediately following the intervention and has decreased by the time of longer-term follow-up assessments. Education and family interventions were found to reduce dietary sodium consumption at follow-up and increase heart failure knowledge following the intervention but had no effect on improving medication adherence (Dunbar et al., 2013). Another study showed that patients' perceived control over the cardiac condition had improved at 3 months after an educational and psychosocial intervention, but that this was not maintained at 12 months (Ågren et al., 2012). Similarly, a psycho-educational intervention with dyads of heart failure patients and their partners had no effect on health, depressive symptoms or perceived control among the patient–partner dyads after 24 months (Liljeroos et al., 2015).

Family interventions targeting family members of patients with CVD

Several studies looked at interventions that addressed the risk of developing CVD and targeted family members of patients with CVD, providing education about diet and exercise or behavioural counselling in an effort to prevent illness development (*see Table 3.2*). Results show that education and intervention groups for family members of patients with CVD registered significant increases in physical activity one year later, with more physical activity in the intervention group than in the control group (Aggarwal et al., 2010). Löfvenmark et al.'s (2013) multi-professional educational programme for family members of patients living with heart failure increased family members' knowledge about the illness, but there was no effect on patients' health care use at follow-up. More research is necessary on how to optimize family interventions and make them more effective. Providing more family-focused sessions and for longer time periods may help families to develop healthy patterns and remind families about them every few months to reinforce their adherence.

Conclusions from the evaluation literature for CVD

Given that CVD is the leading cause of death in the world, comprehensive and effective public health policies are necessary to support its prevention and treatment. The European Society for Cardiology (2016, p. 60), in its *2016 European guidelines on cardiovascular disease prevention in clinical practice*, indicates that: "Governmental and non-governmental organizations (NGOs) such as heart foundations and other health-promoting organizations can be a powerful force in promoting a healthy lifestyle and healthy environments in CVD prevention." This implies that preventive strategies to address unhealthy diets, smoking and physical inactivity must take place at different levels: international (e.g., WHO), national (e.g., governmental, health promoting agencies, NGOs) and regional/local (e.g., NGOs). Global advocacy efforts also contribute to informing the population about the risks and about resources available to address CVD.

The World Heart Federation leads just such a global effort, advocating for effective policies and programmes to promote better heart health. For example, in 2012, it launched its '25 by 25' campaign to reduce premature mortality from CVD by 25 per cent by the year 2025. This is in line with the WHO campaign to reduce NCDs by 25 per cent by 2025 (WHO, 2013). The American Heart Association (AHA, 2011), in its policy statement on *Forecasting the future of cardiovascular disease in the United States*, indicates that, based on evidence, CVD prevalence and costs are projected to increase substantially, and thus effective strategies are needed to limit the burden of CVD. In its scientific statement on *Interventions to promote physical activity and dietary lifestyle changes for cardiovascular risk factor reduction in adults*, AHA (2010) reports that evidence suggests that individual, group and multi-component intervention delivery strategies are effective, but that comparative studies are needed to demonstrate the strengths of implementing a multi-component strategy versus a single-component strategy.

Table 3.2. Family interventions for family members of patients with cardiovascular disease (all RCTs)

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Aggarwal, Liao & Mosca (2010)	Family Intervention Trial for Heart Health (FIT Heart) examined the predictors of physical activity at one year in family members of patients with CVD. The intervention group received education on diet and exercise, including recommendations for regular physical activity and a discussion of how to overcome barriers to exercise, etc.	Master's-level health educator	Adult family members (n=501) of cardiac patients; 36% non-white	United States	The intervention group reported significantly greater physical activity than the control group at one year.
Duncan et al. (2016)	Family-centred brief intervention for reducing obesity and CVD risk: five home visits (60 min. per visit) over 8 to 16 weeks. Each participant was encouraged to invite all family members to the home-based consultation session. The Healthy As programme used a combination of the 'small-changes' approach and group motivational interviewing techniques to encourage physical activity and healthy eating.	Trained health promoter	320 participants	New Zealand	Intervention resulted in decrease in body mass index (BMI), CVD risk and fast food consumption at 12 months.
Reid et al. (2014)	Printed materials on smoking cessation, healthy eating, weight management and physical activity. Intervention: feedback on results of the baseline and 3-month assessments; goal setting; 17 counselling sessions (12 weekly sessions, followed by sessions every few weeks).	Health educators who had received two days of training in counselling	426 family members of patients with coronary artery disease assigned to a family heart health intervention group (n=211) or control group (n=215)	Canada	No effect on the ratio of total cholesterol to high-density lipoprotein (HDL) cholesterol. Participants in intervention group consumed more fruit and vegetables and had more weekly physical activity at 3 months and at 12 months.

This review indicates that family interventions for CVD increase, among patients and their families, knowledge about the disease, including its symptoms, treatment and factors contributing to its evolution such as diet and exercise. This increased knowledge was associated with better psychological functioning and understanding, and better health-related behaviours such as better nutrition (e.g., reduced sodium intake, reduced fast food consumption, increased fruit and vegetable consumption) and increased physical exercise, but there was no direct impact on health. Additionally, the improved knowledge increased family understanding, communication and support and treatment adherence. This is consistent with the findings of previous studies such as Whalley et al.'s (2011) review of psychological interventions for coronary heart disease, which indicated that there was no strong evidence that the interventions reduced total deaths or non-fatal infarction, but they did result in small/moderate improvements in depression and anxiety and could potentially reduce cardiac mortality. Similarly, the Reid, Ski and Thompson (2013) review of psychological interventions for patients with coronary heart disease and their partners indicated that the interventions resulted in modest improvements in patients' health-related quality of life, blood pressure, knowledge of disease and treatment, and satisfaction with care, and in partners' anxiety, knowledge and satisfaction.

While the psycho-education programmes have been found to be effective in increasing patient and family knowledge, their impact tends to decrease over time. Thus, it is recommended that programmes and sessions are spread out over time and provided for longer periods, so that patients and families are periodically reminded about the effective strategies and behaviours to use. For example, Löfvenmark et al. (2011) suggest that heart failure education programmes for family members should be repeated two or three times during a period of six months to maintain the knowledge level.

Family-centred interventions targeting physical activity and nutrition can generate slightly better obesity-related health outcomes than usual care alone (Duncan et al., 2016). Reviews of interventions to improve adherence to CVD guidelines indicate that the interventions can be effective at improving both guideline adherence and patient outcomes and are often more effective than guideline dissemination alone (Jeffery et al., 2015). The importance of family support for cardiovascular health promotion is based on mutual interdependence of the family system, a shared environment, parenting style, caregiver perceptions and genomics (Vedanthan et al., 2016). The dyad structure presents an opportunity for health care professionals to integrate their strengths and skills in a collaborative effort centred on patient and partner (Ågren et al., 2012). Thus, family functioning should be assessed, addressed and improved to guide tailored family–patient interventions for better health-related outcomes (Stamp et al., 2016).

The RCTs were of family interventions for CVD targeting adults. Studies of interventions targeting children and youth are also needed. Given that lifestyle is so important in preventing CVD, it is essential for children to learn healthy habits early on in life. Timing the interventions in childhood has the potential to teach children healthy behaviours and contribute to CVD prevention. Vedanthan et al.'s (2016) review of family-based approaches to cardiovascular health promotion concluded that family-based approaches that target both caregivers and children encourage communication within the family unit and address the structural and environmental conditions in which families function.

The Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents, part of the National Heart, Lung, and Blood Institute (NHLBI) of the United States, recommended in its summary report (NHLBI, 2012) that CVD prevention should begin in childhood. The Expert Panel based its recommendation on evidence that CVD originates in childhood, that the risk factors for the development of atherosclerosis can be identified in childhood and continue from childhood into adult life, and that interventions exist for the management of risk factors. Thus, when applied in childhood, programmes could prevent the development of risk factors and recognize and manage children at increased risk due to identified risk factors.

Interventions that focused on health care provider education also demonstrated significant improvements (Jeffery et al., 2015). More frequent professional contact and ongoing skills training may be necessary to

have a greater impact on dyad outcomes and this warrants further research (Ågren et al., 2012). Most primary care clinicians lack the skills and resources to offer effective lifestyle counselling to reduce heart disease risk (Keyserling et al., 2014). Thus, effective and feasible prevention programmes are needed for typical practice settings. It is important that health care providers understand the influence of social support on anxiety, depression and quality of life when interacting with family members (Löfvenmark et al., 2013).

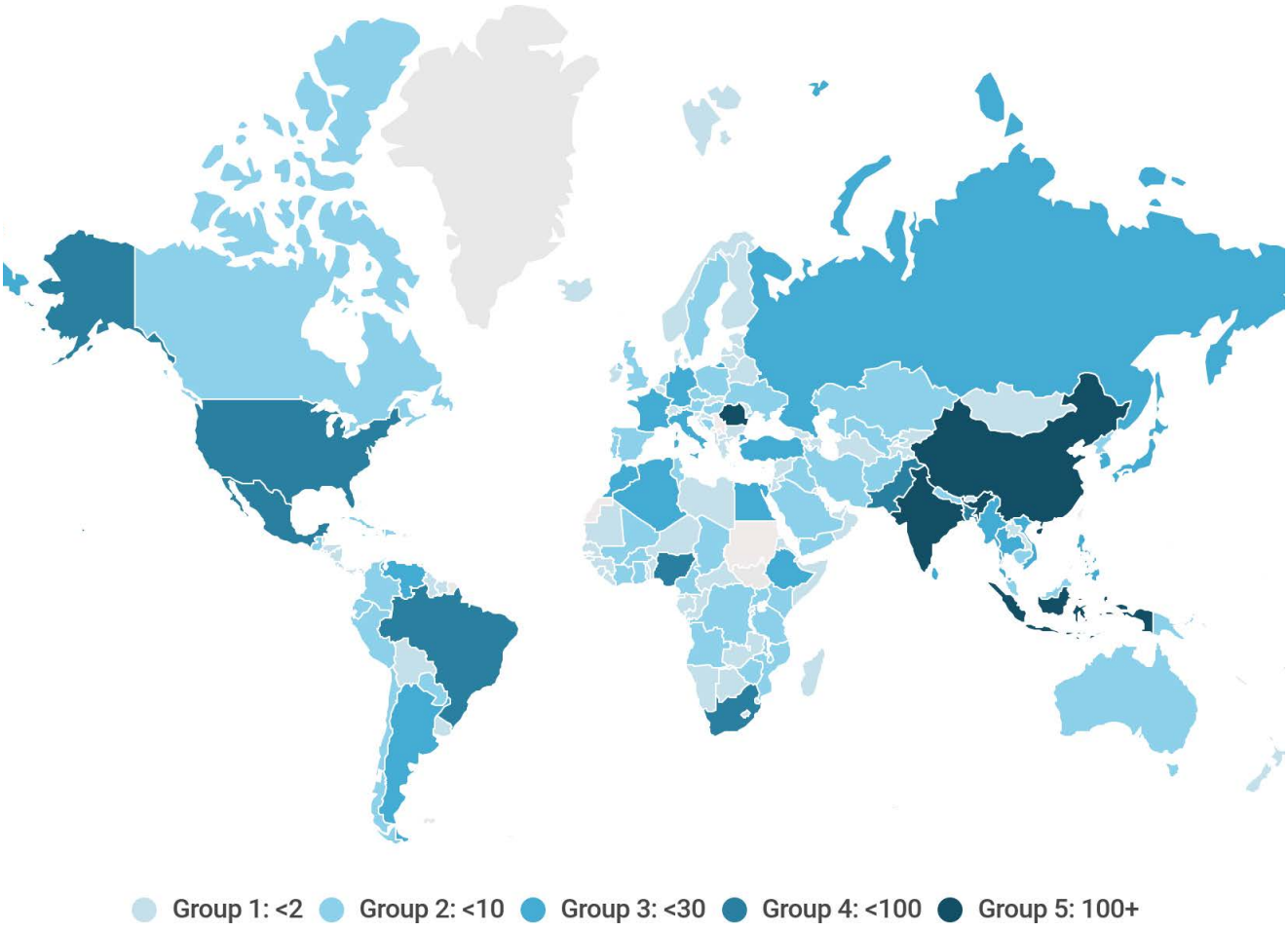
Supportive programmes could also be provided when a family brings a patient with CVD to the hospital. Hospitalization of a spouse, sibling or parent is an opportunity to improve cardiovascular health among other family members by providing family members with preventive programmes (Reid et al., 2014). Thus, organizing educational and counselling sessions for the family members, while their relative is in the hospital receiving medical care, could increase awareness of CVD risk factors, increase adoption of healthy lifestyles and act as a preventive measure.

3.3.2. Family interventions for diabetes

Diabetes is diagnosed by observing raised levels of glucose in the blood, which lead to life-threatening health complications. There are three types of diabetes: type 1 diabetes (T1D) with onset that occurs in children; type 2 diabetes (T2D), the most common type, usually occurs in adulthood; and gestational diabetes, which occurs during pregnancy (IDF, 2015).

Around the world, in 2014, 9 per cent of people aged 18 years and above had diabetes (WHO, 2014). Global health expenditure for diabetes in 2015 was $673 billion, accounting for 12 per cent of health costs and making diabetes a very expensive illness to treat (IDF, 2015). Mortality rates from diabetes vary widely across the globe, an number of the BRICS countries (Brazil, China, India and South Africa), Mexico and the United States have high rates (see Map 3.3).

Map 3.3. Deaths from diabetes, all persons, 2015



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Health Organization, Department of Information, Evidence and Research. (2017).

Diabetes is a lifelong disease that requires complex lifestyle adjustments. Consequently, it is important to have family support during this process. Diabetes self-management education and support increases patients' knowledge about the condition and supports the development of skills necessary to cope effectively with the disease. Including families in this process helps them understand how to support the patient (Baucom et al., 2015; Powers et al., 2015; Rassart et al., 2015). Family relations significantly affect individuals' health-related patterns and outcomes. Spouses are actively involved in illness management with their partners and can provide support in terms of diet (e.g., by sharing meals together), physical exercise, encouragement and treatment adherence (Armour et al., 2005; Franks et al., 2012; Khan et al., 2013; Pereira, Pedras & Machado, 2014). Involvement and support from the patient's social context, characterized by warmth, collaboration and acceptance, particularly from family members, is associated with good diabetes outcomes, while under-involvement and interactions characterized by conflict and criticism are associated with poor results (Race Mackey et al., 2011; Wiebe, Helgeson & Berg, 2016).

Randomized trials of family interventions for diabetes have been conducted in Chile (García-Huidobro et al., 2011), Ireland (Keogh et al., 2011), Taiwan Province of China (Kang et al., 2010), Thailand (Wichit et al., 2017), the United Kingdom (Doherty, Calam & Sanders, 2013) and the United States (e.g., Ellis et al., 2012, 2017;

Freeman, Duke & Harris, 2013; Holmes et al., 2014; Nansel, Iannotti & Liu, 2012; Nansel et al., 2015; Samuel-Hodge et al., 2017; Trief et al., 2016).

These family interventions targeted either adults or youth. Some of the interventions targeting adults were focused on partners and involved the couples in the intervention (Trief et al., 2016), while others were open to family members in general (García-Huidobro et al., 2011; Kang et al., 2010; Keogh et al., 2011; Samuel-Hodge et al., 2017) (*see Table 3.3*). Family interventions targeting youth focused on increasing parenting quality and parental knowledge, skills and involvement (Doherty et al., 2013; Ellis et al., 2012; Katz et al., 2014) (*see Table 3.4*).

Family interventions for diabetes focused on adults and youth

The goals of family interventions for diabetes have been to increase knowledge and skills to enhance self-care behaviours, and in turn improve control of the illness and quality of life, including by improving family interactions (Kang et al., 2010; Wichit et al., 2017), healthy eating (Nansel et al., 2015) or weight loss and control (Samuel-Hodge et al., 2017). Different types of techniques and therapeutic strategies were used, including family counselling during clinic visits, family meetings and home visits (García-Huidobro et al., 2011; Wichit et al., 2017), multi-family group education sessions (Wichit et al., 2017) or family-based group therapy sessions (Kichler et al., 2013). In most cases, interventions provided educational sessions and materials (Kang et al., 2010; Katz et al., 2014; Wichit et al., 2017) or motivational interviewing (Ellis et al., 2017; Keogh et al., 2011). Several interventions involved education and development of coping skills (e.g., attitude and behaviour change, conflict management), followed by practice of those skills and application of the newly acquired knowledge to real life circumstances (e.g., Doherty at al., 2013; Holmes et al., 2014).

Family interventions were grounded in different theoretical frameworks, including social cognitive theory, self-regulation models and systems theory (Nansel et al., 2012), behavioural family systems (Harris, Freeman & Duke, 2015) or self-efficacy theory (Wichit et al., 2017). Assessments occurred at baseline and at follow-up, the timing of which varied from a few weeks later (Samuel-Hodge et al., 2017) to 6 months (Keogh et al., 2011), 12 months (Ellis et al., 2012; García-Huidobro et al., 2011) or even 3 years later (Holmes et al., 2014).

Settings for interventions varied from clinics (Freeman et al., 2013; Nansel et al., 2012; Nansel et al., 2015) to home visits (Ellis et al., 2012) or both (García-Huidobro et al., 2011). Modes of implementation varied from direct modes to modes mediated by technology. Face-to-face interactions predominated and were supplemented by telephone discussions for reinforcement (e.g., Kang et al., 2010; Keogh et al., 2011; Nansel et al., 2012; Trief et al., 2016; Wichit et al., 2017). Some used computer-delivered interventions (Ellis et al., 2017) or internet-based videoconferencing and these were found to be as effective as those provided in the clinic (Freeman et al., 2013; Harris et al., 2015). This is consistent with findings from the Freeman et al. (2013) study, which also indicated that for adolescents with diabetes, internet-based teleconferencing represents a viable alternative to clinic-based care.

Professionals implementing the family interventions for diabetes had a variety of backgrounds, including as health psychologists (Keogh et al., 2011), registered nurses (Wichit et al., 2017), registered dietitians (Samuel-Hodge et al., 2017; Trief et al., 2016), clinicians (García-Huidobro et al., 2011), health professionals (nurses, dietitians, social workers) (Kang et al., 2010), master's-level therapists (psychologists, social workers) (Ellis et al., 2012) or trained research assistants (Nansel et al., 2015).

Table 3.3. Family interventions for diabetes for adults (all RCTs)

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
García-Huidobro et al. (2011)	Family intervention to control type 2 diabetes (T2D) was based on the Innovative Care for Chronic Conditions framework (Epping-Jordan et al., 2004). Family counselling during clinic visits, family meetings and home visits.	Providers trained in motivational interviewing and family counselling; clinicians guided multi-family groups	209 participants with T2D (34% in intervention group)	Chile	Family intervention: significant reduction in haemoglobin A1c levels, but the reduction in A1c levels from baseline to 12 months was not significantly different between clinics.
Kang et al. (2010)	Family partnership intervention care (FPIC) vs conventional care (CC). FPIC: three brief individual educational sessions, two-day group educational sessions, monthly phone discussion.	Health professionals (nurses, dietitians, social workers, physicians)	56 participants: 28 in FPIC group; 28 in CC group	Taiwan Province of China	No significant differences in the reduction of haemoglobin A1c levels or improvement of diabetes self-care behaviours between the groups at six months post-intervention. But significant differences in the scores of family supportive behaviours and patients' knowledge of and attitudes towards diabetes between the groups.
Keogh et al. (2011)	Psychological family intervention: two sessions for patient and a family member in the home, plus follow-up phone call; health psychology and motivational interviewing.	Health psychologist who had received 16 hours of training in motivational interviewing	121 patients and family members assigned to intervention group (IG; n=60) or control group (CG; n=61)	Ireland	At six-month follow-up, IG had significantly lower mean haemoglobin A1c levels than CG, particularly among those with the poorest control at baseline. IG showed significant improvements in beliefs about diabetes, psychological well-being, diet, exercise and family support.
Samuel-Hodge et al. (2017)	Family PArtners in Lifestyle Support (PALS), a family-centred behavioural weight loss intervention for adults with T2D. Dyads: 20 weekly group-based sessions involving weigh-in; group sharing and problem-solving; discussion of nutrition, physical activity or behaviour change. A 'family time' component in every other group session, focused on improving family interactions (cognitive and behavioural skills).	Registered dietitians	108 participants (81% female) in 54 dyads: 36 special intervention (SI) dyads; 18 delayed intervention (DI) dyads	United States	SI participants: greater improvements in haemoglobin A1c levels, depressive symptoms, family interactions, and dietary, physical activity and diabetes self-care behaviours. SI family partners: significant weight loss.

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Trief et al. (2016)	Telephonic couples behaviour change intervention: a series of 12 weekly telephone calls, during which couples were encouraged to provide mutual support for change, by using collaborative problem-solving techniques and recognizing their interdependence.	Dietitians trained for protocol adherence and to promote interaction within couples; audio-taped for supervision purposes	280 couples with a partner with T2D (median age = 56.8 years). RCTs, three arms: couples calls (CC) (n=104); individual calls (IC) (n=94); and diabetes education (DE) (n=82)	United States	No differences between groups on glycaemic control. The CC intervention was effective in lowering haemoglobin A1c levels for individuals with high A1c levels, while neither IC nor DE alone did so. For those with high A1c levels, DE alone was beneficial, but an additional intervention is needed to achieve glycaemic targets.
Wichit et al. (2017)	Family-oriented self-management programme to improve self-efficacy, glycaemic control and quality of life. Routine care plus a family-oriented programme involving education classes, group discussions, home visit, phone follow-up. Programme: three group education sessions at baseline, week 5 and week 9. Diabetes workbook discussed different topics: goals, learning skills.	Registered nurse	140 adults (aged 35 years and older) with T2D, randomly assigned to two groups (70 in each)	Thailand	Diabetes self-efficacy, diabetes knowledge, self-management and quality of life improved in the intervention group but not in the control group.

Table 3.4. Family interventions for diabetes for young people and youth (all RCTs)

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Doherty, Calam & Sanders (2013)	Self-directed Teen Triple P (Positive Parenting Program) workbook (10 weeks; one-hour modules) plus chronic illness tip sheet. Primary outcomes of diabetes-related family conflict and parenting stress assessed at baseline and post-intervention.	University: internet-based study via a dedicated website (national data collection)	Parents of adolescents aged 11–17 years with type 1 diabetes (T1D). RCT: intervention group (n=42); control group (n=37)	United Kingdom	The intervention reduced parent-reported T1D-related family conflict but not parent-reported stress (regardless of the increased parenting self-confidence reported in the intervention group).
Ellis et al. (2012)	Multisystemic therapy (MST): family, peer, school, community and individual interventions. Family interventions aimed at improving parental knowledge regarding diabetes, parenting skills and family organizational routines related to diabetes.	Master's-level therapists (psychologists, social workers)	146 adolescents with T1D or type 2 diabetes (T2D)	United States	Adolescents receiving MST: improved metabolic control at 7 and 12 months compared with adolescents in telephone support. Parents of adolescents receiving MST: significant improvements in adolescent adherence; adolescent-reported adherence remained unchanged.
Ellis et al. (2017)	Intervention: three computer-delivered motivational intervention sessions (The 3Ms) delivered during routine diabetes clinic visits.	Computer-delivered during routine diabetes clinic visits	Adolescents (n=67) aged 11–14 years with T1D and their primary caregiver. RCT, three arms: adolescent and parent motivational intervention (arm 1); adolescent control and parent motivational intervention (arm 2); or adolescent and parent control (arm 3)	United States	Parents in arms 1 and 2: increases in knowledge of the importance of monitoring adolescent diabetes care. Parents in arm 2: trend towards significant increases in direct observation and monitoring of adolescent diabetes care. Adolescents in arm 2: significant improvements in glycaemic control.
Freeman, Duke & Harris (2013)	Intervention compared therapeutic alliance when behavioural health care was delivered to adolescents in-clinic and via internet-based videoconferencing (i.e., Skype). Behavioural family systems therapy; 10 sessions of a family-based behavioural health intervention.	Therapists	71 adolescents aged 12–19 years with poorly controlled T1D and one of their caregivers (32 in intervention group)	United States	No significant differences in working alliance inventory (WAI) for those receiving behavioural health care via Skype versus in-clinic. Adolescent WAI goal and total scores were significantly associated with the number of sessions completed for those in the in-clinic group.

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Harris, Freeman & Duke (2015)	Behavioural family systems therapy for diabetes (BFST-D): face-to-face sessions in clinic and via internet videoconferencing (i.e., Skype). Ten therapy sessions over 12 weeks. Four BFST-D components: problem-solving, communication, cognitive restructuring and family therapy.	Clinicians with a master's or doctoral psychology degree, trained in the intervention and supervised by the first author	90 adolescents aged 12–18 years and at least one caregiver, assigned to receive BFST-D via the clinic (n=44) or Skype (n=46)	United States	Significant improvements in treatment adherence and glycaemic control, maintained at three-month follow-up.
Holmes et al. (2014)	Family teamwork coping skills programme compared with a diabetes education treatment. Coping skills programme aimed to facilitate diabetes management and promote effective family interactions (e.g., attitude and behaviour change).	Graduate-level interventionists	Families of 226 adolescents aged 11–14 years, randomly assigned to individualized coping skills programme or diabetes education	United States	Both treatment groups prevented deterioration in adolescent disease care and improved adolescent and parent quality of life through effective communication and reduced adherence barriers. Contrary to expectations, diabetes education was more effective than the coping skills programme in improving disease adherence and glycaemic control at three-year follow-up.
Katz et al. (2014)	Care ambassador (CA) and family-focused psycho-educational intervention for children with T1D: two-year RCT with three groups: (1) standard care (SC); (2) monthly outreach by a CA (CA+); and (3) monthly outreach by a CA, plus a quarterly clinic-based psycho-educational intervention (CA+Ultra). Intervention aimed to provide realistic expectations and problem-solving strategies related to family diabetes management.	CA: research assistant with a four-year university degree and no medical background, trained in study protocol	153 children aged 8–16 years with T1D. RCT with two age groups (8–12 years or ≥13 years) assigned to one of three groups: SC, CA+ or CA+Ultra	United States	No differences in haemoglobin A1c levels across treatment groups. Among children with suboptimal baseline A1c ≥8%, more children in the psycho-education group maintained or improved their A1c and maintained or increased parent involvement than children in the other two groups combined without negative impact on the child's quality of life or increased diabetes-specific family conflict.
Kichler et al. (2013)	Replication of Kicking in Diabetes Support (K.I.D.S.) treatment protocol (Opipari-Arrigan et al., 2005). Intervention (summarized in a manual) for adolescents and parents, involving six peer- and family-based group therapy sessions focused on developmental aspects of diabetes, parental involvement, communication, problem-solving, and school and peer issues.	Licensed psychologist led parent and adolescent sessions. Psychology postgraduate student trainee co-led the adolescent sessions as a co-therapist	30 adolescents aged 13–17 years with T1DM, all patients of a diabetes clinic, and their parents	United States	At four months post-treatment, parents and adolescents reported increased parental responsibility, and parents reported improved adolescent diabetes-specific quality of life. No significant changes in haemoglobin A1c levels and frequency of health care use at six months prior to and six months following the intervention, but other psychosocial changes observed (i.e., increases in parental responsibility and diabetes-specific quality of life).

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Nansel, Iannotti & Liu (2012)	Clinic-integrated behavioural intervention for families. WE-CAN Manage Diabetes intervention delivered at each routine clinic visit, in several steps: working together; collaborate to determine goal to work on; exploring barriers; choosing solutions; acting on the plan.	Health advisers (specially trained personnel)	Families of young people with T1D (n=390)	United States	Positive effect on glycaemic control, relative to usual care, among adolescents but not pre-adolescents. The effect began after 12 months of exposure (three or four sessions) and increased across time, showing the cumulative effect of repeated exposure to the intervention process at each clinic visit, and of families refining their problem-solving skills.
Nansel et al. (2015)	Behavioural nutrition intervention: nine in-clinic sessions to the young person and parent. Control group: equivalent assessments and number of contacts without dietary advice. Dietary intake: assessed with three-day diet records at six points in 18 months.	Trained research assistants	136 dyads of young person with T1D and parent (intervention group: n=66)	United States	Positive intervention effect across the study duration for the Healthy Eating Index and whole plant food density scores in intervention group vs control group. No difference between groups in haemoglobin A1c levels. The intervention improved dietary quality among young people with T1D but did not affect glycaemic control.

In general, the results indicate that family interventions for diabetes significantly influence family relations but not glycaemic control. This is consistent with previous reviews of psychological interventions used for diabetes (e.g., cognitive behavioural therapy, family therapy), which indicated that RCTs showed that interventions produced improvement in measures of psychological well-being while improved glycaemic control had been modest (Harkness et al., 2010) with only a few interventions sustaining improvements in glycated haemoglobin A1c levels beyond one year (Harvey, 2015). Behavioural nutrition interventions had positive effects for the Healthy Eating Index and whole plant food density scores but made no difference to glycaemic control (Nansel et al., 2015). Adolescents receiving multisystemic therapy had significantly improved metabolic control at 7 and 12 months compared with those in telephone support and parents reported significant improvements in adolescent adherence, but adolescent-reported adherence remained unchanged (Ellis et al., 2012). A psycho-educational intervention was effective in maintaining or improving haemoglobin A1c levels and parental involvement for children with suboptimal baseline glycaemic control but not for the other children (Katz et al., 2014). This finding is similar to that of Heinrich, Schaper and de Vries's (2010) review, which indicated that multi-component self-management interventions for diabetes are effective for diet, self-monitoring of blood glucose, knowledge and diabetes-specific quality of life, and that group interventions with a practical component have the greatest potential to improve metabolic control.

Interventions that include multiple people who share a health risk have the potential to foster significant changes in lifestyle behaviours and in the health-related involvement of members of their social network. There is evidence that adaptation to T1D is optimized in the presence of ongoing family support, supervision and parental involvement (Gayes & Steele, 2014; Jaser, 2011). Continued parental involvement in the management of diabetes care is important as children transition into adolescence, and the best outcomes are evident when this involvement occurs in a warm, collaborative manner. Additionally, parents need support in managing their own distress to maintain this type of involvement.

Research shows that families want to know more about the illness and want to support the affected family member, but also that they may not know how to do so. The Diabetes Attitudes Wishes and Needs 2 (DAWN2) (2011) cross-national study provided a comprehensive assessment of diabetes care and management among people with diabetes, their family members and health care professionals to address self-management, attitudes, disease impact, psychosocial distress, health-related quality of life, and social support (Peyrot et al., 2013). The sample included 2,057 family members of people with diabetes who participated in an online, telephone or in-person survey. Supporting a relative with diabetes was perceived as a burden by 35.3 per cent of respondents; 61.3 per cent of respondents worried about hypoglycaemia; and many respondents did not know how to help the person with diabetes (37.1 per cent) and wanted to be more involved in their care (39.4 per cent) (Kovacs Burns et al., 2013).

Conclusions from the evaluation literature for diabetes

In 2006, to reaffirm the importance of diabetes as a major global health threat, the United Nations developed resolution 61/225 on diabetes and designated World Diabetes Day, held annually on 14 November, a United Nations day (United Nations, 2006). This was based on the powerful Unite for Diabetes campaign, led by IDF in 2006, which raises awareness of diabetes. IDF developed the Global Diabetes Plan 2011–2021, which sets out a 10-year framework of action to guide governments, health care providers and civil society in achieving three objectives: improve health outcomes for people with diabetes, prevent the development of T2D and stop discrimination against people with diabetes.

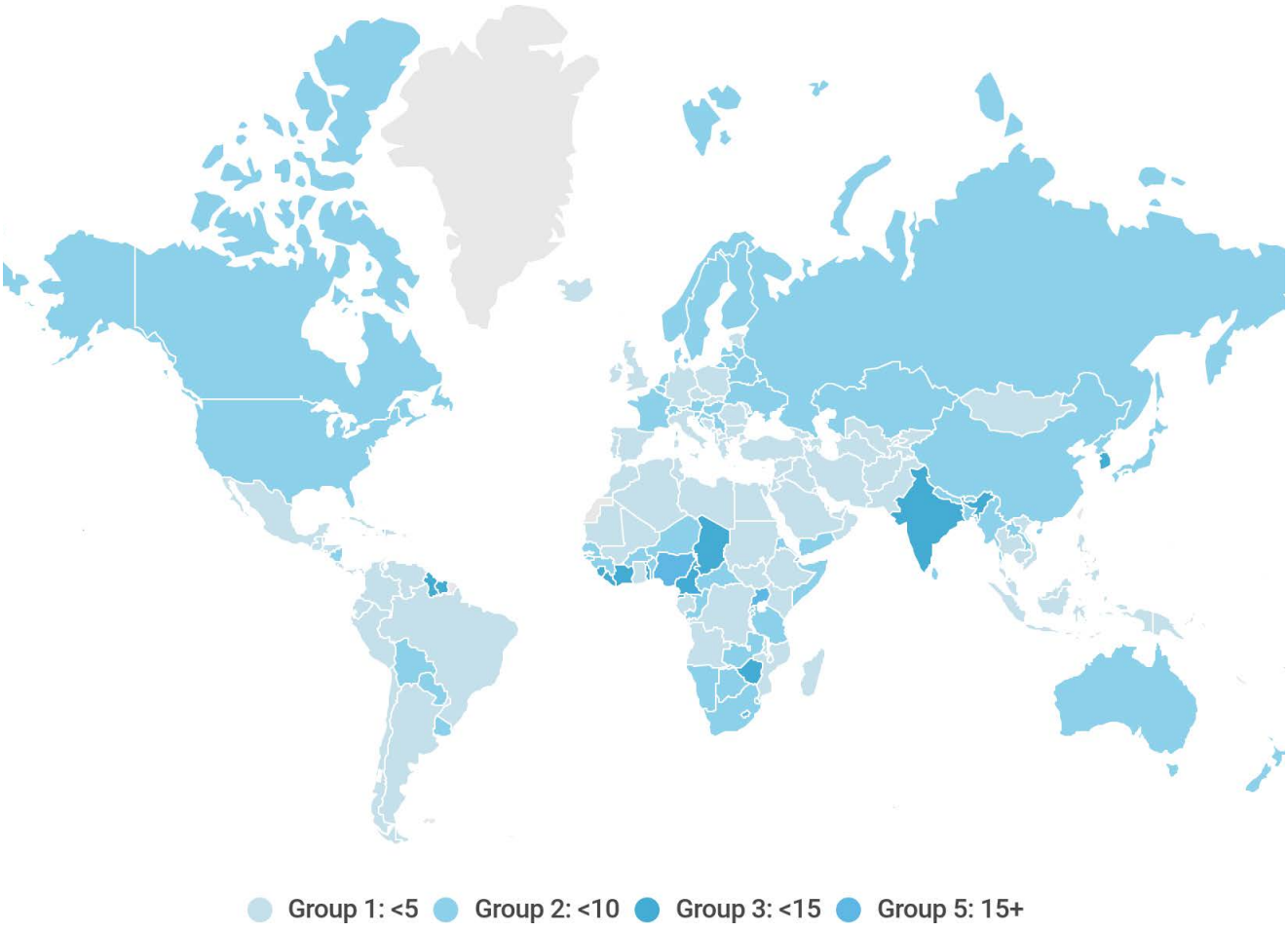
Given the high prevalence of diabetes, it is necessary to develop and implement effective policies around the world to address diabetes. Advocacy is an important mechanism that could potentially drive health-related policy development. Hilliard et al. (2015) developed the Diabetes Advocacy Framework, which covers four levels of engagement: individual actions to meet personal and family needs; community efforts to educate one's personal network or call for change in one's local area; national activities to increase

awareness, raise funds and influence national policy; and international actions to achieve these goals on a global scale and provide assistance to resource-poor nations.

3.3.3. Interventions for suicide

Suicide is a considerable public health problem given its complex consequences at the family and society level. Suicide is the third leading cause of death among adolescents aged 10–19 years in the United States, with more adolescents dying of suicide than from cancer, heart disease, AIDS, birth defects and lung disease combined (WHO, 2018a) (*see Maps 3.4.a and 3.4.b*).

Map 3.4a. Deaths from suicide, females, 2015



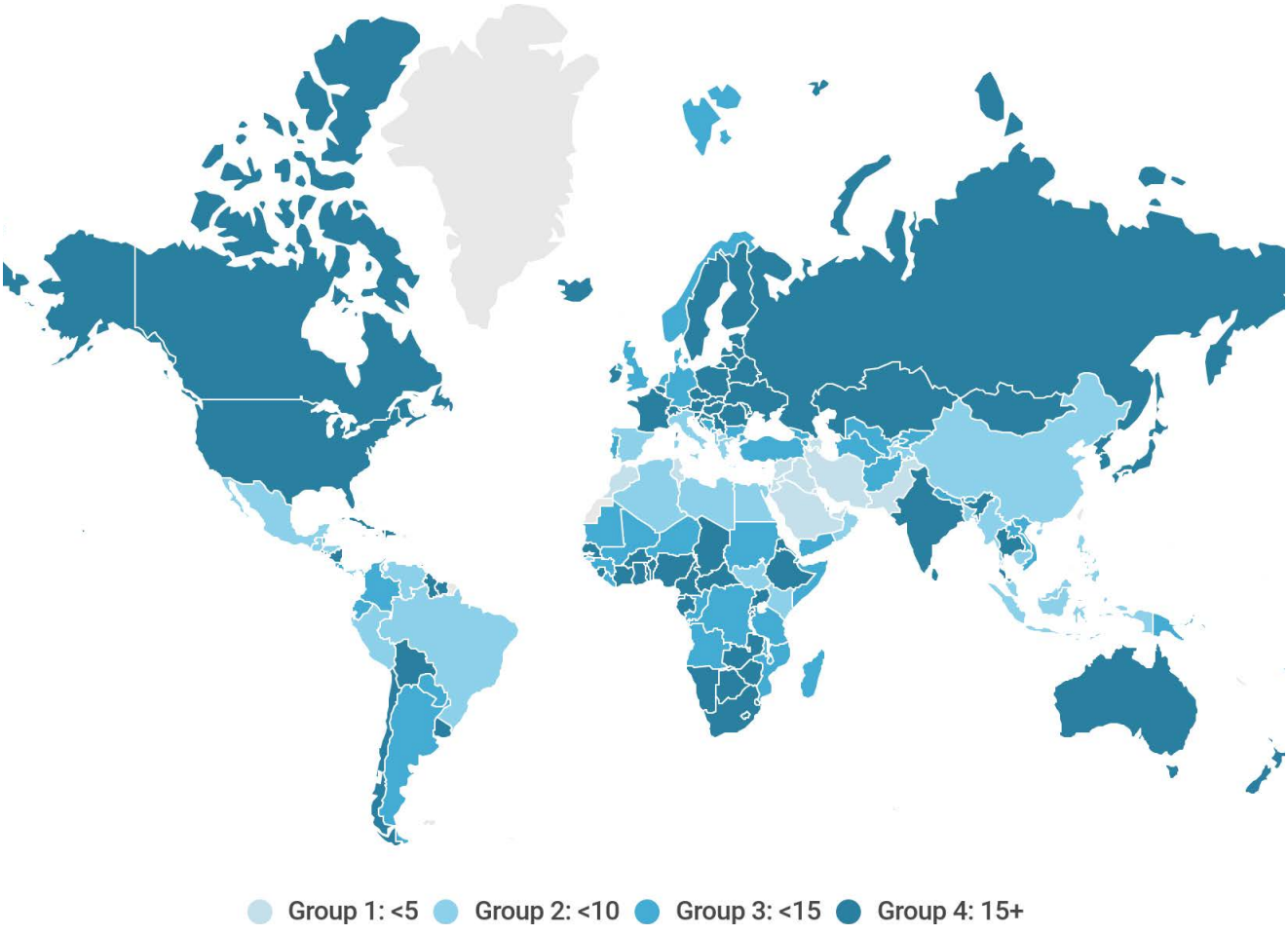
This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Health Organization. (2018). *Global Health Observatory*. Available at: <www.who.int/gho/en>, accessed 14 January 2020.
Note: Colour-coded mortality rates are per 100,000 of the population.

Approximately half of the emotional and behavioural disorders that are risk factors for suicide have their onset before 14 years of age (WHO, 2017; Wyman, 2014). Emotion regulation difficulties and a lack of trusted adults at home and school were associated with increased risk of suicide attempts (Pisani et al.,

2013). Thus, childhood and adolescence are important periods for preventing the incipience of suicidal behaviours (Wyman, 2014).

In terms of addressing suicide, the focus has expanded from young people who are *already* suicidal or at high risk to a more 'upstream' risk and protective factors approach, providing preventive services *before* the emergence of suicidal behaviour (Wyman, 2014). This calls for childhood programmes to strengthen self-regulation skills to be delivered in family and school settings, followed by adolescent programmes that leverage social influences to prevent emerging risk behaviours (e.g., substance abuse) and strengthen relationships and skills. Interventions delivered in normative social systems such as the family and school, where children spend most of their time, have the potential to have a broad impact and reach large numbers of children (Wyman, 2014). For example, through the promotion of positive classroom behaviour, the Good Behavior Game intervention implemented in first and second grade classrooms led to – 15 years later – reduced suicidal behaviour; decreased substance use; and a 50 per cent reduction in the rate of self-reported suicidal ideation and attempts at age 19–21 years (Wilcox et al., 2008).

Map 3.4b. Deaths from suicide, males, 2015



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Health Organization. (2018). *Global Health Observatory*. Available at: <www.who.int/gho/en>, accessed 14 January 2020.
Note: Colour-coded mortality rates are per 100,000 of the population.

Increases in family support and other sources of support, provision of a sufficient dose of treatment, promotion of sobriety, and motivation are associated with protecting adolescents from self-harm (Brent et al., 2013). Motivation for change and commitment to treatment are factors related to different health behaviours (Brent et al., 2013). Motivational interviewing promotes treatment adherence, which is very important given that 30 to 50 per cent of adolescent suicide attempters are non-adherent (Asarnow, 2011; Ougrin, 2013). Treatment adherence on its own is not enough, however, to reduce symptomatology – the quality of treatment also plays an important role (Asarnow, 2011).

Family interventions for suicide

Family interventions for suicide targeted children and adolescents and were conducted in Australia (Pineda & Dadds, 2013), the Netherlands (de Groot et al., 2010), Norway (Mehlum et al., 2014), the United Kingdom (Rossouw & Fonagy, 2012) and the United States (e.g., Connell, McKillop & Dishion, 2016; Diamond et al., 2010; Esposito-Smythers et al., 2011; Gewirtz, DeGarmo & Zamir, 2016; Hooven et al., 2012; Sandler et al., 2016; Vidot et al., 2016) (*see Table 3.5*).

