ZAMBIA

SITUATION ANALYSIS OF CHILDREN AND WOMEN 2008
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Foreword -
Honourable Minister of Finance and National Planning

On behalf of the Government of the Republic of Zambia, I would like to appreciate the support and collaborative efforts of cooperating partners as well as other stakeholders especially UNICEF in carrying out this comprehensive study on the Situation of Women and Children in Zambia. The study was done in accordance with the Monitoring and Evaluation framework of the Fifth National Development Plan (FNDP) 2006-2010 under the Research and Development Programme of the Ministry of Finance and National Planning.

This study is timely as it coincides with the period when Zambia has started the process of preparing the Sixth National Development Plan (SNDP) 2011-2015. The findings and recommendations of this study will therefore help in informing the SNDP by providing the basis for positioning the interests of Zambia’s children and women in development. I wish to emphasise Government’s commitment to ensuring effective participation of children and women in development as essential for achieving national development goals. The FNDP implementation has shown progress in improving social service delivery in the health and education sectors. The health sector policy guidelines and strategic plans have been consistent with the FNDP and the vision 2030. The health indicators so far show that there is greater potential for Zambia to meet the Millennium Development Goal (MDG) target on the reduction by two-thirds of under-5 mortality. Prospects for children in the education sector which has been credited for embracing gender equity are even brighter given that the sector’s strategic plan and implementation framework have been key instruments in influencing prioritisation of resources and the sectors strategic focus. This environment has undoubtedly led to the positive projected assessment of meeting the MDG target on universal primary education.

However, there is still challenges affecting the successful improvement of the situation of children and women in Zambia, these include: HIV and AIDS, “brain drain” in the health sector, high levels of unemployment and poverty, poor access to public services, challenges in the socio-cultural orientations and weakening of family support systems and its negative impact on traditional social security system especially in rural areas.

This study has given useful insights on the extent and depth of some of the challenges and also provides useful recommendations that Government and its stakeholders could use in improving the situation of children and women in the country. The study reinforces the need for Government to continue prioritizing strategies to open up rural areas through infrastructure and human capacity development, to support service delivery. Once this is achieved, the rural population especially children and women will share in the multi-sectoral opportunities that can uplift their livelihoods.

Situmbeko Musokotwane (Dr), MP
Minister of Finance and National Planning
Acknowledgements

This Situation Analysis of Children and Women in Zambia is informed by its component studies, as follows.

- Household Income and Poverty by Dr. Dennis Chiwele, RuralNet Associates Limited
- Epidemics and Overall Disease Burden by Dr. Cosmas Musumali
- Protective Environment for Children and Women by Moses Mwaba and Clare Barkworth, Whydah Consulting Ltd
- Risks to Children and Women Living in Communities Weakened by Severe and Prolonged Stress: Report on the Family, Community, Society and Culture Assessment by Dr. Susan Hunter
- Analysis of National Data by Dr Musonda Lumba.

The scope of the five components was based on a causality analysis which identifies causal relationships between the manifestations, drivers and underlying causes of deprivation and child rights failures. The studies were conducted in consultation with Government and other stakeholders in each sector. Each study stands alone and analyses a particular set of issues.

This synthesis report was prepared by Clare Barkworth, Whydah Consulting, and Dr. Charlotte Harland, UNICEF Zambia.

The preparation of the situation analysis was led by an advisory committee, chaired by the Planning Department of the Ministry of Finance and National Planning under the leadership of Agnes Musunga. In particular, acknowledgements are due to Edward Simukoko, Chola Chabala, Prudence Kaoma, Chris Pain and Wamupu Akapelwa for managing weekly meetings with the consultant team during the research period.

A consultation meeting presented the draft reports for inputs from representatives of 45 organisations, including relevant line ministries, civil society organisations, local and international non-governmental organisations, international cooperating partners and United Nations agencies.

A retreat to consider the synthesis of the five component reports and to identify the recommendations included representatives from the Central Statistics Office, the Ministries of Local Government and Housing, Community Development and Social Services, Education, Finance and National Planning, Labour and Social Security, Sport, Youth and Child Development, the National Food and Nutrition Commission, UNICEF, German Development Cooperation, Irish Aid, Save the Children and World Vision International.

The funding for the component reports and this synthesis report was provided by Irish Aid, the UK Department for International Development (DFID) and UNICEF.
Preface –
Lotta Sylwander, Representative, UNICEF Zambia

Children and women are the heart of Zambian society, the forefront of national development, and the leaders of the future. Whether we focus on poverty reduction, economic development, service delivery or social inclusion, benefits for children and women are integral to our shared objectives, and their participation is essential for success in achieving these goals.

Despite this, it would not yet be correct to claim that children and women enjoy full and universal access to their rights or that they are free to achieve their rightful place. In many respects, the interests of children are left to come after those of adults; the needs of girls and women take second place. Government and its partners are challenged daily by the task of trying to improve food security, increase access to basic services, improve livelihoods and to create a safe and equitable environment in the homes and communities of this nation. This task is fundamental to our shared pledge to reduce poverty, which remains the central commitment and priority for development.

The period of the Fifth National Development Plan has shown the benefits of Government and partners aligning their efforts around a common framework for development. Greater harmonisation has increased the efficiency of resource use, and reduced the significant transaction costs involved in less well managed cooperation. Significant progress has been made in improving monitoring and evaluation systems. Government is providing clear leadership for national development, and cooperating partners are collaborating in line with our clearly agreed joint assistance strategy. The progress and lessons learned on how we work together will be of great benefit as Zambia embarks on the development of the next national development plan.

This situation analysis is therefore timely. There is a strong commitment to accelerating results for the survival and development of Zambia’s children and women, and there is a greatly improved operating environment for implementing the necessary activities. While many vital steps are identified in the plans and policies of many of our sector ministries, the situation analysis provides a comprehensive overview, allowing us to understand the overarching situation of children and women in Zambia today, pointing to areas where closer collaboration can increase efficiency and effectiveness, and highlighting some of the challenges that exist in prioritising our actions for children. The situation analysis will therefore serve as an excellent resource for planning, guiding the definition of goals and the identification of actions that will prove most effective in delivering results for Zambia’s children and women.

Lotta Sylwander
Representative; UNICEF Zambia
1. Introduction:
Understanding the situation of children and women in Zambia

All children have a right to survive, to develop to the full, and to enjoy a safe, healthy and happy childhood. They have a right to healthy physical and emotional development, and to live, learn and be full and respected members of society. As infants, young children or teenagers, in Zambia and throughout the world, all children share these rights which in turn will shape their future, the future of their country, and indeed the global future.

Yet in many poor countries, children face significant hurdles in securing even the most basic standards of survival and development. Compromised by poverty and ill-health even before birth, many children suffer the successive blows of malnutrition, inadequate schooling, poor housing and exposure to danger and harm. Such deprivation has a strong tendency to reproduce itself, as the disadvantages faced by chronically poor girls and boys reduce their opportunities and capacities as adults to provide a better start for their own children.

While the vicious cycle of poverty, vulnerability and deprivation can be described in general terms, however, it is important to remember that in any context, it is caused and entrenched by specific and identifiable factors. In order to improve the lives of children, we need to understand these causal factors and to use this understanding to shape our efforts to respond. If rural households do not grow enough food, we must identify the reasons that this is so. If girls drop out of school, we need to know exactly why. Without analysing what drives the disadvantage that children face, any efforts to bring about improvement will be superficial.

This report has been prepared as a collaborative effort between the Government of the Republic of Zambia (GRZ), its partners UNICEF, Irish Aid, the UK Department for International Development, and others including the United States Agency for International Development, local and international non-governmental organisations (NGOs) and civil society. It is based on six component reports, each of which provide a detailed analysis of the situation of children and women. The studies focused on livelihoods, epidemics, public services, the protective environment, family, community and society and the analysis of national statistical data. This synthesis report describes trends and changes in results for children, identifying the factors that drive the on-going deprivation and vulnerability that affect so many and analysing the achievements and challenges to our efforts to achieve significant improvements.

The situation analysis is timely, completed as Zambia moves into the preparation of the next national development plan. The findings, analysis and recommendations provide the basis for considering how the interests of Zambia’s poorest families, children and women can be best represented, and how results can be accelerated in order to meet our commitments and goals for their survival and development.
The preparation and dissemination of this report therefore creates an opportunity for renewed efforts to improve the lives of Zambian children. However, the true challenge is taking the next step – raising the priority of achieving results for children, forging an effective partnership to intensify efforts, addressing the factors that drive child poverty and deprivation and achieving the rights of all Zambian children to survive, to develop and to enjoy a safe and healthy childhood.

This report starts by looking at the vulnerabilities facing Zambia’s children and women, highlighting the significance and mutual reinforcement of poverty, food insecurity, livelihoods, ill-health and the social environment as drivers of deprivation for children and women. Thereafter, it examines efforts that are in place to address the needs of children and women, describing successes and challenges in basic social service delivery and social protection, and looking at opportunities for further improvement. The following section looks at how the legal and policy environment serves to protect and fulfil the rights of children and women, showing how weaknesses in this respect can perpetuate exclusion and marginalisation, entrench the more harmful elements of social practice and undermine the effectiveness of policies and programmes intended to promote development. Lastly, the report describes seven high priority areas for action, identifying practical, achievable and measurable recommendations to accelerate the achievement of results for Zambia’s children.
2 Vulnerability context for children and women

This section discusses the context of vulnerability that many children and women find themselves in Zambia. It links a range of factors that affect them, and identifies patterns of vulnerability - who is affected, how, where and why. The chapter discusses overall poverty, food security, livelihood, health and the social contexts. It distinguishes between different types of households, rural and urban environment, and geographic locations. The analysis aims to determine how these outcomes overlap and interlink to build an extraordinary web of reinforcing factors which impact negatively on child development and survival.

2.1 Poverty in Zambia

The condition and hazards of poverty goes well beyond the issue of incomes, with deficits in choices and freedoms that extend throughout the lives of the poor. The Human Development Index (HDI) provides a composite measure of multi-dimensional poverty, combining life expectancy, education outcomes and economic standards of living to provide a more meaningful understanding of the experiences and expectations of the poor. Zambia has one of the lowest HDIs in the world. In 2006, it was 44.8% which left Zambia ranking 96th out of the 138 developing countries. In Southern Africa, only Mozambique had a lower HDI than Zambia.\footnote{This is the most commonly used measure of inequality. The coefficient varies between 0 (complete equality) and 1 (complete inequality).}

Zambia’s gross domestic product (GDP) enjoyed consistent average growth of 4.88% between 2000 and 2007.\footnote{2 Vulnerability context for children and women} However, although economic growth and per capita incomes have been rising, poverty has persisted in some sectors of the population, resulting in high levels of inequality. Zambia’s gini coefficient\footnote{3} of 0.508 is high compared to other countries classified as having low HDIs.\footnote{3} Interestingly, Zambia has higher levels of inequality than Malawi, which has a small-scale agricultural rather than mineral based economy.\footnote{4} The discussion in this section reflects on the failures in rural livelihoods and growing disparities between rural and urban people, which might account for these inequalities.

High levels of poverty create most of the threats to the survival and development of children and women. In 2006, 64% of the total population were poor.

Figure 1: Inequality in Countries with Low HDI
There is a distinct contrast in recent poverty trends between the urban and rural populations – most notably, there has been a significant and much welcomed fall in urban poverty rates, reflecting the consistent economic growth referred to above. In contrast, however, this clear pattern has not yet been reproduced in rural areas, and in 2006, 80% of the rural population was poor.

The difference in rural and urban poverty is illustrated further in Figure 3, which shows the absolute numbers of poor people living in rural and urban areas. Even though the overall proportion of Zambians living in poverty has decreased, an increasing population means that the absolute number of poor has risen sharply from just over 6 million people in 1991 to 7.5 million in 2006. This substantial rise is contained in the rural population, where the number of poor people has risen from 4 million to just over 6 million in this period, 50% increase in absolute terms. Furthermore, where the proportion of poor people is higher, the depth of poverty that they experience is much greater than in areas where economic outcomes are more diverse.

Poverty is not homogenous. Households made up of a family with mother, father and children who have not been orphaned are the least likely to be poor. Many households do diverge from this “ideal” and it is the social, traditional and economic barriers that these people face that are the subject of discussion later in this report. In all locations, children and women are disproportionately represented in these poorer households. Households headed by women and old people are more likely to be extremely poor in both rural and urban areas. Nearly 20% of all households are female headed; 82% of these are extremely poor, as compared with 64% of the general population. Households headed by grandparents increased from 20% in 1992 to 33% in 2002, and they care for 13% of all Zambian children. The elderly are heading 8.8% of all households; many of these are widows, and 80% are poor. As the head of household ages, the poorer the household becomes.

Female and elderly headed households are more prevalent in poor rural districts – while the national prevalence of female headed households is 19.3%, there are 10 districts in which...
the rate exceeds 25%,\(^2\) most of which are remote and have very high levels of poverty.\(^7\) In rural areas, women are small scale farmers, and most (82%) of them are poor. Inequality in rural areas is also higher, with a gini coefficient of 0.55 compared to 0.5 in urban areas.\(^8\) Moreover, while these figures refer to female headed households, which are largely comprised of women and children, they are not a complete reflection of female poverty. If they were available, intra-household statistics would reflect the extent of equality in women’s access to and control over resources in male headed households.

The relationship between HIV and AIDS and poverty has been widely discussed in other studies. While there is no direct relationship between poverty prevalence and HIV infection rates, there is plenty of evidence to suggest that for each affected household and person, HIV brings economic pressures and disadvantages that tend to increase poverty. Payment for treatment and travel, time taken for illness and the demands of caring for patients and orphans all undermine productivity, reduce human capital and labour capacity, and lead to the depletion of household assets. Extended families have provided a massive source of support for many affected children and adults, although this capacity is in many cases stretched to (and even beyond) breaking point. These costs have both short- and long-term implications: while the immediate effects often include a reduction in consumption, withdrawing pupils from school and deterioration of living standards, children will often live with the consequences of these deprivations into their adult lives.

### 2.2 Food security

For many poor families in Zambia, the repeated experience of hunger and the struggle to access adequate food is a fundamental characteristic of life. Having access to adequate food, in terms of quantity and quality, wherever and whenever needed for a healthy and productive life is an essential component of human well-being.\(^9\) A typical food insecure household will be one where for part or all of the year, household members consume only one or at most two meals a day, and may go without eating at all for some days. In such households, the daily calorie intake is not adequate for a healthy life and household members are more prone to illness and have inadequate energy for work. Food security impacts on household decision making, on the lives of the household members and the survival and development of their children. Food security affects the health and viability of unborn children and infants, and the long term development and intellectual attainment, mental and psychological development of growing children. Poor nutrition creates susceptibility to disease and infection, including HIV and long term disability. It undermines recovery from illness or shock.

The analysis of food security takes into account issues related to availability, access and utilisation of food - known as the three pillars of food security. It includes issues related to cost of a food basket, climate, agriculture systems, social and policy environment, service delivery, access to markets, and human capacity constraints including gender, education and age of the head of household.

Household expenditure on food gives an idea of constraints in accessing food. Rural households in Zambia consume an average of 65%\(^{10}\) of their income or their own production on food. The poorer the household the higher the percentage consumed. Consequently, there are few other resources left to meet other needs, which accounts for the

\(^2\) Kalabo (44%), Mongu (32%), Serenje (30%), Kaoma (29%), Lukulu (28%), Seseke (28%), Katete (27%), Kabwe (26%), Chadiza (25%) and Lufwanyama (25%).
low expenditures on health (1%) and education (3%). It is suggested by the Jesuit Centre for Theological Reflection (JCTR) that even the bought or home-produced food is inadequate, and the three rural communities tracked in the first quarter of 2008 showed a shortfall in average consumption of nearly half of daily calorific requirements.

For urban households, the proportion of income spent on food is lower at 38%. However, in circumstances where cash is required for rent, transport, water, user fees, fuel and other needs, there is no assurance that this expenditure secures enough food of an appropriate quality and diversity. Current calculations from JCTR estimate a basic urban family food basket (excluding rent) at over K1 million, while many salaried jobs and informal sector incomes are far below this amount.

Availability of food in rural areas is affected by crop production, storage facilities, seasonal factors and market access. Periodic acute but transitory food insecurity is most frequent in the southern part of the country, where farming is historically strong but climatic disasters, decimation of assets over long periods, livestock disease, and inappropriate agricultural policies and over promotion of hybrid maize crops in unsuitable areas, have caused crop failures and food shortages. Although the crop losses in the southern and western parts of the country have attracted emergency responses, there is evidence to show that communities are more resilient than is often assumed.

Seasonal variations consistently affect food insecurity of most rural households. Some 76% of food-crop farmers are food-insecure, predominantly women, enduring severe shortfalls during the September–February lean season. The seasonal nature of food insecurity and its relationship to health and incomes is illustrated in Figure 4 by a study in the Kafue river basin. Food supply peaks towards the end of the rains in March to April, tailing off through the rest of the year towards a critical shortage between October and the following March. Labour demand, in contrast, is highest from September through to the following harvest (with the maximum participation of children and women in planting and weeding), peaking between November and January – just when the food supply is at its lowest. Adding to this problem is the disease burden. Just as the work load is greatest and food is in short supply, weather warms

Figure 4: Perceived Seasonal Food Availability, Labour and Disease
up, water is in short supply, the rains start, and the disease burden accelerates rapidly. All this also coincides with the annual peak demand for cash, supplementing food supplies, paying annual school fees and requirements and meeting the costs of accessing health care.

