UPDATE OF THE SITUATION ANALYSIS OF CHILDREN AND WOMEN IN ZAMBIA
UPDATE OF THE SITUATION ANALYSIS OF CHILDREN AND WOMEN IN ZAMBIA

28 OCTOBER 2013 (REVISED 12 DECEMBER 2013 FOR MALARIA INDICATORS)

Marcio A. Carvalho (macarvalho2008@gmail.com)
Buleti G. Nsemukila (buleti@yahoo.co.uk)
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of contents</td>
<td>4</td>
</tr>
<tr>
<td>List of figures</td>
<td>8</td>
</tr>
<tr>
<td>List of tables</td>
<td>12</td>
</tr>
<tr>
<td>List of abbreviations</td>
<td>13</td>
</tr>
<tr>
<td>Executive summary</td>
<td>17</td>
</tr>
<tr>
<td><strong>PART I: INTRODUCTION</strong></td>
<td>27</td>
</tr>
<tr>
<td>Chapter 1. Introduction to the Situation Analysis</td>
<td>27</td>
</tr>
<tr>
<td>1.1 Objective of the 2013 Updated Situation Analysis</td>
<td>27</td>
</tr>
<tr>
<td>1.2 Methodological framework of the Situation Analysis</td>
<td>27</td>
</tr>
<tr>
<td>1.2.1 Inequality analysis</td>
<td>29</td>
</tr>
<tr>
<td>1.2.2 Issues and limitations with the Updated Situation Analysis</td>
<td>30</td>
</tr>
<tr>
<td>1.2.3 Special note on resilience</td>
<td>31</td>
</tr>
<tr>
<td>1.2.4 Data sources</td>
<td>32</td>
</tr>
<tr>
<td>Chapter 2. Understanding the situation of children and women</td>
<td>33</td>
</tr>
<tr>
<td>2.1 Contextualising children and women in Zambia</td>
<td>33</td>
</tr>
<tr>
<td>2.2 Legal and policy framework</td>
<td>35</td>
</tr>
<tr>
<td>2.3 Economy</td>
<td>36</td>
</tr>
<tr>
<td><strong>PART II: THE CHILD’S RIGHT TO ECONOMIC AND SOCIAL DEVELOPMENT</strong></td>
<td>41</td>
</tr>
<tr>
<td>Chapter 3. Poverty context for children and women</td>
<td>41</td>
</tr>
<tr>
<td>3.1 Poverty in Zambia</td>
<td>42</td>
</tr>
<tr>
<td>3.2 Poverty and gender</td>
<td>49</td>
</tr>
<tr>
<td>3.3 Poverty and inequality</td>
<td>49</td>
</tr>
<tr>
<td>3.4 Child poverty in Zambia</td>
<td>52</td>
</tr>
<tr>
<td>3.5 Causes of poverty in Zambia</td>
<td>59</td>
</tr>
<tr>
<td>3.6 Legal and public policy framework on poverty and social protection</td>
<td>63</td>
</tr>
<tr>
<td>3.7 Conclusions</td>
<td>64</td>
</tr>
<tr>
<td><strong>PART III: THE CHILD’S RIGHT TO SURVIVE AND DEVELOP</strong></td>
<td>67</td>
</tr>
<tr>
<td>– FROM PREGNANCY TO SIX YEARS OLD</td>
<td>67</td>
</tr>
<tr>
<td>Early childhood development</td>
<td>67</td>
</tr>
<tr>
<td>Chapter 4. Child and maternal survival</td>
<td>68</td>
</tr>
<tr>
<td>4.1 Under-five and infant mortality</td>
<td>68</td>
</tr>
<tr>
<td>4.2 Maternal mortality</td>
<td>71</td>
</tr>
<tr>
<td>4.3 Causes of child mortality and maternal mortality in Zambia</td>
<td>72</td>
</tr>
<tr>
<td>4.3.1 Water, sanitation and hygiene</td>
<td>74</td>
</tr>
<tr>
<td>4.3.2 Ante-natal care, delivery and post-natal care</td>
<td>84</td>
</tr>
<tr>
<td>4.3.3 Vaccines</td>
<td>89</td>
</tr>
<tr>
<td>4.3.4 Nutrition</td>
<td>91</td>
</tr>
<tr>
<td>4.4 Conclusions</td>
<td>95</td>
</tr>
<tr>
<td><strong>PART IV: THE CHILD’S RIGHT TO BE FREE FROM HIV, MALARIA AND OTHER DISEASES</strong></td>
<td>97</td>
</tr>
<tr>
<td>Chapter 5: Children and HIV/AIDS</td>
<td>98</td>
</tr>
<tr>
<td>5.1 Mother-to-child transmission</td>
<td>99</td>
</tr>
<tr>
<td>5.2 Children 0-14 living with HIV</td>
<td>101</td>
</tr>
<tr>
<td>5.3 Population 15-19 living with HIV</td>
<td>103</td>
</tr>
<tr>
<td>5.4 Causes of high prevalence of HIV/AIDS in Zambia</td>
<td>105</td>
</tr>
<tr>
<td>5.4.1 Ante- and post-natal care and HIV</td>
<td>105</td>
</tr>
<tr>
<td>5.4.2 Prevention for the young and adult population</td>
<td>107</td>
</tr>
<tr>
<td>5.5 Conclusions</td>
<td>111</td>
</tr>
<tr>
<td>Chapter 6. Malaria and other diseases</td>
<td>113</td>
</tr>
<tr>
<td>6.1 Malaria</td>
<td>113</td>
</tr>
<tr>
<td>6.2 Pneumonia/acute respiratory infection</td>
<td>117</td>
</tr>
<tr>
<td>6.3 Diarrhoea</td>
<td>117</td>
</tr>
</tbody>
</table>
### CONTENTS

6.4 Cholera 118  
6.5 Legal and public policy framework on health 119  
6.6 Conclusions 121  

**PART V: THE CHILD’S RIGHT TO EDUCATION**  
– FROM PRESCHOOL TO 18 YEARS OLD  

**Chapter 7: Education in Zambia** 123  
7.1 Educational profile in Zambia 124  
7.1.1 Early childhood education 126  
7.1.2 Grades 1-7 (primary education) 128  
7.1.3 Grades 8-12 (secondary education) 128  
7.2 Out-of-school children 129  
7.3 Causes of the educational situation 136  
7.3.1 Distance 136  
7.3.2 Socio-economic causes 138  
7.3.3 Water, sanitation and electricity at schools 144  
7.3.4 Student/teacher ratios 147  
7.4 Education learning outcomes in Zambia 149  
7.5 Legal and public policy framework on education 152  
7.6 Conclusions 154  

**PART VI: THE CHILD’S RIGHT TO GROW UP FREE FROM VIOLENCE, NEGLECT AND EXPLOITATION**  

**Chapter 8: Protection of children and women** 157  
8.1 Birth certification 157  
8.2 Child labour 159  
8.3 Child trafficking 160  
8.4 Violence against children and women 161  
8.5 Children in the justice system 165  
8.6 Protection of orphans and vulnerable children 166  
8.7 Children with special needs, including children with disabilities 170  
8.8 Child protection system in Zambia 173  
8.9 Legal and public policy framework on protection of children and women 174  
8.10 Conclusions 175  

**Chapter 9: Standing topics** 176  
9.1 Children and women’s participation 176  
9.2 Technology for development 181  
9.3 Monitoring and evaluating the situation of children, adolescents and women 184  
9.4 Emergency preparedness and response 185  

**References** 187  

**Annex 1: Social transfer programmes in Zambia** 192
LIST OF FIGURES

Figure 1: Zambia Updated SitAn model 29
Figure 2: Zambia’s position in Africa 33
Figure 3: Population, age and sex structure, Zambia total, 2010 34
Figure 4: GDP per capita, 2006-2015 (US$ current prices) 37
Figure 5: GDP annual growth, 2003-2011 (%) 37
Figure 6: GDP composition, 2012 estimate (%) 38
Figure 7: Changes in poverty levels 2006-2010 (%) 42
Figure 8: Absolute number of poor people, 1991-2006 43
Figure 9: Poverty distribution between urban and rural areas in Zambia, 2010 (%) 43
Figure 10: Distribution of rural/urban population by poverty quintile (%) 44
Figure 11: Share of expenditure per quintile, 2010 (%) 45
Figure 12: Comparison of consumption patterns between rich and poor households, 2010 (%) 45
Figure 13: Poor and non-poor population by province, 2010 (%) 46
Figure 14: Ward-level estimates of poverty headcount for Ndola district, selected wards, 2007 48
Figure 15: Ward-level estimates of poverty headcount for Chama district, 2007 48
Figure 16: Gini coefficient at province level, rural and urban, 2010 50
Figure 17: Population distribution into quintiles in three districts 51
Figure 18: Districts with worst vulnerability points 52
Figure 19: Distribution of the population 0-18 years old in terms of poverty, 2010 (%) 53
Figure 20: People living in poverty by age, 2010 (%) 54
Figure 21: Absolute numbers of poor people by age, 2010 55
Figure 22: Distribution of poor population by age group and province, 2010 (%) 55
Figure 23: Comparison between poor child population and overall population distribution, 2010 (%) 56
Figure 24: Population in poverty, districts, 2010 (%) 57
Figure 25: Population 0-18 years old living in poverty, districts, 2010 (%) 57
Figure 26: Coverage and the Human Opportunity Index for Zambia, 2010 (%) 58
Figure 27: Unemployment rate by age group, total, urban and rural, 2010 (%) 60
Figure 28: Persons aged 12 and above in informal sector in urban centres, by poverty status, 2010 (%) 62
Figure 29: Poverty comparison between children 0-6 years old and the whole country, 2010 (%) 68
Figure 30: Under-five, infant and neonatal mortality rates, 1990-2010 (per 1,000 live births) 70

Figure 31: Observed and adjusted maternal mortality estimates, 2010 (per 100,000 live births) 72
Figure 32: Causes of deaths in children under five in Zambia, 2010 (%) 72
Figure 33: Causes of maternal mortality in Zambia, 2011 (%) 73
Figure 34: Population by type of drinking water source, 1990-2011 (%) 74
Figure 35: Poor and rich residences in urban areas with safe water source, 2010 (%) 75
Figure 36: Poor and rich residences in urban areas with improved and safe sources of water for drinking, 2010 (%) 76
Figure 37: Population by type of sanitation means between 1990 and 2011 (%) 77
Figure 38: Type of toilet facility, rural and urban, 2010 (%) of households) 78
Figure 39: Poor and rich households in urban areas with improved/adequate toilet facilities, 2010 (%) 78
Figure 40: Type of refuse disposal, rural and urban, 2010 (%) of households) 79
Figure 41: Type of garbage disposal for low- and high-cost urban households, 2010 (%) 80
Figure 42: Population by source of energy for lightning, rural and urban, 2010 (%) 81
Figure 43: Housing units by type of energy for cooking, 2010 (%) 81
Figure 44: Pregnant women 15-48 years making four or more ANC visits, districts, 2007 (%) 84
Figure 45: Doctor and midwife shortages by province, 2008 (%) 85
Figure 46: Births delivered by a skilled provider, 2007 (%) 88
Figure 47: Pregnant women aged 15-49 giving birth attended by skilled personnel, districts, 2007 (%) 88
Figure 48: Distribution of children 12-23 months who completed various vaccinations (1 measles, 1 BCG, 3 polio, 3 DPT), by province, 2010 (%) 90
Figure 49: Children 12-23 months old who had no vaccinations, by province, 2007 (%) 90
Figure 50: Incidence of stunting based on poverty status, 2010 (%) 92
Figure 51: Incidence of stunting, by province, Zambia (%) 92
Figure 52: Incidence of stunting based on mother’s education, 2010 (%) 93
Figure 53: Nutritional status of children by age, 2007 (%) 93
Figure 54: Age and sex distribution of people living with HIV, 1980-2010 99
Figure 55: HIV prevalence by site, women aged 15-19 years, 2008-2009 100
Figure 56: Pregnant women receiving prophylaxes, 2010 (%) 100
Figure 57: Estimated new infections of infants with HIV and infants dying from HIV, 2000-2015 (%) 101
Figure 58: Estimated number of babies exposed to HIV from mothers who need prophylaxes and actual number of babies on prophylaxes, 2008-2011 102
Figure 59: Population 0-14 years old in need of ART and actually on ART, 2005-2011 102
Figure 60: HIV prevalence in population aged 15-19 by gender and area, 2007 (%) 103
FIGURES

Figure 61: HIV prevalence by age group and gender, 2002 and 2007 (%) 104
Figure 62: Wealth quintile characteristics among HIV-positive population 15-24 years old, 2007 (%) 104
Figure 63: Young women and men 15-24 with comprehensive knowledge of HIV/AIDS, 2005 and 2009 (%) 107
Figure 64: Women and men 15-24 having sexual intercourse before age 15, 2000-2009 (%) 108
Figure 65: Knowledge and use of condoms as prevention, 15-19 year olds, 2009 (%) 108
Figure 66: Respondents with knowledge of an HIV testing site and ever tested for HIV, male and female, 2000-2009 (%) 109
Figure 67: Teachers and pupils with HIV competency, 2009 (%) 110
Figure 68: Adolescents and youth HIV knowledge and risk behaviours (baseline and 2015 targets) (%) 111
Figure 69: Distribution of persons reporting malaria by age group, 2010 (%) 114
Figure 70: Malaria parasite RDT prevalence among children under five by urban and rural area, 2006-2012 (%) 114
Figure 71: Household ownership of at least one ITN by rural and urban area, 2006-2012 (%) 115
Figure 72: ITN use by children under five by rural and urban area, 2006-2012 (%) 115
Figure 73: Households reported sprayed within the previous 12 months, 2006-2012 (%) 116
Figure 74: Number of ITNs distributed, structures sprayed and RDTs distributed, 2003-2010 116
Figure 75: Cholera, number of reported cases, 2006-2010 119
Figure 76: Distribution of persons reporting malaria by age group, 2010 (%) 114
Figure 77: Zambia’s educational system 125
Figure 78: Absolute number of students enrolled in the Zambian educational system, 2011 126
Figure 79: Boys and girls enrolled in primary school (Grades 1-7), 2000-2011 128
Figure 80: Boys and girls enrolled in secondary school (Grades 8-12), 2000-2011 129
Figure 81: 10 year olds who have ever attended school, 1996 and 2007 (%) 130
Figure 82: Comparison of children who have never attended school with children who have attended but no longer are at school, 2010 (%) 131
Figure 83: 15-49 year olds who have completed primary school (%) 132
Figure 84: Dropout rate by gender and grade, 2011 (%) 132
Figure 85: Average dropout rate by province, 2011 (%) 133
Figure 86: Net attendance rate by grade and poverty status, 2010(%) 134
Figure 87: Students in the wrong grade for their age, boys and girls, 2011 (%) 134
Figure 88: School attendance rate by grade group, intra city inequality (%) 135
Figure 89: Distribution of households by school proximity (Grades 1-7), 2010 (%) 137
Figure 90: Distribution of households by school proximity (Grades 8-12), 2010 (%) 137
Figure 91: Absolute number of girls dropping out of Grades 1-12 and girls dropout owing to pregnancy as proportion of all dropouts, 2011 140
Figure 92: Absolute number of girls who drop out in Grades 1-12 and proportion of total dropouts that owe to marriage, 2011 141
Figure 93: Absolute number of girls who drop out of Grades 1-12 and proportion of total dropouts owing to marriage or pregnancy, 2011 142
Figure 94: Rural schools by province, 2011 (%) 144
Figure 95: Schools without water by province, 2011 (%) 145
Figure 96: Ratio of students to sanitation facilities, 2011 146
Figure 97: Student/teacher ratio by grade, 2011 148
Figure 98: Mean performance by school location, 2008 (%) 150
Figure 99: Mean performance by gender, 2008 (%) 150
Figure 100: Mean student performance by school type, 2008 151
Figure 101: Pupils reaching the minimum and desirable levels of performance, 2008 (%) 152
Figure 102: Total public expenditure on education as % of GDP and total government expenditure, 2010 154
Figure 103: Orphaned and vulnerable children whose households receive basic external support (%) 156
Figure 104: Women aged 15-49 who agreed with at least one justification for hitting, by school achievement, 2007 (%) 164
Figure 105: Women aged 15-49 who agree with at least one justification for hitting, by wealth quintile, 2007 (%) 164
Figure 106: Distribution of orphans, by rural and urban area, 2010 (%) 167
Figure 107: Absolute number of orphans 0-17 years, by rural and urban area, 2010 167
Figure 108: Estimated number of orphans owing to HIV/AIDS, 2010-2015 168
Figure 109: Attendance rate for orphan children, by grade, by place of living, 2010 (%) 169
Figure 110: Orphaned and vulnerable children whose households receive basic external support (%) 169
Figure 111: Orphaned and vulnerable children whose households receive basic external support (%) 169
Figure 112: Distribution of persons with disability, by age, 2010 (%) 171
Figure 113: Distribution of population with disabilities, by type of disability, 2010 (%) 171
Figure 114: Children with special needs who have never attended school, or are not currently attending, 2010 (%) 172
Figure 115: Number of mobile phone subscriptions per 100 inhabitants, 2011 182
LIST OF TABLES