Family interventions for suicide, focused on children and adolescents

Family interventions for suicide targeted children and adolescents and their relationships with their parents (Asarnow et al., 2011; de Groot et al., 2010; Gewirtz et al., 2016). Goals of the interventions were to improve follow-up treatment (Asarnow et al., 2011; Hughes & Asarnow, 2013), reduce suicide risk behaviours and related risk factors of depression, anger or drug involvement (Hooven et al., 2012), reduce youth alcohol consumption and suicidal ideation (Esposito-Smythers et al., 2011), increase parental skills (e.g., parental involvement, effective discipline) and reduce stress (Gewirtz et al., 2016). Several interventions focused on parenting and identifying possible risk factors, promotion of healthy family functioning (Connell, McKillop & Dishion, 2016; Vidot et al., 2016) and increasing parenting quality (Gewirtz et al., 2016). Two interventions targeted bereavement by suicide. The Family Bereavement Program targeted bereaved young people with the goal of helping them to process the loss in a healthy way and prevent further mental health problems (Ayers et al., 2014). Its long-term evaluation indicated a significant effect in reducing suicidal ideation (Sandler et al., 2016). The other intervention targeting bereavement, which took a cognitive behavioural approach (de Groot et al., 2010), also indicated that grief therapy can reduce the risk of maladaptive grief among suicidal ideators.

Theoretical frameworks used included family-based cognitive behavioural therapy (Asarnow et al., 2011; Esposito-Smythers et al., 2011), mentalization-based family therapy (Rossouw & Fonagy, 2012) and attachment-based family therapy (Diamond et al., 2010). Ougrin et al.'s (2015) meta-analysis of therapeutic interventions for suicide attempts and self-harm in adolescents indicated that cognitive behavioural therapy, mentalization-based therapy and dialectical behaviour therapy are effective. Cognitive behavioural therapy, dialectical behaviour therapy, problem-solving therapy, mentalization-based treatment and psychodynamic interpersonal therapy have also been found to be useful in preventing suicide attempts in adults (Brown & Jager-Hyman, 2014).

Implementation of the interventions typically included face-to-face sessions, and individual-based and family-based group sessions (Asarnow et al., 2011; Gewirtz et al., 2016; Vidot et al., 2016). This finding is similar to that of Calear et al.'s (2016) review of psychosocial suicide prevention interventions for young people, which showed that such interventions were predominantly face-to-face interventions, with very few technology-mediated interventions identified by the review. Given the accessibility of technologies among young people, this may be an implementation medium to consider for future interventions. Multiple assessments were conducted at baseline, and follow-ups occurred at various times, from 2 months (Asarnow et al., 2011) to 6 months (Diamond et al., 2010) to 12 and 24 months later (Almeida et al., 2012).

The professionals implementing the interventions were clinicians with graduate-level mental health training in psychology, social work, psychiatry or a related mental health field (Asarnow et al., 2011), child and adolescent mental health workers (Pineda & Dadds, 2013; Rossouw & Fonagy, 2012), psychiatric nurses (de Groot et al., 2010), trained facilitators (Gewirtz et al., 2016), or therapists (PhD and master's-level clinical psychologists) (Esposito-Smythers et al., 2011). The various settings in which the interventions took place were hospitals, e.g., emergency departments (Asarnow et al., 2011; Hughes & Asarnow, 2013), health centres (Pineda & Dadds, 2013) and patients' homes (de Groot et al., 2010; Pineda & Dadds, 2013; Vidot et al., 2016).

The results of the RCTs indicate that family interventions for suicide are effective in increasing the family's knowledge about suicidal factors and increasing family functioning and support for the patient. Pineda and Dadds' (2013) study provides evidence that a structured, brief, family-focused intervention can improve family functioning and thus reduce adolescent suicidality and other psychiatric symptoms. This finding is consistent with Diamond et al.'s (2010) study, which found positive benefits of brief, structured interventions for suicidal young people who had been identified in emergency and primary care settings and were treated in outpatient settings. Brent et al. (2013) made several recommendations for future interventions, including providing treatment of sufficient intensity and duration; timing treatment during the hospitalization or soon thereafter (when the risk is higher); and promoting family processes, support for sobriety, positive affect and motivation, and healthy sleep. Providing follow-ups has also been recommended, since data show that patients who received psychotherapy are less likely to attempt suicide during the follow-up period in comparison with patients allocated to receive 'treatment as usual' or with a similar condition (Calati & Courtet, 2016).

Table 3.5. Family interventions for suicide, focused on children and adolescents (all RCTs)

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Asarnow et al. (2011)	Family Intervention for Suicide Prevention (FISP): a brief adolescent and family crisis therapy session in the emergency department (reframing the suicide attempt, educating families on outpatient treatment). Phone contacts, to support outpatient treatment attendance, 48 hours after hospital discharge.	Clinicians with graduate-level mental health training	Suicidal adolescents aged 10–18 years (n=181)	United States	Intervention group: more likely to attend outpatient treatment, compared with usual emergency department patients; higher rate of psychotherapy, combined therapy and medication; more therapy visits. No decreases in suicide attempts.
Connell, McKillop & Dishion (2016)	Family Check-Up (FCU): school-based prevention programme, for Grade 6 students in public schools. Multi-level: universal classroom-based, FCU and family management treatment. FCU: three sessions to identify targets for intervention and support parents' effective family practices.	Intervention staff	998 Grade 6 students and their families	United States	FCU: significant reductions in suicide risk across adolescence and early adulthood.
Cross et al. (2011)	Gatekeeper training as usual, compared with training plus brief behavioural rehearsal (i.e., role-play practice) on learning outcomes after training and at follow-up. Participants in the training plus behavioural rehearsal (T + BR) group had additional group practice after presentation.	Two certified Question, Persuade, Refer programme trainers in the school district	91 school staff and 56 parents	United States	All participants: enhanced knowledge and attitudes; they spread training information to others in their network. T + BR: higher gatekeeper skills after training and at follow-up. Both conditions - decrements at follow-up.
de Groot et al. (2010)	Bereaved family members: four therapy sessions at home, three to six months after the suicide. Grief therapy: cognitive behavioural. Goals: to change frame of reference for grief reactions after suicide, engage emotional process and enhance effective communication.	Psychiatric nurses with knowledge of suicidal behaviour and group dynamics led the sessions	First-degree relatives or spouses recently bereaved by suicide (n=122)	Nether-lands	Suicidal ideators have a history of mental disorder and suicidal behaviour; suicidal ideation is a high risk for adverse bereavement outcomes. Grief therapy reduces the risk of maladaptive grief reactions among suicidal ideators.

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Diamond et al. (2010)	Attachment-based family therapy (ABFT) for three months to reduce suicidal ideation and depression in adolescents, involving individual and family meetings: relational reframe task, adolescent alliance task, parent alliance task, competency task.	Seven PhD or master's-level therapists provided ABFT	Adolescents aged 12–17 years (n=66) and family members	United States	ABFT: greater rates of change in self-reported suicidal ideation at follow-up. More patients in ABFT experienced a clinical recovery on suicidal ideation post-treatment than patients in enhanced usual care; benefits maintained at follow-up. Patterns of depressive symptoms over time: similar across the two groups.
Esposito-Smythers et al. (2011)	Intervention with cognitive behavioural treatment (I-CBT): individual/adolescent (problem-solving), family (communication) and parental training (monitoring) sessions. Motivational interviewing for adolescents to improve readiness for alcohol and other drug (AOD) treatment and for parents to facilitate treatment engagement.	12 therapists trained in I-CBT protocol: 3 PhD clinical psychologists; 8 clinical psychology postdoctoral trainees; 1 master's level clinician	40 adolescents (68% female) and their families	United States	I-CBT: significantly fewer heavy drinking days and days of marijuana use relative to the enhanced treatment as usual group, but not fewer drinking days. I-CBT: significantly less impairment, and fewer suicide attempts, inpatient psychiatric hospitalizations and emergency department visits.
Gewirtz, DeGarmo & Zamir (2016)	After Deployment, Adaptive Parenting Tools (ADAPT): 14-week adaptation of a parent management training programme for military families, focused on encouraging positive parenting skills, positive involvement, monitoring and effective discipline. Weekly groups: active teaching methods (role play).	Two or three military and non-military trained facilitators: National Guard/ Reserve members, spouses, human services providers; most with a master's in human services	Families randomly assigned to ADAPT (n=240) or to services-as-usual, i.e., print/ online parenting resources (n=160)	United States	Participants in ADAPT: improved locus of control and reductions in parental suicidal ideation at 12 months post-baseline; fewer difficulties in emotion regulation; decreased post-traumatic stress disorder.
Hooven et al. (2012)	Promoting CARE suicide prevention: adolescent-only intervention (C-CARE), parent-only intervention (P-CARE), combined adolescent and parent intervention (C + P-CARE), compared with intervention as usual (IAU).	Trained school nurse or counsellor	615 high school students and their parents: C-CARE (n=153); P-CARE (n=155); C + P-CARE (n=164); IAU (n=143)	United States	All groups experienced a decline in risk factors and an increase in protective factors and sustained these improvements over 15 months.
Mehlum et al. (2014)	Dialectical behaviour therapy for adolescents (DBT-A) compared with enhanced usual care to reduce self-harm in adolescents. DBT-A: individual therapy and skills training involving parents or caregivers, lasting 19 weeks.	Intervention staff	77 adolescents with recent and repetitive self-harm treated at community psychiatric outpatient clinics	Norway	DBT-A: superior to enhanced usual care in reducing self-harm, suicidal ideation and depressive symptoms. Number of treatment contacts was a partial mediator of the association between treatment and changes in the severity of suicidal ideation.

Authors	Family intervention	Who is enacting?	For whom?	Where?	What are the results?
Pineda & Dadds (2013)	Resourceful Adolescent Parent Program (RAP-P) plus routine care, compared with routine care only. RAP-P, a brief (four-week), structured family intervention involving a psycho-education programme for parents to provide information about suicidal behaviour and strategies to help their child avoid self-injuries, enhance effective parenting and promote family harmony.	Primary author led family intervention programme; mental health workers led routine care programme	48 suicidal adolescents and their parents	Australia	RAP-P: high recruitment and retention, improvement in family functioning, reductions in adolescent suicidal behaviour and psychiatric disability, compared with routine care; benefits maintained at follow-up. Changes in adolescent suicidality were mediated by family functioning.
Rossouw & Fonagy (2012)	Mentalization-based treatment for adolescents (MBT-A): weekly individual MBT-A (psychotherapy) sessions and monthly mentalization-based family therapy (MBT-F) sessions, all focused on reducing impulsivity and affecting regulation.	22 mental health workers who had six days of training in MBT-A and MBT-F, and supervision	80 adolescents	United Kingdom	MBT-A: more effective than treatment as usual in reducing self-harm and depression in adolescents, by improving mentalization and reducing attachment avoidance.
Sandler et al. (2016)	Long-term follow-up of 244 adolescents who participated in an RCT of the Family Bereavement Program (FBP): examining the intervention effects on suicidal ideation and/or attempts.	Two master's-level counsellors as group leaders	244 adolescents: FBP (n=135); comparison programme (n=109)	United States	FBP: significantly reduced suicidal ideation and/or attempts at the 6-year and 15-year follow-up. Potential benefits of 'upstream' suicide prevention.
Vidot et al. (2016)	Familias Unidas: eight family-centred, multi-parent groups, with parents taking a change agent role through four family sessions. Each parenting skill (e.g., communication) discussed and role played in groups and then enacted with the parent and the adolescent in a family session.	Intervention staff	Hispanic Grade 8 students (n=746) and their caregivers, assigned to Familias Unidas (n=376) or prevention as usual (n= 370)	United States	No significant effects on suicidal behaviours, but parent–adolescent communication found to be a moderator of suicide attempts in the past year, across the intervention.

Conclusions from the evaluation literature on suicide among young people

Policy, programme and advocacy efforts to prevent suicide have been developed in the international arena. World Suicide Prevention Day, held annually on 10 September, is an initiative of the International Association for Suicide Prevention and is co-sponsored by WHO. The 2012 National Strategy for Suicide Prevention resulted from the collaboration between the Office of the Surgeon General (United States) and the National Action Alliance for Suicide Prevention and, was 'a call to action to guide suicide prevention actions in the United States, it includes several goals and objectives designed to prevent suicide' (Office of the Surgeon General, 2012).

Aligned to the recommendations of the National Alliance for Suicide Prevention Research Prioritization Task Force (2014), Sandler et al.'s (2016) study links research on a preventive intervention for mental health problems with suicide prevention research, and notes the "emerging interest in 'upstream' approaches to the prevention of suicide in which interventions delivered in childhood or adolescence to prevent mental health or substance abuse problems have cascading effects to reduce suicide at later developmental periods" (Ibid).

It is essential to provide family interventions to young people at risk of suicide. Factors such as parental death represent a significant risk factor for suicide among offspring and providing preventive services has been found to be effective (Guldin et al., 2015). Similarly, prevention programmes may mitigate the risk of suicidality in parents, which is important as parental suicidality is a strong risk factor for offspring suicidality (Gewirtz et al., 2016). It is also recommended that more family interventions are developed and provided to all age groups, including older adults, among whom, in some regions (e.g., United States), the suicide rate is higher than it is among younger adults or adolescents (Van Orden et al., 2013).

3.4. Conclusions

Family interventions for NCDs and suicide improve among patients and their families understanding of the illness and family functioning in support of each other. While family interventions for CVD were focused on adults, those for diabetes targeted adults and youth, and those for suicide targeted children and adolescents. Given that many of the risk factors for NCDs and for mental illness and suicide are developing in childhood, it is imperative that preventive programmes are offered to children and adolescents.

While most of the interventions have been shown to bring about improvements, many of these had diminished by the time of subsequent follow-ups. Therefore, it is recommended that interventions include educational and counselling elements and that following the initial intervention, less-intensive programmes are provided at suitable intervals as reminders for patients and their families of healthy patterns.

Equally important is creating multidisciplinary teams to develop and implement family interventions, and involving family scientists, such as family life educators or family therapists, as part of the team. Family scientists have theoretical and applied expertise in working with families, especially with those confronted with complex stressors associated with chronic illness.

Working effectively with families, especially vulnerable ones, who deal with chronic, lifelong illness necessitates in-depth and systematic educational training. Providing short-term training (e.g., a matter of days) to health professionals who implement family interventions and work with families may not be sufficient. Therefore, involving family scientists in multidisciplinary teams that implement family interventions is highly recommended. Family life education incorporates a preventive, educational and collaborative approach to family and individual issues and problems (Darling, Cassidy & Powell, 2014). In the United States, family life educators have an undergraduate, master's and/or doctoral degree in the child/human

development or family studies field and can be designated Certified Family Life Educators by the National Council on Family Relations. Taiwan Province of China was the first country or area to enact a Family Education Act (in 2003) to nurture individuals and strengthen families through family life education (Hwang, 2014). Family therapists have a master's and/or doctoral degree in marriage and family therapy or counselling. All family therapists have not only adequate theoretical preparation but also hundreds of hours' experience of working with families in diverse social settings. This extensive experience of working with families could contribute in a positive way to the development and implementation of family interventions to help families cope with cardiovascular illness.

There seems to be willingness in the global policy arena to support health-related policies. The WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, based on the United Nations Political Declaration on the Prevention and Control of Non-communicable Diseases, calls for collaborations between governments, NGOs and academia, and civil society at large, to strengthen efforts to prevent illnesses and develop effective treatments. Families represent a great potential that can be tapped effectively to provide support to patients coping with illnesses. Care has to be exercised, however, so that families are not left alone in caring for their sick family members but are instead supported, financially and otherwise.

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CHAPTER 4.

FAMILIES AND SUSTAINABLE DEVELOPMENT GOAL 4: INCLUSIVE AND EQUITABLE EDUCATION

Chapter 4. Families and Sustainable Development Goal 4: Inclusive and equitable education

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4.1. Introduction

The purpose of this chapter is to explore how family policies, and the services they deliver, can positively influence SDG 4, the goal that defines ambitions for progress in education. In particular, the chapter focuses on how policies and programmes directed to and on behalf of the family – by both governmental and non-governmental actors – can be exploited for the purpose of achieving SDG 4, whilst complementing efforts of the school system.

The chapter is structured as follows. Section 2 provides detail around how education goals are defined in the SDG framework and how family policies fit in; section 3 introduces two indicators representing Targets 4.1 and 4.2 of SDG 4 to provide an indication of where countries presently stand on these targets (and raises some concerns about data quality); section 4 reviews the global evidence – derived from a literature review and quality assurance selection – under the subsections of parental leave policy effects, childcare and preschool policies (and prenatal home care examples), and family cash benefit effects. Section 5 summarizes the evidence and draws a conclusion about how family policies, and the services they deliver, can contribute positive change towards meeting SDG 4 – and specifically school attendance and learning outcomes of preschool- and school-aged children.

As the chapter will show, family policy, and families themselves, are being used as key points of intervention for promoting school attendance and learning at all stages of childhood. What else is clear is that although family policy – when properly designed and supported – has the potential to be very effective in achieving these goals for many children, today's family and education policies are not fit to meet the ambitions of SDG 4 without appropriate reform. Schools and childcare/preschool centres are under-attended and, in some cases, are attended by only the most privileged of children; learning outcomes are vastly unequal (see, for example, UIS, 2017) and many family and education policies struggle to promote equitable learning outcomes. Policymakers and other stakeholders should continue to strengthen efforts that support families to contribute to national education efforts to get every child in a school that is a safe and healthy place and which promotes learning for all. Strong families function in supportive units, providing to all of their members various resources such as time, money, physical resources, interpersonal care and emotional security. Therefore, any policy that can help to provide families with these supports, to function healthily, and to make good choices for child development (e.g., school attendance over child labour), should be considered by policymakers seeking to achieve the SDGs.

4.2. Education in the SDGs

SDG 4 aims to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all. The seven outcome targets under this goal cover broad areas of access and skills development, and – as with each goal in the framework – SDG 4 also includes a list of inputs that countries should seek to deliver as part of reaching the outcome targets (see interagency report: E/CN.3/2016/2/Rev.1).

More specifically, access to education objectives refer to younger children receiving early childhood development services (Target 4.2); children of primary and secondary school age accessing free, equitable and good quality primary and secondary school education (Target 4.1); and affordable and equal access to appropriate technical and vocational courses, including at university, for all women and men (Target 4.3). Learning outcomes cover the objectives to increase literacy levels in the overall population (Target 4.6); school readiness for the youngest; reading and mathematics proficiency for compulsory school-aged children; and technical and vocational skills for young people and adults (see Indicators 4.1.1c and 4.2.1 and Target 4.4). Equitable access – irrespective of gender and for the vulnerable, including those with disabilities, indigenous groups and vulnerable children – and learning related to a range of citizenship issues, human rights, peace and sustainability are all included across the objectives, as well as in two unique targets (Targets 4.5 and 4.7).

Inputs included in the targets under SDG 4 relate to building, safe, non-violent, gender- and disability-sensitive educational facilities, and upgrading existing facilities; and expanding scholarships, teacher numbers and teacher training globally, with a focus on the least developed countries (Targets 4.a, 4.b and 4.c).

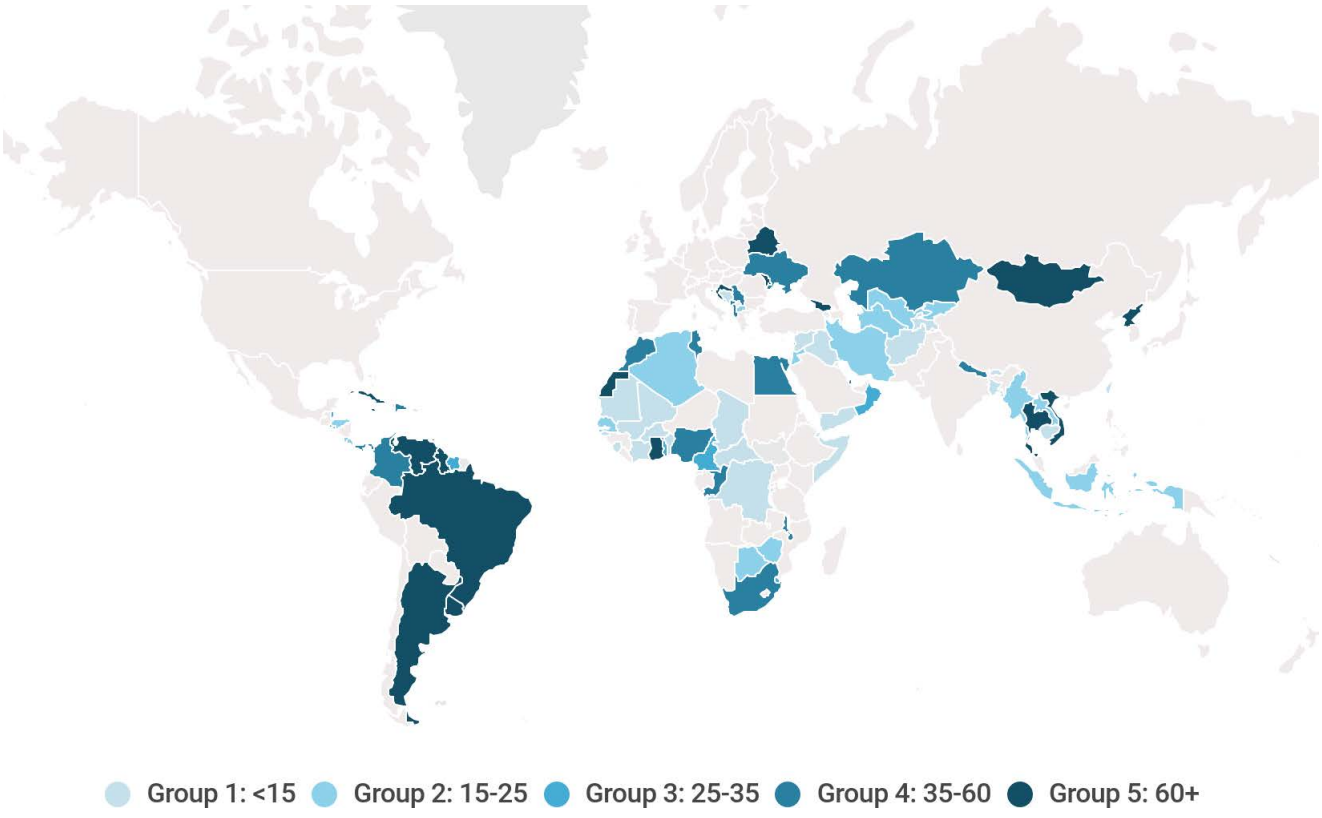
Although each target within each goal has an indicator assigned to it, the pathways through policy to achieving the targets are many and varied. Equitable access to education, at all levels, is affected by many conditions (e.g., income inequality, gender norms), some of which are within the scope of family policy to define. Differences in access to schools and early childhood education and care based on family income, for instance, as well as in learning outcomes based on parental education, are well documented across most of the world. This means that the role of policies affecting parental employment, and family cash and services policies designed to mitigate income poverty and deprivation, will inevitably be influential in meeting SDG 4. Moreover, policy trends suggest that the influence of families and family policy in achieving the specific ambitions of SDG 4 will grow. For instance, in recent years, an increasing number of family policies have been specifically designed to incentivize families to ensure school access for their children (e.g., through conditional cash transfers, or providing school equipment or school meals based on eligibility for family benefits).

4.3. Where countries stand on SDG 4: A recent global picture of preschool attendance and lower secondary completion

This section compares two global education indicators to provide a picture of where countries are currently in terms of meeting SDG 4 ambitions for educational access for preschool children (Target 4.2) and completion rates for secondary school-aged children (Target 4.1). For both cases, measures of equity in outcomes (by income and by gender) are also compared in recognition of the focus, within SDG 4 and the framework as a whole, on equity and on leaving no one behind.

Map 4.1 provides data on the proportion of children aged 3–6 years who are attending an early childhood education programme at the time of the most recent relevant survey. The map covers the global south (although data are also available for high-income countries; see OECD Family Database, 2017) and shows that, on average, among countries with data, fewer than one in two children are attending a preschool setting. Data for this indicator, which are collated by UNICEF statistical teams, are drawn from existing household surveys at the national level, as well as from the MICS and DHS Program databases. National representativity is not always possible and many of the data are old – the results here should be read with these limitations in mind.

Map 4.1. Percentage of children (aged 36–59 months) attending an early childhood education programme (2005–2014)



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: UNICEF global databases (2016), based on DHS, MICS and other nationally representative surveys and censuses. Note: Data refer to attendance in early childhood education: percentage of children aged 36–59 months who are attending an early childhood education programme. Data refer to most recent available year and, where necessary, can differ from this definition or refer to sub-national estimates. For information on these cases, see source. The full list of data estimates by country is available in Annex 3.

Map 4.1 also shows some regional variation in attendance of preschool services by children, with Latin American countries and, with somewhat lesser consistency, the countries of Europe and Central Asia, showing the highest rates of attendance. Countries of the West and Central Africa region, and parts of the Middle East, have the lowest attendance rates. Given the limitations of the data, however, improvements are needed in country coverage and timeliness of data collection in this area, not only to inform progress against SDG targets, but also to provide more accurate data for national monitoring and empirical work on barriers and bottlenecks to children's access to preschool services.

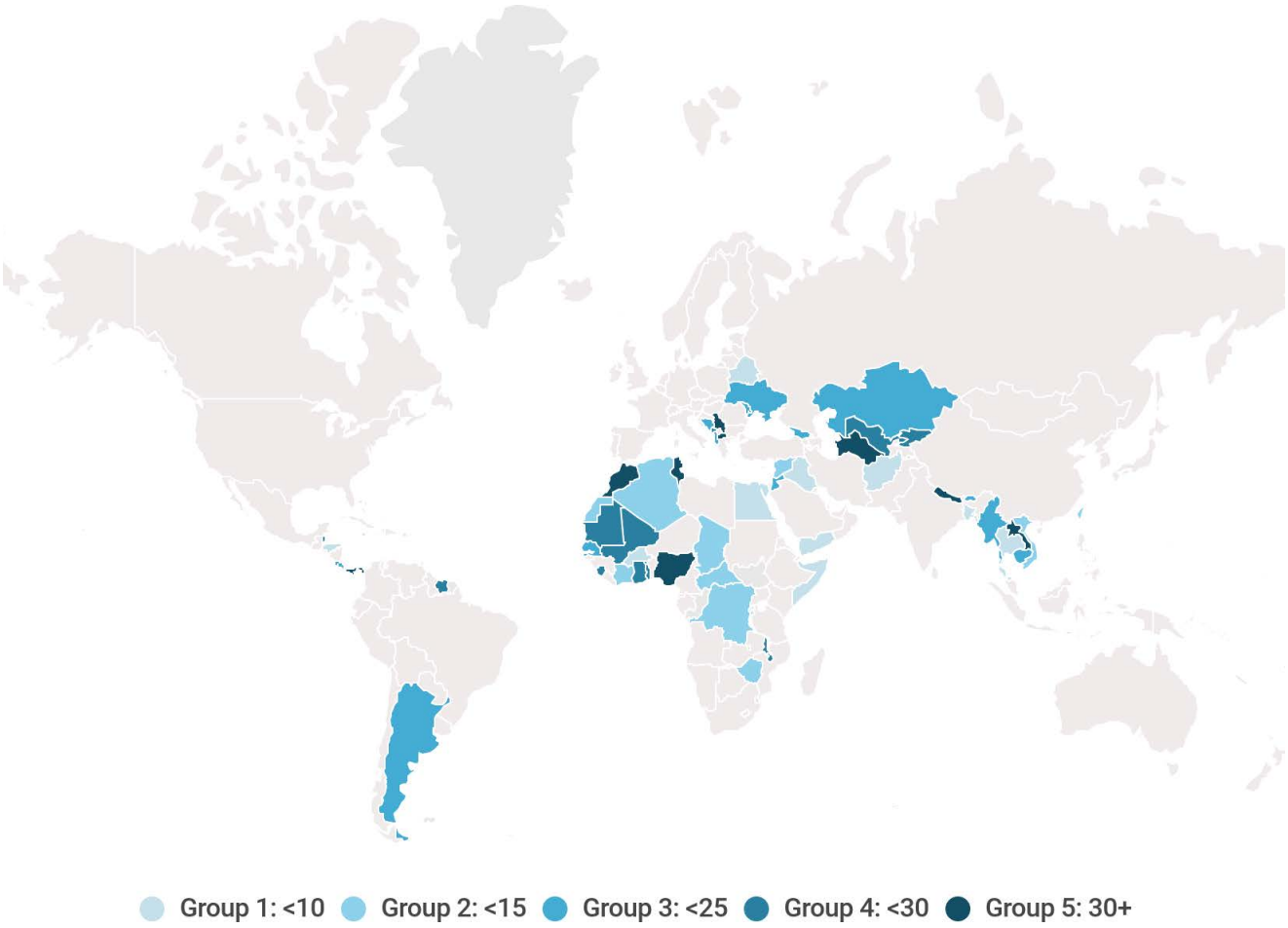
One example of a barrier to preschool attendance is resource poverty, indicated by family and household income. The effect of low income is clearly shown in Map 4.2, which distinguishes countries on the basis of the percentage point gap in preschool attendance between the richest and poorest quintiles of the surveys. The most striking message from this map is that, from all of the countries with data, only one reports lower levels of preschool attendance among richer children than poorer children: Thailand (where the difference in attendance of poor children is 2.5 percentage points higher than that of rich children, in an overall rate of 84% of 3 to 6 year olds attending some pre-schooling – data from 2012). Fifty-seven countries are mapped, 28 fewer than in Map 4.1. Differences in countries included in these maps are due to countries not collecting data on preschool attendance and family income in the same survey, which is not only a limitation for this study, but also inhibits further within-country analysis on the links between poverty and preschool attendance. The ultimate sources of the reported data otherwise remain the same and thus so do the cautions regarding interpretation of the data (old estimates, with some variation in definitions and coverage).

Income-based inequality in preschool attendance shows inconsistent patterns by region, with the countries of Europe and Central Asia showing the most similar outcomes. While this region has mid-range levels of inequality in attendance by income, the majority of countries worldwide are at the higher end of the scale. South East Asian countries show the greatest variability as a group.

A handful of countries have low rates of average attendance, but high levels of inequality favouring richer children and families. For instance – and in contrast to its near neighbour, Thailand – the Lao People's Democratic Republic (data is from 2011-12) reports an average attendance rate of 23 per cent of children aged 3–6 years, but a gap of 50 percentage points between the rates reported for the high-income and low-income groups.

The preschool data, however limited, provide an important indication of how far there is to go to achieve SDG Target 4.2 in each country. As such, the data present a starting point for discussions about which family policies may work best in different countries, based on levels of need, by type of need (e.g., highly-determined by income or otherwise). What the data are unable to shed light on are the intensity of service provision (hours used), broader equity considerations regarding access (e.g., gender, disability, indigenous groups), quality of services provided or outcomes achieved, and these data are needed if country efforts to meet all aspects of SDG 4 are to be effectively informed and monitored. Work by UNICEF survey coordinators for MICS, and by UNICEF as the custodian of SDG Target 4.2, will seek to address these issues in the coming years.

Map 4.2. Percentage point gap between high-income and low-income enrolment in early childhood education services

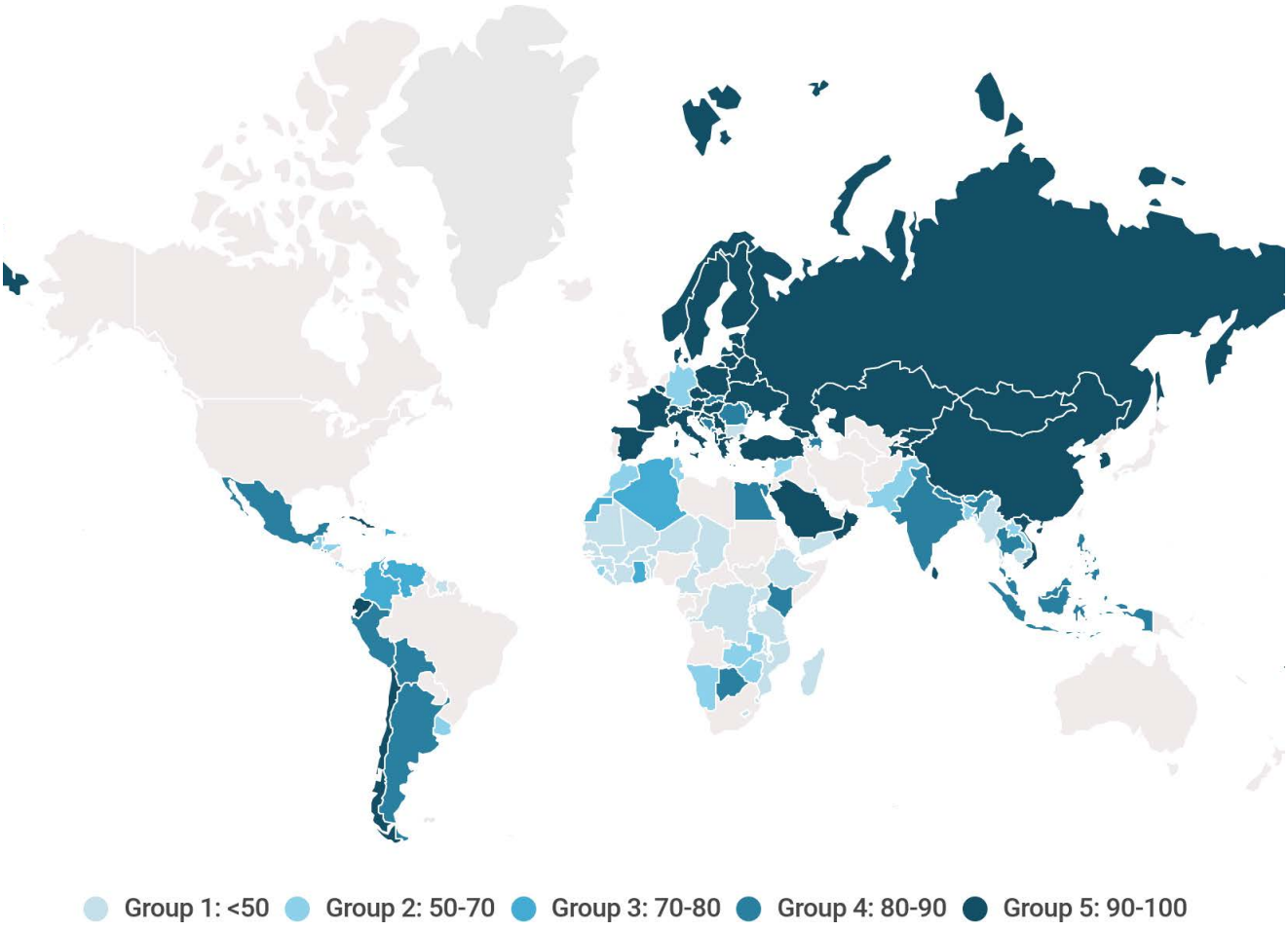


This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: UNICEF global databases (2016), based on DHS, MICS and other nationally representative surveys and censuses. Note: See Map 4.1. Additional countries missing from Map 4.2 are missing due to lack of data suitable for calculating income quintiles. High-income groups are top income quintile members; low-income groups are bottom income quintile members.

Looking a little further on in the education life course, at a more established sub-sector of education, allows for greater country coverage and timeliness of data, and a focus on gender equality. Maps 4.3a and 4.3b are global pictures of lower secondary completion rates for the total population and for girls only in the respective age cohort (*for a scatter plot of the data, see Annex 4.2*).

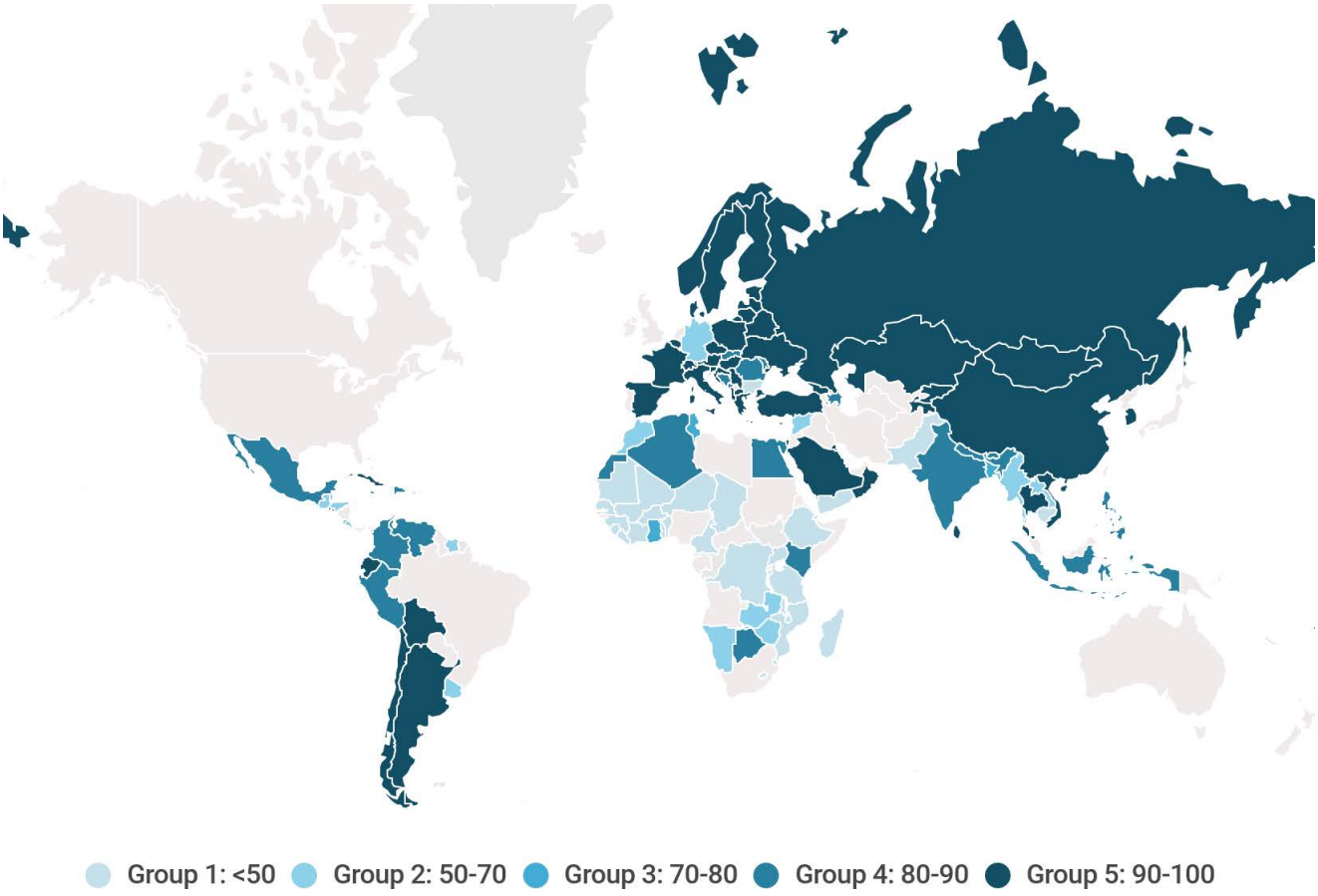
The rates of completion for the lowest post-primary level of school vary massively across the globe. High-income countries in the maps are reporting net rates of over 100 per cent (i.e., more students than children of the relevant age group, as overage and underage students are included in the lower secondary system. On the other hand, countries such as Chad and the Niger have overall completion rates of as low as 17 per cent and 12 per cent respectively, with completion rates for girls only of about 10 per cent.

Map 4.3a. Lower secondary completion rate (% of relevant age group): Females and males (2013–2015)



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Development Indicators. (2017). World Bank. Note: Data are from most recent survey between 2013 and 2015.

Map 4.3b. Lower secondary completion rate (% of relevant age group): Females only (2013–2015)



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Development Indicators. (2017). World Bank. Note: Data are from most recent survey between 2013 and 2015.

Notable gender differences are fortunately quite rare across countries, with girls' completion rates 5 percentage points higher than the overall average in 17 out of 136 countries with data (Algeria, Bangladesh, Bhutan, Cabo Verde, Colombia, Honduras, Kiribati, Kuwait, Lesotho, Oman, the Philippines, Seychelles, Suriname, Tunisia, Tuvalu, Uruguay and Western Sahara) and 5 percentage points lower than the overall average in 10 countries (Benin, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Guinea, Liberia, Liechtenstein, Saudi Arabia, Togo and Yemen). Two countries report very high gender differences: in Suriname, the completion rate of girls is 15 percentage points higher than the average rate; in the Democratic Republic of the Congo, boys' completion is just under 14 percentage points higher.

Where completion rates are low overall, and gender differences are high, this constitutes a dual challenge for the governments of those countries. Chad stands out in this respect.

Although more robust and timely than preschool data, data on school completion rates also suffer from an inability to communicate levels of quality in the education system, and issues of equity beyond gender differences. Importantly, the data alone also do not explain why such differences in access exist within countries – only that they do exist. Comparability is an issue because of country-specific measurement bias, given that rates of repeating students by country are not observed, nor are differences in what constitutes

completion (e.g., course completion or receipt of a qualification). Nonetheless, such maps and, where available, messages of equity within country can be used as a starting point for applying, at a country level, the following evidence of how different family policies influence various educational outcomes of different types.

4.4. Family policy and meeting SDG 4: A review of the evidence

4.4.1. Literature search

The literature search for this chapter was conducted using a Google Scholar search and a JSTOR search. The searches were performed with increasing specificity, starting with a generic keyword search using the terms "family policy and education" and "family interventions and education outcomes". This was followed by a keyword search by type of family policy ("parental leave", "cash transfers", "early childhood education and care", "family income maintenance"), type of educational outcome ("school enrolment", "educational attainment", "educational achievement", "test scores", "access to education") and region ("Africa", "Asia", "Latin America"), in different combinations (e.g., "cash transfers and educational attainment in Latin America"; "early childhood education and educational achievement in Africa"). Other keywords used included: "randomized control trials (RCT)"; "meta-analysis/reviews/evaluations of family interventions". A further search was undertaken to source relevant citations in studies retrieved through the keyword searches.

4.4.2. Selected literature, and papers excluded from the study

The searches uncovered 48 papers in total, 35 of which are reviewed in the following three sections organized according to family policy by life stage: parental leave policies, early childcare/preschool policies, and family cash transfers. Selections and exclusions were determined based on a quality assessment that reviewed each paper for conceptual coherence, appropriate methodology and data validation. In total, 13 papers were excluded, 7 of which did not meet methodological standards, having undertaked evaluations without experimental or quasi-experimental designs. Three further papers evaluated family policies for a range of family outcomes, but had a limited focus on educational outcomes in the final tests. The remaining three excluded papers did not meet the required generalizability standards, due to either being a pilot study or having an unstructured sampling design or small samples overall (*for the full list, see Annex A*).

4.4.3. Parental leave policies and educational outcomes

Table 4.1 summarizes the results of literature on parental leave policies that have been evaluated for their effects on education. In each case, these policies are delivered by a government agency. Results of how parental leave policies affect educational outcomes are rarely straightforward. In a number of cases, results suggest that an optimal duration of leave for achieving positive spillovers for learning and school attendance is mediated by parental engagement with the labour market (and associated by income effects, home care effects and childcare effects) and further by parental levels of education.

