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Summary of midterm reviews of country programmes

Eastern and Southern Africa region

Summary

This summary of midterm reviews of country programmes in the Eastern and Southern Africa region was prepared in response to Executive Board decision 1995/8. The Executive Board is invited to comment on the report and provide guidance to the secretariat.

Introduction

1. This report includes midterm reviews (MTRs) for Namibia (2006-2010), South Africa (2007-2010), Swaziland (2006-2010), and Zambia (2006-2010), conducted in 2008 and early 2009.

2. The Eastern and Southern Africa region records some of the world's highest poverty rates and continues to be the epicentre for the HIV/AIDS epidemic. The programming environment in the region remains diverse, along the continuum of emergency, recovery, transition and development. Within this context of humanitarian needs and increasing inequalities, Eastern and Southern Africa has the greatest shortfalls in achieving the Millennium Development Goals. Child mortality

* E/ICEF/2009/16.

reduction in particular is not on track in most countries in the region to meet the set targets.¹

3. Within the Southern African sub-region, Namibia, South Africa, Swaziland and Zambia need to address the “triple threat” of HIV/AIDS, extreme poverty and food insecurity if development gains are not to be lost.

Midterm reviews

Namibia

4. **Process.** The MTR of the 2006-2010 programme of cooperation was undertaken between February and September 2008, jointly coordinated by the National Planning Commission (NPC) and UNICEF. The MTR purpose, scope and methodologies were jointly articulated by UNICEF and the Government of Namibia. International consultations were followed by a desk review of research and evaluations by independent technical experts, interviews with key informants, stakeholder consultations with partners and focus group discussions with young people.

5. **Update on the situation of children and women.** Namibia has seen significant improvements in a number of areas: the average annual income has nearly doubled since 1993/1994, from N\$5,448 to N\$10,358 in 2003/2004; during the same period, the percentage of poor and severely poor households dropped from 38 per cent to 28 per cent and from 9 per cent to 4 per cent, respectively; adult literacy rate has increased from 76 per cent to 83 per cent; primary school enrolment was 92.3 per cent in 2006. Namibia has made significant progress in access to antiretroviral therapy, prevention of mother-to-child transmission (PMTCT), and early infant diagnosis of HIV. However, a dramatic fall in life expectancy, from 61 years to 49 years, predominantly because of AIDS, has had a negative impact on these development gains. There are significant disparities among geographic areas and ethnic groups, and Namibia has the highest Gini coefficient for income inequality in the world.

6. Since the development of the United Nations Development Assistance Framework (UNDAF) and the country programme, the HIV epidemic and increasing food insecurity have remained the main threats to the realization of children’s rights. The 2006 Namibia Demographic and Health Survey, the Health Sector Review and the MTR of the Third Medium-term Plan on HIV/AIDS revealed more recent data on the situation of children and women. Particularly disturbing are upward trends between 2000 and 2006 in maternal mortality (rising from 271 per 100,000 live births in 2000 to 449 per 100,000 live births in 2006), in infant mortality (from 38 per 1,000 live births to 46 per 1,000 live births) and in child mortality (from 62 per 1,000 live births to 69 per 1,000 live births). Slight reductions in primary school net enrolment are not as worrying as poor quality education outcomes. Namibia remains one of the countries with the poorest access to improved sanitation facilities (one in three nationally). While recent data indicates that the HIV epidemic is stabilizing in Namibia, the country has one of the highest HIV prevalence rates, with 17.8 per cent

¹ Two countries are on track, while eight are showing insufficient and ten no progress in achieving Goal 4. The 1.7 per cent per year reduction of the aggregate under-five mortality rate between 1990 and 2007 is far below the four per cent annually required to achieve the Goal 4 target.

among pregnant women and an estimated 15 per cent in the general adult population.²

7. The 2006 outbreak of the wild polio virus, imported from neighbouring Angola, caused 19 deaths and occurred as Namibia was preparing to be declared polio free for the previous ten years. A nationwide immunization campaign was immediately launched. The early 2008 flooding in northern Namibia resulted in significant internal displacement, along with crop and livestock losses, affecting the already fragile food security in six northern regions.

8. **Progress and key results.** The maternal and child survival and development component focused on supporting the Ministry of Health and Social Services in enhancing immunization and basic child health services through the Reaching Every District (RED) approach, developing a national roadmap on reducing maternal and newborn mortality, and increasing PMTCT coverage to 90 percent of antenatal care facilities. Support to a comprehensive health sector review ensured that key elements of a scale-up plan for Accelerated Child Survival and Development (ACSD) were included in a new National Health Sector Strategic Plan.

9. The education for HIV prevention and mitigation component supported the Ministry of Education in moving towards enhanced quality and institutionalization of extracurricular life skills programmes, and assisted the national outreach campaign on HIV prevention coordinated by the Ministry of Information and Communication Technology. By 2008, HIV prevention life skills programmes were offered in 84 percent of primary schools. Policy dialogue and strategic partnerships, including with the United States Agency for International Development (USAID) and the United States President's Emergency Plan for AIDS Relief, facilitated the development of a national education policy for orphans and vulnerable children (OVCs) and prioritization of most vulnerable adolescents in Namibia's HIV prevention strategy. The 2008 flood emergency provided an opportunity to strengthen emergency preparedness and response capacity within the education sector.

10. The special protection for vulnerable children component supported the Government in the development and roll-out of the 2006-2010 National Plan of Action for OVCs at sub-national levels, including capacity strengthening of the Ministry of Gender Equality and Child Welfare. By late 2008, 95,000 vulnerable children were receiving child welfare grants, up from 40,600 in 2006. Increased access to birth registration was pursued through a partnership with the Ministry of Home Affairs and Immigration. In collaboration with United Nations agencies, institutional capacities of the Ministry of Safety and Security, along with community-based approaches to prevent and respond to child sexual abuse and gender-based violence, were strengthened through 15 women and child protection units, covering all regions.