Table 1: Urban and Rural Population in Zambia, 2000 and 2010 34
Table 2: Distribution of extremely poor, moderately poor and non-poor by province, 2010 (%) 47
Table 3: Poverty status of population 0-18 years old, 2010 (absolute and %) 53
Table 4: Child poverty by urban and rural area, 2010 (absolute and %) 54
Table 5: Poverty figures distributed by age, 2010 (absolute and %) 59
Table 6: Distribution of economically active population by main economic activity status, 2010 (%) 60
Table 7: Distribution of employed persons aged 12 years and above by activity, 2010 (%) 61
Table 8: Persons aged 12 years and above employed in the informal sector, 2010 (%) 61
Table 9: Early childhood mortality rates, provinces, 2007 (per 1,000 live births) 71
Table 10: Maternal mortality ratio estimates, 2010 (per 100,000 live births) 71
Table 11: Source of household drinking water, 2010 75
Table 12: Pupils and teachers reaching minimal HIV competency level (%) 110
Table 13: School-age population that has never attended school, 2010 (%) 130
Table 14: Out-of-school children, 2010 (%) 136
Table 15: Dropout reasons by grade, 2011 (%) 138
Table 16: Dropout reasons for girls, 2011 (%) 140
Table 17: Water availability at schools, 2011 145
Table 18: Energy availability at schools, 2011 147
Table 19: Student/teacher ratio by financing agency, Grades 1-12, provinces and Zambia, 2011 147
Table 20: Mobile phone coverage by main carriers, by province Zambia, 2011 (%) 183

LIST OF ABBREVIATIONS

AfDB: African Development Bank
AIDS: Acquired Immune Deficiency Syndrome
ANC: Ante-Natal Care
ARI: Acute Respiratory Infection
ART: Antiretroviral Therapy
BCG: Bacille Calmette-Guerin (Vaccine)
BPIA: Beijing Platform for Action
CBN: Cost of Basic Needs
CD4: Cluster of Differentiation 4
CEDAW: Convention on the Elimination of all forms of Discrimination Against Women
CLTS: Community-Led Total Sanitation
CPI: Children in Prisons Initiative
CSO: Central Statistical Office
DHS: Demographic and Health Survey
DMMU: Disaster Management and Mitigation Unit
DPT: Diphtheria, Pertussis (Whooping Cough) and Tetanus (Vaccine)
DRC: Democratic Republic of the Congo
EmOC: Emergency Obstetric Care
ECCDE: Early Childhood Care, Development and Education
EFA: Education For All
EmOC: Emergency Obstetric Care
FAO: Food and Agriculture Organization
FDI: Foreign Direct Investment
FGM: Female Genital Mutilation
FNDP: Fifth National Development Plan
GBV: Gender-Based Violence
GDP: Gross Domestic Product
GII: Gender Inequality Index
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI</td>
<td>Gross National Income</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HOI</td>
<td>Human Opportunity Index</td>
</tr>
<tr>
<td>IBRD</td>
<td>International Bank for Reconstruction and Development</td>
</tr>
<tr>
<td>IDA</td>
<td>International Development Association</td>
</tr>
<tr>
<td>IDS</td>
<td>Institute of Development Studies</td>
</tr>
<tr>
<td>IGME</td>
<td>Inter-Agency Group for Child Mortality Estimation</td>
</tr>
<tr>
<td>IHDI</td>
<td>Inequality Human Development Index</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IRS</td>
<td>Indoor Residual Spraying</td>
</tr>
<tr>
<td>ISCED</td>
<td>International Standard Classification of Education</td>
</tr>
<tr>
<td>ITN</td>
<td>Insecticide-Treated Net</td>
</tr>
<tr>
<td>LCMS</td>
<td>Living Conditions Monitoring Survey</td>
</tr>
<tr>
<td>LFS</td>
<td>Labour Force Survey</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MENARO</td>
<td>Middle East and North Africa Regional Office</td>
</tr>
<tr>
<td>Malaria Indicator Survey</td>
<td></td>
</tr>
<tr>
<td>NCD</td>
<td>Non-Communicable Disease</td>
</tr>
<tr>
<td>NFNC</td>
<td>National Food and Nutrition Commission</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NHSP</td>
<td>National Health Strategic Plan</td>
</tr>
<tr>
<td>NIF</td>
<td>National Implementation Framework</td>
</tr>
<tr>
<td>NNSS</td>
<td>National Nutrition Surveillance System</td>
</tr>
<tr>
<td>NRWSSP</td>
<td>National Rural Water Supply and Sanitation Programme</td>
</tr>
<tr>
<td>NUWSSP</td>
<td>National Urban Water Supply and Sanitation Programme</td>
</tr>
<tr>
<td>ODF</td>
<td>Open Defecation-Free</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral Rehydration Solution</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>PPHHW</td>
<td>Global Public-Private Partnership for Handwashing with Soap</td>
</tr>
<tr>
<td>RDT</td>
<td>Rapid Diagnostic Test</td>
</tr>
<tr>
<td>SACMEQ</td>
<td>Southern and Eastern Africa Consortium for Monitoring Educational Quality</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>Sida</td>
<td>Swedish International Development Cooperation Agency</td>
</tr>
<tr>
<td>SiAn</td>
<td>Situation Analysis</td>
</tr>
<tr>
<td>SNDP</td>
<td>Sixth National Development Plan</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>UCW</td>
<td>Understanding Child Work</td>
</tr>
<tr>
<td>UN</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint UN Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>USAID</td>
<td>US Agency for International Development</td>
</tr>
<tr>
<td>VSU</td>
<td>Victim Support Unit</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
</tr>
<tr>
<td>WASHE</td>
<td>Water, Sanitation and Health Education</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WSP</td>
<td>Water and Sanitation Program</td>
</tr>
<tr>
<td>ZICTA</td>
<td>Zambia Information and Communications Technology Authority</td>
</tr>
<tr>
<td>ZVAC</td>
<td>Zambia Vulnerability Assessment Committee</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

In 2008, UNICEF produced a very comprehensive Situation Analysis (SitAn) of Children and Women that assisted in discussions with Government and partners on the main issues related to these populations in the country. Since that date, the country has progressed, improving its social and economic situations to the point that in 2011 it was ranked as a lower-middle-income country.

Taking into consideration all the changes the country has faced in recent years, the objective of this document is to provide an update on the situation of children and women in Zambia, identifying recent patterns and trends in terms of inequalities. The ultimate objective is to contribute to the debate on how to continuously improve the lives of children and women, creating opportunities for the full realisation of their rights to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life.

The Updated SitAn process happened in parallel with the UNICEF 2013 Mid-Term Review, so the discussions and different versions of this document were inputs into the debates in that process. The Updated SitAn was commissioned by UNICEF, and had the support of Government and other international partners in the country.

The challenge in the 2013 Updated SitAn was to focus on bottlenecks without being limited to a list of immediate, underlying and structural causes that affect children and women. The idea was that the Updated SitAn would tell a story, explaining the situation of children and women based on evidence. This is one of the reasons why a slightly different approach was used for this updated document. The 2013 Updated SitAn uses a complementary approach that combines causes and critical determinants into a more comprehensive approach, not only based on the cause–effect relationships but also taking into consideration the complexity that influences the life of children and women.

Inequalities guided discussion in this document. The idea is that inequalities are much greater than just “difference”. Difference, or diversity, is characteristic of human society in the economic, social, civil and political spheres. Indeed, the freedom to make choices that reflect or generate our differences is fundamental to the most powerful articulations of what we mean by development. Difference also creates aspiration and competition, which drives economic as well as political systems in many countries. Beyond difference, discussion on inequalities is often about fairness and social justice. Inequalities predominantly affect individuals and groups suffering multiple human rights deprivations.

The following are the main inequities identified in Zambia; whenever possible, the analysis of the updated SitAn considered them:

- Geographical dimension, subdivided into:
  - Rural/urban
  - Intra-city (within the large cities of Zambia – townships and peri-urban)
  - Provinces
  - Districts
SITUATION ANALYSIS

In comparing the 0-18 age group with the whole population living in poverty, children represent 58% of the latter. In terms of extreme poverty, 59% of all people living in that condition in 2010 were children.

The distribution of the poor child population does not follow the overall population distribution in the country. For example, Lusaka has 17% of the total population of the country, but only 5% of the poor child population. On the other hand, Southern province has 6% of the overall population and 15% of poor children. This means public policies that target high-density areas are not necessarily reaching largest number of poor children.

At district level, adult poverty and poverty among children are very evident:

- In 61 out of the 72 districts in the country, 50% or more of the overall population is living in poverty.
- In 62 districts, 50% or more of the child population (0-18) is living in poverty.
- In 69 districts, the percentage of children living in poverty is higher than the percentage of adults living in poverty.
- In 71 districts, the percentage of children living in poverty is higher than the country’s average (60%).

The twin effects of poverty and inequality are globally recognised as a major detractor of development in general and of human development in particular. While economic growth as a facilitator of development is uncontested, there is increasing evidence to shows growth accompanied by increasing inequality is unsustainable and inefficient. Poverty in Zambia underpins all developmental areas, as this document shows.

The child’s right to survive and develop

Mother and child mortality rates have improved on what they were 10 years ago, but are still very high. Major causes are interrelated and can be attributed to two groups of factors: (i) causes related to water, sanitation and garbage management; and (ii) causes related to lack of appropriate care for pregnant women (antenatal care (ANC)), attention at birth and care in the initial stages of life of the child (postnatal care), including nutrition.

Lack of proper water, sanitation and garbage management affects children and women differently throughout the life cycle. Early in life, water- and sanitation-related diseases such as diarrhoea, measles and pneumonia are one set of causes of child and maternal mortality. Later, poor WASH increases the risk of diseases and the number of diarrhoea cases, leading to school absence and nutritional and health problems that can have life-long negative impacts.

Census data on water and sanitation highlight the rural–urban dichotomy. In rural areas, 50.4% of drinking water comes from safe sources. Meanwhile, in urban areas, 84.4% of drinking water is from safe sources. In terms of intra-city disparities, 94% of houses in the better-off neighborhoods have access to safe water in comparison with 81% of houses in poor residential areas. In poor neighborhoods, 28% of houses have access to public taps, meaning they do not have running water at home, and it is mainly children and women who have to carry their water home. In the better-off areas, only 6.6% fetch their water from public taps.
Although data from the 2007 Demographic and Health Survey (DHS) shows that 94% of women received ANC from a skilled provider (doctor, clinical officer, nurse or midwife) during their last pregnancy, only 60% of women aged 15-49 who had had a live birth in the five years preceding the survey had made four or more ANC visits, matching the international standard recommended by the World Health Organization (WHO). Of those who went to see a doctor before delivery, the majority (87%) received ANC services from a nurse or midwife; 5% received services from a clinical officer and only 2% from a doctor.

In general, 52% of deliveries reported in the 2007 DHS happened at home (91% in rural areas and 9% in urban areas). Skilled health workers attended less than half of all births in Zambia. More than 80% of the births attended to by skilled workers were in urban areas. Also, according to the 2007 DHS, 92% of mothers in the richest quintile had professional support during delivery. For the lowest quintile, it was only 27%.

Only 39% of mothers reported in the 2007 DHS that they came back for post-natal care within two days of delivery. This number likely represents an overestimate since it does not include mothers who do not deliver at health facilities, and whose babies are unknown.

The lowest wealth quintile is worse-off than the highest quintile. Poverty status determines the number and the quality of ante- and post-natal visits, and where babies are born. For mothers in the lowest quintile, the tendency is to have fewer ante- and post-natal visits and to deliver at home. For mothers in the highest quintiles, the chance of having the baby delivered assisted by qualified health staff is much higher. This makes a difference in terms of quality of the delivery, testing for HIV/AIDS and prevention of future diseases.

Malnutrition is the most widespread but least addressed public health problem in Zambia. A child's nutrition is to a large extent affected by poverty and water and sanitation vulnerabilities. Consumption patterns provide evidence of this phenomenon. Poor households in Zambia spend a large share of income on food. As their resources are limited, their priority is food security. Rich households eat better, as they have a higher income that allows them to have access to better overall nutrition and diet variety. Low-quality nutrition in adults and in particular amongst pregnant women and young mothers, ends up affecting children at early ages.

The prevalence of stunting in children under five stands at 45% (CSO, 2007), is above the average for Sub-Saharan Africa (42%). About 9% of children under five have a low birth-weight (less than 2.5 kg), which is a reflection of intra-uterine growth retardation and maternal malnutrition. This figure is likely to be underestimated considering that a large proportion of newborns are not weighed at birth in Zambia.

Although stunting is present in all geographical areas and across all socio-economic groups of the Zambian population, these are exacerbated by inequalities: (i) poverty status: children from extremely poor households (52%) are more stunted than children from wealthier households (40%); (ii) area of residence: the proportion of stunted children is higher in rural areas (48%) than urban areas (42%) (CSO, 2007). Along the same lines, the National Nutrition Surveillance System (NNSS) shows malnutrition among women of reproductive age is higher in rural than in urban areas, with 11% of women aged 15-49 classified as underweight in rural areas compared with 7% of women in urban areas (Ministry of Health, 2009c); (iii) province: for example, children from Northern province are more likely to be stunted than children from Southern province (53% and 49%, respectively); and (iv) mother’s education level: the proportion of stunted children decreases as the mother’s education level increases.

The child’s right to be free from HIV, malaria and other diseases

According to estimates by the Joint UN Programme on HIV/AIDS (UNAIDS), between 900,000 and 1.1 million people in Zambia live with HIV. This represents approximately 13% of the country’s population. Urban areas still have a higher HIV prevalence than rural areas (20% and 10%, respectively). However, numbers are growing in rural areas. Women (16.1%) are more likely to be HIV positive than men (12.3%). There are two reasons for this. First, women are more frequently tested (owing to ANC). Second, they are exposed to the disease due to entrenched forms of discrimination and harmful traditional practices. According to the 2007 DHS, comparing 2007 to 2001 data, prevalence of HIV/AIDS has reduced among women but has been increasing for men in all age groups.

HIV prevention strategies differ according to age group. For children 0-14, transmission from an HIV-positive mother to her child during pregnancy, delivery or breastfeeding is one of the key drivers of AIDS.

Through the implementation of its prevention of mother-to-child transmission (PMTCT) programme, Zambia has made significant progress (National AIDS Council, 2012). The proportion of pregnant women put on prophylaxis to prevent HIV transmission to infants increased from 61.9% in 2008 to 84.5% in 2011. The risk of children acquiring HIV from their mothers in Zambia went down from 30-45% before the era of antiretroviral therapy (ART) to 22% in 2010 and 9% in 2011 at age six weeks. However, infants can still acquire HIV infection during the breastfeeding period. In addition, children 0-14 living with HIV accessing ART remain low in number (34% compared with 80% adult coverage).

For adolescents, prevention involves improved knowledge, behaviour change and the empowerment of girls and young women. Official data shows very low levels of knowledge about the disease and low levels of condom use in sexual relations between adolescents. Even when knowledge on HIV is present, use of preventive measures is low. Furthermore harmful traditional practices may expose young girls to older men, and sexual relationships may occur without the use of condoms. Sexual education among young boys and girls is still a taboo in the country, and the unfortunate result is a large number of young girls getting pregnant and high prevalence of HIV.

Data from the Government of Zambia shows a lack of ART coverage for all populations identified with HIV. Data is not disaggregated by area or economic status. However, access to ART might be more constrained in rural areas and for poor populations.

Almost 50% of the population in Zambia is infected with malaria. According to the National Malaria Control Centre, the disease accounts for 40% of all outpatient attendance, up to 40% of all infant mortality and 15-20% of deaths in children below five years of age. The human and economic impact of the disease is a serious curb on economic development, either directly – through the costs of health care and hospitalisation – or indirectly, through workdays lost to personal illness or caring for a sick child. Malaria accounts for 6.8 million disability-adjusted life years lost in Zambia – more than respiratory infections (5.4 million) or HIV/AIDS (3.2 million). Children are the most affected. Recent data shows the percentage of infected children below five years has reduced in recent years; however, the decline between 2010 and 2012 was very small, mainly in rural areas.

Among other diseases with a severe impact on boys and girls in Zambia are pneumonia (acute respiratory infection), diarrhoea and cholera. These have a clear relationship with lack of proper nutrition and poor quality of...
SUMMARY

SITUATION ANALYSIS

In Zambia, a household head with no or only primary education is seven times more likely to live in poverty than someone with at least tertiary education. The main issue is that families and children receive the benefits of formal education only in the future; meanwhile, they need to survive on a day-to-day basis. There is no incentive to send a child to school if that child could contribute in the short run to meeting a family’s basic needs. Even in the long run, there may be little (perceived) difference in future income opportunities between a child who completes primary education and one who stays in school for only a couple of years.

