

# **Eritrea**

## **Country programme document 2013-2016**

The draft country programme (CPD) document for the Eritrea (E/ICEF/2013/P/L.1) was approved in accordance with decision 2012/17, on an exceptional basis, by the Executive Board at its 2013 first regular session (5-8 February 2013).

The draft CPD was discussed at an informal consultation on 17 December 2012. This final version was approved at the 2013 first regular session of the Executive Board on 8 February 2013.

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*Basic data*<sup>†</sup>  
(2011 unless otherwise stated)

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Child population (millions, under 18 years)	2.6
U5MR (per 1,000 live births)	68
Underweight (% , moderate and severe, 2002)	35 <sup>a</sup>
(urban/rural, poorest/richest)	23.3/40, ...
Maternal mortality ratio (per 100,000 live births, adjusted)	240 <sup>b</sup>
Primary school enrolment/attendance (% , net male/female, 2010)	37/33
Survival rate to last primary grade (% , male/female, 2010)	76
Use of improved drinking water sources (% , 2005)	61
Use of improved sanitation facilities (% , 2005)	14
Adult HIV prevalence rate (% , 15-49 years of age, male/female, 2009)	0.6
Child labour (% , 5-14 years of age, male/female)	..
Birth registration (% , under 5 years of age)	..
GNI per capita (US\$)	430
One-year-olds immunized with DPT3 (%)	99
One-year-olds immunized against measles (%)	99

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<sup>†</sup> More comprehensive country data on children and women can be found at [www.childinfo.org/](http://www.childinfo.org/).

<sup>a</sup> Underweight estimates are based on the WHO Child Growth Standards adopted in 2006.

<sup>b</sup> The United Nations Interagency Group (WHO, UNICEF, UNFPA and The World Bank) produces internationally comparable sets of maternal mortality data, which account for the well documented problems of underreporting and misclassification of maternal deaths, including estimates for countries with no data. Comparable time series on maternal mortality ratios for the years 1990, 1995, 2000, 2005 and 2010 are available at [www.childinfo.org/maternal\\_mortality.html](http://www.childinfo.org/maternal_mortality.html).

## Summary of the situation of children and women

1. The population of Eritrea was estimated by the Ministry of Health at 3.8 million in 2010, with 2.5 per cent annual growth. Despite an urban population drift, about two-thirds of Eritreans live in rural and semi-urban areas. Triggered by recent mining activities, the gross domestic product per capita was estimated at \$549 in 2011, growing at a rate of 8.7 per cent per year. Eritrea is presently developing the export potential of its minerals reserves, which include gold, copper and potash. However, economic and social development efforts continue to be impeded by the ‘no peace, no war’ residual situation from the border conflict with Ethiopia (Human Rights Council Universal Periodic Review, 2009).

2. Agriculture and pastoralism are the main livelihoods for 80 per cent of Eritreans. However, food security continues to be a major challenge. The Government of Eritrea is attempting to boost the domestic food production toward greater self-reliance, but these efforts are hampered by climatic challenges and investment constraints. Rainfall varies dramatically in terms of quantity and reliability.

3. Since 2009, Eritrea has been subject to United Nations Security Council sanctions, which were further tightened in 2011. However, it must be noted that the

Government recognizes the negative impact that corruption could have on national development; a Special Court has been established to implement the zero-tolerance policy on corruption. This has greatly contributed to aid effectiveness.

4. Eritrea is on track to achieve half of the Millennium Development Goals 4, 5, 6 and 7 (water target). The country has made significant progress in child and maternal health. The under-five mortality rate decreased from 136 per 1,000 live births in 1995 to 63 per 1,000 live births in 2010. The maternal mortality declined from an estimated 1,400 per 100,000 live births in 1990 to 486 per 100,000 live births in 2010;<sup>1</sup> the United Nations estimate is 240 per 100,000 live births in 2010. Eritrea appears to be one of few African countries set to achieve Goals 4 and 5.

5. However, there is scope for accelerating progress: prenatal, perinatal and postnatal care services need to be strengthened and coverage of emergency obstetric care expanded. The main causes of under-five mortality are neonatal complications (27 per cent), pneumonia (24 per cent), malnutrition and anaemia (21 per cent) and diarrhoea (13 per cent). Some 20 per cent of under-five deaths occur in the first week of life.<sup>2</sup> Increased attention is required to the early postnatal period while maintaining existing satisfactory levels of immunization, community-based interventions and effective malaria and HIV control, as these have been instrumental in the rapid reduction of under-five mortality rates.