11. The cross-sectoral programme component undertook evidence-informed advocacy to promote public debate on key issues affecting children, including violence and abuse linked to HIV, hygiene and sanitation, and OVCs. In collaboration with the United Nations Development Programme, significant progress has been made to build capacity of planners and statisticians within the

² According to the 2008 HIV sentinel survey of the Ministry of Health and Social Services.

NPC and the regional councils to monitor and analyse the situation of children and families through use of the NamInfo database.

12. **Resources.** For the first two years of the country programme (2006-2007), UNICEF expenditure totalled \$8,474,273, broken down as follows: \$1,367,018 regular resources (RR), and \$7,107,254 other resources (OR), representing 37 per cent of the originally planned country programme budget of \$25 million and 29 per cent of the revised budget ceiling of \$31 million, following an increase in the OR ceiling in 2008. Of the total \$9,254,958 available to the country programme between 2006 and 2007, \$3,286,679 was allocated to maternal and child survival and development, \$3,092,255 for education for HIV prevention and mitigation, \$2,365,409 for special protection of vulnerable children, \$510,613 for cross-sectoral programming.

13. **Constraints and opportunities affecting progress.** Inadequate legal protection and diminishing human resource capabilities at both national and community levels remain key challenges for programme implementation. The provision of integrated services for protection, care and support for children and women, addressing the growing numbers of reported cases of gender-based violence and child exploitation, and increasing access to adolescent-appropriate HIV prevention and treatment services require increased attention. The response to the 2008 emergency highlighted limited preparedness and planning capacity across sectors. One major challenge has been the mobilization of unearmarked funding for senior technical staff, as this affects programme capacity to provide high-level strategic advice and to leverage action and resources in favour of children. The inconsistent application of results-based planning in the UNDAF and the UNICEF country programme presented challenges in monitoring and measuring progress towards results.

14. There are opportunities to strengthen the national development planning approaches through the articulation of a comprehensive social protection framework and disaggregated data on child-related indicators, to feed into child-friendly policy development and national budget allocation processes.

15. **Adjustments.** The MTR confirmed the role of UNICEF in assisting the Government to meet its national, regional and international development objectives, and to strengthen its focus on child-centred evidence-based advocacy and policy development within the broader UNDAF framework. The MTR recommended a consistent application of the results-based management approach.

16. The maternal and child survival and development component will emphasize the development of multi-sectoral policies and action plans related to sanitation and hygiene promotion, neonatal health and infant and child nutrition. As the United Nations Population Fund (UNFPA) expands its role in adolescent-friendly health services, UNICEF will focus on safe motherhood linked to HIV prevention for adolescents and young girls and their partners, to reduce maternal mortality. The geographic focus will be on low performing districts with the highest HIV prevalence rates within the original five focus regions.

17. The education for HIV prevention and mitigation component will expand its focus to cover both in- and out-of-school youth in all regions. Support for the national HIV prevention campaign will include behavioural change communication linked to services, to address the key drivers of the epidemic, including multiple and

concurrent partners and trans-generational sex. A results-based and measurable programme monitoring framework with clearly defined quality and behavioural outcomes will be introduced. Quality education programming support will expand beyond OVCs to all vulnerable children in disadvantaged communities, including strengthening emergency response capacity in the sector.

18. The special protection for vulnerable children component will align strategic results, outcomes and outputs with the National Plan of Action for OVCs and increase emphasis on multisectoral capacity strengthening for the Plan's roll-out. The gender-based violence subcomponent will move beyond promotion and focus on violence against children, concentrating on capacity development of community-based protection mechanisms to reduce abuse, violence and exploitation, including trafficking.

19. Restructuring of the cross-cutting programme component will concentrate on integrated results-based planning and monitoring, communication for development, social policy development, and child-centred research. A new subcomponent on social policy, analysis and research will ensure that high-quality disaggregated data is available for effective and efficient child-friendly policy development. It aims to contribute to the adoption of a child-centred approach for development policies, planning and allocation of resources and the development of a comprehensive social protection approach. The new communication for development subcomponent will facilitate internal technical coordination and leadership to support behaviour-change interventions across all programme components. The new planning and programme monitoring subcomponent will focus on internal coordination and harmonization of results-based planning and monitoring of country programme goals, including emergency and gender-related issues. The external communication and advocacy subcomponent will contribute to increased visibility and action on key children's rights. Partnerships will be pursued with the private sector, professional associations and key opinion leaders.

20. The revised programme results, as amended through the MTR, will serve to further focus the programme on supporting NDP 3, national sectoral plans and the multisectoral HIV/AIDS response. All programme results and targets emphasize direct links to HIV prevention, care and mitigation.

South Africa

21. **Process.** The MTR of the 2007-2010 country programme is based on a series of consultations and reviews which took place in 2008 and 2009, involving the Government, United Nations agencies and other partners. In preparation for the new UNDAF and country programme planning process, the South Africa country office opted for a light MTR, based on key evaluations and review processes of 2008: (a) the joint evaluation of the role and contribution of the United Nations system for South Africa, conducted by the United Nations Evaluation Group and the Government of South Africa; (b) annual UNDAF progress consultations between the Government and the United Nations system; (c) UNICEF annual review consultations with national counterparts; (d) the situation analysis of children in South Africa; and (e) the 15-year review of the National Development Plan. The implementation of the 2007-2010 UNDAF midterm evaluation, which was expected to inform the MTR, was postponed to the second half of 2009.