Early childhood education is still incipient in Zambia. The number of children who frequent such schools is very low, and most of the facilities are financed by charities or through the private sector. Primary education is free in Zambia, and the country has shown strong progress on the main indicators for this level. However, creating a real dent in future poverty will only happen by ensuring children complete at least secondary or tertiary education. Currently, only few students graduate into secondary education and even fewer go into tertiary education. According to the Ministry of Education, in 2011 522,000 students were enrolled in Grade 1; 220,000 in Grade 6; 86,000 in Grade 10; and 76,000 in Grade 12. In terms of tertiary education, 14,000 boys and girls are enrolled at all levels of the university system.

In comparing data from the 2010 Census with the 2011 Annual School Census, Zambia has around 3.7 million children who should be in school but are not (aged 7-18). Most probably, these children are involved in non-paid agricultural work to help their families, work in low-paid jobs in the informal sector or simply stay at home, without high expectations for their present and future. The country faces two problems related to school attendance. First, children enter school late. This is mainly because of distances to schools, lack of transport and child labour. Second, children begin dropping out of school at around age 13. This is mainly for the same reasons, plus early pregnancy and marriage for girls, and also because of the introduction of school fees: Grade 8 (age 13) is when the system transitions from free education (primary school) to paid education (secondary school).

Girls leave school earlier and more often than boys, mostly as a result of early marriage and early and unplanned pregnancies, which has been increasing in the country in recent years: the number of pregnant girls in Grades 1-9 increased from 3,663 cases in 2002 to almost 14,000 cases in 2011. For Grades 10-12, the numbers increased from 765 in 2002 to nearly 1,800 in 2011. These numbers shows a clear relationship with women’s empowerment and reflect the precarious situation of women in Zambia.

The net attendance rate is a good way to capture the number of individuals attending school who are in the correct grade for their age. The indicator “penalises” the country if children are enrolled but in the wrong grade for their age. When disaggregated by socio-economic status, it highlights inequality as driven by poverty. Inequality in terms of net attendance between the extremely poor and the non-poor is 9.5 percentage points for Grades 1-4 and almost 30 points for Grades 10-12. Even with an overall low rate for the non-poor in Grades 10-12, three times more non-poor children than poor children are enrolled in these grades.

This indicator is the first in a set of three evidence categories that help in determining the future of the country in terms of education if nothing is done. Non-poor families are keeping their children at school; poor families are not. To reduce the gap between poor and rich, more poor children need to enrol in and stay at school.

A second set of evidence is related to the consumption patterns of poor and rich families in Zambia. Rich families spend more on education for adults – meaning better job qualifications – and on their children2 – translating in better opportunities for the future. Poor households basically have one option, which is to have their children in tuition-free public schools, and, at some point, if they can, to pay fees and other costs so they can complete secondary school.

Finally, the third set of evidence relates to the opportunity children have to move into the tertiary education system. Back in 2001, data from the Ministry of Education showed 1.97 million children enrolled in Grades 1-9. On average, in Zambia, 15% of enrolments between Grades 1 and 9 concern Grade 1. Therefore, one would expect around 297,000 children to be enrolled in Grade 1 in 2001. Those children are the ones who should be in the university system in 2012/13 if they completed their education without any delays or repetition – which is rare in the country. In 2012, data from the Ministry of Education shows some 14,000 boys and girls enrolled in tertiary classes in the University of Zambia and Copperbelt University. As the data do not specify how many students entered university in 2012, this is estimated at 3,520 students.2 From this, it can be estimated that only 1% of the children who entered Grade 1 in 2001 graduated to university level and had access to a better education, creating a better economic and social prospective.

Students from poor families also suffer in terms of quality of education. Data from the Ministry of Education shows that poor children studying at rural schools have the worst scores in the country. They study in schools with no electricity and no running water. Children from private schools have the best scores, and all the amenities that incentivise the use of new technologies for learning, improving their chances of a better future.

1 The standard definition of the net attendance rate is “the number of pupils in the official age group for a given level of education who attend school in that level, expressed as a percentage of the population in that age group”.

2 Although this is fairly equally spread when expressed as a proportion – probably reflecting tuition fee exemption.

3 The average university degree is four years. The number of students entering the tertiary system is equivalent to one-quarter of the total number of students in universities.
The child’s right to grow up free from violence, neglect and exploitation

Birth registration is the foundation for safeguarding many of the child’s civil, political, economic, social and cultural rights. In Zambia, only 17% of the 0-17 year old population has a birth certificate. This document is unknown to many families that do not have the incentive to obtain one.

Child labour is concentrated in agriculture, and in domestic labour, mainly small household chores related to fetching water, helping with young siblings and cattle rearing. The share of rural children in employment in 2008 was three times that of their urban peers. There is also a regional component in this phenomenon: in 2008 16% of children in Lusaka worked, compared with 55% in Eastern province and 52% in Northern province; and an age component: child economic activity rises sharply with age, but numbers of even very young working children are far from negligible. Around 14% of seven year olds and 22% of eight year olds are already in employment.

Child trafficking is a hidden violation of the rights of children in Zambia, and encompasses national and international components. There are no data or estimations related to child trafficking, given its nature, but anecdotal evidence points to considerable numbers of children brought to urban areas of the country for domestic work. In terms of international trafficking, some cases of child trafficking to and from neighbouring countries have been reported, mainly for labour, but some for prostitution.

Poverty strikes hard in terms of psychological and physical violence and abuse; however, it is not the only variable that explains violence against children and women in the country. Issues related to the protection of children and women should be also interpreted using the dual legal system of the country: customary law and the modern legal system sometimes do not agree in terms of response to violations involving vulnerable populations.

The extent of gender-based violence (GBV) is difficult to measure, as few incidents are reported, either because women fear reprisals, are ashamed, expect to endure violence at the hands of male family members or feel there is no one of trust to report to. There is a cultural preconception involved in GBV that is present even in those who suffer from violence. According to the 2007 DHS, 62% of women feel wife beating is justified in certain circumstances. This perception does not change with age but is highly influenced by the education of the woman: the more educated, the lower the acceptance of violence. Wealth is not as effective a determinant: 47% of women in the wealthiest quintile still believe domestic violence is justifiable under certain circumstances.

Child marriages are frequent in Zambia. According to an assessment by the Ministry of Gender and Child Development, within Zambia 46% of all women were married under 18 years of age. Data is not disaggregated by wealth or any other factor that allows for an inequality analysis; however, qualitative assessments point to the fact that poor girls living in rural areas are those who get pregnant at an early age and end up marrying. These girls drop out of school, and are at higher risk of continuing to live in poverty. In addition, the risk of being infected with HIV/AIDS and/or other sexually transmitted diseases is very high among these populations.

Using 2010 Census data, in proportional terms, the orphan population represents 16% of the 0-18 urban population, and 11% of the rural population in the same age group. However, in absolute terms, 56% of the orphan population is located in rural areas. From the total of 861,000 orphaned children in the country, 185,000 have lost both father and mother. Most of the orphans in the country are orphaned because of HIV/AIDS. UNAIDS estimates shows that around 680,000 orphans were orphaned by the disease in 2011.

Economic factors play an important role in orphanhood. According to the 2010 Living Conditions Monitoring Survey (LCMS), 53% of orphans in the country come from small-scale houses – houses characterised as poor in rural areas of the country, and used in this document as a proxy for extreme poverty households. In contrast, less than 3% are from the high-cost stratum – rich households located in urban areas of the country, used as proxy for rich households. In terms of intra-city inequalities, 74% of orphans in urban areas come from low-cost households and 7% from high-cost households.

In terms of schooling, Census data from 2010 confirms that 14% of the orphan population of school age (7-17 years old) have never attended school. There are no major disparities in terms of orphan boys and girls who have never attended school, but a significant difference in terms of place of living: 79% of orphan children who have never attended school live in rural areas of the country. Among those who went to school, 10% had stopped at the time of the Census. The general attendance rate for orphaned children in Zambia is 76%, with variations in terms of age and place of living.

The adolescent population presents a major challenge to the country in the coming years. This population has suffered high HIV incidence; if they were not born infected with HIV, some are contracting it because of the absence of appropriate measures, caused by insufficient information, mistaken behavioural attitudes and/or lack of empowerment (in this case, this relates mainly to adolescent girls). It is also the population that has come of age with a deficiency of appropriate water and sanitation, causing them to experience constant health issues that end up having a negative impact on their learning and professional skills.

In terms of economic prospects, most children dropping out school do so when they are becoming adolescents, before entering secondary level. They are not learning the necessary educational and working skills that could help them in the future. This is the population that is facing high levels of unemployment in the cities, and is frequently found in the informal market. In addition, girls are leaving school in great numbers because of early pregnancy and/or marriage. This combination of factors is leading a large proportion of today’s population into tomorrow’s poverty.

Adolescent participation is important to ensure children partake in decision making on issues that affect their lives, especially when they are involved at the community level. Adolescents, when involved in decision making through participation, become agents of positive change for their communities, especially on issues that concern them.
1.1 Objective of the 2013 Updated Situation Analysis

In 2008, the UN Children’s Fund (UNICEF) produced a very comprehensive Situation Analysis (SitAn) of Children and Women that contributed to discussions with the Zambian Government and partners of the main issues related to these populations in the country. Since then, the Zambian Government and its partners have produced a series of data, surveys and analysis that have helped enable a better understanding of the situation of children and women. The country has also changed, and improved its economic situation so that in 2011 it was ranked as a low-middle-income country.

Taking into consideration all the changes the country has faced in the past years, the objective of this document is to provide an update on the situation of children and women in Zambia, identifying recent patterns and trends in terms of inequalities. The ultimate objective is to contribute to the debate on how to continuously improve the lives of children and women, creating opportunities for the full realisation of their rights to survival, to develop to the fullest, to protection from harmful influences, abuse and exploitation and to participate fully in family, cultural and social life. All this lies within the four core principles of the UN Convention on the Rights of the Child (UNCRC): non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. On women, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the implementation strategy through the Beijing Platform for Action are particularly significant, and frame this Updated SitAn.

The Updated SitAn process happened in parallel with the UNICEF 2013 Mid-Term Review process, so the discussions for and the different versions of this document were used as inputs for the discussions for the latter process. The Updated SitAn was commissioned by UNICEF, and had support from the Government and other international partners in the country. The SitAn process was also used in Government management processes as a tool in the discussions that routinely take place in terms of strategies for children and women.

1.2 Methodological framework of the Situation Analysis

The Updated SitAn adopted a human rights framework that assumes rights are interdependent and interrelated. The realisation of one right often depends, wholly or in part, on the realisation of others. For instance, realisation of the right to health may depend, in certain circumstances, on realisation of the right to water and sanitation, education and information. Hence, it is impossible to disassociate the problems of one area from those of another, and to improve the situation of children and women by fixing just one issue.

The methodological process for updating the Zambia SitAn followed the steps indicated in UNICEF’s Guidance on Conducting Situation Analysis of Children’s and Women’s Rights (2011), and used some insights from its Global Assessment on Situation Analysis of Children’s and Women’s Rights (2012a). First, we conducted an
**INTRODUCTION**

assessment of the manifestations of child rights shortfalls and inequalities in child outcomes, based on the material available in the country. We followed this with an analysis of the major causes of child rights shortfalls and inequities and concluded with a validation of the analysis for the realisation of child rights with equity, carried out by UNICEF with Government and other stakeholders.

Among the main tools suggested for use in developing a SitAn – causality analysis, role pattern analysis, capacity gap analysis and enabling environment analysis – the first was emphasised in the 2013 Updated SitAn, focusing on identifying critical determinants in the provision and use of essential interventions and services for children and women.

Role pattern analysis was very prominent and explicit in the original 2008 SitAn, hence the updated document deliberately followed a different path. Capacity gap analysis was also very strong in the original SitAn. The 2013 version addressed capacities, but these were mostly integrated into the overall analysis. The legal and policy framework is also part of the overall analysis: each chapter provides a brief discussion on this in relation to the environment that affects children; however, a deeper analysis on the results of these policies is still needed. It was understood that an evaluation would be necessary to assess results and changes in terms of policies for children and women.

The challenge in the Updated SitAn was to focus on bottlenecks, but without limiting this to a list of immediate, underlying and structural causes that affect children and women. The aim was for the 2013 SitAn to tell a story, to explain the situation of children and women based on evidence. This is one of the reasons a slightly different approach was employed. The Updated SitAn combines causes and critical determinants into a more comprehensive approach, not only based on cause–effect relationships but also taking into consideration the complexities that influence the lived realities of children and women.

As such, the model of analysis used in the document places the situation of children and women in a system that is influenced by (i) contextual factors, represented by economic, political and institutional environments that frame the country situation; (ii) supply-side factors, represented by the availability of services, budgets and adequate means to realise human rights, as well as the duty-bearers in the human rights approach; (iii) demand-side factors, representing common knowledge, attitudes and practices at community level – rights-holders; and (iv) personal factors, representing individual wishes, aspirations, education and health status, among other aspects (Figure 1).

The idea behind adding a personal, individual factor into the model of analysis was to make it possible to take into consideration the fact that people respond to different stimuli and have different aspirations. These individualities need to be respected when determining public policies.

For example, an individual might have a personal threshold that limits his/her employability. Some of these limitations might come from contextual, supply- or demand-side factors, but it may be the lack of appropriate health, schooling and nutrition has had an impact on the individual and influenced their current situation. Along the same lines, a child who did not have a proper supply of nutrients in the early stages of life might have access to school and health at an older age, but still carry a health condition that needs to be addressed in order for him/her to prosper in life. The notion that one size fits all is not equitable, and cannot be used to explain the situation of children and women in Zambia.

---

**Figure 1: Zambia Updated SitAn model**

Source: Based on Bamberger and Segone (2011).

1.2.1 Inequality analysis

The Zambia Updated SitAn is focused on inequalities, and it uses the concepts and the framework described in the UNICEF and UN Women (2013) Synthesis Report on the Global Thematic Consultation on Addressing Inequalities. The underlying concept contends that inequalities are much greater than just “difference”. Difference, or diversity, is characteristic of human society in the economic, social, civil and political spheres. Indeed, the freedom to make choices that reflect or generate our differences is fundamental to the most powerful articulations of what we mean by development. Difference also creates aspiration and competition, which drives economic as well as political systems in many countries.

Beyond difference, discussion on inequalities is often about fairness and social justice. Inequalities predominantly affect individuals and groups suffering multiple human rights deprivations. Typically, marginalised and excluded groups lag behind in the enjoyment of one particular right, owing to lack of access to other rights such as decent jobs, food, housing, health, sexual and reproductive health, information, education, participation, physical integrity or judicial remedies. Multiple deprivations and inequalities are often closely associated with and reinforced by specific forms of discrimination in the realisation of civil, political, economic, social and cultural rights. Examples include, but are not limited to, discrimination related to gender, age, caste, race, ethnic and indigenous identity, minority status, (dis)ability, place of residence, marital and family status, HIV status and sexual orientation.
Different forms of inequality overlap. They reinforce each other and create unique forms of discrimination and exclusion. Inequalities are both the cause and the consequence of multiple forms of discrimination that tend to reproduce themselves over time and over generations (UNICEF, 2013). Inequalities are present in many different dimensions, depending on local context. The following are the main inequities identified in Zambia; whenever possible, the analysis of the Updated SitAn takes into consideration:

- Geographical dimension, subdivided into
  - Rural/Urban
  - Intra-city (within the large cities of Zambia — townships and peri-urban)
  - Provinces
  - Districts
- Gender
- Household socio-economic status
- Age

These dimensions can also be combined into two broad categories: economic inequalities and social inequalities. The current paper shows that, in Zambia, poverty (economic issues) drives a number of inequalities, whereas norms or roles (social issues) drive others – and that in several instances a combination of social and economic drivers is at work.

In using these dimensions, it is openly acknowledged that a child born in one district has a higher or lower chance of having access to clean water and adequate sanitation. Along the same lines, a girl has a lower chance than a boy of completing 12 years of schooling. If this girl lives in a rural area, her chances of getting pregnant early and not finishing school are much higher than those of her peers in urban areas.

1.2.2 Issues and limitations with the Updated Situation Analysis

The way the 2013 Updated SitAn presents broader topics does not follow the UNICEF Zambia country programme. The SitAn tries to describe the situation of children and women in simple and comprehensive terms, and for this reason it looks at some issues in their totality, without paying particular attention to the area of the issue UNICEF handles. For example, HIV/AIDS is a crosscutting issue that is handled by different sections at UNICEF in Zambia (under Health, Education and Adolescents, among others). In this SitAn, Part III covers HIV/AIDS and other diseases as a stand-alone issue. The document also explores some areas that are not part of UNICEF’s focus areas.

No specific section is dedicated to gender. Rather, it is mainstream throughout the analysis. Gender, mainly issues related to girls and women, is an integral part of the SitAn, and therefore covered in all the chapters. In fact, gender is one of the biggest determinants of inequality in the country, and it is important to note that the situation of women in the country needs a much more complex analysis than what is conducted within this document. The gender analysis in this document is developed alongside an analysis of effects and impacts on the life of children. Therefore, the document does not cover many other issues related to women’s rights. Further studies should address this.

In the same fashion, there is no specific chapter for adolescents’ issues. These were also considered crosscutting, with subjects related to adolescents mainstreamed throughout the document. At the same time as the Updated SitAn was being developed, an Adolescent Report Card for Zambia was being produced. The idea is that both the Updated SitAn and the Adolescent Report Card will complement each other. Therefore, many topics related to adolescents not covered in this document are being treated in the latter.

