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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATIONS*

Eastern and southern Africa region

SUMMARY

The present document contains recommendations for funding programmes in the eastern and southern Africa region with annual planning levels not exceeding $1,000,000. It also contains one recommendation for additional general resources to fund the approved country programme in the same region for which the balance of approved general resources is not sufficient to fund the programme up to the approved programme period. The Executive Director recommends that the Executive Board approve:

(a) The following amounts from general resources, subject to the availability of funds, and the following amounts in supplementary funds, subject to the availability of specific-purpose contributions, for the country programmes listed below:

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Mauritius	3 750 000	500 000	1996-2000
Swaziland	3 750 000	2 750 000	1996-2000

(b) Additional general resources in the following amount to achieve the objectives of the country programme as originally approved by the Board:

Country/programme	Amount (United States dollars)	Current programme cycle
Swaziland	100 000	1991-1995

Summaries of individual recommendations follow.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

I. MAURITIUS

Basic data (1993 unless otherwise stated)

Child population (millions, 0-15 years)	0.3
U5MR (per 1,000 live births)	22
IMR (per 1,000 live births)	19
Underweight (% moderate and severe) (1985)	23.9
Maternal mortality rate (per 100,000 live births) (1982)	99
Literacy (% male/female) (1990)	85/75
Primary school enrolment (% net, male/female) (1991)	87/90
Primary schoolchildren reaching grade 5 (%) (1991)	98
Access to safe water (%) (1990)	97
Access to health services (%) (1985)	100
GNP per capita (1992)	$2,700

One-year-olds fully immunized against:

tuberculosis:	87 per cent
diphtheria/pertussis/tetanus:	88 per cent
measles:	84 per cent
poliomyelitis:	89 per cent

Pregnant women immunized against:

tetanus:	78 per cent

The situation of children and women

1. The success of development in Mauritius in the past decade is reflected in its positive socio-economic indicators. Of all member countries of the Organization of African Unity, Mauritius has the lowest maternal mortality rate (MMR), the second lowest infant mortality rate (IMR), about the highest primary and secondary school enrolment ratios and the lowest fertility rate. Out of the 12 mid-decade goals which are relevant to Mauritius, 7 have been already achieved and the remaining 5 are on course for achievement. Those achieved include immunization coverage, elimination of neonatal tetanus, reduction in measles mortality and morbidity, elimination of poliomyelitis, ratification of the Convention on the Rights of the Child, strengthening of basic education and universal access to safe drinking water and sanitary means of excreta disposal.

2. However, in order to achieve and sustain all the decade goals, as adopted in the Mauritius national programme of action, Mauritius must meet a number of challenges in the context of its rapid economic and societal development: increased efficiency in the delivery of basic services; disparity reduction between districts; and the adoption of healthier lifestyles.

3. The priorities for children's health include reducing the high level of perinatal mortality, currently at 25 deaths per 1,000 live births, and the persistence of water-borne diseases, worm infestation and anaemia. The

declining caring capacity of families because both parents are working, changes in consumption patterns and poor nutritional and hygienic practices contribute to persistent undernutrition among children. Breast-feeding is compromised by premature weaning practices. Although no cases of vitamin A or iodine deficiencies have been reported in recent years, subclinical disorders cannot yet be ruled out. The combination of poor nutrition status of women and their heavy workloads are a hazard, especially during pregnancies, because of the high prevalences of anaemia, hypertension and diabetes, premature deliveries and low-birth-weight babies. Poor knowledge about human sexuality, contraception and low condom use are concerns in view of the rising number of people infected with the human immunodeficiency virus (HIV) - from 19 in 1992 to 80 in 1994 - and the increase in teenage pregnancies. Public health services are free, but suffer from several problems - poor management, uncertain sustainability, underutilization of rural basic health services - and the quality of care appears to be below the expectations of most users.

4. Some 30,000 children under three years of age are cared for during working hours by someone other than the mother. Caregivers are generally untrained and poorly motivated. Enrolment is 80 per cent in pre-primary schools, which are mostly private, but they have inadequate infrastructure, insufficient supervision, poor pedagogical materials and inadequately trained staff. Primary education is free and compulsory, and infrastructure, personnel and basic equipment provide universal access. However, the failure rate for the certificate in primary education is 43 per cent, with wide disparities among schools. Failures stem from low household incomes combined with low parental educational levels and marginal competency in the language of instruction. Semi-literacy and illiteracy are persistent problems. Literacy development activities cater for only 10 per cent of the need.