22. **Update on the situation of children and women.** With a gross domestic product of \$281 billion and per capita income of \$5,740 in 2008, South Africa ranks as a middle-income country. However, 41 per cent of the population in 2007 lived below the national poverty line, with women and children disproportionately affected, at 68 per cent. At 59 per 1,000 live births in 2007, the under-five mortality rate has remained almost unchanged over the past two decades.³ The 2005 National Food Consumption Survey found that, among children between 1 and 9 years, 18 per cent were stunted, 9.3 per cent underweight and 4.5 per cent wasted, with little progress since 1995. Likewise, maternal mortality has remained around 150 per 100,000 per live births (Demographic and Health Survey 1998). AIDS accounts for 20 per cent of maternal deaths.

23. South Africa is the hardest-hit country by HIV and AIDS in absolute numbers, with 5.2 million people living with HIV in 2008 and an estimated 527,000 new infections per year. The prevalence rate is 18.8 per cent among the general population (15 to 49 years old) and 28 per cent among antenatal care attendees. Around 250,000 to 300,000 newborns are annually at risk of being infected through mother-to-child transmission. The 2008 Household Survey of HIV and AIDS prevalence by the Nelson Mandela Foundation and the Human Science Research Council found that HIV prevalence among children aged 2 to 14 years declined, from 5.6 per cent in 2002 to 2.5 per cent in 2008. About one third of the country's 3.8 million orphans have lost one or both parents to AIDS. The tuberculosis (TB) incidence rate was 645 per 100,000 people in 2005, up sharply from 169 per 100,000 people in 1998, with between 50 per cent to 80 per cent HIV-positive TB patients and 15 per cent to 25 per cent of recorded TB cases among children.

24. South Africa is on track to achieve Millennium Development Goal 2. The gross enrolment rate is 98 per cent in primary education and 85 per cent in secondary education, with the gender parity index at 0.98 and 1.03, respectively. The Children's Act, the Child Justice Act and the Sexual Offences Act have been signed into law.

25. **Progress and key results.** The strengthened partnership with the Government in the areas of health, education, social development and protection contributed to leveraging policies and programmes, building national capacities and strengthening systems for scale-up of delivery.

26. Successful advocacy and upstream technical assistance provided through the child survival and development component contributed to scaling-up of high-impact interventions: 91 per cent of pregnant women deliver in health facilities attended by doctors and nurses; the proportion of pregnant women tested for HIV increased from 59 per cent in 2006 to 80 per cent in 2008, and access of HIV-positive pregnant women and babies to single-dose Nevirapine increased from 48 per cent and 39 per cent in 2006 to 75 per cent and 47 per cent in 2008, respectively. Immunization coverage remained high for most of the antigens: 97 per cent of infants received three doses of combined diphtheria/pertussis/tetanus vaccine and 83 per cent were immunized against measles. The number of eligible HIV-infected children on highly active antiretroviral therapy (HAART) nearly tripled, from 23,369 in 2006 to 62,558 in 2008. More than 40 per cent of the 545 maternity facilities were accredited as

³ Most deaths are due to conditions that are either preventable or treatable, such as AIDS (35 per cent), neonatal causes (30 per cent), diarrhoea (11 per cent), pneumonia (6 per cent) and injuries (5 per cent); 60 per cent of children dying are malnourished.

“baby-friendly hospitals” and 68 per cent of primary health care facilities have health workers trained according to the Integrated Management of Childhood Illnesses.

27. In collaboration with the World Health Organization, UNFPA, the Joint United Nations programme on HIV/AIDS, academic institutions and civil society organizations, the programme supported the development of the National HIV and AIDS Strategic Plan 2007-2011, targeting universal coverage for PMTCT and paediatric HIV and AIDS care and treatment by 2011, the revision of national PMTCT guidelines and the national PMTCT Acceleration Plan.

28. The programme contributed to the formulation of the first National Strategic Plan on Maternal, Neonatal, Child and Women’s Health and Nutrition 2008-2013, the development of an infant and young child feeding policy and guidelines, and national regulations on the marketing of infant foods. The evidence-base for MNCH scale-up was strengthened through collaboration with the Universities of Kwazulu Natal and Western Cape on a multi-country study on the impact of HAART on PMTCT and breastfeeding. In collaboration with Pretoria University, a basic antenatal care model to reduce peri-natal deaths is being rolled out in all provinces by the National Department of Health. Cooperation with the University of Limpopo on a neonatal care model resulted in initial data indicating a 10 per cent reduction in neonatal mortality, and led to the roll-out of the model to 40 hospitals. In 2008, the first national vitamin A supplementation campaign to fill a coverage gap reached more than 3.2 million children aged 1 to 4 years. In partnership with non-governmental organizations (NGOs) and United Nations agencies, UNICEF responded to the 2008 xenophobic attacks in South Africa through the provision of basic medical supplies, vitamin A supplementation, water and sanitation, immunization and counselling on infant feeding. During the 2008 cholera outbreak, UNICEF supported hygiene promotion.

29. Strategic policy engagement in the education and adolescent development programme facilitated key results. The national integrated plan for early childhood development (ECD) incorporated care and support for OVCs through an integrated community-based package of child survival, development and protection services at household, community and central levels, focusing on young children affected by poverty and HIV and AIDS. Continued evidence-based advocacy to leverage investment in ECD led to recognition as a national priority and increased national budget resource allocations in 2008. The Child-Friendly School (CFS) programme expanded from 25 model schools in 2006 to 585 schools in 2008, with government commitment to expand further to 5,000 of 26,000 schools. National CFS guidelines and an accreditation system were developed, based on lessons learned from the CFS model. The life skills-based sports for development programme addressed violence in schools.

30. By 2008, more than 8 million vulnerable children were receiving child support grants, and caregivers of around 500,000 children in formal care were receiving foster care grants through the Government’s social protection programme. The child protection component helped identify and facilitate access of eligible children and families to social grants, and monitored impact and performance of the national social protection programme. Around 400 child care forums are providing integrated services to around 200,000 children. A national Child Care and Protection Forum was established to guide implementation of the Children’s Act, including strategy

formulation on child protection system development for alternative care, prevention and early intervention. A partnership with the National Prosecuting Authority reached 10,500 victims of violence annually through comprehensive support centres. The “Accelerating Child and Women’s Protection through Prevention and Response to Violence and HIV” project laid the groundwork for scale-up of the Thuthuzela Care Centre model and violence-prevention activities. Working in cooperation with United Nations and NGO partners, the programme strengthened capacity and inclusiveness of national care and protection systems, to address the specific care needs of migrant children, particularly unaccompanied children, from Zimbabwe.