As much as possible, we used a lifecycle approach within the chapters in order to facilitate understanding. In many cases, though, this was not possible, since the issues being described did not limit themselves to age. The 2008 SitAn was done in a very participatory and exploratory manner. It included many meetings and studies on different areas carried out exclusively for the SitAn. The 2013 Updated SitAn did not follow the same model, mainly because of financial and time constraints. It focused on the desk review of documents and data, interviews with key stakeholders and limited field visits. Hence, it did not have as strong a participatory component. However, the analysis and the results presented in the updated document were discussed by a high-level panel formed of members of the Government, partners and the UN. The final version tried to capture their suggestions without losing the independence of the exercise. As such, the 2013 Updated SitAn tries to present a scenario that is as close to the reality as possible, without judgement or values.

The field visit that took place during the 2013 updating process did not have as an objective to collect qualitative data for the analysis. The visits were limited to some districts in two regions of the country. Essentially, the field visits were used to capture life stories to illustrate the Updated SitAn. These stories are presented in boxes throughout the text and they represent the lives of real people met during the field trips. They are not scientifically representative in terms of the size of the sample and selection of interviewees, but all those who read the stories agreed that they offer a good snap shot of the life of the majority of Zambians living in the rural and urban areas of the country.

1.2.3 Special note on resilience

Resilience is the ability to withstand threats or to adapt to new strategies in the face of shocks and crises, in ways that preserve the integrity of individuals, households and communities (while not deepening their vulnerability) with a focus on merging humanitarian and development programming to better address overlapping risks and stresses (FAO et al., 2012). While resilience was originally seen as a strategy to cope with crisis, its concepts have been shifted more and more into overall development, and have become a strategy to understand and help in improving the day-to-day life of vulnerable people and in reducing their future burden. According to UN...
Without focusing explicitly on resilience, the Updated SitAn has adopted parts of the concept. As mentioned, resilience is seen as a strategy to better understand how vulnerable children, women and their families live, the problems they face and the issues they have to cope with every day. This was at the core of the SitAn: trying to understand the causes underlying current living conditions. Along the same lines, instead of looking at specific problems in isolation, as sector approaches often do, a resilience approach considers a number of different issues and perspectives all together. It calls for a holistic approach, and encourages organisations to adopt cross-sectoral and inter-disciplinary approaches that enable them to see the bigger picture (IDS, 2013). That also underpins the methodology used in the Updated SitAn, as Figure 1 shows.

Thus, the SitAn covers the strategies children and women use to cope with their situation, which is the most important aspect of the resilience approach. However, it did not use a resilience analysis methodology, which should be based on understanding how vulnerable groups cope with their problems, with a strong focus on qualitative assessment of different groups in different regions of the country. It is recommended that such a study be conducted in the future.

1.2.4 Data sources

All the data utilised in this Updated SitAn come from official governmental sources, international agencies and small-scale surveys and studies. While the data for some of these surveys cannot be extrapolated to the country as a whole, they give a good perspective in terms of indicators in some of the worst-off regions. Those datasets that were limited in terms of region were used very carefully, and this is always mentioned in the text. Data was disaggregated as much as possible to cover all the inequalities taken into consideration in the country. Intra-city disparity is one specific area that still needs further improvement in terms of data gaps and future data collection. Inequalities within the big cities in Zambia are not so evident in the recent available data. In order to analyse this phenomenon, we used two main data sources. First, we used micro-level estimates of poverty in Zambia done by the Central Statistical Office (CSO) in 2007. This study used data comparison between the 2000 Census and the 2002/03 Living Conditions Monitoring Survey (LCMS) in order to calculate ward-level poverty headcounts. Second, stratum data available in the 2010 LCMS was used as a proxy of intra-city poverty. The 2010 LCMS analyses urban data in three strata: low-cost, medium-cost and high-cost. These represent three different socio-economic realities, allowing for comparison between better-off households in the cities (high-cost) and the worst-off households in the cities (low-cost) (CSO, 2012a).
Zambia has a very young population structure. Census data estimates the child population (18 and younger) at 52.5% of the overall country population, a small increase if compared with the 2000 population (52.2%). The child population is still higher in rural areas than in urban areas (55.4% and 48%, respectively). Women represent 50.7% of all the people in the country (Figure 3).

Table 1: Urban and Rural Population in Zambia, 2000 and 2010

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2010</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, rural areas</td>
<td>6,458,729</td>
<td>7,919,216</td>
<td>22.6%</td>
</tr>
<tr>
<td>Population, urban areas</td>
<td>3,426,882</td>
<td>5,173,450</td>
<td>51.0%</td>
</tr>
<tr>
<td>Total</td>
<td>9,885,611</td>
<td>13,092,666</td>
<td>32.1%</td>
</tr>
<tr>
<td>% rural</td>
<td>65</td>
<td>60</td>
<td></td>
</tr>
</tbody>
</table>

Source: CSO (2012b).

2.2 Legal and policy framework

The Zambian Constitution, as the supreme law of the land, provides for the care of institutions, procedures, processes, and functions of state and Government organs, functionaries, and institutions. Article 2 of the current Constitution (1996, as amended in 2006) provides protection for the fundamental rights and freedoms of all Zambians. Constitutional development in Zambia spans over four decades and has always included a Bill of Rights. All the fundamental rights and freedoms in the Zambian Constitution are guaranteed and justiciable. The Constitution also provides for economic, social, and cultural rights, which are, however, non-justiciable, and therefore not legally enforceable.

The Constitution allows for the practice of a dual legal system based on both statutory and customary laws. This dual legal system has implications for how the legal framework impacts on the status and welfare of both women and children in Zambia. While statutory laws do provide for equality for women, especially in terms of inheritance and ownership of land, the majority of the Zambian population still seek legal redress from the local courts that administer customary laws, simply because they are less expensive and are easily accessible in most areas of Zambia.

Zambia is party to various international and regional instruments that have influenced the development of policies on women and children. Among the international and regional instruments are CEDAW, the Beijing Platform for Action (BPfA); the African Solemn Declaration on Gender; and the Southern African Development Community (SADC) Declaration on Gender and Development. However, these international and regional instruments for the promotion of gender equality have not been domesticated or integrated comprehensively into national laws. In 2000, the Government of Zambia introduced the National Gender Policy, with the overall vision of achieving full participation of both women and men in the development process at all levels in order to ensure sustainable development and attainment of equality and equity between the sexes. The Gender Policy committed the Government to specific measures across a wide spectrum of social and economic sectors that include agriculture, land, education and skills development, culture, health, gender-based violence and decision-making.

Like issues concerning women, matters concerning children have equally been influenced by international and regional instruments to which Zambia is a party. On 30 September 1990, Zambia signed UNCRC; it ratified it on 6 December 1991. Zambia also signed the 1990 African Charter on the Rights and Welfare of the Child (ACRWC). The UNCRC is the main instrument in international human rights that govern the rights and welfare of children; it defines a child as anyone aged zero to 18 years unless the age of majority in a state is attained earlier. While the current Constitution guarantees rights to all persons including children, it does not define the age of a child.
In fact, these legal anomalies have led to inconsistency in defining the age of the child in Zambia. Zambia is currently drafting a new Constitution and Bill of Rights with the intent of ensuring domestication of the UNCRC through the constitutional reform process. Although the UNCRC has not yet been fully domesticated, a review of child-related legislation has been conducted and amendments to laws to address gaps in domestication are being undertaken. As with women’s rights, the Zambian dual legal system of statutory and customary laws is often applied inconsistently, resulting in poor implementation of the rights of the child. Overall, Zambia has more than 26 pieces of legislation that provide for and regulate the rights of children.

Zambia adopted a National Child Policy in 2006 and a National Plan of Action was subsequently developed, with the following broader goals:

- Improve the standard of living and quality of life of the child
- Make the child an integral part of national development
- Improve support for and protection of orphans and vulnerable children
- Improve support for and protection of children living in especially difficult circumstances
- Create an environment that places the highest priority on the needs of women and children and that recognises and strives to fulfil their rights

With the change in Government in September 2011, there are plans to review and amend both the gender and the child policies. The recently re-organised Ministry of Gender and Child Development is responsible for initiating policy for the protection and promotion of the human rights of women and children in Zambia.

### 2.3 Economy

In 2011, the World Bank raised Zambia to lower-middle-income status, mainly because of the increase in terms of gross domestic product (GDP) per capita. In current US dollars, the 2011 GDP for the country is around US$ 19.21 billion. According to the World Bank (2012b), total national income has risen by more than 56% in the past eight years (based on 5.7% p.a. real GDP growth 2002-2010; and population growth averaging 2.8% p.a.). International Monetary Fund (IMF) data (October 2012) shows that per capita GDP increased from about US$ 890 in 2006 to US$1,221 in 2010, with estimates that this value might reach US$ 1,860 in 2015 (Figure 4).

---

10 According to the World Bank, as of 1 July 2011, low-income economies are those that had average incomes of US$ 1,005 or less in 2010, and middle-income economies are in the sub-category with average incomes of US$ 1,006 to US$ 3,975. World Bank uses gross national income (GNI) as the basis for the calculation.

11 http://data.worldbank.org/country/zambia

12 According to the UN, preliminary estimates from the Zambian Government for 2012 are that real GDP grew by 7.3% compared with 6.8% in 2011. Consistent with positive economic growth rates has been an improvement in real GDP per capita, which rose to an estimated US$ 1,221 in 2010, with estimates that this value might reach US$ 1,860 in 2015 (Figure 4).
Net foreign direct investment (FDI) and portfolio investments have been growing steadily, from US$ 350 million in 2009 to an estimated US$ 991 million in 2012. FDI inflows continue to be directed mainly at the mining sector, with manufacturing, communications and financial institutions also contributing to recent FDI growth (World Bank, 2012a).

Although most of the GDP comes from services and agriculture (Figure 6), 64% of the country’s exports in 2012 were related to copper and cobalt.13

![Figure 6: GDP composition, 2012 estimate (%)](image)

Source: AIDB (2012).

Agricultural GDP growth has averaged 7.2% since 2009, and much of this is accounted for by a massive increase in the production of maize – the staple food crop in Zambia – which has more than doubled since the 2008 season, but also by the diversification of the sector. The construction sector has also been important to Zambia’s growth in recent years, accounting for some 21.1% of the economy in 2011. The rebound in mining activity and increased public expenditure on infrastructure boosted construction, giving an average sector growth rate of 17% in 2012 and 2013 (AIDB, 2012).

Zambia’s reclassification as a middle-income country has generated some uncertainties in the economic forecast of the country. On the positive side, the Government feels the new classification will further boost investments in Zambia, since the country has become more credit-worthy in the eyes of the international lending community, which will translate into more capital inflows into the financial sector, creating wealth and jobs.

The new rating will also allow the country to be eligible for two new international funding sources: International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD) loans. While the first is concessional – interest-free loans and grants for programmes aimed at boosting economic growth and improving people’s living conditions, the second is non-concessional and repaid at commercial rates. They are usually employed in infrastructure.

On the negative side, there is some uncertainty in terms of future foreign aid support to social programmes in the country. In fact, some donors are already reducing or cutting their funding to the country. These cuts are not fully explained by the country’s new classification, but this might have an impact on future donor decisions. For the 2013 National Budget, it is estimated that external funding (foreign grants and loans) are responsible for 17.5% of the country’s revenue, representing 4.6% of GDP (Government of Zambia, 2012). The impact in terms of foreign aid might actually be bigger, since international organisations implement projects and actions in the country without the funds necessarily being channelled through the Government’s budget.

Chapter 3. Poverty Context for Children and Women

This chapter presents an overview of poverty in general with a focused discussion of child poverty. It looks at how poverty presents different configurations in terms of inequalities, and briefly explores some causes of this phenomenon. This chapter does not exhaust the discussion on poverty or its effects; however, both are mainstreamed throughout the document.

MDG summary

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
<th>Indicator</th>
<th>Current data*</th>
<th>2015 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eradicate extreme poverty and hunger</td>
<td>Halve, between 1990 and 2015, the proportion of people living in extreme poverty</td>
<td>Proportion of population living in extreme poverty (%)</td>
<td>42.3 (2010)</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poverty gap ratio</td>
<td>28.0 (2010)</td>
<td>31.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gini coefficient</td>
<td>0.65 (2010)</td>
<td>0.34</td>
</tr>
<tr>
<td>Achieve full and productive employment and decent work for all, including women and young people</td>
<td>Employment to population ratio</td>
<td>Proportion of employed people living below the poverty line</td>
<td>68.6 (2008)</td>
<td>66.4 (2006)</td>
</tr>
<tr>
<td>Halve, between 1990 and 2015, the proportion of people who suffer from hunger</td>
<td>Prevalence of underweight children (under five years of age) (%)</td>
<td>13.3 (2010)</td>
<td>12.5</td>
<td></td>
</tr>
</tbody>
</table>

Note: * All data for the MDG tables in the document come from UNICEF (2010; 2013a).
3.1 Poverty in Zambia

Despite robust growth in recent years, poverty remains very high in Zambia. According to 2010 LCMS data, around 60% of the population in Zambia could be considered poor, subdivided into extremely poor (42%) and moderately poor (18%). In absolute numbers, 7.9 million people lived in poverty, with 5.5 million of those living in extreme poverty with insufficient resources to meet their daily minimum food requirements.

Although poverty has declined marginally when comparing 2006 and 2010 (Figure 7) data, the absolute number of poor has increased (from about 6 million in 1991 to 7.9 million in 2010). This trend was also identified in the 2008 SitAn, which compared poverty numbers between 1991 and 2006 (Figure 8).

Figure 7: Changes in poverty levels 2006-2010 (%)

In order to calculate the poverty lines, the CSO uses two statistical measures. The food poverty line method – based on the Cost of Basic Needs (CBN) – is used to calculate extreme poverty. The basic needs basket (that includes food poverty and non-food needs such as shelter, clothing, good health and education) is used as parameter to calculate moderate poverty.

The most recent data shows that, in general terms, (i) 84% of the poor population lives in rural areas; and (ii) 89% of the extremely poor are located in rural areas as well (Figure 9).

Figure 8: Absolute number of poor people, 1991-2006

Figure 9: Poverty distribution between urban and rural areas in Zambia, 2010 (%)
The World Bank has calculated the dollar values for poverty in rural and urban Zambia (World Bank, 2012b). In 2010, an extremely poor person in Zambia would live with the equivalent of US$ 0.68 a day, or US$ 20.52 a month. A poor person in a rural area would live with the equivalent of US$ 1.01 daily (US$ 30.43 monthly); in an urban area, the poor person would live with US$ 1.25 daily, or US$ 37.61 monthly.

Along the same lines, Figure 10 shows that nearly 90% of the poorest income quintile is made up of people who live in rural areas, whereas just 30% of the wealthiest income quintile lives in rural regions (UNICEF Zambia, 2010).

Figure 10: Distribution of rural/urban population by poverty quintile (%)

Rich families in Zambia are responsible for 60% of total expenditure in the country. The bottom 20% is responsible for around 4% of all expenditures in the country (Figure 11).

Figure 11: Share of expenditure per quintile, 2010 (%)

The pattern of consumption is also very different between poor and rich households in the country. Using small-scale rural properties as a proxy for poor households, and high-cost households as a proxy for rich households, it is possible to differentiate the pattern of consumption between rich and poor populations in Zambia.

Figure 12: Comparison of consumption patterns between rich and poor households, 2010 (%)

80% of the population living in rural small-scale properties are poor. Meanwhile, only 7% of the population living in urban high-cost households are poor.
As Figure 12 shows, poor households in Zambia spend a bigger share of their income on food. This is to be expected, since they make less money than richer households, and more often have more children. As their resources are limited, they have to fulfil their first priority, which is eating. Rich households eat better as they have a higher income that allows them to access better overall nutrition. In addition, they are able to save more to invest in better houses with better sanitation – as Chapter 4.3 shows. As a result, richer families do not need spend much as much on health, as they live in a better environment, their health is also better. However, the poor do not spend as much on health, despite living in worse conditions. This is due to Government provision of basic health care and medicines in free health centres and hospitals.

Richer households are also able to spend more on education for adults – meaning better job qualifications – and for their children – translating into better future opportunities. Those who live in poor households have to send their children to public schools, and, at a later stage, are required to pay fees so they can attend secondary school.

The share of monthly income spent on alcohol is almost the same amongst rich and poor households. While for the better-off population alcohol is used for entertainment and social interaction, for the poor it is often only a temporary relief from their problems. Alcohol abuse is often connected with cases of sexual abuse and gender violence in rural and peri-urban areas.

Poverty also exists at provincial level. Taking into consideration poverty estimates for the nine provinces, in only two of them (Copperbelt and Lusaka) is the percentage of people not living in poverty higher than that of those living in poverty (Figure 13 and Table 2).

As mentioned, intra-city inequalities are not so evident in the recent available data in Zambia. In terms of intra-city poverty, on average, 38% of the population in the low-cost stratum living in cities is considered poor (CSO, 2012a). These families may live in the townships and peri-urban areas of the big cities in Zambia. In the high-cost stratum, only 7% are poor. In fact, as demonstrated in this document, high-cost households represent the better-off population in the country in terms of education, health and water and sanitation, among others.