The earliest parental leave policy to be evaluated for its effects on education was the increase, to 18 weeks, of both paid and unpaid maternity leave in Norway in July 1977 (Carneiro et al., 2011). Eligible mothers across Norway were studied, along with their children, before and after the extension of the leave period, using administrative data and a regression discontinuity design. This design recreates a control and treatment model, separated by time (specifically, the Norway evaluation compared children born just before and just after the reform, with mothers in the later sample having benefited from the change in maternity leave entitlements). Results of this early and modest increase to the parental leave policy (compared with leave extensions) showed a 2.7 percentage point decline in secondary school dropout among children and a 5 per

cent increase in wages at the age of 30 years. The effects were strongest for children of mothers with low education, where a 5.2 percentage point decline in secondary school dropout was seen, alongside an 8 per cent increase in wages at age 30.

Other early reforms have been evaluated by Dustmann and Schönberg (2012) across a series of three major expansions in maternity leave coverage in Germany (1979, 1986, 1992). The first two reforms were to paid leave and were extensions from 2 to 6 months and from 6 to 10 months respectively. The third reform was an extension of unpaid leave from 18 to 36 months. Using a difference-in-difference design, again comparing outcomes of children born shortly before and shortly after the changes in maternity leave legislation, the study found only small education effects of paid leave extensions and indications of negative effects of the unpaid extension. The early paid leave extension (expansion in paid leave from two to six months in 1979) added no more than six days to an educational career and less than one third of a percentage point to wages at the age of 28 years. The 1986 reform fared no better, with secondary school completion effects measuring less than half a percentage point. Of note was the effect of the 1992 expansion in unpaid leave coverage, which the authors suggest could have been negative, reducing university-track school enrolment through income effects (expanded leave resulted in a loss of income) and lower access to out-of-home care for children over the age of 18 months.

Rasmussen (2010) evaluated the effects of a Danish reform from 1984, which increased parents' birth-related leave from 14 to 20 weeks. This comparatively small extension was evaluated using administrative data and discontinuity analysis, as with the Norwegian example above. Some 16 years later, there was no observed effect of increasing maternity leave on children's secondary school educational outcomes (enrolment or grade point average).

In the late 1980s, the Swedish government extended parental leave for families with children born after 1988 from 12 to 15 months. Liu and Skans' (2010) analysis of the reform produced mixed results, broadly in favour of educated mothers. In the full sample of parents receiving extended leave conditions, no effect was seen on children's test scores and grades at 16 years of age. The study did, however, find positive effects for children of well-educated mothers, a finding explained through the ability of more educated mothers to pass on more of their own educational advantages to their children, over a longer period of time.

Since the 1977 reform in Norway, which extended leave to 18 weeks, and was evaluated by Carneiro et al. (2011), a series of further maternity policy reforms in Norway have expanded paid maternity leave from 18 to 35 weeks. The seven major reforms since 1997 have since been evaluated by Dahl et al. (2016) with a view to assessing whether the subsequent expansions had any added effect on outcomes, and thereby justifying the reforms. Following regression discontinuity analysis of each of the expansions following the 1977 reform, the authors concluded that the expansions in maternity leave beyond 18 weeks had little or no effect on children's academic achievement or graduation from secondary school.

The latest evaluation to be reviewed here comes from Baker and Milligan (2010), who assessed the increase in maternity/parental leave in Canada in 2000. This reform resulted in job-protected, partially compensated maternity leave increasing in duration from roughly six months to one year in most provinces. The authors used data from Canada's National Longitudinal Survey of Children and Youth and regression discontinuity analysis, concluding that although maternal care for the child increases, and despite being seen alongside corresponding decreases in full-time maternal employment and unlicensed non-relative care, the impact on child development was negligible or not attributable to the reform.

Table 4.1. Summary of parental leave interventions and evaluations of their effects on education

Authors	Family intervention description (How are they doing it?)	For whom?	Where? What level?	How is it evaluated?	What are the results?
Carneiro et al. (2011)	Increased paid and unpaid maternity leave to 18 weeks (1977).	Eligible mothers	Norway, state level	Regression discontinuity analysis, using registry data	Decline in secondary school dropout and increase in wages at age 30 – effects are larger for mothers with low education.
Dustmann & Schönberg (2012)	Expansions in maternity leave coverage in Germany (1979, 1986, 1992): from 2 to 6 months in 1979; from 6 to 10 months in 1986; unpaid leave raised from 18 to 36 months in 1992.	Eligible mothers	Germany, state level	Difference-in-difference design	Schooling increased by no more than six days, and wages at age 28 by no more than 0.3 percentage points. Raised the probability of completing high-track schools by no more than 0.42 percentage points. Marginally lower attainment, mediated by lower labour market engagement, and subsequent income and lower childcare effects.
Rasmussen (2010)	Increased parents' birth-related leave from 14 to 20 weeks (1984).	Eligible mothers	Denmark, state level	Regression discontinuity analysis, administrative data	No measurable effect on children's secondary school outcomes
Liu & Skans (2010)	Parental leave extended from 12 to 15 months for children born after 1988.	Eligible mothers	Sweden, state level	Regression analysis	No effect on learning and grades at age 16; overall positive effects for children of well-educated mothers.
Dahl et al. (2016)	Expansions in paid maternity leave from 18 to 35 weeks (1997).	Eligible mothers	Norway, state level	Regression discontinuity analysis	Successive expansions in maternity leave beyond 18 weeks had little effect on children's schooling. No effect of paid leave on children's academic achievement or graduation from secondary school.
Baker & Milligan (2010)	Increase in duration of job-protected, partially compensated maternity leave from six months to one year in most provinces (2000).	Eligible mothers	Canada, federal and provincial levels	Longitudinal design with time-sensitive controls	Maternal care increased significantly, but effects on measure of child development were negligible.

The combined literature on parental leave interventions and their effects on education outcomes can be summarized in the following key points.

First, the geographic coverage of these studies – particularly the focus on high-income settings – is a serious limitation for assessing the extent to which they can inform the needs of the global community of policymakers. It is noted, however, that policymakers in the field of education are unlikely to promote parental leave policies as a first-stage intervention or draw from their own resources to enact such policies. Rather, what is clear is that supporting families in raising young children – balancing leave time and income to neither oversupply time nor undersupply money – has been shown, in countries with available data, to support longer-term education outcomes of children. This leads to the conclusion that the education system would benefit from stronger parental leave policies, and so these findings can, at least, inform understanding of the need for a portfolio of child policies that span education and social protection.

Second, in terms of parental leave policies themselves, time effects are evident, and longer leave does not always produce stronger positive effects. This is likely to be due to mediator effects that are important to children's learning development, including parental employment (this and parental education are important mediators of the effect of family policy on education), and associated home care effects, which feed into poverty and peer factors (related to socialization and peer learning) and complicate the direct effects of parenting time in infancy.

4.4.4. Early childhood policies (care and education) and educational outcomes

An area of family policy with a good deal of evidence connecting it to education outcomes is childcare/preschool. The difficulty of disentangling childcare policies and preschool or early learning policies (which can be managed by social protection, education or even health ministries – or at various levels of governance) has led this review to include evidence of all types of preschool care programmes (including some references to home visiting programmes) for education effects. Table 4.2 summarizes the results of the literature review of research syntheses and childcare/preschool policies that have been evaluated for effects on education.

The headline findings of the review are that childcare and preschool are consistently and often strongly linked to short-term education outcomes and, in some cases, lasting education outcomes. More often than not, the effects are stronger for lower-income families (likely to reflect the relative improvement in care conditions out-of-home as compared with higher-income groups). On the one occasion that results were not positive, the delivery mechanism in use was privately provided, subsidized childcare, for which only a subgroup of recipients was studied (Lefebvre et al., 2008).

Review studies/research syntheses: Childcare and preschool policies

The earliest childcare/preschool effect study covered here, by Barnett (1995), reviewed 36 studies focusing on early childhood development programmes and examined their long-term effects on children from low-income families. This was a comprehensive review, drawing from global sources, and included studies of preschool education, Head Start (a United States government programme), childcare and home visiting programmes. It focused primarily on the effects of programme participation on children's cognitive development. Results indicated that early childhood development programmes can produce large short-term benefits for children's cognitive development (among other outcomes) and sizeable long-term effects on school outcomes.

Currie (2001) reviewed 13 integrated preschool programmes, including home visitation, on cognitive development of children from various socio-economic backgrounds, also drawing evidence primarily from

the United States. The overarching conclusion of the review was that early childhood care programmes have significant short- and medium-term benefits, and the effects are often greater for more disadvantaged children.

Anderson et al.'s (2003) literature review on childcare/preschool effect studies summarises findings from 350 articles that assessed the effectiveness of multiple early childhood development programmes and their impact on education outcomes (achievement, language, cognition, etc.). Overall, the review records a considerable and positive impact of early childhood care interventions on education outcomes.

Pianta et al.'s (2009) review adds another point of comparison: type of childcare/preschool policy, allowing for a comparison of large- and small-scale programmes. The review drew on evidence from studies of childcare and public school programmes, and a wide range of research methods, including experiments. The authors reiterate the well-documented finding that preschool programmes have lasting positive effects on young children's cognitive and social development (as others have concluded) and add that these lasting positive impacts have been found for large-scale public programmes as well as for intensive programmes implemented on a small scale (including by civil society). Some of the literature in Pianta et al.'s (2009) review showed negative effects on children's social behaviour, but the negative effects did not show up in the evidence derived from experimental studies.

A later multi-country review from Burger (2010) provided evidence to distinguish the short- and long-term effects of early childhood education and care programmes. The author concludes that such programmes have considerable positive short-term effects, but somewhat smaller long-term effects, on cognitive development; and that, in relative terms, children from socio-economically disadvantaged families made as much, or slightly more, progress in these programmes, as their more advantaged peers.

Unique in methodological terms to the review studies is Camilli et al.'s (2010) meta-analysis of 123 studies on the impact of early childhood interventions on cognitive outcomes. Perhaps unsurprisingly, given the findings of the literature reviews, the meta-analysis concludes that early childhood interventions have positive effects on cognitive development.

The last childcare/preschool policy review included in this chapter is Nores and Barnett's (2010) review of international (non-US) evidence on the benefits of early childhood interventions. A total of 38 studies of 30 interventions in 23 countries were analysed. This review served as a check on the consensus on the effects of childcare/preschool, mainly driven by the US evaluations, and provides some much-needed external validation of earlier messages. Nores and Barnett (2010) found that children from across the different countries and contexts receive substantial cognitive, behavioural, health and schooling benefits from childcare/preschool interventions, and the benefits are sustained over time. Interventions with an educational or stimulation component have the largest cognitive effects.

Evaluative studies: Childcare/preschool policies

The first of three evaluative studies of childcare/preschool policies to come from the United States is from Graces et al. (2002), which reviews Head Start, an early public intervention. This integrated services programme for disadvantaged preschool children aims to provide a nurturing learning environment. Services included in Head Start are: facilitation and monitoring of the use of preventive medical care by participants, and provision of nutritious meals and snacks. Sibling studies showed that white children who had attended Head Start are significantly more likely to complete secondary school and attend university than siblings who had not participated in the programme. African American Head Start participants are less likely than their non-participating siblings to have been involved with law enforcement and more likely to have finished secondary school.

Lowell et al. (2011) reviewed the effects of Child FIRST (Child and Family Interagency, Resource, Support, and Training), a home-based, psychotherapeutic, parent–child intervention embedded in a system of care – and involving mental health clinicians – for vulnerable families with children from the prenatal stage to 6 years of age in Connecticut, United States. The evaluation of Child FIRST involved an RCT, which showed, at the 12-month follow-up, significant improvements to language (odds ratio of 4.4) and externalizing symptoms (odds ratio of 4.7) compared with children undergoing usual care treatment.

Most recently, North Carolina's Smart Start and More at Four early childhood programmes were reviewed by Dodge et al. (2017). Smart Start provides early childhood services for children from birth to 4 years of age, which aim to ensure that all children enter primary school healthy and ready to learn. More at Four (now known as NC-Pre-K) is a pre-kindergarten programme for vulnerable four-year-old children that started in 2001 and which aims to improve school readiness among these children in the year prior to joining kindergarten. (Vulnerability is defined as annual family income at or below 75 per cent of the state median, limited English proficiency, disability, chronic illness and/or developmental need.) The authors undertook student-level studies and found positive associations between programme attendance and reading and mathematics test scores, reductions in special educational needs, and grade retention in each grade.

The French *école maternelle* system was evaluated by Dumas and Lefranc (2010) to assess whether its expansion since the 1960s and 1970s to nearly all three-year-olds (about 90 per cent enrolment) and to all four-year-olds has had an effect on later education outcomes. Results of the regression-based analysis show that the expansion had some sizeable and persistent effects on subsequent schooling outcomes (repetitions, test scores, secondary school graduation) and wages. Children from low to middle socio-economic groups benefit more from the interventions.

The final childcare/preschool evaluation study to be discussed is Lefebvre et al.'s (2008) assessment of the efficacy of a low-fee universal childcare policy in Québec, Canada. In 1997, licensed and regulated private providers of childcare services began offering day care places at the reduced fee of $5 per day per child for children aged 4 years; by 2000, this was expanded to all children aged 0–59 months (i.e., children not eligible for kindergarten). Using a difference-in-difference approach, the authors reveal a substantial negative effect of the policy on cognitive development for four- and five-year-olds in the programme. For four-year-olds, the policy decreased test scores of children (Peabody Picture Vocabulary Test) by, on average, one fifth of a standard deviation. Moreover, results for two sub-samples of children, grouped according to maternal education level (mothers with a secondary education or less; mothers with a university degree), suggest that the policy did not reduce 'social' gaps in school readiness and that the policy effects are sensitive to maternal education level.

Table 4.2. Summary of research syntheses and early childhood care/development interventions, and evaluations for effects on education

Authors	Family intervention (or review)	For whom?	What level?	How is it evaluated?	What are the results?
Barnett (1995)	Research synthesis (36 studies) on early childhood development and low-income families (preschool education, Head Start, childcare, and home visiting programmes).	Preschool children	Global	Systematic review of literature findings	Large short-term benefits for children's cognitive development and sizeable long-term effects on school outcomes.
Currie (2001)	Research synthesis article on the effects of multiple preschool programmes on cognitive development.	Preschool children	United States mainly	Systematic review of literature findings	The study concludes that early childhood care programmes have significant short- and medium-term benefits, and the effects are often greater for more disadvantaged children.
Anderson et al. (2003)	Research synthesis (350 studies) on the effectiveness of early childhood development programmes on education outcomes (achievement, language, cognition, etc.).	Preschool children	Global	Systematic review of literature findings	Considerable and positive impact of early childhood care interventions on education outcomes.
Pianta (2009)	Research synthesis of evidence from studies of childcare, Head Start and public school programmes, using a wide range of research methods, including experiments.	Preschool children	Global	Systematic review of literature findings	Lasting positive effects on young children's cognitive and social development. Mixed evidence of effects on social behaviour (negative effects not confirmed by experimental studies).
Nores & Barnett (2010)	Research synthesis which reviews international (non-US) evidence on the benefits of early childhood interventions. A total of 38 contrasts of 30 interventions in 23 countries were analysed.	Preschool children	Global	Review and systematization of literature findings	The study finds that children from different countries and contexts receive substantial cognitive, behavioural, health and schooling benefits from early childhood interventions, and the benefits are sustained over time. Interventions with an educational or stimulation component have the largest cognitive effects.

Authors	Family intervention (or review)	For whom?	What level?	How is it evaluated?	What are the results?
Burger (2010)	Research synthesis on the effects of multiple preschool programmes on cognitive development of children from various socio-economic backgrounds.	Preschool children	Global	Systematic review of literature findings	The majority of recent early childhood education and care programmes have considerable positive short-term effects and somewhat smaller long-term effects on cognitive development (some additional gains for low socio-economic status children).
Camilli et al. (2010)	Meta-analysis of 123 studies on the impact of early childhood interventions on cognitive outcomes.	Preschool children	Global	Review and meta-analysis	Positive effects on cognitive development.
Barnett (2011)	Research synthesis of studies that focus on the US Head Start and Early Head Start programmes.	Preschool children	Global	Systematic review of literature findings	Mixed results.
Dodge et al. (2017)	North Carolina's Smart Start and More at Four programmes.	Smart Start: preschool children; More at Four: high-risk preschool children	North Carolina, United States	Student-level regression models with county and year fixed effects	Significant positive impacts of each programme on reading and mathematics test scores, reductions in special educational needs, and grade retention in each grade.
Dumas & Lefranc (2010)	A large-scale expansion of preschool enrolment in France in the 1960s and 1970s.	All preschool children	France, state level	Regression analysis	Sizeable and persistent effects on schooling outcomes (repetitions, test scores, secondary school graduation) and wages. Premium effects for low socio-economic status children.
Graces et al. (2002)	Head Start: an early public intervention programme for disadvantaged preschool children.	Preschool children at risk of poverty and social exclusion	United States, federal and local admin-istration	Regression analysis	White children: increased secondary school completion and university attendance. African American children: increased secondary school completion and lower engagement with police.
Lefebvre et al. (2008)	A low-fee universal childcare policy in Québec, Canada.	All preschool children	Québec, Canada, provincial level	Difference-in-difference approach (inter-provincial)	Results reveal substantial negative effects of the policy on cognitive development for four- and five-year-olds. The policy did not reduce 'social' gaps in school readiness.
Lowell et al. (2011)	Child FIRST (Child and Family Interagency, Resource, Support, and Training) programme.	Vulnerable children from prenatal stage to 6 years of age	Bridgeport, Connecti-cut, United States	Randomized controlled trial (sub-sample of eligible group)	Improvement in language and externalizing symptoms compared with usual care children.

The review of the literature that synthesizes early childhood development policy effects on education outcomes can be summarized in the following key points.

First, early childhood development policies are designed with multiple goals in mind, and so isolating single effects, such as learning effects, should not define the efficacy of these programmes. For instance, childcare/preschool policies have multiple goals including: parenting support, care, freeing parents to work, child health and development, and school readiness. Because of this, the findings here should be used to inform the continued growth and improved design of these important family policies, rather than be used to justify their existence (or not).

Second, comparing these findings to the global data – which show almost universal levels of under-enrolment in early childhood education settings for lower-income groups – and combining this with observed effects on learning and later productivity can flag a potential issue for inequality in learning, and cycles of disadvantage. Indeed, results point to the potential of pre-school programmes to foster equality of opportunity and reduce the intergenerational transmission of inequality, a central challenge to achieving all SDGs; if the poorest children miss out, these efforts will be suboptimal. As policymakers seek to build all early childhood development policies, and then continue to improve their quality and effects, the issue of equitable access should remain a primary consideration.

Third, as with parental leave policies, the family effects of the early childhood development policy (the effect on earning potential, employment, and parenting practices) can create indirect routes by which positive effects of early childhood development are strengthened or diminished. For example, short hours can restrict earnings opportunities and increase poverty risks, which act as a burden on family progress and thus also restrict child development.

4.4.5. Family cash transfers and education outcomes

Family poverty is a key determinant of children's well-being. It is consistently linked in the literature to poorer well-being outcomes, including education (OECD, 2011; Richardson & Bradshaw, 2012). Family cash transfers have two important roles: one is to top up family investment in child development; the other is to combat poverty (either sporadic or persistent forms) to ensure that a family has the resources to access the basic necessities to meet a relative living standard, or to lower the risk of further deterioration of their living conditions, and an accumulation of need and vulnerability (i.e., serve as a safety net). For many family cash benefits worldwide, the benefit's purpose – to provide education resources or access to schools, or to meet educational goals – is explicitly defined. In some countries, cash benefits counterbalance the opportunity costs of child labour, meaning that parents are more likely to send children to school. It is therefore not a huge leap to conclude that governments see families as key agents in educational decision-making for their children – gatekeepers to the necessities for learning – and family policies as a fundamental mechanism for promoting educational goals in country.

This section of the chapter introduces 17 studies uncovered in the search for relevant literature, 2 of which are research syntheses and 15 of which relate findings of evaluations of both unconditional cash transfers (UCTs) and conditional cash transfers (CCTs) paid for the purposes of achieving an educational goal. Table 4.3 summarizes the results of the literature review of research syntheses and family cash benefit policies. Results show many promising family policy interventions for improving enrolment in and attendance at school, particularly among younger and lower-income children. Effects on learning outcomes are inconsistent.

Review articles: Family cash transfers

The earliest review article that covers the effects of family cash transfers on education outcomes is from Rawlings and Rubio (2005). It reviews evaluation results for multiple cash transfer programmes aimed at improving schooling outcomes in poor households in Colombia, Honduras, Jamaica, Mexico, Nicaragua and Turkey. Of the studies reviewed, the authors conclude that the clearest evidence of effects comes from cash transfer programmes found in Colombia, Mexico and Nicaragua, specifically for effects on increasing school enrolment rates.

Rather than take a country focus, Adato and Bassett (2009) reviewed 20 impact assessments of cash transfers, splitting their sample equally into 10 UCTs and 10 CCTs. The studies themselves come from Africa, Asia and Latin America, and the authors reviewed UCTs in Africa for their impact on school enrolment, showing that these do work to increase and protect children's education. Significant and positive effects on enrolment (ranging from a 2 to 12 percentage point increase) were reported across the board in South Africa (through both child support grants and support grants), Malawi and Zambia for children of compulsory school age.

The most comprehensive and recent research synthesis, prepared by Baird et al. (2014), covers 75 reports that in turn span 35 different CCT and UCT programmes aimed at improving education outcomes. The authors' findings show that both CCTs and UCTs improve the odds of being enrolled in and attending school compared with the absence of a cash transfer programme. The effect sizes for enrolment and attendance are always larger for CCTs compared with UCTs, but the difference is not statistically significant. In contrast to the effects for enrolment and attendance, cash transfer programmes at best have a small effect on improving test scores.

Evaluative studies: Family cash benefits

The first two evaluative studies of family cash benefits come from Colombia and review the CCT programme Familias en Acción, which provides conditional subsidies for investments in education, nutrition and health for poor households with children aged 7–17 years living in the country's rural municipalities. Attanasio et al. (2010) used a treatment/control group analysis (with non-random selection of municipalities) and difference-in-difference methodology with combined data sources to conclude that the programme increases school enrolment rates of children aged 14–17 years by 5 to 7 percentage points, and further increases the already high enrolment rate of children aged 8–13 years by around 1 to 3 percentage points.

Baez and Camacho (2011), also evaluating Familias en Acción, this time using data-matching techniques with household surveys and a regression discontinuity design, found that participant children (particularly girls and beneficiaries in rural areas) are 4 to 8 percentage points more likely than non-participant children to finish secondary school. But programme recipients who completed secondary school were found to perform at similar levels in test scores to equally poor non-recipients of the benefit. This finding held even after correcting for possible selection bias when low-performing students in the treatment group entered school.

Three CCT studies reviewed Ecuador's Bono de Desarrollo Humano CCT programme (Oosterbeek, Ponce & Schady, 2008; Schady & Araujo, 2008; Ponce & Bedi, 2010), which has health and education components (the latter requiring children aged 6–15 years to enrol in school and attend 90 per cent of days per month). Oosterbeek et al. (2008) used a randomized experiment for families around the first quintile of the poverty index, with a regression discontinuity design including families around the second quintile of this index, which is the programme's eligibility threshold. They found that for families in the lowest income quintile, the impact on school enrolment is positive, while it is equal to zero for those families around the second quintile. Schady and Araujo (2008) also found significant increases in school enrolment for programme participants. In contrast, Ponce and Bedi (2010) reviewed the effects of the programme on learning outcomes and found

no impact of the programme on second grade cognitive achievement (measured as test scores). This suggests that for children to learn, there is a need for additional and complementary school-based interventions around the Ecuadorian programme that are designed to improve quality of education.

Another Latin American family cash transfer with a focus on education was assessed in a study by Behrman et al. (2011). The Mexican CCT programme PROGRESA/Oportunidades was evaluated using both experimental and non-experimental estimators based on groups with different programme exposure (difference-in-difference estimates). The findings show positive impacts on schooling and the evidence suggests these schooling effects are robust over time.

Maluccio and Flores (2004) reviewed the effects of Nicaragua's Red de Protección Social (RPS) CCT programme, which had supplemented income to increase household expenditure on food, reduce primary school desertion and improve the health care and nutritional status of children under 5 years of age. The study concluded that the programme had positive effects on enrolment for primary school children that were larger for the extremely poor. RPS was evaluated again some years later by Gitter and Barham (2009) using a randomized trial experimental design and difference-in-difference comparison of control and treatment communities. RPS again showed the largest positive impacts on school enrolment for children in poorer households, but also had an effect for two distinct groups: (1) those in coffee communities during higher price years; and (2) households with little or no land wealth experiencing droughts. The authors explained these findings as RPS helping poor households to meet current consumption needs and so reducing the need for child labour market earnings in the first instance, and droughts reducing returns to child labour in the second instance – in both case removing some of the opportunity costs of school attendance.

Another study in Nicaragua by Macours et al. (2012) evaluated the Atención a Crisis benefit – a cash transfer programme that made sizeable payments to poor households in the country's rural areas. As part of this, an additional education transfer was made to households with children aged 7–15 years who had not finished primary school, conditional upon the school enrolment and regular attendance of those children. The education conditionality was monitored in practice in communities of six municipalities in rural Nicaragua and studied under RCT conditions. Results showed that in households randomly assigned to receive benefits, there were significantly higher levels in measured child development nine months after participation in the programme began. Notably, there was no observed fade-out of programme effects two years following the end of programme participation.

An evaluation has also been undertaken of Brazil's Bolsa Escola programme (Glewwe & Kassouf, 2012), which began in 1995 and was incorporated into the Bolsa Família programme from 2003. As Bolsa Escola, the programme provided monthly cash payments to poor households if their children (aged 6–15 years) were enrolled in school. Benefits were extended to poor families with children aged 0–5 years or with a pregnant or breastfeeding woman, and to all very poor families (including those without children). Using regression analysis, Glewwe and Kassouf (2012) studied cumulative effects of the programme and determined that Bolsa Escola had increased enrolment by about 5.5 per cent in the earlier grades and by just over 6 per cent in Grades 5–8. Moreover, the authors found some evidence to attribute the Bolsa programmes with lowering dropout rates by about 0.5 percentage points and raising grade promotion rates, also by modest degrees (less than 1 percentage point in each cohort).

Family cash transfer effects on education were also evaluated in Malawi, Morocco, Pakistan and the Philippines. Baird et al. (2011) reported the result of a family cash benefit experiment targeting adolescent girls in Malawi. The experiment featured two distinct interventions: unconditional transfers (UCT arm) and transfers conditional on school attendance (CCT arm). The results of the experiment were evaluated using an RCT. Although there was a modest decline in the dropout rate in the UCT arm in comparison with the control group, it was only 43 per cent as large as the impact in the CCT arm at the end of the two-year programme. The CCT arm also outperformed the UCT arm in tests of English reading comprehension. An

interesting additional finding was that teenage pregnancy and marriage rates were substantially lower in the UCT arm than in the CCT arm, entirely due to the impact of UCTs on these outcomes among girls who dropped out of school.

Benhassine et al. (2014) published an evaluation of the Moroccan labelled cash transfer, a small cash transfer made to fathers of school-aged children in poor rural communities, not conditional on school attendance but explicitly labelled as an education support programme. In an evaluative RCT study, the labelled cash transfer was shown to contribute large gains to school participation.

Chaudhury and Parajuli (2010) evaluated a female school stipend programme in the Punjab region of Pakistan, under which each girl received a payment conditional upon her enrolment in a government school for girls (Grades 6–8) in a target district and maintenance of an average class attendance of at least 80 per cent. Eligible female students received 200 Pakistani rupees per month when conditions were met. The study drew upon data from provincial school censuses and employed impact evaluation analysis, including difference-in-difference, triple differencing and a regression discontinuity design, to show an average increase of six female students per school in terms of absolute change, and an increase of 9 per cent in female enrolment in relative terms over three years (2003–2005).

The final study included in this review is an assessment of the Pantawid Pamilyang Pilipino Program (4Ps) in the Philippines, which provides cash transfers to poor households conditional on school enrolment and regular attendance of children aged 6–14 years (Chaudhury & Okamura, 2012). This government CCT programme for poor households was evaluated using school enrolment rates from before and after programme implementation, drawing on panel data from three regions of the country for difference-in-difference and regression discontinuity design studies. The analysis found an almost 9 per cent increase in enrolment among the younger cohort aged 9–12 years (as of 2011) who were eligible for grants under the 4Ps programme throughout 2008–2011. The programme was able to help address the education gap between beneficiary and non-beneficiary households in a short amount of time. No statistically significant impact was found, however, for the older cohort of children aged 13–17 years (as of 2011), most of whom were no longer eligible for grants due to the age limit (14 years) set by the 4Ps programme.

Table 4.3. Summary of family cash benefit research syntheses and evaluations for effects on education

Authors	Family intervention (or review)	For whom?	Where? What level?	How is it evaluated?	What are the results?
Rawlings & Rubio (2005)	Literature review of evaluation results for multiple cash transfer programmes aimed at improving schooling outcomes.	Poor households	Colombia, Honduras, Jamaica, Mexico, Nicaragua and Turkey	Review and systematization of literature findings	There is clear evidence of the success of programmes in Colombia, Mexico and Nicaragua in increasing enrolment rates.
Adato & Bassett (2009)	Literature review of the assessments of 20 cash transfer programmes: 10 unconditional cash transfers (UCTs) and 10 conditional cash transfers (CCTs).	Vulnerable children and families	Africa, Latin America, Asia	Review and systematization of literature findings	UCTs were related to increased enrolment in Malawi, South Africa and Zambia.
Baird et al. (2014)	Review of 75 reports that cover 35 different CCT and UCT programmes aimed at improving education outcomes.	Vulnerable children and families	Global	Review and systematization of literature findings	Both CCTs and UCTs improve the odds of being enrolled in and attending school compared with no cash transfer programme. The effect sizes for enrolment and attendance are always larger for CCTs, compared with the impacts of UCTs.
Attanasio et al. (2010)	CCT programme Familias en Acción	Poor households with children aged 7–17 years	Rural parts of Colombia, municipalities	Treatment/control group design and difference-in-difference	Increased school enrolment rates of children aged 14–17 years, as well as those aged 8–13 years.
Baez & Camacho (2011)	CCT programme Familias en Acción	Poor households with children aged 7–17 years	Rural parts of Colombia, municipalities	Regression discontinuity design	Increased secondary school completion (rural girls).
Gitter & Barham (2009)	Red de Protección Social	Poor households	Nicaragua, regional level	Randomized trial experimental design, difference-in-difference	Largest positive impacts on school enrolment for children in poorer households and for those in coffee communities during higher price years. Some effect during droughts (opportunity cost lowered).

Authors	Family intervention (or review)	For whom?	Where? What level?	How is it evaluated?	What are the results?
Glewwe & Kassouf (2012)	Bolsa Escola (later renamed Bolsa Família) programme, which began in 1995.	Poor households	Brazil, municipalities	Regression analysis	Increased enrolment in Brazil by about 5.5 per cent in Grades 1–4 and by about 6.5 per cent in Grades 5–8. Lowered dropout rates, and raised grade promotion rates for children in Grades 1–4 and in Grades 5–8.
Macours et al. (2012)	Atención a Crisis	Poor households	Rural Nicaragua, communities in six municipalities	RCT	Significantly higher levels of development nine months after the programme began. There is no fade-out of programme effects two years after the programme ended.
Ponce & Bedi (2010)	Bono de Desarrollo Humano	Poor households	Ecuador	Regression discontinuity analysis	No impact of the programme on second grade cognitive achievement (test scores).
Oosterbeek, Ponce & Schady (2008)	Bono de Desarrollo Humano	Poor households	Ecuador	Randomized experiment for families around the first and second quintile of the poverty index using a regression discontinuity design	For the first quintile of the poverty index only, the impact on school enrolment is positive.
Maluccio & Flores (2004)	Red de Protección Social	Poor households	Nicaragua	RCT	Positive effects on enrolment that are larger for the extremely poor.
Schady & Araujo (2008)	Bono de Desarrollo Humano	Poor households	Ecuador	RCT	Significant increases in enrolment.
Behrman et al. (2011)	PROGRESA/Oportunidades CCT programme	Vulnerable children/ families	Mexico	Difference-in-difference estimates	The results show positive impacts on schooling. The evidence suggests schooling effects are robust over time.
Baird et al. (2011)	A programme in Malawi for adolescent girls, offering UCTs and CCTs on school attendance.	Adolescent girls and their families	Zomba district, Malawi	RCT	Modest decline in the dropout rate in the UCT arm; large effects in the CCT arm on dropout rate and English reading comprehension.
Benhassine et al. (2014)	Labelled cash transfer	School-aged children in poor rural communities	Morocco	RCT (pilot)	Large gains in school participation.

Authors	Family intervention (or review)	For whom?	Where? What level?	How is it evaluated?	What are the results?
Chaudhury & Parajuli (2010)	Female school stipend programme	Girls at public secondary school and families	Punjab, Pakistan, district level	Difference-in-difference, triple differencing and regression discontinuity design	Increase in school enrolment among girls.
Chaudhury & Okamura (2012)	Pantawid Pamilyang Pilipino Program	Poor households	Philippines	Difference-in-difference and regression discontinuity design	Increase in enrolment among the younger cohort aged 9–12 years (as of 2011); no statistically significant impact found for the older cohort of children aged 13–17 years (grant cut-off was age 14).

Section summary

The review of the literature on family cash benefit effects on education outcomes can be summarized in the following key points.

First, although CCTs can compel families to enrol their children in school, and even incentivize learning outcomes, there are several serious equality and safety concerns that need to be addressed. For instance, enrolling children into unsafe schools, and keeping them there, as a condition of receiving family cash benefits is arguably highly unethical and contrary to the rights of the child.

Second, there is limited evidence that enrolment leads to learning. This could be for several reasons, including: school quality; lowering of group learning outcomes, related to increased enrolment of children with higher learning needs; and cases where children enrol in school but do not attend for various reasons.

And third, a number of family cash benefits and supplements not reviewed here also remain options for policymakers seeking to produce 'education-friendly' family cash benefits. For instance, universal cash effects were not reviewed, and neither were family cash supports to provide school meals, nor uniform or equipment subsidies. These latter types of family cash supplements are common in high-income settings to support low-income families with additional costs related to sending children to school, and they provide more direct routes by which education goals could be achieved through family cash benefits (see, for example, Richardson & Bradshaw, 2012).

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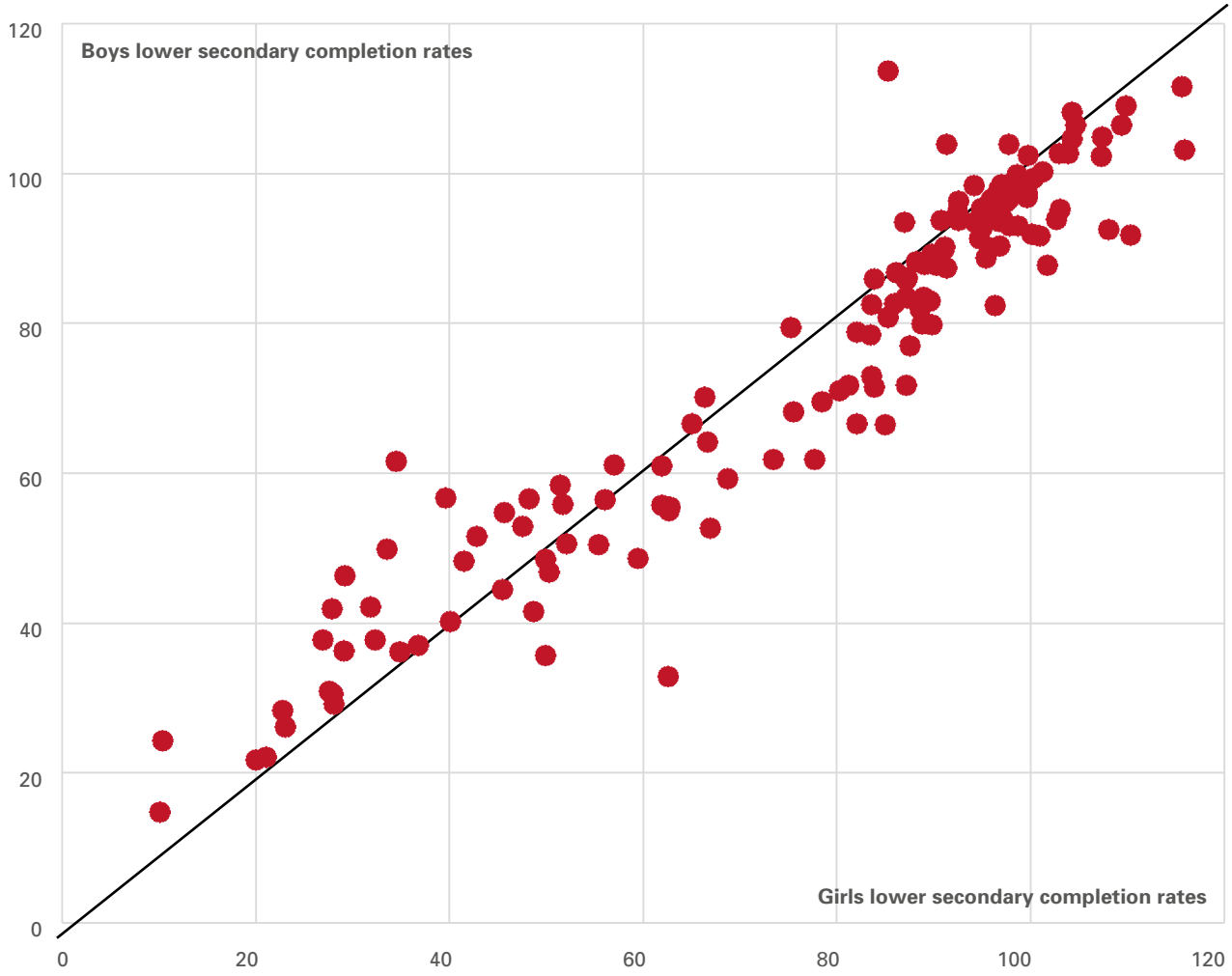
Annex 4.1. Excluded Studies

Parental leave policies	
Ekberg, J., Eriksson, R., & Friebel, G. (2013). Parental leave – A policy evaluation of the Swedish "Daddy-Month" reform. *Journal of Public Economics*, *97*, 131–143.	Limited focus on schooling outcomes
Gregg, P., & Waldfogel, J. (2005). Introduction to Symposium on Parental Leave, Early Maternal Employment, and Child Outcomes. *The Economic Journal*, *115*.	Review article with limited focus on education outcomes
Nomaguchi, K. M. (2006). Maternal Employment, Nonparental Care, Mother-Child Interactions, and Child Outcomes During Preschool Years. *Journal of Marriage and Family*, *68*(5), 1341–1369.	Non-experimental or quasi-experimental design
Early childhood education and care policies	
Belsky, J., Vandell, D. L., Burchinal, M., Clarke-Stewart, K. A., McCartney, K., & Owen, M. T. (2007). Are there long-term effects of early child care? *Child Development*, *78*(2), 681–701.	Non-experimental or quasi-experimental design
Burchinal, M., Vandergrift, N., Pianta, R., & Mashburn, A. (2010). Threshold analysis of association between child care quality and child outcomes for low-income children in pre-kindergarten programs. *Early Childhood Research Quarterly*, *25*(2), 166–176.	Non-experimental or quasi-experimental design
Del Boca, D., Pasqua, S., & Suardi, S. (2015). Childcare, mothers' work and children's schooling outcomes. An analysis of Italian data (No. 30). Families and Societies Working Paper.	Non-experimental or quasi-experimental design
Duncan, G. J. (2003). Modeling the impacts of child care quality on children's preschool cognitive development. *Child Development*, *74*(5), 1454–1475.	Non-experimental or quasi-experimental design
Hiilamo, H., Haataja, A., & Merikukka, M. (2015). Children who do not attend day care: what are the implications for educational outcomes? Families and Societies Working Paper Series, 42	Non-experimental or quasi-experimental design
Loeb, S., Bridges, M., Bassok, D., Fuller, B., & Rumberger, R. W. (2007). How much is too much? The influence of preschool centers on children's social and cognitive development. *Economics of Education Review*, *26*(1), 52–66.	Non-experimental or quasi-experimental design
Cash transfers	
Handa, S., Peterman, A., Huang, C., Halpern, C., Pettifor, A., & Thirumurthy, H. (2015). Impact of the Kenya Cash Transfer for Orphans and Vulnerable Children on early pregnancy and marriage of adolescent girls. *Social Science & Medicine*, *141*, 36–45.	Limited focus on schooling outcomes
Akresh, R., De Walque, D., & Kazianga, H. (2013). Cash transfers and child schooling: Evidence from a randomized evaluation of the role of conditionality. Policy Research Working Paper 6340, World Bank, Washington, D.C.	Pilot study; small sample
Garcia, S., & Hill, J. (2010). Impact of conditional cash transfers on children's school achievement: evidence from Colombia. *Journal of Development Effectiveness*, *2*(1), 117–137.	Weak design
Mo, D., Zhang, L., Yi, H., Luo, R., Rozelle, S., & Brinton, C. (2013). School dropouts and conditional cash transfers: Evidence from a randomised controlled trial in rural China's junior high schools. *The Journal of Development Studies*, *49*(2), 190–207.	Small sample

Annex 4.2. scatter plot of lower secondary completion rates: Females and males



Source: World Development Indicators. (2017). World Bank.

Annex 4.3. Data used in maps in Chapter 4

Country or area	Lower secondary completion rate (% of relevant age group), overall total (2013/2015)	Lower secondary completion rate (% of relevant age group), girls only (2013/2015)	Percentage of children aged 36–59 months who are attending an early childhood education programme (2005–2014)	Percentage point gap between high-income and low-income enrolment in childcare (2005–2014)
Afghanistan	...	...	1.00	2.90
Albania	92.41	90.73	39.80	20.20
Algeria	79.42	87.18	16.60	14.30
Andorra	...	...	...	...
Angola	...	...	...	...
Antigua and Barbuda	85.27	88.56	...	...
Argentina	89.45	91.30	63.30	22.00
Armenia	...	...	...	...
Australia	...	...	...	...
Austria	96.37	95.96	...	...
Azerbaijan	86.62	86.12	...	...
Bahamas	...	...	...	...
Bahrain	...	...	...	...
Bangladesh	67.64	73.48	13.40	4.10
Barbados	...	...	89.70	...
Belarus	109.55	109.82	87.60	3.70
Belgium	95.57	97.04	...	...
Belize	64.15	68.74	31.70	27.40
Benin	41.85	33.53	13.00	...
Bhutan	77.72	83.82	9.50	17.00
Bolivia (Plurinational State of)	89.65	90.38	...	...
Bosnia and Herzegovina	84.33	85.95	13.10	18.00
Botswana	86.75	87.23	17.80	...
Brazil	...	...	70.10	...
Bulgaria	47.49	42.85	...	...
Burkina Faso	24.75	23.06	2.20	6.90
Burundi	25.64	22.77	4.70	5.00
Cabo Verde	75.70	84.93	...	...
Cambodia	45.07	45.47	14.50	23.60

Country or area	Lower secondary completion rate (% of relevant age group), overall total (2013/2015)	Lower secondary completion rate (% of relevant age group), girls only (2013/2015)	Percentage of children aged 36–59 months who are attending an early childhood education programme (2005–2014)	Percentage point gap between high-income and low-income enrolment in childcare (2005–2014)
Cameroon	35.68	34.88	27.60	...
Canada	...	...	...	...
Central African Republic	...	...	5.00	11.60
Chad	17.51	10.38	4.70	11.00
Chile	96.87	97.40	...	...
China	98.24	99.62	...	...
Colombia	78.24	83.53	36.50	...
Comoros	45.14	48.65	...	...
Congo	...	...	36.40	...
Costa Rica	58.83	62.63	17.50	22.40
Côte d'Ivoire	32.52	26.89	4.50	10.90
Croatia	95.23	96.71	71.70	...
Cuba	95.83	98.66	75.90	...
Cyprus	100.85	101.26	...	...
Czechia	98.42	99.29	...	...
Democratic Republic of the Congo	48.23	34.50	6.90	13.30
Denmark	96.20	96.63	...	...
Djibouti	45.05	41.49	13.50	...
Dominica	93.07	95.86	...	...
Dominican Republic	75.67	80.22	39.80	...
Ecuador	94.54	94.85	...	...
Egypt	83.07	85.29	47.40	2.70
El Salvador	85.44	87.18	25.00	...
Equatorial Guinea	...	...	...	...
Eritrea	...	...	...	...
Estonia	106.41	104.27	...	...
Eswatini	49.33	49.90	29.50	...
Ethiopia	29.38	27.95	...	...
Fiji	98.24	102.65	...	...
Finland	97.36	97.11	...	...
France	103.39	103.91	...	...