5. Child abuse and neglect are on the rise, and domestic violence has become a leading issue affecting family life. Although most discriminatory laws have been removed, attitudes and practices still prevent the full development and contribution of women to society. After laying the foundation of the country's economic miracle by a major reduction in births and by joining the workforce in massive numbers, women must now be able to gain access to quality day-care services which will allow them and their families to develop fully.

Programme cooperation, 1990-1995

6. The current programme, approved at the 1990 session of the Executive Board (E/ICEF/1990/P/L.17) for $1,500,000 from general resources, addressed the social problems affecting women and children, especially the need to reduce disparities between the islands of Mauritius and Rodrigues. To increase support for national efforts towards the achievement of the decade goals, the 1992 Executive Board approved an additional amount of $1,500,000 from general resources (E/ICEF/1992/P/L.35). A short-duration programme for 1995 was approved by the Executive Board in 1994 (E/ICEF/1994/P/L.19).

7. Most of the country programme objectives were met, including 95 per cent coverage of expanded programme on immunization (EPI) antigens and a reduction in IMR and in the under-five mortality rate (U5MR) from 20 and 25 to 19 and 22 per 1,000 live births, respectively. UNICEF advocacy at the highest levels of

government helped to make maximum use of the limited UNICEF resources and contributed to the rapid ratification of the Convention on the Rights of the Child in 1990 and the adoption of the national programme of action in 1992, whose decade goals are also included in the latest national development plan. As national capacity for service delivery is strong, UNICEF contributed mainly to pilot or innovative approaches, often in collaboration with non-governmental or private sector partners, in training, technical support for advocacy and policy development.

8. UNICEF support to the master plan for education helped (a) to establish nine regional centres, with an annual training capacity of 360 pre-primary teachers; (b) to launch a pilot campaign to combat school absenteeism and raise primary school completion rates; (c) to formulate the national plan of action on special education, which called for the creation of a technical unit and the preparation of a training design on the early identification of disabilities; and (d) to evaluate the national literacy programme in 1993 and reorient it towards basic education for adolescents.

9. In Rodrigues, UNICEF supported formal and informal education through teacher training and the provision of teaching aids and basic equipment. Enrolment at pre-primary schools increased from 46 per cent in 1990 to 70 per cent in 1993. With the active participation of communities, the supply of safe water and improvement of sanitation facilities were significant, and UNICEF support to this sector will no longer be required. The evaluation of the Rodrigues area-based programme highlighted the contribution of the community health workers scheme to the reduction of IMR from 34.7 to 21.1 per 1,000 live births between 1990 and 1993.

10. UNICEF assisted the national EPI through the provision of vaccines and equipment. As part of a health sector review, UNICEF sponsored studies on costing and financing of peripheral health services, roles and performances of village health committees and perinatal mortality. The national nutrition survey, supported by UNICEF, will provide the basis for a surveillance system. UNICEF assistance to the national programme for the control of the acquired immunodeficiency syndrome (AIDS) covered information, education and communication activities for groups most at risk. UNICEF and the World Health Organization (WHO) jointly supported the Baby-Friendly Hospital Initiative in the five national hospitals.

11. To strengthen further national capacity in social analysis and planning, studies were undertaken in collaboration with the United Nations Development Programme (UNDP) and universities, covering issues affecting women and vulnerable groups and those related to family problems in Rodrigues. Information, education and communication materials on healthy lifestyles, including Facts for Life, were produced and disseminated in collaboration with the Food and Agriculture Organization of the United Nations (FAO), the World Food Programme (WFP) and WHO. However, pre-testing, evaluation and feedback on communication campaigns have usually been weak.

Lessons learned

12. Past cooperation indicated that the compatibility of policy goals between the Government and UNICEF, combined with the limited resource capacity of UNICEF, creates a favourable context for UNICEF roles in advocacy and policy development. Hence, country programme priorities are evolving away from service delivery issues towards the search for more rational planning of human and financial resources for the social sectors. As the development process in Mauritius is progressing rapidly, UNICEF cooperation will become more adaptive so as to respond better to emerging priorities for children and women. In this context, improved monitoring and evaluation mechanisms are of paramount importance.

Recommended programme cooperation, 1996-2000

Estimated annual expenditure

(In thousands of United States dollars)

	1996	1997	1998	1999	2000	Total
General resources						
Health	200	200	200	200	200	1 000
Education	300	300	300	300	300	1 500
Social policy development, advocacy and monitoring	250	250	250	250	250	1 250
Subtotal	750	750	750	750	750	3 750
Supplementary funding						
Health	50	50	50	50	50	250
Education	50	50	50	50	50	250
Subtotal	100	100	100	100	100	500
Total	850	850	850	850	850	4 250

Country programme preparation process

13. The latest national development plan presents the Government's policy of pursuing growth with equity and monitoring the impacts of industrialization and rapid social change in terms of changing lifestyles, particularly where family welfare is concerned.

