Swaziland

Country programme document 2011-2015

The draft country programme document for Swaziland (E/ICEF/2010/P/L.12) was presented to the Executive Board for discussion and comments at its 2010 annual session (1-4 June 2010).

The document was subsequently revised, and this final version was approved at the 2010 second regular session of the Executive Board on 9 September 2010.

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Basic data† *(2008, unless otherwise stated)*	
Child population (millions, under 18 years)	0.6
U5MR (per 1,000 live births)	83
Underweight (%, moderate and severe, 2006-2007)	5
Maternal mortality ratio* (per 100,000 live births, 2000-2007)	590
Primary school enrolment (% net, male/female, 2006)	83/86
Survival rate to last primary grade (%, 2004)	71
Use of improved drinking water sources (%, 2006)	60
Use of improved sanitation facilities (%, 2006)	50
Adult HIV prevalence rate (%, 2007)	26.1
Child labour (%, children 5-14 years old, 2000)	9
GNI per capita (US$)	2 520
One-year-olds immunized with DPT3 (%)	95
One-year-olds immunized against measles (%)	95

† More comprehensive country data on children and women can be found at www.childinfo.org.

* The 2005 estimate developed by WHO, UNICEF, UNFPA and the World Bank, adjusted for underreporting and misclassification of maternal deaths, is 390 per 100,000 live births.

Summary of the situation of children and women

1. The Kingdom of Swaziland has enjoyed a long history of political stability, yet poverty, food insecurity and external economic shocks continue to be daunting challenges for the country. These have been compounded by the rapid spread of HIV/AIDS over the past two decades. It has now reached pandemic levels, destroying hopes of achieving many of the Millennium Development Goals. More than two thirds of the population lives below the poverty line and 63 per cent live in extreme poverty. Wealth is unevenly distributed, as reflected by a Gini coefficient of 0.507.[1] The economic picture has worsened in recent years, with gross domestic product declining from 3.5 per cent in 2007 to just 0.4 per cent in 2009. The Government is the largest employer in the country and has relied on Southern African Customs Union receipts to meet a heavy public-sector salary bill (56-70 per cent of total government expenditure). Swaziland's allocation from this source will decline in 2010/2011, resulting in a significant budget deficit that will affect government initiatives in some sectors. The country continues to be affected by the fallout of the global economic downturn and the food and fuel crises of 2007-2008. Swaziland has been particularly hard hit, given its heavy reliance on imports of food and other commodities and remittances from family members abroad, and this has contributed to rising unemployment and the erosion of purchasing power among Swazi households.

2. Food insecurity has been exacerbated during recent years by recurrent droughts in parts of the country, causing high levels of malnutrition and leaving 25 per cent of the population facing a food deficit in 2009. The Swaziland

[1] Latest Household Income and Expenditure Survey.

Demographic and Health Survey of 2006/2007 found that almost three in ten children under five were showing signs of stunting (32 per cent of males and 26 per cent of females). Limited access to clean water and sanitation and weak infrastructure for service provision are contributing factors to childhood illnesses, such as diarrhoea, which causes 10 per cent of all childhood deaths. Pneumonia also remains a major concern, contributing to 12 per cent of childhood deaths.

3. HIV/AIDS, with a prevalence rate of 26 per cent among the general population, is by far the greatest challenge facing the country. Women have been particularly affected: prevalence among women aged 15-49 years is 31 per cent, compared to 20 per cent among men in the same age group. The rate among pregnant women has risen dramatically, from 3.9 per cent in 1992 to 42 per cent in 2008. HIV/AIDS accounts for 60 per cent of hospital admissions and 47 per cent of deaths among children under five, according to Ministry of Health estimates. HIV/AIDS is further associated with the resurgence of tuberculosis; prevalence has increased 400-fold over the last 15 years. The underlying causes of the high HIV prevalence are multiple and deeply embedded in socio-economic conditions. Key drivers of the epidemic include multiple and concurrent partners, intergenerational sex, low levels of male circumcision, sexual violence, transactional sex and early sexual debut.