6. Progress has been made in achieving Goal 6, combating HIV/AIDS, malaria and other diseases. The HIV prevalence rate is an estimated 0.8 per cent (United Nations data, 2008). With 67 per cent of the population living in malaria-endemic areas, the Ministry of Health scaled up targeted responses over the past years. Latest available figures show that the under-five malaria case fatality has decreased, from 6 per cent in 1999 to 0.3 per cent in 2011.

7. A national nutrition surveillance system is in place, covering 48 sites all over the country. The national nutrition programme response is linked to information provided through this system, which showed a high rate of malnutrition in 2009, compared to an improved situation in 2011. During the biannual national child health weeks, all children under five underwent mid-upper-arm circumference measurement. All children detected with a critical nutrition situation were referred to either community-based or facility treatment options.

8. According to a 2011 national survey,<sup>3</sup> 39 per cent of the population remain without safe drinking water access, compared to 84 per cent in 1993 and a 2015 target of 21 per cent; 72 per cent are without access to a basic sanitation facility, compared to 87 per cent in 1993 and a 2015 target of 35 per cent. The adoption of community-led total sanitation (CLTS) as a nation-wide strategy, rolled out in 2009, has accelerated progress, but shortfalls remain, with significant spatial disparities (improved latrine access is 92 per cent in urban areas and 25 per cent in rural areas). Key challenges include diminishing water resources, periodic droughts, poor sanitation access, and weak operation and maintenance of water supply systems.

9. The education trends in the first decade after independence were impressive, as the number of schools increased and new schools were opened in rural areas. A

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<sup>1</sup> Eritrean Population and Health Survey, 2010.

<sup>2</sup> Ministry of Health, National Child Survival Strategy, 2009-2013.

<sup>3</sup> Ministry of Land, Water and Environment, Water Supply Coverage and Functionality Status Survey and Analysis, 2011.

very low net enrolment ratio of 23 per cent rose to 52.6 per cent in 2005 but declined to 49.6 per cent in 2010 (Education Management Information System, 2009/2010). The specific challenges are inequitable access, gender disparities and low learner achievement. The factors that hinder children in accessing education spring from supply and demand sides. On the supply side, there is a shortage of schools, combined with overcrowded classrooms, shortage of female teachers and trained teachers in mother tongue, lack of sanitation facilities, difficulties in adapting the implementation of the school curriculum to local realities, and inadequate supply of learning and instructional materials. The demand-side factors include poverty, particularly inability to afford the direct or indirect costs to schooling, limited parental and community involvement in schooling, as well as social and cultural obstacles, such as early marriage and undervaluing the benefits of education.

10. Significant progress was made in accelerating the abandonment of female genital mutilation/cutting practices (FGM/C). According to disaggregated national analysis of the Eritrean Population and Health Survey 2010, the prevalence rate declined from 89 per cent to 83 per cent — this was due to the sustained collective action of the community and the systemic institutionalized response across government sectors as well as criminalization of the practice.

11. The presence of landmines is still widespread, potentially affecting 650,000 people, the majority of them children. Some 40 per cent of children under five are still not registered at birth, an estimated 105,000 children are orphans and 23,000 children are living with a disability, while the number of children in contact with the law increased from 6,000 in 2008 to 8,000 in 2010.<sup>4</sup> The 2011 Health Management Information System indicates that injuries from landmines, road accidents, drowning, burns and falls, and other violence are now among the first five morbidity factors for children above five years in Eritrea.

12. Eritrea is party to five of the seven core international human rights treaties, including some of their optional protocols; and it has acceded to two of the three African human rights treaties. The Government is preparing to accede to the remaining core international human rights treaties. As one of the first State signatories to the Convention on the Rights of the Child, Eritrea remains fully committed to its operationalization. In early 2012, the Government submitted its fourth periodic report to the Convention on the Rights of the Child, including its initial report on the two Optional Protocols. An inter-ministerial framework to guide the Government's actions with regard to the Convention on the Rights of the Child has been established; this has facilitated the translation and publication of the Convention's provisions in six local languages. In line with Eritrea's principle of self-reliance, any assistance will focus on the national priorities and policy guidelines for bilateral and multilateral cooperation.

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<sup>4</sup> Government of State of Eritrea, fourth periodic report on the Convention on the Rights of the Child.