31. The social transformation and strategic leveraging component contributed to more effective social grants programmes and improved child welfare strategies. The Child Support Grant (CSG) qualitative and quantitative studies, completed in partnership with the Department of Social Development and the South Africa Social Security Agency, consolidated the evidence base for the current grant and intensified national dialogue on reaching the most vulnerable children as well as increasing the eligibility age for CSG to 17 years. A public expenditure tracking study, developed in cooperation with the Department of Education and National Treasury, reviewed spending efficiency and equity issues in ECD programmes. Strategic support was provided to the national and provincial legislatures on strengthening parliamentary oversight and legislation.

32. The planning, monitoring and evaluation component and the Office on the Rights of the Child in the Presidency undertook a situation analysis of South African children. A DevInfo database was established, and ownership is being transferred to the Statistics Office South Africa.

33. The external relations and strategic partnerships component raised ZAR 5,891,947 from corporate and individual donors and leveraged ZAR 10,200,000 through corporate partnerships.

34. **Resources.** The approved country programme budget is \$31,988,000, of which \$3,988,000 is from RR and \$28,000,000 from OR. The total expenditure from January 2007 to May 2009 is \$21,120,816. Of these \$2,265,987 are from RR and the remainder from OR. The office has exceeded its OR ceiling and has received approval to receive additional funds. Of the total \$39,587,490 available between 2007 and 2009, the following allocations were made: \$11,849,723 for education and adolescent development; \$8,585,032 for child survival and development; \$11,504,755 for protection of orphans and vulnerable children; \$2,375,624 for programme planning, monitoring and evaluation; \$1,998,772 for social transformation and strategic leveraging; \$875,884 for external relations and strategic partnerships; and \$1,740,516 for cross-sectoral costs.

35. **Constraints and opportunities affecting progress.** Despite a favourable policy environment and legislative framework, challenges to implementation and monitoring remain. Widespread poverty and disparity require sustained and substantial social sector investments for well targeted and proven high-impact programmes. Recent legislative reforms, including the Children’s Act, provide an opportunity to advance the agenda for children. Increased political commitment is expected to accelerate the HIV and AIDS response for children. Constraints include weak implementation capacity at all levels and slow decision-making processes. This will require an increased focus on ensuring timely service delivery through

better targeting and accountability, strengthened partnerships with civil society organizations, United Nations agencies and bilateral organizations, and a stronger monitoring and evaluation framework. Work at community level has progressed, yet greater investment and systems development are needed to scale up interventions.

36. **Adjustments.** The MTR concluded that the country programme is on track. Working under government leadership and in close partnership with the United Nations country team (UNCT), civil society and development partners, the programme will now focus on scaling up key programme components. The programme will track the impact of the global economic downturn on South African children, provide coherent support to national climate change mitigation and adaptation efforts and consolidate ongoing technological innovation initiatives to achieve results for children.

37. National efforts to improve maternal and child health will be adjusted, placing greater emphasis on improved quality of care in health facilities to reduce hospital-based maternal and neonatal mortality by at least 15 per cent. Community-based maternal, neonatal and child health and nutrition interventions will be scaled up, with focus on 18 priority districts, to reduce malnutrition and neonatal and child mortality by at least 10 per cent and 30 per cent, respectively. HAART referral for pregnant women and eligible children, targeting a reduction in the 6-week mother-to-child transmission rate to less than 10 per cent and a doubling of the number of children on HAART, will be introduced in primary health care facilities. Community-based communication campaigns will be scaled up, to change health, nutrition and HIV behaviours, with special emphasis on improving MNCH and PMTCT data management systems.

38. The education and adolescent development component will support the scale up of the child-friendly schools initiative towards the targeted 5,000 schools. The scope of the child protection component will be expanded to address child labour, child trafficking and child prostitution, especially in light of the 2009 and 2010 international football events. The focus will be on strengthening systems for the effective delivery of services, programme communication to raise public awareness on violence against children and on how to prevent it, and child participation in violence prevention.

39. The social policy component will provide advisory support and analysis tools to national and provincial governments for effective participation in decision-making on child-related policies. The monitoring and evaluation function will focus on improved collection and analysis of disaggregated data to inform policy implementation. The communication for development component will target behaviour change, to address identified shortcomings in prevention of child protection violations and HIV prevention.

Swaziland

40. **Process.** The MTR of the 2006-2010 country programme, conducted jointly by the Government of Swaziland and UNICEF, was aligned with midterm reviews of other United Nations agencies and designed to feed into the UNDAF review in late 2008. The MTR was based on new findings from the Swaziland Demographics and Health Survey, the National Census, the UNICEF child deprivation analysis and an MTR report on the situation of women and children. An internal outcome progress review and questionnaire feed-back on country programme effectiveness informed

MTR stakeholder consultations, involving more than 150 individuals, including Government officials and representatives of donors, the UNCT, NGOs and young people. Each programme reviewed progress against targeted outcomes in the Country Programme Action Plan (CPAP), identifying strengths, weaknesses, opportunities and threats. Recommendations were endorsed by stakeholders in October 2008.

41. **Update on the situation of children and women.** Swaziland continues to struggle with the three interrelated challenges of HIV/AIDS, poverty and food insecurity. Seven in ten people in Swaziland live below the poverty line and almost four in ten live in extreme poverty. HIV/AIDS and poverty are compounded by declining food security. Following several years of persistent drought, Swaziland suffered one of the worst crop failures in recent history in 2006/2007, when an estimated 40 per cent of the population required external food aid.