Country or area	Lower secondary completion rate (% of relevant age group), overall total (2013/2015)	Lower secondary completion rate (% of relevant age group), girls only (2013/2015)	Percentage of children aged 36–59 months who are attending an early childhood education programme (2005–2014)	Percentage point gap between high-income and low-income enrolment in childcare (2005–2014)
Gabon	...	...	...	...
Gambia	61.55	61.89	18.10	13.70
Georgia	101.26	99.74	65.70	17.60
Germany	56.40	56.03	...	...
Ghana	77.51	75.24	68.20	28.30
Greece	97.88	97.00	...	...
Grenada	96.03	100.11	...	...
Guatemala	59.19	56.99	...	...
Guinea	35.07	27.86	...	...
Guinea-Bissau	...	...	13.10	...
Guyana	...	...	61.00	...
Haiti	...	...	...	...
Honduras	54.09	59.47	18.90	9.30
Hungary	93.93	94.20	...	...
Iceland	...	...	...	...
India	80.92	83.42	...	...
Indonesia	86.32	89.63	16.80	...
Iran (Islamic Republic of)	...	...	20.19	...
Iraq	...	...	3.80	6.00
Ireland	...	...	...	...
Israel	99.89	100.27	...	...
Italy	102.89	102.93	...	...
Jamaica	86.30	88.96	91.50	8.50
Japan	...	...	...	...
Jordan	...	...	21.70	17.20
Kazakhstan	107.98	109.37	37.00	23.50
Kenya	83.11	83.52	...	...
Kiribati	100.91	110.27	...	...
Democratic People's Republic of Korea	...	...	97.80	...
Republic of Korea	97.43	96.66	...	...

Country or area	Lower secondary completion rate (% of relevant age group), overall total (2013/2015)	Lower secondary completion rate (% of relevant age group), girls only (2013/2015)	Percentage of children aged 36–59 months who are attending an early childhood education programme (2005–2014)	Percentage point gap between high-income and low-income enrolment in childcare (2005–2014)
Kuwait	88.99	96.31	...	...
Kyrgyzstan	90.54	91.05	22.70	27.30
Lao People's Democratic Republic	53.92	51.71	23.00	50.00
Latvia	106.20	107.40	...	...
Lebanon	58.99	61.90	61.70	...
Lesotho	42.86	49.92	...	...
Liberia	37.20	31.86	...	...
Libya	...	...	...	...
Liechtenstein	98.51	85.25	...	...
Lithuania	99.33	98.56	...	...
Luxembourg	98.73	98.48	...	...
Madagascar	37.05	36.77	...	...
Malawi	21.04	20.05	39.20	27.60
Malaysia	85.36	...	...	...
Maldives	93.07	94.67	...	...
Mali	32.95	29.13	10.10	29.70
Malta	90.14	86.95	...	...
Marshall Islands	...	...	...	...
Mauritania	28.77	28.08	13.60	27.70
Mauritius	84.82	89.78	...	...
Mexico	80.56	82.08	...	...
Micronesia (Federated States of)	...	...	...	...
Monaco	...	...	...	...
Mongolia	113.70	115.61	68.20	...
Montenegro	89.64	89.83	39.90	25.60
Morocco	68.39	66.31	38.50	39.80
Mozambique	21.69	21.02	...	...
Myanmar	48.67	50.27	22.90	23.10
Namibia	59.21	62.70	...	...
Nauru	...	...	...	...
Nepal	84.37	88.79	50.70	32.80

Country or area	Lower secondary completion rate (% of relevant age group), overall total (2013/2015)	Lower secondary completion rate (% of relevant age group), girls only (2013/2015)	Percentage of children aged 36–59 months who are attending an early childhood education programme (2005–2014)	Percentage point gap between high-income and low-income enrolment in childcare (2005–2014)
Netherlands	...	...	...	...
New Zealand	...	...	...	...
Nicaragua	...	...	...	...
Niger	12.57	10.11	...	...
Nigeria	...	...	42.60	41.40
North Macedonia	96.27	100.90	21.80	34.10
Norway	97.27	97.75	...	...
Oman	94.33	101.68	29.20	...
Pakistan	50.52	45.68	...	...
Palau	104.76	107.27	...	...
Panama	...	...	36.80	30.20
Papua New Guinea	...	...	...	...
Paraguay	...	...	...	...
Peru	85.40	87.25	...	...
Philippines	82.18	87.51	...	...
Poland	95.27	94.93	...	...
Portugal	...	...	...	...
Qatar	...	...	40.80	...
Republic of Moldova	85.00	83.80	70.60	17.00
Romania	88.54	89.01	...	...
Russian Federation	98.57	99.61	...	...
Rwanda	...	...	...	...
Saint Lucia	86.55	87.11	85.30	...
Samoa	101.03	97.73	...	...
Saudi Arabia	97.77	91.34	...	...
Senegal	40.29	40.06	21.60	21.80
Serbia	96.28	96.77	50.20	31.40
Seychelles	109.47	115.87	...	...
Sierra Leone	52.46	48.15	13.90	28.40
Singapore	...	...	...	...
Slovakia	88.35	88.22	...	...

Country or area	Lower secondary completion rate (% of relevant age group), overall total (2013/2015)	Lower secondary completion rate (% of relevant age group), girls only (2013/2015)	Percentage of children aged 36–59 months who are attending an early childhood education programme (2005–2014)	Percentage point gap between high-income and low-income enrolment in childcare (2005–2014)
Slovenia	93.96	94.99	...	...
Solomon Islands	66.01	65.04	...	...
Somalia	...	...	2.30	3.50
South Africa	...	...	36.60	...
Spain	93.62	96.80	...	...
Sri Lanka	96.16	96.68	...	...
Sudan	50.35	47.51	22.30	...
Suriname	47.56	62.58	34.30	29.00
Sweden	104.54	104.27	...	...
Switzerland	95.44	97.81	...	...
Syrian Arab Republic	51.43	52.06	7.50	10.60
Taiwan Province of China	...	...	7.50	10.60
Tajikistan	96.43	94.13	6.10	...
Thailand	89.12	90.27	84.40	-2.50
Timor-Leste	71.87	75.52	...	...
Togo	37.93	29.22	25.90	26.20
Tonga	...	...	...	...
Trinidad and Tobago	...	...	74.70	12.60
Tunisia	69.67	77.69	44.30	36.60
Turkey	94.57	92.50	...	...
Turkmenistan	...	...	24.40	39.90
Tuvalu	100.00	108.00	...	...
Uganda	29.36	27.58	...	...
Ukraine	95.69	95.48	51.90	16.50
United Arab Emirates	...	...	...	...
United Kingdom	...	...	...	...
United Republic of Tanzania	35.13	32.28	...	...
United States	...	...	...	...
Uruguay	59.78	66.86	81.40	...
Uzbekistan	...	...	19.70	26.20
Vanuatu	52.88	55.34	...	...

Country or area	Lower secondary completion rate (% of relevant age group), overall total (2013/2015)	Lower secondary completion rate (% of relevant age group), girls only (2013/2015)	Percentage of children aged 36–59 months who are attending an early childhood education programme (2005–2014)	Percentage point gap between high-income and low-income enrolment in childcare (2005–2014)
Venezuela (Bolivarian Republic of)	76.47	81.19	65.70	...
Viet Nam	93.77	92.40	71.30	14.40
Western Sahara	74.33	82.07	71.30	14.40
Yemen	48.45	39.56	2.60	5.80
Zambia	55.07	51.42	...	...
Zimbabwe	65.53	66.60	21.60	11.90

Source: Data on lower secondary completion rate (columns 2 and 3) are from: World Development Indicators. (2017). World Bank. Data on early childhood education attendance and enrolment in childcare (columns 4 and 5) are from: UNICEF (2016). Note: The lower secondary completion rate may exceed 100 per cent due to the inclusion of overage and underage students in the lower secondary education system.

CHAPTER 5.

FAMILIES AND SUSTAINABLE DEVELOPMENT GOAL 5: GENDER EQUALITY

Chapter 5. Families and Sustainable Development Goal 5: Gender equality

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5.1. Introduction

The past four decades have witnessed substantial progress towards gender equality. In 1979, when the United Nations General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women, the majority of girls worldwide did not have a chance to grow up imagining what they could do in the future, beyond marriage and motherhood. There have been substantial advances since then in women's legal rights, educational opportunities, health status, employment and decision-making power. Much of the progress has been credited to the voices of women and advocacy agents who promoted international conventions, treaties and resolutions and the subsequent legislative changes in member states that pledged to be bound by these international instruments.

Progress towards gender equality, however, is still far from complete. While principles of gender non-discrimination have been incorporated into legal frameworks in most countries, many of the stipulations are not entirely enforced. Persistent occupational gender segregation is still observed both horizontally and vertically; women are over-represented in the informal economy, in part-time jobs with little job security and in low-paid occupations such as domestic service and care work. Vertical gender segregation is still visible and women's share of top management positions in large corporations remains too low. As will be discussed later, a gender wage gap is still prevalent. It is expected to take more than 70 years before this gap closes completely (ILO, 2016b). The processes of direct and indirect discrimination and their effects are still poorly understood. Gender inequality remains a persistent challenge for the international community as a major obstacle to sustainable development. SDG 5, amongst other gender-related targets in the framework, aims to continue the progress already made by the international community towards gender equality.

This chapter seeks to contribute to our knowledge of how family policy can positively enhance gender equality and help to achieve SDG 5. The chapter pays special attention to those family policies that address the needs of women and men who wish to reconcile their work and family responsibilities.

Given these considerations, this chapter focuses in particular on the family policies that aim to address the work-and-family conflict for the following reasons:

- The interplay within family profoundly affects power relationships between women and men through the allocation of roles and responsibilities for domestic work and the upbringing of children. How women and men spend their time within the family mirrors and reproduces the differences in their access to resources outside the home, namely income and political power. Gender inequality in the public sphere is both the cause and result of inequality in the private sphere.
- Reconciling the work-and-family conflict is also important because it is one of the most difficult conundrums facing humanity. As a society, reasonable economic growth must be maintained; at the same time, sound care must be provided to bring up the next generation to maintain a sustainable society. The competing demands of production and reproduction are particularly acute in developed countries where fertility has long fallen below replacement levels.

- At the individual level, women and men need to maintain an adequate balance between paid employment and family responsibilities. The proposed solutions to this dilemma vary among countries. The prescribed policies depend on many factors, such as the country's demographic structures (fertility, mortality, mobility, availability of immigrant workers), social policies (welfare system, family structure, labour policies, etc.), labour market structure (industry compositions, degree of gender segregation, etc.) and gender role ideologies (what is thought to be appropriate for women and men). These country-level variations have prompted numerous studies to examine the effects of family policies on female labour force participation behaviour, fertility trends, child outcomes, men's participation in domestic work, and many other social outcomes that are directly and indirectly associated with gender equality.

This chapter consists of five sections, beginning with a brief description of SDG 5 in the following section. Section 3 then introduces two indicators to assess where the world currently stands in terms of achieving the goal. Section 4 will discuss global evidence uncovered by the literature review, and the final section summarizes and discusses the implications of the findings.

5.2. Gender equality in the SDGs

SDG 5 aims to achieve gender equality not only as a fundamental human right, but also as a necessary condition for achieving peaceful, inclusive and sustainable development. Although gender equality is enshrined as a stand-alone goal of its own, it is also a cross-cutting issue deeply interlinked with many of the other SDGs, including poverty (SDG 1), food security (SDG 2), health (SDG 3) and education (SDG 4). For example, women still make up a high proportion of people living in income poverty (e.g., Chant, 2006) and gender equality is expected to contribute to the reduction of poverty through improvements in women's income, health, education and access to and control over land and other resources. Women play a critical role in the global food system, including in food production, preparation, consumption, and distribution. During the last half decade, while the overall proportion of the population engaged in agriculture was in decline, the percentage of females involved in agriculture increased (FAO, 2011). Improving educational opportunities for women has long been known to have a high social return in terms of reducing infant and child mortality and improving children's health and education (Schultz, 1995). When women have more influence over economic decisions, their families allocate more of their income to food, health, education, children's clothing and children's nutrition (e.g., Doss, 2006, 2014).

SDG 5 consists of six outcome targets and three sub-targets. These targets serve as practical starting points and translate gender equality as ending discrimination (Target 5.1), violence (Target 5.2) and harmful practices against women and girls (Target 5.3). Equality between the sexes also means equal rights in the public sphere, including equal access to economic resources and land ownership (Target 5.A) and equal opportunities for leadership in political, economic and public life (Target 5.5). All of these targets are supported by enforceable legislation and sound policies that promote gender equality and the empowerment of women and girls. In tandem with women's empowerment in the public sphere, SDG 5 also calls for recognition of unpaid care and domestic work. Through provision of public services and infrastructure as well as promotion of shared responsibility within the household and family, Target 5.4 aims to enhance acknowledgement of care work and domestic work that are unpaid.[8]

8 Target 5.4, as specified in United Nations Resolution A/RES/70/1 of 25 September 2015, reads: "promotion of shared responsibility within the household and the family *as nationally appropriate*" (emphasis added), suggesting an interpretational leeway in how each country enforces the target (United Nations General Assembly, 2015).

This chapter identifies Target 5.1 (ending discrimination) and Target 5.4 (recognition of unpaid work) as the gender equality targets most relevant to a family policy perspective and approach. The following section discusses the indicators used to assess progress towards these two targets.

5.2.1. Indicators

The United Nations Statistics Division (UNSD) provides an official list of indicators that help to review the implementation and advances of each SDG by its targets. Target 5.1 refers to legal frameworks being in place to promote, enforce and monitor equality and gender non-discrimination. The indicator for Target 5.4 considers the proportion of time spent on unpaid domestic and care work, disaggregated by sex, age, and location.

It is true that the legal system in some countries still does not guarantee equality between women and men and may even impose explicit discrimination against women. In this sense, the presence (or lack thereof) of a legal framework that ensures gender equality is still regarded as a valid and relevant measurement to assess progress towards SDG 5.

Gender wage gap

While the importance of legal stipulations is acknowledged, this chapter uses gender wage gap as the first indicator to evaluate progress towards gender equality for the following two reasons. First, the aim of this report is to focus on outcomes rather than inputs or means, and income is the fundamental resource that can be transferred for goods and services available in the market. Income is, therefore, a vital tool in building a picture of where women and men stand in a specific context. Second, income is a powerful determinant of individual well-being, and is positively related to one's longevity, physical and mental health, education, power, self-esteem and many other indicators that measure human development. In this sense, equality in access to monetary reward can itself be understood as an indicator of gender equality. A secure income and economic autonomy enable women to make claims within the family (England & Kilbourne, 1990) and to exit from an unsatisfying relationship (Hobson, 1990). The gender wage gap captures the relative differences in women's and men's capability to access this critical resource and can be used a good proxy for measuring the overall difference in well-being of females and males.

The gender wage gap is defined as the difference between female and male wages relative to male wages. It reads as a distance in wages between females and males within a country. Data for international comparison are available from two sources: OECD and ILO. OECD reports the gender wage gap as the difference between female and male median wages. ILO provides information on *mean* earnings of both sexes in local currencies, and the gender wage gap can be calculated using the same formula as used by OECD. In this chapter, ILO data are used to depict the present state of the gender wage gap globally, since the ILO data cover a wider range of countries.

Time spent on paid and unpaid work

The second indicator adopted is the average amount of time women and men spend in unpaid work, which is included in the official UNSD list of indicators for the SDGs and also in the minimum set of gender indicators proposed by the Inter-agency and Expert Group on Gender Statistics. The data used come from UNSD and are based on country-level data from national statistical offices, supplemented by data from Eurostat, OECD, the United Nations Economic Commission for Europe and the United Nations Economic Commission for Latin America and the Caribbean. Time-use statistics are quantitative summaries of how individuals allocate their time over a specified period – typically over the 24 hours of a day or over the 7 days of a week. A unique tool for exploring a broad range of policy concerns, time-use statistics can be used to assess quality of life or general well-being, analyse division of labour between women and men, improve estimates of all forms of work (paid and unpaid) and understand household production and its contribution to GDP. As noted in the *Stiglitz Report*, measuring the amount of domestic work is important from the perspective of assessing both the total quantity of household services produced and how family chores are distributed between women and men (Stiglitz, Sen & Fitoussi, 2009).

There have been considerable advances in the availability of time-use surveys over the past two decades. The 2015 UNSD review of gender statistics found that 85 countries worldwide have conducted time-use surveys, with the oldest survey conducted in Belgium in 1966. Given the difficulties in conducting time-use surveys that are comparable across countries, this is a substantial achievement. It remains a challenge, however, to bolster the technical capacity to design universally applicable and comparable time-use survey methods.

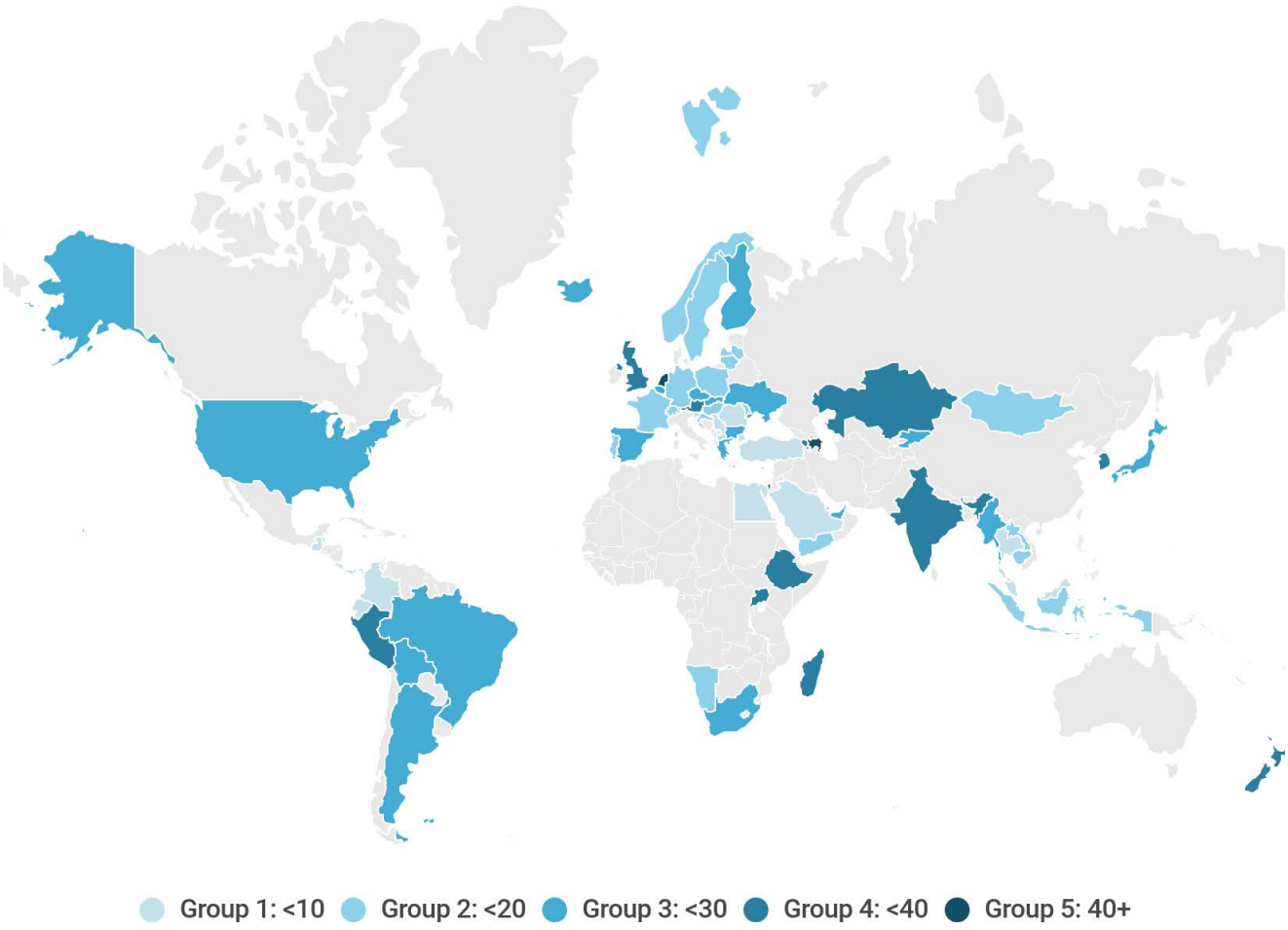
5.2.2. Where do countries stand on SDG 5?

Within the limitations described above, two indicators are used in this chapter to capture the present state of gender equality in both the public and private sphere: gender wage gap, for the allocation of economic resources between women and men; and time-use for paid and unpaid work, for the distribution of housework and care responsibilities.

Gender wage gap

The gap between women and men on income remains wide across the globe, as shown in Map 5.1. This world map depicts the present state of the gender wage gap calculated using the mean monthly earnings of women and men in local currencies, as compiled by ILO. Though ILO data are unavailable for some important countries covered by OECD data, such as Australia and the United States, they otherwise offer much wider coverage of countries and regions.

Map 5.1. Gender wage gap by country (% difference)



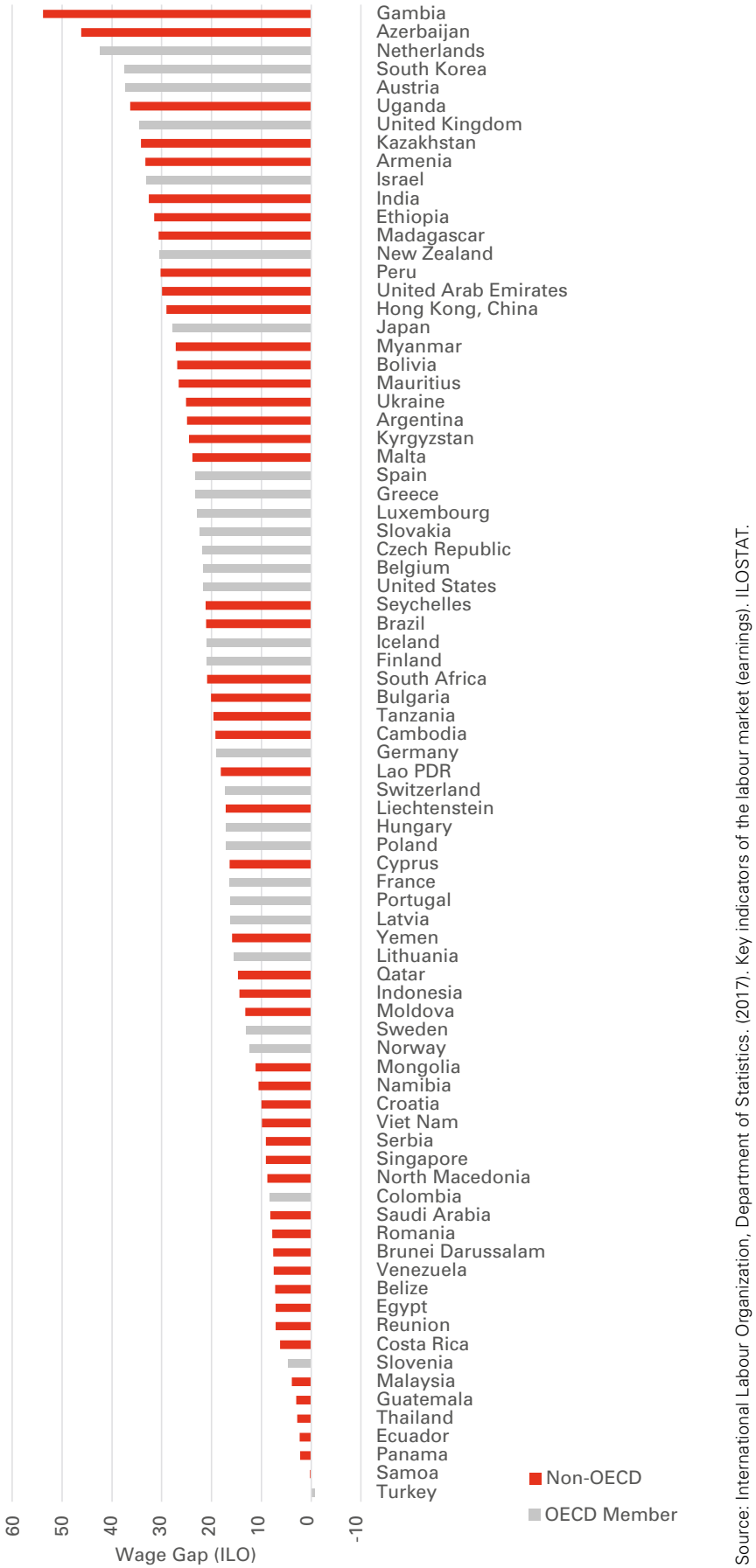
This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: International Labour Organization, Department of Statistics. (2017). Key indicators of the labour market (earnings). ILOSTAT.

Figure 5.1 shows the gender wage gap ranked in ascending order by country. OECD countries are coloured orange and non-OECD countries are blue. The gender wage gap varies from -1 in Turkey to 46 in Azerbaijan.[9]

The figure shows the prevalence of gender wage gaps regardless of stage of economic development. Four of the top 10 worst gender wage gaps calculated using ILO data are found in OECD member countries: the Netherlands, Austria, the United Kingdom and Israel (from worst to least worst). When gender wage gap is compared across OECD Member countries using OECD data, the Netherlands ranks about average and neither the United Kingdom, Austria nor Israel stand out as having a large gender wage gap.

9 Turkey is the only country that shows a negative wage gap (women earning more than men). The data from Turkey are, however, based on the establishment survey and only cover women and men in waged employment, while more than 40 per cent of female workers are reported to be 'unregistered' (ILO, 2016a). Hence, comparatively narrow wage gaps in Turkey are due to the small share of women in waged employment, who are often more educated than their male peers (ILO, OECD, IMF & World Bank, 2016).

Figure 5.1. Gender wage gap (ILO)



Source: International Labour Organization, Department of Statistics. (2017). Key indicators of the labour market (earnings). ILOSTAT.

These discrepancies between rankings made using OECD member country data and rankings made using the world data compiled by ILO are partially attributable to differences in data collection methods. While the focus of OECD data is limited to full-time workers (employed and self-employed), data compiled by ILO come from a variety of sources and so span a wider range of incomes. Practices differ across countries in regard to the sources and methods used for collecting and compiling earnings data, making cross-country comparisons extremely difficult. The sources (establishment censuses and surveys, and household surveys), and their scope of information, may vary in their coverage of workers, e.g., some may exclude part-time employees. Some countries exclude small businesses from the surveys, which also affects the wages reported in the data (ILO, 2017).

Exclusion of certain groups of workers, however, may be regarded as constant *within* countries and is expected to have a marginal effect on trends over time.[10] The data with less than full coverage are, therefore, a meaningful proxy for estimating the wage gap between women and men. Moreover, given the fact that women are over-represented in informal sectors and part-time work, and that they work fewer hours with shorter tenure than their male counterparts, it is hardly likely that the gender wage gap reported by ILO is biased in favour of women. That is, the data presented above on the gender wage gap may be understated rather than overstated. Except for in Turkey, where selection biases have affected the wage disparity in women's favour, women around the world are paid less than men, to the extent that there is typically a substantial gender wage gap regardless of the country's stage of economic development.

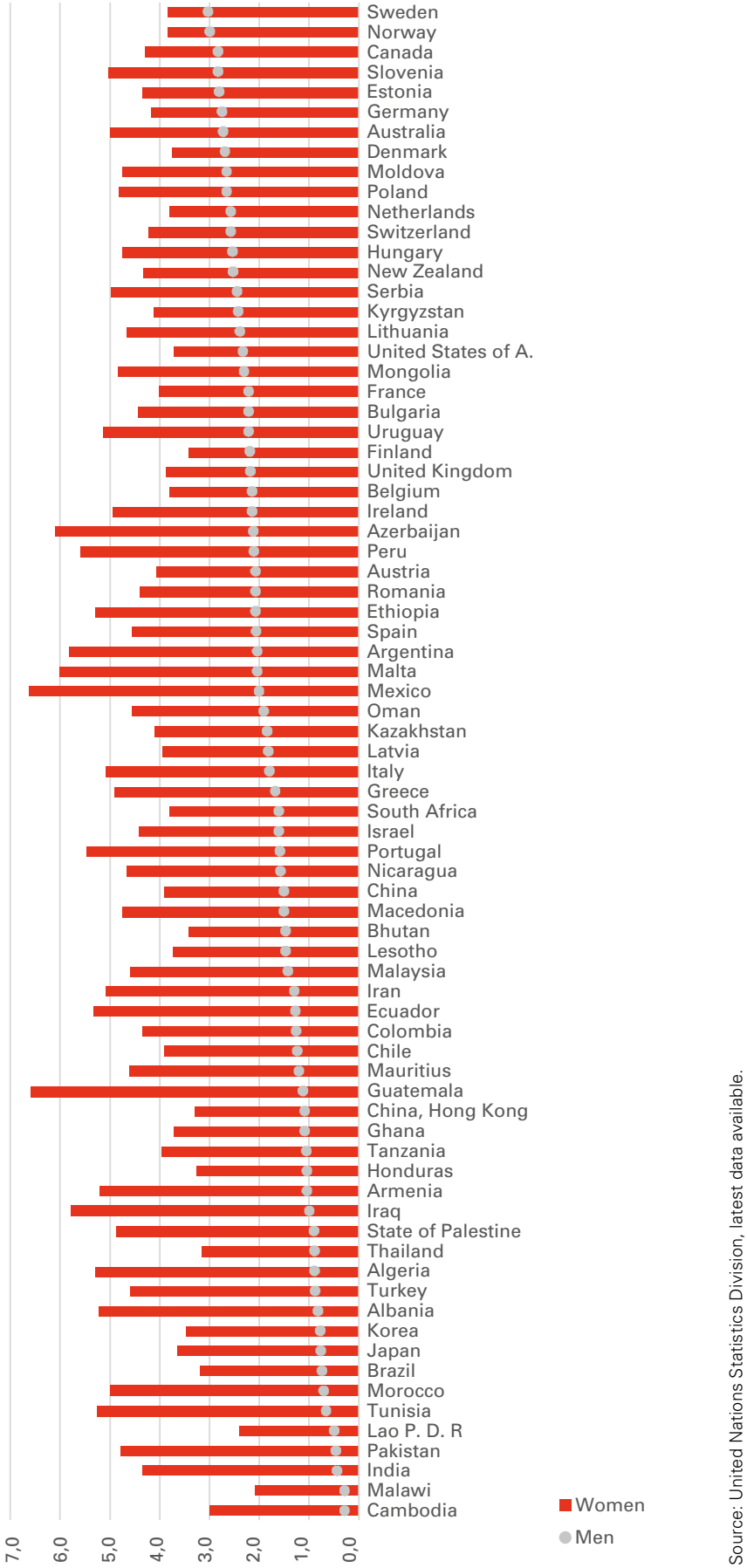
Time spent on paid and unpaid work

The considerable gaps between the economic rewards women and men receive are derived from their different patterns of labour supply and unequal share of responsibility for household and family, notable in the different amounts of time spent on unpaid work. Women are less likely to work for pay, and where they do, are more prone to working shorter hours and working part-time (ILO, 2016b). According to an ILO calculation based on data from 121 countries – covering 92 per cent of total employment worldwide – women represent less than 40 per cent of total employment, but comprise 57 per cent of the part-time workforce (ILO, 2016b). Women are more likely to have held their jobs for less time and have experienced more career interruptions than their male counterparts. There is a general notion of an increase in women's labour force participation. But the global female labour force participation rate actually decreased slightly (from 52.4 to 49.6 per cent) from 1995 to 2015, and the likelihood of a woman being in the job market remains about 27 percentage points lower than that of a man (ILO, 2016b).

The fewer hours that women spend in paid work is partly explained by the effect of the greater expectations and responsibilities placed on women to maintain the household and to care for children and older persons. Figure 5.2 plots the time that women and men spend on unpaid work by country. The graph is sorted by the amount of time men spend on unpaid work, in ascending order. While men in Canada, Norway and Sweden spend about 3 hours on unpaid work, men in Cambodia and Malawi do so for only 30 minutes. The amounts of time that women and men spend on unpaid work are not correlated. In Mexico, women spend 6.6 hours on unpaid work; in Malta, 6 hours; and in Argentina, 5.8 hours. Meanwhile, women in Malawi spend 2 hours on unpaid work (about the same as men in Argentina: 2.05 hours) and in Cambodia, 3 hours (about the same as men in Canada, Norway and Sweden: 3 hours). The total sum of time women *and* men spend on unpaid work varies from 8 hours in Mexico to 2.4 hours in Malawi. The proportion of men's contribution to women's provision in unpaid work ranges from more than 70 per cent in Denmark, Norway and Sweden to approximately 10 per cent in Cambodia, India and Pakistan.

10 There is a caveat, however: many countries also change their survey methods over time.

Figure 5.2. Average time (in hours) spent on unpaid work, by gender



Source: United Nations Statistics Division, latest data available.

Time-use survey data are susceptible to methodological differences such as the design of survey instrument (e.g., handling of commuting and study time, or time to collect water and fuel), the span of time surveyed, and the days of the week observed. These differences make cross-country comparisons extremely challenging, if not impossible (*for a discussion of cross-country studies, see Box 5.1*). Time-use data are also sensitive to the socio-economic context of household work, for example, because only respondents of certain age ranges may be included in the survey.[11] Time spent on unpaid work is also susceptible to the availability of commodified goods and services. For example, baking bread may be indispensable for meal preparations in some countries, while in other countries, where bread is a commodity routinely bought from a shop, baking bread at home may be conceptualized as a 'hobby'. Likewise, categories of unpaid work change over time. For instance, sewing used to take up a considerable portion of housework, but has disappeared from the survey instrument in many developed countries. Despite these cross-country comparability issues, it is evident that women bear a disproportionate responsibility for unpaid work.

Box 5.1. Cross-country studies

The country-level approach tries to capture the impact of family policy based on cross-country (and often cross-time) variation, using comparative country-level aggregate data compiled by international organizations. The variables employed, however, are inevitably coarse and leave many of the unobserved heterogeneities unspecified, which makes identification of causal impact very problematic. Moreover, family policy is very complex and does not stand alone in isolation. It has to be studied in conjunction with many other areas of legislation that affect families, such as the tax and pension system, employment regulations, pay equity between part-time and full-time work, availability of subsidized day care and early childhood education, school hours, and so on.

In general, cross-country studies tend to find a more positive effect on female employment for relatively short durations of leave from work than micro-level studies, but with a curvilinear effect observed. For example, Ruhm (1998) examined the effect of parental leave on female employment and wages during the period 1989–1993 in nine European Union countries using cross-sectional, cross-time data and found a positive association for provision of short-duration leave, with a higher female employment-to-population ratio. At the same time, however, he suggests that this increase may have been an artefact of the introduction of new employment category as 'employed but absent from work' instead of simply 'unemployed'. He also found non-linearity of the effect, meaning lengthier leave is associated with a reduction in relative wages (Ruhm, 1998).

This approach has been expanded and updated with a more recent and wider set of country data. Thévenon and Solaz (2013) used cross-sectional, cross-time data for 30 OECD member countries for the period 1970–2010 and confirmed the finding of the Ruhm (1998) study. Thévenon and Solaz note that provision of a relatively short period of leave reduces the gender employment gap, while a prolonged period of leave (more than two years) has the opposite effect. Blau and Kahn (2013) also confirm the trade-off between the family policies that make it easier for women to combine work and family, and women's advancement at work. Using aggregate data from 21 OECD member countries, the authors argue that 'family-friendly' policies facilitate labour force entry for less career-oriented women. Moreover, long-duration paid parental leave and part-time work may encourage women who would otherwise have had a strong labour force commitment to take a part-time job or lower-level position.

11 Age ranges differ by countries (e.g., 10+, 15+ 20-70, etc.) and sometimes by the year of surveys. Some states report multiple age ranges for the same year, in which case, age ranges were chosen that give the most amount of information across the period. For details, see UNSD 2017.

More recently, Olivetti and Petrongolo (2017) replicate the macro-level analysis using OECD Family Database, harmonized with labour statistics. The method employed was a fixed-effect model of female labour outcome (employment rate, employment gap, earnings gap, and fertility) regressed on the length of job-protected weeks and other indicators of family leave policies. The results show that moderate-length job-protected entitlements (about one year) are associated with a smaller earnings gap, but a curvilinear effect is observed with lengthier leave, which is associated with a larger wage gap.

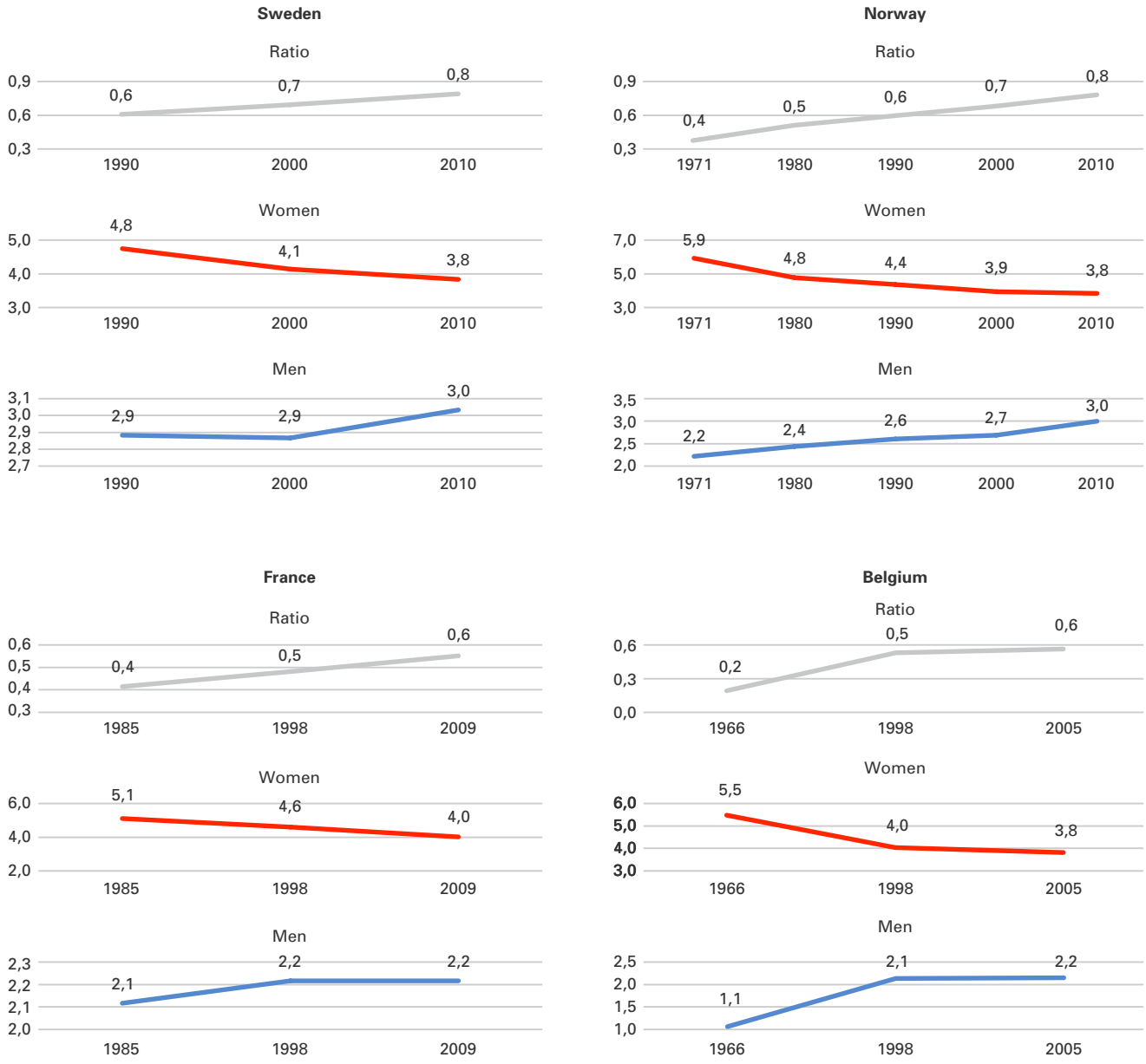
Given the substantial differences among countries in the total time women and men spend on unpaid work, the proportion of men's contribution of unpaid work against that of women was used to observe if there has been any change over time. Among 40 countries for which data are available for more than two points in time, most countries did not display any substantial changes. That is, women have continued to shoulder the lion's share of unpaid work, and this trend has not changed in general. A small number of countries – Sweden, France, Norway and Belgium – showed some increase in the proportion of men's time spent on unpaid work relative to that of women. Figure 5.3 demonstrates the trend in the male-to-female ratio of time spent on unpaid work across these four countries, with the real time spent by women and men shown in the lower two panels of each country's graph.

In Sweden, the forerunner in terms of men's involvement in housework, the male-to-female ratio of hours spent in unpaid work increased from 0.60 in 1990 to 0.79 in 2010. During this period, men's contribution in real time showed no significant change, while women's time decreased from 4.75 hours to 3.03 hours. In Norway, the male-to-female ratio of unpaid work increased from 0.37 in 1971 to 0.78 in 2010, due to the decrease in women's contribution from 5.91 hours to 3.83 hours – a reduction of almost 2 hours. Likewise, in France, the male-to-female ratio increased from 0.41 to 0.55, but this was derived from the decrease in women's time spent on unpaid work, from 5.11 hours to 4.01 hours.

The exception to this pattern is Belgium, where the proportion of men's contribution to unpaid work increased from 20 per cent in 1985 to about 56 per cent in 2009. During this period, the actual time women spent on unpaid work decreased from 5.5 hours to 3.8 hours, while men increased their time from 1.65 hours to 2.15 hours. This result may be overstating the trend, however, because Belgium is one of the few countries with time-use data collected in the 1960s. In contrast, the baseline data for Sweden, Norway and France date from the 1970s and 1990s.