## Key results and lessons learned from previous cooperation, 2007-2012

### Key results achieved

13. A major achievement of the country programme was the partnership with the Government to support its efforts to reduce under-five child mortality and maternal mortality. During the previous programme cycle, a total of 210 community-based and 57 therapeutic feeding facilities as well as 263 supplementary feeding programme sites were operational, covering 80 per cent of severely and moderately malnourished children in Eritrea. Blanket supplementary feeding in four out of six regions (*zobas*) reached 90 per cent of the targeted children and women to prevent further deterioration of nutritional status. The immunization system was further strengthened with the introduction of *pentavalent* vaccine in 2008, as well as procurement of vaccines, availability of injection safety materials and training of service providers. These contributed to maintaining more than 80 per cent coverage of three doses of combined diphtheria/pertussis/tetanus vaccine, reducing vaccine-preventable diseases to the extent that no measles deaths or polio cases were reported, and the neonatal tetanus elimination target was achieved. UNICEF work with the Ministry of Health on prevention of mother-to-child transmission of HIV contributed to increased access to HIV testing services, with 72.5 per cent of health facilities offering HIV testing, while 48 per cent of pregnant women attending antenatal care tested for HIV in 2011.

14. UNICEF supported the Ministry of Health in introducing the CLTS programme in 2007, with implementation starting the following year. Since 2008, 165 of 2,663 villages have been declared open defecation free; this corresponds to 344,660 people out of an estimated 3.8 million, constituting roughly 10 per cent of the population. The water, sanitation and hygiene (WASH) programme component supported the Water Resources Department of the Government to improve water supplies for 247,377 people in rural areas. Some 154 WASH committees were formed and trained to build local sustainability.

15. The basic education and gender equality programme produced good results, notably in the areas of access and equity to education. Successful approaches, such as the complementary elementary education and the nomadic education projects, were able to reach the very remote areas of the country and enrol 14,175 children (45 per cent girls) for the first time. Life-skills education has been integrated from upper elementary (grade 4) to secondary level, and all children in schools are benefiting from such interventions. The child-friendly schools project was less successful, mainly due to a lack of resources for replication. The focus has now turned to mainstreaming the principles of child-friendly schools in sector dialogue and strategy.

16. The child protection programme supported the Government in scaling up the community-based alternative care system, reaching 7,362 orphans (47 per cent females). The reunification programme included various policy options, such as community reunification, adoption, fostering, as well as placement in group homes or orphanages as a last resort. Some 4,515 families with children infected with HIV/AIDS were provided with cash grants to start small-scale income-generating activities. The 2007 Proclamation banning FGM/C was a milestone in combating a practice that is still deeply rooted in the cultural and religious beliefs; significant

progress was made primarily due to increased government commitment, criminalization of the practice and sustained with advocacy support from UNICEF, the World Health Organization and the United Nations Population Fund. In addition, behaviour change (of not cutting girls) was increasingly accepted through community networking, public health education, life-skills education and engagement of religious leaders. Consequently, the incidence dropped dramatically, declining to 33 per cent and 11.9 per cent, respectively, among girls under 15 and girls under five. However, as reported in the Government's fourth periodic report on the Convention on the Rights of the Child, national disparities still exist across the regions (*zobas*) despite progress in various areas of the programme. Regrettably, according to data from the 2011 Health Management Information System, child injuries from all causes, such as landmines, road accidents, domestic falls, drowning and forest burns increased among children over 5 years, from approximately 8,000 cases in 2001 to 40,677 cases in 2011. In recent years, resource constraints have jeopardized the gains made so far in child protection.

17. Some 540,000 people (70 per cent children) living in areas contaminated by mines were reached with mine risk education activities, including internally displaced children. UNICEF and the World Health Organization began action in 2009 towards addressing child injuries from all causes. This resulted in development of an integrated national injury surveillance system for the monitoring of incidence, trends and related risk factors. Additionally, the emergency response system was strengthened through the provision of first-aid kits and health technology equipment for the rehabilitation and physiotherapy centres for child victims. A national policy for persons with disabilities and the 2012-2016 National Strategic Plan on Child Injury, Violence and Disability Prevention were developed, providing a strategic framework for the care and protection of children.