42. With the highest prevalence rate in the world, at 26 per cent among the adult population, and reaching 49 per cent among women aged 25-29 years, the HIV epidemic is an extreme development challenge. Due largely to AIDS, life expectancy has declined within a decade from 60 years to 40 years and one third of all children are now classified as OVCs. Females carry a huge burden because of HIV and reproductive health risks⁴ — they are infected with the HIV virus at an earlier age than males; they are the primary care givers of those affected; and they face stigma and often rejection if they disclose their HIV status.

43. The cumulative effects of this triple threat have serious repercussions for children's health and development. The under-five mortality rate doubled from 1992 to 2006/2007 and stands at 120 deaths per 1,000 live births. Stunting and wasting rates among children under five years have remained unchanged since 2000, at 30 per cent and 3 per cent, respectively. While anaemia remains widespread, with 42 per cent of children under the age of five affected, there is evidence of progress on micronutrient supplementation. Due in part to the recurrent droughts, lack of access to clean water and sanitation, at 25 per cent and 20 per cent, respectively, are the most common deprivations suffered by children.

44. Primary school enrolment increased notably, from 72 per cent in 2000 to an estimated 93 per cent in 2007.⁵ Secondary school enrolment increased slightly, from 29 per cent in 2000 to 33 per cent in 2007, with some gender disparity.⁶ While the influx of primary school students is attributable to the Government's free provision of books and the introduction of education grants for OVCs, other school-related expenses, including uniform and transport costs, remain a barrier to access, contributing to continuing high drop-out rates.⁷ It is estimated that only 30 per cent of primary school entrants complete 10 years of education and only 23 per cent finish the full secondary cycle.

45. With the growing strain on community life caused by HIV, poverty and drought, and the erosion of traditional social safety nets, children are increasingly

⁴ The life-time risk of dying from pregnancy and child birth is high.

⁵ Primary school enrolment shows near gender parity: 92 per cent for girls and 94 per cent for boys.

⁶ Secondary school enrolment is 30 per cent for girls and 37 per cent boys.

⁷ Drop-out rates are 6 per cent per grade at lower primary school and 10 per cent at upper primary school.

exposed to neglect, abuse and exploitation. A 2007 nationwide study on violence against children, supported jointly with the United States Centers for Disease Control and Prevention, revealed alarming levels of abuse of females across the country: 33 per cent experience sexual abuse, and 25 per cent, physical abuse, by the time they are 18; one in three children is exposed to emotional abuse; and many children are subject to exploitation through different forms of child labour.

46. **Progress and key results.** The child survival and development component supported the Government in strengthening rural health service delivery through high-impact interventions for child survival, improving maternal health interventions, and increasing access to safe water, primary prevention and PMTCT. With UNICEF, the United States President's Emergency Plan for AIDS Relief and Baylor Clinic as partners, the PMTCT programme was rapidly scaled up, attaining the second-highest PMTCT coverage rate in Africa.⁸ Service provision for exposed or infected children improved significantly, with more than half of all HIV-positive children accessing antiretrovirals in 2007. Revitalized child survival initiatives, including the development of a child survival plan and implementation of high-impact interventions through routine systems and campaigns, contributed to maintaining the country's zero polio status, maternal and neonatal tetanus elimination and consistently high immunization coverage rates.⁹ To combat diarrhoeal diseases, zinc therapy and low-osmolarity oral rehydration salts were introduced in all hospitals and health centres. A national policy on infant and young child feeding, a draft food security and nutrition policy, a draft code of marketing for breast milk substitutes, and guidelines on HIV and nutrition were developed. An annual deworming campaign was launched, while vitamin A supplementation was provided during the annual Child Health Days and during routine immunization visits. Therapeutic feeding for children with severe acute malnutrition is now offered at major hospitals and community clinics. In response to the drought emergency, UNICEF and partners contributed to increasing access to safe drinking water from 180 Neighbourhood Care Points (NCPs) in 2005 to 425 NCPs in 2008 and from 220 primary schools to 250 during the same period. Access to safe sanitation at NCPs increased from 20 per cent to 50 per cent.

47. The safety nets programme supported the development of six national policies and laws to improve the situation of women and children, including the revised Children's Policy and the Social Welfare Policy. The National Plan of Action for OVCs 2006-2010, outlining a common OVCs stakeholder strategy was launched. Following the submission of the first report to the Committee on the Rights of the Child in 2006, UNICEF supported the Government in responding to 72 Concluding Observations. Country-wide, intensive information campaigns raised national awareness about different forms of violence, exploitation and abuse against children.¹⁰ The programme supported community-based mechanisms for violence and abuse detection and reporting, and assistance for survivors, through a country-wide network of community child protectors. NCPs continued to act as safe havens in the community for OVCs with a total of 665 NCPs reaching an estimated 30,000 children. Over 64,000 children had their births registered through a no-fee registration campaign, and efforts are progressing to institutionalize birth registration in health facilities. Emergency relief in response to the drought and

⁸ PMTCT coverage increased from 71 per cent in 2006 to 80 per cent in 2008.

⁹ DPT3 coverage for children under one year was 82 per cent, compared to 62 per cent in 2005.

¹⁰ This includes sexual, physical, and emotional abuse, child labour and property grabbing.

forest fires included survival kits, blankets and other essential commodities, and UNICEF played a lead role in coordinating, advocating and strengthening institutional capacity for emergency preparedness and response for child protection.