4. The adverse effects of these challenges are far-reaching, severely affecting the daily life of most Swazis, especially children. Life expectancy has dropped from 60.7 years in 1998 to 45.3 years in 2007, and under-five mortality has risen from 60 per 1,000 live births in 1992 to 120 per 1,000 live births in 2006-2007. The maternal mortality ratio has more than doubled, from 229 per 100,000 live births in 1996 to 589 per 100,000 live births in 2006-2007. According to the Demographic and Health Survey, almost one in four children has lost one of their parents. This has severely eroded traditional family structures. Only 22 per cent of children under the age of 18 live with both parents, and about one third do not live with either biological parent. Elderly caregivers and children caring for other children are now common practices in Swazi culture. Women shoulder the greatest burdens of caring for the increasing numbers of orphans and vulnerable children, and face the risk of losing property rights if the male head of the household dies.

5. With the growing strain on family and community life, the erosion of traditional safety nets and increasing demand for government-provided health and social welfare services, many children are unable to enjoy their rights. For example, only 61 per cent of orphaned and vulnerable children have even their basic needs met (a pair of shoes, two sets of clothes and one meal per day). Children are also at high risk of abuse and exploitation, with three in ten girls experiencing some form of sexual abuse by the time they are 18 years old, and one in four experiencing physical abuse, according to a 2007 study by UNICEF and the United States Centers for Disease Control and Prevention.

6. Yet some advances bode well for the future. In 2005, the country adopted a constitution that contains provisions for a more democratic system, including an independent judiciary, a detailed bill of rights, greater rights for women and the establishment of human rights and anti-corruption commissions. The constitution has also heralded the introduction of free primary education, which is now being introduced through a phased elimination of primary school fees, beginning with grades 1 and 2. With a primary school enrolment rate of 93 per cent in 2007, the free

primary education campaign brings Swaziland within reach of the Millennium Development Goal for education. These achievements are particularly significant in light of findings from the Demographic and Health Survey indicating a correlation between higher levels of education and lower HIV prevalence. However, education quality remains a concern, as the country continues to struggle with high drop-out and repetition rates, resulting in only 44 per cent of primary school entrants completing 10 years of basic education. Access to early childhood learning is also a challenge, with only 21.6 per cent of children accessing some form of early learning services prior to entering the formal education system.

7. Following the submission of its report to the Committee on the Rights of the Child in 2006, the Government has followed up on key recommendations made by the Committee, including the need to incorporate international conventions into national law, strengthen coordination mechanisms of children's initiatives and prevent child abuse, child labour and human trafficking. However, in some instances there have been long delays in finalizing and adopting policies and laws.

Key results and lessons learned from previous cooperation, 2006-2010

Key results achieved

8. The placement of children's affairs in the Deputy Prime Minister's Office and the creation of the National Children's Coordinating Unit, two outcomes that UNICEF advocated, have helped raise the profile of children in the national discourse. Since the Deputy Prime Minister's Office assumed responsibility for children's issues, Swaziland has seen a more rapid review and approval of a number of important instruments, including the Children's Policy, the Social Development Policy, legislation against trafficking and endorsement of the optional protocols to the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. With further development of the capacity of the National Children's Coordinating Unit and the Department of Social Welfare, the Deputy Prime Minister's Office will have the potential to achieve even greater outcomes for children in the future.

9. Swaziland has made significant progress in mitigating the worst effects of the HIV pandemic and in improving access to treatment, while progress on primary prevention has been more limited. Under the first National Strategic Plan on HIV/AIDS, coordination efforts and access to services for prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy improved with assistance from development partners, including the World Health Organization, UNICEF and the (United States) President's Emergency Plan for AIDS Relief (PEPFAR). Almost eight in ten health care facilities in the country now offer PMTCT services, resulting in HIV testing of 81 per cent of pregnant women who attend antenatal clinics. Of the total estimated population of HIV-positive pregnant women, 74 per cent received antiretroviral prophylaxis to prevent transmission to their babies, and 64 per cent of HIV-exposed children also received the prophylaxis. Antiretroviral therapy continues to be free of charge, and access is being scaled up with assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Paediatric HIV care has been strengthened, including through the introduction of polymerase chain reaction testing of genetic material (known as DNA PCR) for early infant diagnosis through

the UNICEF global partnership with Futball Club Barcelona. In 2009, an estimated 75 per cent of children in need of antiretroviral therapy received treatment, up from 26 per cent in 2006. With significant success in promoting access to PMTCT and paediatric care, service quality is now being supported through a national quality improvement system.