18. The advocacy and partnerships for children programme provided technical assistance to strengthen national capacities for collecting data on the situation of children and women, and contributed to the realization of children's rights through networking, partnerships and participation. UNICEF supported the National Statistics Office to conduct and finalize the Eritrean Population and Health Survey. Partnerships with the Ministry of Information and National Union of Eritrean Youth and Students resulted in training of national media professionals in reporting on children and raising child participation through such activities as the creation of a seven kilometre long continuous painting.

### **Lessons learned**

19. Good economic performance is not the only factor in achieving Millennium Development Goals and in reducing mortality. In Eritrea, the well-established and strong community-based health and nutrition services provided an opportunity to identify sick and needy children and refer them in time, provide timely basic services closer to their communities and reduce the workload in health facilities. The biannual child health nutrition and vaccination weeks were valuable in improving access to immunization services and in tracing dropouts. In the absence of potential partners and limited logistical capacity, advanced planning is crucial in ensuring that blanket feeding is provided during the peak pre-harvest period. All above-mentioned efforts were drivers a successful, sustained achievement toward Goals 4 and 5.

20. The move from a household subsidy-based approach to a community-based approach in CLTS represented a radical shift in sanitation programming, as it facilitated the increased participation, involvement and engagement of communities in identifying its own needs and in responding to them individually, using indigenous technical know-how and encouraging greater ownership. Additionally, it has been noted that CLTS creates social expectations around sanitation, thereby creating demand for sanitation services.

21. The systemic approach towards the abandonment of FGM/C proved to be successful and innovative. Known as ‘Habarawi’ and meaning “collective” in Tigrinya, the methodology adopted to reduce the practice simultaneously integrated all levels of society — from the Government to religious leaders, youth and women’s organizations, community leaders, former circumcisers and victims. Each sector actively played a role in building this consensus. The approach is currently being documented, to be shared with other countries facing challenges in reducing the practice of FGM/C.

22. The success of the nomadic education programme can be attributed to the following factors: (a) continuous community-wide campaigns in nomadic areas; (b) collaboration with communities in setting up learning spaces with locally available materials; (c) recruitment of teachers and facilitators from the local communities; (d) provision of education incentives in the form of schooling materials and uniforms; and (e) introduction of flexible curricula that allow the children of the nomadic communities to join classes according to their movement patterns.

## The country programme, 2013-2016

### Summary budget table

<i>Programme component</i>	<i>(In thousands of United States dollars)</i>		
	<i>Regular resources</i>	<i>Other resources</i>	<i>Total</i>
Health and nutrition	1 046	17 200	18 246
Basic education	990	6 734	7 724
Water, sanitation and hygiene	996	12 000	12 996
Child protection	960	5 815	6 775
Advocacy and partnerships	1 841	720	2 561
Cross-sectoral	2 019	2 400	4 419
<b>Total</b>	<b>7 852</b>	<b>44 869</b>	<b>52 721</b>

*Note:* Additional emergency funding from consolidated appeals is anticipated.

### Preparation process

23. The country programme was developed in consultation with core ministries for each programme component within their strategic plans, with coordination via the Ministry of National Development and additional consultation with the Ministry of Foreign Affairs. The process was guided by national development goals and priorities, national planning documents, the Millennium Declaration and Millennium Development Goals targets, the midterm review of the United Nations Development

Assistance Framework, recommendations from the Human Rights Council Universal Periodic Review and the Committee on the Rights of the Child, as well as the draft United Nations country team strategic partnership framework (collectively reviewed as part of an analysis of the situation of Eritrean children, carried out to inform that process).

### **Programme components, results and strategies**

24. The country programme incorporates actions within and across the programme components to support domestic agencies, relevant government institutions and local communities to better integrate disaster risk reduction and emergency preparedness within national strategic planning, preparedness and services. The programme scope will be nationwide, focusing on equity and gender equality, targeting the most vulnerable and hard-to-reach children and women. Primary strategic attention in the development of the programme has been directed to vertical integration, from the national level to the subregional (sub-zoba) level, linking policy and planning with local priorities and actions, implementing effective service integration strategies in accelerating outcomes, and strengthening mechanisms for performance and results monitoring, environmental threats and sustainability. Service delivery will emphasize community empowerment and rural access to interventions, supported by communication-for-development strategies aimed to promote resilience and self-reliance and reduce dependence, through community mobilization and documentation of experiences and best practices. Capacity development will include strengthening of the management capability of zoba and sub-zoba services and of primary national actors in child rights, complemented by knowledge management measures across service providers, with particular attention given to the education and empowerment of duty bearers and caregivers, based on participatory approaches.