48. In line with Government commitment to universal primary education (UPE) by 2009, the education and life-skills programme supported the development of a national education policy statement and UPE plan of action, the deployment of volunteer teachers in 40 community “Education for All” schools and the provision of equipment and materials. The Schools as Centres of Care and Support (SCCS) pilot initiative created a positive learning environment in 360 schools. Collaboration with the Government and NGOs increased access to safe drinking water and improved sanitation and hygiene in all SCCS schools, and cooperation with the World Food Programme ensured that all children in SCCS schools received at least one hot meal per day. Culturally appropriate life skills education is now offered in 75 per cent of schools. Important steps towards universal access to Early Childhood Care and Development (ECCD) included the development of an ECCD policy and progress on harmonization of NCPs and community pre-schools. As part of a national effort to combat violence against children, UNICEF supported the amendment of the Teaching Service Act, which toughens penalties for child-abuse. An estimated 60 per cent of schools have at least one teacher and one counsellor trained in child protection, and the Ministry of Education runs a toll-free violence reporting telephone line. Teachers in “inclusive model schools” were equipped with skills to identify and support children with special education needs, and an inclusive education policy and corresponding guidelines are now in place.

49. Communication initiatives supported by the advocacy and communication component engaged tens of thousands of children and adults on HIV/AIDS and child abuse topics through theatre, radio, film, community dialogues and special events. A national study on violence against children and accelerated efforts to enhance data collection contributed to placing violence against women and children on the national agenda. UNICEF played a catalytic role, building consensus and strong partnerships, such as the Child Protection Network and the revived water, sanitation and hygiene education (WASH) stakeholder forum, and increasing partner capacities on children’s issues. The creation of a social policy unit within the country programme further improved information and analysis capacities on child vulnerability.

50. **Resources.** From the beginning of the country programme in 2006 until the end of 2008, UNICEF expenditure total \$18,862,000, broken down as follows: \$3,945,000 RR; \$14,917,000 OR, representing 75 per cent of the originally planned CPAP budget of \$25,000,000. Of the total \$13,761,000 available to the country programme between 2006 and 2008, \$3,270,000 (24 per cent) was allocated for child survival and development; \$3,270,000 (24 per cent) for education and life skills; \$4,770,000 (35 per cent) for safety nets for child protection; \$2,451,000 (18 per cent) for advocacy and communication for child rights. The Swaziland country office succeeded in securing \$18 million in OR and \$2,789,458 million in emergency funds, and was granted a budget ceiling increase from originally \$21,250,000 to \$36,250,000. Despite overall successful resource mobilization, the water and sanitation and nutrition components remained underfunded.

51. **Constraints and opportunities affecting progress.** The overall decline in government social sector spending between 2006 and 2008¹¹ has been most marked in education, while both health and social protection received slight increases in national budget allocations. Despite limited in-country donor presence, UNICEF mobilized increased resources for critical HIV prevention, child health, education, and vulnerability interventions. However, the impact of the global economic crisis is anticipated to result in continuing budget constraints and anticipated decline in donor contributions.

52. A number of national policy developments have improved the programming environment, including the launch of the Poverty Reduction Strategy and Action Programme (PRSAP), the introduction of the National Multisectoral HIV and AIDS Strategic Plan and a national plan of action for OVCs. Since 2006, the Government has embarked on a national decentralization process and created the Ministry of Regional Development and Youth Affairs. The establishment of the national children's coordination unit represents a major advancement in institutional capacity to develop and operationalize laws and policies relating to children. Ratification is underway of the African Charter on the Rights and Welfare of Children and the two Optional Protocols to the Convention of the Rights of the Child.

53. Accelerated United Nations coherence efforts in recent years have resulted in strengthened joint programming mechanisms, greater synergies and more streamlined assistance. The UNDAF alignment with the PRSAP and the first joint midterm review of the UNDAF in late 2008, were major milestones in the harmonization of United Nations support and provide opportunities for a consolidated response to the triple threat. The creation of the national children's coordination unit established leadership among stakeholders working for the promotion and protection of children's rights.

54. The MTR identified four major cross-cutting challenges: (a) limited behaviour change for HIV prevention despite successful awareness raising efforts; (b) delay in finalization and adoption of national policies and laws; (c) increased child vulnerability in urban and peri-urban areas; and (d) shortage of skilled professionals, adversely affecting provision and delivery of key social services.

55. **Adjustments.** The MTR recommended that the country programme maintain its current focus while working on refining approaches and strategies on promoting the rights of children at all levels. Accordingly, adjustments strengthen the use of a rights-based approach to programming and a more systematic approach to mainstreaming HIV/AIDS prevention, gender equity and violence prevention. Improving partner emergency preparedness and response capacities, with special emphasis on national capacity development, will be prioritized. A comprehensive programme on primary prevention of HIV among young people will be introduced, to address shortcomings in HIV-related results.

56. The country programme will enhance harmonization with new national instruments and evolving United Nations reform. Advocacy to ensure speedy approval of draft policies and legislation on children, as well as ratification, domestication and monitoring of regional and global treaties and conventions, will be intensified. To address concerns about programme ownership and sustainability,

¹¹ Social sector spending declined from 39.6 per cent of the total budget in 2006/2007 to 36.3 per cent in 2007/2008 and 37.4 per cent in 2008/2009.

greater engagement of communities, civil society and government institutions will be fostered.

57. The child survival and development component will accelerate support for improved access to maternal and newborn care, PMTCT and paediatric HIV care, and develop a comprehensive programme of support for primary prevention of HIV. Efforts to increase access to integrated, high-impact health and nutrition interventions will prioritize hard-to-reach areas, and water, sanitation and hygiene education sector support will be scaled up in rural and peri-urban areas.

58. The safety nets for child protection component will focus on: (a) consolidation and implementation of key policies and legislation on child protection; (b) promote adoption of a systems-based approach to child protection; (c) national scale-up of community-based programming; and (d) development of a comprehensive strategy for prevention and management of violence against children.

59. The education and life skills component will continue to work with partners to intensify efforts to plan for and implement UPE.