In summary, the ratio changes in these four countries were caused by women decreasing their time spent on unpaid work, *not* by men increasing their contributions.

Figure 5.3. Trends in male-to-female ratio of time spent on unpaid work, and the real time spent by women and men on unpaid work (by country, various dates)



Source: United Nations Statistics Division.

5.3. Effects of parental leave policy on gender equality: A review of the evidence

Parental leave policies are almost universal today, but they began life as policies for maternity protection. This goes back to the first International Labour Conference in 1919 when the Maternity Protection Convention, 1919 (No. 3) was adopted. It was followed by the Maternity Protection Convention (Revised) in 1952 (No. 103) and again in 2000 (No. 183). Maternity leave was originally designed to promote the health of a mother and her newborn baby by providing a mother time to physically recover from the childbirth and to build her psychological attachment to her child. It was later developed as a statutory provision of the right to return to the previous employment, so that the female workers would not be discriminated against for maternity reasons.

The fact that the parental leave policy has originated from a scheme of maternity protection has made the relationship between parental leave policies and gender equality somewhat ambiguous. For one thing, maternity is a contentious issue in regard to gender equality, because debates over maternity and motherhood have been central to the feminist discourse. Critiques on maternity/motherhood argue that femininity cannot be reduced to the assumption that women innately have a caregiving nature. Simply put, not all women will choose to become a mother.

On the other hand, concerns have been expressed that gender equality is likely to be tangential, or even instrumental, in the justification for providing leave for employees with parental obligations (O'Connor, 2005). Declining fertility among industrialized nations and the prospect of a shrinking pool of productive workers have obviously played a significant role in the promotion of policies to address the work-and-family conflict, which encourage the labour supply of women with children.

The conundrum of how to meet the competing demands of economic productivity and reproduction in postmodern societies cannot be solved solely by achieving gender equality. The tensions between work and family are also deeply related to our beliefs and values in relation to gender, generation and class, which are interrelated but often in conflict with each other.

As stated in the introduction to this chapter, gender equality is defined here as equal access to monetary rewards *and* an equal distribution of unpaid work between women and men. In this respect, the effect of family leave policies on gender equality will be assessed by answering the following two questions:

1. What is the impact of parental leave on women's labour force participation behaviour and on their income?

2. Which designs of parental leave policies are most likely to raise men's take-up rate for parental leave and increase their participation in unpaid work?

In 2014, ILO reviewed parental leave policies in 185 countries and territories and found that all of them except Papua New Guinea have laws mandating some form of parental leave (ILO, 2014).[12] ILO also saw that there is significant variation in the duration of leave and level of compensation across the various provisions. The job-protected leave available to either parent varies from 12 weeks in the United States to 156 weeks in France, Germany, Poland, the Russian Federation and some other countries in Eastern Europe. The majority of countries (98 out of 185 countries, as at 2013) provide at least 14 weeks of maternity leave, among which 42 countries meet or exceed the 18 weeks of leave proposed in the Maternity Protection Recommendation, 2000 (No. 191) (ILO, 2014). Among OECD member countries alone, the maximum job-

12 For an update on this mapping, see: https://www.undp.org/content/undp/en/home/librarypage/womens-empowerment/gender-equality-as-an-accelerator-for-achieving-the-sdgs.html

protected leave for mothers varies from the 12 weeks in the United States to 166 weeks in Spain. The amount of cash benefit and its source also differ widely. The average payment rate for mothers, measured as a percentage of national earnings in 2014, varies from no payment in the United States to 100 per cent coverage in Spain and the Netherlands. (Olivetti & Petrongolo, 2017).

The recent trend is towards expansion in leave coverage. Canada, for example, increased paid family leave from 25 weeks to 50 weeks in 2000. In 2004, the state of California, United States, strengthened maternity rights, allowing for up to six months of maternity leave. Other countries that have recently extended the parental benefit include the United Kingdom (in 2003 and 2007), Denmark (in 2002) and Germany (in 1979, 1986, 1992 and 1993) (Schönberg & Ludsteck, 2014). Sweden was the first country to introduce a gender-inclusive leave policy, in 1974, enabling mothers and fathers to share six months of parental leave. Other developed countries began to supplement maternal leave for mothers around the time of childbirth with parental leave to care for children in their early years (OECD, 2017).

The country-level variations in family policies and the historical changes within countries have prompted numerous studies to examine the effects of family policies on many social outcomes that are directly and indirectly associated with gender equality. The literature that examines the effects of family policies on gender equality can be roughly categorized into two groups: within-country approach and country-level approach (*see Box 5.1*).

This chapter will focus on the within-country approach, which examines the impact of specific policy within a country by combining longitudinal micro-data from before and after the policy change with a natural experimental design. This method is more robust in specifying the causal impact of a certain policy but considers only one policy intervention at a time. The challenge is assessing the generalizability of a particular intervention in a specific time and place to a different cultural and social setting. With these limitations in mind, the following section will present the results of the literature review.

5.3.1. Literature search

The literature search was undertaken 2017, using Web of Science and the EndNote search engine connected to EBSCO and PubMed. The first round of searches used the keywords: "family policy" and "gender equality" (Web of Science, 68 hits, oldest published in 1996); and "parental leave" and "gender equality" (Web of Science, 107 hits, oldest published in 1990). EndNote, when directly connected to the Thomson Reuters Web of Science Core Collection, was used for the keyword search "gender equality" and "family policy", which found 401 articles, with the oldest published in 1994; and for "gender equality and "parental leave", which surfaced 135 articles from 1990 onwards. Articles that had reviewed the literature were also scanned for source references.

These bibliographic trends that date from the 1990s seem to reflect the development of theorizing and research in welfare states and welfare regimes (Esping-Andersen et al., 2002; Esping-Andersen, 1990). They also reflect the secular increase in female employment (particularly among mothers) and expansion of provision in policies to reconcile the work-and-family conflict. The literature on parental leave policy is heavily concentrated on developed countries. Table 5.1 lists the articles accepted for the review in this chapter.

Table 5.1. List of articles on the effect of parental leave policies on women (quasi-experimental designs)

Authors	Family intervention description (How are they doing it?)	Who is enacting?	For whom?	Where? What level?	How is it evaluated?	What are the results?
Kluve & Tamm (2013)	Added generosity in parental leave from 1 January 2007, offering earnings-related benefit at 67% replacement rate for either father or mother for up to 12 months. If father and mother both participate, they receive 2 extra months, resulting in 14 months of leave in total.	Government	Parents	Germany	Survey data from parents with children born in the last quarter of 2006 and parents with children born in the first quarter of 2007 – i.e., before and after the reform – natural experiment.	Found significant decrease in mothers' employment probability during the 12 months after giving birth, and an increase in mothers' employment probability after the transfer expires. The implementation of two 'daddy months' is currently not reflected in significant changes to fathers' time devoted to childcare.
Gangl & Ziefle (2015)	Extension of leave period in 1991 (from 12 to 18 weeks), in 1992 (from 18 to 36 months) and in 2001, providing additional flexibility enabling parents to take three years' leave between a child's second and eighth birthdays.	Government	Parents	Germany, East and West	German Socio-Economic Panel data and difference-in-difference, triple differencing, and instrumental variable estimators for panel data.	Increasing the generosity of leave entitlements led to a decline in mothers' work commitment in both East and West Germany. Policy-induced shifts in mothers' preferences contributed to hindering women's labour force participation.
Hofferth & Curtin (2003)	Family and Medical Leave Act of 1992 (FMLA): unpaid job-protected leave.	US federal government	Parents	United States, national level	1984–1997 waves of the data from the Panel Study of Income Dynamics and its 1997 Child Development Supplement.	Women who return to work are more likely to return to the same job after the enactment of FMLA, but this is true *only* in states that had not passed a parental leave statute prior to FMLA. Finally, FMLA and leave are not associated with increased wages in the two years following childbirth.

Authors	Family intervention description (How are they doing it?)	Who is enacting?	For whom?	Where? What level?	How is it evaluated?	What are the results?
Schönberg & Ludsteck (2014)	Five major expansions in maternity leave coverage in Germany.	Government	Mothers	Germany, national level	Social security records provided by the Institute for Labour Market Research. Complete work histories including the leave period. Difference-in-difference design.	Each expansion in leave coverage reduced mothers' post-birth employment rates in the short term. The longer-term effects of the expansions on mothers' post-birth labour market outcomes are, however, small. The 1986 reform extended paid maternity leave beyond the period provided for job security.
Lalive et al. (2014)	Reforms to leave in Austria: 1990 reform extended job protection and cash benefit from 1 to 2 years; 1996 kept 2-year job protection but reduced cash benefit period to 18 months; 2000 reform again kept job protection at 2 years but increased cash benefit to 30 months.	Government	Parents	Austria, national level	Data: Austrian Social Security Database, comparing mothers' career outcomes, for those who gave birth before and after the policy changes in 1990, 1996 and 2000, for effects of the length of cash benefits and job protection.	Longer leave durations significantly delay return to work. Nevertheless, despite the significant delays in return to work among mothers exposed to the more generous leave regimes, detrimental effects on their labour market outcomes in the medium term are not found.
Lalive & Zweimueller (2009)	Austria: reform increasing the duration of parental leave from 1 to 2 years for any child born on or after 1 July 1990 AND reduction in parental leave duration in 1996, from 24 to 18 months.	Government	Parents	Austria, national level	Data: Austrian Social Security Database, individual history of employment, earnings, and parental leave take-ups.	Longer parental leave increases fertility (more mothers who gave birth to their first child after the reform had a second child than mothers in the control group) and extended parental leave significantly reduces return to work. The reversal of the reform in 1996 increased employment and earnings but compressed the time between births.

Authors	Family intervention description (How are they doing it?)	Who is enacting?	For whom?	Where? What level?	How is it evaluated?	What are the results?
Waldfogel (1998)	United States: Family and Medical Leave Act of 1992, enacted at federal level in 1993 – 12 weeks of unpaid parental leave and leave policies. Britain: Trade Union Reform and Employment Rights Act 1993, and European Directive of Council of Ministers, implemented March 1994.	Firm base and/ or union base prior to enactment of Family and Medical Leave Act of 1992 (in United States)	Parents	United States and United Kingdom national level	Data: National Longitudinal Survey of Youth (NLSY) for United States; National Child Development Study (NCDS) for Britain. NCDS followed babies born in 1958, when they reached the age of 7, 11, 16, 23 and 33. Data selected from NLSY (which began in 1976) for equivalent age groups. Ordinary least squares regression to access the effects of having children on differences in wages (fixed-effect model).	Women who had leave coverage and returned to work after childbirth received a wage premium that offset the negative wage effects of having children.
Baum (2003)	United States: Family and Medical Leave Act of 1992 (FMLA), enacted at federal level in 1993: 12 weeks of unpaid parental leave.	US federal government	Parents	United States, national level	NLSY data; difference-in-difference estimator, taking advantage of variations in state-level maternity leave legislation and FMLA.	Maternity leave legislation did not have significant effects on employment and wages of women. The result holds true for women who work for employers that are covered by FMLA.
Baker & Milligan (2008)	Canada: reforms in parental leave by provinces. Modest expansion (from 17 to 18 weeks) in the 1970s; larger expansion (to 34, 29 and 52 weeks) in the 1990s.	Canadian provinces	Parents	Canada, provincial level	Labour Force Survey from 1976 to 2002. Two samples, panel and time series of cross-section.	Job-protected leave can increase the time mothers spend with their newborn babies and increase the likelihood of return to the pre-birth employer. Job continuity associated with expansion of leave entitlement, but this effect comes from two sources: (1) from those who continued their jobs rather than leaving entirely; and (2) from those who changed to part-time jobs.

Authors	Family intervention description (How are they doing it?)	Who is enacting?	For whom?	Where? What level?	How is it evaluated?	What are the results?
Hondralis (2017)	2011: up to 18 weeks of paid leave, receiving the Australian minimum wage (approximately A$673 per week before tax).	Government	Parents	Australia, national level	Data: Household, Income and Labour Dynamics in Australia survey 2008–2013: 2008–2010 data on pre-reform births vs 2011–2013 data on post-reform births; propensity score matching and assessed the probability of working in a certain week after childbirth.	Women do postpone the return to work until the end of the entitlement period. Highly educated women react strongly to the available policy and markedly adjust their employment behaviour. Policies are powerful in shaping the employment behaviour.
Rønsen & Kitterød (2015)	Introduction of 'daddy quota' and its extension from 4 weeks in 1993 to 14 weeks in 2013 (but later reduced to 10 weeks in 2014); research was administered before the reduction.	Government	Parents	Norway, national level	Panel from Norwegian Labour Force Survey 1996–2010.	Women in Norway returned to work significantly faster after the policy change. Public or subsidized day care was greatly expanded at the same time, however, so the authors did not find the daddy quota solely responsible for the timing of work re-entry.
Schönberg & Ludsteck (2014)	Expansion of job protection period: from 2 to 6 months in 1979; from 6 to 10 months in 1986; from 10 to 12 months in 1988; from 12 to 18 months in 1992; and from 18 to 36 months in 1993. Maternity benefit expansion: 1986, 1992, 1993.	Government	Parents	Germany, national level	Data: social security records provided by the Institute for Labour Market Research. Difference-in-difference design comparing labour market outcomes of mothers who give birth shortly before and shortly after a change in maternity leave legislation in years of policy changes and years when no changes have taken place.	Each expansion in leave coverage reduced mothers' post-birth employment rates in the short term. The longer-term effects of the expansions on mothers' post-birth labour market outcomes are, however, small.

5.3.2. Impact of parental leave policy on women's labour market outcomes

Thirty years of research in the form of gender impact assessments of parental leave policies have found mixed results. While some scholars claim that generous leave policies have some favourable effects on female labour market outcomes (Gornick, Meyers & Ross, 1998), serious concerns have been raised about a certain unintended adverse effect on gender equality. It is argued that developed welfare states facilitate women's access to the labour force, yet, at the same time, such policies are negatively associated with women's prospects of reaching higher positions in the labour market compared with men (Mandel & Semyonov, 2006). That is, nations characterized by progressive and 'family-friendly' policies tend to have an elevated level of gender segregation that does not favour women (Charles & Grusky, 2004; Mandel, 2012; Mandel & Semyonov, 2006). The negative association between the generosity of parental leave entitlement and women's labour outcome, known as the 'welfare state paradox', has been a focus of debate for some time.

Theoretically, the impact of parental leave policy on gender equality is ambiguous. It may foster employment by supporting mothers who would otherwise have withdrawn from the labour market, and by encouraging women who were not previously employed to work for pay, because leave benefit makes employment more plausible. Conversely, a parental leave mandate increases labour costs and may prompt employers to engage in statistical discrimination against women.

The changes in parental leave policies in many countries have enabled the use of a quasi-experimental design in assessing the impact of policies on women's labour outcome. In the United States, by the time the Family and Medical Leave Act of 1992 (FMLA) was enacted at the federal level in 1993,12 states and the District of Columbia had already stipulated similar leave provision (Waldfogel, 1998). This staggered introduction of legislation enabled Baum (2003) to assess the effect of parental leave policies. Using National Longitudinal Survey of Youth data and the difference-in-difference estimator approach, the author did not find a significant effect of legislation on the wages of women.

Likewise, Hofferth and Curtin (2003) assessed the effect of FMLA using the 1984–1997 waves of data from the Panel Study of Income Dynamics and its 1997 Child Development Supplement. The findings suggest that women who gave birth after FMLA was enacted in 1993 were more likely to return to the same job *only* in states that had not previously passed a paid parental leave statute. That is, although not as powerful a job retention policy as paid leave, unpaid leave can help to retain workers. On the other hand, FMLA and unpaid leave are not associated with an increase in wages in the two years following childbirth (Hofferth and Curtin, 2003).

Using a similar approach, Waldfogel (1998) examined the effect of childbirth and parental leave policies on women's earnings in the United Kingdom and the United States. National Longitudinal Survey of Youth data were used for the United States and National Child Development Study data for United Kingdom. The author found a strong 'motherhood penalty' in both countries: about 40–50 per cent of the wage gap was explained by parental status, i.e., women are penalized for having children, and another 30–40 per cent by family status, i.e., mothers are penalized for taking more time out of the labour market. The results also showed that women who had parental leave and returned to work after childbirth received a wage 'premium' that offset the negative wage effects of children. This positive effect is partly explained by employer characteristics (in the United States) and previous wages (in United Kingdom), but after controlling for these factors, the premium of leave entitlement remained significant.

In Austria, Lalive and Zweimueller (2009) and Lalive et al. (2014) examined the effects of sequential changes in leave benefit in 1990, 1996 and 2000. The 1990 reform extended the job protection and cash benefit from 1 to 2 years; the 1996 reform kept the job protection period unchanged but decreased the cash benefit period from 2 years to 18 months; the 2000 reform again kept job protection at 2 years but this time increased the cash benefit to 30 months. Using the Austrian Social Security Database, the authors compared

mothers' career outcomes for those who had children before and after these policy changes. The analysis found that longer leave durations significantly delay mothers' return to work. Nevertheless, despite the significant delays to labour force re-entry for mothers exposed to the more generous leave regimes, no evidence was found that the delays had any detrimental effect on their labour market outcomes in the medium term (Lalive et al., 2014; Lalive & Zweimueller, 2009).

In Germany, five major sequential reforms that expanded maternity leave coverage took place from the late 1970s to 2007. Schönberg and Ludsteck (2014) examined the effect of these policy changes by constructing complete work histories of women and men covered by social security records. The results show that each expansion in leave coverage reduced mothers' post-birth employment rates. In the long term (two to six years after childbirth), there was no improvement in mothers' labour market participation (Schönberg & Ludsteck, 2014).

Using a similar scheme, Gangel and Ziefle (2015) examined the effect of the extension of parental leave entitlement in Germany. They used German Socio-Economic Panel data (1990–2004 waves) – which dated from the time of the Federal Republic of Germany (West Germany) and the German Democratic Republic (East Germany) – and found that increased generosity of leave entitlement leads to a decline in mothers' work commitment in both East and West Germany. They conclude that policy-induced shifts in mothers' preferences contributed to hindering women's labour force participation.

Similar policy impact in shaping employment behaviour was confirmed in Australia when paid leave became available in 2011. The policy provided entitled mothers with up to 18 weeks of paid leave at the Australian minimum wage. Using data from the Household, Income and Labour Dynamics in Australia survey, Hondralis (2017) found that women who gave birth after the reform did postpone their return to work until the end of the entitlement period. Women with higher education react strongly to the available policy and markedly adjust their employment behaviour.

Baker and Milligan (2008) examined the impact of policy change in Canada, where job-protected leave provisions are under provincial rather than federal legislation. Using the panel sample and between-province time series data created using the Labour Force Survey results from 1976 to 2002, the authors found that modest leave entitlements of 17–18 weeks do not change the length of time mothers spend away from work. Longer leave durations do have a substantive impact on behaviour, however, leading to more time spent at home.

5.3.3. Paternity leave policy and fathers' take-up rate and participation in unpaid work

Gender equality cannot be achieved unless men take a more active role in parenting. The European Union Parental Leave Directive 2010/18 recommended that non-transferable parental leave for fathers be introduced. Today, leave entitlement for fathers is granted in 79 countries out of the 167 for which data are available (ILO, 2014). Among OECD member countries, 26 countries provide at least a few days of paid leave that can be used only by fathers (OECD, 2016).

The duration of paternity leave varies widely, from only one day in Tunisia to one year in Japan. Despite the prevalence of the legal entitlement, the take-up rate among fathers has been very low. Fathers comprise less than 1 per cent of leave recipients in Czechia; in Finland and Poland, the proportion is 2 per cent; and in Austria, it is 3 per cent (International Network on Leave Policies and Research, 2012). Fathers are more likely to take leave, however, in countries where the leave entitlement for fathers is non-transferable and well paid. This trend is most prevalent in Nordic countries.

Sweden was the first country to introduce a gender-inclusive leave policy, in 1974, enabling mothers and fathers to share the period of parental leave. Men's actual take-up rate, however, did not change until 1995,

when the Swedish government decided to create what is called 'daddy month', a month of parental leave exclusively reserved for fathers. In 2002, a second daddy month was added.

Norway is another pioneer, introducing a fathers' quota of four weeks of leave in 1993 – two years before the daddy month policy was adopted in Sweden. The fathers' quota in Norway was extended to 14 weeks through consecutive reforms and then reduced to 10 weeks in 2014 (Norwegian Labour and Welfare Administration, 2014). Iceland provides fathers with the largest non-transferable share of parental leave: three months are reserved for the father, three months for the mother, and three additional months can be allocated between parents (Steingrimsdottir & Vardardottir, 2015). Likewise, Québec in Canada established a 'daddy quota' in 2006. It is operated through the Québec Parental Insurance Plan (Patnaik, 2018). In Germany too, non-transferable paid paternity leave was established in 2007 (Kluve & Tamm, 2013).

These recent reforms enabled the natural experiment design to be used to assess the effect of paternity leave by comparing the outcomes of parents with children born before the reform with outcomes of parents with children born after the reform. The existing literature suggests three important findings (*see Table 5.2*).

First, as a direct effect, a non-transferable daddy quota increases the take-up rate of parental leave by fathers. In Norway, the introduction of a daddy quota in 1993 increased the take-up rate of fathers from 3 per cent before 1993 to 60 per cent in 1995 (Rege & Solli, 2013). Iceland introduced a reform in 2001 that gives parents the option to add one month of parental leave to the allotted six months, on condition that the additional month is used by the father. The reform created substantial incentives for fathers to be more involved in caring for their children during the first months of life and the take-up rate in the first year was 82.4 per cent (Steingrimsdottir & Vardardottir, 2015). In Sweden, the incentive provided by the daddy month encouraged men to take approximately 15 days' more parental leave, which accounts for an increase of about 50 per cent from the pre-reform average (Ekberg, Eriksson & Friebel, 2013). A similar effect was confirmed in Germany (Kluve & Tamm, 2013) and in Canada (Patnaik, 2018), where fathers' take-up rate of parental leave increased after the introduction of non-transferable paternity leave. This evidence shows that a parental leave period that is non-transferable to mothers (a 'use-it-or-lose-it' quota) is a powerful instrument for increasing men's participation in parental leave.

Second, findings on the effect of policy reform on fathers' involvement in childcare and domestic work are mixed. Using a cross-section, cross-time research design, a daddy quota was found to be associated with men taking more time within the family and childcare. Using the Multinational Time Use Study, which includes data from eight industrialized countries[13] between 1971 and 2005, Boll, Leppin and Reich (2014) report that policies that introduced a daddy quota are strongly associated with fathers spending more time with their children. According to the authors' estimate, one extra parental leave week exclusively reserved for fathers is associated with an increase in time spent by a father with his child of roughly 7 minutes per week. This association, however, is observed only among highly educated fathers; no effect was identified for fathers with lower levels of education (Boll et al., 2014).

Ekberg et al. (2013) operationalized 'involvement in childcare' as whether or not parents use the leave to which they are entitled to care for sick children. Their results indicate that Swedish fathers in the treatment group are no more likely to take time off from work to care for sick children than the control group, who did not have a choice of how to use the daddy quota. In Germany, Kluve and Tamm (2013) find that fathers are not more involved in childcare beyond the period of leave allocated to them.

On the other hand, in Québec, the first province of Canada to introduce the daddy quota, Patnaik (2018) finds that its introduction was effective in changing gender dynamics within the household, not only in the short term, but also for one to three years following the reform. Using the 'time diary' data from Canada's

13 The countries analysed are: Canada, Denmark, Finland, Italy, the Netherlands, Norway, Sweden and the United Kingdom.

General Social Survey, Patnaik found that fathers spent 37 minutes longer in non-market work per day following the reform, while mothers reduced their time spent on housework by 18 minutes.

Third, there is some evidence that the daddy quota leads to fewer conflicts regarding the division of household chores. Kotsadam (2011) found that the daddy quota introduced in Norway reduces the level of conflicts over household work within couples, but this does not necessarily mean that men are doing more of the housework. Rønsen and Kitterød (2015) report that after the introduction of the reform in Norway, especially in the mid-2000s, women returned to work significantly faster. They fail, however, to disaggregate the effects of the policy reform and the expansion of subsidized day care services, which occurred at the same time. In Iceland, the introduction of the daddy quota is credited with improving marital stability. After the reform, those fathers entitled to paternity leave were less likely to divorce during the first 10 years of their child's life (Steingrimsdottir & Vardardottir, 2015).

Table 5.2. List of articles on the effect of parental leave policies on fathers' involvement in childcare (quasi-experimental designs)

Authors	Family intervention description	Who is enacting?	For who?F For whom?	Where? What level?	How is it evaluated?	What are the results?
Kotsadam & Finseraas (2011)	Daddy quota in Norway (1993): four weeks of leave reserved exclusively for fathers; non-transferable to mothers.	Norwegian government	Fathers	Norway, national level	Data: Life Course, Generation and Gender 2007–2008 study. Control group parents with last child born between 1 April 1991 and 30 March 1993 vs experiment group parents whose last child was born between 1 April 1993 and 30 March 1995. Quasi-experimental design.	Respondents whose last child was born just after the reform report an 11% lower level of conflicts over household division of labour and that they are 50% more likely to equally divide the task of washing clothes than respondents who had their last child just before the reform. (But this does not necessarily mean that men are doing more of the housework.)
Ekberg, Eriksson & Friebel (2013)	1995 'daddy month' reform: this reserved one month of the parental leave for the father.	Swedish government	Fathers	Sweden, national level	Data: Swedish registry and employment data. Assessed involvement in childcare of fathers as measured by whether or not fathers use the leave to care for sick children. Comparison: fathers who had children before the reform and those who had children after the reform.	Strong short-term effects of the incentives on male parental leave are found, but no behavioural effects in the household. Fathers in the treatment group do not take larger shares of the leave to care for sick children, which is the measure used for household work. The authors also investigated a second dataset on fathers' and mothers' long-term wages and employment without finding evidence for substantial effects of the reform.
Patnaik (2018)	Québec Parental Insurance Plan introduced in 2006, improving compensation and reserving five weeks of leave (the 'daddy quota') exclusively for fathers.	Québec provincial government	Fathers	Canada, provincial level	Benefit claims from the 2002–2010 rounds of the Employment Insurance Coverage Survey, for long-term effect; and 'time diary' data from Canada's General Social Survey.	Leave reserved for fathers did increase fathers' take-up; fathers not only responded to the higher benefit but also to the daddy-only label associated with quota. Majority of families did not exhaust leave benefit before the daddy quota reform. Long-term effect was observed in the time-use pattern that showed an increase in the hours men spend on unpaid work.

Authors	Family intervention description	Who is enacting?	For who?F For whom?	Where? What level?	How is it evaluated?	What are the results?
Rege & Solli (2013)	Introduction of a paternity leave quota in 1993, reserving 4 weeks of the total 42 weeks of paid parental leave exclusively for the father.	Norwegian government	Fathers	Norway, national level	Data: Norwegian registry data. Difference-in-difference model that exploits differences in fathers' exposure to the paternity leave.	Increased fathers' take-up rate from 3% in 1993 to 60% in 1995. Fathers who took paternity leave experienced a decline in earnings.
Steingrims-dottir & Vardardottir (2015)	In 2001, a 'use-it-or-lose-it' paternity leave quota given to fathers: option to add one month of parental leave to the allotted six months, but only if the additional month was used by the father.	Iceland	Fathers	Iceland, national level	Register-based panel dataset comprising a sample of 600 Icelandic families who had children in the three months before and the three months after the first change to the parental leave system. Difference-in-difference model estimating the risk of divorce.	Created substantial economic incentives for fathers to be more involved in caring for their children during the first months of life, and the take-up rate in the first year was 82.4%. Parents who are entitled to paternity leave are less likely to divorce during the first 10 years of their child's life.

In summary, providing father-specific leave seems to increase men's participation in parental leave, at least when the leave is well paid. The countries mentioned above provide compensation of 80 to 100 per cent of pay during paternity leave. The importance of monetary benefits cannot be overemphasized because the leave decision can be driven by simple financial logic. Regardless of the policy design, there is a strong incentive for a couple to allocate their time for paid and unpaid work according to the comparative financial advantage (Becker, 1985, 1991). Given the persistence of a gender wage gap, it is more likely that fathers will continue working, unless otherwise compelled. In this respect, simply providing fathers with an exclusive leave entitlement is not enough – it must not only be provided as a non-transferable and 'use-it-or-lose-it' option for fathers, but it must also be well paid.

5.4. Family policy and meeting SDG 5: Summarizing the evidence

This chapter reviewed the present state of gender equality and research on how family policy can contribute to gender equality in line with SDG 5. The indicators used are gender wage gap and time spent on unpaid work by women and men.

Equal pay has been a long-standing concern of ILO, and almost all OECD member countries have legislation to ensure equal pay for equal work, regardless of gender. Nevertheless, men's wages are much higher than women's wages, with an average difference of from about 15 per cent in OECD member countries to 23 per cent worldwide based on ILO data. The gender wage gap is partly attributed to differences in level of education, work hours, tenure, type of occupation and number of hours spent on paid and unpaid work. In all countries, women spend more time on unpaid domestic work and assume more responsibilities in domestic care work. A few countries showed an increase in the male-to-female ratio of time spent on unpaid work – but this change was driven by women decreasing the time they spent on unpaid work, rather than by men increasing their contribution.

The unequal distribution of unpaid work and care responsibilities between women and men in the private sphere is both the cause and result of gender inequality in the public sphere – most importantly, in the labour market. The wage gap between women and men is further manifested in the additional gap in wages observed between mothers (who earn less) and non-mother women (Staff & Mortimer, 2012). In contrast, working fathers earn more than their childless counterparts. The opposite effects of parenthood on women's and men's pay, notably the 'motherhood penalty' and the 'fatherhood premium', are at the core of why a family perspective is crucial in achieving gender equality.

As reviewed in this chapter, countries characterized by 'family-friendly' policies with longer and more generous leave provisions tend to have a higher level of gender segregation that disadvantages women. Maternity leave policies are expected to promote and achieve gender equality in the workplace by securing the right to return to the previous employment position. Research findings suggest, however, that the opposite is true – that is, a negative association has been found between generous parental leave entitlement and women's labour force outcomes. This phenomenon, dubbed the 'welfare state paradox', has been the focus of the research for the last two decades.

The studies that use micro-level analysis with a natural experimental design generally find that the provision of longer parental leave durations for childbirth discourages female labour force participation. Although the job protection element of leave entitlement enables more women to stay in the labour force, extension of the duration of leave or increased wage compensation work as incentives for mothers to spend a longer time at home. Consequently, generous and longer parental leave is found to have a negative effect on gender equality in the labour market.

On the other hand, fathers' responses to changes in leave policies are very limited. Only when the leave entitlement is made non-transferable to mothers and provided as a bonus period of 'use-it-or-lose-it' are fathers more likely to take the leave. Research suggests that a wage replacement level of 80 per cent is the necessary condition for a higher take-up rate among fathers. Even in an exceptional case where paternity leave is mandatory (Portugal since 2009), fathers' take-up rate remains at about 50 per cent (Wall & Leitaro, 2016). In other words, fathers need to be strongly incentivized, or even cajoled, to take leave from work when they become parents.

More time at home for parents following childbirth is the direction in which most developed countries are heading. This trend means, in reality, more time at home for mothers and little, if any, more time for fathers. As noted above, mothers are more likely to delay their return to work for as long as their leave entitlement and compensation allow them, while fathers do not respond to leave entitlements. Longer leave would increase the amount of childcare and housework done by mothers, and women doing a greater share of such work continues to reinforce the gendered division of unpaid work. The underlying frame of the work-and-family conflict continues to be a 'women's affair'. Concerns about the negative consequences of longer parental leave are most prominent for higher-skilled, higher-earning professional workers. It is because these workers are hard to replace, and employers may be reluctant to place women in such jobs, that substitution of one worker for another is difficult.

Whether a policy is viewed as effective or not depends on the desired outcome. Parents spending more time at home means children are receiving a greater amount of parental care at home. From the perspective of child development, this is a desirable outcome. The primary attachment between baby and primary caregiver (the mother, in most cases), which is built during the neonatal period, is crucially important for the child's later development (Waters & Cummings, 2000). Having a 'loving' mother (or other primary caregiver), developing in an organized environment and achieving a secure attachment to the mother or other primary caregiver acts as a protective factor for the infant against social and emotional maladjustment (Egeland & Hiester, 1995). Literature on the importance of early childhood programmes, however, rarely frames arguments around gender equality. In this respect, gender equality is only part of the nexus.

Family policy is often about competition among competing values and embodiment thereof, more so than other policy fields. The reproduction and care of the next generation are necessary conditions of a sustainable society. As family policies are directly related to the nexus of production and reproduction, they inevitably confront the challenge of what is good for children versus what enhances gender equality. Consequently, family polices that balance these two goals will be needed should the targets outlined across multiple SDGs be met.

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Annex 5. Summary of studies reviewed in Chapter 5

Article	Family intervention description (How are they doing it?)	Who is enacting?	For whom?	Where? What level?	How is it evaluated?
Castro-Garcia, C., & M. Pazos-Moran. (2016). Parental Leave Policy and Gender Equality in Europe. *Feminist Economics*, *22*(3), 51–73. doi: 10.1080/13545701.2015.1082033	Cross-section analysis on parental leave schema (non-transferability, duration, payment compulsory period) and their effect on proportion of parental leave men use /comparison of policy design to induce fathers to take leave.	21 European countries, 2008–2010	Parents	21 European countries	Cross sectional comparison of design. Examines entitlement characteristics, such as non-transferability, duration, payment, compulsory period, and other policies to assess their effect on the proportion of leave men use out of the total parental leave in each country.
Gasser, M., & Liechti, L. (2015). Gender equality trade-offs re-examined: evidence from Swiss cantons. *Community, Work & Family, 18*(3), 249–267. doi:10.1080/1366 8803.2014.1002753	In 2005 was maternity insurance introduced at federal level, and there is, as yet, no statutory paternity leave nor a right to work part-time.	Not particularly targeted to the policy itself	N/A	Swiss Cantons	Cross-sectional comparison between 26 cantons before implementation of the maternity insurance in 2005. Data: Population Census, Cross-sectional
Boll, C., Leppin, J., & Reich, N. (2014). Paternal childcare and parental leave policies: evidence from industrialized countries. *Review of Economics of the Household, 12*(1), 129–158. doi:10.1007/ s11150-013-9211-z	Cross section, cross-time analysis to estimate the relation between parental leave policies and paternal childcare time (in minutes).		Fathers		Multinational Time Use Study (MTUS, Gershuny and Fisher, 2010) from eight industrialized countries from 1971 to 2005: Sweden (1991, 2000), Norway (1981, 1990, 2000), Netherlands (1975, 1980, 1985, 1990, 1995, 2000, 2005), Canada (1971, 1981, 1986, 1992, 1998), Denmark (1991, 2001), United Kingdom (1974, 1983, 1987, 1995, 2000, 2005), Italy (1989, 2001) and Finland (1979, 1987, 1999)
Lewis, J., & Campbell, M. (2007). UK Work/Family Balance Policies and Gender Equality, 1997–2005. *Social Politics: International Studies in Gender, State & Society*, *14*(1), 4–30. doi: 10.1093/sp/ jxm005	Examines the aims and nature of work-family-balance policy and assess how they promote gender equality.	United Kingdom	N/A	United Kingdom, 1997–2005	Work and family balance policy has not been framed as a gender equality issue.

Article	Family intervention description (How are they doing it?)	Who is enacting?	For whom?	Where? What level?	How is it evaluated?
Boll, C., Leppin, J., & Reich, N. (2014). Paternal childcare and parental leave policies: Evidence from industrialized countries. *Review of Economics of the Household, 12*(1), 129–158. doi:10.1007/s11150-013-9211-z	1971 to 2005 Cross-national, cross-section analysis to estimate the association between national parental leave arrangements and paternal childcare.	Sweden, Norway Netherlands, Canada, Denmark, United Kingdom, Italy and Finland	Fathers	National	Multinational Time Use Study (MTUS) with national parental leave characteristics from eight industrialized countries from 1971 to 2005. Cross-section OLS.
Hallden, K., Levanon, A., & Kricheli-Katz, T. (2016). Does the Motherhood Wage Penalty Differ by Individual Skill and Country Family Policy? A Longitudinal Study of Ten European Countries. *Social Politics, 23*(3), 363–388. doi:10.1093/sp/jxv032	Cross-country analysis on parental leave scheme on motherhood penalty, disaggregated by skill level.	Austria, Denmark, Finland, France, (former West) Germany, Ireland, Italy, Portugal, Spain and United Kingdom	Mothers	Austria, Denmark, Finland, France, (former West) Germany, Ireland, Italy, Portugal, Spain and the United Kingdom	European Community Household Panel (ECHP) with Hausman-Taylor Model / Comparison of wage of the wage of the same women before and after becoming a mother
Boeckmann, I., Misra, J., & Budig, M. J. (2015). Cultural and Institutional Factors Shaping Mothers' Employment and Working Hours in Post-industrial Countries. *Social Forces, 93*(4), 1301–1333. doi:10.1093/sf/sou119	Cross-national comparison, /variation for gap in employment and working hours, controlling for individual and household level differences.	19 European countries, 1996–2001	Mothers	National, controlled for individual and household differences	National Data Centre in Luxembourg (LIS) harmonized with national statistics elsewhere.
Thévenon, O., & Solaz, A. (2013). *Labour Market Effects of Parental Leave Policies in OECD Countries*, OECD Publishing.	Cross-section, cross-time analysis of 30 OECD countries 1970-2010.	30 OECD countries	Women and men aged 25–54	National	Cross-country, cross-time analysis
Blau, F. D., & Kahn, L. M. (2013). Female Labor Supply: Why Is the United States Falling Behind? *American Economic Review, 103*(3), 251–256. doi:10.1257/aer.103.3.251	Cross-section differences of leave policies.	21 OECD countries	Women and men aged 25–54	National	Linear regression of women's LFPRs, men's LFPRs, male-female differences in LFPRs and log of the male-female ratio in LFPR. OECD aggregate annual data

Article	Family intervention description (How are they doing it?)	Who is enacting?	For whom?	Where? What level?	How is it evaluated?
Olivetti, C., & Petrongolo, B. (2017). The Economic Consequences of Family Policies: Lessons from a Century of Legislation in High-Income Countries. *The Journal of Economic Perspectives, 31*(1), 205–230.	Cross-national comparison of family policies in	15 developed countries	Parents	National level: Spain, France, Germany, Finland, Norway, Sweden, United Kingdom, Greece, Japan, Australia, Canada, Denmark, Italy, Netherlands, United States	OECD Family Database, harmonized with labour statistics. Fixed-effect model on female labour outcome (female employment rate, employment gap earning gap and fertility) regressed on length of job protected weeks, (allowing non-linearity), percentage paid leave, etc.
Ruhm, C. J. (1998). The economic consequences of parental leave mandates: Lessons from Europe. *Quarterly Journal of Economics, 113*(1), 285–317. doi:10.1162/003355398555586	Cross-section, cross-time analysis to estimate the relation between parental leave policies and paternal childcare time. (in minutes)	government	Mothers	Cross-country, cross-section	Data: ILO Legislative Services, global survey on Protection of Working Mothers and Social Security Programs Throughout the World published by US Social Security Administration. 1969-1993 cross sectional data in Denmark, Finland, France, Germany, Greece, Ireland, Italy, Norway and Sweden). Elimination of unpaid leave, and 'take-up' rates not included in the model.
Gornick, J. C., Meyers, M. K., & Ross, K. E. (1998). Public policies and the employment of mothers: A cross-national study. *Social Science Quarterly, 79*(1), 35–54.	Cross-country comparison/ dependent variable, whether or not the leave policy is: (1) legislated; (2) paid; (3) replacement rate; (4) coverage; (5) paternity, etc. summarized as 'generosity'	14 countries	Mothers	National	Child penalty is estimated using microdata from the Luxembourg Income Study (LIS). The independent variable is national policy performance, as captured in two composite indexes of policy indicators. The dependent variable is the magnitude of each country's 'child penalty': the regression-adjusted estimate of the decrease in mothers' employment probability given the presence of young children at home.

CHAPTER 6.

FAMILIES AND SUSTAINABLE DEVELOPMENT GOAL 8: YOUTH EMPLOYMENT

Chapter 6. Families and Sustainable Development Goal 8: Youth Employment

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6.1. Introduction

The 2030 Agenda for Sustainable Development, comprising 17 SDGs and 169 targets, sets out a universal plan of action that seeks to eradicate poverty and achieve prosperity, while ensuring that no one is left behind. To achieve the 2030 Agenda, it is critical to promote full and productive employment and decent work for all, including for young people.

Today's youth – those aged 15–24 years – are the world's next generation (International Federation for Family Development [IFFD], 2016). Youth represent a crucial resource for society, accounting for over 18 per cent of the global population and more than 15 per cent of the world's labour force (ILO, 2016). Accordingly, addressing labour market issues faced by youth is imperative not only for the well-being of young people and their families, but also for achieving inclusive growth and enhancing human capital.

The current chapter focuses on the links between families, family policy and SDG 8, which aims for the attainment of sustainable economic growth, full employment and decent work for all. Two of its corresponding targets are Target 8.5, on achieving full and productive employment for young people, and Target 8.6, on reducing the proportion of youth not in employment, education or training. For Target 8.5, a relevant indicator is unemployment rate; for Target 8.6, it is the proportion of youth not in education, employment or training.

This chapter aims to address two main issues: (1) the role of the family in promoting youth employment; and (2) how family policy and relevant family interventions can improve youth performance in the labour market. As the chapter will show, the home environment and family background, including parental employment and education, serve as an important mediator for youth labour market transition and employment prospects. It is therefore essential that policymakers and other stakeholders strengthen their efforts in supporting families so that young people can achieve better employment outcomes. This will allow young people to pursue decent and self-sufficient lives, form their own families and improve the well-being of their family members and society overall.

The evidence reviewed for this chapter suggests that labour market interventions aimed at creating productive, quality and well-paid jobs, including for youth, should be seen as an integral part of family policies that can facilitate youth employment and, by doing so, achieve broader development outcomes, including poverty reduction, economic prosperity and a more inclusive and cohesive society. As stated in chapter 4 of the present report, strong and stable families function in supportive units, while providing various resources to all members such as time, financial and physical resources, interpersonal care and emotional security. It is therefore vital that relevant policies and programmes help families to provide this support so as to increase opportunities and improve outcomes for youth employment.

The chapter is organized as follows. Section 2 will show the interlinkages between families, youth employment and the 2030 Agenda. Section 3 will provide data on recent global, regional and national trends in youth unemployment and youth not in employment, education or training. It will also identify main drivers behind these trends and briefly discuss consequences for families, the economy and society. Section 4 will provide evidence from a literature review on how families and family policy contribute to youth development and employment. Section 5 will close the chapter with concluding remarks and recommendations on family

policy interventions that can complement labour market policies, to improve youth employment opportunities and outcomes.