25. **Health and nutrition.** This programme component aims to fulfil the rights of Eritrean children to health and nutrition. It supports the promotion and provision of quality preventive, curative and rehabilitative health and nutrition care services so that they are appropriate, affordable and accessible to all, and supports progress towards meeting the child and women-related targets of the Millennium Development Goals and those for accelerated child survival development. There are three programme component results expected by 2016: (a) improved access and utilization of basic packages of child health services (integrated maternal and neonatal care interventions and expanded programme of immunization services), giving priority to hard-to-reach and remote areas; (b) improved access and utilization of basic packages of maternal health services and interventions, giving priority to hard-to-reach and remote areas; and (c) underweight prevalence among children under five reduced, from 38 per cent (2010) to 23 per cent, focussing on the most disadvantaged groups and hard-to-reach and remote areas.

26. The programme will achieve those key results by maintaining existing interventions and scaling up measures that leverage further progress, notably in neonatal care, under-five nutrition, integrated management of neonatal and childhood illnesses, vaccination, maternal health, paediatric HIV and prevention of mother-to-child transmission of HIV. Further, attention will be on community-based intervention, including provision of outreach services. The main implementing partner will be the Ministry of Health, in close collaboration with United Nations organizations.



27. **Basic education.** This component recognizes the need to focus selectively on higher-impact strategies that add value to efforts by the Ministry of Education in strengthening education performance. The main goal will be to enhance participation and retention rates, with particular emphasis on equity with quality. It aims to build on previous progress in the areas of complementary elementary education, nomadic education and to assist the Government in enhancing the quality of basic education. The key programme results expected by 2016 are as follows: (a) equitable access to basic formal and non-formal education ensured for 50,000 children (with particular emphasis on girls) in Anseba, Dehub, Gash Barka, Debubawi K'eyih Bahri (SRS) and Semenawi Keyih Bahri (NRS). This result will be achieved in partnership with the Ministry of Education, particularly the departments of general education and research and human resource development, and the regional and local administrations. Further, the focus will be on enhancing, by 2016, access to an education that meets minimum standards, as defined by Government: (b) learning outcomes will have improved for all children. This result will be achieved by supporting the mainstreaming of government initiatives to enhance education quality and by focussing on enhancing the quality of education for marginalized groups, specifically through support to nomadic education, complementary elementary education, girls' education and vulnerable children.

28. **Water, sanitation and hygiene (WASH).** This component will contribute to the achievement of Goal 7 target 10 on improved drinking water and sanitation. It aims to increase improved and safe access to WASH services and practices, focusing on vulnerable groups, including people in drought-prone areas. There are three programme component results, across all six zobas, expected by 2016: (a) 80 additional communities will have environmentally sustainable improved drinking water sources; (b) 300 selected villages will become open defecation free; and (c) gender-sensitive WASH facilities are installed and utilized within 30 selected elementary schools in rural areas.

29. The key results will be achieved through a demand-responsive participatory approach, to advance equitable outcomes, with a focus on rural populations. It will involve coordination, collaboration and partnerships with the United Nations Development Programme and the Food and Agriculture Organization of the United Nations, as well as donor agencies, the Water Resources Department, the Ministry of Health and regional and local administrations involved in construction, rehabilitation or upgrading of water supplies and in improving the sanitation and hygiene situation. Community water and sanitation committees will manage systems, with full participation of women in key positions. Household-based water management options (e.g. self-supply) will be explored to increase self-reliance and sustainability. Children, teachers and community representatives will be involved in preparing school WASH plans. The primary outcomes will focus on the Government's commitments to achieving the Millennium Development Goals targets in accessing safe water and improved sanitation, which have been accelerated since 2007 using the CLTS methodology and a focus on improving knowledge, encouraging community and household ownership, as well as better household hygiene practices and upgraded school-based WASH facilities.

30. **Child protection.** This component aims to support the strengthening of the national social welfare system for protecting children and young people in the most disadvantaged communities from harmful practices, injuries, violence and exploitation, as well as promoting the realization of children's rights to justice and

birth registration. The expected component results are as follows: (a) children and adolescents at risk are protected from harmful practices, exposure to injuries, violence and exploitation; and (b) the integrated national social welfare assistance system strengthened.