Zambia

60. **Process.** The MTR of the 2007-2010 country programme was completed in early 2009, as a part of the joint UNDAF/MTR process in Zambia, involving consultations with the Government, donors and civil society partners. Within this broader framework, the MTR was a lighter process, focusing on specific results identified in the country programme document.

61. **Update on the situation of children and women.** Data from the 2007 Living Conditions Monitoring Survey (LCMS) showed a sharp change in the distribution of poverty, with a significant decline in urban poverty and a rise in rural poverty. Access to health, education, protection, water and sanitation is generally available in urban areas but limited in rural areas. The economic crisis further threatens to reverse gains made since 2000.

62. The 2007 LCMS and preliminary findings of the 2007 Zambia Demographic and Health Survey recorded significant progress in the health sector, with drastic reductions in maternal and under-five mortality rates: maternal mortality was reduced to 591 deaths per 100,000 live births¹² and under-five mortality stands at 119 per 1,000 live births.¹³ HIV prevalence in the general population dropped from 15.6 per cent in 2002 to 14.3 per cent in 2007, and exclusive breastfeeding has increased from 40 per cent in 2002 to 61 per cent in 2007.

63. Zambia has made significant progress in school enrolment and completion. In 2007, the primary general enrolment rate reached 130 per cent, and completion rates rose to 91 per cent. Significant headway has been made in enrolling girls, orphans and vulnerable children. A quantitative 2000-2007 education impact evaluation documented a 67 per cent enrolment increase for grades 1 through 7: from 1.6 million pupils in 2000 to 2.8 million in 2007. With a gender disparity index of 0.96, Zambia is on track to meet Millennium Development Goal 2 on universal primary education by 2015. However, two-thirds of girls do not complete their primary schooling.

¹² Reduced from 729 per 100,000 live births in 2002.

¹³ Reduced from 168 per 1,000 live births in 2002.

64. **Progress and key results.** The health and nutrition component contributed to significant progress: children's access to ARVs has increased and use of PMTCT services has improved, from 26 per cent in 2006 to 39 per cent in 2007. Follow-up and identification have been improved through the revision of under-five child health cards to include information on maternal/infant HIV status; 500,000 such cards were printed in 2008. A roll-out plan for emergency obstetric and neonatal care was introduced to improve skilled delivery. Safe motherhood action groups, introduced to create community awareness and demand for skilled attendance at delivery, are functional in 24 of 44 districts.

65. Routine immunization coverage remains high, with 95 per cent DPT3 coverage in 2008, and polio-free and maternal neonatal tetanus elimination status have been maintained. A nationally representative malaria indicator survey conducted in 2008 found that 72 per cent of households own at least one mosquito net, and 62 per cent of these have at least one insecticide-treated net, representing an increase of 50 per cent and 38 per cent, respectively, compared to the 2006 Malaria Indicator survey.

66. By December 2007, biannual nutrition surveillance and monitoring had started in three provinces, to be scaled-up nationally. Efforts to improve micronutrient supplementation are on course, with vitamin A coverage around 70 per cent and a robust national programme on salt iodation. UNICEF supported national health worker capacity building efforts on infant and young child feeding and management of severe malnutrition. Integration of nutrition and HIV and AIDS programming has been enhanced through the development and dissemination of nutrition guidelines on care and support for people living with HIV/AIDS.

67. The education component supported the Government's response to the HIV/AIDS challenge by developing an HIV/AIDS workplace policy for teachers and the life skills education programme for pupils. Advocacy efforts leveraged government commitment for the translation of the Education Sector Policy on HIV and AIDS to the school level. UNICEF contributed to the mainstreaming of life skills into basic school and teacher training curricula, as well as capacity building for the development of school-based HIV and AIDS response plans. The programme contributed to increased access through upgrading and construction of community schools in four provinces and to gender parity through sensitization campaigns for local leaders on the importance of girl's education. Community schools have become key providers of education services, currently educating 17 per cent of all basic school pupils. In recognition of this important role, newly adopted community school guidelines provide for increasing teacher and learning material support to community schools.

68. The programme contributed to policy, strategy and curriculum development within the Government's early childhood care development and education (ECCDE) programme and to ECCDE service provision, in partnerships with NGOs. Media sensitization raised the ECCDE profile and capacity development for specialists strengthened skills in curriculum development and dissemination of national child assessment tools. Despite initial achievements, the percentage of children enrolled in the first grade with prior ECCDE experience remains very low (17.1 per cent).

69. The School Sanitation and Hygiene Education (SSHE) Forum was established under the Ministry of Education for improved information sharing and coordination of WASHE in schools. Within the framework of the National Rural Water Supply and Sanitation Programme, the self supply programme for rural water supply under

the water, sanitation and hygiene education component upgraded over 100 traditional water systems, serving approximately 7,500 people in Luapula province. Under the community-led total sanitation programme in Southern province, improved sanitation and hygiene reached approximately 150,000 people; an additional 100,000 people accessed household water treatment through significant community mobilization and empowerment efforts, involving the training of peer educators and teachers and the formation of WASHE groups in 30 schools. Sanitation facilities were constructed or rehabilitated in 48 basic and community schools and clean water provided in 10 schools in Eastern, Southern, Western and Luapula provinces.

70. The child protection programme contributed to leveraging social protection as a key strategy for OVCs care and support. In partnership with United Kingdom Department for International Development (DFID) and Care Zambia, district social welfare officers' capacity on the implementation of cash transfers was strengthened in six pilot districts. UNICEF supported the Government in undertaking a comprehensive study on street children, which guided policy discussions on provision of alternative care, strengthening of child protection systems at district level, and the finalization of the National Plan of Action for Children, including a monitoring and evaluation framework for roll-out in 30 pilot districts.