14. The programme of cooperation was prepared by an interministerial committee and included consultations with national institutions and organizations. Existing research and surveys provided inputs for the situation analysis and programme preparation. A strategy meeting, held in May 1994, decided on major directions. Given the achievements in Mauritius in terms of child survival and

development (CSD), the proposed country programme will initiate a transitional phase leading to a gradual diminution of programme inputs after the year 2000.

Programme objectives and strategies

15. The 1996-2000 programme of cooperation will facilitate and play a catalytic role in the achievement of the goals of the Mauritius national programme of action. UNICEF cooperation will help the Government (a) to improve further the quality and utilization of basic services for women and children, with a particular focus on education and health; (b) to reduce further disparities both within and between islands; and (c) to strengthen the sustainability of progress towards the achievements of the decade goals. The programme of cooperation will focus on four of the seven strategic decade goals: (a) reduction of IMR and U5MR to 12 and 19 per 1,000 live births, respectively; (b) reduction by half of MMR; (c) reduction of severe and moderate child malnutrition to 7 per cent; and (d) acquisition of a basic education by 80 per cent of primary-school-age children. These goals were selected as they represent the centre-pieces of the country's commitment to its children.

16. As in the past, but more so in the proposed programme, UNICEF support will be used as a pre-investment strategy prior to the expansion of government programmes. The three proposed sectoral programmes - social policy development, advocacy and monitoring; health; and education - are interrelated so that results from operational research and studies will feed into activities to increase the coverage and quality of all programmes. In turn, successes will be used to generate nationwide changes in coverage through information-sharing, policy development and major advocacy activities. Based on the high education level of the public and the wide range of community organizations, IEC activities will help to increase the caring capacity of families, strengthen the demand for quality services and promote healthier lifestyles. Where capacity-building and empowerment can be critically complemented with service delivery, UNICEF will provide assistance for services on a limited basis. Programme activities will be targeted using local indicators to reach better vulnerable groups, especially women and girls, and to reduce disparities.

Social policy development, advocacy and monitoring

17. The objectives of this programme are (a) to improve the information base of all decision makers, both inside and outside Government, with responsibilities for social policy development; (b) to study ways to improve cost-effective and sustainable strategies in the current transition to the next stage of development; and (c) to foster public awareness, discussion and support for children's and women's needs and rights.

18. The strategy will be to increase capacity-building for the collection, analysis, dissemination and use of data in the policy formulation process and in monitoring progress towards the national programme of action goals. Efforts will continue to generate more disaggregated statistics to assist in identifying vulnerable groups, pockets of poverty, gender disparities and problem areas. Special attention will be paid to the financing and management of social services and other issues of relevance as a follow-up to the World Summit for Social Development and the Fourth World Conference on Women. UNICEF will

support strengthening of inter-agency collaboration in support of national efforts to develop social policies and sectoral plans, for example in health sector reform.

19. Advocacy will build on the already positive experiences in forging partnerships for children, consolidating relations with the media and producing and disseminating information on child development issues. Full use of various special events and other opportunities such as the fiftieth anniversary of UNICEF will be a priority. Based on sound and gender-sensitive research, priority for advocacy will be full implementation and dissemination of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Recurrent themes for advocacy will include the situation of women in the labour force; child abuse and neglect; women's roles in social, economic and political decision-making; parenting practices; and absenteeism of girls from school. UNICEF will continue to cooperate with the university, and a knowledge centre on children will be established. Education for development will be promoted, with an emphasis on helping children to understand and appreciate cultural and linguistic diversity in a multi-cultural and multilingual society and in the world.

Health

20. The challenge in the health sector is to achieve the decade goals, in a sustainable way, through a more rational use of financial, infrastructure and human resources. The main strategy of the health programme is to increase the efficiency of maternal and child health (MCH) services through improved utilization of more accountable and effective basic services and to reduce the prevalence of preventable communicable/non-communicable diseases.

21. The MCH project will strengthen the capacity of health services in districts with indicators reflecting less progress than national averages with respect to care for high-risk pregnancies, foetal distress and neonatal intensive care. The nutrition component will support training and information, education and communication activities (a) to promote better dietary, hygienic and child-feeding practices, including breast-feeding; (b) to promote further growth monitoring and promotion; and (c) to improve the treatment of worm infestation and diarrhoea among children. The third component of the project is aimed at improving the management capacity of mid-level and peripheral health teams. Research and analysis will be devoted to the issues of quality assurance and institutional accountability of first-line services. Local health committees and non-governmental organizations will help to set up forums to improve communication between health providers and users. While the provision of vaccines will be ensured through the government budget, UNICEF will continue to support EPI through monitoring activities.