 Accessibility to markets and services is a critical determinant of household food security. The more remote a household is located, the more vulnerable it is to food insecurity. One analysis showed that households in remote areas more than 6 kilometres from a tarred road were nearly 90% food insecure compared to none in the city of Ndola, and 21% in provincial towns. Nutrition patterns showed the same – in households in remote areas more than 6 kms from a tarred road, 63% of children were stunted.18

While the causes of food insecurity and malnutrition (see below) are complex, patterns of vulnerability are more predictable. Households which are most likely to be exposed to either chronic or occasional food insecurity and whose children are most likely to be malnourished include those in households whose heads are either female or elderly; households dependent on small scale agriculture, or where there is a high dependency ratio; households where the mother is not educated or is malnourished herself; where there are labour constraints affecting production, food storage and preparation, often as a result of HIV.19 Given the scale of the relationship between these factors and food insecurity / malnutrition, the design of interventions should ensure that vulnerable households are targeted, addressing immediate shortfalls, developing human capacity and build improved livelihoods. Without raising the participation of most affected groups, although some improvements may be seen in the general population, the disparities in outcome and opportunity experienced by most vulnerable groups are likely to grow.

2.3 Livelihoods

The Zambian economy has grown since 2000, particularly in urban areas, in the construction, tourism, transport and mining industries. In contrast, growth in agriculture, the mainstay of the rural economy and main source of income for some 75% of the working population, averaged just 1.26% between 2000 and 2005.

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<tr>
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* The figure applies to 2000 to 2003.
In the urban sector, formal sector employment has fallen significantly since the early 1990s. New investment over the past fifteen years has not created the anticipated increase in formal sector jobs; this failure coupled with a decline in real wages, has caused an explosion of the urban informal sector and in particular the participation of women. Women, who are less likely to be employed in the formal sector, tend to be involved with informal trading activities with low barriers to entry, which are consequently very competitive. They spend increasingly long hours at work in the hope of taking home enough to meet some basic family requirements. Women are robbed of time to look after children and take care of household chores leaving children, often girls, to look after younger siblings, themselves often dropping out of school to do so. Correct child feeding, attending clinics, and child discipline are sacrificed. Where single women have been forced into more risky activities, temporary migration or commercial sex work, children spend prolonged periods without adult care, and are at greater risk of abandonment or orphanhood.

In rural areas, agriculture is the main source of livelihoods, accounting for 73% of all employed persons. Women dominate the agriculture sector, which involves the young and the old. Although the great potential in Zambia’s agricultural sector has often been recognised, a range of factors has contributed to shortcomings in its full realisation. These include shortcomings in the capacity to engage in farming (HIV and AIDS, inadequate equipment and poor levels of awareness and education) as well as in the policy environment and delivery of services (rural credit, markets and extension), and challenges in the natural environment, including declining soil fertility and climate change. Similar challenges affect other rural livelihoods, including ranching, fishing, forestry and non-wood forest products.

Most adults have the capacity to work and to support their dependents, but are exposed to insecurity and periodic shocks as a result of limitations in their livelihood strategies. Where this is so, people will try to adapt their livelihoods, often using the strategies outlined in figure 6. These strategies may increase resilience at household level, but may also depend on increasing levels of child or women’s labour, with consequences for educational outcomes, health and family life.

Some of the actions often referred to as ‘coping strategies’ are may be indicative of a failure to cope – people eat less, withdraw children from school, sell productive assets, devalue their social status by begging and/or borrowing. Women more commonly resort to such strategies than men, sometimes incurring significant costs that leave household members less resilient to future shocks in the short or long term. In some cases, households break up in response to falling incomes. Migration, divorce, abandonment and
early marriage are used to reduce liabilities and dependence in the short term, but often create further and future risk for children and women.

Livelihoods failure can also be the result of shocks and emergencies. Some of these are related to personal or household crises – death, illness, divorce and other events that create social or economic stress. Others result from external contingencies, including drought and excessive rainfall. In rural areas, where livelihoods diversity tends to be very narrow in any given area, climatic emergencies tend to affect the majority of households, including those who may usually be economically secure. Even in urban areas, events such as the closure of markets due to flooding or outbreaks of cholera tend to affect a large number of informal sector actors. In such cases, options for coping with livelihoods stress rapidly narrow as remaining opportunities and potential sources of support become rapidly crowded out.

2.4 Ill health

Over the past two decades, increased vulnerability to disease and ill health have threatened the lives, well-being and livelihoods of many Zambians, especially children and women. HIV and AIDS, tuberculosis (TB), malaria, childhood diseases, pneumonia, acute respiratory infection (ARI) and sexually transmitted infections (STIs) persist, and create a significant constraint to social and economic development. These combine to form multiple, concurrent epidemics, absorbing household time and capacity, and undermining the much-needed human resource base. At household and community level, ill health exerts huge stress, while the poor health of the nation negatively affects economic growth. With children and women especially vulnerable, the deficits and demands of ill health undermine the fabric of family life, culture and society.

2.4.1 Childhood diseases, respiratory infections and pneumonia

Childhood diseases continue to pose huge challenges for the health and survival of poor children. In combination with HIV and TB, diseases such as ARI, pneumonia, diarrhoea, STIs and infections of the skin and mouth that would otherwise be manageable become “opportunistic”, widespread and chronic. The combination of these is a major contributing factor to child mortality. Between 2000 and 2007, the incidence and case fatality for ARIs, diarrhoeal diseases and skin infections among under-5s have remained static at high level. Among the 36,000 under-5 hospital admissions for ARI annually, some 2,200 children will die; for the 24,000 under-5s hospitalised with diarrhoea, 1,500 will die. Besides these, there are many others who will die without being admitted, or without even being seen by a health provider.

Pneumonia kills more children than any other illness globally - more than AIDS and malaria combined. Worldwide over 2 million children die from pneumonia each year, accounting for almost 20% under-5 deaths worldwide. The same statistics are mirrored in Zambia, with an estimated 22% of under-5 deaths attributed to pneumonia. ARI and pneumonia are common among children in poor communities in Zambia, with a case rate of some 600 infections per 1000 children under-5 years per year. Of those who are admitted for treatment, the case fatality rate is some...
Further, given that this estimate is based on facility level data, excluding under-5 deaths occurring in communities, the real burden is likely to be higher.

The causes of pneumonia and ARI are multiple. Children are particularly vulnerable when their immune system is suppressed, when they are exposed to poor air quality (especially from fires, smoke and dust pollution), and when they are living in densely crowded conditions. As a result, pneumonia may occur among children infected with HIV or diseases such as measles or malaria, and those living in poor and deprived rural and urban communities, including locations close to industrial and mining sites.

It has been argued that the strong focus on HIV and AIDS, TB and malaria has caused a neglect of other infectious diseases such as pneumonia and diarrhoea. Besides this, the multiple causes of pneumonia and intractable links to poverty and environmental health have perhaps undermined efforts to address the disease. However, section 3.1.3 describes innovative efforts to introduce community based case management of pneumonia, which is expected to reduce both prevalence as well as case fatalities.

### 2.4.2 Malaria

Malaria is endemic in Zambia. Over 4 million people are infected annually, with some 6,000 to 8,000 deaths. Malaria accounts for some 30% of outpatient visits annually, creating a huge burden on primary health care services.

Children under-5 and pregnant women remain the most vulnerable groups to malaria. For children under-5, the malaria burden is highest among those aged 1-3. Overall, about 35 to 50% of under-5 mortality and 20% maternal mortality are attributed to malaria.

Risk of malaria is strongly related to geographical location. The worst affected areas are the hot, low lying river valleys, lakes and wetlands, where 40% of children aged 5-14 years are constantly infected with the malaria parasite. These areas are typically remote, and show high levels of poverty. The main urban areas of Zambia are outside the very high prevalence areas, but nonetheless malaria poses a significant health threat. While richer residential areas are purposefully located away from the low-lying land, rivers and streams associated with malaria, informal settlements and poor shanty compounds are found in the outlying and marginal areas, often characterised by risk of malaria.

### 2.4.3 Malnutrition

In Zambia, malnutrition rates have long been high, but there has been a noticeable increase during the past decade. While the burden of other infectious and preventable diseases is high and contributes significantly to child morbidity and mortality as shown in figure 8, malnutrition is perhaps the most significant factor in this respect, underlying up to 52% of all under-5 deaths in Zambia.
The stunting rate in under-5 children stands at 45% while 5% are acutely malnourished (wasted) and 19% are underweight. The severe acute malnutrition prevalence in Zambia is 2.2%, translating nationally into 44,000 severely and acutely malnourished children at any point in time. The rates of micronutrient deficiencies are also high in Zambia with 53% vitamin A deficiency and 4% of school age children suffering from iodine deficiency disorders while 46% have iron deficiency anaemia. Poverty coupled with current rising food and fuel price, scarcity of food due to extensive crop loss due to flooding in the previous two agriculture seasons and in some cases, lack of knowledge on proper infant feeding practices further exacerbates the underlying chronic nutrition problems prevailing in the general population.

Being breast-fed in the first two years of life provides a critical basis for child survival, growth, development and psychosocial well-being; good breast-feeding practices offer the greatest single opportunity to reduce the burden of child morbidity and mortality, reducing mortality in under-5 children by 13%. Zambia has made tremendous progress in the promotion of exclusive breast-feeding for the first two years of life: the proportion of mothers breast-feeding their babies without any form of supplementation rose from just 25% in 1991 to 40% in 2001, reaching 61% by 2007.

Even in the context of HIV, exclusive breast-feeding remains the best feeding option for children under the age of 6 months. However, many mothers living with HIV need support from spouses, family, community and healthcare workers. With many reported misconceptions and sources of misinformation, mothers need to be assured and supported to ensure that they maintain exclusive breast-feeding. Further, although Zambia has domesticated the international code of marketing of

Figure 8: Causes of Under-5 mortality in Zambia

- Malaria: 23%
- Diarrhoea: 19%
- Neonatal: 19%
- ARI: 17%
- Other: 22%

Malnutrition and HIV and AIDS either cause or underlie 52% and 16% of all child mortality (i.e. they are either part of ‘other’, or underlying ARI, Neonatal, Diarrhoea, Malaria and other sorts of other).

Figure 9: Transitory food insecurity (left), Chronic malnutrition / stunting by district (right)
breast milk substitutes, efforts on enforcement and public awareness need continued attention. Conversely failure to support breast-feeding will lead to malnutrition and consequences for physical and cognitive development, mortality and mortality.

Nutritional status, in particular stunting, is a robust indicator of vulnerability to chronic food insecurity. Rural areas have shown consistently higher levels of stunting than urban areas and in 2007, 48% rural and 39% urban children were stunted.  Although the southern parts of the country suffer transitory food insecurity, it is actually the northern districts that show the highest levels of stunting, a nutritional outcome of chronic food insecurity. Whereas climatic conditions are more secure, social and market conditions mean that opportunities for secure livelihoods are scant, and chronic food insecurity is widespread. This north-south divide is illustrated in figure 9, showing that chronically inadequate diets in the northern districts are creating significant threats to children’s survival and development.

2.4.4 HIV and AIDS

Zambia is at the centre of the HIV pandemic in southern Africa. Over the past 25 years, HIV has touched all age groups, all social strata, all districts, and all families throughout the country. Even where HIV prevalence is lowest, it is still very high by any standards. Among 15-49 year olds, overall infection rates are 14.3%. Figure 11 shows that this peaks at 26% of women in their early 30s, and 24% of men in their early 40s. Over 1 million people are estimated to have died from AIDS since the start of the pandemic. This loss has profound effects throughout society. Families have lost husbands, wives and children, leaving orphans in the care of grandparents and other relatives. Industries, businesses, schools and hospitals lose trained and skilled workers. The result is the erosion of human capital and the national economy, with household, local and national efforts for development repeatedly undermined by the costs and the losses of the pandemic.

In recent years, there have been some signs that the HIV pandemic may no longer be growing. Indications of overall prevalence and of new infections suggest slight decreases for some population groups and areas. Encouragingly, these appear stronger among groups who have been particularly targeted by HIV programming (young women, for example). However, there is no room for complaisance. Prevalence rates have risen sharply in other

\[\text{Figure 10: Changes in HIV Prevalence by Province / Urban and Rural – 2001-2 and 2007} \]
areas, risk of infection is much greater among some groups, and risky behaviour (especially with regard to condom use and multiple concurrent partners) remains common and even expanding among some groups – especially urban and more educated people. Overall infection rates declined slightly in urban areas and in some provinces between 2001/2 and 2007, although the results are not statistically significant. In Central, Luapula and Western Provinces, infection rates rose substantially. This stagnation may forewarn of a bleak future for rural areas, and probably indicates poor access to information, social pressure and slow behaviour change.

HIV prevalence is higher in urban areas than rural areas, among wealthier and more educated people, and where people are mobile. While this may suggest a negative correlation between poverty and HIV prevalence, drawing inferences around the incidence of HIV is complicated by the possibility of higher survival rates among the rich – a consequence that may result from better living conditions, diet and access to services. There is no doubt that poverty reduces access to knowledge and creates circumstances of sometimes unavoidable risk of HIV, and that AIDS creates significant economic stress for those infected and affected.

Overall infection rates are higher among women than men. This phenomenon is a result of their physiological vulnerability but also the complex interrelationship between the pandemic and power. At first glance, the association of infection with wealth might suggest that HIV is a disease that affects those with choice and control, but HIV infection may equally be driven by a power imbalance between the powerful and powerless, particularly in the negotiation of relationships. The imbalance is expressed through prevailing gender norms that discourage women and girls from taking control of their sexual experiences, including young girls having relationships with older men, abuse in schools and work places, the obligation of wives to consent to sex with their husbands and domestic and sexual violence against children and women.

The well-being of Zambian children is severely compromised by the pandemic. Mother to child transmission is the second most important factor of transmission – children from HIV positive mothers being infected before, during or during delivery. Children living with HIV have only very recently become a target for testing and treatment, and even now the course of the pandemic among children.

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**Figure 11: HIV Prevalence, by Sex and Age**

![HIV Prevalence Graph]

**Figure 12: Proportion of Children Orphaned by Age**

![Orphaned Children Graph]
is not monitored. While the medical needs of infants as well as older children are being rapidly scaled up, the social needs of older children living with HIV as well as parents and caregivers supporting children on antiretroviral therapy (ART) have not yet been so widely addressed.

For many more children, HIV has created stress, trauma and eventually orphanhood as their parents get sick, and later die. There are an estimated 993,000 orphaned children in Zambia, and many young adults who remain affected by the loss of their parents. Many children have had to nurse dying parents with very limited support, advice or equipment, and later been deprived of family property, forced to move, separated from siblings, withdrawn from school, and exposed to a variety of risks, threats and abuse. Nearly one-third of children between the ages of 15 and 18 have lost at least one parent, a figure that is even higher among families of most at-risk populations. Rates of orphanhood in Zambia are the second highest in Africa – a powerful reminder of the need for the greatest possible efforts to be made.

HIV and AIDS undermines household stability and resilience by precipitating a depletion of financial, physical, human and social assets, limiting the capacity of poor households to recover and develop. HIV and AIDS therefore contributes to intergenerational poverty, with present day ill-health creating deficits that affect lives far into the future.

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3For example, the ZDHS does not capture children
Achievements and challenges in addressing HIV and AIDS are discussed in section 3.1.3.

### 2.4.5 Tuberculosis

The HIV pandemic has precipitated a dramatic increase in the rate of TB infection. Around 55,000 people develop TB every year, one of the six highest in Africa, with infection rates highest in urban areas in Lusaka, the Copperbelt and Southern Provinces. Although new cases have fallen somewhat since 2004, TB rates remain as high as 800 per 100,000 people in densely populated urban areas. TB is highly contagious, and flourishes in poor, overcrowded residential areas. While 70% of cases are associated with HIV, poor living conditions in urban areas are conducive to infection, and some 30% of cases occur in patients who are HIV negative.

Although prevalence is lower than in urban areas, rates of TB infection in rural areas also give reason for concern. The quality of TB care provided is often compromised by the general shortage of staff, especially in rural facilities. Similarly, other health systems weaknesses, e.g. referral, transport and laboratory services disadvantage the provision of TB services in rural areas. As a result, rural districts have a much lower TB cure rate than urban districts.

Clinical reports suggest that maternal TB is leading to an alarming number of cases of both moderate and severe forms of paediatric TB. However, services addressing paediatric TB lag far behind those focusing on adults. Even where there are staff trained in management of TB in children, the diagnosis of TB among under-5s remains problematic. Prevalence statistics do not reflect infection among children, and as a result it is hard to assess clinical needs or identify gaps in service provision.

### 2.4.6 Multiple concurrent epidemics

The analysis of ill-health and poverty argues that HIV and AIDS, TB and malaria can be classified as the underlying epidemics that have increased the incidence of opportunistic infections or spin-off epidemics, complicated the management of childhood diseases prevalent among poor households, and increased the incidence of non communicable diseases in both children and adults. The overall picture is of multiple, concurrent epidemics and ill health that reinforce each other, undermining child and maternal survival on a broad scale.
One example is the combination of HIV and malaria during pregnancy, which threatens the lives of pregnant women and new born infants. HIV contributes to more frequent and severe episodes of malaria in pregnant women, resulting in maternal anaemia and low birth weight infants. Simultaneously, malaria increases the chances of HIV transmission from mother to child. The combination of the two epidemics therefore brings severe, negative consequences for pregnant women and their children.