71. Cooperation with the judiciary and police increased knowledge about the protection of children in the criminal justice system, with 306 judges, magistrates, police officers, prosecutors and social workers trained in court preparation for child witnesses. The scale-up of one stop centres and places of safety resulted in a coordinated and cohesive response to gender-based violence in eight provinces. National campaigns on child protection and gender-based violence contributed to increased reporting on child abuse and violence cases. Children benefited from strengthened legal and regulatory frameworks through the child justice transformation process, the newly passed anti-trafficking law and the establishment of women's and children's units in police stations. UNICEF was instrumental in the formation of a children's caucus in the national Parliament to advocate for children's issues in all parliamentary activities. The development of a roadmap for the child law review and the cooperation with the Zambia Law Development Commission in conducting a legislative audit on child-related laws guided the reform process.

72. **Resources.** In total, of the \$33,826,457 funded resources for 2006 and 2007, \$16,015,064 were RR, \$14,456,489 OR and \$3,354,904 emergency funds. The total amount spent in that period was \$15,188,407 RR and \$13,952,386 OR. Increased expenditure has occurred particularly in health and nutrition and in education, while water and sanitation and child protection were underfunded in terms of planned OR for the first two years of the cycle. Most funding was allocated to health and nutrition and HIV/AIDS, \$12,868,299 (38 per cent), while "basic education" received \$6,515,548 (19 per cent), WASH \$3,630,786 (11 per cent), child protection and empowerment \$3,580,022 (11 per cent), participatory planning, monitoring and evaluation \$4,743,314 (14 per cent); cross-sectoral costs were \$2,488,568 (7 per cent).

73. **Constraints and opportunities affecting progress.** Broad stakeholder support and practical alignment around the Fifth National Development Plan (2006-2010), and key aid coordination instruments, including the Joint Assistance Strategy in

Zambia 2007-2010 and the UNDAF 2007-2010, provide an environment conducive for progress.

74. Key constraints include low social service budget provisions at national, provincial and district levels as well as limited human resource capacities. The fragile health system, due to low capacity to undertake accelerated programme scale-up and monitoring for action, provides poor service delivery.

75. Despite marked increases in knowledge levels among adolescents and young people on HIV/AIDS prevention, there is no evidence of corresponding behaviour change. The overloaded curriculum, coupled with limited pupil-teacher contact time, lack of sufficient educational materials and poor conditions of service for teachers, have contributed to low education quality. Direct funding for schools is limited and irregular. A new sector-wide approach to programming (SWAp) provides an opportunity for coordinated stakeholder support to education.

76. In child protection, the rapid turnover of trained and experienced personnel in the social services sector, the judiciary and the police reduces the impact of capacity development programmes. Nevertheless, strong and diverse partnerships provide opportunities for creating a critical mass of rights-based interventions to more effectively target vulnerable children.

77. **Adjustments.** The programme will strengthen the use of human rights-based approach to programming (HRBAP) and a results-based management (RBM) to facilitate a more measurable and explicitly child rights-focused approach. Based on situation analysis and MTR findings, the health and nutrition programme will increase community engagement to respond to the human resource crisis and to strengthen continuum of care approaches. An integrated programme design will be developed to improve technical efficiency and foster progress in accelerating child survival and development and renewed focus on HIV/AIDS prevention programming. The education programme will take the CFS best practices to scale, targeting low-performing districts, and phase out school construction. A three-pronged ECCDE advocacy strategy will prioritize increased government and NGO participation in service delivery. The child protection programme will focus social protection interventions on populations in the lowest-income quintile, to facilitate disparity reduction. Work with district development committees will focus on HIV/AIDS and special protection measures. The WASHE programme will increase partnership development and engagement in the SWAp and provide technical assistance to the Government to cover 20 programme districts. Specific strategy development and coordinated interventions with other United Nations agencies will be pursued to address increased needs in urban and peri-urban areas.

Conclusion

78. The increasingly adverse global environment, affecting economic conditions and poverty levels, has influenced the strategic focus of UNICEF programming in the region. This strategic shift — towards performance-based resource allocation, evidence-based action and increased community engagement for scale-up of high-impact interventions, combined with upstream contributions towards system building and strengthening, along with communication for social change and integration of emergency response into regular programming — is geared to helping countries in the region achieve the Millennium Development Goals under difficult

circumstances. In the context of the new aid environment, shifting the UNICEF focus towards harmonization with other development partners as part of a “One United Nations” team in supporting national priorities is of critical importance.

79. The MTRs confirm the strong commitment of Governments, UNICEF and partners in the four countries to achieving the Millennium Development Goals and contributing to the social protection agenda. The MTRs recommended a continued focus on accelerating child survival and development — through outreach and campaign interventions and increased attention to health systems strengthening. Progress made towards achieving the Goals in education is encouraging, yet sustained support will be required to ensure that the most vulnerable children are not excluded, remaining gender gaps addressed and quality further improved. While the MTRs recorded significant progress in PMTCT, there has been limited progress on HIV prevention in all countries under review, despite marked increase in knowledge levels among young people, due to limited corresponding behaviour change. Substantial efforts and innovative programme strategies will be required to ensure that Goal 6, target 7, to halt and reverse the spread of HIV by 2015, will be achieved.

80. The MTRs highlighted significant progress in programming for orphans and other children affected by AIDS. In a region experiencing frequent emergencies, high levels of poverty, rapid urbanization and increasing disparities, national action plans and cooperation programmes reflected the need for broader targeting, beyond children orphaned or made vulnerable by AIDS, and for increasing alignment of AIDS mitigation efforts with poverty reduction and social protection strategies, with a focus on strengthening family care capacities.

81. In all countries under review, new programmatic approaches to tackle increasing disparities between urban and rural areas and emerging urban and peri-urban vulnerabilities will be required.

82. As a leading partner in the various United Nations country teams in the region, UNICEF remains committed to ensuring that United Nations cooperation is aligned with national development plans, as was evident in the joint management of the MTR process and the clear linkages between the UNICEF MTRs and the respective UNDAF MTRs in all countries under review.