22. The behavioural health project focuses on (a) improving reproductive health, including sexually transmitted diseases/AIDS and early pregnancies; (b) inadequate dietary and lifestyles habits; and (c) underutilization and by-passing of peripheral health facilities. UNICEF will assist with the development of appropriate health promotion materials and provide technical support to the information, education and communication unit of the Ministry of Health. Based on research and analysis, UNICEF cooperation to improve

utilization of MCH services will develop communication strategies to encourage parents to use nearby MCH services.

Education

23. The focus of the education programme is (a) to develop standards for early childhood development; (b) to expand early childhood development activities to cover 70 per cent of children under the age of three years; (c) to achieve universal access and improvement of the quality of pre-primary education; (d) to reduce failure rates in low achieving primary schools from 70 to 40 per cent; and (e) to reduce illiteracy in adolescents from 7.5 to 3.7 per cent for the island of Mauritius and from 29.3 to 14 per cent for the island of Rodrigues. The programme will target low performing primary schools and day-care centres whose children move on to those schools.

24. The early childhood development project targets 101,500 children under five years of age and their families. Priority will be for policy development, establishing regulations and training of supervisors, managers and day-care givers. An information, education and communication campaign will raise parental awareness of child development issues, promote child care and stimulation, and create a demand for quality services. In early childhood development, UNICEF will support in-service teacher training and the development of pedagogical materials, including emphasis on achievement of linguistic skills.

25. The basic education project will support a comprehensive approach to increase certificate of primary education success rates in low performing schools. UNICEF assistance will cover activities such as supplementary education, improving the learning environment, research and analysis and literacy activities for 13,000 adolescents. UNICEF will support curriculum review, essential learning and teaching materials and training for literacy activities.

Cooperation with other agencies

26. The country programme was developed in consultation with other United Nations agencies in Mauritius in line with a country strategy note (1994-1997) being prepared by the Government. Ongoing collaboration will be further developed with WHO and the United Nations Population Fund (UNFPA) for technical support in youth reproductive health, MCH and nutrition activities; with UNDP for support to operational research in social sector financing; and with the World Bank in early childhood development activities and health sector reform. Follow-up will be undertaken on the joint United Nations Educational, Scientific and Cultural Organization (UNESCO)/UNICEF project on the monitoring of Education for All.

Programme management

27. Overall coordination will be the responsibility of the Ministry of Economic Planning and Development, which will collaborate with UNICEF on all aspects of the programme, especially intersectoral coordination among participating ministries, non-governmental organizations and other partners. Implementing

ministries and agencies will designate officers as focal points to UNICEF for this cooperation. A monitoring and evaluation plan has been prepared as part of the country programme. Relevant ministries will provide data for indicators as part of their regular information-gathering activities for quarterly progress reports. Annual reviews of programme implementation will be organized to provide the basis for the preparation of annual project plans of action. A mid-term review is planned for 1998 to assess the effectiveness of strategies and progress towards the objectives so that course corrections can be made as appropriate.

28. Past experience, including with Greeting Card and related Operations, indicates that a number of local non-governmental organizations, service clubs and enterprises are willing to undertake fund-raising activities for UNICEF.

29. The UNICEF sub-office in Mauritius is headed by one international Professional staff and supported by three national Professional officers (for programme, information/communication and operations work). Given the high level of technical support required by the proposed programme of cooperation, additional support will be sought through the United Nations Volunteers programme.

II. SWAZILAND

Basic data (1993 unless otherwise stated)

Child population (millions, 0-15 years)	0.4
U5MR (per 1,000 live births)	141
IMR (per 1,000 live births) (1992)	98
Underweight (% moderate and severe) (1983-1984)	9.7
Maternal mortality rate (per 100,000 live births) (1990)	110
Literacy (% male/female) (1986)	70/65
Primary school enrolment (% net, male/female) (1994)	80/78
Primary schoolchildren reaching grade 5 (%) (1990)	80
Access to safe water (%) (1990)	60
Access to health services (%)	85
GNP per capita (1992)	$1,090

One-year-olds fully immunized against:

tuberculosis:	98 per cent
diphtheria/pertussis/tetanus:	89 per cent
measles:	85 per cent
poliomyelitis:	86 per cent

Pregnant women immunized against:

tetanus:	74 per cent

The situation of children and women

30. Swaziland is a patrilinear society in which many of the traditional structures are inextricably interwoven with modern ones and, therefore, influence social norms, politics, law and the economy. All Swazis are formally subjects of one of the 200 chiefs through whom land is allocated. Chieftainships are grouped under 55 administrative centres called Tinkhundla, which, in turn, are grouped into four regions, each with a regional administrator and a regional health management team.