We also used micro-level estimates that allow poverty numbers to be estimated at ward level. Despite using data from 2000 and 2002, the importance of this work is to shows how poverty varies within districts in Zambia, and among them, and also in the bigger urban centres (Lusaka, Ndola, Kitwe, Livingstone, Chipata and Kabwe).

This data indicates that urban centres have high internal inequality. For example in the Ndola district, located in the Copperbelt province, around 59% of the population lives in poverty.17 When this information is disaggregated by ward, poverty in the worst-off wards is four times higher than that in the better-off ward (Figure 14). The same pattern can be found in all the other big cities in Zambia. On the other hand, less urban districts do not present the same difference. In Chama district, in Eastern province, there is not much variation in terms of poverty between the wards (Figure 15).

---

17 This estimate is different from the estimate calculated using the 2010 LCMS data. The main reason for this is the data and the method used: the 2007 analysis used data from 2000 and 2002, calculating poverty based on statistical inference; the poverty analysis in this document used 2010 data, and estimations made by the CSO. This difference does not jeopardise the objectivity of this analysis, which shows how poverty varies within cities in Zambia.
3.2 Poverty and gender

In statistical terms, if isolated from other variables, there are no significant differences between men and women in terms of poverty. Data shows that, on average, 60.5% of the male population and almost the same numbers of females (60.3%) are poor. In terms of the overall poor population, women represent 51% (4.04 million people) and men 49% (3.85 million people).

Despite the very similar numbers, poverty hits women harder, since they are the most affected in terms of violence, health problems and other vulnerabilities and deprivations. They are also those in charge of taking care of the children when husbands abandon the family. Poverty for women might not be as evident in the numbers, but society places a higher responsibility on them for the survival and health of their children. Unfortunately, poverty is only one of the aspects that place women in a worse situation than men in Zambia. This situation is described as much as possible in all the coming chapters and sections of this SitAn.

Poverty and gender

During the field trip, we met lots of young mothers carrying one, two and sometimes three young children. Their stories were very similar: they all left school because of early pregnancy, and did not go back to finish their education. They sustain their family cultivating certain products (mainly corn and tomatoes), and get extra income selling these on the roads. A few are married, which, according them, helps alleviate their economic needs. Those not married (some never, others abandoned by their husband) said they lived in poverty. They have to work for themselves, some without any family or government support, to keep their children alive. They feel they are in the worst-off situation because they are women. If they were men, they would probably not need to worry as much. The stories of these brave women illustrate this situation analysis.

3.3 Poverty and inequality

Based on Human Development Index (HDI) standards, Zambia is still considered a low human development country. Zambia’s HDI for 2012 was 0.448 – positioning the country at 163 out of 187 countries and territories. When the HDI value is discounted for inequality – the IHDI – the index falls to 0.283, a loss of 36.7% owing to inequality in the distribution of the dimension indices (UNDP, 2013).

The 2010 LCMS report provides a Gini coefficient\(^\text{18}\) for nine provinces, for urban and rural areas and for the country (Figure 16). At country level, a coefficient of 0.55 is among the highest in the world. Similar numbers are present at province level, and also in rural and urban regions. Even those provinces that are less poor than others, Lusaka for example, present a high Gini coefficient. Lower levels in the Gini coefficient do not determine that one province is actually better off than others in terms of poverty; a low Gini coefficient might indicate that poverty is actually so wide-spread in the area that there is not much difference in terms of poverty – since most of the population is poor.

\(^{18}\) This is the most commonly used measure of inequality. The coefficient varies between 0, complete equality, and 1, complete inequality (one person has all the income or consumption, all others have none).
UNICEF analysis (2010) goes deeper and tried to identify how poverty is spread at district level. The first piece of evidence from the study found that, in Zambia, people in the very poorest districts are poorer than those in districts where overall poverty levels are lower. In the least-poor districts, poor people are on average less than 10% below the poverty line; in the poorest districts, their income is on average 60% below the poverty line. In approximate terms, this means that, if the poverty line is about US$ 1 per day per adult, the average shortfall in the richer districts is US$ 0.10, whereas in the poorest districts it is US$ 0.60.

Along the same lines, a quintile analysis in three districts (Chilubi Island, Lusaka and Mpika) showed very different poverty distributions (Figure 17). For Chilubi Island, one of the poorest districts in the country, just 3% of the population is in the top national quintile, whereas 50% is at the bottom national quintile. For Lusaka the situation is completely different: few are in the lowest national quintile and the majority is in the top quintile. This evidence points to a strong disparity in terms of services and opportunities for children and women at district level. For better analysis, UNICEF Zambia has created the Index of District Vulnerability, using data related to poverty, access to services, chronic deprivation, geographical remoteness and social inclusion. Sixteen indicators were transformed into vulnerability points, and allocated among the districts for analysis.

Further examination of the data showed that 15 of the 72 districts in Zambia are the most vulnerable in the country (Figure 18). These are divided into two groups. The first represents the eight districts with the worst scoring. They received 33% of the total vulnerability points (three times greater than average). These eight districts are very hard to reach: only one is connected to any other location by a road paved with tarmac, and many have severe physical constraints besides gravel roads. The total population of these districts is approximately 800,000, or 7% of the country population (2000 Census).

The second worst-off group has seven districts. These received 19% of the points, two times more than the average. These districts are also fairly hard to reach, although noticeably less so than the eight mentioned earlier. Most have considerable geographical access issues within the district. The population of these seven districts is about 780,000 people.

---

\[19\] Chama, Chironga, Chilubi, Kalabo, Kaputa, Luwingu, Senanga and Shangombo.

\[20\] Isoka, Lukulu, Mbala, Mbangwa, Munape, Sanyiwa and Serenje.
In identifying these districts, UNICEF helped pinpoint entry points in terms of social development for the country. In a scenario where resources are scarce, and decisions on where to invest to maximise returns in the short term are necessary, these 15 districts should be a priority in terms of public policies for children and women. Where it is impossible to reach all vulnerable children and women in the country, the prioritisation of these areas could represent a quick boost in fighting disparities and inequalities in the country.

### 3.4 Child poverty in Zambia

Children are among the most affected by poverty. According to 2010 LCMS data, Zambia is home to 7.08 million children 0-18 years old, representing 54% of the country’s population. Of the total population 0-18 years old in Zambia, 4.6 million children, adolescents and young adults lived in poverty in 2010, or 65% of that population. In general terms, 46% of the population 0-18 years old lived in extreme poverty and 19% in moderate poverty; 35% were considered non-poor (Table 3 and Figure 19). Child poverty is predominantly rural: 85% of the poor child population lives in rural areas (Table 4).

#### Table 3: Poverty status of population 0-18 years old, 2010 (absolute and %)

<table>
<thead>
<tr>
<th></th>
<th>Absolute numbers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely poor</td>
<td>3,262,895</td>
<td>46</td>
</tr>
<tr>
<td>Moderately poor</td>
<td>1,314,292</td>
<td>19</td>
</tr>
<tr>
<td>Total poor population*</td>
<td>4,577,247</td>
<td>65</td>
</tr>
<tr>
<td>Non-poor</td>
<td>2,505,196</td>
<td>35</td>
</tr>
<tr>
<td>Total population 0-18</td>
<td>7,082,443</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: *The total poor population is the extremely poor plus the moderately poor categories.

Source: Authors’ calculations based on CSO (2012a).

#### Table 4: Child poverty by urban and rural area, 2010 (absolute and %)

<table>
<thead>
<tr>
<th></th>
<th>Absolute numbers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>689,490</td>
<td>15</td>
</tr>
<tr>
<td>Rural</td>
<td>3,887,756</td>
<td>85</td>
</tr>
<tr>
<td>Total</td>
<td>4,577,246</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Authors’ calculations based on CSO (2012a).

In comparing the 0-18 age group with the whole population living in poverty, children represented 58% of all the poor population in the country. In terms of extreme poverty, 59% of all people living in that condition were children (Table 5).
Table 5: Poverty figures distributed by age, 2010 (absolute and %)

<table>
<thead>
<tr>
<th></th>
<th>0-18 years (%)</th>
<th>0-18 absolute numbers</th>
<th>19+ years (%)</th>
<th>19+ absolute numbers</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely poor</td>
<td>59</td>
<td>3,262,955</td>
<td>41</td>
<td>2,254,249</td>
<td>100</td>
</tr>
<tr>
<td>Moderately poor</td>
<td>55</td>
<td>1,314,292</td>
<td>45</td>
<td>1,059,661</td>
<td>100</td>
</tr>
<tr>
<td>Total poor population</td>
<td>58</td>
<td>4,577,247</td>
<td>42</td>
<td>3,313,910</td>
<td>100</td>
</tr>
<tr>
<td>Non-poor</td>
<td>48</td>
<td>2,505,196</td>
<td>52</td>
<td>2,666,858</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: * The total poor population is the extremely poor plus the moderately poor categories.
Source: Authors’ calculations based on CSO (2012a).

When disaggregating the percentage of people living in poverty per individual age (Figure 20), it’s clear that children at different ages are above the country’s average poverty line.

Figure 20: People living in poverty by age, 2010 (%)

Child poverty is distributed almost evenly among the provinces, with the exception of Lusaka and Western provinces (Figure 22) that have a slightly smaller percentage of children living in poverty.

Figure 22: Distribution of poor population by age group and province, 2010 (%)
However, when the data is analysed using different lenses, it is possible to note the distribution of the poor child population in Zambia does not follow the overall population distribution in the country (Figure 23). For example, while Lusaka holds 14% of the total population of the country, only 5% of the poor children population lives there. The same pattern is found in Copperbelt province. On the other hand, in all other provinces, the percentage of poor children is higher than the population distribution. That means public policies that target high-density areas are not necessarily reaching a larger number of poor children.

Figure 23: Comparison between poor child population and overall population distribution, 2010 (%)

Source: Authors’ calculations based on CSO (2012a).

At district level, poverty and poverty among children are very evident (Figures 24 and 25):

- In 61 out of the 72 districts in the country, 50% or more of the overall population is living in poverty.
- In 62 districts, 50% or more of the child population (0-18) is living in poverty.
- In 69 out of the 72 districts, the percentage of children living in poverty is higher than the percentage of adults living in poverty.
- In 71 districts, the percentage of children living in poverty is higher than the country’s average (60%).

Figure 24: Population living in poverty, districts, 2010 (%)

Source: Authors’ calculations based on CSO (2012a).

Figure 25: Population 0-18 years old living in poverty, districts, 2010 (%)

Source: Authors’ calculations based on CSO (2012a).
3.5 Causes of poverty in Zambia

The improvements in the economy have not translated into poverty reduction and, as is shown throughout this report, do not reflect substantial change in social indicators and in the realisation of children’s rights. In using the same structure as the one pointed out in the methodological section of this report, poverty in Zambia could be seen as the consequence but also the cause of the non-realisation of the rights of boys and girls in the country.

In terms of contextual factors, the World Bank (2012b) calls attention to two aspects that have a direct relation with poverty: (i) the pattern of economic growth in Zambia has been highly unequal, meaning some sectors – and populations – have benefited much more than others; and (ii) the country’s economic growth has not increased the incomes of the poor rapidly enough to lift them out of poverty. The same report presents three causes that explain much of these two phenomena, related to the economic, political and institutional factors that influence poverty among children and women.

First, there is a sector component of economic growth. In Zambia, economic growth has historically been concentrated in capital-intensive industries such as construction, mining and transport. However, the vast majority of the very poor derive their livelihoods from subsistence smallholder agriculture, a sector in which until recently growth rates have been dismal. Furthermore, a significant share of output fails to translate into household income gains. This is particularly true in extractive sectors like mining and commercial agriculture that have high foreign ownership levels, and is common in resource-based economies.

The second cause is related to the geographical component of growth. Growth has taken place in urban areas, whereas the poorest tend to live in remote areas barely connected to markets and the cash economy. For example, in the Copperbelt and Lusaka, poverty incidence is fairly low (Figure 13 and Table 2), whereas in the rest of the country, which is dominated by agriculture, poverty rates can reach as high as 80%.

Finally, the third cause is related to structural forms. Economic growth in the country has not been labour-intensive, particularly in those sectors in which the poor tend to work (subsistence agriculture and in the informal sector). Also, markets are only weakly integrated, and the poor tend to have few skills and low education levels. Agricultural growth has been robust in the past three years, and the strong national economic growth may take some time to trickle down into the sectors (and areas) that generate income for the poor. However, as pointed out by the World Bank (2012b), these gains have accrued on average to larger farmers, and, to the extent that they owe to extensive input subsidies and a run of good weather, it is also quite possible that they will not be sustainable.

Unemployment and underemployment are also at the core of poverty in Zambia. They are a mixture of contextual and supply-side factors that are highly influenced by personal aspects such as knowledge and education.

Data from the LCMS (Table 6) shows that, in 2010, 13% of the population considered part of the labour force and economically active was unemployed. Unemployment is higher among women (14%) against 12% for men. Also, 25% of working women were categorised as unpaid family workers, against 9% of men in that same category.

The gap between the coverage (red dot on Figure 26) and the HOI is the underlying measure of inequality in each opportunity. For instance, coverage in terms of access to waste disposal services is low, and it is low for all children in the country. Therefore, there is a lack of opportunity for the entire population aged 0-18, which is going to have an impact on health, education and employability. On the other hand, the opportunity index is low that will improve their future well-being.

Figure 26: Coverage and the Human Opportunity Index for Zambia, 2010 (%)
Table 6: Distribution of economically active population by main economic activity status, 2010 (%)

<table>
<thead>
<tr>
<th></th>
<th>Paid employment</th>
<th>Unpaid family worker</th>
<th>Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>79</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Female</td>
<td>61</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>Rural</td>
<td>71</td>
<td>24</td>
<td>5</td>
</tr>
<tr>
<td>Urban</td>
<td>68</td>
<td>2</td>
<td>29</td>
</tr>
<tr>
<td>Total Zambia</td>
<td>70</td>
<td>17</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: Authors’ calculations based on CSO (2012a).

In looking only at the unemployment data, urban areas seem to be worse-off than rural areas (29% unemployment against 5% in rural areas). However, in crossing the high number of the poor population in rural areas with unemployment numbers, it is possible to assume that, despite being employed, the rural population is engaged in subsistence agriculture and/or work in extremely hazardous conditions with low wages. As a matter of fact, International Labour Organization (ILO) data shows that, in 2010, 72% of rural paid workers in Zambia worked in precarious types of work (ILO, 2012).

There is an indirect correlation between age and unemployment rates, meaning the younger the person, the higher the probability he/she is going to be unemployed. This is a phenomenon that mainly affects those under 30 years old (Figure 27), with a high burden on adolescents and young people.

Figure 27: Unemployment rate by age group, total, urban and rural, 2010 (%)

According to the African Development Bank (AfDB, 2012), about 300,000 young people enter the labour market each year, with few employment opportunities. It is reasonable to assume these young people enter the market without finishing formal school and without proper skills for high paid jobs.

Most of the work force in Zambia is located in agriculture, forestry and fishery sectors (almost 67% of the employed population), followed by different types of services. Construction – a sector that represents almost 21.1% of GDP – is responsible for less than 2% of employment. Mining – the main export product from Zambia – employs only 1.4% of the labour workforce in the country (Table 7).

Table 7: Distribution of employed persons aged 12 years and above by activity, 2010 (%)

<table>
<thead>
<tr>
<th>Activity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture, forestry and fisheries</td>
<td>66.7</td>
</tr>
<tr>
<td>Mining and quarrying</td>
<td>1.4</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>2.9</td>
</tr>
<tr>
<td>Electricity, gas and water</td>
<td>0.4</td>
</tr>
<tr>
<td>Construction</td>
<td>1.8</td>
</tr>
<tr>
<td>Wholesale and retail trade and repairs</td>
<td>10.3</td>
</tr>
<tr>
<td>Hotels and restaurants</td>
<td>1</td>
</tr>
<tr>
<td>Transportation and communication</td>
<td>2.6</td>
</tr>
<tr>
<td>Finance, insurance and real estate</td>
<td>0.5</td>
</tr>
<tr>
<td>Community, social and personal services</td>
<td>8.5</td>
</tr>
<tr>
<td>Other</td>
<td>1.8</td>
</tr>
<tr>
<td>No information</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: CSO (2012a).
Adding to the labour situation, about 83% of the working population is employed in the informal sector (89.5% for females, 76% for males). For women in rural areas the situation is even worse: almost 96% are in the informal market (Table 8). In Eastern and Luapula provinces, almost all women are in the informal sector (96.6% and 96.5%, respectively). Lusaka is the province with fewest women in the informal sector (66.3%).

Table 8: Persons aged 12 years and above employed in the informal sector, 2010 (%)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>87.9</td>
<td>95.4</td>
<td>91.8</td>
</tr>
<tr>
<td>Urban</td>
<td>51.6</td>
<td>69</td>
<td>58.4</td>
</tr>
<tr>
<td>Total Zambia</td>
<td>76.1</td>
<td>89.5</td>
<td>82.6</td>
</tr>
</tbody>
</table>

Source: CSO (2012a).