Malnutrition and diarrhoea form a similar vicious cycle. Malnutrition impairs overall immunity, such that undernourished children are more likely to suffer diarrhoea. This impairs the appetite and causes dehydration, exposing children to further infection, making it more difficult for the body to absorb food, and increasing metabolism, so causing further nutritional deficiency. Likewise, malnutrition reinforces a range of other diseases, with airborne related disease mortality estimated to be 100 times greater among severely malnourished children compared to well nourished children.46

2.5 Social context

Any analysis of livelihoods, poverty and prospects for development is incomplete without examination of the social context. People’s lives are inevitably framed by social relationships, mutuality and communication. Effective coordination, collaboration and collective action are essential for managing local communities and national societies, while social and cultural priorities, constraints and opportunities form the basis of what people hope to achieve and how they are able to go about meeting their goals.

The social environment is shaped by people, but some people have more influence than others. Those with greater power and influence in other domains tend to have more power in determining social values, relationships and priorities. For children and women, who in the Zambian context may often be considered subordinate to men, the prevailing social environment can be a source of exclusion and marginalisation, rather than opportunity.

This section explores three aspects of the social environment – the social environment and gender, the social environment and children, and the social context and disability.

2.5.1 Social environment for women

Outcomes for Zambian women and girls are strongly shaped by social norms which support widespread discrimination. Women are generally regarded as subordinate to their male counterparts, have less voice, less autonomy, fewer opportunities and lowered
self-esteem, from childhood to old age. Scarce resources are less likely to be directed to their needs, the deprivations and suffering they face are not fully taken into account, and the significant contribution they make to household, local and national development is undervalued. Women are the principal caregivers to children, but the quality of their parenting is affected by their level of education and their ability to participate in decision making. The household and social values related to the position of women in the household or in society form a powerful part of children’s learning and development, tending to reinforce the norms for future generations. A change in male-female relationships would address some of the vulnerabilities and improve their chances to better participate in national growth and development, but the change is challenging.

The qualitative assessment report relates how girls and women are defined in society through their relationship with men, as fathers and husbands, respectively. Women are often taken to have the social status of children until they are married; on marriage they are recognised and considered ‘rich’ regardless of their husband’s behaviour. In the event of a divorce they lose their identity in the local society, feel marginalised, and may even be mocked. If their husband dies, some community respondents in North-Western Province report that some women face blame for the death, and in places must pay sometimes large sums of money to be “cleansed”, which may involve having sex with a relative of their late husband.

Women have less access than men to productive resources such as land, markets to sell products, to finance and financial institutions, and inputs to improve productivity. While women are among the hardest working in poor households, and are usually responsible to put food on the table, social taboos on women’s behaviour and on the type of work she is able to carry out has restricted their access to a decent livelihood, prevented them from maintaining their assets. For example, in many areas women are still considered unable to put a roof on a building, ride a bicycle, or take produce to market, although in others this is changing.

The research noted changing gender roles and responsibilities, probably as a result of chronic poverty. Some men seem to be increasingly abandoning their responsibility for their families. In Kasempe and Mufumbwe, some women said that it was easy for men to abandon their family and set up new families. In Milenge, others said their husbands and fathers have abrogated their traditional role as head of the home. In many cases, women have become household heads, with little support from their husbands. In many farming communities, men are traditionally responsible for land preparation and marketing, while women are responsible for weeding and harvesting. Some women also complained that they rarely see the proceeds of the sale of the crop, which in cases they say is spent on alcohol by their husbands. Where bride price is expected but not paid to the husband’s family, men may convincingly deny responsibility for the children of the marriage. Where the cleansing fee is not paid by the widow on the death of her husband, or if the widow refuses to participate in ritual cleansing, the husband’s family is not expected to assist to support the children and will take the property belonging to the widow. Other research substantiates this changing sense of responsibility in the context of chronic poverty. The World Bank found that the household as a social institution is crumbling under the weight of poverty. Some households disintegrate as men do not accept that their wives are the main “bread winner” which necessitates a redistribution of power within the household. This redistribution of power can result in alcohol abuse, domestic violence and family breakdown. Coupled with
possible breakdown is social solidarity and adherence to social norms and discipline, increased lawlessness and violence is likely.

Others argue that the extended family is not disintegrating as a result of chronic poverty but its nature is changing. The elderly, especially elderly women, and the young, are increasingly playing a critical role in caring for children orphaned after the death of the children’s parents. The Zambian traditional respect for the elderly extends through “normal” old age, with status derived from being an old person. But those who are most elderly and have buried many children and grandchildren are treated with great superstition, often associated with witchcraft, excluded socially and their lives threatened. The qualitative assessment reports a practice of “Chikondo” from North-western Province, whereby the community identify a witch or wizard as being responsible for several deaths, usually their own children and their grandchildren. The coffin of the dead directs its bearers to the person responsible, usually an elderly woman or man, who is then battered to death with the coffin.

Violence against women is one social mechanism which perpetuates women’s subordinate position in relation to men. The extent of gender-based violence (GBV) is difficult to know as few incidents are reported either because the women fear reprisals, are ashamed, expect to endure violence at the hands of male family members, or feel that there is no one of trust to report to. Recent reports on the incidence of violence suggest an increase, although these arguments are often rejected with the impossible expectation that this should be statistically proven to have any value. Women are repeatedly taught that “talking outside the home”, or discussing what happens in the marriage with anyone else, is shameful and indeed justification for divorce. Women and girls may face sexual abuse over a prolonged period, but will not report it if threatened with the prospect of family break-up, further violence or loss of access to education. More than half of women who have been married in Zambia have been beaten or abused by their husbands and about half of both men and women think that wife beating is justified for specified reasons, such as infidelity.

2.5.2 Social environment for children

Children have a right to care, to access their basic needs, to protection and to age-appropriate participation in society. However, there are issues in
the social environment that undermine the realisation of all these rights and as with women, the social status of children is generally law.

Within the household, needs of children are often treated as secondary to that of adults. At the most basic level, this can affect what children eat. On a routine basis, children eat after their fathers and also their mothers. Where household resources are limited, and even where they are not so limited, food preparation is oriented around adult diet requirements. As a result of the number and type of meals they have, many children are chronically malnourished, many in households where sufficient food is in fact available. Health service providers often comment on the number of patients where food preparation and feeding rather than poverty are the major causes of malnutrition.

Children have little opportunity to express their opinions and to participate in decision making in households, at school or in the community. Indeed, practices around up-bringing and education often teach children (especially girls) to keep quiet, not to express themselves for fear of ridicule, and to show respect for adults through unquestioning compliance. Where children have experienced the trauma of losing parents and being moved to live with other relatives, they are rarely consulted on what they would like to happen, often split up from siblings with little regard or even prior communication, and new carers often do not take time to allow them to share their feelings on what has happened to them. This approach, where children’s needs and feelings are undervalued, is the result of a social environment that considers them less significant members of society.

### 2.5.3 Neglect, abuse and exploitation

Having been brought up to comply with adult decisions and instructions in silence, it is not surprising that young adolescent girls are especially susceptible to exploitation. On the one hand, they are viewed as highly desirable by men of all ages, but on the other they are often left to deal with the responsibilities of other children in the family, labour in the home, sometimes at the expense of their education. Both of these result in exploitation for many. The prevailing social environment produces young girls who have few skills to negotiate or control their education or work prospects, their sexual experiences, pregnancies, risk of HIV or marriage. While many efforts are directed towards building life-skills among adolescent girls, the success of these endeavours would be greatly enhanced if there were a concerted change of attitude that recognised the social status of children, especially girls, as valuable members of society from early childhood onwards.

Although the issues around teenage girls and the social environment are subject to discussion, those of their male counterparts are much neglected. Boys are subjected to a male-oriented social environment. Sexual experience, toughness, emotional strength and economic success are highly emphasised in circumstances where many young men are not able to live up to these expectations, or will engage in risky behaviour in order to do so. Very much left alone to cope, and with less consideration of what might be helpful or supportive than for girls, the social environment is in many ways unhelpful to the development of a generation of young men able to promote equitable development for themselves, their partners and their children.

In circumstances of poverty, vulnerability and deficits in public services, many children are subjected to risk of harm and abuse. Children without their parents, especially their mother, make them more vulnerable to abuse and neglect, violence, exploitation and discrimination.
An orphaned child being passed to an extended family does not necessarily ensure protection; there are many cases where this has exacerbated exploitation and abuse. The threat, as well as the experience, of diverse forms of abuse is a denial of the child’s right to safety and security, and is a cause of long term physical, psychological and social damage. There is limited evidence but what there is suggests that violence against children is common. In a survey in 20 districts published in 2001, half the children interviewed had experienced physical abuse in the family. Abuse is more common among younger children than older children. Over three quarters of children who live in rural areas and do not go to school were reported to suffer abuse. About half the cases of abuse result in serious physical injury, while all instances cause fear, alarm and anguish.

Many children experience abuse outside the family. Although reliable data is rare, one-third of the children interviewed in 1998 had experienced abuse by known people in positions of power at school or in the workplace. More recently, an assessment of correctional institutions estimated that 70% of children had been physically abused, while research with street children suggests that violence is both a reason why children leave home, and a common experience on the streets.

The widespread use of physical violence against children is detrimental to their survival and development, and to the growth of an equitable society that respects the rights of all. The normalisation of violence within state institutions reinforces it as a social norm, and undermines alternative means of resolving disputes, raising children and inculcating appropriate values.

Understanding child neglect presents a challenge. Children face poor access to food, schooling, clothing and other essentials mostly as a result of household incapacity, but also lack of awareness of the children’s needs, and wilful or discriminatory denial. Figure 14 describes different forms of child neglect, highlighting the need to understand each case in order to provide an appropriate response in the best interests of the child. Child neglect manifests itself as large numbers of street children, child begging, dropping out of school and commercial sex work of young girl.

Child sexual abuse is a deeply problematic issue in Zambia. On the surface, prevailing social norms are based on conservative family values, strongly influenced by church teachings around marriage, fidelity and sex. There are fixed and limited channels in which to talk to children about sex. In parallel, however, there are many common practices that contradict these norms. In rural and urban areas, instances of infidelity, multiple concurrent partners, and early sexual experience are said to be common. Child sexual abuse therefore takes place in an environment where there is much

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“...”

Family, Community, Culture and Society Report
(respondents from community focus group in Luapula Province)
silence around common practice of sexual relations. Just as sex outside the strict auspices of marriage is (somewhat misleadingly) said to be taboo and alien to Zambian culture, so is child sexual abuse.

The research suggests that most child sex abuse involves men who are known to the victim, from within the family or community – fathers, uncles, stepfathers, siblings, and teachers. Thus abusers are often those in positions of power and authority with respect to their victims. The combination of being a taboo subject and being associated with those who have power means that many children are highly reluctant to report their abuse, even where their silence will prolong its perpetration. Many of the cases brought to the attention of the Victim Support Unit (VSU) of the Zambia Police come to light when mothers and caregivers notice physical signs or behaviour changes that result from the abuse. However, research also suggests that when abuse occurs within the family, mothers and caregivers may either blame or threaten the victim, or demand their compliance in order to preserve their households. These cases are much less likely to be reported.

Some children, especially girls, are subject to commercial sexual exploitation. This is mostly an urban phenomenon in areas of high economic growth. Many of them are very young, and in some cases their parents are aware of their activities and some are even forced to do so by their parents. Early marriage of girls for financial gain is also common, especially in rural areas, and accounts for high levels of school drop outs. Early marriage is closely linked to the payment of bride price.

The factors that support the abuse of children also shape the prevalence of violence and abuse of women. The social norms that simultaneously deny and permit violence, the pressure to tolerate violence, abuse and humiliation, the perpetuation of harm with people in the family and in positions of power, abuse of alcohol, and the weakness of the legal response and other forms of victims support are all common to the widespread incidence of violence against children and women.

Discussed further in section 4, the only recourse for most rural women and children is customary law that tends to perpetuate the abuse of children and young girls. The perpetrator is fined to compensate the victim’s family, with offences that would attract substantial sentence under statutory law receiving cursory punishment under customary law. The abuse or impregnation of a teenage girl, past puberty, is treated as an insignificant issue, particularly if she is known to the perpetrator and deemed to have consented. The customary and social sanction around the abuse of post-pubescent girls is a significant contributor to poor education outcomes for girls, early marriage and life-threatening teenage pregnancy. Nearly half the girls of Zambia are married by the time they are 18.\textsuperscript{61}

![Figure 15: Factors that Increase the Incidence of Abuse](image-url)
Early marriage contracted under customary law, mainly a rural phenomenon, is linked to payment of a bride price, and as such is widely recognised as a coping strategy for the poor.

Although there is some discussion of the abuse of teenage boys by older women, the abuse of boys by men is an almost entirely taboo subject. Expressed social norms are absolutely opposed to male homosexuality, and any mention of either consenting sex between men or sexual abuse of boys by men is simultaneously denied, condemned and blamed on foreigners. Nonetheless, research with street children suggests that the sexual exploitation of boys most certainly occurs. It is highly likely that boys affected in this way would have significant reservations around reporting their experiences.

2.5.4 Child labour

Child labour is widespread in Zambia; nearly half of all boys and girls under the age of 17 are involved in child labour. The most recent data from 2005 suggests that some 866,000 children under the age of 12 and 715,000 under 10 engaged in economic activities.

Child labour is not the same as the work that children usually do in their homes, farms and businesses as part of the usual process of socialisation, learning and normal participation in family life; participation in such work is generally considered to be positive, supporting family well-being and giving children valuable experience. Campaigns to eliminate child labour do not seek to undermine these social norms. Hazardous child labour is defined as work that is mentally, physically, socially or morally dangerous, interferes with education, or inappropriate in terms of where children work, what they do, or the time they spend working. What is appropriate for a seventeen year old is clearly different than for a seven year old, and global definitions are disaggregated by age. For example, in Zambia, children labourers aged between 7 and 11 work for an average of 24 hours per week; for all ages there is a statistically significant relationship between the numbers of hours worked and reported levels of ill-health.

Child labour in Zambia is largely a rural phenomenon. Children in rural areas are more likely to work, and less likely to go to school. Further, this pattern is more pronounced regionally, with some 79% and 77% of children in Northern and Eastern Provinces.
respectively engaged in economic activities at an age and to an extent that exceeds normal expectations for family participation, compared to less than 10% in Lusaka and the Copperbelt.

Children who work lag behind those who do not in terms of school attendance and performance. As children grow older, they are more likely to work, and those that do so lag a full grade behind those who do not by the end of the first school cycle.

Over three-quarters of children who work do so in hazardous conditions or at night. Many of these are engaged in agricultural labour tasks deemed inappropriate for their age group. More boys than girls work, but the proportion of girls working has increased between 1999 and 2005. Most working children work away from home, including some who are very young – there are over 1000 children under the age of 9 who work away from home. These children are mostly occupied in domestic labour; invisible because it is confined in the home, but often dangerous. Children engaged in domestic work in the home or outside handle fuel and fire and are often expected to take on responsibilities inappropriate for their age, looking after younger children, and working long hours. They are deprived of care, schooling, play and social activities.

Descriptive evidence suggests that economic considerations play a major role in parents’ decisions to involve their children in work. When asked what would happen if their children stopped working, over half of adult respondents stated that either household living standards would decline (17%), household survival would be threatened (16%) or that the household enterprise would not be able to operate (20%). Simple correlations also show a strong inverse relationship between household income and child involvement in economic activity – underscoring the fact that efforts to reduce child labour are unlikely to be effective without accompanying efforts to improve household incomes.

### 2.5.5 Child trafficking

Zambia is increasingly giving cause for concern as a “source” country from which human trafficking victims are recruited and also as a “transit” country through which traffickers transport their victims en route to their destination countries. Human trafficking is fuelled by poverty, lack of awareness and ignorance. Children, especially girls, from poor families are at risk of being trafficked for domestic and farm labour as well as for commercial sexual exploitation, vulnerable to false promises of a better life, job or education.

Most often, children are trafficked within Zambia from rural to urban areas to work as domestic labour – very often within the extended family network. They are often “recruited or sourced” to work in homes as domestic servants, or as cheap manual labour on farms, or for the purposes of commercial sexual exploitation. Internal trafficking is exacerbated by cultural traditions that encourage children to go
and live with extended family members to assist with household chores in return for schooling. Although many children benefit from the situation, particularly orphans and children from poverty-stricken families, recent research suggests that many children are trafficked to be exploited in domestic and agricultural work, and for commercial sexual exploitation. It appears that problems in accessing school in rural areas encourage parents and caregivers to agree to alternative and potentially risky moves for their children; that girls are more frequently trafficked than boys; and that even in the worst of circumstances, children who have been trafficked often feel they have no alternative than to remain where they are.

The extended family has been cited as Zambia’s safety net and coping mechanism. However, the frequency with which orphaned and even non-orphaned children are moved between households exposes many to the risks of domestic trafficking and exploitation. While moves to stay with extended family members offer better care and opportunity to a great many children, in some cases this is a source of risk. As such, community based approaches are needed to tackle the problem, encouraging parents, caregivers and children themselves to be more cautious in trusting ‘opportunities’ they may be offered.