10. Delivery of other life-saving interventions, such as childhood immunization, was sustained across the country. Polio has been eradicated; maternal and neonatal tetanus, vitamin A deficiency and iodine deficiency disorders have been virtually eliminated. The combined diphtheria/pertussis/tetanus vaccine coverage for children under the age of one year was over 90 per cent, and measles coverage was 82.7 per cent. Advocacy for new vaccines by the World Health Organization and UNICEF resulted in the Government adding Haemophilus influenzae type B (Hib) vaccine to the Expanded Programme on Immunization schedule. Acute diarrhoea, malnutrition, safe water supply, sanitation and hand-washing with soap have also received attention.

11. Free primary education now covers children in the first and second grades and will incorporate one additional grade each year until all children in primary schools are included by 2015. UNICEF assistance for the sector complemented government allocations for orphans and vulnerable children, which has increased every year since 2004. The first phase of the child-friendly school initiative has reached 40 per cent of primary schools in the country, with a package of services that includes HIV prevention, health and life-skills education as well as stigma reduction and psychosocial support. These combined efforts to improve education access and quality have contributed to rising school attendance, from 71 per cent for both males and females in 1997-2002 to 83 per cent for males and 86 per cent for females in 2000-2007. With support from the European Union and UNICEF, the Ministry of Education and Training also developed its first policy on early childhood care and development (ECCD).

12. Swaziland launched a costed five-year National Plan of Action for Orphaned and Vulnerable Children and successfully introduced and scaled up community-run care centres (NCPs) and a cadre of community-based child protectors. Today, Swaziland has over 950 NCPs, of which UNICEF has directly supported over 700, reaching more than 50,000 children. A new vision and strategy have been developed, aimed at converting NCPs into ECCD centres offering comprehensive and standardized services for vulnerable children, including psychosocial support, protection, early learning, health care and nutrition.

13. To strengthen disaster risk reduction, Swaziland established a national disaster management agency, responsible for coordinating emergency preparedness and response.

14. Capacities for results-based management were strengthened through support to national information management systems and surveys. Community-based monitoring was launched through the *KaGogo* (literally ‘grandmother’s house’) centres, through which the Government coordinates development assistance and monitoring at the community level. With the support of UNICEF and other partners, Swaziland documented child poverty, the situation of child-headed households, reasons for high-school dropout and the epidemiology of violence against children and young women. Advocacy and communication initiatives garnered support for children’s issues among opinion leaders and the general public. Members of

Parliament were made aware of pending legislation and protocols, the Parliament's Portfolio Committee on Children was informed on children's issues and journalists were trained in children's rights and child-sensitive reporting. National communication campaigns, community mobilization and an HIV prevention toolkit were used to promote positive social and behaviour change, including HIV and violence prevention and health and hygiene practices.

Lessons learned

15. Swaziland's experience in responding to HIV/AIDS shows that much can be achieved through in a short period of time, even in a country with few resources, a shortage of key public sector personnel and specialist expertise, and a lack of capacity among non-governmental organizations working in the sector. Intensive training and mentoring have been key to progress within this context. As the interventions expand, missed opportunities for integrated service delivery are becoming more apparent and critical to further progress. In light of the protracted HIV emergency, more intensive efforts are needed to make best use of all health encounters to (a) further improve coverage and quality of priority HIV services and (b) promote new or lagging interventions, such as male circumcision, including for newborns. A systematic plan for capacity development, involving close collaboration with United Nations and other development partners, will be essential to ensure long-term sustainability.

16. Prevention of HIV has lagged behind progress in treatment and impact mitigation. Lessons learned include the need for coherent, sustained and culturally sensitive messages that are age-specific and respond directly to the local drivers of the epidemic. The new country programme aims to work more closely with leadership (governmental, traditional and youth) at the national and community levels to find innovative ways of addressing stigma, discrimination and norms that contribute to the spread of the disease.

17. Swaziland has a small donor base and no local presence of international financial institutions. UNICEF efforts to mobilize resources for children from the largest contributors to the national HIV response (Government; the Global Fund; and PEPFAR) have had encouraging results. The key to leveraging resources has been UNICEF capacity to pilot innovative interventions that create the evidence base that encourages investment. An example has been the use of grants to improve school attendance of orphaned and vulnerable children and delivery of basic services through NCPs. Direct government support to education grants for these children increased from $2 million in 2002 to $17 million in 2009. The National Emergency Response Council on HIV and AIDS funded the upgrading of 84 per cent of NCPs, where orphaned and vulnerable children get at least one hot meal a day, enjoy adult supervision by a trained community member and have access to other basic services. The World Food Programme is assisting with feeding, and PEPFAR is supporting service delivery for children at 200 NCPs. In the new country programme, UNICEF will continue to pilot innovative, high-impact interventions and to reach out to existing and new donors to scale these up.