6.2. Youth employment in the SDGs

Youth is generally understood as a period of transition from childhood to adulthood. While the latter is generally associated with being in employment and is characterized by independence, youth is often associated with being in compulsory education and is characterized by dependence.[14] Yet, patterns of transition vary greatly due to differences in educational attainment, choice of profession, availability of jobs and housing, lifestyle, aspirations, family background and institutions (Thévenon & Neyer, 2014).[15] For statistical purposes, the United Nations defines 'youth' as those persons aged 15 to 24 years.[16] Beyond this statistical definition, the meaning of youth varies across societies and may change with circumstances, especially with shifts in demographic, economic and sociocultural settings. For the purpose of this report, the present chapter adopts the United Nations definition of youth, while acknowledging the heterogeneity of meanings in various contexts.

The 2030 Agenda recognizes young women and men as critical agents of change, while acknowledging youth unemployment as a major concern and emphasizing the need to promote youth employment.[17] The achievement of the 2030 Agenda to a large extent depends on how well families are empowered to contribute to the SDGs (IFFD, 2016). Families do better in a supportive policy environment – one that helps them to support their children's transition to adulthood, and in which young people are engaged in paid, productive work. This in turn provides an economic foundation from which young people can create their own families.

Despite recognition of the importance of youth employment, many young people today face increasing uncertainty on entering the labour market, which can have damaging effects on the young people themselves, and on the economy and society at large. Unemployed or underemployed youth are more vulnerable to poverty and social exclusion, are less able to contribute effectively to national development, and have fewer opportunities to exercise their rights as citizens. In this situation, they have less to spend as consumers, less to invest and often have little voice with which to bring about change in their lives and communities (O'Higgins, 2001). In certain cases, this results in social unrest and a rejection of the existing socio-economic system by young people (ILO, 2016). Widespread youth unemployment and underemployment also inhibits the development of human capital and innovation in the economy, thus jeopardizing the achievement of SDG 8 and the 2030 Agenda overall.

Trends in the labour market require individuals today to undertake more education and training than was required decades ago to become economically secure enough to establish a family (Berlin et al., 2010). In many countries, increases in earnings inequality, and in employment instability and shortening of job tenure as a result of higher turnover, as well as increases in housing prices and in the cost of living, have also strengthened the difficulties that young people face in attempting to establish an independent and self-sufficient family (Thévenon & Neyer, 2014). As a consequence, economic independence and other events leading to adulthood (such as completion of education, transition from education to work, family formation)

14 http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf

15 The changes that have traditionally been associated with growing up, such as finding a job, leaving home, getting married and becoming a parent, may occur simultaneously or not at all, and many of them are reversible (Johnson-Hanks 2002; Valentine 2003). In both developed and developing countries, young people tend to traverse back and forth between time and place boundaries rather than passing through linear life stages, which shifts the notions of childhood, youth and adulthood (Burgess 2005; Christiansen et al. 2006; Honwana and de Boeck 2005; Langevang 2008; van Blerk 2008).

16 Secretary-General's Report to the General Assembly, A/36/215, 1981

17 https://sustainabledevelopment.un.org/post2015/transformingourworld

are now achieved much later than was the case for previous cohorts, and a significant proportion of young people have to rely on the support of their family and/or the state (Smeeding & Phillips, 2002). Various factors are argued to be responsible for this trend, including reduced economic opportunities, technological changes and the spread of globalization (Blossfeld et al., 2005; Danziger & Ratner, 2010).

Unless youth are equipped with the support they need to succeed, there is a risk of leaving millions of young people behind. While policies that are aimed at ensuring access to the labour market and creating decent jobs are essential, it is important to also create relevant interventions to strengthen families. As this chapter will show, differences in access to employment opportunities are often based on family situation, household income and parental employment. This implies that the role of policies that affect families and parental employment in particular, along with family benefits and services, will be essential in achieving SDG 8. The 2030 Agenda provides an opportunity to incorporate youth in family policy as part of comprehensive sustainable development strategies.

6.3. Youth unemployment: Trends and drivers

6.3.1. The unemployment rate[18]

Although the global economy has shown fairly consistent growth over the past two decades, young people entering the labour market today are less likely to secure a decent job than in 1995 (United Nations Department of Economic and Social Affairs [UNDESA], 2016). Indeed, as noted by Eurofound (2014), "Economic growth has in many places not translated into sufficient levels of jobs creation, especially for youth. In addition, in some parts of the world, young people's ability to engage and become economically independent has been affected by the 2008 global economic crisis and, more recently, by a slowdown in global economic growth" (Eurofound, 2014).

After the global youth unemployment rate reached 14 per cent in 2013 – its highest point in the past two decades – it stood at 13.6 per cent in 2016, with the number of unemployed youth globally amounting to 71 million (ILOSTAT, World Bank Indicators). In 2016, based on available data, the unemployment rate among youth was highest globally among high-income countries, at 15.3 per cent; among middle-income countries, it was 13.8 per cent; and the lowest unemployment rate was registered among low-income countries, at 9.8 per cent (ILOSTAT, World Bank Indicators).[19]

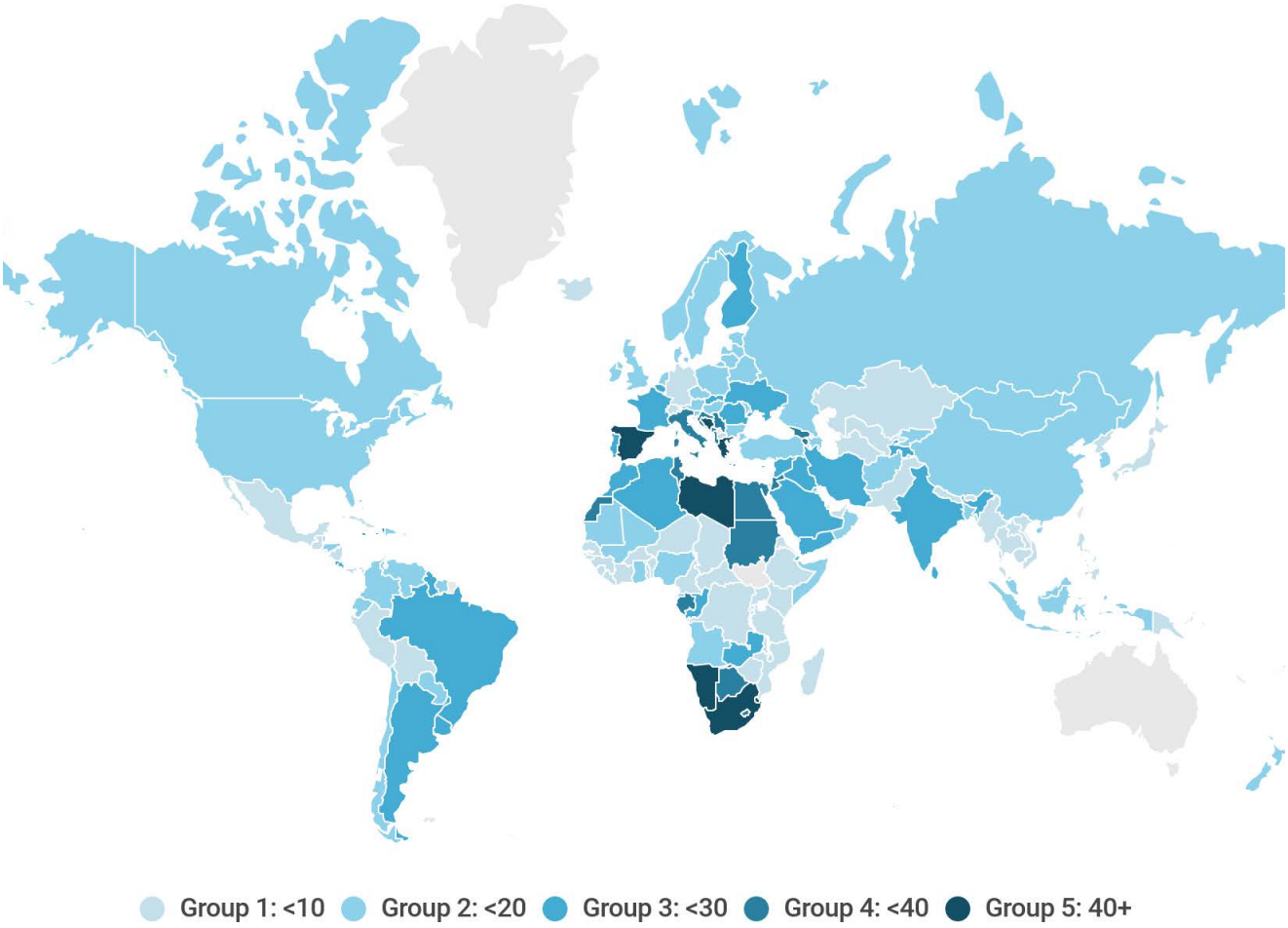
Map 6.1 provides data on the share of youth aged 15–24 years in the labour force who are without work but available for and seeking employment (*for a discussion of gender and youth unemployment, see Box 6.1*). It shows that youth unemployment affects all countries, with the highest youth unemployment rates in sub-Saharan Africa in 2016 found in South Africa (53.6 per cent), and Namibia (44.4 per cent); in the Middle East,

18 The unemployment rate measures the number of unemployed persons as a percentage of the total number of persons in the labour force.

19 The terms 'employment' and 'unemployment' are tricky concepts, particularly when applied in developing/low-income countries, due to data availability and quality, hence any such figures have to be treated with caution. This is especially problematic in countries characterized by a large informal sector, where work is often irregular, insecure and precarious (Bunnell and Harris, 2012). The African Economic Outlook (2012) suggested that a focus on 'unemployment' rates in Africa makes little sense as few among those living in poverty can afford not to be employed. Instead, vulnerable employment, underemployment and working poverty are commonplace. In 2016, for example, 247 million people across most of sub-Saharan Africa were in vulnerable employment, equivalent to around 68 per cent of all those with jobs (ILO, 2017). Looking at the unemployment rate alone fails to take into account this reality. It assumes that those in employment are materially better off than the unemployed. Yet, in most African countries, this assumption does not hold. In fact, the unemployed are less likely to experience poverty than many self-employed or underemployed (Gough et al., 2013).

in Libya (50.1 per cent); and in Eastern Europe, in Bosnia and Herzegovina (55.0 per cent) and North Macedonia (48.2 per cent). The lowest youth unemployment rates are generally found in Western Europe – notably in Germany (7.0 per cent) – with the exception of Greece (47.2 per cent), Spain (44.4 per cent) and Italy (37.8 per cent) – and in South East Asia, notably in Myanmar (2.6 per cent) and Thailand (3.8 per cent).

Map 6.1. Youth unemployment, as % of total labour force aged 15–24 years, 2016



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: World Development Indicators, 2017.
Note: Youth unemployment affects all countries of the world regardless of stage of economic development.

The unemployment statistics, however, understate the true nature of the youth labour market challenges.[20] Large numbers of young people are working but do not earn enough to lift themselves out of poverty. In fact, roughly 156 million youth in emerging and developing countries live in extreme or moderate poverty despite being in employment (ILO, 2016). Moreover, youth exhibit a higher incidence of working poverty than adults: 37.7 per cent of working youth were living in extreme or moderate poverty in 2016, compared with 26 per cent of working adults (ILO, 2016). This indicates that young people in these countries often have to work in poor-quality and low-paid jobs to provide the basic necessities of life for themselves and their families. The higher incidence of working poverty and informal labour among youth is associated with the high proportions of youth who are engaged in domestic service and unpaid family work, especially in developing countries (ILO, 2013). For instance, across 14 Latin American countries, the share of young contributing family workers as a proportion of total youth employment exceeded the corresponding share of adult contributing family workers in all of the countries analysed (ILO, 2015). The fundamental challenge in emerging and developing countries therefore remains to improve the quality of work available for the majority of young people who are already working but are underemployed or engaged in informal jobs.[21]

Meanwhile, in developed countries with available information, youth are more at risk of relative poverty (defined as living on less than 60 per cent of the median income) despite having a job. For example, the share of employed youth aged 18–24 years categorized as being at risk of poverty was estimated at 16.8 per cent in the European Union in 2015, compared with an estimated 12.5 per cent of working adults aged 25–59 years (Eurostat). In addition to receiving low pay, young people frequently work involuntarily in informal, part-time or temporary jobs. For example, among youth employed in part-time and temporary positions in the European Union in 2014, approximately 29 per cent and 37 per cent respectively were doing so involuntarily (ILO, 2016).

A marked erosion in employment conditions – including a shift from long-term employment contracts to short-term and/or part-time contracts and temporary work, the loss of entitlement to insurance and benefits, and longer working hours – has changed the playing field for young labour market entrants, reinforcing the youth employment challenge.

20 In some contexts, for instance, in Eastern Europe, relatively low official unemployment rates can be partly explained by the small incentive to register as unemployed (including among youth) due to the low value of unemployment benefits (Dugarova, 2016). Registered unemployment statistics can be further distorted by the fact that income-earning activities such as agricultural work may not be considered a job in certain settings, which does not allow farmers to register as unemployed (when out of work) and claim unemployment benefits (Kuddo, 2009).

21 Facing the prospect of unemployment, working poverty and/or vulnerable forms of employment, young people tend to look abroad for better education and employment opportunities. In 2015, almost 51 million international migrants were aged 15–29 years, more than half of whom resided in developed economies (ILO, 2016).

Box 6.1. The gender dimension in youth unemployment

Across most labour market indicators, wide disparities exist between young females and males, with employment prospects continuing to be more favourable for the latter virtually everywhere (ILO, 2016). Such disparities represent inequalities of opportunity and reflect deep-rooted socio-economic and cultural challenges that tend to disproportionately disadvantage women.

For example, in 2016, 13.7 per cent of young women in the global labour force were unemployed – a full percentage point higher than their young male counterparts. The Arab States and countries of North Africa exhibit the largest gaps in employment rates between female and male youth aged 15–24 years – at 20.3 percentage points and 27.6 percentage points respectively in 2016 – despite the rising educational attainment of young women in these regions. Female unemployment rates are not, however, uniformly higher than those of males. For instance, in 2016, in a number of regions (i.e., Northern, Southern and Western Europe; East Asia; and North America) unemployment rates among female youth were lower than among their male counterparts (ILO, 2016).

Even when employed, female youth are more likely to be in informal and vulnerable employment, largely due to the higher share of female workers in unpaid family work, which is a component of vulnerable employment (UN Women, 2016). In sub-Saharan Africa, for example, the share of female workers categorized as contributing family workers (30.6 per cent) is more than twice the rate for their male counterparts (14 per cent), with women additionally over-represented in informal non-agricultural employment (ILO, 2016). While the gender wage gap is closing in certain developed contexts, persistent earnings disparities between young women and young men in some regions continue to interfere with women's full economic engagement. Globally, young women are also less likely than young men to become entrepreneurs, which further limits the employment options for female youth.

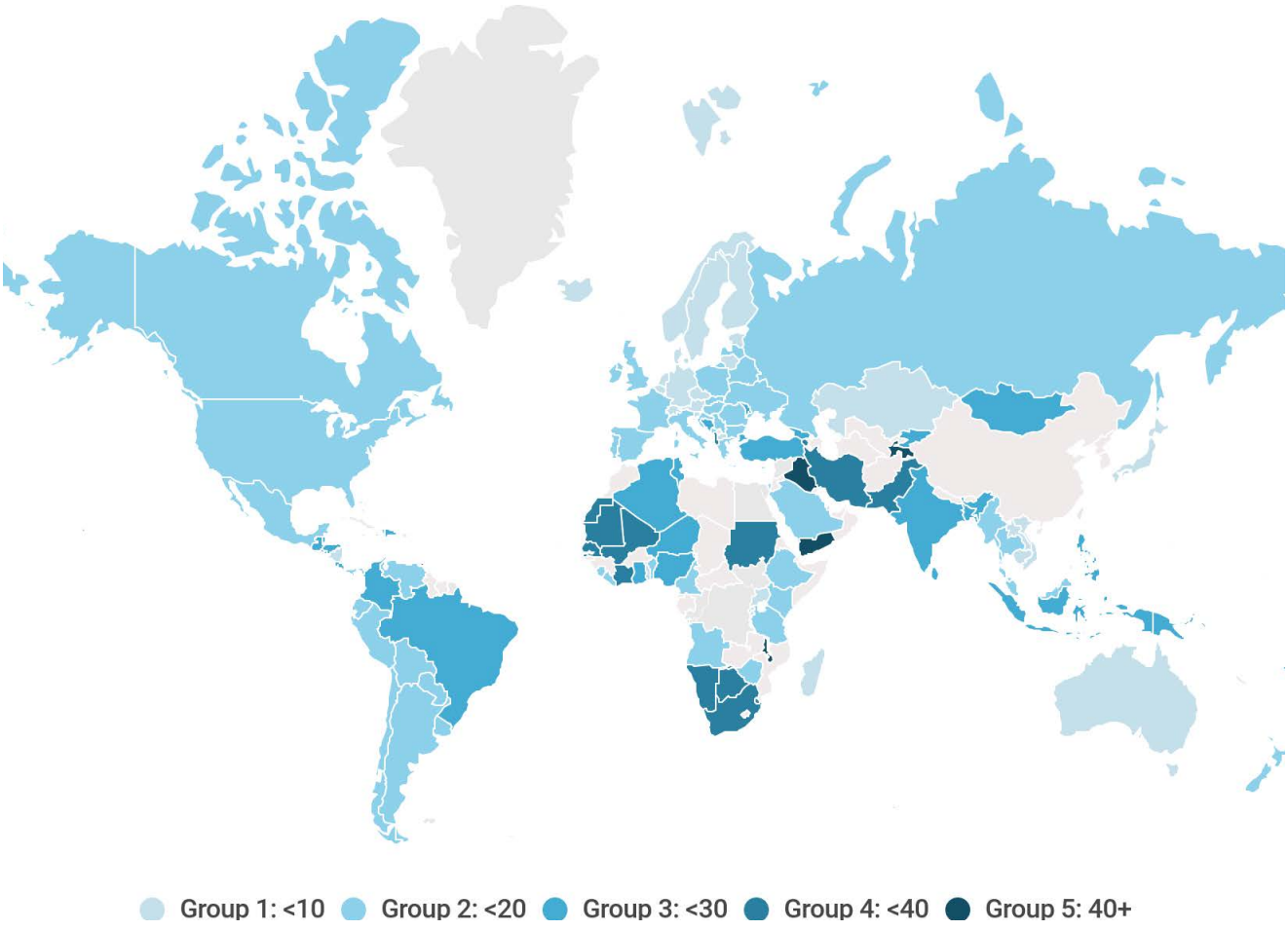
Recent ILO school-to-work transition surveys indicate that different regions have common reasons for female inactivity. For instance, in Latin America and the Caribbean, Central Asia, North Africa and the Arab States, family responsibilities were cited as the most common reason for inactivity among young women. In South Asia, inactivity was mainly attributed to lower levels of educational attainment and to the disproportionately large burden that women bear in the household in terms of family responsibilities and housework (Elder & Kring, 2016).

6.3.2.Youth not in employment, education or training[22]

As youth unemployment rates remain persistently high and transitions from education into work become increasingly difficult, a growing share of youth fall into the category of not in education, employment or training (NEET), with the attendant risks of skills deterioration, underemployment and discouragement (ILO, 2016).

Map 6.2 shows data on the proportion of NEET youth aged 15–24 years as a percentage of the total youth population. The highest NEET rates are reported in Trinidad and Tobago (52.5 per cent in 2013) and Yemen (44.8 per cent in 2014). In many parts of the Middle East and Africa, NEET data are unavailable.

Map 6.2. Youth NEET, % – age 15-24, 2009 - 2016

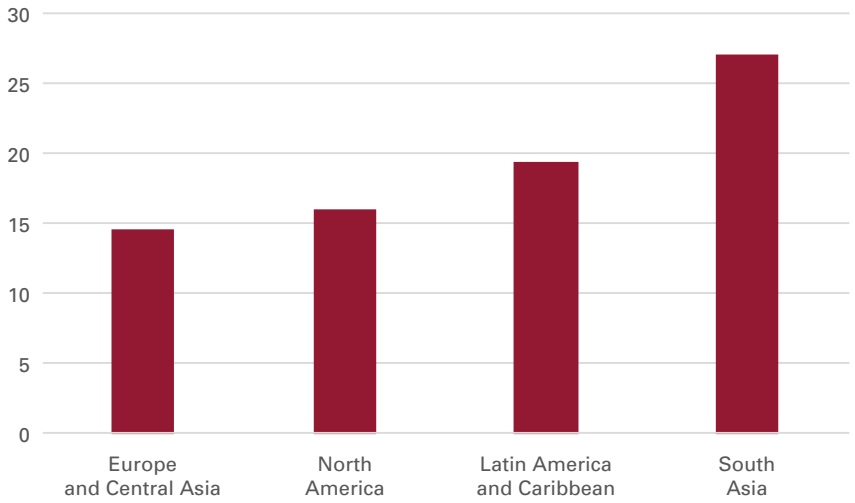


This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: International Labour Organization Department of Statistics. (2017).

22 The share of youth not in education, employment or training (NEET) conveys the number of young persons in this situation as a percentage of the total youth population. It provides a measure of youth who are outside the education system, not in training and not in employment, and thus serves as a broader measure of potential youth labour market entrants than youth unemployment, since it also includes young persons outside the labour force not in education or training.

According to recent World Development Indicators data, the regions with the lowest NEET rate for young people are Europe and Central Asia (14.6 per cent) and North America (15.9 per cent), followed by Latin America and Caribbean (19.3 per cent), with South Asia the region with the highest NEET rate (27.1 per cent) (*see Figure 6.1*).

Figure 6.1. NEET rates for young people (aged 15–29) for regions with available data, 2014 (% of population aged 15–29)



Source: World Development Indicators. Note: Data for South Asia are for 2010, data for North America are for 2012.

At the country level, survey evidence for 28 low- and middle-income countries indicates that roughly one quarter of the population aged 15–29 years old are categorized as NEET (Elder, 2015). Results also show how dramatically the NEET rate increases as a young person ages. This issue is particularly severe in developed countries, where, despite widespread access to tertiary education opportunities, NEET rates for young people over the age of 20 are consistently higher – and by a wide margin – than for young people aged 15–19 years. Unemployment seems to be the main driver of NEET rates: for example, in Europe, only 6 per cent of NEET youth are classified as 'discouraged' (Eurofound, 2016).

6.3.3. Root causes of youth unemployment

Among the major causes of youth unemployment are inflexible labour markets and regulations that make it difficult for young people to secure stable employment trajectories (ILO, 2016). High youth unemployment rates are often the consequence of a labour market biased against young people. For example, employers tend to lay off young workers first, because the cost to establishments of releasing young people is generally perceived as lower than for older workers. Also, employment protection legislation usually only applies following a minimum period of employment, and compensation for redundancy usually increases with tenure. Young people are likely to have shorter job tenures than older workers and will therefore tend to be easier and less expensive to dismiss. Finally, since they comprise a disproportionate share of new jobseekers, young people will suffer most from economically induced reductions or freezes in hiring by businesses.

Another main reason for youth unemployment is the quality and relevance of education, which is often ill-equipped to meet the changing and diverse needs of the labour market (UNDESA, 2016). There has been a growing mismatch between the skills that young people learn in the education system and those required in the workplace.

Other factors that account for difficulties encountered by young people when entering the workforce include lack of information, networks and connections, especially among youth from families with limited economic resources and social capital (ManpowerGroup, 2012). As a result, young people do not know how to navigate the labour market to identify and pursue available jobs or to find and use relevant resources. Furthermore, young people often lack the experience and credentials that are required by employers. Many employers see these deficits as a significant barrier to the productivity of inexperienced youth, but at the same time they are reluctant to invest their own resources in training young people. Yet, often only a small number of available jobs are suited to entry-level skills. In some labour markets, especially in developing countries, there is simply a demographic mismatch between the number of young people seeking work and the level of local economic activity. Most available work may be in informal or underdeveloped industry sectors. Some young people also lack the so-called 'twenty-first century workplace skills', such as cooperation, communication, critical thinking and creativity, which are often necessary to find employment (ManpowerGroup, 2012). These skills are not necessarily taught at school or university and young people must learn them elsewhere, for example, through specialized courses or extracurricular activities.

6.3.4. Consequences of youth unemployment

Long-term youth unemployment can have severe consequences. Unemployed youth have been called 'a lost generation', not only because of productivity loss, but also because of the long-term direct and indirect impacts that unemployment has on young people and their families (O'Reilly et al., 2015). The effects of long-term youth joblessness leave a legacy that reduces lifetime earnings, increases the risk of future periods of unemployment and augments the likelihood of precarious employment (Bell & Blanchflower, 2011).

The lost generation effect also has an impact on families. Youth in many countries now live with their parents into their late twenties or even mid-thirties (Martin, 2009), which contributes to the so-called 'full nest syndrome'. In economic terms, it affects long-term material accumulation and the opportunities that this creates, either to live independently or to start a family. The consequences of encountering barriers when attempting to make the transition to independent adulthood – through employment, housing and family formation – will likely have an aggregate effect in relation to demographic and fertility trends (O'Reilly et al., 2015).

Alongside the shift in youth living situations, the impact of returning home to live with parents, as well as difficulty finding a fulfilling job, can lead to mental health risks. Being unemployed for a long period of time in youth has been correlated with decreased happiness, reduced job satisfaction and other mental health issues (Morsy, 2012). Lack of engagement in regular paid employment can result in a vicious downward circle in terms of subjective perceptions of recognition, value and well-being (O'Reilly et al., 2015). Youth who are neither working nor studying have no formal opportunities to learn and improve their skills. They are progressively marginalized from the labour market and in turn can develop antisocial behaviour, with chronic unemployment associated with an increased incidence of criminal behaviour (ManpowerGroup, 2012). As these young people grow older and raise families, their own failure to accumulate economic and social capital can perpetuate the same cycle for their children.

6.4. Family and youth employment: Evidence from the literature review

6.4.1. Literature search

The literature search was conducted using electronic databases such as Academic Search, Google Scholar and JSTOR, to surface studies published during the period 2000–2017. The year 2000 was chosen in order to find as many as possible relatively recent studies on the impact of families and family policy on youth employment. Searches were undertaken using the following keywords, in different combinations: "family", "family policy", "family interventions", "youth employment", "youth unemployment", "parents", "young people", "economic activity", "employment opportunities", "employment outcomes", "not in employment, education or training (NEET)", "developed countries", "developing countries", "Africa", "Asia", "Europe", "Latin America", "North America". To identify examples of relevant policies and programmes that specifically link families and youth employment, a review of experimental literature on family policy was further conducted. The search included "active labour market policies (ALMPs)" involving "family or parents", "foster care", "family benefits" and "conditional cash transfers (CCTs)". An additional search was carried out to find out whether these policies and programmes have been adequately evaluated using "randomized control trials (RCTs)", "meta-analysis" and other "assessment methods".

Searches selected only peer-reviewed articles. In addition, websites of international organizations working on youth employment were examined including those of the International Labour Organization (ILO), United Nations Department of Economic and Social Affairs (UNDESA), United Nations Development Programme (UNDP), European Commission, Organisation for Economic Co-operation and Development (OECD), UN Women, World Bank and World Economic Forum. Relevant published reports and research/working/discussion papers from these organizations were considered. References in the reports, peer-reviewed articles and other technical papers were also checked for suitable studies and, where relevant, some of these studies, even if not recent, were also reviewed for this chapter. Selections were determined based on conceptual coherence, appropriate methodology and data validation.

6.4.2. A role for the family in youth development and employment

In many contexts, the family is central to almost every choice that an individual family member makes. Decisions regarding choice of profession for young people and discussions about job prospects are often held within the home environment and can often be influenced by family expectations and aspirations (Blustein et al., 1997). Family has a strong impact on shaping adolescent career development, occupational plans and attitudes toward job success (Steinberg, 2004).

The literature review shows that family factors, such as parental work legacy, parental education, household income, nationality and location, play an essential role in youth labour market transitions (Ekhaugen, 2009; Hadjivassiliou et al., 2015). Some researchers maintain that the experience of parents shapes the opportunities of their children through the transmission of resources and cultural capital (Warmuth et al., 2014). It has also been reported that parental support positively predicts career interest and career decisionmaking among adolescents (Ferry et al., 2000; Paa & McWhirter, 2000; Turner & Lapan, 2003). Some argue that parents have the biggest influence on their children's future educational and vocational choices (Khasawneh, 2010). Youth who generally perceive their parents as supportive are more likely to consider work an important part of their life, seek leadership positions in their chosen field, and expect to be successful in their chosen career (Kenny et al., 2003).

Families can support young people during labour market transitions and influence their employment prospects in a variety of ways. These can include sharing resources in the form of co-residence, financial resources and transfers (Heath & Calvert, 2013), housing, time and emotional support. These forms of support can differ by country, socio-economic situation and gender, among other variables (Ayllón, 2015;

Blossfeld et al., 2005; Nazio, 2008).[23] When jobs are scarce, parents can become a particularly valuable factor in getting a job (Berloffa, Modena & Villa, 2011). According to Swartz et al. (2011), parental support can be temporary support that contributes to human capital accumulation or other major goals of social status attainment, for example, university financial support (Henretta et al., 2012; Kalenkoski & Pabilonia, 2010) or help to purchase housing (Kurz & Blossfeld, 2004). In many contexts, parents are inclined to help adult children in need where they can (Wightman et al., 2012).

Whiston and Keller (2004) found that adolescent career development is influenced by two interdependent family contextual factors: (1) family structural variables such as parental education, occupation and socio-economic status; and (2) family process variables such as family relationships, parental aspirations and family support (Newman, 2005). Youth from higher-status backgrounds often aspire to higher-status or more prestigious occupations (Fouad & Brown, 2000) and have higher occupational expectations (Rojewski & Kim, 2003). Furthermore, since much education takes place in the home, youth who have well-educated parents may have advantages in finding and keeping jobs over peers who have the same amount of formal schooling (Rees & Gray, 1982).

One possible explanation for the effect of family structural factors on career development, beyond parents' education and occupational attainment, is differential access to relational resources (Lindstrom et al., 2007). Parents of higher socio-economic status are also more likely to provide instrumental assistance such as job leads and career information. This is in contrast to young adults from lower-status families who may be provided with less support and experience a greater number of relational disruptions and less structured involvement from parents in the career development process (Blustein et al., 2002). Drawing on extensive qualitative data, Aryeetey et al. (2013) explored the reasons behind young people's choice of apprenticeship type in Ghana, demonstrating the important influence of the financial situation within the home since training costs and capital needed to set up in business vary considerably by apprenticeship. For many young people, an overriding consideration was how to finance their training, and many traced their difficulties in doing so to the challenging circumstances of their parents or guardians.

Yet, overall, family process variables appear to have a more powerful influence on career development than family structural variables (Whiston & Keller, 2004). These findings support previous research that pointed out that patterns and quality of family interactions, including parenting style and parental attitudes, influence adolescent vocational identity development and affect their interests, goals and values related to career planning (Aryeetey et al., 2013; Penick & Jepsen, 1992; Young & Friesen, 1992). Turner and Lapan (2002) found that perceived parental support is a significant predictor of career self-efficacy among adolescents in the general population.

A key component of family process is family interactions. An earlier study by Young et al. (1988) examined the specific behaviours and activities occurring within the family context that affect career decision-making. When asked about activities they used to assist in adolescent career development, a sample of 207 parents reported that the most critical interpersonal interactions they provided were helping and protecting, affirming and understanding, and watching and managing (Young et al., 1988). Additional evidence points to the importance of intentional career-related activities undertaken by parents. Blustein et al.'s (2002) qualitative analyses found that young adults from high socio-economic backgrounds were particularly helped by parental encouragement of career exploration, guidance in career planning, and the provision of relevant job leads.

23 Evidence suggests that financial transfers from parents to their adult children are less likely to take place but are more intense (i.e., involve larger amounts) in Southern Europe than in the Nordic countries (Albertini & Kohli, 2013). Financial transfers have different aims and meanings across the countries. In Southern Europe, parents support their children mainly through co-residence, and little economic support passes the walls of the house. In the Nordic countries, in contrast, parent–child co-residence is non-normative. Children leave the parental home early and then receive direct and explicit help from them. The continental European countries fall somewhere in between these two extremes.

Setting aside positive family factors, there are also indications that family problems can be essential predictors of youth unemployment. These problems include parental divorce, parental unemployment, low parental education level, and a low degree of parental affective involvement. Several studies have found that adults who experienced parental divorce as children tend to have lower socio-economic attainment, including in the labour market, and greater marital instability, when compared with those who grew up in continuously intact families (McLanahan & Sandefur, 1994). Parental divorce can also have negative effects on adolescent attitudes and behaviour (such as self-presentation), which has implications for getting and keeping a job. Similar to divorce, parental unemployment can affect adolescents (Derks et al., 1996). The consequences for young adults may be particularly serious when both parents have had less education and are unemployed. Unemployed parents tend to have smaller and less varied social networks than employed parents, which can diminish access to employment information or opportunities and weaken young people's position in the labour market (de Goede et al., 2000). Recent growth in long-term unemployment for certain categories of youth has been attributed to 'inheritance' from their parents, who had experienced unemployment in previous recessions, which in turn exacerbates pockets of generational disadvantage for some young people (O'Reilly et al., 2015).

Parental unemployment can become an 'unintended legacy' for young people, depending on where they live and how the economy around them has changed (Ekhaugen, 2009; Headey & Verick, 2006; Macdonald, Shildrick & Furlong, 2013; Macmillan, 2014). This approach attributes intergenerational unemployment to factors such as poor role models and transmission of certain attitudes towards employment and welfare dependency (Wilson, 1987). The concentration of unemployment within the family also has implications for the level of poverty experienced by unemployed youth (de Graaf-Zijl & Nolan, 2011).

In fact, there is a general consensus in the literature on the existence of a positive correlation between the worklessness of parents and their children (Corak et al., 2004; Bratberg et al., 2008; Oreopulos et al., 2008; Ekhaugen, 2009; Macmillan, 2013; Gregg et al., 2012; Mäder et al., 2014; Zwysen, 2015).[24] For example, using the 2011 European Union Statistics on Income and Living Conditions ad hoc module on intergenerational transmission of disadvantages, Berloffa, Matteazzi and Villa (2016) examined the extent to which family background affects youth labour market outcomes, focusing on young adults aged 25–34 years. The empirical findings provide evidence of an intergenerational persistence of worklessness and the positive role of parental employment in explaining youth labour market outcomes. Furthermore, the study shows the relevance of a gender dimension in the intergenerational transmission of jobs and occupations. The mother's working condition during adolescence systematically affects a daughter's probability of being employed in future, while employment of the father generally increases a son's probability of future employment. This is in line with findings of previous research on the intergenerational correlation in labour market participation between fathers and sons (Black & Devereux, 2011) and between mothers and daughters (Fernández, Fogli & Olivetti, 2004; Fortin, 2005; Kawaguchi & Miyazaki, 2009).

When analysing the intergenerational transmission of worklessness, one has to consider that the link between the parent's and young person's unemployment may be explained by the correlation between their observable and unobservable characteristics. Observable characteristics include educational attainments, occupational choice and social networks. Unobservable characteristics – ability, motivation and other non-cognitive traits – may also be correlated across generations, affecting individual labour market outcomes. The intergenerational transmission of worklessness may be an effect of the persistence of certain individual features at the family level or an effect of a causal link between parental unemployment and youth unemployment. Indeed, experiencing parental unemployment may affect an adolescent's attitude towards unemployment status by reducing the stigma associated with worklessness. It may also be that parents who had experienced unemployment had reduced their investments in children's human capital

24 'Worklessness' has a broader meaning than 'unemployment'. The 'unemployed' is used to refer to people who are actively looking for work and available to start work, while the 'workless' can also include people who are out of work and yet are not considered unemployed. For example, people who are caring for children or other family members would be included in the definition of worklessness, but omitted from unemployment statistics.

because of their difficult financial conditions due to unemployment. Empirical evidence for Norway (Ekhaugen, 2009), Sweden (Corak et al., 2004), the United Kingdom (Macmillan, 2010) and Germany (Mäder et al., 2014) shows a positive intergenerational correlation in unemployment, but no clear causal effect. In contrast, Corak et al. (2004) and Oreopoulos, Page and Stevens (2008) found evidence of a causal intergenerational effect in Canada.

In families coping with problems, it is especially important that young people are assured of emotional support. Lack of parental affective involvement can have long-term negative effects on adolescent development, such as in the areas of self-esteem and self-consciousness, which are relevant to the domain of employment. This all highlights the role of family socialization in the behaviour of young people. This interpretation is consistent with several qualitative descriptions of the problems that adult children of divorce experience (Wallerstein et al., 1988). Through the process of socialization, parental divorce and low parental affective involvement may increase the likelihood that children fail to learn adaptive interpersonal skills, such as reaching a compromise and communicating effectively (Amato, 1996). This, in turn, can handicap their job prospects. Of course, there may be alternative explanations. Parents with personality deficits, for example, may pass these characteristics on to their children (for instance, through their child-rearing methods), increasing their risk of unemployment and/or divorce (Amato, 1996).

It should be noted that while problems in the family increase the risk of unemployment, the majority of adult children of divorced, unemployed and/or affectively remote parents do get and continue to hold jobs. Moreover, although several of the correlations in these studies were statistically significant, they were not very large. Parental troubles affect, but certainly do not wholly determine, young people's employment situation (de Goede et al., 2000).

Alongside the impact of parental work legacies on youth employment prospects, the patterns of leaving home have become more diverse, not always reflecting a simple step towards economic independence. Young people leave home for different reasons and, increasingly, intermittently return. Newman (2012) refers to this emerging phenomenon as the 'boomerang generation', responsible for creating 'accordion families' that shrink and expand in relation to these generational movements. But these negative connotations depend on whether this experience of intermittently returning home is seen as a long- or short-term trajectory, and the phenomenon should also be linked to economic status – not all families are able to continue supporting their adult children (O'Reilly et al., 2015).

As youth navigate a labour market marked by insecurity and uncertainty, their ability to deal with rapidly shifting opportunities is strengthened through family support. Hardgrove et al. (2015) observe that as young people experience precarious livelihoods, material support and housing provided by family members is crucial to their ability to transition into and out of precarious work. Without this important foundation in place, the instability and uncertainty of labour market opportunities are unrewarding for many young people, who must also cope with precarious living and family life situations. In short, without a reliable springboard in the form of family support, youth are unlikely to address and take up labour market opportunities that are precarious.

One should also keep in mind that prolonged family support is not without its drawbacks. It may play a role in solidifying, or even exacerbating, economic inequalities and may be a strain for families with few resources. Youth without access to a family which can provide for them during difficult times or when they need further/higher education may find themselves at a disadvantage. In addition, young people's dependency on their family may be prolonged and parents may extend their support further, beyond the labour market transition period. Thus, families are absorbing some of the problems associated with an economy that requires more education but offers less stable employment and lower wages for young people. In any case, what is apparent is the ongoing significance of family, especially in regard to the increasing importance and relevance of intergenerational assistance (Swartz et al., 2011).

6.4.3. Family policy and youth employment

The extent to which family policy can support youth in their employment situation in different national contexts partly depends on the definition of youth. When youth are seen as an extension of childhood – which means being in education (up to secondary level) and financially dependent – parents are still deemed to support them (Chevalier, 2016). Family policy plays an important role in this case, as support to young people can be provided via intra-family redistribution of family benefits as well as tax relief for parents. Such benefits often stipulate age restrictions and conditions on parental income. In the United Kingdom, for example, parents are eligible to receive a tax credit or a means-tested child benefit if a young person is in eligible education or training up to the age of 20. In Belgium, a young person is entitled to a child benefit up to the age of 25, if she or he is in education or an apprenticeship or looking for a job. Similarly, in the Netherlands and Germany, a child benefit can be provided if a young person is still in school or is registered with a public employment service as a jobseeker. In Germany, at time of writing, it can be paid up until a young person reaches 25 years of age, on condition that she or he is undertaking relevant training for an occupation.

On the other hand, when youth are seen as adults, parents are no longer assumed to support their children, and there is little room for family policy. In this case, young people are seen as independent. This is also reflected in the aforementioned child benefits, which are terminated if a young person starts paid work.

Two main observations are made based on the review of experimental literature on family policies and relevant family policy interventions that link family and youth employment (*see Table 6.1*). First, to our knowledge, most family policy interventions are not directly aimed at improving youth performance in the labour market. In fact, most policy interventions for youth employment fall under labour market policy and, where appropriate, under youth policy, and there are few or no linkages with family policy. This is despite the research evidence showing the importance of the family, parental factors and home environment in youth development and employment, as discussed in the previous subsection. Second, in situations where countries do implement policies and programmes that link family and youth employment, rigorous and systematic evaluation of these interventions is generally lacking. Evaluation studies have mainly focused on the effectiveness of labour market policies in improving employment outcomes of specific population groups, including youth, or on the impact of family policies such as family benefits on reducing poverty (in its multiple dimensions, including health and education) and increasing the living standards of families and family members.[25]

Nonetheless, it has been possible to identify several studies that evaluate family policy interventions aimed at improving youth performance in the labour market. These interventions are related to: (1) foster care programmes that help young people to transition out of foster care and start an independent, self-sufficient life, including through their engagement in productive activities; and (2) CCT programmes that seek to strengthen human capital of young people as a means to break the intergenerational cycle of poverty, including through their participation in the labour market.

25 For a review of evaluations of active labour market policies (ALMPs) and their impact on young people, see, for example, O'Higgins (2017).

Employment support for youth leaving foster care

Many studies highlight generally poor employment outcomes for youth transitioning out of foster care. Across the existing literature, youth who have left foster care are found to have less stable employment and lower earnings than youth in the general population (Dworsky, 2005), and many of these trends persist into early adulthood (Courtney et al., 2011; Pecora et al., 2006). Employment programmes that provide effective career development, employment training and job placement services for youth in care as well as for those who have exited it, are therefore particularly important to help address the challenges that foster youth face. Yet, little is known about what kind of programmes and which programme components are most effective in this area (Fernandes-Alcantara, 2016). A study by Zinn and Courtney (2015) used random assignment to evaluate the impact of an employment assistance programme for foster youth on the rate of employment, income and other outcomes among adolescents in substitute care in Kern County, California, United States. They found limited positive effects on the performance of young people in the labour market, with no statistically significant impacts of the evaluated programme on any measured employment outcome. Similarly, an experimental study by Stewart et al. (2014) observed persistent low rates of employment and earnings for foster youth in North Carolina, United States, who continue to struggle up to the age of 30. As youth in foster care often benefit from multiple forms of support, it is important to supplement employment services with other components such as education, housing and transportation subsidies, as part of a comprehensive package to ensure that all foster youth needs are met (Edelstein & Lowenstein, 2014).