2.5.6 Disability

The Convention on the Rights of Persons with Disabilities states: “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and active participation in society on an equal basis with others” (Article 1). Therefore to understand disability requires recognition of the broad spectrum of disabilities that affect children within Zambian communities. The Convention on the Rights of the Child (CRC) is fundamental in guaranteeing the human rights of all children regardless of their ability and lays the foundation for our understanding of inclusion in society of children with disabilities.

On this basis, inclusion requires the removal of barriers that prevent children with disabilities becoming full and active members of society and providing the appropriate protective and supportive environments in which children’s rights can be respected and enhanced.

Understanding of different forms of disability in Zambia is limited, and practical measures for the inclusion of...
disabled children are scant. The Fifth National Development Plan (FNDP) seeks to address
disability, but in order to identify practical actions the analysis would have to go further in
distinguishing the issues and needs for inclusion around different forms of impairment. The
tendency to generalise around disability has weakened inclusion and the fulfilment of the
rights of children with disabilities.

Measuring the extent of disability is a problem because there is no reliable data on the
number of persons that are disabled or on the number of people affected by a specific
disability. For planning purposes, Zambia uses the World Health Organisation (WHO)
estimate, which results in an estimate of 1 million disabled persons. The 1990 census
sought to measure disability by asking “do you have a disability?”, yielding subjective
results. A functional approach, however, applied in the Zambian context estimates just over
13% prevalence of disability. It is likely, therefore, that there are substantially more than 1
million disabled persons, especially if those children born with congenital impairments who
die at a young age are included.

Poverty and disability are closely linked. The incidence and impact of disability is
compounded by not only an individuals’ lack of access to adequate and appropriate medical
care but also their exposure to unsafe environments.71 The ‘vicious cycle of disability and
poverty’ suggests that poor people are more likely to become disabled as a result of poor
maternal health, inaccessibility of preventive or curative services, dangerous work and so
on. Once disabled, people face additional costs in meeting basic needs, and are less likely to
access education, life skills or work, and more likely to become poor.

This cycle is fuelled by social attitudes towards disability. Barriers within society have
been seen to promote exclusion, stigmatisation and discrimination rather than promoting
the equality and non-discrimination that would remove many of the barriers to inclusion.
The disabled and their families, especially women, suffer stigma and discrimination which
includes environmental, attitudinal and institutional barriers. The disabled are “invisible”,
and often sent away by less poor families to even poorer distant relatives to be cared for.
The disabled are stigmatised, suffer sexual assault and are often not allowed to marry.
The mothers of disabled children may be blamed for the disability, and fathers sometimes
disown disabled children. Social beliefs about disability include the fear that disability is
associated with evil, witchcraft or infidelity, which serve to entrench the marginalisation of
disabled people.

Whatever the disability, the impact of that disability on lives and livelihoods is severely
negative. Families with disabled children face the forbidding costs of accessing treatment
(including transport), which may include the indirect costs to the caregivers whose capacity
to work and earn a living is severely curtailed. The education system makes no allowances
for disabled children and most parents of disabled children do not know that disabled
children also have a right to education. Even where a disabled person has a qualification,
they are unlikely to be employed or to marry. They are largely excluded in HIV and AIDS
programmes which appear to consider disabled people as sexless, and have little access to
specialist health care for rehabilitation.

Disabled people show a similar profile to the non-disabled poor, but have much less
chance of overcoming shared problems. They typically lack access to health and education,
clean water and sanitation, have poor housing and may live in over-crowded, unsanitary
and unsafe areas. Disabled people are typically excluded from development activities. Credit programmes regard disabled people as unsafe debtors. Disabled people are often unable to contribute to development activities that require some investment (financial, labour, time) on the part of those taking part. Disabled people are very largely absent as actors and clients in the provision of services, schools, development programmes, employers, and financial institutions, as staff, clients or interest groups. There are no disabled Members of Parliament, and no more than a few disabled elected councillors.

Congenital disability affects men and women at the same rate, but there is a distinct and gendered pattern among those who acquire a disability. Men are more likely to become disabled as a result of work related accidents and violence, whereas the greatest risks affecting women are the result of maternal health complications. Prevalence rates are higher for women than men, and they may also suffer higher mortality from neglect, malnutrition, and poor health care. Girls and women who are disabled face discrimination and exclusion within the family, receiving less care and food and facing a higher risk of physical and mental abuse. Disabled women are less likely to marry than disabled men.

 Discrimination against disabled people is legitimised by the social environment to the point where exclusion has become the accepted norm. The severe limitations facing disabled children, women and their families are self-evident, but nonetheless generally accepted. For the situation of disabled people to be as poor as it is, it is clear that this acceptance must be common throughout Zambian society. If efforts to move towards more equitable, inclusive development, as defined in the new United Nations Convention on the Rights of Persons with Disabilities, are to be realised, addressing the challenges of the social environment must be at the very top of the agenda.

### 2.6 Closing comment: vulnerability context

This section analysed the current patterns of vulnerability and concludes that children and women are more likely to experience extreme poverty, livelihood failure, chronic and transitory food insecurity, and high incidences of disease, especially in remote rural areas. Isolation and exclusion are factors that drive vulnerability. Households headed by women, the elderly, and the disabled in remote areas, with large numbers of children, who are not educated, have poor access to productive assets, and whose assets have been severely depleted are the most vulnerable to inadequate food security. Food insecure households with malnourished children are more vulnerable to seasonal shocks and ill health. Whereas HIV and AIDS affect better off urban populations, prevalence is stagnating in rural areas and this may forewarn of seriously increased rates.
Coupled with malaria, TB and other childhood diseases that could easily be prevented, young children and pregnant women are the most vulnerable.

In circumstances of chronic poverty, coping strategies that are available often depend on children, and damage them. Unable to access basic needs, subject to excessive and inappropriate labour, and propelled prematurely to adult responsibilities, marriage and indeed parenthood, children in poverty become the source of coping, losing years of their childhood in order to reduce household requirements or supplement incomes. Women too are vulnerable, responsible for providing for the household. They work longer hours in highly competitive and non viable work in order to maintain livelihoods. Women depend on a range of coping strategies based on a combination of reducing expenditure, selling assets and seeking supplementary income through work, borrowing or begging. In each of these instances, children are further affected: reducing expenditure affects diet and access to basic services, selling assets undermines household incomes with the same effects, and seeking supplementary income can either increase dependence on child labour, or leave children to fend for themselves as parents migrate in search of opportunity. Children, especially girl children, experience poverty in ways that reinforce their circumstances, limit their expectations and entrap them in intergenerational deprivation.

The structure of society may be changing as a result of long term chronic poverty, and increasing numbers of highly vulnerable households such as female, elderly and child headed, are emerging. These households are the most vulnerable, are stigmatised and yet they are critical to the survival of many children. There is evidence that prolonged poverty and repeated shocks may have stressed the traditional moral order in families and communities. Children and women are subjected to levels of physical, psychological and sexual violence that far exceed any traditionally acceptable practices but have little access to protection. As violence against children and women increases, it is more likely to become “normal” and as such accepted. The physical and psychological consequences of socially accepted violence undermine prospects for equitable participation, and could result in the loss of much of the possible value and sustainability of development effort.

There are several sources of strength and hope that will require building upon if change is to happen. Urban women are able to articulate their experiences; they are better able to negotiate for change; they are leading lives independent of social norms and practices that discriminate against them; and urban based girls remain in school longer. In many rural communities, women are involved in providing collective mutual support systems. Women are keen to help themselves, and where services and support are provided they are able to participate in development and have their voice heard. The changing family support system from the extended family to variations that play a critical role in supporting children needs to be recognised and itself supported. The next section reviews some of the issues related to the support framework available to vulnerable households.
3  Context of support to children and women

The preceding section discussed who the vulnerable are, where they are, the vulnerabilities children and women are facing – ill health, food insecurity, failure of livelihoods, and the social context in which the vulnerable reside. The outcomes of these vulnerabilities and how children and women have been affected were also discussed.

Service delivery, protective mechanisms and policy are all critical to addressing the cycle of deprivation identified in Section 2. This section analyses the context of support available to children and women that addresses their vulnerabilities and the negative outcomes. This section will assess how successful service delivery, protective mechanisms and the policy framework are in addressing poverty, changing attitudes, addressing vulnerabilities, and changing negative outcomes.

3.1  Service delivery

Prospects for child survival and development are significantly impacted by access to services. The distribution of resources, access to and availability of essential public services has a profound effect on the poor. Access to service delivery is determined by availability and distance to service centres and information; the poverty, food security, health, education, gender and social status of the household; the costs of the services offered; the costs involved in transport and time; availability of infrastructure and equipment; and the quality, completeness and consistency of the services.

The cost of accessing service delivery remains the main reason why the poor do not access services, especially in urban areas. The poor are least able meet the costs of health, most likely to drop out of school, and pay more or proportionally more for services than the better off (for example, the charge for water is up to five times greater from a public tap than from a private household water connection). However, reducing cost does not necessarily solve the problem; availability of services may be negatively affected by revenue losses, or other costs may create barriers. These may include the time and transport to reach services that are far away,
3. Context of support to children and women

3.1 Education

The CRC establishes that children have a right to free, compulsory basic education. The realisation of this right does not only entail being registered at a school, but far more – all children must attend, learn, and progress through a complete course of education, in a safe environment that offers equitable opportunities to boys and girls, rich and poor, in urban and rural areas, and meets the needs of the 10 to 15% of children with special physical or learning requirement.

The National Policy on Education was developed in 1996, and has since been put into practice through a series of implementation frameworks. By far the most significant measure in this period has been the introduction of the free basic education policy of 2002. Since that time, enrolment of children at primary school has increased by an average of 9% annually and net attendance has improved from 57% in 2004 to 76% in 2006 at primary level and 18% to 37% at secondary level.

Government schools have been unable to absorb all these additional pupils. Community schools, set up by churches and other faith-based organisations (FBOs), communities, NGOs and individuals, have provided education for many pupils unable to access Government schools. In 2007, there were 495,563 children in grades 1 to 9 in community schools, out of a total of 3.2 million in this range.77
These schools range from externally resourced, fully staffed and equipped establishments attached to NGOs or FBOs, to unequipped, unresourced and untrained volunteers, gathering children in a half-built or unsuitable structure. Community schools often replace the standard seven year primary curriculum with an abbreviated four year programme, aiming to provide an accelerated route to a full primary curriculum. Recognising the inconsistencies and risks posed by the mushrooming of unregulated and unsupervised community schools, in 2007 Government took responsibility for registering community schools, training unqualified teachers and directing a basic level of funding to support operations.

The removal of user fees for primary aged children in 2002 has helped to reduce the cost of education, and has made a significant impact on enrolment rates. Nonetheless, there are still significant constraints to attendance besides the cost of fees, identified in figure 17. These factors, together with the consequences of vulnerability discussed in section 2, reduce timely, consistent and full access to basic education. Urban children and those from less poor households and communities are all more likely to enrol at the correct age, and to remain in and progress through school. Attendance rates for children in rural areas are 9% lower than for children in urban areas.\(^78\)

For children living in rural areas, the distance to school may create a significant barrier to timely entry to grade 1, hamper attendance in the rainy season, or even deter enrolment altogether. This is cited as the main reason for over a quarter of Zambian children who do not go to school.\(^79\) In contrast, in urban areas, people live close to schools but the demand for places may outstrip supply – there are not enough classrooms. There is currently a shortfall of 22,000 classrooms and much of the education infrastructure requires rehabilitation. In rural areas, where teachers will not remain unless

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Family, Community, Culture and Society Report (comment by teacher in Western Province)

“There is no food at their homes, and no money for uniforms. Children want to belong. Other children see them and laugh, because they look poor.”

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Figure 18: Poverty and School Attendance

![Figure 18: Poverty and School Attendance](image-url)
provided with decent housing, over 6,000 staff houses are required. While an ambitious infrastructure programme has been launched, the challenges posed by rising school populations and the consequences of inadequate maintenance remain significant.

Poor children, children living in rural areas, girls and orphans all drop out of school more readily than others. These disparities are manifested throughout the educational cycle, with disadvantaged children more likely to enrol late, show worse rates of attendance and progression, and drop out sooner. Children drop out of school to work either at home or outside, and to take care of the sick or siblings. Gender is also significant; in almost all circumstances, boys are more likely to realise their right to education than girls. Girls from extremely poor households are less likely to attend school, they start later, and girls are still dropping out in greater numbers than boys, especially at secondary levels. Stigma, poverty and hunger have been widely reported as reasons why children do not attend school. Many children whose mothers die will inevitably leave school, and most children living with their grandmothers do not go to school. Most disabled children also do not go to school.

For rural girls there is also a strong likelihood of pregnancy – figure 19 shows that in 2007, nearly 13,000 school girls dropped out of school as a result of pregnancy. While this may be explained through rising attendance levels, the incidence of pregnancy among school girls is a matter of great concern. Although it appears that rates of pregnancy among urban school girls is falling – perhaps the result of lifeskills education – rates remain high in rural areas.

Some parents engaged in livelihoods that require seasonal migration have attempted to keep their daughters in school, but leaving girls unsupervised at home or in lodgings resulted in increasing teenage pregnancies. In Mumbwa for example, there were 461 pregnancies among the pupils of 28 schools in a two year period (2007-2008). Other gender related pressures that impact on children leaving school are the threat of sexual abuse by teachers, discussed in Section 2, and inadequate sanitation, with girls complaining of inadequate privacy and facilities to deal with menstruation at the school. Although the re-admission policy exists for girls to resume their education after delivery, where pregnancy is the result of a teacher’s abuse it is highly unlikely that this option will be chosen.

Enrolling does not guarantee attendance and likewise attendance does not guarantee educational outcomes. There remains concern over the quality of education offered in schools, and in levels of educational

### Table: Pregnanacies, Grades 1 -12, Urban/Rural, 2004 - 2007

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Grades 1-9</td>
<td>1,405</td>
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<td>Grades 10-12</td>
<td>721</td>
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<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grades 1-9</td>
<td>7,706</td>
<td>8,892</td>
<td>9,940</td>
</tr>
<tr>
<td>Grades 10-12</td>
<td>609</td>
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<td>886</td>
</tr>
<tr>
<td>Total</td>
<td>10,441</td>
<td>11,994</td>
<td>12,833</td>
</tr>
</tbody>
</table>

### Figure 19: Pregnanacies, Grades 1 -12, Urban/Rural, 2004 - 2007

### Figure 20: Pupil Teacher Ratio by Province
achievement. The free basic education policy encouraged school enrolment but this has resulted in increasing pupil teacher ratios, especially in remote peripheral areas. Fewer teachers are trained and teacher deployment tends to be regressive. Schools with pupils from high income parents have the most experienced teachers and significantly lower pupil teacher ratios. There are significantly more teachers in urban areas, with wholly inadequate provision in many remote rural schools. Figure 20 shows that teachers in Northern Province teach classes that have nearly double the number of pupils that those in Lusaka.

When present, teachers are required to provide each class with just 3.5 hours of instruction daily; in urban areas this often falls to just 2.5 hours, and classroom time is often shared between teaching and preparing other lessons. However, even where deployed, teachers are not always present. Teachers in remote schools may take several days a month travelling to the district centre to collect wages, resulting in severe disruption where there are only one or two teachers. Others are absent as a result of illness, low morale or in the pursuit of alternative income sources.82

Completion and repetition rates indicate efficiency and performance in the education sector. Completion rates have improved since 2000, but girls still lag behind boys, and children living in rural areas lag behind their urban counterparts. Rural girls have a 65% completion rate whereas their urban sisters boast a 96% completion rate. Learning achievements are improving but are still below the minimum accepted level and long way below the desirable level. According to the 2006 National Assessment, only 35.2% of grade 5 pupils showed mastery in the nationally defined learning competencies in English and 39.0% in mathematics.83 Rural provinces have generally lower learning achievement levels than urban provinces.

Figure 21 shows increasing expenditure on education as a percentage of GDP since 2000. The increase is to enable the sector to reach its targets of increased recruitment of teachers, procurement of educational materials and construction of classrooms and teachers’ houses. The education sector is also characterised by high levels of external funding (21%).

The secondary and high school sectors cover Grades 8 to 9 and 10 to 12, respectively. These two sectors face many challenges ranging from inadequate supply to perceived low levels of education outcomes. While participation rates have been low since Independence, the outcomes of high school education in the earlier years were resoundingly effective. Secondary and high schools were able to provide an adequate base of skilled and semi skilled personnel for national industries, the private sector and civil service, and schools and colleges. However, investments in high school education were affected by the changing economic fortunes of the
country. Following economic collapse of the late 1970s, investment in secondary education fell. Since 1991, while resource allocation to high schools remained largely stagnant, the number of secondary level classes rose as primary schools converted into basic schools, adding grades 8 and 9, with some basic schools upgraded into high schools. In 2007, there were 3.2 million pupils enrolled in 8,013 basic schools (Grades 1 to 9), and just 219,000 pupils in 583 secondary schools. Luapula Province has the lowest proportion (5.5%) of children in high school nationally, while Copperbelt Province has the highest at 26.6%.84

The upgrading of primary schools (grades 1-7) to basic schools (grades 1-9) and some to high schools (grade 10-12) has challenges around infrastructure, falling standards and quality of education. There has been little investment in infrastructure, and many high schools are dilapidated. Most schools offering grades 8 and 9 have no science laboratories or libraries to support adequate learning,85 undermining attainment. These deficits in both science and arts are evident even in terms of the readiness of students entering into the universities and colleges. In the long run, the poor quality of secondary education and its effects on tertiary performance poses a threat to national development.