The country programme, 2011-2015

Summary budget table

	(In thousands of United States dollars)		
Programme	*Regular resources*	*Other resources*	*Total*
Child survival and development	750	10 000	10 750
Basic education	750	7 000	7 750
Child protection	750	9 000	9 750
Advocacy and communications	560	2 000	2 560
Social policy and monitoring and evaluation	385	1 250	1 635
Cross-sectoral costs	560	2 500	3 060
Total	**3 755**	**31 750**	**35 505**

Note: Other resources do not include emergency funds, which will be raised when needed.

Preparation process

18. The development of the country programme drew from a number of reviews and consultations. In 2008, UNICEF undertook a situation analysis on children and women and a midterm review, which involved extensive consultations with partner organizations from Government, donor representatives, United Nations agencies and civil society, including young people. A midterm review of the United Nations Development Assistance Framework (UNDAF) 2006-2010 was also carried out in 2008, followed by a complementary country analysis in 2009, laying the foundation for the development of the UNDAF for 2011-2015. Its preparation involved wide-ranging consultations with United Nations partners and stakeholders to define the four pillars of United Nations support for the coming planning cycle. The United Nations country team, including UNICEF, successfully carried out several joint initiatives to test modalities for collaboration. These included the Joint United Nations Programme on HIV/AIDS, prevention of gender-based violence and strengthening of monitoring and evaluation systems. A number of sector analyses by development partners and the midterm review of the National Plan of Action for Orphaned and Vulnerable Children, as well as an assessment of progress in implementing the recommendations from the Committee on the Rights of the Child, all provided valuable input and evidence to inform the development of the new UNICEF country programme.

Programme component results and strategies

19. The overarching goal of the country programme is to assist Swaziland in sustaining its progress towards realizing the Millennium Declaration and Millennium Development Goals relating to children. It retains the focus of the previous country programme priorities because the factors affecting the situation of children and women remain the same: HIV/AIDS, poverty, low access to water and sanitation, and drought. Key expected results are as follows:

(a) Increased coverage of quality PMTCT and paediatric HIV care to reduce the incidence of new HIV infections in mothers and children, treat infected children

and follow up with HIV-infected mothers to ensure they receive family planning to prevent unwanted pregnancy and antiretroviral treatment;

(b) Increased coverage and quality of curative services for childhood illnesses, especially pneumonia, maternal and neonatal complications, and acute malnutrition;

(c) Increased and sustained coverage of high-impact preventive maternal, newborn and child health, nutrition and water, sanitation and hygiene (WASH) interventions, with a focus on the worst-affected regions, to address other factors that contribute to child morbidity and mortality, such as pneumonia and diarrhoea;

(d) Increased rates of enrolment in primary school, from 93 per cent in 2007 to 100 per cent by 2015, and increased rates of completion in quality basic education by both boys and girls, from 44 per cent in 2007 to 70 per cent by 2015;

(e) At least 90 per cent of children and young people, especially adolescents, have adequate gender, livelihood and life skills for HIV prevention and to support the transition to adulthood;

(f) Increased access of children under the age of 9 years, particularly the most vulnerable, to a holistic package of ECCD services, reflecting the new realities resulting from HIV/AIDS;

(g) Strengthened legislative and enforcement systems and improved protection and response capacity to protect women and children from violence, exploitation and abuse at national and subnational levels;

(h) Strengthened child-sensitive social protection programmes for vulnerable children and families, including those infected or affected by HIV;

(i) Strengthened institutional capacity, particularly within the Government, for effective communication to generate positive social and behavioural change, with a specific focus on HIV-related high-risk behaviours, including multiple and concurrent partners;

(j) Research, policy analysis and monitoring and evaluation initiatives to produce high-quality evidence for making child-friendly laws, policies, programmes and budgets;

(k) National systems and structures to enhance integration of disaster risk reduction in development programmes, mainstream gender issues and prepare for and respond to emergencies to ensure fulfilment of the core commitments to children in emergencies.