31. The key results will be achieved through preventive, protective and rehabilitative strategies, particularly policy dialogue, facilitation of South-South cooperation, encouragement of entrepreneurship skills and partnership building, including advocacy for improving access to child and adolescent-friendly basic social services, birth registration and social justice. Efforts will involve exploring feasible technological initiatives, scholarly surveys and documentation. Adolescents and young people will be reached through counselling and comprehensive health and life skills education. UNICEF will support the Government in mapping communities collectively abandoning FGM/C and strengthen the capacities of local structures in promoting safety nets and social behaviour change towards early marriage. It will also promote the integration of mine risk education and prevention of injuries, violence and disabilities within the broader public health system.

32. **Advocacy and partnerships for children.** This component comprises technical support in strengthening national capacities in data collection, research and policy analysis and advocacy that are also mainstreamed within the individual programme components. This includes attention to cross-sectoral linkages in enhancing the complementarity of those components. There are two overarching interventions: (a) strengthened capacity of the Ministry of Information and civil society organizations to promote child rights and children's participation; and (b) enhanced monitoring, reporting and evaluation mechanisms. The strategic position of UNICEF will be enhanced by leveraging external resources towards agreed national priorities. Communication-for-development activities will be central to informing vulnerable children and young people and engaging them in accessing support networks and social networking for their improved protection.

33. **Cross sectoral.** This component will cover management and support for the country programme, including programme planning and coordination, with particular emphasis on mainstreaming of gender awareness. Expenses related to supply, logistics, information technology, administration and finance are included in this component.

#### **Relationship to national priorities and the UNDAF**

34. While the Government's national development plan has yet to be shared with the United Nations organizations, the various ministries' sector plans have been finalized and are available. These have been instrumental in informing the priorities for action. The United Nations is currently developing a strategic partnership cooperation framework that will ensure national priorities are sufficiently reflected within the country programme.

#### **Relationship to international priorities**

35. The country programme contributes to attaining child and women-related Millennium Development Goals and to maintaining such momentum beyond 2015. Its activities on legislative reform, policy development, strengthening implementation mechanisms and enhanced participation contribute to all focus areas of the UNICEF medium-term strategic plan, and reflect key recommendations of the

Committee on the Rights of the Child, provisions of the African Charter on the Rights and Welfare of the Child and principles of the Convention on the Elimination of All Forms of Discrimination against Women. The programme supports the commitments and priorities of Education for All, the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction, the International Labour Organization Convention 13 on the minimum age for employment, and the principles and commitments of A World Fit for Children as well as those of Africa Fit for Children. The Government has announced its intention to ratify additional international human rights instruments relevant to the Eritrean child.

### **Major partnerships**

36. Beyond the bilateral Framework of Cooperation 2011-2012, major partnerships are with individual government ministries on specific activities within each programme component. Other key partners include the National Union of Eritrean Youth and Students and the National Union of Eritrean Women, especially in areas of implementation, advocacy and capacity strengthening. These will be carried out under the overall coordination of the Ministry of National Development, and will be complemented by UNICEF leveraging associated resources from international development cooperation partners. There is capacity for possible joint programming under this framework. UNICEF will collaborate with other United Nations organizations in Eritrea. Key international partners include the Gavi Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Partnership for Education. UNICEF will facilitate the engagement of the Government with these partners. The harnessing of partnerships for improved sustainability of behaviour change across many areas means that an emphasis on the participation of families, children and key local personnel (teachers and health workers) is critical to building sustainability toward improved self-reliance.

37. UNICEF will harness its comparative advantage in supporting the Government in the strategic development of South-South cooperation, with an emphasis on regional linkages and technical exchanges.

### **Monitoring, evaluation and programme management**

38. Key indicators for monitoring progress towards programme results, and strategic choices for monitoring and evaluation activities, are detailed in the summary results matrix and the five-year Integrated Monitoring and Evaluation Plan. It incorporates research, programme monitoring and evaluation activities, and will be updated annually. Government management information systems in health and education remain key sources of information, with UNICEF supporting qualitative improvements and associated developments within related but more limited sectors, including child protection. UNICEF, within the strategic framework of partnership with Government, will support relevant institutions with data systems, coordination, monitoring and evaluation. The Government has already indicated that this is a priority for the country.

39. UNICEF will conduct annual programme reviews, with a midterm review to take place in 2014. To minimize transaction costs to the Government and other partners, the country programme review will be incorporated within wider sectoral reviews wherever possible.