It has been suggested that the high school curriculum is narrowly academic, omitting practical and vocational subjects that may prepare learners for later life.86 Previous inclusion of industrial arts, science and similar subjects in the secondary curriculum has fallen away as most high schools lack workshops and laboratories. A forthcoming review is expected to revisit these areas of learning, and identify appropriate means of reintroducing them.

3.1.2 Water and sanitation

Child survival and development significantly depend on access to clean water and adequate sanitation – these are critical to the well-being and health of children and women. Diarrhoea, often resulting from poor water supply, sanitation and hygiene, is a leading cause of child mortality and the immediate cause of nearly 20% of child deaths. Further, diarrhoea contributes to the malnutrition and physical weakness that greatly increases susceptibility to other causes of death.87

Poor access to water creates a significant labour demand on women and children who are principally responsible for water collection, requiring them to walk long distances in some rural areas or spend a significant amount of time queuing in urban areas. For women who are disabled, ill or caring for ill people, this is particularly demanding. Women are usually responsible for looking after children suffering diarrhoeal diseases that result from poor water access, while poor sanitation discourages girls from attending school.

In 2006, 58% of households had access to safe drinking water, 43% in rural areas and 88% in urban locations.88 Only 13% of rural residents have access to adequate sanitation.89 In urban areas, access to safe water rises to 88%, but there is concern over issues of quality and overcrowding. Only 40% of small scale rural households, which consist predominantly of women, were accessing safe water.
The National Water Policy of 1994 – a progressive policy currently being updated – seeks to provide sustainable access to water ‘facilitating equitable provision of adequate quantity and quality of water for all competing users at acceptable costs, and ensuring the security of supply under varying conditions’.\textsuperscript{90}

The means by which access to water and sanitation is measured does not take into account waiting time, seasonal interruption in supply, water quality and the functionality of equipment. National Water Supply and Sanitation Council (NWASCO), the regulator of commercial water utilities in urban areas, has developed performance standards that reflect all these issues for urban and peri-urban water supply companies, but these have not all been extended into rural areas or utilised in national statistics. Similarly, adequate sanitation is defined as access to a flush toilet or ventilated improved pit latrine only (regardless of the number of people sharing), and does not recognise the possibility of an adequate pit latrine – in practice, the most feasible strategy for improving sanitation in rural areas - nor does it take into account poor sewerage systems. For both water and sanitation, regular assessment of access and quality is limited to formal and legal settlements, hence excluding some of the least well served urban areas.

Notwithstanding the shortcomings in national data, access to clean water in rural areas has shown little overall improvement in the past 10 years. Eastern and Luapula Provinces have experienced some deterioration, while figure 22 shows that Luapula remains the worst with just over 10% of the population accessing safe water. On one hand, poor access to water has little to do with absolute lack of water: a district-level analysis shows the poorest levels of access are largely clustered in the remote districts in the north, where rainfall is high and arguably safe water can most certainly be sourced. On the other hand, these areas have had low levels of social investment, and the high levels of chronic malnutrition and poverty that prevail are closely related to access to safe water. In the much drier districts of the south, where transitory food insecurity resulting from drought occurs, access to safe water has been improved in recent years as a result of targeted investments, led by the Disaster Management and Mitigation Unit (DMMU).

Efforts to improve water and sanitation in rural areas are guided by the National Rural Water Supply and Sanitation Programme (NRWSSP). The Local Authorities are responsible for rural water and sanitation and are expected to use the water, sanitation and hygiene education (WASHE) approach as the basis for participation at the community, area, district, provincial and national levels. At village level, the WASHE committee is intended to encourage community leadership and ownership in improving water supplies. The procedures for accessing a water project are demand-led, requiring the committee to be established and apply for improvements. Although the WASHE approach has demonstrable merit, challenges remain in ensuring that the poorest and most remote communities are aware of the requirements and able to respond to them. Recent work on the “community led total sanitation” approach, which mobilises local commitment to the elimination of poor sanitary practices, is showing good results. Further, in view of the significance of access to water to the well-being of women, the requirement that community committees have at least

<table>
<thead>
<tr>
<th>Province</th>
<th>Central</th>
<th>C/belt</th>
<th>East</th>
<th>Luapula</th>
<th>Lusaka</th>
<th>North</th>
<th>N-West</th>
<th>South</th>
<th>West</th>
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<tbody>
<tr>
<td>Water</td>
<td>43.8</td>
<td>70.9</td>
<td>43.6</td>
<td>18.8</td>
<td>91.0</td>
<td>21.0</td>
<td>31.6</td>
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<tr>
<td>Sanitation</td>
<td>10.9</td>
<td>47.0</td>
<td>2.6</td>
<td>2.3</td>
<td>25.8</td>
<td>3.7</td>
<td>2.9</td>
<td>13.4</td>
<td>3.3</td>
</tr>
</tbody>
</table>
30% women members seems to act as a limit to their participation. Previous experiences demonstrate that the creation of women’s active leadership strengthens the role and participation of women in development projects and improves likelihood of success and sustainability.91

In urban areas, access to water is much higher, but over-crowding, costs, intermittent availability, long waiting time and poor water quality are constraints. For many, water is available for only a few hours a day, a situation made worse by on-going electricity shortages. National urban coverage in 2006/07 was 68% of the urban population, ranging between 92% to 40%.92 There is a need to reach an additional 3 million urban people to meet the Millennium Development Goals (MDGs).93 Further, while 37% of urban households use water-borne toilets, the fact that many households share a single toilet means that even these pose significant health threats. Just 10-15% of households are connected to sewerage systems, which are in any case over-loaded and not sufficient for safe treatment of sewerage. All other sanitation goes directly into pits of varying quality, often close to open wells, which is believed to contribute to seasonal outbreaks of cholera and dysentery in overcrowded residential areas. In qualitative research, urban women in under-served compounds expressed grave concerns about access to water and sanitation, expressing constant fear of water-borne diseases and related environmental health issues arising from poor sewerage, drainage and garbage collection.

Reducing the incidence of diarrhoea and water-borne diseases is not only about improving access to clean water. Indeed, access to clean water is no guarantee of good hygiene. Figure 23 shows that significant improvements in cases of diarrhoea can be achieved through improving sanitation facilities, home-based water treatment and hand-washing with soap. In fact, hand-washing with soap – the cheapest and most accessible strategy – is show to be the most effective means of reducing the incidence of diarrhoea.94

Efforts to improve urban and peri-urban water supply have been focused on the provision of water through Commercial Utilities (CUs), of which 10 now exist. The CUs have brought improvements in urban water supply, but there are still significant barriers to access facing people in the poorest residential areas, those without cash to pay for water, and those with special needs including the elderly, disabled, and those requiring home-based care. Clean water costs more for the poor than for the rich; NWASCO approves CU water charges, which are currently five times more per cubic metre at public taps than for private household connections. There has been little progress on cost-waiver schemes. Furthermore, the focus of Government and cooperating partner efforts, NWASCO and the CUs has been on water, rather overlooking the very serious problem of sanitation.

Public spending on water and sanitation has been low, but increases are planned. A comprehensive sector support fund has been established by Government and cooperating partners (led by SIDA and JICA) to finance peri-urban water supply projects. However, there is as yet no overarching plan and budget for improving urban water and sanitation,
and on-going activities fall far short of what would be required to meet basic needs. Current commitments to rural water supply cover the majority of rural districts, although the scale of available resources is still less than half of what was budgeted in the NRWSSP. Further, investment in the water sector is heavily donor-dependent, with just 8% of expenditure in the sector coming from the Government budget.

Under the Government’s decentralisation policy, local authorities are given the mandate for water and sanitation provision. Perhaps the biggest challenge to the sector, therefore, is the limited capacity of district councils, especially with respect to financial management and technical expertise. There is a critical need to address this if access to water and sanitation is to be increased in line with national targets.

Child survival and development is critically undermined by the lack of safe water and sanitation, and women and girls expend much time and energy accessing water and coping with the consequences of poor supplies. Addressing this problem requires immediate attention to the special needs of the disabled, sick, elderly, and poorest, as well as an increase in resources and enhanced Government leadership to improve access to services in rural and urban areas.

### 3.1.3 Health

The first and most basic right of children is the right to life. Poor women and children are the most exposed to high health risks. In Zambia, an unacceptable number of children die. About 20% of children born in Zambia do not live past their fifth birthday, while 10% of children die before they reach their first birthday. Close to 1% of the women who are pregnant in any given year will die in child birth, with a life time risk that 1 in 16 of all women will die resulting from maternal health problems. Adult mortality is also high. The leading causes of death in Zambia is AIDS (1,236/100,000), respiratory infections in children, malaria, diarrhoeal diseases and TB. While both under-5 and infant mortality rates have fallen in recent years, estimates suggest that Zambia ranks 176th out of 189 countries in the world reporting figures on infant and child mortality.

The majority of childhood deaths are due to a small number of common, preventable and treatable conditions, which include infections, malnutrition, neonatal conditions, respiratory infections and pneumonia, occurring singly or in combination. Malaria is a major cause of maternal anaemia and subsequent low birth weight plus neonatal deaths. Many young infants die at home without ever being seen by a health provider, while the poor management of these conditions among other young children create an unnecessarily high mortality rate.

AIDS and TB are among the significant underlying causes of childhood death. Largely understood as epidemics among adults, transmission from adults to infants and children has nonetheless undermined health and led to many deaths. Despite this, health systems, treatment protocols,
health provider capacities and even data collection remain largely focused on adults. Moves to extend the continuum of prevention of mother to child transmission (PMTCT) services to the testing and treatment of infected children represent a move towards a greater inclusion of children’s health needs, and with the rate of expansion of health service delivery around HIV prevention and treatment, further progress can be expected.

The poor status of maternal health is a significant driver of child and infant mortality. Although reportedly falling, maternal death rates remain very high – still some four to five times greater than might be expected with existing levels of services. The immediate causes of maternal mortality are the lack of access or uptake of maternal health services (antenatal and delivery care), poor nutrition and malaria. Haemorrhage, sepsis, obstructed labour, eclampsia and obstructed labour account for some 50% of maternal deaths. Risk of maternal death among teenage mothers is particularly high, who are twice as likely to die during childbirth as women aged 20 and above (rising to five times among girls aged 14 and below). Furthermore, some 13% of all maternal deaths result from unsafe abortions among teenage girls.

Access and utilisation of quality maternal, newborn and child health services and supervision by a trained health professional are essential in reducing the risk of complications and infections during delivery and is a critical factor in addressing maternal and neonatal morbidity and mortality. Infant, under-5 and maternal mortality are all highest in poor, remote rural areas. Service delivery, immunisation coverage are also the worst for the remote rural districts. The poor rural women and children have the poorest access to health services. Poor individuals are less likely to consult health professionals or even a traditional healer or take medication when sick or injured, compared with wealthier individuals.

The gradual removal of user fees has resulted in improved access to health care, but the costs of transport and prescription drugs remain a barrier to health services for the majority of the very poor. The costs of health care fall disproportionably on the poor, as poorest spend 1/5th of their total expenditure on health, four times greater than the wealthiest, and obtain less adequate services. Long distances to the nearest facility and/or non-availability of public transport also appear to be significant barriers to utilisation and access.

Figure 25 summarises common problems around the availability of health staff, distance to health facilities, and costs that impact on many Zambian women. However, where local efforts are made to address these problems, marked improvements have been seen. Most notable are the efforts of faith-based rural hospitals and targeted interventions in North-Western Province: there are 15 rural districts that achieve levels of supervised delivery on a par with the 5 best-performing urban districts, and in each case these results are attributable to specific service providers.

The quality of services is partly determined by staff – numbers, qualifications and experience. Government recognises that staffing levels in the health sector are low: the number of available staff in 2005 was less than 50% of the recommended establishment, in spite of recent growth in per capita expenditure on health care since 2000. Concerted efforts have been made to develop a long-term strategy to train and retain health service staff.

Resource allocations to the health sector are not based on
deprivation and health status, and urban centres receive nearly twice that of rural provinces. The poorest, most remote and least urbanised districts and provinces receive the lowest per capita allocation, restricting health outcomes for children and women living in rural areas. Figure 26 compares the per capita expenditure between rural and urban provinces and shows the marked urban bias in staffing levels.

One response to constraints in access to medical staff has been to build skills and increase the participation of community members in preventing, identifying and managing common illnesses, including malaria. A good example of this is the community case management of

The personnel crisis in the health sector means that many women outside Lusaka and the Copperbelt are reluctant to expend the effort and resources necessary to reach health centres. In 2005, just 23% of health facilities could offer appropriately qualified staff to conduct deliveries. Where complications arise, emergency obstetric services were largely not available, with just 8% of needs met. Further, many women are reluctant to consult male health staff on maternal or gynaecological health matters.

In rural areas, many women live far from health centres and cannot reach there once labour has started. Only a third of women have their babies in a clinic. Traditional birth attendants may refer women showing danger signs during pregnancy, but even so they may lack the means to stay close to the health centre for as long as may be required. Where mothers’ shelters are available, maternal and infant health outcomes rapidly improve. Elsewhere, women in labour with severe complications regularly arrive at distant heath centres on bicycles, ox carts or dug-out canoes.

In urban areas, a high proportion of deliveries take place in health facilities (83%). However, those that take place at home and with unqualified attendants are much more likely to involve poor mothers; only 3% of maternal deaths occur in middle and higher income groups. The cause of this may be the deterrent effects of cost – transport for mother and family members, food and other needs for the period of admission, gloves and other required medical supplies – as well as reduced access to adequate nutrition and other threats to general health.

Maternal mortality rates vary significantly by age. Teenage mothers, particularly younger teenagers, experience mortality rates some two to three times greater than older mothers.
pneumonia. Community health workers and others are trained to reduce the incidence of pneumonia (through promoting exclusive breastfeeding, providing zinc supplementation and reducing indoor air pollution), treat cases of respiratory infection with simple antibiotics, and recognise and refer children showing signs of more dangerous infections. While there are no country level results on the effectiveness of community management of pneumonia as yet from Zambia, results from similar initiatives in nine countries show a significant reduced overall mortality in children 0–4 years by 24% and pneumonia-specific mortality in children 0–4 years by 36%. While these results are promising, however, it is important that community services are seen as an additional and empowering supplement to facility-based services – which need to be strengthened – rather than a substitute.

Responses to HIV in the health sector have accelerated significantly in the past four years, and nearly two-thirds of those who need drug treatment are now accessing ART. Over 20,000 enrol for PMTCT and ART per quarter and - despite deficits in health service staffing, infrastructure, supplies and equipment - are expected to continue to do so. Women and children’s access to ART has increased as a third of women attending PMTCT now access ART. ART and PMTCT services have been scaled up at an impressive rate, and are expected to achieve universal access by 2010. Home Based Care programmes have also increased significantly, with clients accessing care through the Ministry of Health (MoH), NGOs, FBOs and other community based programmes.

Challenges remain in providing equitable, universal access to treatment. People may be unable to meet the transport costs to reach centres for their monthly check up and replenishment of antiretroviral drugs. PLWHA face long waiting times and many do not go regularly for CD4 count. Recent rises in food prices are likely to increase these challenges, as household budgets are stretched and access to a good diet becomes harder.

The concentration of ART sites and clients is highest in Lusaka (figure 28) as a result of the numerous private sector actors and international NGO support, with fewer sites and clients in rural provinces. Where service provision is more extensive, health workers and clients report competition for human resources and infrastructure between HIV and other health care services. In urban centres, where there are diverse externally funded HIV and AIDS programmes, provincial and district managers note that health staff can be overwhelmed by conflicting demands and assignments. The resources available to HIV and AIDS programmes are in the region of US$257m per year. Maintaining a growing number of people on life-long ART is expensive and the sector is highly dependent on external resources.
resources (93%), which would be hard to sustain from national resources without a significant impact on other areas of essential spending. Long term agreements with external partners are needed to provide assurances for fiscal planning, security for patients and equitable access.

Prevention should remain the focus and efforts to reduce new infections need to be supported outside the health sector. While health-based messages have created a reasonable level of knowledge about the epidemic, the young girls and women and those who are most vulnerable to the epidemic need also to have the power and skills to utilise their knowledge. Without addressing the social and gender imbalances that govern sexual behaviour and drive the HIV epidemic, it is scarcely reasonable to expect a significant reversal in HIV prevalence.

There are probably about 10,000 TB cases in Zambia undetected and untreated. Where TB is treated, the predominantly rural provinces (Western, Eastern, Northern, Luapula and North-western) have the lowest TB cure rates, while Lusaka has the highest (93%). There are very few specifically trained TB staff and services are provided as part of the primary health care system. There are a small number of people who are resistant and require hard-to-get and expensive second line drugs. The threat of a highly resistant variant of TB is real and would increase TB related morbidity.