Within urban centres, the disparities in terms of employment in the informal sector are also striking. Almost 78% of women living in low-cost houses – representing women living in poverty – have informal jobs. On average, almost 66% of the poor population in urban settlements who work are employed in the informal sector. For those who represent the rich stratum of the cities, 36% are employed in the informal sector (Figure 28).

Figure 28: Persons aged 12 and above in informal sector in urban centres, by poverty status, 2010 (%)

There are many problems associated with the high number of workers in the informal sector. The first is the impact this phenomenon has in terms of tax revenues. If 3.75 million workers are not contributing to the system, taxes are not being collected, representing fewer resources for basic services for the population. The second problem is the lack of stability and security at work for those in the informal market, who do not have their labour rights guaranteed by formal laws. Third, according to the 2008 Labour Force Survey (LFS), 74% of the urban workforce in Zambia is engaged in the informal sector in a mix of activities that changes with opportunity and seasons, but mostly involves unskilled labour or petty trading. There is no development of new technologies, knowledge or skills in the informal market, resulting in a lack of incentives for the development of a better workforce in the country. Finally, the future problems the Government is going to face when the current labour force is at retirement age, and it has to provide services and benefits for an older population that has not contributed to the pension system. If this is not fixed now, Zambia might face a serious social problem and probably a bigger government debt 30 years from now.

Another consequence is the low use of financial services by the population. 67% of the population still does not have access to financial services (AfDB, 2012), reducing the amount of money being lent and borrowed within the country, increasing the cost of the loans and jeopardising internal investments in the local productivity.

3.6 Legal and public policy framework on poverty and social protection

Zambia does not have an explicit national policy on poverty. Instead, policies, strategies and programmes for poverty reduction have been articulated in the Poverty Reduction Strategy Paper (2002-2004), the Fifth National Development Plan (FNDP 2006-2010) and currently the Sixth National Development Plan (SNDP 2011-2015). Developed under the theme sustained economic growth and poverty reduction, the SNDP focuses on policies, strategies and programmes that will contribute significantly to addressing challenges of realising broad-based pro-poor growth, employment creation and human development. Among the objectives of the SNDP are (i) accelerate infrastructure development; (ii) economic growth and diversification; (iii) promote rural investment and accelerate poverty reduction; and (iv) enhance human development.

In 2011, Zambia had 13 safety net or transfer programmes to help the country fight poverty (World Bank, 2012b). Nine out of them targeted children. According to the World Bank, it was clear that those programmes were very small in scale and covered only 1% of the population. Most of the existing programmes delivered per capita benefits that were equivalent to about 10% to 15% of the food poverty line. In some cases, this may be enough to significantly reduce the extreme poverty gap for recipient households. In some geographic areas of the country, the extreme poverty gap is much deeper than the national average. In general, the poorest 20% of households are living so far below the food poverty line that these amounts are not sufficient to bring their consumption up to adequate levels.

Defined by the World Bank as any programme that directly transfers either in-kind resources or cash to households.

Please refer to Annex 1 for a brief description of the programmes.
The World Bank analysis pointed out many problems related to supply-side factors in the social transfer programmes in Zambia, relating mainly to management and targeting. First, responsibility for the different transfer programmes is held by different ministries, with no effective centralised direction of programming or strategy. Institutional fragmentation raises the cost of implementing the programmes because it increases the administrative costs, and leads to overlaps and gaps in the provision of transfers. Some households may receive benefits from multiple programmes, others equally poor or poorer receive none.

Second, there are clear problems with registration of beneficiaries and monitoring of benefits and impacts. There is no central registry to enable programmes to identify each other’s beneficiaries to prevent any unnecessary overlaps, nor any clear recertification or exit requirements, nor any way to exploit any potential synergies between interventions.

Third, there is a lack of long-term policy strategy. Along the same lines, management capacity in the agencies that implement cash transfer programmes has historically been limited. As a matter of fact, as discussed throughout this report, management capacity seems to be one of the main constraints for the country in all areas related to development. This leads to excessive reliance on volunteers and short-term staff, creating risks in terms of the sustainability of actions and not generating local knowledge, technologies and human capacity within the country.

3.7 Conclusions

Poverty has a negative impact on the realisation of all rights for children and women, affecting health, nutrition, education, protection and participation, among others. It is not only the cause of many inequalities in Zambia but also the consequence of them.

Poverty in Zambia has many causes, and one not mentioned so far but that affects the current situation is an inherited historical burden. This relatively new democracy has evolved much in economic and social terms since its independence in the 1960s. However, years of exploitation cannot simply be erased with good intentions or good policies, and the historical aspect might need to be taken into consideration today. In fact, as is seen in this document, the historical and traditional perspective is one of the main reasons for the inequalities in many areas of the country.

That said the objective of this chapter was to provide a simple but clear snapshot of how economic growth in the country and poverty are moving in different directions. The current pattern of growth and trends in poverty indicate that, if specific policies to alleviate and change poverty are not implemented, inequalities might actually increase in the coming years.

Experiences in Latin America are valid for Southern Africa, and for Zambia. In that region, for a long time, the main economic model relied on trickle down wealth, and growth at any cost. This type of economic model led to the highest social and economic disparity in the world in the 1960s-1980s, with some groups and regions benefiting from economic development but the largest parts of the population still living in misery. Later, society realised that accelerated economic growth without social investments in the most vulnerable populations would actually increase the gap between poor and rich. The solution in the late 1990s and the 2000s was a mix of economic and social investments, with Government taking a lead and investing in the most vulnerable populations so they could improve their life skills and their chances of improving in life.

Children are a very important part of the poverty equation. As seen in this chapter, they are the poorest population in the country. They are poor as individuals because they live in poor households. In practical terms, for each one or two adults who live in a poor house, three or more children are living in poverty.

Using a systematic perspective, few of the poor children today are going to be able to get rid of their poverty trap. As is described later in this report, these children live in poor households without basic water, sanitation and electricity. They live with many brothers and sisters and are constantly facing so many vulnerabilities until this type of life becomes “normal” for them. These children do not go to school, or they drop out of school early without learning skills that will help them to find a good job and support a family. If they are girls, the situation is even worse. The chances that they are going to be pregnant early in life and abandon any chance of a better economic situation are huge. These children are going to be left behind, and in 10-15 years from now they are still going to be poor, and probably their children are going to be poor, perpetuating a vicious cycle.

Unfortunately, Zambia suffers from inequalities where, according to the concept used by UNICEF and UN Women (2013), the lottery of birth determines the opportunities and the resources children have in life. In Zambia, as well as other countries in the region, success depends more on structural causes than on talent.

This chapter identified some of the causes of poverty, but there still needs to be a better understanding of how poor families cope with the challenges and burdens of poverty. Resilience could be a tool to help in understanding vulnerability in the country, and helping develop better public policies. Poverty and inequality are the roots of many current problems, and also the results of past public policy choices. The country has evolved and has accumulated knowledge on poverty, vulnerability and inequalities; it now has the conditions to start fighting this problem.
Children have the right to live. Governments should ensure that children survive and develop healthily (UNCRC, Article 6).

Children have the right to good quality health care – the best health care possible – to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy (UNCRC, Article 24).

Mothers should have appropriate pre-natal and post-natal health care (UNCRC, Article 24).

### MDG summary

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
<th>Indicator</th>
<th>Current data</th>
<th>2015 target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce child mortality</strong></td>
<td>Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</td>
<td>Under-five mortality rate</td>
<td>138 (2010)</td>
<td>63.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infant mortality rate</td>
<td>76 (2010)</td>
<td>35.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One year olds immunised against measles (%)</td>
<td>94 (2010)</td>
<td>100</td>
</tr>
<tr>
<td><strong>Improve maternal health</strong></td>
<td>Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio</td>
<td>Maternal mortality ratio (deaths per 100,000 live births)</td>
<td>483 (2010)</td>
<td>162.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Births attended by skilled personnel</td>
<td>46.5 (2007)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Ensure environmental sustainability</strong></td>
<td>Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation</td>
<td>Proportion of population without access to an improved water source (%)</td>
<td>39.9 (2010)</td>
<td>25.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of population without access to improved sanitation facilities (%)</td>
<td>67.3 (2010)</td>
<td>13</td>
</tr>
<tr>
<td><strong>Eradicate extreme hunger</strong></td>
<td>Halve, between 1990 and 2015, the proportion of people who suffer from hunger</td>
<td>Prevalence of underweight children (under five years of age) (%)</td>
<td>13.3 (2010)</td>
<td>12.5</td>
</tr>
</tbody>
</table>

### Early childhood development

Within the lifecycle, early childhood (zero to six years) is the phase that has the greatest impact on the future development of the child, and future adult. Briefly, until two years of age, the child’s emotional stability is strongly affected by their environment. By the age of three, the vocabulary potential is determined, and by age four the child has reached much of the mental capability that they will have as an adult (World Bank, 1999). In the first six years, 90% of brain synapses are formed (UNICEF, 2001).

There is a strong likelihood that a child with low nutritional and cognitive development in early childhood will have future problems in school. Cost benefit analyses suggests that early intervention in education for children aged four to six years can make a difference in improving the chances of achieving a higher level of education, reducing repetition and having a higher income in the future. Studies in 51 countries have shown that, on average,
one year of school increases the income of a future adult at 9.7% (Psacharopoulos and Patrinos, 2004). Thus, a failure to develop the potential of children under six years in both cognitive and educational levels plays a significant role in the continuity of intergenerational poverty (McGregor et al., 2007).

Likewise, a study sponsored by the US Centre for Disease Control and Prevention (Rapoport, 2003) showed that every dollar invested in the immunisation of young children saves US$ 6.30 in future medical costs. When counting the indirect benefits to society as a whole (reduction of absence at school and at work, diseases, disabilities etc.), each dollar invested in vaccinations contributes US$ 18.50 per person. A different study conducted in the US showed that the direct and indirect savings for a country which provides routine vaccination to children will can reach US$ 10.5 billion and US$ 42 billion, respectively (Zhou, 2001).

Evidence has shown that significant benefits can be gained in the reversal of poverty in the future when investments are made early in a child’s life (Walker et al., 2005). For every dollar invested in childhood, the return in adulthood is approximately US$ 7. This means that the initial investment is offset in higher learning, higher wages, better health, more taxes, less crime and lower costs related of violence, all translating in the realisation of people’s rights. A poor child attending two years of quality early childhood education can expect 18% more in their purchasing power as an adult (World Bank, 1999). By ensuring optimal iron supplement in early childhood, between 13% and 25% of the adult wage gain is guaranteed (World Bank Brazil, 2001). Thus, investment in early childhood is the best strategy to reduce inequalities, fight poverty and build a society with sustainable social and environmental conditions.

Zambia has approximately 2.6 million boys and girls 6 years old and younger, which represents 37% of all children (0-18 years old) in the country. Six out of every ten children at this age group live in poverty (Figure 29).

Figure 29: Poverty comparison between children 0-6 years old and the whole country, 2010 (%)

Zambia has approximately 2.6 million boys and girls 6 years old and younger, which represents 37% of all children (0-18 years old) in the country. Six out of every ten children at this age group live in poverty (Figure 29).

CHAPTER 4.
CHILD AND MATERNAL SURVIVAL

This chapter has as its objective to capture the relationship between the early years of children’s life and the quality of mother care. It starts by presenting numbers for infant and maternal mortality, and the causes of both. The causes are interchangeable and categorised into two: (i) poor access to water and sanitation; and (ii) lack of appropriate attention during pregnancy, at birth, during delivery and post-partum.

As much as possible, the chapter tries to describe the problem, shows the evidence and define the factors that lead to the situation. It clearly depicts factors from the four categories described in the methodology (contextual, supply, demand and personal). They all interact and explain part of the problem that affects children and women in terms of survival and early development.

Water, sanitation and waste management problems are presented in this chapter; however, it is well known that their effects are not limited to one specific age group. The idea of presenting this issue in this chapter was to set the basis for the discussion that takes place in subsequent chapters on health issues, education and protection.

4.1 Under-five and infant mortality

Under-five and infant mortality rates have been decreasing in Zambia since 1990 (Figure 30). Estimates for 2010 were 83 per 1,000 live births for under-fives\(^{27}\) and 53 per 1,000 live births for infants. In the same fashion, neonatal mortality rates have achieved the lowest level in history, with 27 per 1,000 live births in 2010. Despite these improvements, according to UNICEF, Zambia occupies the 21st worst position among the 193 countries ranked by under-five mortality rate (UNICEF, 2012b). In fact many young infants die at home without ever being seen by a health worker. Hence, infant mortality numbers might be higher than estimated.\(^{28}\)

\(^{27}\) The UN Inter-Agency Group for Child Mortality Estimation (IGME) estimates the under-five mortality rate for Zambia at 83 per 1,000 live births, within low and high margins of 76 and 110 per 1,000 live births.

\(^{28}\) The Zambia Demographic and Health Survey from 2007 estimated the following figures: under-five mortality 110 per 1,000, infant mortality 70 per 1,000, neonatal mortality 34 per 1,000. They are all near the estimations made by IGME.
Despite the advance in terms of rates, today the chances of a child surviving to celebrate their first birthday are smaller than they were in 1990. In 1990, the infant mortality rate accounted for around 59% of deaths before the age of five; in 2010, this number had increased to 64%. Along the same lines, in 1990 38% of deaths occurred in the first four weeks after the baby was born (neonatal mortality); in 2010, 51% of fatalities occurred in this period.

In terms of geographical disparities, the latest Zambia Demographic and Health Survey (DHS) (CSO, 2007) found that Luapula, Northern and Western provinces present the worst mortality rates in the country. It is important to mention that even the most developed provinces still present high rates of under-five mortality. Another phenomenon the 2007 DHS shows is the small gap in terms of urban and rural rates for early childhood mortality (Table 9).

### Table 9: Early childhood mortality rates, provinces, 2007 (per 1,000 live births)

<table>
<thead>
<tr>
<th>Province</th>
<th>Neonatal mortality</th>
<th>Post-neonatal mortality</th>
<th>Infant mortality</th>
<th>Child mortality</th>
<th>Under-five mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>33</td>
<td>31</td>
<td>64</td>
<td>57</td>
<td>118</td>
</tr>
<tr>
<td>Copperbelt</td>
<td>30</td>
<td>49</td>
<td>79</td>
<td>59</td>
<td>133</td>
</tr>
<tr>
<td>Eastern</td>
<td>44</td>
<td>38</td>
<td>82</td>
<td>75</td>
<td>151</td>
</tr>
<tr>
<td>Luapula</td>
<td>33</td>
<td>64</td>
<td>97</td>
<td>66</td>
<td>157</td>
</tr>
<tr>
<td>Lusaka</td>
<td>39</td>
<td>46</td>
<td>85</td>
<td>55</td>
<td>135</td>
</tr>
<tr>
<td>Northern</td>
<td>34</td>
<td>60</td>
<td>94</td>
<td>72</td>
<td>159</td>
</tr>
<tr>
<td>North-Western</td>
<td>28</td>
<td>36</td>
<td>65</td>
<td>46</td>
<td>108</td>
</tr>
<tr>
<td>Southern</td>
<td>37</td>
<td>27</td>
<td>64</td>
<td>42</td>
<td>103</td>
</tr>
<tr>
<td>Western</td>
<td>48</td>
<td>49</td>
<td>97</td>
<td>47</td>
<td>139</td>
</tr>
<tr>
<td>Urban</td>
<td>34</td>
<td>46</td>
<td>80</td>
<td>56</td>
<td>132</td>
</tr>
<tr>
<td>Rural</td>
<td>37</td>
<td>45</td>
<td>82</td>
<td>62</td>
<td>139</td>
</tr>
</tbody>
</table>


#### 4.2 Maternal mortality

IGME estimates that maternal mortality in Zambia is around 440 per 100,000 live births, with 220 for its low estimate and 790 for its highest value (Table 10). These numbers represent a small difference from the 2005 estimate. The maternal mortality ratio reported for the seven years previous to the 2007 DHS was estimated as 591 maternal deaths per 100,000 live births.

### Table 10: Maternal mortality ratio estimates, 2010 (per 100,000 live births)

<table>
<thead>
<tr>
<th>Year</th>
<th>Numeric value</th>
<th>Low value</th>
<th>High value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>500</td>
<td>250</td>
<td>810</td>
</tr>
<tr>
<td>2010</td>
<td>440</td>
<td>220</td>
<td>790</td>
</tr>
</tbody>
</table>

Source: IGME.

The 2010 Zambia Census assessed the maternal mortality ratio at 483 per 100,000 live births, within the estimated range of the IGME. The rate in rural areas (517) was higher compared with that in urban areas (428). At provincial level, Muchinga (330) had the lowest ratio, and Western province (786) the highest (Figure 31).

In terms of age, the risk of maternal death among teenage mothers is particularly high. Teenage mothers are twice as likely to die during childbirth as women aged twenty and above (rising to five times as high among girls aged fourteen and below). Furthermore, some 13% of all maternal deaths result from unsafe abortions among teenage girls (UNICEF Zambia, 2008).
4.3 Causes of child mortality and maternal mortality in Zambia

The determinants of child mortality and maternal mortality are interchangeable, with the poor status of maternal health a significant driver of child and infant mortality (UNICEF Zambia, 2008).