Table 6.1 Evaluation of family interventions for youth employment

Authors	Family intervention description	For whom?	Where? What level?	How is it evaluated?	What are the results?
Zinn & Courtney (2015)	Employment assistance programme	Eligible young people aged 16 years and older in foster care	United States, county level	Random assignment evaluation using data collected via multi-wave, in-person interviews of 254 foster youth.	No statistically significant impacts on any measured employment outcome.
Stewart et al. (2014)	Welfare support	Eligible young people who have transitioned out of foster care	United States, state level	Evaluation using child welfare, wage and public assistance administrative data. Statistical analyses include bivariate, multivariate and trajectory models.	Low rates of employment and earnings persisted up to the age of 30.
Behrman et al. (2011)	PROGRESA/ Oportunidades conditional cash transfer (CCT) programme	Families with children	Mexico, rural areas	Experimental and non-experimental estimators based on groups with different programme exposure.	Positive impacts on increases in work for older girls, and on shifts from agricultural to non-agricultural employment.
Rodríguez-Oreggia & Freije (2012)	PROGRESA/ Oportunidades CCT programme	Young people aged 14–24 years	Mexico, rural areas	Multi-treatment methodology for different time exposure to the programme, using data of the selected age cohort from the 2007 wave of the Rural Households Evaluation Survey.	Limited positive impacts on employment, wages or intergenerational occupational mobility.

Further examples of existing foster care schemes that, among other services, provide assistance to obtain employment and training in relevant skills include the Chafee Foster Care Independence Program (formerly known as the Independent Living Program) in the United States, and the Leaving Care policy and the Transition to Independent Living Allowance in Australia. The Transition to Independent Living Allowance, for example, provides a one-off allowance of A$1,500 to eligible young people aged 15–25 years who are about to, or have already, exited formal or informal care, to help them transition to an independent life.[26] The Leaving Care policy ensures that youth leaving foster care receive the necessary support in accessing employment and social services.[27] To our knowledge, these interventions have not yet been rigorously evaluated.

Conditional cash transfers and youth employment

One of the most widely known CCT schemes is the PROGRESA/Oportunidades programme in Mexico, which has been in operation in the country since 1997. It provides cash transfers to families living in extreme poverty, conditional on school attendance by children and health clinic visits by children and adults, and gives nutritional supplements to pregnant women and small children. While the main objective of Oportunidades (as for many other CCT programmes in the region) is to break the intergenerational transmission of poverty, the implication is that better nutrition, health and education levels will improve the capacity of beneficiaries to engage in more productive activities in the labour market, increasing their earnings and eventually enabling them to move out of poverty. Despite the fact that Oportunidades has been evaluated numerous times, only a few studies have assessed the long-term effects of the programme on labour market performance of young people, with mixed findings. Using experimental and non-experimental estimators based on groups with different programme exposure, an evaluation study by Behrman et al. (2011) found positive impacts of Oportunidades on labour market participation, seen in increases in work for older girls and shifts from agricultural to non-agricultural employment. In contrast, a study by Rodríguez-Oreggia and Freije (2012), using a module for the population aged 14–24 years in the 2007 wave of the Rural Households Evaluation Survey and applying a multi-treatment methodology for different time exposure to the programme, showed that after 10 years of implementation of the programme, the impact on employment, wages and intergenerational occupational mobility among this cohort in rural areas in 2007 was rather limited. The authors conclude that the impact of CCTs on employment and wages of beneficiaries depends not only on accumulation of human capital, but also on labour market conditions and opportunities of the locality where participants live.

When interpreting labour market impacts, one should bear in mind certain limitations. One of these is that, in most cases, beneficiaries have yet to transition out of school to the labour market, or have only recently started to work; thus, the impact of an intervention on their performance in the labour market is difficult to assess due to the trade-off between additional schooling and limited work experience (Molina-Millan et al., 2016). Another important limitation is the availability of reliable data on labour force participation in the informal sector, which accounts for a significant share of employment in each region, including among youth (ILO, 2015).

26 https://www.dss.gov.au/sites/default/files/documents/trans_to_ind.pdf

27 https://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Leaving%20Care%20Policy.pdf

6.5. Family policy and meeting SDG 8: Summarizing the evidence

As the literature review shows, youth unemployment negatively affects young people and their families. In addition, it has serious implications for the wider economy, through reduced outputs and tax revenues and untapped human capital (Garcia & Fares, 2008).

Policy interventions to generate youth employment tend to adopt the following approaches: increasing economic growth to broaden opportunities for employment; increasing youth capabilities through education and skills training; and making labour market interventions to promote youth employment. Policies are typically introduced to strengthen or create labour market institutions that help young people to access jobs, promote entrepreneurship and direct the training of youth towards market needs (Gough et al., 2013).

Scaling up investments in decent jobs for youth is argued to be the best way to ensure that young people can realize their aspirations and actively participate in society (ILO, 2015). Such an approach is also an investment in the well-being of families, society and inclusive and sustainable development. Nurturing today's youth can be done by investing in their education; supporting lifelong learning and training opportunities that facilitate adjustments to technological and labour market changes; and providing them with social protection and employment services. Specific policy measures include employment services, job search assistance, vocational programmes and apprenticeships, skills training programmes, mentoring/coaching support, career advice and counselling, and cash transfer programmes in developing countries. In India and Uganda, CCTs have provided resources for funding job searches and for supporting high-quality training and skills development, while also increasing access to other sources of credit for entrepreneurship (UNDP, 2015).

Income support is critical during the period of youth labour market transition. At this time, many young people have no income from paid employment, as they are either in education or have no job. Therefore, it is important to provide social benefits that young people can claim when not employed. These include education-related benefits such as grants and loans, family allowances and tax relief for families. Universally accessible grants are provided in Denmark to support young people's living standards. The United Kingdom provides loans to facilitate the economic independence of further/higher education students, making it possible for many young people to leave the parental home while completing their education. In addition, social assistance in the form of unemployment benefits can make finding a job affordable and reduce young people's worries about income poverty associated with unemployment. Housing benefits may be of high importance for unemployed youth who find a job in an area far away from the parental home. Similarly, tax credit programmes may play a significant role in complementing the earnings of low-qualified youths in their first job.

In addition to ensuring decent jobs and income support for parents and their adult children, it is important to inform and educate families about a variety of employment options and opportunities, the skills they need to be successful in the workplace, and the range of vocational and on-the-job training programmes available. This can help to broaden the array of career options for consideration and expand young people's career aspirations.

Furthermore, parental leave policies that facilitate the return-to-work transition and the work-and-family balance are crucial in tackling gender differences in unemployment. These policies include paid and job-protected parental leave combined with institutional childcare availability; support for flexible forms of work (such as part-time work, flexible working hours, or working from home); and measures that help to mitigate the consequences of leave-related skills depreciation (e.g., training or re-qualification programmes designed for women returning to work after childbirth).

While the issue of youth unemployment cannot be abstracted from economic growth, the labour market and education, what should not be overlooked in policymaking is the role of families and family policy in shaping youth employment prospects and outcomes. Available evidence from research studies calls for family policy interventions that address both youth and parental unemployment. One of the main objectives of such policy interventions should be to break the intergenerational transmission of disadvantages. Helping parents to be in paid work will contribute not only to the economic well-being of their adult children, but may also positively affect young people's attitudes, behaviours and labour market outcomes. Despite existing evidence on the importance of families, and parents in particular, in young people's labour market transition and career development, policymakers pay little attention to family policies and programmes when considering youth unemployment.

A strategy to combat youth unemployment should combine policies aimed at both the demand- and supply-side of the economy in question. Training and skills development are essential but insufficient conditions for employment-intensive growth; better results are usually achieved in an environment that promotes overall growth. A synergy of complementary macroeconomic labour market policies, social protection policies and family policies is needed to move towards improved employment outcomes for youth.

The overarching objective to achieve youth employment, of sufficient quantity and quality, needs therefore to be embedded within a more comprehensive framework – one that provides youth and their families with economic security, social protection and adequate resources. Addressing youth unemployment requires a holistic approach that combines an analysis of changes in the economic sphere around labour market flexibility, skills attainment and employer demand, with an understanding of the impact of family legacies in creating increasingly polarized trajectories for today's youth. The success of policy initiatives and investments will be shaped by national actors' ability to effectively implement such a rounded approach (O'Reilly et al., 2015).

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CHAPTER 7.

FAMILIES AND SUSTAINABLE DEVELOPMENT GOAL 16: ENDING VIOLENCE

Chapter 7. Families and Sustainable Development Goal 16: Ending violence

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7.1. Introduction

The United Nations (2018) policy statement on why freedom from fear and violence is important to achievement of the SDGs states: "Violence, in all its forms, has a pervasive impact on societies. Violence affects children's health, development and well-being, and their ability to thrive. It causes trauma and weakens social inclusion.… Peaceful, just and inclusive societies are necessary to achieve the Sustainable Development Goals (SDGs). People everywhere need to be free of fear from all forms of violence and feel safe as they go about their lives whatever their ethnicity, faith or sexual orientation."

The pervasive effects of violence, and costs to the individual and to societies globally, underline the need for effective social policy to primarily prevent violence and, where necessary, treat cases where they are found. This chapter outlines evidence from the literature on family policies and interventions that can assist with achieving SDG targets related to the prevention of violence. Before doing so, it underlines how violence affects all countries – rich and poor – by presenting rates of violent discipline of children, and rates of intentional homicide across the world.

The chapter is structured as follows. Section 7.2 reviews how references to ending violence are relevant across a number of SDGs and targets and looks at key points in the ending violence discourse related to types of violence (and their interrelation), where violence occurs, and existing frames for violence prevention. Section 7.3 introduces and critiques two indicators on the prevalence of violence globally respectively related to Target 16.1 on violent discipline of children and Target 16.2 on intentional homicide. Section 7.4 introduces the literature review and discussion of how family policies and interventions – such as parenting programmes and family-focused school or community interventions – can contribute to the achievement of SDG 16. Section 7.5 summarizes and concludes.

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7.2. 'Ending violence' in the SDGs

A number of targets in the SDGs relate to safety and elimination of violence. These are found under SDG 16 (Targets 16.1, 16.2 and 16.9), SDG 3 (Targets 3.4 and 3.5) and SDG 4 (Target 4.a).

Specifically, the targets relevant to SDG 16 are:

16.1 Significantly reduce all forms of violence and related death rates everywhere

16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children

16.9 By 2030, provide legal identity for all, including birth registration

The importance of implementing concrete strategies to facilitate the achievement of these and other SDG targets relating to violence prevention is clear not only when considering both the personal toll on victims but also the economic costs to society.

For instance, one estimate of the total economic impact of all forms of violence and conflict on the global economy comes to $13.6 trillion, or 13.3 per cent of world GDP (Institute for Economics and Peace, 2016). In regard to specific forms of interpersonal violence, a 2005 report to the United Nations suggests that the best estimate of the economic cost of violence against women, per country, is somewhere between $1 billion and $8 billion annually (Day, McKenna & Bowlus, 2005).

Similar costs are estimated in relation to violence against children. For example, in Australia, a country of about 25 million people, A$4.3 billion was spent on child protection, out-of-home care services, family support services and intensive family support services in the 2014/15 fiscal year (Child Family Community Australia [CFCA], 2018). In explaining this estimate, CFCA (2018) stated:

> "…the consequences of child abuse and neglect can affect social cohesion and result in considerable costs and ongoing government expenditure (Segal, 2015). Consequences such as educational failures, premature death and low workforce participation can lead to a considerable reduction in the productive potential of society and a lower gross domestic product (Segal, 2015). Taking costs such as these into account, a number of researchers have sought to estimate the long-term financial costs of child abuse and neglect in Australia. Taylor and colleagues (2008), for example, estimated that the annual cost in 2007 of child abuse and neglect for all people ever abused in Australia was $4 billion; while the value of the burden of disease – a measure of lifetime costs of fear, mental anguish and pain relating to child abuse and neglect – represented a further $6.7 billion. The report also estimated that the lifetime costs for the population of children reportedly abused for the first time in 2007 would be $6 billion, with the burden of disease representing a further $7.7 billion."

Given the significant body of research showing that poorly treated parental mental ill health and substance misuse are significant risk factors for violence against children (i.e., child abuse and neglect), other relevant targets in the SDGs are found under SDG 3:

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

And finally, a supporting action under SDG 4 related to freedom from violence, is to:

4.A Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all

One of the challenges in considering policies, programmes and other services or community interventions for violence prevention is the broad range of distinct types of interpersonal violence to be addressed. Indeed, although many countries have explicit policies and action agendas to address violence against women and children (due to prevalence data showing the disproportionate burden of disease borne by them), it must be acknowledged that men too are victims of interpersonal violence – though not at the same rates or in the same contexts as women and children (Webster & Flood, 2015).

In the same way, diverse types of families present various levels of risk in terms of violence and opportunities for ending violence. Domestic violence, and forms of violent discipline against children, occur in the family unit, and are influenced by a range of factors, including parenting practices and parental issues related to stress and drug and alcohol abuse (issues covered in SDG Target 3.5). One clear route towards preventing interpersonal violence, and addressing the needs of all families, is to reduce these stressors as early as possible, which means seeing families – and understanding their lives, environments, knowledge, and attitudes to parenting practices – independent of wealth or education. Poverty has long been associated with child protection issues, and it stands to reason that in a family with existing violence risks the increased stressors of poverty may further accentuate risk, but direct causal evidence on poverty and increased violence is not forthcoming.

Given that families (including new partners of parents) can be involved in perpetrating violence, it is rational to see family-based treatment, or a focus on family policy, as a key pillar to ending violence in all societies globally. For all people, violence can also occur outside of the family (in school, at work, in the local community – indeed wherever human interaction occurs). Families also have a role in this context, both in supporting victims of violence and in setting social norms regarding the unacceptability of violence in the family and in the wider community.

Clearly, violence against the person is a serious violation to be addressed in its own right, and it should be addressed even if positive spillovers into other life outcomes were not so readily seen. That said, if family policy interventions designed to lower rates of interpersonal violence and set community standards are effective, they can bring about direct improvements to health (mental and physical), education, quality of local environments, and much more.

Relationship between interpersonal victimization types

Although from the perspective of interventions and evaluations it may be more convenient and conceptually 'cleaner' to focus on individual types of violence, it is now widely acknowledged that the issue of intersectionality is paramount and must be considered both when trying to understand the causes and consequences of violence and when devising possible points of intervention or prevention. (For an overview of concepts such as poly-victimization, multi-type maltreatment, and adverse childhood experiences, which show the high degree of overlap between children's and young people's experiences of interpersonal violence, see: Finkelhor, Ormrod & Turner, 2009; Price-Robertson, Higgins & Vassallo, 2013.)

Furthermore, studies on re-victimization over the life course show that individuals who have once been victimized suffer a higher risk of subsequent victimization – regardless of the type of violence experienced (e.g., Wittebrood & Nieuwbeerta, 2000). Understanding the co-occurrence of different types of violence is important in understanding their impact. For example, in their systematic review of poly-victimization among children and adolescents in resource-constrained countries, Le et al. (2016) found rates of violence and victimization much higher than in more affluent settings, and confirmed the strong relationship between poly-victimization and mental health problems.

Understanding the different types of violence is also important in terms of prevention – and the potential for policies or programmes to achieve multiple benefits by addressing a broader range of violence types. Often, multiple risk factors can be mitigated – and multiple protective factors enhanced – through the same intervention (Toumbourou et al., 2017). Thus, when considering policies that could assist with achieving SDG targets relating to violence prevention, it is appropriate to look holistically at the efficacy of interventions to prevent interpersonal violence in its broadest sense.

Another challenge to an evidence-based approach to policies and programmes to support prevention of interpersonal violence is the lack of depth in psycho-social research relevant to the field. Such research requires thorough examination of the effectiveness of strategies, which range from individual therapy for those at risk of perpetrating interpersonal violence to population-level strategies to address structural drivers that enable and excuse violence.

Where does interpersonal violence typically occur?

The most common setting for interpersonal violence is in the context of the family home. Literature on violence against women shows that the greatest risk is in the home or from partners/ex-partners. Child maltreatment literature tells the same story – that children are at greatest risk of harm from their parents or caregivers. But recently there has been a focus globally on risks to children in organizational settings, both historically in places like orphanages (or children's homes) and in the vast array of youth-serving organizations that now proliferate in high-income countries (Higgins, Kaufman & Erooga, 2016). For example, in Australia, a five-year investigation by the Royal Commission into Institutional Responses to Child Sexual Abuse has recently concluded;[29] and many other anglophone western democracies have held inquiries into aspects of abuse within government organizations, churches, hospitals and other institutions (e.g., the Inquiry into Historical Institutional Abuse in Northern Ireland between 1922 and 1995). [30]

29 See www.childabuseroyalcommission.gov.au. See www.childabuseroyalcommission.gov.au and https://safeguardingchildren.acu.edu.au

30 See: https://www.hiainquiry.org. For a list of reviews of other recent enquiries inquiries into child sexual abuse conducted in the decade 2002–2013 in the United Kingdom, Ireland, United States, Canada and New Zealand, see: https://aifs.gov.au/cfca/institutional-child-sexual-abuse-inquiries-2002-2013.

Analysis of risk factors suggests that those organizations that are most similar to a family setting also carry the highest risk of abuse occurring. This risk is due to the presence of factors that can be used to build the trust of a potential victim, overcome obstacles and excuse behaviour or prevent its observation by other, potentially protective adults (Kaufman et al., 2016).

For example, in Australia, it is estimated that in one state alone, Victoria, there are up to 50,000 separate organizations serving the child and adolescent population of about 1.3 million young people under 18 years of age. (Implementation of the Child Safe Standards is now a legislative requirement in Victoria, across early childhood services, education and care, recreation/leisure, sports, arts, culture, health, welfare, justice, religious and other youth-serving sectors.) This highlights that the focus of effective violence prevention strategies needs to be incredibly broad, to address risks not only in the home and in family structures, but also in organizations providing services to children, youth and families, and in the broader community (where attitudes towards, and the value placed on, children and women are acknowledged as important determinants of violence; see Webster & Flood, 2015).

Given the concentration of violence in the home, and in relation to children, and the risks of maltreatment due to poor parenting (e.g., lack of supervision; poor knowledge of, or efficacy in implementing, non-violent positive parenting practices), parenting skills training represents an important group of interventions (Prinz et al., 2009). The problem is, however, that when a programme is offered selectively to groups, those who need it most are seldom the ones who attend (Sanders, Higgins & Prinz, 2018).

As Prinz et al. (2009) have noted, few violence prevention strategies are offered in a truly population-based manner, and based on the current review, it would seem that the authors' trial in the United States is the only evidence of a whole-of-population tiered intervention (and in a reasonably large geographic area). Additionally, to best demonstrate the effectiveness of a parenting strategy or programme in reducing the likelihood of children being subjected to violence by their caregivers, its evaluation would need to be based on national measurement of drivers of/protective factors for parenting skills. For example, when families come to the attention of statutory child protection authorities, common risk factors for child maltreatment that are seen are: poorly treated mental illness, drug and alcohol problems, and broader family violence (Higgins & Katz, 2008, 2011). To prevent the need for children at risk to first have to come to the attention of authorities, however, it would be important to know where these negative family environments (and hence poor parenting capacities) exist at the population level (Mullan & Higgins, 2014). Similarly, to prevent interparental or other interpersonal violence, data would be needed on the risks and protective factors within relationships that interventions such as respectful relationships programmes try to address. Such data are not currently available worldwide.

Existing conceptual frameworks for violence prevention

To create and support conditions of safety, prevention efforts need to be focused on addressing the preconditions that facilitate interpersonal violence, based on a conceptual understanding of the causal and contributing factors (such as enablers or determinants) at each of the levels of the socioecological model (e.g., as set out by Urie Bronfrenbrenner) – i.e., individual, family, community, society (Quadara & Wall, 2012; Walden & Wall, 2014). Interpersonal violence is a complex phenomenon that is linked not only to external and objective factors, but also to a number of psychological, behavioural and socio-economic issues, making it difficult to identify its determinants.

In a number of developed countries, jurisdiction-wide strategies and funding schemes have prompted considerable research, building the evidence base explaining the leading causal factors and strategies for addressing the problems of interpersonal violence. In addition, organizations such as the United States Centers for Disease Control and Prevention (CDC, 2014; Fortson et al., 2016), the United Kingdom's NSPCC (National Society for the Prevention of Cruelty to Children), and public health advocacy initiatives like

Australia's VicHealth (Victorian Health Promotion Foundation) have outlined the nature and causes of interpersonal violence, and evidence-based strategies for addressing its different types.

Through its National Framework for Protecting Australia's Children 2009–2020, Australia outlined an ambitious, long-term approach to ensuring the safety and well-being of its children. Its aim was for a substantial and sustained reduction in levels of child abuse and neglect.[31] Australia also offers examples of key strategies and organizations relating to ending violence against women, including: the National Plan to Reduce Violence against Women and their Children 2010–2022; Our Watch; and VicHealth.[32]

The Change the Story framework for action published by Our Watch identifies 10 actions to prevent violence against women based on an extensive review of the research literature.[33] The first five actions, targeted at the gendered drivers of violence, are to:

- Challenge condoning of violence against women.
- Promote women's independence and decision-making in public life and relationships.
- Foster positive personal identities and challenge gender stereotypes and roles.
- Strengthen positive, equal and respectful relations between and among women and men, girls and boys.
- Promote and normalise gender equality in public and private life.

Five further actions, to address the violence-reinforcing factors identified by Our Watch, are to:

- Challenge the normalisation of violence as an expression of masculinity or male dominance.
- Prevent exposure to violence and support those affected to reduce its consequences.
- Address the intersections between social norms relating to alcohol and gender.
- Reduce backlash by engaging men and boys in gender equality, building relationship skills and social connections.
- Promote broader social equality and address structural discrimination and disadvantage.

Many researchers have noted the particular vulnerability to interpersonal violence in communities of First Nations peoples affected by colonization and its associated impacts (i.e., dispossession; dislocation and disconnection from land, family, community and culture; and the ongoing legacy of intergenerational trauma). Similar themes have emerged in Canada, the United States, New Zealand and Australia, where indigenous peoples suffer significantly higher rates of interpersonal violence – particularly family violence and child maltreatment, widely acknowledged to be affected by the intergenerational trauma of dispossession and cultural dislocation in the context of ongoing economic and social disadvantage and discrimination (Closing the Gap Clearinghouse, 2016).

31 See: https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/protecting-children-is-everyones-business.

32 https://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022; www.ourwatch.org.au; and www.vichealth.vic.gov.au/our-work/preventing-violence-against-women.

33 See: https://www.ourwatch.org.au/What-We-Do/National-Primary-Prevention-Framework

Although the depth of research and conceptual work in the area of interpersonal violence is positive, there remain considerable gaps in the research as well as variability in some key areas. For example, there is variability in how closely interventions focus on seeking to achieve violence prevention, given the complexity in defining targeted behaviours (i.e., interpersonal violence). There is also variability in the degree to which interventions acknowledge and address the intersectionality of causal factors, and the opportunities to address them holistically in the intervention. Some interventions target more distal factors seen as underlying drivers of interpersonal violence (such as gender inequality, a recognized yet distal determinant of domestic violence perpetrated against women) while others target the proximal relationship between lack of knowledge of, and self-efficacy in, use of non-violent discipline techniques and the physical abuse of children. Given these challenges, few violence prevention programmes or intervention strategies are based on an explicit programme logic or 'theory of change'. The absence of agreed processes (and hence targets for intervention) makes it challenging to evaluate and make comparisons across interventions.

7.3. Data review: Global estimates of interpersonal violence

Two indicators of interpersonal violence offer relatively well-populated global data across developed and developing nations: proportion of children aged 2–14 years who have experienced any violent discipline; and intentional homicide rate. These are drawn respectively from two global collections of series data: (1) the global UNICEF Multiple Indicator Cluster Surveys (MICS) programme (indicator on violent discipline against children); and (2) the United Nations Office on Drugs and Crime (UNODC) International Homicide Statistics database (indicator on intentional homicide rate).

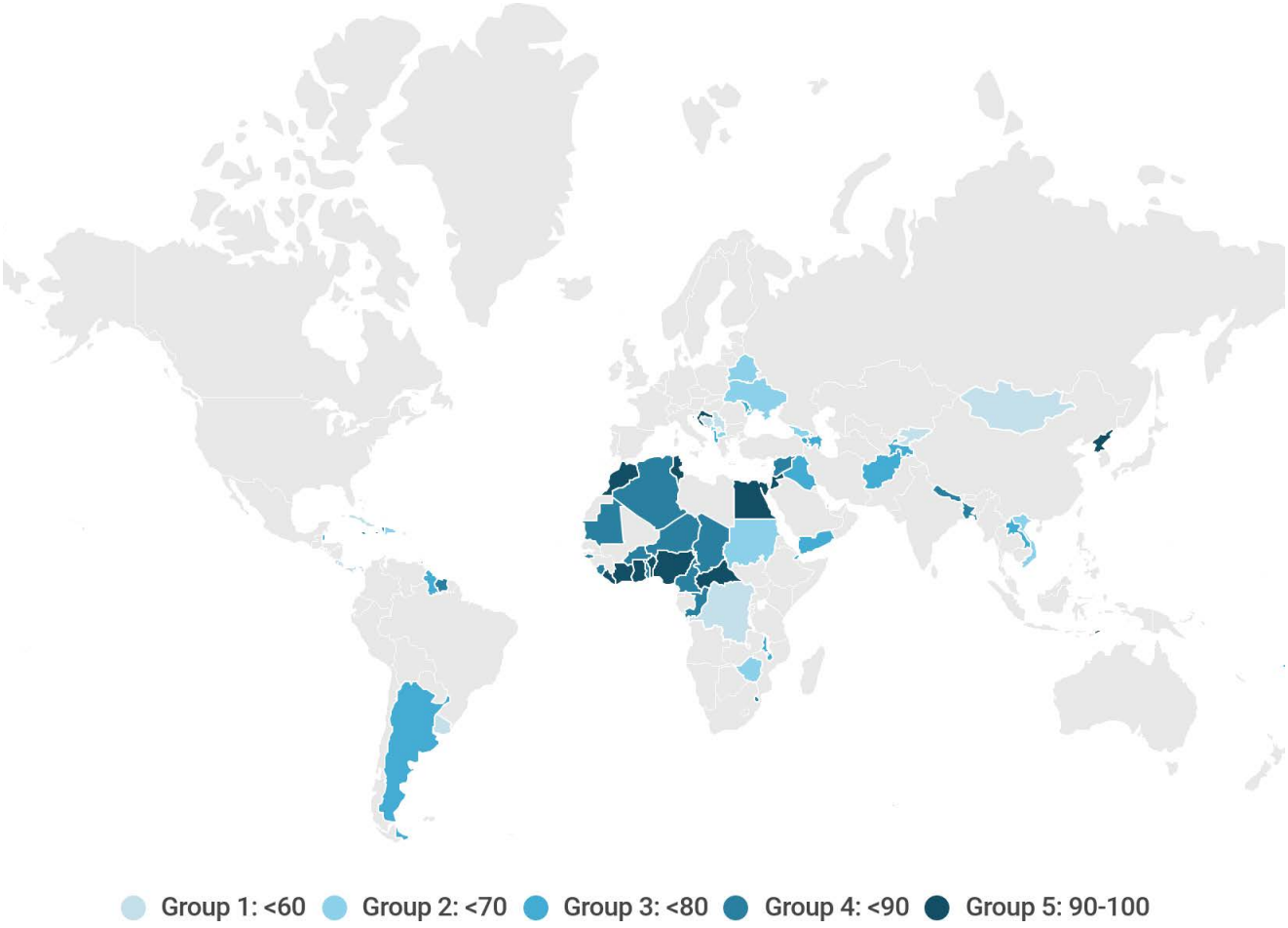
Proportion of children aged 2–14 years who have experienced any violent discipline (2010–2015)

The first global data indicator is the proportion of children aged 2–14 years who have experienced any violent discipline (psychological aggression and/or physical punishment) during the period 2010–2015 (*see Map 7.1 and Annex 7.1*). The UNICEF Data and Analytics Section compiled this series using data from international surveys (Demographic and Health Surveys [DHS] and MICS) and other nationally representative surveys.[34] Data were collected during face-to-face interviews in carefully selected nationally (or sub-nationally) representative samples of households.

Most children across the globe are exposed to violent discipline – some 60–90 per cent of children are affected in most countries where data are available. However, there are notable data gaps (across all years) for many countries, including Australia, Canada, New Zealand, the United Kingdom, the United States as well as most Asia-Pacific countries and, indeed, many other European countries (*see Map 7.1*).

34 Info: https://www.unicef.org/ceecis/overview_regional_issues_7616.html

Map 7.1. Proportion (%) of children aged 2–14 years who have experienced any violent discipline, 2010–2015



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: UNICEF global databases (2016), based on DHS, MICS and other nationally representative surveys.

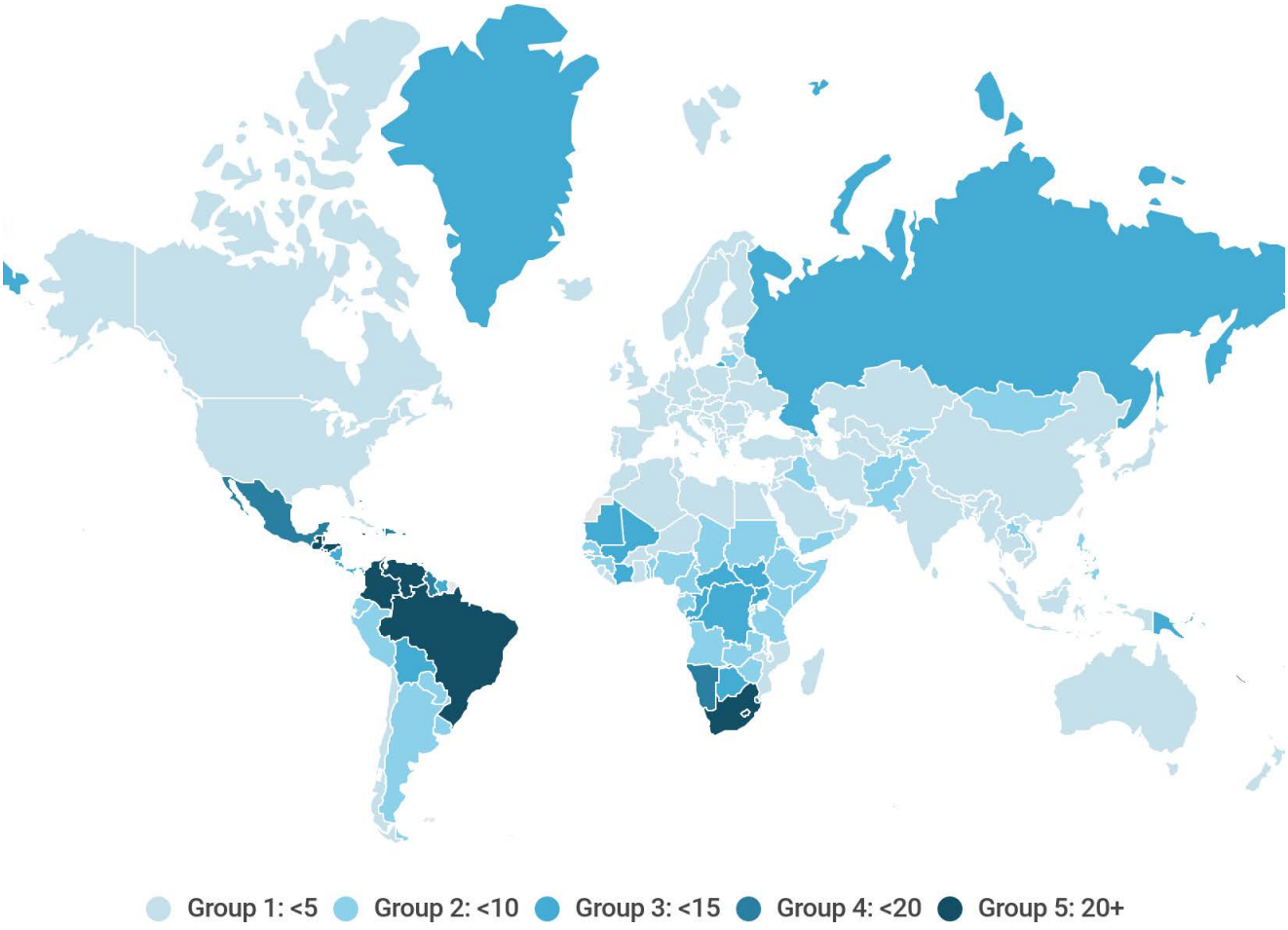
Within countries, when data are compared by particular characteristics, very few differences emerge. This is true for gender, with girls and boys in most countries appearing to be similarly exposed to interpersonal violence (*though see also Annex 7.1*); urban vs rural location; and household wealth (little variation across quartiles). There are a few exceptions, where rates of violent discipline are higher (i.e., gap of more than 5 percentage points) for boys than girls (in Albania, Barbados, Bosnia and Herzegovina, Georgia, Jamaica, Kyrgyzstan, Montenegro, Qatar, Saint Lucia and Viet Nam – with the biggest differences seen in Ukraine and Costa Rica, each of which shows a gap of 13 percentage points). In no country with available data are rates of violent discipline higher for girls, which is in stark contrast to other measures of interpersonal violence, particularly sexual violence, where girls are at greater risk (Webster & Flood, 2015).

As the available data are not time series data, it was not possible to look at changes in rates over time.

Number of victims of intentional homicide per 100,000 population (2015)

The second global data indicator is the intentional homicide rate per 100,000 people (*see Map 7.2 and Annex 7.2*). Data on intentional homicides are estimates of unlawful homicides purposely inflicted as a result of domestic disputes, interpersonal violence, violent conflicts over land resources, inter-gang violence over turf or control, and predatory violence and killing by armed groups. Intentional homicide does not encompass all intentional killing; the differentiator for inclusion (or not) is usually the organization of the killing. The intentional homicide statistic measures injuries and fatalities resulting directly from violence, including assaults (beatings, abuse, burnings) and armed violence, but not from accidents or self-inflicted injuries, expressed in terms of a unit per 100,000 population.

Map 7.2. Number of victims of intentional homicide (per 100,000 people), 2015



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: United Nations Office on Drugs and Crime. (2017). *International Homicide Statistics database*.

Globally, in 2015, around 7.7 persons on average, per 100,000 population, were victims of intentional homicide. While intentional homicide rates have typically declined over the past decade, people in some countries of Latin America, sub-Saharan Africa and Asia face increased risk of intentional murder (*see Annex 7.2*). Central America appears to have a concentration of homicide hot spots, but this raises the question of whether data not only reflect the extreme end of domestic/family interpersonal violence, but also extreme interpersonal violence relating to drug issues.

7.3.1. Data limitations

The data present a very narrow picture of the complex and variable nature of the construct of interpersonal violence. Unlike many other aspects of health and well-being (measured by indices), violence is difficult to measure because it often occurs 'unseen' (in the home or otherwise in private) and therefore cannot be measured by a third party (as, for example, immunization rates can be). Asking individuals themselves about their experiences of victimization is costly, sensitive and ethically challenging (for a detailed analysis of the challenges of collecting prevalence data on child abuse, particularly sexual abuse, see: Mathews et al., 2015). Many developed countries lack rigorous, regularly updated, national-level interpersonal violence prevalence data for this reason, so it is not surprising that less developed nations struggle even more to collect such information.

One of the difficulties is that the most widely available indicator on a global scale – the intentional homicide rate – is both wider and narrower than the kinds of interpersonal violence that are the focus of the SDGs and of the interventions reviewed in the literature. It is wider, in that it includes homicides relating to strangers and other non-familial relationships (e.g., work colleagues, neighbours). And it is also narrower, in that fatal violence represents just the tip of the iceberg in regard to the overall prevalence and burden of disease from violence.

There are also concerns with gaps in the data globally. Regarding the proportion of children aged 2–14 years who have experienced any violent discipline, many countries are missing data. This is due to a dearth of data on the violent discipline of children (across all years) for countries such as Australia, Canada, New Zealand, the United Kingdom, the United States, as well as most Asia-Pacific countries and, indeed, many other European countries. In fact, data are mostly available for low- and middle-income countries. Moreover, some data differ from the standard definition or refer to only part of a country (*see Annex 7.2*). The vast majority of children across the globe are exposed to violent discipline (psychological aggression and/or physical punishment) – specifically, 60–90 per cent of children experience violent discipline in most of the countries where data are available.

With regard to the number of victims of intentional homicide per 100,000 population, data are based on national administrative data and are therefore not always available in all countries (*see Annex 7.2*). This indicator shows large variability in intentional homicide rates between countries – underlining relative success across the globe in producing safe communities and societies. The rate ranges from a low of less than 1 per 100,000 people (found in many countries, e.g., Algeria) to a high of around 30 per 100,000, depending on the year (e.g., Bahamas: 35 in 2011; El Salvador: 72 in 2011; Honduras: 93 in 2011). Many countries had missing data for one or more of the data collection years, and some had very few available data points (e.g., Zimbabwe had data only for 2010 and 2012).

7.4. Families, family policy and ending violence: Evidence from the literature

To review evidence on families, family policy and experiences of violence and ending violence, an initial search was undertaken for peer-reviewed, English language reports published in the period January 2010–January 2017, using the following keywords in various combinations: "family violence", "partner violence", "marital violence", "domestic violence", "spouse abuse", "spousal abuse", "battering abuse", "child abuse", "child sexual abuse", "child neglect", "child maltreatment + preventing", "prevention", "reducing", "reduction", "reduce", "decreasing"; and "violence, bullying", "trafficking", "institutional abuse + children", "adolescents", "teens", "child", "teenager", "young people + preventing", "prevention", "reducing", "reduction", "reduce", "decreasing". The following databases were searched: PsycINFO and PsycARTICLES, Psychology and Behavioral Sciences Collection, SocINDEX, MEDLINE and FAMILY (Australian Family & Society Abstracts).

A further search was undertaken to follow up keywords referring to regions of the global south (e.g., "child maltreatment + preventing" and "Africa", "Asia" or "Latin America") since the first search surfaced a disproportionate number of studies for western democracies.

To also include key reports from the grey literature, the initial searches were supplemented by an additional search in the National Criminal Justice Reference Service database (Australia) for reports published in the period January 2005–January 2017 citing any of: "crime prevention", "bullying", "child abuse/exploitation", "child protection/health", "domestic violence", "juvenile justice – sex offences", "school safety", "sex offender registries", "trafficking in persons". Also, the Cochrane Library and the Campbell Collaboration library were browsed for: "violence", "abuse", "battering", "maltreatment", "neglect", "bullying" and "trafficking" (no date restriction). Finally, bibliographies of selected reports found on the WHO and Our Watch websites were searched.

In total, the search resulted in the identification of 358 studies published from 2002 to 2017. In total, 63 of the 358 reports were accepted, and the rest excluded. Since the intention of this chapter is to provide a representative sample of the best evidence (rather than a comprehensive review of all evidence relating to violence prevention), the focus is only on those reports that provide the highest-quality evidence, including systematic reviews and randomized controlled trials (RCTs).

In the health and social sciences, almost every quality rating system that reviews implementation studies acknowledges systematic reviews and RCTs as being at the top of the 'hierarchy of evidence' in terms of quality (Leigh, 2009). Their quality is also acknowledged by evidence websites – such as the Child Welfare Information Gateway, which is a service of the Children's Bureau, Administration for Children and Families, US Department of Health and Human Services.[35] Using such data to inform policies and programmes enhances the degree to which policymakers and practitioners have confidence to implement interventions (Leigh, 2009).

This chapter is based on key messages gleaned from reviewing 22 RCTs presented in peer-reviewed papers that demonstrated a solid methodology. Systematic reviews provide supporting evidence on the topics of focus.

35 http://www.cibhs.org/resource-vendor/child-welfare-information-gateway). See also: http://www.cibhs.org/introduction/ebp-definitions.

Uneven coverage of violence types

Although the quality of the literature reviewed in this chapter is high (given the number of RCTs and systematic reviews found), there are significant limitations regarding types of violence prevention programmes. The studies predominantly cover the following two types of interpersonal violence:

- domestic and family violence – including intimate partner violence, sexual assault and date rape
- child maltreatment – including physical abuse, sexual abuse, psychological/emotional abuse, neglect, and exposure to domestic/family violence.

More studies meeting the search criteria focus on domestic/family violence than child maltreatment, while other types of violence, such as bullying, cyberbullying and peer violence, show limited coverage. Interestingly, although one of the better global data sources relates to intentional homicide, this form of interpersonal violence has not been the focus of family-related intervention research to the same extent as other forms of domestic violence and child maltreatment.

Operationalizing the concept of violence prevention

Methodologically, it is ethically sensitive – and practically difficult – to measure interpersonal violence, but particularly so for child maltreatment. Therefore, based on objective and categorical measures of violence (usually operationalized as statutory child maltreatment reports), few studies demonstrate convincing evidence of the relevant family intervention's effectiveness in prevention. (Note that statutory child maltreatment reports are themselves a proxy – reflecting service system activity, rather than harm or absence of harm to children – and not a population-level measure, nor a clinical outcome measure.)

This limitation in operationalization is also connected to the difficulty in measuring the absence of violence, because measuring treatment of symptoms that are already present is much easier than demonstrating the successful avoidance of the occurrence of a possible future event.

Given the conceptual closeness of many other available measures (such as parental and family functioning, and child development), good proxy measures of programme outcomes can instead be used. This means that researchers typically focus on measuring a programme's effectiveness in terms of its success in addressing known risk factors, or enhancing known protective factors, i.e., by creating 'conditions of safety' for the child or adult in question (again, with a focus on factors from across the socioecological model).

Geographic coverage

While acknowledging that the literature search was limited to English language publications, a disproportionate number of the studies reviewed come from North America, the United Kingdom and Australia. This is consistent with related areas of research – including the broader topic of children and adolescents – in which studies from the global south are limited (with the exception of research from high-income countries), despite the majority of the world's children and adolescents living in resource-constrained countries.

What are the typical interventions?

What may be considered a 'typical' intervention will necessarily be determined by the scope and coverage of the interventions reviewed. For instance, Barlow et al.'s (2006) systematic review of 15 systematic reviews on the effectiveness of interventions to prevent child maltreatment (physical abuse and neglect), focused on five groups of common interventions: home visiting programmes, multimodal interventions, parenting programmes, intensive family preservation programmes, and family-focused casework and multisystemic family therapy.[36]

For this chapter, however, the kinds of interventions covered in the literature were broadly categorized into the following four groups:

- Parenting programmes: intensive home visiting programmes for parents and children, both perinatal and ongoing (for addressing domestic violence and child maltreatment); other post-natal care-based interventions (to address domestic violence).
- Interpersonal violence interventions: sexual abuse prevention education, previously known as 'protective behaviour programmes' (for sexual abuse prevention, as well as some broader effects on peer bullying); healthy/respectful relationship education – typically school-based – for young people (to prevent interpersonal violence, including date rape, intimate partner violence and sexual violence, domestic violence and violence against women).
- School-based programmes: cyberbullying prevention, peer violence prevention and sexual violence prevention through education programmes in school.
- Community-based mobilization: participatory learning, social action, and engagement strategies to educate parents, build capacity of local communities – particularly those with high levels of disadvantage – to support families through tools such as 'playgroups', which provide opportunities to model good parenting skills, convey information, provide peer support and raise referral opportunities for more intensive services (to address child maltreatment and to a lesser extent, interpersonal violence and violence against women). A good example is the Australian government's Communities for Children place-based intervention strategy (Edwards et al., 2014).