20. The country programme will be based on several strategic approaches:

(a) Exploit opportunities presented by other programme components as platforms for prevention and control of HIV in order to enhance the effectiveness of HIV-specific interventions. This will include using child-friendly schools to promote HIV prevention, antenatal clinics to prevent mother-to-child transmission and communication to address the drivers of the epidemic;

(b) Serve as a catalyst and convener of partners, building consensus on child rights and supporting analytical and innovative thinking and sharing of experiences. Collaboration will be fostered with other development partners and donors to strengthen commitment to children and leverage resources for them;

(c) Address gaps in the capacity of duty bearers, through a human rights-based approach to programming, with an emphasis on disparities that prevent children and women from realizing their rights. Family-centred and community-based approaches will be promoted, ensuring development initiatives are sensitive to and build on capacities and systems at the family and community level;

(d) Use communication for development to influence social and behaviour change and increase uptake of services, through culturally sensitive approaches that build on past achievements and link traditional and religious norms with international standards;

(e) Collaborate with key stakeholders to conduct pilots and identify innovative approaches to increasing meaningful participation of children, women and men in policy, planning and programming;

(f) Mainstream gender, disaster risk reduction and environmental sustainability in all components.

Relationship to national priorities and the UNDAF

21. The new country programme has been aligned with the national development priorities of the Government of Swaziland, as articulated in the Poverty Reduction Strategy and Action Plan 2006-2015, the National Strategic Framework for HIV 2009-2014, the Government of Swaziland Programme of Action 2009-2013 and several sector-wide approaches (SWAps). Prepared alongside the UNDAF 2011-2015, the country programme contributes to all four pillars of United Nations support in Swaziland: HIV/AIDS, basic social services, poverty and governance. The country programme reflects shifts in national priorities for support to children identified during the midterm review of the National Plan of Action for Orphaned and Vulnerable Children, as well as findings from the assessment of progress in implementing the Convention of the Rights of the Child.

Relationship to international priorities

22. The Convention of the Rights of the Child and the African Charter on the Rights and Welfare of the Child embody the guiding principles of the country programme. Programme design, strategies and planned results have been guided by the Convention on the Elimination of All Forms of Discrimination against Women, *A World Fit for Children*, the Millennium Declaration and Millennium Development Goals, the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action and the Hyogo Framework for Action. The key result areas correspond to all five focus areas of the UNICEF medium-term strategic plan and draw on the four-pronged approach of the 'Four Ps' within the Unite for Children, Unite against AIDS campaign.[2]

Programme components

23. **Child survival and development.** This component directly responds to the leading causes of infant and child mortality. It will be implemented within the framework of the Swaziland Health Sector Policy, the National Health Sector

[2] The four Ps are (1) *preventing* mother-to-child transmission of HIV; (2) *providing* paediatric treatment of AIDS; (3) *promoting* awareness to prevent infection among adolescents and young people; and (4) *protecting* and supporting children affected by AIDS.

Strategic Plan, the National Strategic Framework for HIV and AIDS, and the Joint United Nations Programme on HIV/AIDS. To meet targets for universal access, this component will (a) sustain and reinforce UNICEF support for PMTCT interventions, particularly the scale-up of the four-pronged approach to prevention of mother-to-child transmission of HIV and paediatric AIDS treatment activities, including neonatal male circumcision; (b) invest in capacity development of national institutions, to ensure the consolidation of past gains, and increase coverage of other high-impact, preventive maternal, neonatal and child health and nutrition interventions, including antenatal care, skilled attendance at birth, immunization, vitamin A supplementation, exclusive breastfeeding and complementary feeding; and (c) support the improvement of coverage and quality of curative services for childhood illnesses (especially pneumonia, diarrhoea, maternal and neonatal complications, and acute malnutrition) in an environment where HIV is a major underlying cause of morbidity, including the expansion in coverage of WASH services for women and children in rural areas, especially in primary schools.

24. **Basic education**. This component will contribute to efforts by the Ministry of Education and Training to provide free basic education to all children, paying particular attention to vulnerable children and girls. It will prioritize support to the Ministry in the following areas: (a) effective planning, coordination, implementation and monitoring of the education system and advocacy for the adoption and implementation of education policies; (b) improved access to early childhood care and education services, as well as access, retention and completion of basic education, particularly for vulnerable children, especially girls; (c) expansion to all schools of the child-friendly school initiative, strengthening quality education in a protective environment; (d) in collaboration with the United Nations Population Fund, strengthened quality of HIV-prevention initiatives; (e) strengthened focus on teachers, teacher training and child-centred and gender-sensitive teaching methodologies; and (f) creation of learning opportunities for out-of-school children and adolescents.