Zambia has made significant progress in the prevention and control of malaria in the last six years, through the Roll Back Malaria partnership. An estimated $120m has been invested from Government and partners in staff training, insecticide-treated nets and indoor residual spraying, with each component including public outreach and awareness. Health workers have been trained in accurate diagnosis and treatment of malaria. Some 3.6 million long-lasting insecticide-treated nets were distributed between 2006 and 2008, and indoor residual spraying was expanded to 34 districts by 2008. These activities have had substantial results: in the two years
to 2008, reported malaria deaths declined by 47%, parasite prevalence declined 53%, and the percentage of children with severe anaemia declined 68%. The combined impact of these interventions is estimated to have reduced mortality related to malaria by some 66%, largely among children. However, further improvements are necessary and achievable; more nets are needed, and spraying could be extended. Of particular concern is the reported frequency of essential drug stock-outs, which suggest a very high risk of drug shortages in remote rural areas – the very places where infection and mortality rates are highest.

Immunisation is the most basic of preventive services to improve child health and survival. Overall coverage of full immunisation remains below target levels, and the proportion of children receiving all immunisations within the first year of life has not improved as anticipated over the past decade. A high proportion of children who do not fully immunised live in remote rural areas; of the sixteen districts that have full immunisation rates below 60%, all but one are in very remote rural areas. In these districts, the delivery of services is constrained, particularly with regard to cold chain maintenance, transport and other logistics. Staff availability is poor at the facility level (especially in remote rural health centres) and so are the requisite skills for programme management and service provision. Notwithstanding these challenges, however, this geographical concentration of service failures mean that targeted and intensive programmes to improve performance have had significant rates of success.

Twice-yearly child health weeks have been critical in supporting child health outcomes. The weeks provide intensive coverage of immunisation, vitamin A supplementation, deworming, malaria control, growth monitoring, child health checks, bed net distribution and treatment and health education. The purpose of child health weeks is not to replace regular services, but to provide a focus for ensuring that outreach is comprehensive, including those who are often un-reached, and increasing knowledge on key child health issues among parents and caregivers. Results show widespread coverage is regularly achieved, and suggest that health weeks have been significant in eradicating polio and achieving a substantial drop in measles and tetanus.

The success of integrated health responses, such as the child health weeks, needs to be built on, towards the creation of universal routine access to facility and community based health services that meet the preventive and curative needs of people throughout Zambia. In order to achieve this, comprehensive support to basic health services is needed from Government and its cooperating partners. This support should broaden the achievements seen in well funded but narrowly defined or disease-based interventions (such as those around HIV) to meet the integrated health needs of a population whose development is fundamentally compromised by chronic, concurrent or repeated experiences of ill-health.
3.2 Social protection

Experience tells us that highly vulnerable children and their families require consistent, systematic and holistic support. This includes food, shelter, ensure access to education and health services, paralegal services, psychosocial counselling and income generating activities. Without this, the insecurity and shocks experienced by the poor are themselves incompatible with sustained and inclusive national development. This recognition is inherent in the foundation of modern economics, and identified in the Universal Declaration of Human Rights, which identifies ‘the right to social protection in times of need’.

More recently, the need for comprehensive social protection has attracted greater levels of attention, particularly in developing countries. In Zambia, the FNDP included a chapter on social protection, defining it as ‘policies and practices that protect and promote the livelihoods and welfare of people suffering from critical levels of deprivation, and/or vulnerable to risks and shocks’. This definition usefully provides a framework for all efforts to specifically target the poor and vulnerable people, embracing both long standing and new strategies for reducing poverty and promoting inclusive social and economic development.

There are several social protection schemes managed by government, NGOs, FBOs and local community groups. As many of these are limited in terms of resources and coverage, it is difficult to estimate the extent of access to such support. The main social protection programmes offered to the poor and destitute by Government are the Public Welfare Assistance Scheme (PWAS), the pilot Social Cash Transfer Schemes, the Food Security Pack programme (FSP) and Assistance to Basic Education programme. While all of these programmes could be said to exclude potential clients as a result of constraints in funding, new initiatives by Government and cooperating partners are in hand to expand social transfer programming, using a range of modalities to reflect the needs of different populations.

Currently, less than 0.2% of GDP or less than 1% of public expenditure is spent on social protection. Figure 31 shows increasing projected allocations to health, education and water and sanitation, whilst
figure 32 shows that allocations to social protection have fallen. Although regionally and internationally, social protection is rapidly becoming accepted as an integral and essential component of the basic social services that underpin economic development, in Zambia fears that such expenditures are expensive, consumption oriented, and peripheral to achieving growth objectives persist.

Many social protection programmes target specific groups such as street children, and orphans and vulnerable children (OVC); while many of those included are legitimate clients for social protection, there are many others who fall outside these programmes. For example, the entry point for the Ministry of Education bursary scheme is the school and as education attendance is not compulsory, the system is likely to exclude children who do not attend school. Similarly, school feeding programmes do not address malnutrition for those children not attending school. Nearly a quarter of children enrolled in primary school are single or double orphans, but only 2% receive a bursary. With low levels of coverage, there is little hope of equity of access or eligibility. Likewise, more boys benefited from education support under PWAS than girls, and 70% of the total support to education is for secondary education.

The qualitative assessment reports that the most vulnerable women, the elderly and disabled, are not included in the women’s group activities supported by social protection programmes because they are considered not physically able, they are unable to meet conditions of entry, or they are not included in mainstream development of the community. Resources for community based women’s programmes have been moved from MCDSS to the Citizens Economic Empowerment Commission; the lack of presence of the Commission at district or sub-district level may reduce access to resources for poor rural women.

Support to food security programmes usually depends on modalities initiated after an emergency situation. Government and donors support lasts as long as the “crisis”, but as noted elsewhere the problem of food security in Zambia is chronic and needs a long term strategy. Figure 4 suggests that chronic food insecurity is driven by seasonal issues, and in particular by the coincidence of low household food supplies and high disease burden through the labour intensive farming season. Nonetheless, programmes that intend to address chronic food insecurity suffer from poor and erratic funding. The FSP aims to reach 200,000 chronically vulnerable but viable households, including female and elderly headed households, but resource constraints mean that just a fraction of these households have been reached.

There have been a number of programmes aimed at addressing the problem of street children, ranging from institutional care, skills training and feeding programmes. While an estimated 500 children have been reintegrated into families, little has been achieved in terms of addressing the very significant and widespread factors that continue to drive children on to the streets. The Zambian Agency for Persons with Disabilities is responsible for provision of services to the disabled but is unable to achieve its objectives as key staff positions are not filled, its budget is spent on administration matters and only those disabled persons who have the transport and knowledge to come to the office are assisted.

The Department of Social Welfare is seriously understaffed and recent efforts to recruit staff were not fully successful. Poor office facilities, accommodation and physical assets as

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4 The ZK15bn budgeted for 2006–2007 for the FSP was less than 10% of the funding required to meet the target group. Only 20,000 farmers were reached in 2006 reducing to 9,000 in 2007/2008 season, an average of 80 households from one – two agricultural camps per district.
well as inadequate operational funds continue to erode the image of the Ministry of Community Development and Social Services (MCDSS), the social protection agenda and motivation of those working in the sector.

### 3.3 Management and coordination of service delivery

The vulnerabilities and outcomes resulting from these vulnerabilities for children and women are multi dimensional, cutting across all sectors. Because successes and failures in one sector impacts and threatens successes and failures in other sectors, there is a need to provide a holistic coordinated approach to address the poor outcomes identified in Section 2. This section reviews the management and coordination of sectors at national and local levels. It also comments on possibilities to improve inter sector coordination so that a more integrated holistic approach to children and women can be realised.

Coordination within sectors at the national level has improved as a result of the Paris Declaration and the planning processes of the Poverty Reduction Strategy Paper (PRSP) and subsequently the FNDP. Sector Advisory Groups (SAGs) and Task Forces were formed which improved effective partnerships, increased sharing of resources and responsibilities, and enhanced agency buy in. Specific sector themes committees plan and implement targeted interventions. The Vulnerability Assessment Committee (VAC), led by the DMMU was set up to monitor transitory food security, crop production, food access and availability and use of coping strategies, usually in an emergency situation. A Food Security Task Force, led by Ministry of Agriculture and Cooperatives, has recently been established to develop, implement and monitor a long term strategy for chronic food insecurity.

The sector wide approach (SWAp), direct budget support and pool mechanisms of donor funding have resulted in improved coordination at the national level. Cooperating partners share a commitment to sector visions, national policy and Sector Investment Plans. Donor coordination and harmonisation has also improved as a result of the Joint Assistance Strategy for Zambia (JASZ) which has established partnerships and aligned donor support to government priorities, harmonised processes and improved the management of resources.

While coordination has improved as a result of the various mechanisms established under the FNDP, mechanisms to coordinate between the sectors are weak. The National Development Coordinating Committee (NDCC) is supposed to be the national committee which would coordinate sectors but has never met. A national SAG conference takes place on an annual basis which
could provide a forum for cross sector coordination but does not yet do so. Cross SAG coordination and horizontal linkages are poor and sets the scene for absence of coordination at all levels of administration, planning and implementation. Efforts to improve coordination around children’s development have been generally ineffective: a national orphans and vulnerable children steering committee has been notionally in place for some years but rarely meets, while commitment and consensus around the role of a proposed children’s council is limited. Coordination of food security programmes and other long term social protection strategies is necessary to develop the mix of broad based response to food security that takes into account transitory and chronic food insecurity. Targeted interventions and formation of intervention-specific task forces, have tended to fragment some sectors into a series of interventions planned and implemented in vertical “silos” with little coordination with other programmes within the sector.

There are several district and sub district level committees, where most sectors are coordinated by their sector specific district, sub district and community level committees. Decentralisation established national, provincial and district level coordinating committees which were designed to institutionalise a framework for planning, coordinating, implementing and monitoring development in a multi sector approach. With the slow implementation of decentralisation, the purpose and effectiveness of these structures has been undermined. Linkages between sector committees are precarious, because the authority of the District Development Coordinating Committee (DDCC) is weakened by the lack of any authority over resources. Better resourced sectors maintain vertical linkages with their headquarters at the expense of horizontal coordination at the district level. Inadequate operational resources in weaker sectors also undermine coordination and organisational capacity and there is little sharing of resources between sectors. Social Welfare Officers from less well resourced districts have to borrow computers or photocopiers, have no transport or budget to travel outside the district centre, and are not able to share accounting capacity.

To address these issues, sector support to the implementation of decentralisation, rather than vertical sector devolution, would improve coordination and collaboration at the district and sub district levels. This process would be supported by improvements in local authority grants, and the devolution of the budget process. While a framework policy on decentralisation exists, however, the necessary commitment and resources to support implementation is lacking. Clear guidelines would clarify the relationship between sector management at district level in relation to the DDCC. Fiscal decentralisation would give the local authority and its DDCC more coordinating and decision making functions and strategic planning would improve harmonisation of an integrated multi sector approach that could address the needs of women and children.

Most sectoral plans place emphasis on the active participation of communities in the development process, many establishing community level committees and volunteers. Demand driven development approaches developed in the 1990s are now the norm rather than the exception. Procedures and processes at the district and community levels are already developed and in use. The planning, implementation and operations and maintenance cycle described for the WASHE strategy, for example, ensures participation at community, area and district levels through the committees at those levels. The appraisal process and its criteria lend an opportunity for improved coordination and avoidance of duplication of effort – a process which could be replicated by other sectors. However, the means of replication need to be considered carefully; a multiplicity of committees might
produce splintered or unprioritised local plans, while excessive demands on a single structure may stretch the capacities of local volunteers.

Through the 1990s, civil society played an increasing role in Zambian development. From the end of the one-party system in 1991, Zambian civil society strengthened in terms of both voice and community based activities. The needs and circumstances of children and women are addressed by churches, community organisations and a range of NGOs forming a vocal women’s lobby. In the context of poverty, strong evidence-based advocacy around children and women originates from FBO and NGO networks. However, more recently the effectiveness of civil society has been affected by access to funds. With the moves in the international community towards budget support and alignment around Government programmes, there is less money and less inclination to fund either community based activities or policy advocacy and lobbying. While resources for community based work addressing issues of HIV and AIDS are relatively easy to access, changes in aid architecture have reduced the scope and diversity of civil society advocacy. Those that remain most vocal are the FBOs with access to funding from their own networks. However, there are many instances where partnership and coordination between Government and civil society has proved effective in reaching development objectives at national and local level, and the importance of ensuring an active civil society sector should not be understated.

Civil society has increasingly become involved in the provision of information through community radio. Community radio provides an effective medium for the promotion of social change. Radio not only increases the flow of information into remote communities, but also presents and sometimes facilitates discussion around social and cultural norms. When local radio succeeds in developing local programmes and inviting community participation, the opportunities to promote social change and give voice to ordinary people are considerable. Radio is a particularly powerful medium for women and children, if a radio and batteries are accessible to them.

3.4 Closing comment: support to children and women

The issue of shortfalls in service delivery can be discussed in terms of sector outcomes. However, outside the scope of sector analysis lies the problem of management and coordination in service delivery, which tends to undermine efficiency, fragmented service delivery and increase costs. This in turn weakens access to a sufficient “basket” of basic services for ordinary people, creating multiple transaction costs and confusion around rights and entitlements.
Section 2 discussed the multi-dimensional nature of vulnerabilities facing children and women in Zambia and noted how these collide and intertwine to reinforce and entrench poverty. Section 2 also noted that rural poverty remains pervasive; the poorest areas are the most remote, while female and elderly headed and small scale farmers (also mostly female) are the poorest people. Remote rural areas suffer the highest levels of chronic malnutrition, especially in the northern parts of the country. Female and elderly headed households are the most food insecure and these households provide care for many vulnerable children.

There is a massive demand for improved infrastructure in the rural areas - a minimum of 22,000 classrooms and 6,500 teachers’ houses are required; 27% of water facilities are in need of repair, 10,000 additional water points are required, along with 3 million latrines; 92% of health facilities fall short of national standards. The capacity of sector ministries to provide such infrastructure is limited. Government should consider making greater use of district and community level capacity. A District Local Development Fund in the context of decentralisation has in the past been demonstrated to be a useful model for supporting the infrastructure development at community level. A multi-sector pooled basket using a single set of modalities, criteria and targeting mechanisms would effectively coordinate infrastructure development below the district level. The benefit would be improved community participation and ownership, especially that of women; increased community management in infrastructure maintenance and management; improved accountability of sector service delivery to clients; and substantial savings.

Shortages of staff in the social sector affect health, education, social protection, community policing and VSU, improvements in water and sanitation and so on. The less qualified and experienced staff are often found in rural areas where needs are greatest, creating further disparities and entrenching poverty and deprivation.

The sector strategies to improve human capacity are laudable but there is a need for a coordinated single approach so that conditions related to rural allowances, rural service before promotion and weighted incentive schemes (the more remote, the more incentives), are the same for each sector. Further, a coordinated arrangement could recognise and therefore encourage rural employees who take on responsibilities across other sectors (such as a teacher who supervises social welfare committees, or a health worker who maintains water points). While there may be merit in having a number of community committees (school, health, WASHE, welfare etc.) rather than overstretching a single entity, greater
coordination across sectors would allow synergies between them. The increased use of existing community based service delivery is also an opportunity to improve access to service delivery. These should be strengthened with more capacity built at district level to develop these approaches, and at the community level. Where appropriate, community level private service providers should also be recognised as actors in strengthening local systems.

The Central Statistics Office implements a range of regular national and thematic surveys, while key ministries have developed information systems. These data sources support planning for service delivery, although challenges remain in generating consistent, reliable and comparable information. Further, increased cross-sectoral data generation and analysis would provide greater insights into the progress made on achieving meaningful improvements in the well-being of children and women. The reinstatement of the Study Fund in the Ministry of Finance and National Planning presents an opportunity to oversee progress in this respect.
Section 2 described the vulnerability context for children and women in Zambia, in terms of livelihood, food security, health, and social contexts. Rural poverty remains pervasive, and women are among the poorest. The social context of vulnerable children and women living in remote and poor households was described, and although they are the principal care givers to the children of Zambia, women are subjected to widespread discrimination. Some of the discrimination is caused by deeply entrenched traditional norms but increasingly by changes to household structures, and gender roles and responsibilities, resulting from chronic and extreme poverty. Violence involving children and women perpetuates the disadvantaged position of women in relation to men and the status of children in relation to adults. Children are working in hazardous conditions, some away from home often at a very young age, and many leave school to supplement the household income. Girls are married off at puberty, often for a price, and become very young mothers, which threatens their lives. Girls who try to stay in school face sexual abuse by their teachers, and children who have lost their parents leave school and face abuse from relatives who take them in to “care” for them. The elderly who play a critical role in caring for children are violently abused and stigmatised.

Section 3 reviewed service delivery to children and women, and its impact on the poor outcomes resulting from poor food security, weak livelihoods, ill health, poor education attainment and social stresses. Access to services is worst in rural and remote parts of Zambia and many children and women do not have access to clean water, education, health or social protection.

This section discusses the protective and policy environment in Zambia. It reviews the measures in place that illustrate the commitment of the Government of Zambia to addressing and realising the economic, social and cultural rights of children and women through the legislative and policy frameworks. It begins by discussing the legislative framework of international conventions, ratification of those conventions by Zambia and the national legislative framework that protects children and women from violence, sexual abuse, child labour, trafficking, neglect and exploitation and discrimination. Issues related to the policy framework provided by the FNDP are discussed in terms of improving the development context for children and women.