Figures 32 and 33, respectively, depict the main causes of death for children under five years old in 2010, and the main causes of death for mothers in 2007. These could be separated into two main categories. The first contains deaths related to lack of proper water, sanitation and waste management. Different types of diarrhoea, measles and even pneumonia\(^\text{29}\) could easily be avoided if families, mothers and children had access to clean water and appropriate sanitation facilities at home and in the health facilities where babies are delivered.

The second category includes deaths related to the appropriate care of pregnant women, attention at birth and care post-partum and in the initial stages of life of the newborn (ante- and post-natal care). Neonatal sepsis, congenital anomalies, birth asphyxia and prematurity could all be reduced with appropriate access to quality maternal health services (antenatal and delivery care, including a clean delivery environment). Along the same lines, vaccines and appropriate nutrition can substantially reduce the number of deaths in the first five years of life. These are all items explored in the next sub-sections of this report.

---

\(^{29}\) Hand-washing with soap is one of the most effective and inexpensive ways to prevent pneumonia, reducing the risk of lower acute respiratory infections by 25\% (PPPHW, 2008).
4.3.1 Water, sanitation and hygiene

Inadequate access to safe water and sanitation services, coupled with poor hygiene practices and housing infrastructure, sickens and kills hundreds of children every day, and leads to impoverishment and diminished opportunities for thousands more. According to the World Health Organization (WHO), better management of water resources reduces transmission of malaria and other vector-borne diseases.

The National Nutrition Surveillance System (NNSS) shows that, in 2009, less than two-thirds (60%) of households had access to improved water sources. The results further show that only a few households are using improved sanitary facilities (traditional pit latrines, ventilated improved pit latrines or waterborne toilets). 2010 Census data on water and sanitation stresses the rural-urban dichotomy (Table 11). While in rural areas, 83% of the water supply for use at home, including human consumption, comes from boreholes (protected and unprotected), unprotected wells and rivers/dams or streams, in urban areas, almost 70% of the water consumed at home comes from piped water inside the housing unit, piped water outside the housing unit within a stand/plot, communal taps and protected wells. These two realities are very different in terms of the quality of water. UNICEF and the WHO estimate that 32% of the water consumed in rural houses comes from unimproved sources, and 22% comes from surface waters (Figure 34) that might also have problems related to their quality.

**No water and running water in health facilities across the country**

There are no data on the number of health centres without electricity and running water; however, it seems most rural health centres do not have these amenities. One rural health center visited opens its services when it is day and closes when it gets dark, since there is no electricity – and personnel – to open at night. The water comes from a nearby borehole, where children from the community fetch their water and animals spend part of the day drinking. The health clinic cannot handle any procedure that depends on electricity. Vaccines that need to be refrigerated are kept in a kerosene fridge. In another rural health centre visited, the kerosene fridge was broken.

**Figure 34: Population by type of drinking water source, 1990-2011 (%)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Urban (Piped)</th>
<th>Urban (External)</th>
<th>Rural</th>
<th>Urban (Other)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>8%</td>
<td>7%</td>
<td>43%</td>
<td>3%</td>
</tr>
<tr>
<td>2000</td>
<td>10%</td>
<td>6%</td>
<td>25%</td>
<td>3%</td>
</tr>
<tr>
<td>2010</td>
<td>12%</td>
<td>6%</td>
<td>22%</td>
<td>3%</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Source of household drinking water, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: household drinking water</td>
</tr>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Piped water inside housing unit</td>
</tr>
<tr>
<td>Piped water outside housing unit</td>
</tr>
<tr>
<td>Communal tap</td>
</tr>
<tr>
<td>Protected well</td>
</tr>
<tr>
<td>Protected borehole</td>
</tr>
<tr>
<td>Unprotected well</td>
</tr>
<tr>
<td>Unprotected borehole</td>
</tr>
<tr>
<td>River/dam/stream</td>
</tr>
<tr>
<td>Rain water tank</td>
</tr>
<tr>
<td>Other tap</td>
</tr>
<tr>
<td>Water kiosk</td>
</tr>
<tr>
<td>Water vendor</td>
</tr>
<tr>
<td>Mineral/bottled water</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Source: CSO (2012b).

**Figure 35: Poor and rich residences in urban areas with safe water source, 2010 (%)**

<table>
<thead>
<tr>
<th>Source: CSO (2012a).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower cost</td>
</tr>
<tr>
<td>High cost</td>
</tr>
<tr>
<td>Total urban</td>
</tr>
</tbody>
</table>
In terms of intra-city disparities, using the proxy of lower cost as poor residences and higher cost as rich residences, the urban areas of the country also present visible disparities in terms of water sources for use and consumption. A total of 94% of houses classified as high income have access to safe water in comparison with 80% of poor houses in the cities of Zambia (Figure 35). Of the poor houses in the cities, 28% have access to public taps, meaning they do not have running water at home. And mainly children and women have to carry their water home. In the higher-cost houses, only 6.6% fetch their water from public taps. The same pattern can be seen in terms of drinking water (Figure 36).

**Figure 36: Poor and rich residences in urban areas with improved and safe sources of water for drinking, 2010 (%)**

In terms of sanitation, according to the 2010 Census, almost 520,000 households do not have access to toilet facilities, representing almost 20% of the houses in the country – among these, 91% are located in rural areas. Estimates from WHO and UNICEF indicate open defecation is practised by 17% of the overall population in Zambia (27% in rural areas, against 2% in urban areas).

The lack of hygiene and sanitation represents a heavy cost for the country. According to a study carried out by the Water and Sanitation Program (WSP, 2012), poor sanitation costs Zambia the equivalent of US$ 194 million. This sum is the equivalent of US$ 16.4 per person in Zambia per year or 1.3% of national GDP. Pit latrines are the main type of toilet facility in the country, with 95% of households in rural areas using this type of sanitation facility. Pit latrines are cheap but have to be built at a safe distance from the house and from the nearest water source. Flush private toilets connected to the water sewer system are really available only in urban areas, and are few (Figure 38).
Within the cities, the difference between rich and poor households is also apparent in terms of sanitation facilities. While on average, according to the 2010 LCMS, 66% of urban households have improved/adequate toilet facilities, poor households are below this average. A total of 58% of low-cost residences have these facilities. On the other hand, 90% of rich households have access to appropriate sanitation facilities (Figure 39).

Figure 39: Poor and rich households in urban areas with improved/adequate toilet facilities, 2010 (%)

Source: CSO (2012a).

Waste management, especially in urban settings, is closely related to the population’s health and well-being. There is strong evidence connecting landfill and improper garbage disposal with low birth-weight, foetal and infant mortality, spontaneous abortion and the occurrence of birth defects (Rushton, 2003). In addition, depending on the method used to manage waste, the presence of mosquitos, other insects and rodents may increase in nearby areas. Only 7% of residences in the country have regular trash disposal. Most residences in Zambia use garbage pits or bury their trash – the data does not allow for any assessment of whether the pits are in proper sites, or whether they follow the correct sanitation standards. The 2010 Census reveals that roadside dumping and other dumping are also frequent in the country, mainly in rural areas (Figure 40).

Figure 40: Type of refuse disposal, rural and urban, 2010 (% of households)

Source: Authors’ calculations, based on CSO (2012b).

Figure 41 presents urban disparity. Dumping around the house or the neighbourhood is still very high for poor residences in urban centres in Zambia. Regular trash collection is two times more frequent for rich households than for poor ones.
The source of energy used for lighting (and cooking) in households is directly related to children’s safety. Combustible materials such as wood, candles and paraffin are dangerous since they can easily ignite and lead to permanent health problems or even death; in addition, indoor burning of polluting fuels has been associated worldwide with Acute Lower Respiratory Infections (ALRIs) among children less than five years old (Barnes et al., 2009; Kilabuko and Nakai, 2007). These materials are the main source of lighting in rural areas in Zambia. Electricity is available in only 3% of houses in rural settlements in the country. Even in urban areas electricity is not that common, with almost half of the houses without electricity in the cities (Figure 42).

In terms of sources of energy for cooking, besides safety, the type of fuel utilised is also related to child labour. A total of 85% of houses in rural Zambia use wood as a primary type of energy for cooking and 12% use charcoal (Figure 43). Searching for wood is a task frequently performed by children and women, and takes time away from studying and playing.

---

30 75% of the population in rural areas (almost 6 million people) live in housing units whose roof is made of thatch/palm leaf, an easily combustible material. During the dry season, cooking happens most of the time outside the house. However, oral reports mention that during the rainy season cooking happens inside the houses.
SURVIVAL

As we have seen, according to a study carried out by the WSP (2012), poor sanitation costs Zambia the equivalent of US$ 194 million. This sum is the equivalent of US$ 16.4 per person in Zambia per year or 1.3% of national GDP (2012).

UNICEF Zambia conducted a bottleneck analysis in 2012 on the water and sanitation situation in Solwezi district (UNICEF Zambia, 2012c). Despite being conducted in one locality, the analysis can be expanded to other rural areas in the country, and it presents a very accurate picture of the main barriers in this sector. The main bottlenecks can be divided into the categories used in this SitAn to understand the shortfalls in terms of children and women.

The first point is related to the lack of capacity at district level (contextual and supply-side factors). According to the UNICEF analysis, the districts lack specific and inclusive total sanitation and hygiene plans that could engage all stakeholders. The districts have not yet mobilised human resources to roll out effective WASH plans. It seems the current approach is fragmented and inefficient, with different departments and NGOs performing their own tasks, without clear coordination of efforts. In the same fashion, a top-down approach that is based on political promises of free water for the population is still prevalent. Communities do not participate in the decision-making process, limiting the sense of ownership of WASH facilities.

In management terms, some reports mention considerable difficulty at district council level to engage drilling contractors in some districts, especially those far from Lusaka. As a result, the procurement process is delayed and the quality of facilities is not up to par. According to the UNICEF bottleneck analysis, lack of quality in the construction of water supply facilities is the main bottleneck to the sustainability of water supply services in rural areas. There are no local drilling companies in some districts. In addition, reports indicate that districts have inadequate resources (funds and personnel) for implementing WASH policies and to monitor them in terms of usage and quality. The size of the district, poor road infrastructure and dispersed settlement patterns make routine monitoring challenging and resource intensive, especially in outlying wards of Solwezi.

A different UNICEF assessment covering nine districts, showed 90% of water points installed between 2010 and 2011 in those districts were functional and used as intended (UNICEF Zambia, 2012b). Those that were not functional were owing to drilling and maintenance problems. For those that worked, 36% presented issues in terms of availability of water, quality of water and location. The assessment also showed that some of the water points did not follow the proper standards to guarantee the quality of the water.

This leads to limited investment in WASH by district councils. In Solwezi, the council has been hesitant to commit its own funds, with the council’s expenditure on WASH significantly less than the planned 6%. The council’s perception described by UNICEF is that WASH “should be funded by donors rather than the Council”. This reduces both the budget and the council’s stake in WASH, reflecting its low priority compared with other sectors.

On the demand side, the bottleneck analysis on Solwezi district showed very few households practising hand-washing with soap or ash after using the toilet. There is scant data on hand-washing practices in Zambia, but qualitative reports point to it not being common. This behaviour is connected to personal factors such as lack of knowledge on the benefits of the practice, but also limited knowledge on the construction of low-cost hand-washing facilities requiring a very limited amount of water, such as tippy-taps. Besides, many communities are not properly sensitised to WASH issues, and do not know their rights and responsibilities. Communities lack understanding of the potential benefits of WASH, how to request an improved service and their related rights and responsibilities. This limits both demand for services and interest in sustaining them.

The analysis also pointed out the non-integration of efforts and areas. There is an inadequate focus on school WASH facilities and hygiene promotion in particular, with teachers not systematically engaged in hygiene promotion. This apparent omission reduces the potential impacts of Community-Led Total Sanitation (CLTS) rollout, as the current set-up for hygiene promotion does not focus specifically on schools. Open defecation-free (ODF) communities may still have a school with inadequate sanitation.

Rapid urbanisation coupled with poor city planning leads to the outgrowing of deprived communities within urban centres or on the outskirts of cities. These areas lack proper attention in terms of health, education and water and sanitation, among other things. The last Joint Monitoring Report clearly shows that, access to safe water and improved sanitation shows is improving in rural Zambia but worsening in urban areas (see Figures 34 and 37, above).

Legal and public policy framework on WASH

The current Zambian Constitution of 1996 (as amended in 2006) includes the Bill of Rights that provides for a framework within which the regulation and allocation of water can take place. Indeed, under economic and social rights for water and sanitation in the draft Constitution, a person has the right to clean and safe water in adequate amounts and to reasonable sanitation.

Until the new Water Act was enacted in 2011 and became operational in October 2012, Zambia’s water law was based on principles of English Common Law. The Act was enacted during the colonial period in 1949 to support the Department of Irrigation and Rural Development, which later became the Department of Water Affairs. The mandate of the department was to manage and develop water resources for industrial use and to accelerate rural development through irrigation. Under the 1949 Ordinance, the Water Board was established with the mandate of allocating water and issuing of water rights. In 1980, the Local Administration Act was enacted, giving local authorities the responsibility for providing water supply and sanitation services.

In addition, a number of laws have been enacted to enforce on matters of WASH. These include the Public Health Act, CAP 295, of the Laws of Zambia (enacted in 1930) and responsible for monitoring sanitation; health education; monitoring of drinking water quality; setting standards; and general sanitation supervision throughout the country. The Water Supply and Sanitation Act, No. 28, of 1997 regulates water supply and sanitation service providers.

Although the National Gender Policy provides for measures including those on water and sanitation, highlighting the influence of this issue on women and girls, there is almost no measure on WASH in the National Child Policy.

31 More on WASH for schools is in Chapter 7.
The first National Water Policy was adopted in 1994 with the mandate of ensuring better water resource management and water supply and sanitation. For rural areas, the Government adopted the Water, Sanitation and Health Education (WASHE) strategy in 1996 for the improvement of water supply and sanitation. Meanwhile, the 1994 National Water Policy was revised in 2010 and aligned with the National Vision 2030 and development plans, namely, the FNDP (2006-2010) and the SNDP (2011-2015). The revised policy, currently supported by the new Water Act of 2011, provides a direction and framework for integrated management, development and utilisation of water resources. The policy’s main goal is to provide sustainable water resource management and development with a view to facilitating equitable provision of adequate and quality water supply and sanitation in a timely manner.

Equally important has been the articulation of the Water Supply and Sanitation subsector in both the FNDP and the SNDP based on the National Urban Water Supply and Sanitation Programme (NUWSSP 2011-2030) and the National Rural Water Supply and Sanitation Programme (NRWSSP 2011-2015) under the responsibility of the Ministry of Local Government and Housing through the local authorities.

4.3.2 Ante-natal care, delivery and post-natal care

Ante-natal care

Despite the fact that data from the 2007 DHS shows 94% of women received antenatal care (ANC) from a skilled provider (doctor, clinical officer, nurse or midwife) during their last pregnancy, only 60% of women aged 15-49 years old who had had a live birth in the five years preceding the DHS had made four or more ANC visits, matching the international standard recommended by the WHO. Access to ANC is not evenly distributed among districts in Zambia. In the vast majority of cases, pregnant women made fewer than four ANC care visits (Figure 44).

Figure 44: Pregnant women 15-48 years making four or more ANC visits, districts, 2007 (%)


Almost 76% of mothers who had made ANC visits started their ANC very late:22 53% said they had their first visit between the fourth and fifth months of pregnancy, and 23% between the sixth and seventh months. In being that late for the first antenatal visit, mothers – and babies – miss services that are offered early in the pregnancy.23 Among those who went to see a doctor before delivery, the majority (87%) received ANC services from a nurse or midwife; 5% received ANC services from a clinical officer, and only 2% from a doctor. These percentages reflect a structural problem in the health system in Zambia, framed by contextual and supply-side factors. According to the Annual Health Statistical Bulletin 2008 (Ministry of Health, 2009a), in 2008 Zambia had 46% less doctors than it needed. The same happened to midwives; the country had 53% less midwives than the recommended number (Figure 45).

Figure 45: Doctor and midwife shortages by province, 2008 (%)

Source: Ministry of Health (2009a).

There are three main contextual and supply side factors with a negative impact on the number of ANC visits. First, distance to health centres is still a burden for the majority of the population in the country, especially those who live in rural areas. LCMS data shows that 25% of residences in the country are located more than 5 km from health centres. Also, roads are generally not paved, and there is no regular transport between rural communities and the health centres and/or the district hospital, generally located at the district “boma”.24
Second, economic, social, and traditional factors, such as the mobility of some populations owing to their tradition of fishing and cattle-rearing as a form of livelihood, and the myths and beliefs still present in some rural areas of the country, have an impact on the number of ANC visits. For instance, in Sammya district, women reported waiting for elderly women to verbally confirm they were pregnant before they could start ANC. The belief was that, if young women started ANC before elderly women confirmed the pregnancy, they might end up losing the baby in mysterious circumstances (UNICEF and University of Zambia, 2012).