25. **Child protection.** This component contributes to the National Strategic Framework for HIV and AIDS, the National Plan of Action for Orphaned and Vulnerable Children, the Social Development Policy and the Children's Policy in the following ways: (a) support effective legislative and enforcement systems and improved protection and response to violence, exploitation and abuse; (b) assist relevant institutions to implement reporting on implementation of the Convention of the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women and systematically follow up on recommendations by the relevant committees; and (c) strengthen child-sensitive social protection programmes for vulnerable children and families.

26. **Advocacy and communication.** This component will contribute to the national response for prevention of HIV, an area that takes on greater importance as Swaziland consolidates its impressive gains in prevention of mother-to-child transmission and the roll-out of more effective treatment for HIV-positive persons. It will (a) strengthen communication for development and ensure its integration into all programme areas to generate positive social and behavioural change, emphasizing high-risk behaviours and violence prevention; (b) empower communities, including children, women and families, with comprehensive knowledge, skills, motivation and authority to reduce risks and mitigate the impact of HIV infection; (c) foster the engagement of children and adolescents through

meaningful dialogue on issues affecting them; and (d) communicate children's rights and related responsibilities in culturally sensitive and child-friendly forms.

27. **Social policy and monitoring and evaluation.** This component emphasizes HIV/AIDS, particularly prevention, as well as poverty reduction, vulnerability and disparities. It will (a) strengthen the capacity of child-related institutions, of both the Government and civil society, to conduct research and policy analysis to produce high-quality evidence in support of child-friendly laws, policies, programmes and budgets; (b) strengthen management information systems as well as monitoring and evaluation systems at national and subnational levels; (c) build alliances with development partners and civil society stakeholders to advocate for improvement in the situation of especially the most disadvantaged children and women; and (d) ensure that gender issues are addressed in all programme components.

28. **Cross-sectoral costs** include operational costs as well as programme coordination and planning, strategic information management, coordination of disaster risk reduction and emergency response.

Major partnerships

29. Principal partners of UNICEF in implementing the country programme will be the Ministries of Economic Planning and Development, Health and Education and Training, as well as the Deputy Prime Minister's Office, which houses the National Children's Coordinating Unit, the National Emergency Response Council on HIV/AIDS and the National Disaster Management Agency. Civil society organizations, including faith-based organizations, remain core partners in service delivery. To expand the partnership base and strengthen capacity, stronger alliances will be forged with communities and community-based organizations. Linkages will also be promoted with the private sector and academic institutions to draw on specific areas of expertise. In the spirit of 'delivering as one', UNICEF will work in close partnership with all United Nations agencies in the country to achieve the national development priorities through the UNDAF. Multilateral and bilateral stakeholders working in areas affecting children in the country will remain valued partners, including the United States Government, the Global Fund, the European Union and the World Bank. Global partnerships will also be harnessed to leverage resources for children. In light of the proven effectiveness of stakeholder committees, UNICEF will promote the work of committees such as the Child Protection Network, the Education Committee as well as stakeholder forums in food and nutrition, and water, sanitation and hygiene. Nascent SWAps will become key coordinating mechanisms in social sectors and guide UNICEF cooperation with partners.

Monitoring, evaluation and programme management

30. Performance indicators and targets will draw on the medium-term strategic plan and will be aligned with the UNDAF and national monitoring frameworks. Data will be disaggregated by gender, age and region to expose underlying disparities. The information required to monitor the country programme will draw on national sources, including SwaziInfo, Central Statistics Office data, reports from national management information systems and national surveys. The recently implemented community-based monitoring system will also provide critical data for tracking the situation of children and women. National capacities to collect, analyse

and disseminate data will be supported by UNICEF through technical and financial assistance as part of a national move to promote results-based management.

31. Project implementation will be monitored directly through field visits, progress reports and spots checks, as part of the harmonized approach to cash transfers. Key management priorities will be tracked monthly, while joint United Nations annual reviews will provide the opportunity to consolidate information on progress in achieving the results identified in the UNICEF Integrated Monitoring and Evaluation Plan and the UNDAF results matrix. Project-specific reviews and evaluations will be conducted according to identified needs. These will inform programming through continuous organizational learning and contribute to a midterm review in 2013 and an end-of-cycle evaluation in 2015. The midterm review and country programme evaluation will be aligned with the UNDAF review processes and carried out in partnership with the Government of Swaziland. The implementation of the country programme will be coordinated by the country management team, in partnership with the Ministry of Economic Planning and Development.