7.4.1. Key messages from the literature

When taking a strict view of the efficacy of interventions in terms of the intended outcomes on prevention of interpersonal violence, many of the studies were inconclusive. There was very limited evidence of direct reductions in child abuse and neglect – largely due to the difficulties in operationalizing and measuring child maltreatment, as well as the limited window for such behaviours to occur (and therefore be measured). Similarly, few RCTs or systematic reviews showed direct evidence of population-level reductions in cases of domestic violence.

Nevertheless, despite these difficulties, some studies provided promising family-focused practices for the prevention and treatment of violence. Below, introduced separately, are the reviews of the literature on parenting programmes, programmes for the prevention of interpersonal violence, school-based programmes, and community-based interventions to prevent violence.

36 The authors concluded: "There was limited evidence of the effectiveness of services in improving objective measures of abuse and neglect … but good evidence of modest benefits in improving a range of outcomes that are associated with physical abuse and neglect, including parental and family functioning and child development." (Barlow et al., 2006, p. 6).

Parenting programmes

Parenting programmes have been shown to be effective preventive strategies in high-income countries to prevent violence among children, but research on their effectiveness in lower-income countries is limited to date (*for a summary of reviewed studies, see Table 7.1*).

Parenting interventions can use a range of delivery mechanisms (e.g., group-based or individual; home visiting; multi-component interventions; media engagement; training) and can be offered in many different settings (e.g., primary health care, hospitals, early childhood centres, schools, homes, community centres). Home visitations have a considerable evidence base for reducing child abuse, but the findings vary considerably. Although home visiting programmes are one of the most frequently studied parenting interventions, and among those for which the strongest evidence exists (especially in high-income countries), direct impacts on violence prevention/reduction are not always demonstrated. For example, Duggan et al. (2004) found little evidence of home visiting leading to direct reductions in child abuse, however, it can have positive effects on proxy markers for abuse, such as hospitalization rates (Olds, 2002), subsequent birth timing, childcare enrolments and stable partner relationships (Olds et al., 2007). Fergusson et al. (2013) noted: "The results of this 9-year trial show that programmes like Early Start can produce modest changes in outcomes relating to childhood well-being, including unintentional injury, harsh discipline, parenting competence, and child behaviour; however, these benefits do not generalize to family-level change." Reviews of parenting interventions routinely find good evidence that they reduce levels of harsh/abusive parenting, however.

Regarding positive interventions, Avellar and Supplee (2013), in a review of home visiting programmes, found that five of six programmes that assessed child maltreatment as an outcome had positive results. A more recent RCT study, by Lachman et al. (2017), confirmed a positive effect. The study examined the initial effects of a parenting programme in reducing the risk of child maltreatment in highly deprived communities in Cape Town, South Africa. The parenting programme aimed to change parenting behaviours through a series of training sessions on managing parent–child relationships using non-violent discipline strategies and community participatory methods. Results provided evidence of effectiveness in reducing the risk of child maltreatment by improving positive parenting behaviour.

Most of the evidence for the prevention of child maltreatment through parenting interventions relates to physical abuse and neglect (MacMillan et al., 2009). There is less evidence for the prevention of sexual and emotional abuse because these forms of maltreatment are often the focus of different types of interventions or, in the case of emotional abuse, are less well studied. A systematic review (Mejia, Calam & Sanders, 2012) was carried out to identify evaluations of programmes targeting emotional or behavioural outcomes in children. Among those studies evaluating interventions designed to prevent negative emotional and behavioural outcomes on children, only one had a strong methodology – confirming the limited evidence available and the opportunities for further programmes and research.

Table 7.1. Summary of parenting programmes and their effects on reducing violence (all RCTs)

Authors	Family intervention description (How are they doing it?)	Where?	For whom?	What are the results?
Duggan et al. (2004)	The Healthy Start Program for family functioning; cognitive behavioural therapy with gender re-education. Home visitors.	Oahu, Hawaii	Families assessed as at-risk of child abuse at the time of their childn's birth.	Results are not showing effective evidence on prevention of violent discipline of children and neglect of children.
DuMont et al. (2011)	Healthy Families New York (HFNY) intensive home visiting programme. Home visits are conducted by family support workers.	New York, United States	The HFNY evaluation included young women who were randomly assigned to the intervention or control groups prior to the birth of their first child, as well as older women who entered the study after the birth of their first child or a subsequent child.	Effective evidence of reduction of physical aggression (self-reported); effective evidence of prevention of violent discipline of children.
Fergusson et al. (2013)	Early start programme: intensive home visiting to families facing multiple challenges. Family support workers with qualifications in nursing, teaching or allied disciplines.	Christchurch, New Zealand	Families	Effective evidence of reduction of physical aggression (self-reported); reduced hospitalization.
Green et al. (2014)	Healthy Families Oregon home visiting programme. Programme staff.	Oregon, United States	New parents assessed to be at risk.	Improved access to health checks and improved child developmental activities for children.
Kiely et al. (2010)	Intervention for intimate partner violence (IPV) emphasizing safety behaviours. Social workers or psychologists (specially trained).	Washington, D.C., United States	Women ≥18 years old and ≤28 weeks pregnant.	Women were less likely to have recurrent episodes of IPV; for women experiencing sexual IPV, the intervention did not significantly reduce their incidence of episodes.
Lachman et al. (2017)	Sinovuyo Caring Families Programme for Young Children: intervention using training programmes and a community-based participatory approach on improving parent–child relationships and improving positive parenting behaviour.	Cape Town, South Africa	Low-income parents with children aged 3–8 years.	Reduced the risk of child maltreatment.

Authors	Family intervention description (How are they doing it?)	Where?	For whom?	What are the results?
LeCroy & Krysik (2011)	Healthy Families Arizona: services and home visiting intervention. Home visitors.	Arizona, United States	Families	No effective change in reducing the social acceptance of violence among families; evidence of reduction of violent discipline on children (verbal aggression, shouting, yelling and screaming, or minor corporal aggression such as slapping the child's hand). Acts of major physical aggression were rare.
Mejdoubi et al. (2013)	Strong Communities for Children: a multi-year, comprehensive community-based initiative to prevent child maltreatment and improve children's safety. Prenatal and post-natal home visits by nurses.	Netherlands	Low educated women under 25 years of age and pregnant with first child.	Psychological aggression and assault (both victim and perpetrator) among women in the intervention group was reduced significantly.
Olds (2002)	Prenatal and post-natal home visits by nurses.	New York, Tennessee and Colorado, United States	Women who have had no previous live births, and each intervention has focused recruitment on women who were low-income, unmarried and adolescent.	Women in the intervention group had 80% fewer verified cases of child abuse and neglect than those in the control group; reduced levels of emergency hospitalization for children.
Olds et al. (2007)	Prenatal and infancy home visits in a public system of obstetric and paediatric care.	Memphis, Tennessee, United States	Women who have had no previous live births, with risk-aligned socio-economic characteristics.	Nurse-visited children demonstrated higher IQs and language scores and fewer behavioural problems in the borderline or clinical range.
Pronyk et al. (2006)	Microfinance loans combined with training.	Rural Limpopo province, South Africa	Women residing in villages.	The study provides evidence that the intervention can reduce intimate partner violence experienced by participants.
Sharps et al. (2016)	Domestic Violence Enhanced Home Visitation Program: prenatal and post-natal home visits by community health nurses.	United States, multiple sites	Women (English-speaking pregnant females aged 14 years or older, low-income, from prenatal home visiting programmes).	IPV decreased over time.

Interpersonal violence interventions

Interpersonal violence in the literature refers to domestic violence, gender-based violence and intimate partner violence (*see also Table 7.1*). Intimate partner violence and child maltreatment often occur together in households and exposing children to such violence can lead to negative outcomes.

In the literature review, interventions targeting interpersonal violence were found mostly in systematic reviews, while most of the RCT studies targeted mixed types of interventions. For example, Pronyk et al. (2007) found training combined with provision of microfinance reduced interpersonal violence in rural South Africa. The fact that such interventions typically featured in systematic reviews resulted in a corresponding lack of detail on their specific nature, however. Thus, evidence in this area can only be used to support generic – rather than specific – guidance on interventions, e.g., enhancing community self-efficacy (Beyer et al., 2015).

Nevertheless, the review does show that results of different interventions vary depending on whether their target group was high-risk families, with few other studies able to show equally compelling evidence for improvements in conditions of safety for families that most need it (as defined by a greater number or severity of risk factors, and fewer/weaker protective factors). This may be because, even when interventions are targeted at those experiencing family violence – rather than population-wide interventions (e.g., Sharps et al., 2016) – programmes struggle to attract and retain those who are most vulnerable. That said, some strong positive outcomes for high-risk families have been observed among the interventions, such as for comprehensive home visiting for high-risk, first-time parents (Green et al., 2014) and targeted programmes like SafeCare (Whitaker, 2014).

One systematic review of six RCTs (Smedslund et al., 2011) on cognitive behavioural therapy for men who use physical violence with their female partners found a statistically significant, but small, reduction in relative risk of violence. Overall, the authors concluded that there were too few RCTs to make definitive statements about the efficacy of cognitive behavioural therapy in men's use of violence (Smedslund et al., 2011). Another RCT study based on cognitive behavioural therapy for men (Alexander et al., 2010) suggested the importance of tailoring abuser intervention programmes to individuals' initial readiness to change. Results showed significant reductions in female partners' reports of physical aggression at follow-up, but not to changes in men's self-reported aggression.

In other cases, little evidence was found for the efficacy of treatment for offenders. A systematic review by Feder et al. (2008) focused on four experimental and six quasi-experimental studies. The experimental studies looked at the effects of courts mandating a batterer intervention programme compared with no treatment or a routine treatment approach. This was particularly targeted at men facing or convicted of domestic violence charges. The findings raised doubts about the effectiveness of court-mandated batterer intervention programmes in reducing re-assault among men convicted of misdemeanour domestic violence.

School-based programmes

Interventions in schools to prevent violence can improve family functioning and relationships at home (*for a summary of reviewed studies, see Table 7.2*). These interventions target children of different ages.

There are mixed findings for the efficacy of violence/harassment prevention programmes in school (e.g., Taylor et al., 2010; Wolfe et al., 2009). School-based interventions to reduce dating violence, such as the Safe Dates Project, appear to have small, but long-lasting reductions in victimization (Foshee et al., 2004). But an evaluation of a coach-delivered anti-violence programme for athletes found no significant effects of the intervention for intentions to intervene, gender-equitable attitudes, recognition of abuse, or positive bystander behaviours (Miller et al., 2013). Taylor et al. (2010) found instead mixed findings for an intervention addressing gender-based violence/sexual harassment, with some positive effects on girls in the form of reduced experience of victimization and sexual dating victimization. Wolfe et al. (2009) found a reduction in physical violence when reviewing a programme that taught adolescents about healthy relationships. The intervention effect was greater in boys than in girls.

Programmes to prevent bullying and cybervictimization in schools have shown significant effects. Williford et al. (2013) analysed the effects of a school programme against bullying in Finland. Results revealed a significant intervention effect on the frequency of cybervictimization; students reported lower frequencies of cybervictimization at post-test than students in a control group. The programme was also effective for reducing students' internalizing problems and improving their peer-group perceptions. Changes in anxiety and depression, and positive peer perceptions were found to be predicted by reductions in victimization. Results of a school-based intervention on teen dating violence showed that knowledge and attitudes can be positively influenced, even though the impact on dating violence perpetration was unclear – highlighting the need for programme refinement to more directly support skill-building and behaviour change (De La Rue et al., 2014).

These findings suggest, for interventions where there is a more direct link between desired outcome (negative behaviours being targeted) and intervention, evaluators are more likely to demonstrate positive impacts.

Table 7.2. Summary of school-based programmes and their effects on reducing violence

Authors	Family intervention description (How are they doing it?)	Where?	For whom?	What are the results?
Cross et al. (2016)	Cyber Friendly Schools programme on adolescent cyberbullying behaviour.	Perth, Australia	Grade 8 students (aged 13 years)	The programme was associated with significantly greater declines in the odds of involvement in cybervictimization and perpetration from pre-intervention to the first post-test. No other differences were evident between the study conditions.
Foshee et al. (2004)	Safe Dates Project: a school-based intervention on the prevention and reduction of dating violence among adolescents. The intervention included a theatre production performed by students, training sessions taught by health and physical education teachers, and a poster contest.	North Carolina, United States	Adolescents enrolled in Grade 8	Adolescents receiving the Safe Dates intervention reported significantly less physical, serious physical, and sexual dating violence perpetration and victimization four years after the programme.
Miller et al. (2012)	Coaching Boys into Men programme: trained coaches to talk to male athletes about stopping violence against girls/women.	Sacramento County, California, United States	Coaches and secondary school male athletes	Twelve-month follow-up from this cluster RCT demonstrated not only reductions in negative bystander intervention behaviours (fewer intervention athletes supporting peers' abusive behaviours) but also less abuse perpetration. There were no significant effects, however.
Taylor et al. (2010) – RCT	Five-session curriculum addressing gender-based violence/sexual harassment based on the theory of reasoned action.	Cleveland, Ohio, United States	Grade 6 and 7 students (aged 11–13 years)	Mixed findings: - Experience of victimization: girls experienced less sexual victimization and less non-sexual victimization from peers than boys did. - Perpetrating violence: girls perpetrated fewer incidents of sexual dating victimization than boys did. Intervention increased perpetration of dating violence and dating sexual violence; no differences for gender. - Sexual peer violence: girls perpetrated fewer incidents of victimization and sexual dating victimization than boys did.
Williford et al. (2012) – RCT	KiVa programme: a school-wide intervention curriculum and activities against bullying, including involvement of parents and teachers.	Finland	Students in late elementary (Grades 4–6) and middle school (Grades 7–9)	Effective for reducing students' internalizing problems and improving their peer-group perceptions.

Authors	Family intervention description (How are they doing it?)	Where?	For whom?	What are the results?
Williford et al. (2013) – RCT	KiVa programme: a school-wide intervention curriculum and activities against bullying and cyberbullying, including involvement of parents and teachers.	Finland	Students in late elementary (Grades 4–6) and middle school (Grades 7–9)	Results revealed a significant intervention effect on the frequency of cybervictimization; KiVa students reported lower frequencies of cybervictimization at post-test than students in a control group.
Wolfe et al. (2009) – RCT	Teaching of adolescents about healthy relationships: 21-lesson curriculum delivered in 28 hours, covering personal safety and injury prevention; healthy growth and sexuality; substance use and abuse.	Ontario, Canada	Students in middle school (Grade 9 health classes)	Reduced physical dating violence; the intervention effect was greater in boys than in girls.

Community-based interventions

Community-based prevention programmes focused on reducing child maltreatment cover home visiting programmes, parenting programmes, and paediatric care in the form of prenatal and post-natal programmes (*for a summary of reviewed studies, see Table 7.3*).

In preventing intimate partner violence, and reducing children's exposure to violence, effective programmes are typically those that involve community mobilization, paired with training and actions to promote gender equality. In particular, efforts to change social norms at the local level are a common goal of such interventions, especially in low- and middle-income countries. For example, in Uganda, Abramsky et al. (2014) studied the effects of a community-based intervention to prevent violence against women and reduce the risk of HIV transmission. The programme focused on attitudes towards and social acceptance of violence. Social acceptance of violence was reduced among women and community members reported increased support for women who decide to refuse sex. The same project was then studied to measure its impact on reducing children's exposure to violence, and positive effects were found (Kyegombe et al., 2015).

Alexander et al. (2010) studied the effects of a gender re-education community mobilization intervention (targeting men) to prevent violence against women in the United States. In this case, however, the programme showed no positive effects on reducing men's self-reported psychological or physical aggressions against other community members.

Table 7.3. Summary of community-based programmes and their effects on reducing violence (all RCTs)

Authors	Family intervention description (How are they doing it?)	Where?	For whom?	What are the results?
Abramsky et al. (2014)	Community intervention to prevent violence against women and reduce HIV risk, led by Centre for Domestic Violence Prevention.	Two areas in Kampala, Uganda	Adults under 50 years of age who had lived in the area for at least one year	Social acceptance of men's use of violence was significantly lower among women in the intervention group. More community members reported attitudes supporting acceptability of a woman to refuse sex, but no significant reduction in experience of intimate partner violence (IPV).
Alexander et al. (2010)	Community mobilization intervention to prevent violence against women and reduce HIV risk behaviours. Cognitive behavioural therapy with gender re-education, delivered by therapist.	Montgomery County, Maryland, United States	Adult male clients referred to Abused Persons Program	No evidence of an interaction between treatment type and readiness to change on either self-reported psychological or physical aggression. Significant reductions in female partners' reports of physical aggression at follow-up, but no changes in men's self-reported aggression.
Kyegombe et al. (2015)	Intervention to prevent IPV against women, to reduce children's exposure to violence. Community activities: trainings, local activism activities, and media and advocacy strategies.	Kampala, Uganda	Communities, both women and men	Children's exposure to IPV was reduced.
McDonell et al. (2015)	Strong Communities for Children: a multi-year, comprehensive community-based initiative to prevent child maltreatment and improve children's safety.	South Carolina, United States	Parents or caregivers of children under 10 years of age	Strong Communities for Children samples showed significant changes in the expected direction for social support, collective efficacy, child safety in the home, observed parenting practices, parental stress, parental efficacy, self-reported parenting practices, and rates of officially substantiated child maltreatment.

Summary comments on the limitations of this review

The proliferation of different kinds of interventions makes comparisons difficult, and in turn limits the generalizability of findings related to any given type of intervention and its ability to reduce experiences of violence and its effects.

Moreover, concepts – and their measures – often suffer from poor construct validity (Evans et al., 2014). And unlike many areas of health research in the social sciences/child welfare arena, where interventions are often more clearly defined (e.g., administration of a particular drug, at a particular dose; or use of a defined, agreed surgical technique or even behavioural intervention), interventions of this nature are also less amenable to such definition or constraint. Therefore, it is very unusual to find multiple studies using exactly the same type of intervention, and this too constrains the generalizability of intervention and its effects (see, for example, Arango et al., 2014)

It should also be noted that few of the interventions were implemented and evaluated population-wide. Most were programmes targeting subgroups in specific locations, which – to a degree – leaves the questions of scalability and transferability of practice underinformed. In one exception comparing local to national interventions, however, Farrington (2014) found that in relation to delinquency, aggression and bullying, there was a greater effect for programmes delivered using universal (public health) principles (see Sanders et al., 2017).

7.5. Conclusions

Family-related policies and programmes/interventions are integrally connected to achievement of SDG targets related to prevention of violence. Although this chapter has focused on SDG 16, a range of actions relating to other SDGs also support and promote safety and prevention of violence, particularly actions relating to gender equality (SDG 5), and health promotion activities that address risk factors for child maltreatment, such as parental mental ill health and substance misuse (SDG 3).

Most of the evidence regarding effective interventions comes from research in western democracies. Much of the evidence is in English and comes from articles in peer-reviewed journals written by academics and scholars from universities or research institutions based in industrialized high-income countries, whereas evidence from low- and middle-income countries is limited. Yet, the absence of nationwide, globally comparable data on children's exposure to violent discipline prevents any inferences to be drawn about whether the presence of such policies and programmes in general (reflecting the body of research reviewed here) is successful in reducing children's exposure to violence. The greater emphasis on evidence of the effectiveness of domestic violence prevention suggests there is considerable scope to implement specific child maltreatment prevention programmes/policies, and strategies to end the use of violence by parents in western democracies.

Given the disconnect between the limited global data on interpersonal violence and the research evidence on what works (focusing primarily on drivers of violence and factors that support preconditions of safety in the environment), it is not possible to draw any conclusions about geographic associations between implementation of particular types of policies, programmes or interventions and a lower rate of interpersonal violence.

The aim of a public health approach to preventing interpersonal violence is to shift the focus away from responding to high-risk situations (e.g., children requiring statutory intervention from child protection authorities, or justice responses to women seeking safety from domestic violence) towards addressing the needs of all families, and to move the population distribution of risk factors towards the positive end for all

families (Mullan & Higgins, 2014). To illustrate, two potential types of public health intervention are described: (1) parenting programmes and supports; and (2) public information programmes about safety for children (based on implications of Mullan & Higgins, 2014).

Parenting programmes and supports

Parenting programmes can be delivered as part of a public health approach to strengthen and support parenting (Sanders, 2008) and to prevent child maltreatment (Sanders, Cann & Markie-Dadds, 2003; Sanders & Pidgeon, 2011). Prinz et al. (2009) provided evidence of a significant prevention effect of a parenting programme – the Triple P: Positive Parenting Program, delivered jurisdiction-wide in one county of North Carolina, United States – showing reductions in rates of statutory reports of child maltreatment. Although not jurisdiction-wide, the Every Family trial in Australia showed positive effects for delivery of the Triple P intervention in 30 sites across the state capital cities of the country's three most populous states (Sanders et al., 2005).

Criteria for success in implementing public health initiatives to address complex social phenomena, such as prevention of interpersonal violence, can be summarized under three domains: (1) a good understanding of the prevalence of the particular problem being targeted; (2) knowledge pertaining to the prevalence of the risk and protective factors that underlie those problems; and (3) evidence that changing risk and protective factors improves the intended safety/well-being outcomes (Prinz et al., 2009; Sanders, 2012). Across the systematic reviews and RCTs, it was a challenge to find interventions with strong claims across all three criteria.

There is a range of other evidence-based approaches to supporting parents and addressing problematic parenting behaviour – for example, through individual parenting education, counselling and mediation (particularly in the context of parental separation). Parental education and support is also a key feature of home visiting programmes and other parenting supports (see Holzer et al., 2006; Wise et al., 2005).[37]

There is strong evidence that the home environment – particularly parental behaviours – is an important determinant of children's early development and well-being. Although parenting programmes (even those with the highest evidence of their effectiveness, particularly those that are modularized, structured, manualized, etc.) and home visiting programmes (usually a suite of services that may include particular components such as parenting programmes and coaching or mentoring) have been shown to improve parenting skills, with the notable exception of Prinz et al. (2009), there is no strong evidence that they are sufficient to prevent child maltreatment (Holzer et al., 2006).

Public information programmes

Public information programmes are a more familiar tool used by governments to effect broader changes in the behaviour of the population in general. Examples abound, including public health campaigns around alcohol, smoking and skin cancer, and road trauma (drink-driving and safe-driving campaigns). Recent campaigns highlighting how parental alcohol consumption affects children offer an interesting template for how such campaigns can be used to educate parents about the influence they have over children. Some recent examples from Australia are DrinkWise Australia's Kids Absorb Your Drinking campaign and its Under Your Influence campaign; and the National Association for the Prevention of Child Abuse and Neglect's Children See, Children Do campaign. Research has explored the utility of popular media to promote positive parenting practices more generally (Sanders & Prinz, 2008) and to promote the prevention of child maltreatment (Saunders & Goddard, 2002). Similarly, there are violence prevention strategies that promote

37 For a list of other publications, see http://www.aifs.gov.au/cfca/topics/parenting.php

respectful relationships, and target the known risk factors, such as gender inequality. For example, The Line, a primary prevention behaviour change campaign in Australia targeted at young people aged 12–20 years, encourages healthy and respectful relationships by challenging and changing attitudes and behaviours that support violence.[38] Public health campaigns have limitations that should be borne in mind, however. There is limited evidence to tackle the question of whether or not social marketing campaigns are effective in addressing concrete outcomes like rates of child abuse and neglect – and evaluations of such campaigns are notoriously difficult to conduct with any rigour (Horsfall, Bromfield & McDonald, 2010).

While public information programmes can assist, there are limitations to their effectiveness, particularly when knowledge or attitudes alone are insufficient to effect change. They need to be targeted at attitudes or behaviours that are modifiable, with clear links to strategies for achieving the desired change. Adopting a broad information campaign may have limited effects if it is not directed towards a behaviour that can be changed and does not point to sources of support for bringing about that change. For example, the Quit initiative used across Australia is effective in responding to the problem of smoking because it targets broad social attitudes and provides concrete actions and supports for quitting smoking.

In summary

Families play an important role both in the perpetration of violence and in protecting their members from harm. Therefore, it is rational to see family-based treatment, or a focus on family support policies, as key pillars to ending violence in all societies globally. Although violence can occur outside of the family too (in school, at work, in the local community – indeed, wherever human interaction occurs), families also have a role here, in supporting victims of violence and setting social norms regarding the unacceptability of violence in the family and in the wider community.

Violence against the person is a serious violation of an individual's right to safety, which should be addressed in its own right, even if positive social and personal spillover effects were not so readily seen. Evidence suggests that family interventions designed to lower rates of interpersonal violence, and to set community standards and norms that reject violence in all its forms, can – if effective – lead to direct improvements to health (mental and physical) and education, quality of local environments and much more. Efforts towards achieving the SDGs, beyond SDG 16 alone, can also benefit from stronger family policy and safer families.

38 See: http://www.theline.org.au/

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Annex 7.1. Data table: violent discipline (2010–2015)

Country	Any violent discipline (total)	Sex	
		Male	Female
Afghanistan	74	75	74
Albania	77	81	73
Algeria	86	88	85
Argentina	72	74	71
Armenia	70	72	67
Azerbaijan	77	80	74
Bangladesh	82	83	82
Barbados	75	78	72
Belarus	65	67	62
Belize	71	71	70
Benin	91	-	-
Bosnia and Herzegovina	55	60	50
Burkina Faso	83	84	82
Cameroon	85	-	-
Central African Republic	92	92	92
Chad	84	85	84
Congo	83	-	-
Costa Rica	46	52	39
Côte d'Ivoire	91	91	91
Croatia	-	-	-
Cuba	36	37	35
Democratic People's Republic of Korea	-	-	-
Democratic Republic of the Congo	82	82	81
Djibouti	72	73	71
Dominican Republic	63	-	-
Egypt	93	93	93
El Salvador	52	-	-
Eswatini	88	-	-
Fiji	72	-	-
Gambia	90	90	91
Georgia	67	70	63
Ghana	94	94	94

Country	Any violent discipline (total)	Sex	
		Male	Female
Guinea-Bissau	82	-	-
Guyana	70	-	-
Haiti	85	85	84
Iraq	79	81	77
Jamaica	85	87	82
Jordan	90	91	89
Kazakhstan	49	54	45
Kiribati	81	-	-
Kyrgyzstan	57	60	54
Lao People's Democratic Republic	76	77	74
Lebanon	82	82	82
Liberia	90	90	90
Malawi	72	73	72
Mauritania	87	87	87
Mongolia	47	-	-
Montenegro	69	73	66
Morocco	91	92	90
Nepal	82	83	81
Niger	82	82	81
Nigeria	91	91	90
North Macedonia	69	71	67
Panama	45	47	43
Qatar	50	53	46
Republic of Moldova	76	77	74
Saint Lucia	68	71	64
Sao Tome and Principe	80	-	-
Serbia	43	44	42
Sierra Leone	82	81	82
Solomon Islands	72	-	-
State of Palestine	92	93	92
Sudan	64	-	-
Suriname	86	87	85
Syrian Arab Republic	89	90	88
Tajikistan	78	80	75

Country	Any violent discipline (total)	Sex	
		Male	Female
Timor-Leste	-	-	-
Togo	81	81	80
Tonga	-	-	-
Trinidad and Tobago	77	78	77
Tunisia	93	94	92
Ukraine	61	68	55
Uruguay	55	58	51
Vanuatu	84	83	84
Viet Nam	68	72	65
Yemen	79	81	77
Zimbabwe	63	63	62

Annex 7.2. Data Table: Intentional homicides per 100,000 people

Country or Area	2010	2011	2012	2013	2014	2015
Afghanistan	3.5	4.3	6.6	..	..	..
Albania	4.4	4.9	5.5	4.3	4	2.3
Algeria	0.7	0.8	1.3	1.3	1.5	1.4
American Samoa	..	..	..	..	..	..
Andorra	1.2	1.2	0	0	0	0
Angola	..	..	9.8	..	..	9.6
Antigua and Barbuda	6.9	..	11.2	..	..	..
Argentina	..	..	..	..	7.6	6.5
Armenia	1.9	2.4	2.2	2	..	2.5
Aruba	3.9	..	..	..	..	..
Australia	1.1	1.1	1.1	1.1	1	1
Austria	0.7	0.9	1	0.7	0.5	0.5
Azerbaijan	2.1	..	2.2	2.3	2.5	..
Bahamas	26.1	34.6	29.8	..	..	..
Bahrain	0.9	0.5	..	..	..	..
Bangladesh	2.6	2.6	2.6	2.8	2.8	2.5
Barbados	11.1	9.6	7.8	8.5	8.8	10.9
Belarus	5.1	3.9	3.6	3.5	3.6	..
Belgium	1.7	1.9	1.8	1.8	1.8	1.9
Belize	40.1	37.7	43.1	28.8	34.4	..
Benin	..	..	6.3	..	..	6
Bermuda	10.9	12.6	7.9	4.8	..	6.5
Bhutan	1.9	3	3.9	2.5	2.7	..
Bolivia	10.6	10.2	12.4	..	..	..
Bosnia and Herzegovina	1.5	1.3	1.6	1.2	1.3	1.5
Botswana	14.8	..	..	..	..	..
Brazil	20.9	21.5	23.8	23.6	24.6	26.7
British Virgin Islands	..	..	..	..	..	..
Brunei Darussalam	0.3	..	..	0.5	..	..
Bulgaria	2	1.7	1.9	1.5	1.6	1.8
Burkina Faso	0.6	0.6	0.7	..	..	..
Burundi	3.7	3.6	4.5	4	4	..
Cabo Verde	8	10.7	11.2	10.6	..	8.8

Country or Area	2010	2011	2012	2013	2014	2015
Cambodia	2.3	1.8	..	..	..	..
Cameroon	3.5	2.6	2.7	..	..	5.9
Canada	1.4	1.5	1.6	1.4	..	1.7
Cayman Islands	..	..	..	..	..	..
Central African Republic	..	..	13.2	..	..	13.1
Chad	..	..	9.2	..	..	9
Channel Islands	..	..	..	..	..	..
Chile	3.2	3.7	2.5	3.2	3.6	..
China	1	0.9	0.8	..	..	..
Colombia	32.7	34.1	31.3	32.6	27.9	26.5
Comoros	..	..	7.8	..	..	7.6
Congo	..	..	10.5	..	..	10.1
Costa Rica	11.6	10.3	8.7	8.7	10	11.8
Côte d'Ivoire	..	..	11.4	..	..	11.8
Croatia	1.4	1.1	1.2	1.1	0.8	0.9
Cuba	4.5	4.7	..	..	..	..
Curacao	..	..	..	..	..	..
Cyprus	0.7	0.8	1.9	1.1	0.1	1.3
Czechia	0.1	0.8	0.1	0.9	0.7	0.7
Democratic Republic of the Congo	..	..	12.5	..	..	13.4
Democratic People's Reublic of Korea	..	..	4.7	..	..	4.4
Denmark	0.8	0.8	0.7	0.7	1	1
Djibouti	..	..	7	..	..	6.8
Dominica	21.1	8.4	..	..	..	..
Dominican Republic	25	25.1	22.3	..	17.4	..
Ecuador	17.7	15.5	12.5	11	8.2	..
Egypt	2.2	3.2	..	..	..	..
El Salvador	66	72.2	42.7	41.3	64.2	108.6
Equatorial Guinea	..	..	3.4	..	..	3.2
Eswatini	17.4	..	..	..	..	..
Eritrea	..	..	9.7	..	..	7.5
Estonia	5.3	4.9	4.8	3.9	3.1	3.2
Ethiopia	..	..	8	..	..	7.6
Faroe Islands	..	..	..	..	..	..

Country or Area	2010	2011	2012	2013	2014	2015
Fiji	2.8	..	3	..	..	..
Finland	2.2	2	1.6	1.6	1.6	1.6
France	1.3	1.4	1.2	1.2	1.2	1.6
French Polynesia	..	..	..	..	..	..
Gabon	..	..	9.4	..	..	9
Gambia	..	..	9.4	..	..	9.1
Georgia	4.4	..	..	..	2.7	..
Germany	0.1	0.9	0.8	0.8	0.9	0.8
Ghana	1.7	1.7	..	..	..	..
Gibraltar	..	..	..	..	..	..
Greece	1.6	1.6	1.5	1.4	0.1	0.8
Greenland	10.6	1.8	..	..	..	12.5
Grenada	9.6	3.8	13.3	5.7	7.5	..
Guam	1.9	2.5	..	..	..	..
Guatemala	40.5	37.7	33.5	33.5	31.2	..
Guinea	..	..	8.7	..	..	8.5
Guinea-Bissau	..	..	9.9	..	..	9.2
Guyana	18.6	17.2	18.3	20.4	..	19.4
Haiti	6.8	9	10	..	..	..
Honduras	83.1	93.2	92.7	86.1	74.6	63.8
Hong Kong SAR, China	0.5	0.2	0.4	0.9	..	0.3
Hungary	1.4	1.5	1.2	1.6	1.5	..
Iceland	0.6	0.9	0.3	0.3	..	0.9
India	3.4	3.5	3.4	3.3	3.2	..
Indonesia	0.4	0.6	0.6	0.6	0.5	..
Iran (Islamic Republic of)	..	..	4.8	..	..	4.1
Iraq	8.3	7.9	..	..	..	..
Ireland	1.1	0.9	1.2	1.1	1.1	0.6
Isle of Man	..	..	..	..	..	..
Israel	2	2	1.7	..	..	1.4
Italy	0.9	0.9	0.9	0.8	0.8	0.8
Jamaica	52.8	41.2	39.8	43.3	36.1	43.2
Japan	0.4	0.3	0.3	0.3	0.3	..
Jordan	1.8	2.1	2.3	..	..	..
Kazakhstan	9.5	9.6	8.7	7.4	..	4.8

Country or Area	2010	2011	2012	2013	2014	2015
Kenya	5.6	6.4	6.5	6.6	5.9	5.8
Kiribati	3.9	10.5	7.5	..	..	..
Kosovo[39]	5.8	3.4	4.9	2.2	..	1.6
Kuwait	2	1.8	1.8	..	..	..
Kyrgyzstan	19.6	8.9	5.3	3.6	3.7	5.1
Lao People's Democratic Republic	..	..	7.3	..	..	6.9
Latvia	3.3	3.3	4.8	3.4	3.9	4.1
Lebanon	3.8	3.7	3.9	4.5	4.3	3.9
Lesotho	38	..	..	..	..	..
Liberia	3.3	3.9	3.2	..	..	..
Libya	..	..	2.5	..	..	2.5
Liechtenstein	2.8	0	..	0	2.7	0
Lithuania	7	6.9	6.7	6.7	5.5	6
Luxembourg	2	0.8	0	0.2	0.7	..
Macao, China	0.7	1.3	1.3	1.4	1	0.2
Madagascar	0.6	..	..	..	..	..
Malawi	3.5	2.3	1.8	..	..	..
Malaysia	1.9	..	..	..	..	..
Maldives	1.8	0.9	2.9	0.9	..	..
Mali	..	..	10.2	..	..	10.8
Malta	0.94	0.7	2.9	1.7	1.4	1
Marshall Islands	..	..	4.7	..	..	..
Mauritania	..	..	11.4	..	..	10.2
Mauritius	2.6	2.7	..	..	..	..
Mexico	21.7	22.6	21.3	18.6	15.7	16.3
Micronesia, Fed. Sts.	..	..	4.8	..	..	4.7
Moldova	6.5	7.5	5.6	4.1	3.2	..
Monaco	..	..	..	..	..	..
Mongolia	8.8	9.6	7.1	7.3	7.5	7.2
Montenegro	2.4	3.4	2.7	1.6	3.2	2.7
Morocco	1.4	1.4	1.2	1.3	1	..
Mozambique	3.6	..	..	..	..	..
Myanmar	1.7	2.4	2.5	..	..	2.4
Namibia	14.3	13.7	16.9	..	..	..

39 All references to Kosovo in this publication should be understood to be in the context of United Nations Security Council resolution 1244 (1999).

Country or Area	2010	2011	2012	2013	2014	2015
Nauru	..	..	1.3	..	..	..
Nepal	3	2.9	..	..	..	..
Netherlands	0.9	0.9	0.9	0.7	..	0.6
New Caledonia	..	..	..	..	..	..
New Zealand	0.98	0.9	0.9	1	0.9	..
Nicaragua	13.7	12.7	11.5	..	..	..
Niger	..	4.9	4.5	..	..	..
Nigeria	..	..	10.1	..	..	9.8
North Macedonia	2.1	1.5	1.4	1.1	1.6	..
Northern Mariana Islands	..	..	..	..	..	..
Norway	0.6	2.2	0.5	0.9	0.6	..
Oman	..	1.1	..	..	..	..
Pakistan	7.8	8	7.8	..	..	..
Palau	..	..	3.1	..	..	..
Panama	21	20.6	17.5	17.4	..	11.4
Papua New Guinea	10.4	..	..	..	..	..
Paraguay	11.9	10.4	10.2	9.3	8.8	9.3
Peru	9.2	9.6	9.5	6.6	6.7	7.2
Philippines	9.6	9.2	8.8	9.4	9.9	..
Poland	1.1	1.2	0.99	0.8	0.7	0.7
Portugal	1.2	1.1	1.2	1.4	0.9	1
Puerto Rico	26.5	..	26.5	23.9	18.5	15.9
Qatar	..	..	7.2	..	..	8.1
Republic of Korea	..	0.9	0.8	0.7	0.7	..
Romania	2	1.7	1.9	1.7	1.5	1.5
Russian Federation	10.2	9.7	9.2	8.9	9.5	11.3
Rwanda	4.9	..	..	..	..	..
Samoa	8.6	..	..	3.2	..	..
San Marino	0	0	..	..	..	..
Sao Tome and Principe	3.5	3.4	..	..	..	..
Saudi Arabia	..	..	6.2	..	..	1.5
Senegal	..	..	7.9	..	..	7.3
Serbia	1.4	1.5	1.2	1.6	1.3	1.1
Seychelles	2.1	..	..	..	..	..
Sierra Leone	2.8	3.2	1.9	..	..	1.9

Country or Area	2010	2011	2012	2013	2014	2015
Singapore	0.4	0.3	0.2	0.3	0.3	0.2
Sint Maarten (Dutch part)	..	..	..	..	..	..
Slovak Republic	1.6	1.8	1.4	1.4	1.1	0.9
Slovenia	0.7	0.8	0.7	0.6	0.7	1.2
Solomon Islands	..	..	..	..	..	..
Somalia	..	..	5.6	..	..	5.6
South Africa	30.9	29.9	30.8	31.9	33	34.3
South Sudan	..	..	13.9	..	..	..
Spain	0.8	0.8	0.8	0.7	0.7	0.7
Sri Lanka	3.8	3.6	3.3	2.9	..	..
St. Kitts and Nevis	40.1	64.2	33.6	..	..	..
St. Lucia	24.8	..	21.6	..	..	..
St. Martin (French part)	..	..	..	..	..	..
St. Vincent and the Grenadines	22.9	19.2	25.6	..	..	..
State of Palestine	0.7	0.6	0.6	..	..	..
Sudan	..	..	6.5	..	..	6.5
Suriname	..	..	9.5	..	..	10.7
Sweden	0.1	0.9	0.7	0.9	0.9	1.1
Switzerland	0.7	0.6	0.6	0.7	0.5	0.7
Syrian Arab Republic	2.2	..	..	..	..	..
Tajikistan	2	1.9	1.3	1.4	..	..
Thailand	5.5	4.9	4.9	4.3	3.9	3.5
Timor-Leste	3.7	..	..	..	..	..
Togo	..	..	9.2	..	..	9.1
Tonga	0.1	1.9	0.1	..	..	..
Trinidad and Tobago	35.6	26.4	28.3	30.3	25.9	30.9
Tunisia	2.7	..	3.1	..	..	..
Turkey	4.2	4.2	4.3	..	..	..
Turkmenistan	..	..	4.3	..	..	4.2
Turks and Caicos Islands	..	..	..	..	..	..
Tuvalu	10.2	10.2	20.3	..	..	..
Uganda	9.5	11	11.5	10.5	11.8	..
Ukraine	4.4	..	..	..	..	..
United Arab Emirates	0.8	0.6	0.8	0.6	0.7	0.7
United Kingdom	1.2	1	1	0.9	..	..

Country or Area	2010	2011	2012	2013	2014	2015
United Republic of Tanzania	..	..	7.9	..	..	7
United States	4.8	4.7	4.7	3.9	..	4.9
Uruguay	6.1	5.9	7.9	7.6	7.8	8.4
Uzbekistan	..	..	3.2	..	..	3
Vanuatu	..	..	2.9	..	..	2.1
Venezuela (Bolivarian Republic of)	45.1	47.9	53.8	..	62	57.1
Viet Nam	1.5	1.5	..	..	..	..
Virgin Islands (U.S.)	52.6	..	..	..	..	..
Yemen	4.7	5.7	6.5	6.7	..	..
Zambia	5.8	..	..	..	..	..
Zimbabwe	5.1	..	6.7	..	..	..

Annex 7.3. Summary of anti-violence programme effects for SDG 16 and beyond

Complementary SDG areas	Specific outcomes	Summary of the evidence reviewed
SDG 3	Access to health checks	A family home visiting programme for new parents resulted in increased reporting of infant access to health checks
SDG 3	Hospitalization	Two evaluations of Intensive home visiting for vulnerable parents both pre and post-natal, in four settings, were shown to reduce rates of hospitalisation.
SDG 4	Developmental activities (e.g., reading to children) and child outcomes	Two nurse-led family home visiting services, pre and post-natal, showed impact on parental development activities, and child outcomes. The KiVa school bullying intervention in Finland – which involves parents - also registered an effect on boys' outcomes related to anxiety.
SDG 16	Self-reporting of physical aggression	Reduction in self-reported physical aggression were found, again, to be a result of intensive nurse family partnerships, and home visiting. In contrast, a more clinical approach to treatment, cognitive behavioural therapy and 'gender re-education' for men, had no effects.
SDG 16	Reduced social acceptance of violence (e.g., intimate partner violence, child corporal punishment/ violent discipline)	Reduced social acceptance of violence was found to be an effect of community interventions involving women and men (the example is from Uganda). Whereas violence in the form of violent discipline of children (including shouting and hitting) was not reduced in two nurse home visiting interventions (in the United States) but reduced in a Dutch version of the intervention which was delivered as a community intervention.
SDGs 16, 3, 4, 5	Decrease in experiences of violence	Empowerment plays a role in each of the interventions that have shown success in decreasing experience of violence. In the case of intimate partner violence, home visiting and avoidance strategies are shown to result in reduced experiences. Providing micro-finance to women, along with training, has also been shown to reduce experiences of violence. In contrast, community intervention, and a single nurse home visiting intervention for new mothers did not register significant effects in term of domestic violence. Finally, children who experience the KiVa anti-bullying programme also report lower rates of victimization.
SDGs 16, 3, 4	Prevention of violent discipline of children and neglect	Four studies, all of which evaluate home visiting by a nurse to new mothers in the United States (of the type described above), evaluated for an impact on parents using violent discipline, found that on three occasions the treatment reduced the phenomena. The evaluation in Hawaii did not registered reductions.

for every child, answers

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