Third, the quality of ANC (supply-side factors) is also an issue that influences the first ANC visit, and subsequent visits. Research sponsored by UNICEF (UNICEF and University of Zambia, 2012) in four of the most vulnerable districts in the country showed that less than 33% of health personnel were trained in focused ANC. In fact, lack of personnel – as seen in Figure 46 – and human resource capacity was pointed out as one of the causes of low ANC attendance across the four districts. The study also reports that less than 40% of pregnant women in those districts made more than four ANC visits.

Another measure of quality for ANC is related to the supply and availability of essential commodities for pregnant women, such as IPTp, iron, folic acid and HIV test kits for ANC in health facilities, as well as adequate equipment for ANC and birth. A report by UNICEF and University of Zambia showed the availability of these commodities in the previous three months had been significantly low in all the districts (less than 34%), with one district having no stocks of these commodities at all.

Delivery

In general, 52% of deliveries reported in the 2007 DHS happened at home (of all births at home, 91% were in rural areas, and only 9% in urban areas). Some of the reasons for home deliveries are very similar to the ones that influence the low number of ANC visits.

First, although trained traditional birth attendants (TBAs) are encouraged to deliver babies at health centres instead of conducting home deliveries long distances and associated transport costs make this option impractical. In the above-mentioned project districts, the proportion of the population residing within 1 km of a health facility was only 31%; 59% were within 5 km; and the rest (more than 40%) have to travel more than 5 km to access any type of health facility (UNICEF and University of Zambia, 2012). About two out of five women reported transportation (42%) and distance to health facility (41%) as big problems leading them to deliver at home (CSO, 2007), within addition to distance, public transport is not available, and most roads connecting rural settlements in the country with health facilities are not paved and dangerous to drive on. In this sense, home delivery could be considered cheaper, and in some sense safer, than travelling to a health clinic or hospital.

Second, there is an implicit barrier connected to the economic situation of pregnant women in rural areas that has a greater impact on utilisation than just the transport to the health centre. In the qualitative assessment carried out by UNICEF in Zambia and the University of Zambia, some women reported feeling ashamed of delivering at health centres because they lacked baby clothes and other delivery requirements.

Baby delivery kit

There are no monetary fees for deliveries at public health facilities in Zambia. However, anecdotal evidence confirmed by different qualitative assessments, and by visits made during the SitAn process, shows some mothers are asked for a litre of disinfectant product to be used by the hospital, and, sometimes, for a baby delivery kit. One mother said she was asked for clothes for the baby, a dish to bathe the newborn and something for her to wear after delivery. She knows some patients are discharged after delivery only if someone from the family presents these items. She also mentioned that some friends did not deliver at the health facility since they did not have the kit, and were ashamed of their poor condition. Officially, there is no such a thing as a delivery kit, but health personnel, midwives and nurses confirm that they ask mothers to prepare some clothes for her and the baby, as well as baby powder to be used after birth.

A third reason in the four districts covered by the same qualitative study was related to the gender of the health worker. Some women said they were not happy to be attended to by male health workers during delivery. In such cases, they preferred to deliver at home, attended to by relatives or by a TBA.

Quality of delivery

A fourth cause hindering a higher number of births in health institutions is quality of care, including lack of staff (quantity and quality); poor infrastructure at health institutions; and lack of medicines. The problem lies in the lack of analysis. Does quality follow low demand for services, or do mothers not deliver at health centres because of the perceived lack of quality?

Gaps between urban and rural areas, and different economic groups, are clearly depicted in the 2007 DHS. Data shows that skilled health workers35 attended less than 47% of births in Zambia; 83% of births that were attended to by skilled workers were in urban areas. Also, 92% of mothers in the richest quintile had professional support during delivery. For the lowest quintile, only 27% of mothers had access to skilled health workers.

The differences are bigger at province and district levels. Data from the 2007 DHS reproduced in Figure 46 shows a great difference in terms of skilled providers attending births by province. While in Luakaka and Copperbelt the numbers are over 75%, in Northern province only 3 of every 10 births were assisted by a doctor, clinical officer and/or nurse/midwife. Within individual provinces, inequalities are further perpetuated down to the district level, as shown by trends within Copperbelt province, where skilled birth attendance coverage for Kitwe district was 84% in 2000 and 77.1% in 2010, and coverage in Luangwa district 25.4% in 1990 and 20.7% in 2010 (University of Washington and University of Zambia, 2011).

35 Following the WHO definition, accredited health professionals are midwives, doctors or nurses who have been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postpartum period, and in the identification, management and referral of complications in women and newborns. TBAs, trained or untrained, are excluded from the category of skilled health workers.
Few districts in Zambia present a high average of births attended by a skilled professional (Figure 47). In terms of capacity at district level, data from the UNICEF and a University of Zambia survey (2012) shows extremely low numbers of health personnel trained in emergency obstetric care (EmOC): 2%, 9.3%, 12% and 20% for Luwingu, Chiengi, Samfya and Mungwi districts, respectively. The same research shows delivery kits are available at the health facilities in these districts but have not been used as expected.

Post-natal care

Only 39% of the mothers surveyed reported in the 2007 DHS that they came back for post-natal care within two days of delivery. That number might actually be overestimated, since it does not include those mothers who do not deliver at health facilities, and where the delivery outcome is unknown. The main causes associated with poor and low post-natal care are the same as the causes for low ANC visits and the small number of births in health facilities.

First, difficulties in access – in combination with traditional views on post-natal care – do not create any incentive for mothers to come back to health facilities. The same distance and lack of transport that reduced use of health facilities for ANC and delivery also impact on post-natal care. In the qualitative study in the four districts (UNICEF and University of Zambia, 2012), the traditional view from older women and men was that women who have just given birth are weak and tired – which could be true, since the average time of staying at the hospital after delivery is six hours, and most mothers have to walk back home with their babies – and their babies are too fragile to be carried on their back. They are therefore not encouraged by their peers to travel long distances to a health facility for the post-natal visit.

Second, the same study points to lack of information on the importance of post-natal care in communities. If perceptions on the importance of ANC are still weak, perceptions regarding going back to a doctor, soon after birth, without the baby being sick, might be even weaker.

Finally, a third cause, pointed to by the UNICEF Zambia 2008 SitAn, is an economic factor that affects those who did not deliver their baby in a health facility. The gradual removal of user fees has resulted in improved access to health care; however, as the UNICEF and University of Zambia (2012) study, shows some women who deliver at home are charged fines. According to the study, this is an overriding reason for low performance in Luapula. Although the policy was meant to encourage women to deliver in health facilities, it actually discourages women from coming for postnatal checks if they happen to deliver at home.

4.3.3 Vaccines

Low universal vaccination is one cause of high numbers of children dying under the age of five in Zambia. LCMS data shows that 76.5% of boys and girls 12-23 months had at least one dose of BCG, DPT, polio and/or measles immunisation in 2010; only 55.4% of the children in that age group in the country had full immunisation of those four vaccines. Full immunisation is the four vaccines varies according to the provinces, with only two provinces achieving more than 60% coverage – Eastern and Western provinces (Figure 48).
Malnutrition is the most widespread but least addressed public health problem in Zambia. Nutrition-related factors are responsible for about 33% of child deaths worldwide (Save the Children, 2012). In the case of Zambia, it is one of the major factors influencing the health status of children and mothers. UNICEF (2008) describes poor nutrition as one of the main drivers of high maternal and child mortality figures in the country. Even when nutrition is not directly responsible for deaths, nutrition status negatively influences other diseases, aggravating the poor physical condition of children and women. The first MDG calls for eradication of extreme poverty and hunger and uses prevalence of underweight in children under five as an indicator of progress. Although Zambia has experienced a decrease in underweight from 21% in 1992 (DHS) to 15% in 2007 (DHS), the burden of stunting has remained unacceptably high. The prevalence of stunting in children under five stands at 45% (CSO, 2007), above the average for Sub-Saharan Africa (42%). Further, about 9% children under five have a low birth weight (less than 2.5 kg), which is a reflection of intra-uterine growth retardation and maternal malnutrition. This is likely to be underestimated, considering that a large proportion of newborns are not weighed at birth in Zambia.

During one of our visits to a school, we were very fortunate to meet by coincidence a social health worker who was weighing children under a large tree near the school. She hung the scale on a tree branch and the mothers were starting to line up, waiting for their turn. In one day, the community health worker saw, on average, 362 children, but she knows there are more mothers and children in the nearby village who do not come to the weighing station. She writes the children’s weight and height on the under-five cards: some pink – for the girls – some blue – for the boys. Some of them – almost half of those we saw – were marked as HD, which means home delivery. She said a good number of children would have to go to the near health centre since they were underweight. Her experience is that underweight children are common in the region. At the health centre, when a child’s nutritional situation is not too severe, she receives some vitamins from the nurse and goes back home, but sometimes boys and girls have to stay in the health centre because of their dangerous nutritional situation.

To have an impact on stunting levels, nutrition interventions need to be targeted to women during pregnancy and to children from birth to 18 months of age.

4.3.4 Nutrition

Malnutrition is one form of growth failure. Stunting occurs over time, unlike acute malnutrition (wasting), which is a process that, in most cases, occurs because of a recent and severe process of weight loss, which is often associated with acute starvation and/or severe disease. A child who is stunted often appears to be normally proportioned but is actually shorter than normal for his/her age. Stunting starts before birth and is caused by poor nutrition during pregnancy and/or breastfeeding, and by chronic infections and illness after birth. To have an impact on stunting levels, nutrition interventions need to be targeted to women during pregnancy and to children from birth to 18 months of age.
Along with growth faltering, under-nutrition in early childhood has a significant adverse impact on child survival and cognitive development. It is estimated that under-nutrition contributes to 33% of under-five child deaths worldwide (WHO, 2008). Iodine deficiency alone may result in a loss of 10 to 15 IQ points. Thus, good nutrition is essential to achieving most of the MDGs including reduced child mortality (MDG4) and universal primary education (MDG2).

Although stunting is present in all geographical areas and socio-economic groups of the Zambian population, inequalities are easily discerned according to (i) poverty status: children from extremely poor households (52%) are more stunted than children from wealthier households (40%); (Figure 50); (ii) area of residence: the proportion of stunted children is higher in rural areas (48%) than in urban areas (42%) (CSO, 2007). Along the same lines, the NNSS shows that malnutrition among women of reproductive age is higher in rural areas than in urban areas, with 11% of women aged 15-49 classified as underweight in rural areas compared with 7% of women in urban areas (Ministry of Health, 2009c); (iii) province: for example, children from Northern province are more likely to be stunted than children from Southern province (53% and 40%, respectively) (Figure 51); and (iv) by mother’s education level: the proportion of stunted children decreases as the mother’s education level increases (Figure 52).

Stunting is a phenomenon of early childhood reflecting multiple nutritional deficiencies and infections and peaks between 6 to 24 months during the critical period of rapid growth and brain development. As shown in Figure 53, stunting increases sharply in the first two years of life from 26% among children aged six to eight months to 59% in children aged eighteen to twenty-three months before reaching a plateau in the third and fourth year.

The main causes of stunting are related to (i) poor nutrition of mothers during pregnancy; (ii) lack of appropriate nutrition in the first 18 months of life; and (iii) frequent waterborne diseases common among children, especially those who live in rural areas. Inappropriate feeding practices in infant and young children owing to a combination of poor maternal knowledge and lack of access to nutritious food are widespread in Zambia. Delayed initiation of breastfeeding and mixed feeding (other liquids besides breast milk) are common. Furthermore, children do not receive complementary foods at the right age (too early rather than too late), are not fed enough during the day and have food of inadequate quality.
Maternal malnutrition is present in Zambia with the emergence of over-nutrition and related non-communicable diseases (NCDs). Although data on NCDs in adults and over-nutrition in children are scarce, Zambia is in an epidemic transition with a double burden of under-nutrition and over-nutrition as well as communicable and non-communicable diseases. About 10% of women of reproductive age are underweight; 19% are overweight or obese (CSO, 2007). The proportion of overweight or obese women is higher in urban areas (30%) than in rural areas. Women with the highest education level are more likely to be overweight or obese (47%) than women with no education (10%). Furthermore, the proportion of overweight or obese women increases with wealth status, with 7% in the lowest and 35% in the highest wealth quintile.

Breastfeeding is almost universal (98%); however, only 61% of infants below six months of age are exclusively breastfed (CSO, 2007). Younger infants are more likely to be exclusively breastfed, with 86% in infants below two months compared with 35% in infants aged four to five months. Furthermore, 57% of infants are breastfed within an hour of birth and 93% started breastfeeding within the first day. The mean duration of breastfeeding is 20 months. Although 84% of breastfed infants receive complementary food (CSO, 2007), its introduction is not timely. Early introduction of complementary food before the recommended age of six months is common, with about 20% and 50% of infants two to three and four to five months, respectively, having received semi-solid food in addition to breast milk (ibid.). This data does not reflect the quality of complementary feeding received; meeting the minimum standards of dietary quality is a challenge in Zambia. Feed frequency and food diversity in children 6-23 months is also not in line with the age-specific recommended standards. Only 44% of breastfed children aged 6-23 months meets the minimum standards with respect to food frequency (number of times fed according to age) and food diversity (number of food groups consumed) (ibid.). Urban children (53%) are more likely to be fed according to the recommended standards than rural children (40%), as are children with mothers with a higher level of education (58%), compared with those with mothers with no education (35%), and children from wealthier households (54%, vs. 42% of those in poorer households).

Deficiencies of micronutrients are also widespread and represent a silent emergency. The prevalence of anaemia, a proxy of iron deficiency, stands at 61% in children under five (2010 National Malaria Survey) while the frequency of iron deficiency is generally about 2.5 times that of anaemia. The high prevalence of stunting, a proxy of the population’s zinc status, indicates zinc deficiency is of public health significance in Zambia. Vitamin A deficiency, estimated at 54% in children under five (NFNC, 2003), is still very high despite biannual supplementation since 1997 and mandatory fortification of sugar with vitamin A since 1998. On the other hand, remarkable progress has been made in sustained elimination of iodine deficiency, which is no longer a public health problem (NFNC, 2011).

Finally, the last evident cause of malnutrition is related to the heavy burden of malaria, diarrhoeal diseases and acute respiratory infections, which have a higher burden on children. There is a strong relationship between nutrition and sanitation. According to the WHO, nutritional status is compromised where people are exposed to high levels of infection owing to unsafe and insufficient water supply and inadequate sanitation.

Legal and public policy framework on nutrition

Overall, nutrition governance in Zambia is anchored in the National Food and Nutrition Commission Act of 1967, CAP 308, of the Laws of Zambia, which gives the National Food and Nutrition Commission (NFNC) the mandate to spearhead and coordinate the food and nutrition sector. The Government adopted the National Food and Nutrition Policy in 2006; this articulates the need for a multi-sector approach to food and nutrition issues in the country, streamlined in national development plans. Indeed, the overarching objective of the nutrition sector within the SNDP (2011-2015) is to improve the nutritional status of the Zambian population through quality nutrition services and increased availability, access and utilisation of quality and safe foods. Recently, the NFNC developed a five-year strategic plan (2011-2015), which aims at better operationalising the 2006 policy while offering better guidance and synergy to the current plans and programmes in Zambia, especially the promotion of “1000 Critical Days” that prevent stunting in children under two years of age and bring added health and productivity to families and the country as whole. It recognises the critical need for approaching many food and nutrition problems through a decentralised means with major participation from provinces, districts and communities.

4.4 Conclusions

In terms of the life cycle, the period between gestation and six years old is the most significant for children, where, as described earlier, children’s cognitive and physical future is decided. Under-five and maternal mortality rates have reduced over the years, but they are still high. The causes are similar and are divided into two groups. One is more centred in contextual factors rooted in the infrastructure problems the country faces in terms of roads, water, sanitation and garbage disposal. The second is related to the supply factor pointed out in the methodology of this report: mothers (and children) are deprived of quality ANC, delivery and post-natal care. Numbers of visits are low, the structure of health centres is not appropriate and the capacity of health personnel is still very weak. The numbers are astonishing. Only 2% of mothers who delivered in health centres saw a doctor before delivering. Most mothers in the country saw nurses or midwives before giving birth. One of the reasons for this is there is no availability of doctors in the country; Zambia has 46% fewer doctors than needed. In this sense, there is a high chance that a mother in a rural area of the country will never see a doctor throughout the entire pregnancy and delivery period.

Postnatal care follows the same pattern: few mothers bring their newborns for postnatal follow-up. Mothers have no incentive to come back with their children, especially if they live far from the health facility.

Children’s nutritional status is the combined result of the antenatal period, current feeding practices and the quality of water and sanitation facilities. The results of simple equation are tough for Zambia: almost half the country’s children aged zero to five years old are underweight. This affects not only their health but also education and future employability.

37 The Ministry of Health (2009a) shows that, among children aged 6-59 months, one-in-three (27%) are boys who have been vaccinated and 14% overweight. Among girls of the same age, 16% are underweight and 22% overweight.

38 A detailed analysis of these topics is presented in Chapter 5.