4.1 Legislative framework

4.1.1 International conventions

Zambia is a signatory to the United Nations CRC that encompasses the child’s right to survive, to develop and the right to be protected (figure 34). Zambia is also a party to the African Charter on the Rights and Welfare of the Child, the Convention on the Worst Forms of Child Labour (which prohibits the worst forms of child labour – slavery, prostitution,
trafficking of drugs and dangerous work), and the Convention on the Elimination of all Forms of Discrimination against Women.

However, the Zambian constitution requires that the provisions of international conventions be domesticated into national legislation in order to be effected. While there have been some changes in legislation that relate to these conventions, there have not been systematic attempts to fully domesticate the provisions of any of them. One factor that may deter rapid action in this respect are concerns around incorporating rights as judiciable elements of national law. The conventions each create obligations for the State that could have significant financial implications — for example, the right of disabled children to special care implies guarantees that are currently not provided for in national education expenditures. Debate continues around these issues in the context of the on-going constitutional reform process.

4.1.2 National legislative framework and implementation

The Zambian constitution establishes the right to gender equality, and recognises the rights of children to identity, nationality, education and legal protection. The constitution protects persons, including children, from slavery and servitude, torture or inhuman and degrading punishment and guarantees young persons from all forms of exploitation, neglect, trafficking or cruelty. Subject to on-going debate, the constitution currently recognises civil and political rights, but does not guarantee economic, social or cultural rights.

There are several pieces of legislation, backed up the Penal Code, that aim to protect children and women. These are complemented by national policies, discussed below.

The legislation impacting most on children and women are:

- Adoption Act, Cap 54
- Affiliation and Maintenance of Children Act, Cap 54
- Juvenile Act Cap 53
- Employment of Young Persons and Children’s Act, Cap 274
- Will and Administration of Estate Act, Cap 60
- Intestate Succession Act, Cap 59
- Zambian Police (Amendment) Act No.14 of 1999, amends the Zambia Police Act Cap 107
- Births and Deaths Registration Act, Cap 51
- Day Nurseries Act, Cap 313
- Probation of Offenders Act, Cap 93

There are, however, gaps and inconsistencies. The legal framework does not provide a uniform, coherent or consolidated approach to issues affecting children and women. For example, both the constitution and the Employment of Young Persons and Children...
Act protect children from harmful labour and any labour before the age of 15, but are silent on commercial sexual exploitation of children as one of the worst forms of child labour. The constitution does not define the age of a child and definitions of age depend on context specific pieces of legislation. Customary law defines a girl child as one that has not yet reached puberty. Children under 15 are protected from exploitation under the employment laws. A juvenile is one that has not reached 19, a person below 21 requires parental permission to marry under the marriage act but sexual consent is 16. The provisions of the Penal Code establish 8 years as the age of criminal responsibility, which results in the imprisonment of young children with adult offenders.

A Gender-Based Violence bill was first drafted in 2002, based on National Gender Policy (2000), but was returned for redrafting in 2006. The bill promotes measures that address GBV, including improving awareness, coordination and capacity of those involved with different aspects of gender violence, and strengthening women’s participation in law enforcement. The Gender in Development Division (GIDD) in Cabinet Office leads on these issues and in spite of some positive changes in policy, progress remains limited mainly because of inadequate resources, and poor government commitment. A Gender Consultative Forum has been established, and a group of NGOs submitted the ‘365 Day Action Plan to End GBV’ to the GIDD for incorporation in the National Plan.

The Penal Code prohibits virtually all the abuses associated with sexual violence, coercion and discrimination documented in this report. The VSU was established under the Zambia Police Act in 1994 to deal with cases related to property grabbing, spouse battering, and sexual abuse brought before it by female and juvenile victims. VSUs are established in over 300 police stations and posts countrywide, and are accessible to the general public. All cases which are reported to the VSU are prosecuted by specially trained officers. Moreover, VSU has carried out campaigns to make women aware of their rights. Recently, the Zambia Police has also established the Sexual Crimes Unit and the Child Protection Unit to deal with cases related to child abuse.

There have also been good results where local efforts and community support to victims have been made to respond to instances of abuse where children and women are more likely to report cases, will seek help in overcoming the effects of abuse and address the circumstances that rendered them vulnerable in the first place. But law enforcement, however, faces huge challenges. The poor capacity of those responsible for enforcement, limited community, parental and child awareness of their rights and mechanisms of protection, entrenched discriminatory attitude of some police and judiciary bodies, social pressure to withdraw cases and reconcile with abusers and very limited access to legal aid all conspire against access to legal protection. Efforts are needed to strengthen the implementation of statutory law and improve services intended to support victims.

The picture is further complicated by the fact that Zambian law has two parallel legal systems: customary law and statutory law. In general, customary law grants significantly fewer rights to women and girls than statutory law and is principally based on male power, authority, and domination over women. Customary law prevails in cases of traditional...
marriage, pregnancy, inheritance and domestic disputes; indeed where a case falls under the jurisdiction of local courts, customary law prevails unless respondents have previously taken steps to establish their rights under statutory law (drawing up wills, marrying under the provisions of the Marriage Act etc.).

The local courts do not have jurisdiction to try more serious offences. Battery, rape, defilement, and murder of women in domestic incidents are criminal matters which are covered by the Penal Code and should only be heard in the Magistrate’s or High Court. However, some forms of offence (such as defilement of teenage girls) are commonly heard in local courts, with victims and their families receiving some form of compensation for “damages”, rather than the perpetrator receiving a sentence. Where customary law is deemed applicable, statutory law is deemed subordinate. When customary law takes precedence, “the worst victims are women and girls, stemming from the social and cultural factors which degrade [their] position.”

Figure 36 gives two examples where customary and statutory law contradict and how the application of traditional law in local courts does not necessarily protect girls and women from abuse. Most rural women only have access to local courts, because they are less expensive and are accessible in all districts. Referral systems are weak and cases of violence against children and women tend to heard in local courts, reinforcing the idea that abuse of women and girls is an offence against family status rather than a serious criminal offence against the victim herself.

The implementation of customary law is strongly influenced by the views of incumbent traditional leaders. Those who live under a strong and enlightened local leadership may have greater levels of protection, security and rights. However, the nature of traditional leadership is inconsistent.

4.2 Birth registration
The CRC establishes the right of all children to have a name and a nationality (article 7) and for the preservation of their identity (article 8). Both of these rights are realised through the provision of a birth certificate. Equally, birth registration can be seen to provide benefits throughout a child’s life by regulating the administration of juvenile justice, and aiding in the combating of child abuse, child marriage and child trafficking. Birth registration is an intrinsic component of child protection and can implicitly and explicitly be utilised to promote associated rights addressed throughout the CRC. Further, birth registration facilitates the collection of data on the numbers of children. This information can be used to inform strategic decision-making in the development of programmes that promote children’s rights and their progressive realisation. In the
context of HIV and AIDS, for example, birth registration systems allow states to monitor their population, enabling effective policies to be formulated and implemented, protecting and fulfilling the rights of people living with HIV and communities affected by the pandemic.

Birth registration within Zambia is among the lowest in the world, despite being made compulsory within the Births and Deaths Registration Act of 1973. Birth registration statistics have not been submitted to Zambia’s Central Statistics Office (CSO) since 2001 and therefore there is no reliable data on births registered. The most up-to-date Government statistics on birth registration currently put the number of under-5s registered within Zambia at 10%, however, indications from a recent 2008 UNICEF review suggest registration rates in 2002 were 2.3%, 1.7% in 2005 and 1.8% in 2006.

There are underlying reasons for low rates of birth registration within Zambia and these were identified in a recent survey as: a lack of public knowledge or demand for birth registration, together with fears around disclosure of personal information; complex, centralised and under-resourced legislative and administrative procedures for birth registration; and the low priority placed on birth registration by Government.

Notwithstanding this, there is growing recognition at national level of the need for birth registration. With the increasing commitment and leadership attached to the attainment of universal birth registration, as well as international interest in supporting a successful outcome, rapid improvements in performance are possible, and should be encouraged.

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5 These results are based on the projected number of births and actual birth registrations in each province in the stated year. Some of those registered could be adults or older children; the proportions indicated are therefore the maximum possible levels of infant birth registration – actual levels may be lower.
4.3 Mainstreaming policies for children and women

Prior to 1997, it was assumed that sustainable economic growth was the major instrument for addressing poverty; poverty reduction programmes were oriented towards the provision of social infrastructure intended to build the human resource base. However, as the international community argued eradicating extreme poverty required broad-based social, economic and structural change, MCDSS was designated as lead for poverty reduction, and a poverty reduction framework was adopted by Cabinet in 1998. This plan was poorly developed, and the decision to allocate institutional responsibility for ‘poverty’ in the social welfare ministry further undermined prospects for implementation.

Although the 1998 poverty reduction framework remained unimplemented, almost immediately it was adopted it became clear that a more comprehensive, realistic and well-developed national PRSP was needed to form the focus of cooperation between the Government and the international community. The responsibility for poverty reduction shifted to the Ministry of Finance, and the 2002-2005 PRSP was developed using an elaborate and consultatory process involving civil society, the private sector and stakeholders in communities and districts throughout Zambia. Although the implementation of the PRSP was again compromised, the approach used for planning guided the development of its successor, the FNDP.

The FNDP, the focus of cooperation between the Zambian Government and its partners, has guided implementation and coordination around health, education, social protection, children and youth, food security, HIV and AIDS and other sectors. The JASZ has provided a framework for more effective partnership around the FNDP, while SWAs, baskets, pooled funds and budget support have sought to enhance the effectiveness of resources directed towards FNDP programmes with poverty related outcomes. The main goal of the FNDP remains that broad based economic growth and employment creation is to reduce poverty. Agriculture is regarded as having the greatest potential for economic growth and poverty reduction, as well as tourism, manufacturing and mining. Increased emphasis on health and education and some attention to mainstreaming of gender, HIV and AIDS and disability is evident.

While many sector policies are well represented in the FNDP, and it provides a good foundation for tackling poverty, there are nonetheless some weaknesses. While the FNDP is comprehensive, it lacks focus and prioritisation (particularly around actions for pro-poor inclusive economic development, including job creation, small scale business development and small scale agriculture). As a result, the FNDP exceeds resource availability, which undermines the extent to which the medium term expenditure framework (MTEF)
and annual budget process are guided by articulated priorities. Further, the relationship between plans and institutional capacity are weak: for example, the analysis and objectives around social protection, children, women and food security are strong, but the actions identified overlook the need for increased capacity in the weak parts of Government responsible for implementation.

The problem of striking a balance between stand-alone chapters and awarding sufficient mainstreaming in other sectors is evident for gender, HIV and AIDS, disability and food security. Whilst the FNDP recognises that these issues are multi-sectoral by nature, attempts to mainstream actions through relevant sectors have in practice been weak. Further, the inter-linkages between health, education and water and sanitation are largely overlooked. If the linkages between different sectors were better articulated, a coordinated approach to service delivery for women and children might be more easily achievable.

Two specific policies related to the protection of children and women are the National Child Policy (2006) and National Gender Policy (2000). The National Child Policy was revised to take account of the adoption of the CRC and emerging issues related to poverty, child labour, trafficking, HIV and AIDS and child abuse. It makes the child the focus for development so as to ensure that children live to their full potential where their rights and responsibilities are fulfilled.

It aims to consolidate all existing and proposed legislation pertaining to children into one easily accessible and comprehensive statute and provide a watch dog on child exploitation. The National Gender Policy outlines measures to address GBV and forms the basis of the Gender-Based Violence bill.

4.4 Closing comment: protection context for children and women

Ratification of international conventions, law reform, application of the law, and accessible legal support form the basis of the protective environment for children and women. But improved legislation and implementation of that legislation is slow to show results. Legislation alone will not change behaviour. Even targeted programmes will not, as these tend to be limited to by site and target group and deal with those that have already been victimised. “Girl-friendly” or women’s programmes may help beneficiaries negotiate some improvements in their lives, but often do not concurrently address institutional or social norms that create exclusion in the first place. Girls are encouraged to attend school, for example, but there is little dialogue around institutional and social norms that deter them, undermine their performance or harm them as a consequence of their participation. The challenge to stop discrimination and address deep seated discriminatory attitudes requires substantial behaviour change. Encouraging open discussion, breaking the silence and acknowledging the existence of taboo behaviour, such as defilement, and providing opportunities for women and children to talk about violence, abuse and discrimination are all essential. Adolescents, especially young girls, need to be able to learn facts and skills to improve self protection, improve their capacity to express themselves and their self esteem, and prepare for life as adults and parents. Legal reforms and change in legal practices need also to be coupled with improvements in basic social services, and an integration of protective mechanisms across sectors, ensuring that service delivery is consciously child and woman centred and sector officers have capacity in protection practices. Families and communities also have an important role to play in the implementation of preventative protective measures but these need defining.
Definitions and measurements and reporting of abuses against children and women are difficult. Cases of abuse, GBV and defilement are often unreported, because of reluctance to challenge the social status quo, and the likelihood that the abused will be subject to further abuse at the hands of police and courts, and retribution by family and community. However, experience shows that those who know they have access to a sympathetic VSU or equivalent are more likely to report cases of abuse. Where these services exist, affected children and women are willing to use them.

Government has ratified conventions and must now show commitment to actively approve pending legislation which would ensure implementation of a coherent protective mechanism that addresses many of the issues discussed in section 2. For example, Government and its partners are happy to express commitment to social change in the interests of women and children but it is now important to understand better what is required to translate commitment into results. It requires a firm commitment to equitable and rights-based development, a re-orientation of public resources and services, and redirecting efforts towards inclusive economic and social development. This has implications for the status quo in public sector management, and also for parts of the private sector.

The FNDP has provided a good basis for social development and sector policies are well represented. However, there is little integration around issues related to children and women, and there is no recognition of the linkages between sector strategies. Mainstreaming appears to have been a difficult concept for sector planners and depending on mainstreaming of critical issues such as gender and disability could be interpreted as a way of further marginalising these issues. If the linkages and interdependence between policies and strategies were better articulated, a coordinated approach to service delivery and protection for children and women might be more achievable.
5 Meeting the challenge, making a difference

The foregoing analysis underlines the urgent need to address the needs of children and women; without efforts to increase inclusion in the opportunities of development and growth, today’s generation of children will face further disadvantage as the adults and parents of tomorrow. Too many families have difficulty maintaining sustainable livelihoods as their asset base is weakened by chronic poverty; women are poorer than men, and they are discriminated against in access and control over resources which could otherwise strengthen their chances of a sustainable livelihood. Female poverty is a strong driver for child poverty, and an unacceptable number of children are malnourished, die young, are not educated and abused in unacceptable ways. Economic insecurity, HIV and AIDS, seasonal factors, area based vulnerabilities (in particular remoteness), policy shocks, natural disasters, poor service delivery, changing social structures and no protection all add to the entrenchment of poverty. These cannot be addressed by half measures.

The analysis has provided substantial evidence that vulnerability is driven by various factors, which overlap and combine to create highly negative outcomes for children and women. Physical isolation is a one significant factor. Rural and remote areas have the greatest levels of poverty, and receive the least in terms of resource allocation and service provision. Children and women in the most remote parts of the country have the worst outcomes in terms of livelihoods, food security, health, education and sense of agency and belonging.

Social isolation, as a result of gender, age, social status and disability also determines the pattern of vulnerability. Women face multiple risks, taking up increasing responsibilities with poor outcomes for themselves and their children. Many rural girls still do not go to school, despite the knowledge that a women’s education is one of the most important variables in sustainable development. The disabled are for all intents and purposes invisible to all but their carers – usually women. Some rural women rarely leave their community, and their social isolation is exacerbated by poor access to information and external stimuli which might introduce change. Service providers are helpless when it comes to addressing the diverse needs of the poor and are regarded by the poor as distant and unhelpful.

Persistent shocks have weakened the resilience of families and communities, making recovery hard. These include ill health; death of family members; sudden change of policy; and climatic and seasonal shocks. Children and women are often affected by mechanisms to cope with these shocks – children may leave school, work or marry at very young ages, while grandmothers look after many young children and many women work long hours. Natural resources are being increasingly used to supplement livelihoods in an unsustainable way. These coping mechanisms reinforce intergenerational poverty and social isolation.

The consequences of chronic vulnerability are first and foremost a lack of sufficient food and basic needs – such as clean water, education and health. Households that are insecure are not able to invest in the future, and find it hard to believe improvements are possible.
High prevalence of domestic violence against children and women further undermines their self perception and confidence, again making change more difficult and further entrenching poverty.

It is in this context of vulnerability and poverty that this analysis concludes that the public service, policy and legislative framework needs to be strengthened and coordinated. The interdependence of sectors needs to be recognised in planning, so that the successes of one sector can supported others. Services need to reach the poor, with a greater emphasis on reaching remote areas. The needs of the chronically poor need should be of the greatest concern to policy makers.

This final section discusses seven critical areas which require improvements. This analysis has shown that factors of vulnerability overlap and combine to deepen the poverty of children and women. Likewise, the strategies to improve the situation of children and women need to overlap to support and strengthen each other. An integrated holistic approach is required and only addressing one area or worse a part of one area will not change the situation.

In addition, approaches that prevent rather than mitigate the outcomes of chronic vulnerability are required. Disaster management may be necessary, but it would be more effective in the long term to correct agricultural policies that encourage unsustainable practices that cause crop failure. Understanding factors that drive children to the street and addressing these would be more effective than rounding the street children up so that the manifestation of the failure is no longer visible.
A new approach is required that changes the mind set of policy makers, communities, cooperating partners and technical advisors so that a common understanding of the complexity and interconnectedness of these issues is reached, one that takes these issues out of the “welfare box” to the centre stage of economic development and growth.

5.1 Integrated and equitable service delivery

5.1.1 Integration of service delivery

The interdependence of public services on the well-being of women and children is a recurring theme, throughout the analysis. There is a relationship between educational achievement, nutrition, learning capacity and good health; social protection and school attendance; mother’s educational achievement and school attendance; mother’s mortality and school attendance; safe water and nutrition. Educational achievement is the most effective way to improve outcomes for the poor, especially women, and to break cycles of intergenerational deprivation. Although the ingredients of the basic services are understood, (figure 38) and are already presented in sector strategies and the FNDP, the need for integration of services sufficient to support equitable national development is less evident. Integration of services is required to provide a complete holistic package for women and children and the eventual basket would need to be agreed.

Figure 38: Basket of Basic Services for Children and their Families Necessary for Equitable National Development

<table>
<thead>
<tr>
<th>Social Protection</th>
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<tbody>
<tr>
<td>Provide security against extreme vulnerability, and violence, especially female headed households, OVCs and elderly, and disabled</td>
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<table>
<thead>
<tr>
<th>Food Security</th>
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<tbody>
<tr>
<td>Availability, access, use of nutritious food for children and adults, wherever and whenever needed for healthy productive life</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
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<tbody>
<tr>
<td>Early childhood development, equitable access, free basic compulsory education, improved retention and completion for boys and girls</td>
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</table>

<table>
<thead>
<tr>
<th>Water and Sanitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equitable provision of adequate quantity and quality water and sanitation in rural and urban areas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equitable access to health facilities as close to the family as possible (women and children)</td>
</tr>
</tbody>
</table>

Coordination and integration of services in a decentralised environment with effective partnerships between local communities and relevant government ministries at the community and district level would be the strategic place to start. The institutional structures for coordination are in place at these levels - the DDCCs, Area Development Committees, and Residents’ Development Committees - and there is ample evidence and experience that strategies that provide opportunities and prevent problems are better planned and implemented at the lowest levels. Front line community based service delivery
systems should be resurrected and supported, so that services may be delivered using existing models of community health service, the WASHE and the PWAS systems, and Home based Care networks. Local committees, volunteers and service providers need to be incorporated, both as a means of increasing knowledge and capacity, as well as of scaling up results. Attention needs to be directed towards understanding when incentives and payment are appropriate and cost-effective. Local needs analysis is needed to identify local priorities for children as well as local mechanisms on how these services can be better brought together to meet the basic needs of children of all ages so that investment in one sector is not wasted because another sector is unable to provide the services. The processes and institutions, which facilitate the analysis of local problems and solutions, and community participation in decision making, are already developed and in use.

Leadership is required at the district and community level. This leadership is necessary to articulate local needs, mobilise community participation, forge broad local networks and alliances for child health and survival, and allow local knowledge and memory to support analysis, planning and decision making. Child interventions if planned and implemented at local levels, would take into account the local social capital, and the efforts of other agencies relevant for addressing key determinants (education, adult literacy, food and public facility hygiene, water and sanitation, food security, works and infrastructure). The active participation of children themselves and women especially is essential to ensure interventions are appropriately prioritised and made relevant to local needs.

Fragmentation within sectors wastes resources and staff time and creates confusion at the user level. There are ample opportunities to improve the packaging of services either within sectors or between different sectors that enables resources to be shared, and services to be combined to create a more holistic delivery.

5.1.2 Improve access to trained and qualified staff

There is a need to address the problems associated with the retention of qualified and appropriate staff in rural areas (including female staff for maternity facilities). An in-depth study to find synergies in meeting cross sectoral needs may be useful, and the provisions of retention schemes for essential workers should be common to all sectors.

Suggestions to explore may include:
- Incentive scheme for officers serving in rural areas, which is performance linked.
- Condition of promotion is a minimum of 3 years service in a rural and remote area
- Invest in training opportunities in rural areas, and offer
scholarships to persons from those and other remote areas on condition that they
serve in rural areas for an agreed period after qualifying.

- Offer improved housing conditions in rural areas, including power (solar), water
and sanitation.
- Train staff in basic information to allow an integrated holistic approach to child
development, including protection mechanisms for abuse.
- Make specialists available to local authorities to assist on early childhood
development, special needs, HIV and AIDS, paralegal, nutrition and legal
protection.
- Increase integration of services with mandates for simple service delivery in other
sectors – for example, train teachers in social protection and nutrition.

The strength of the cadre of community based organisations has been noted but these
require improved coordination, adequate resources and skills. Expectations of what
community volunteers are able to deliver should be realistic – community contributions add
value but cannot substitute for skilled service provision. A common policy is necessary for
all sectors, recognising community contributions and creating consistency in how people
are rewarded for their efforts.

5.1.3 Improve infrastructure

Significant investments in infrastructure are needed, particularly around schools, health
centres and facilities to support community development. These require both finance and
capacity. Improving partnerships or co funding mechanisms with NGOs, FBOs and private
sector to improve infrastructure may be considered. Sector ministries do not necessarily
have the capacity to build large numbers of small infrastructure throughout the country,
in particular in rural areas, where the work is urgently required. The lack of collaboration
between sector ministries in planning infrastructure development creates further costs and
inefficiencies. Mechanisms to fund community efforts to implement capital infrastructure
projects have successfully been used in the past and could easily be reinstated. However,
it is important to ensure that community participation is linked to projects where recurrent
expenditure and staffing has been planned for. Without prioritisation and coordination, a
proliferation of unplanned infrastructure would not result in improved service provision.

5.1.4 Provide sources of absolute support

The staff and facilities at service centres need to become sources of absolute support
for their clients; people need to trust that services and providers are acting in their best
interests, and do not represent sources of hostility or threat. Nurses and health workers,
police, teachers, community based workers and volunteers involved in service provision
need to be trained in standards of services, client relationships as well as basic legal rights
for children and women.

Actions to support this need to focus on both building capacity and responding to cases
of abuse, neglect and hostility. Effective responses to complaints are essential to create
confidence among clients, and to remove the widespread belief that local service providers
are able to get away with transgressions. Proactive interventions are needed to address
institutionalised discrimination and ambivalence around children’s and women’s rights.

5.1.5 Meet the needs of all vulnerable children

Services need to be accessible to all vulnerable groups. Targeting should be done at the
lowest possible level but requires a national recognition that resource allocation should
be needs based. Policies related to user fees should be consistent between sectors, and service delivery should be flexible to local needs in terms of hours of service, availability, and type of services on offer.

5.2 Social change

Rural women in Zambia have a history of association and collective support. These associations need to be recognised and supported as useful support mechanisms for vulnerable children and women.

The nature of the extended family is changing as a result of HIV and AIDS, and of the growing economic demands on urban and rural families. Elderly women and men are increasingly looking after children, and extended family relatives remain the main-stay of social support to those in greatest need, particularly orphans. Their role must be recognised and supported nationwide, building the capacity of caregivers and providing partnership through community based services. With both economic and social support, as well as more accessible services, extended families can continue and grow as the best first-line providers of care for Zambia’s orphans and vulnerable children.

An improved understanding of the perceptions of men under severe social stress is necessary to develop acceptable and stronger strategies of support. In addition, a programme to improve the understanding of adolescent boys of gender issues should be supported.

The role of traditional leadership is also critical to the social standing and protection of children and women in the community.

There is a healthy network of community based organisations supported by various NGOs, churches and HIV and AIDS organisations. Many have the active participation of many children and women, and represent a potential opportunity for promoting social change. Supporting NGOs and churches to facilitate training and advocacy programmes for social awareness and change is an opportunity. Use of local and community radio may also be an effective way of introducing the idea of open discussion of taboo subjects.

The capacity of existing victim support mechanisms need strengthening both in terms of coverage and in capacities to understand the issues surrounding abuse, addressing entrenched discriminatory attitudes and social pressures. Improving parental and child awareness of their rights and the role of the VSU would
be part of the process. Definitions, measurement and reporting of issues related to abuse need to be clarified. Data collection mechanisms need to be improved to allow monitoring and reporting of abuse and factors that allow abuse to take place.

5.3 Legal framework

Government needs to domesticate its commitments to international conventions into a strong legal framework that protects children and women, and supports necessary social change. The approval of the Disability Bill and the finalisations of the Gender-Based Violence Bill would be great achievements in this respect. The constitutional review process should also consider how a uniform and consolidated approach to issues affecting children and women could be established. A first step would be the standardisation of various definitions of age related to marriage, work and criminality of children.

A review of all legislation that affects children and women should inform government on changes required. To be effective however, this must include not only statutory law but also a review and revision of the role of customary law in women’s lives, and the inconsistencies with statutory and customary rights. Moves by the judiciary towards developing guidelines for customary law are important in this respect.

There is a need to develop a legislative framework that would address many of the issues relevant to epidemics: stigma and discrimination, client confidentiality, wilful transmission, provider-initiated testing and counselling in health facilities, GBV and child defilement in the context of HIV, and others. A National Health act would not only establish a national health system, but would also provide the legal framework for responding to the public health and socio-economic dimensions of epidemics, and would harmonise the existing 27 pieces of legislation relevant to health.

5.4 Economic environment

The analysis has provided substantial evidence to show that weak livelihoods and high levels of poverty are largely an outcome of economic policies. Growth alone has not and will not address issues of poverty and exclusion. More attention needs to be paid to understanding what pro-poor economic policies are and then advocating for them.

The notion of pro-poor growth is often cited as a retrospective criticism when the benefits of economic development do not reach the poor. However, there is no consensus or detailed analysis of what would be required to ensure broad participation in accelerated growth, besides some generalised notion of wishing to see more jobs and more small scale farming. The economic policies of this decade have rather focused on the magnitude of “wealth creation”, rather than distribution. There are several problems associated. One is that while the FNDP targeted 7% broad-based growth, the 5% that was achieved was not located where the poor are - that is, largely in the agriculture sector. Rather, growth has been driven by a mining boom which has now slowed, and its benefits more narrowly restricted than anticipated.

In addition, because the focus is on growth itself rather than inclusive growth, issues of poverty and exclusion are not recognised as the business of economists, but rather marginalised

“Since economic policy is the dominant concern at the centre of power, the fact that inclusion is not a fundamental part of how we think about growth has a significant effect in maintaining poverty.”
Meeting the challenge, making a difference
to compete for scarce human and financial resources in the social sector. Providing security
and opportunity for the vulnerable – social protection, in the Government definition – is
considered expenditure on consumption, rather than a prerequisite for inclusive, pro-
poor growth. As a result, the continued exclusion of women in the formal sector, the
entrenchment of poverty in rural households and the pervasive use of child labour in the
success of some sectors has tended to be obscured in dialogue around economic policy and
outcomes. Concerted efforts are required to ensure that all actors in economic policy see
inclusive growth and equitable development as the fundamental goal of economic policy,
rather than as an eventual outcome or subsidiary social goal.

5.5 Planning and budgeting

The FNDP provides a good basis for development. It does not, however, acknowledge
linkages between sectors and nor has it successfully mainstreamed critical factors that
drive deprivation for children and women. There is a need to better articulate a coordinated
approach to the development, service delivery and protection of children and women. A
holistic, integrated, multi sector package is required to address the needs of children and
women. Complementary investments in different sectors are required to be combined in
order to sustain results in any one sector. For example, education is a key determinant of
health status, as health is of education status.

The analysis noted that there was little coordination between sectors in the national
planning systems. The role of the NDCC and the annual national SAG conference could
both be strengthened in this respect, providing the coordination and horizontal linkages
between sectors.

An effective means of coordinating activities for children is essential. At present, there are
a range of sectoral plans and programmes within the framework of the FNDP supporting
and protecting children. These include policies, interventions and services in health,
education, social protection, labour, the police and legal reform. However, the realisation
of Government’s substantial commitment for children depends on sustained performance
across all of these sectors, as each reinforces results in the other. Conversely, deficits in one
sector significantly undermine achieving the expected results in others. As a result, in order
to achieve the greatest and most rapid results for children, a means of enhancing both cross-
sectoral coordination and high level accountability are essential.

Putting children at the centre of a strategy and identifying relevant sector policies, strategies
and programmes that prevent as well as mitigate against poor outcomes for children
and women may allow a “child centred” holistic strategy to emerge. A good monitoring
framework may then be developed around this strategy, which would allow measurement
of those factors that impact on children’s well-being and also measure successes against
different sector indicators. A monitoring system would provide the evidence of successes
and failures and identify areas of increased focus.

Planning systems are in place at the decentralised level that could be strengthened to allow
improved local level planning for children. Many districts have developed strategic plans
for poverty reduction which may be used to prioritise resources and improved services
according to local conditions. The planning system allows for wide participation but it
requires dedicated local leadership, common vision, and shared responsibility across
agencies. It also requires listening to children, their families and their carers. Most of all, it
requires commitment to decentralisation by central government, simplified funding streams related to local planning, clear accountabilities, and well defined monitoring and review system.

Resources are centrally controlled and insufficient to meet diverse demands. There is a reluctance to prioritise decisively. Budgets are planned at the centre, with inputs from different levels of government but generally based on increments. Incremental budgeting tends to magnify inequality in resource distribution between different locations and sectors. Increased use of activity based budgeting based on local needs would improve the prevailing allocations. In addition, resource allocations based on deprivation would be a positive move to addressing the bias against remote rural areas. Although the MTEF is intended to provide a medium term forecast of government expenditure, in practice each year it changes substantially, undermining its function as a long term planning tool.

5.6 Emergency preparedness and response

A stronger evidence based assessment for emergency interventions needs to take into account not only transitory or short-term food insecurity, but also analyse those factors that reduce resilience of households, and therefore expose people to shocks with irreversible consequences. This would include deaths, fragile livelihoods, undiversified local economies and market collapse.

The linkages between emergency interventions and long term programmes addressing chronic poverty and food insecurity should be strengthened. For example, school feeding exists both as an emergency or short term measure, and as a more long term programme addressing chronic malnutrition. The linkages and synergies between these programmes need to be found, creating sustained and appropriately sequenced improvements for vulnerable communities. The extreme poverty situation in some areas of Zambia may
qualify for emergency type interventions, but do not qualify because of the modalities of emergency intervention.

Effective government leadership is essential in achieving improved emergency preparedness and response. A comprehensive review of the role, structures and capacity of the DMMU and of the mechanisms for collaboration between Government, cooperating partners and NGOs around emergencies is a necessary starting point.

5.7 Collective commitment for change: reforming the social and political environment

With all the words, resources and plans that have been expended in the name of the children of Zambia, there is little to show in terms of sustained improvement in child survival and development. Over the years, analysis has shown incremental gains in one sector or another often later lost as priorities change and as the benefits of institutional capacity building are dissipated. This situation needs to change.

Zambia needs strong leadership, committed to the future of every Zambian child. This leadership at every level needs to address the status quo, the prevailing priorities, and the poor implementation and use of resources with vigour and dedication. Leadership should be prepared to commit themselves to what they intend to achieve, represented by national planning tools, such as the FNDP, and should be accountable to this framework. If the leadership is not accountable to commitments made then public servants are unlikely to perform. While this accountability is between the government and its citizens, cooperating partners and civil society organisations should also take this accountability seriously and seek best possible outcomes for children and women.
## Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSO</td>
<td>Central Statistical Office</td>
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<td>CU</td>
<td>Commercial Utility</td>
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<td>DDCC</td>
<td>District Development Coordinating Committee</td>
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<tr>
<td>DFID</td>
<td>UK Department for International Development</td>
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<tr>
<td>DMMU</td>
<td>Disaster Management and Mitigation Unit</td>
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<td>FBO</td>
<td>Faith-Based Organisation</td>
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<td>FNDP</td>
<td>Fifth National Development Plan</td>
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<td>FSP</td>
<td>Food Security Pack</td>
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<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GIDD</td>
<td>Gender in Development Division</td>
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<td>GRZ</td>
<td>Government of the Republic of Zambia</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<td>JASZ</td>
<td>Joint Assistance Strategy for Zambia</td>
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<td>JCTR</td>
<td>Jesuit Centre for Theological Reflection</td>
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<tr>
<td>MCDSS</td>
<td>Ministry of Community Development and Social Services</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MFNP</td>
<td>Ministry of Finance and National Planning</td>
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<td>MoE</td>
<td>Ministry of Education</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<tr>
<td>NDCC</td>
<td>National Development Coordinating Committee</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<td>PWAS</td>
<td>Public Welfare Assistance Scheme</td>
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<td>SAG</td>
<td>Sector Advisory Group</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>SWAp</td>
<td>Sector Wide Approach</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>VAC</td>
<td>Vulnerability Assistance Committee</td>
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<tr>
<td>VSU</td>
<td>Victim Support Unit</td>
</tr>
<tr>
<td>WASHE</td>
<td>Water, Sanitation and Hygiene Education</td>
</tr>
<tr>
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