31. The estimated population for 1994 is 894,100 and the per capita gross national product is $1,050. However, poverty and deprivation have increased in the 1990s owing to declining family incomes. In this connection, 39 per cent of all households are headed by women, with an incidence of poverty nearly double that of male-headed households. Some 72 per cent of Swazis are rural dwellers, many of whom live in absolute poverty. Poverty could worsen owing to an anticipated reduction in the Southern African Customs Union transfers to Swaziland, which account for nearly one half of government budget resources.

32. In the mid-1980s, Swaziland experienced rapid economic growth and progress towards achieving the goals for children for the year 2000. Immunization coverage of infants rose from 14 to 89 per cent and use of oral rehydration therapy (ORT) is estimated at 84 per cent. Life expectancy has increased by 29 per cent and IMR declined by an impressive 41 per cent from 168 per 1,000 live births in 1966 to 98 in 1992. However, infant and under-five mortality are highest in the savannah eastern part of Swaziland.

33. One quarter of all infant mortality occurs during the neonatal period owing to low birth weight, congenital syphilis or perinatal conditions. Some 55 per cent of all infant deaths occur between the second and sixth months of life. Hence, in contrast to many other countries, the majority of infant deaths occur after the neonatal period. Most infant deaths could be prevented through relatively simple initiatives by villages and Tinkhundla by giving greater attention to improved antenatal and post-natal care. Acute respiratory infections (ARI), diarrhoeal diseases and malnutrition, combined with non-exclusive breast-feeding, poor weaning practices and unsanitary living conditions, account for 53 per cent of reported infant mortality and 70 per cent of under-five deaths.

34. A national AIDS programme sentinel surveillance survey estimates HIV prevalence at 18.5 per cent among the sexually active population as opposed to 3.9 per cent in 1992; 18 and 58 per cent of reported AIDS cases are in children under 4 years of age and adults between 20 and 39 years of age, respectively. Some 23 per cent of mothers aged 15-19 years are HIV-positive, and females in this age-group are infected at a rate four times greater than that of males. It is estimated that by 1996, 5 per cent of all Swazi children will be orphaned because of AIDS.

35. The official MMR of 110 per 100,000 live births is probably underestimated as the sample covers only 56 per cent of deliveries, those which occur in health facilities. Some 75 per cent of maternal deaths are a result of direct obstetric causes of induced abortion, eclampsia, obstructed labour, haemorrhage

and infection. The remaining maternal deaths are attributed to the mother's age, high parity, closely spaced pregnancies, multiple infections and poor nutritional status. Teenage pregnancies account for 27 per cent of all recorded deliveries, a figure that could rise as the high population growth rate of 3.2 per cent creates a larger adolescent population.

36. Chronic malnutrition affects 3 out of every 10 children. Undernutrition is a serious problem between the ages of 6 and 24 months and is associated with inadequate breast-feeding and weaning practices. Virtually all mothers initiate breast-feeding and continue nursing up to 18 months, but only 8 per cent practise exclusive breast-feeding. Two thirds of all infants are introduced to supplementary foods at age two months, and breast-feeding is often interrupted when the baby is ill.

37. A 1993 iodine deficiency survey confirmed that moderate to severe iodine deficiency ranges from 6 to 38 per cent, with the most acute situation in western Swaziland. Although a study of vitamin A deficiency has yet to be undertaken, the relatively high infant and child morbidity and mortality rates suggest a problem, especially in areas with chronic drought.

38. Although the Government currently spends 41 per cent of its revenue on social programmes, the population living in isolated, rural pockets is still underserved. For example, only 16 per cent of the three- to five-year age-group are enrolled in pre-schools. The annual primary school drop-out rate is 5 per cent and the repetition rate is 26 per cent. There is social pressure on girls to leave school upon completion of primary education to work or if they become pregnant. In 1994, gross and net enrolment rates for primary school were 100 and 80 per cent, respectively, and the adult literacy rate was 70 per cent.

39. Some 80 per cent of the urban population and 40 per cent of rural dwellers have access to safe drinking water. This level may not be sustained unless there is a more clearly defined government policy on sustainability and improved maintenance of water systems.

40. The most important challenge to improving and maintaining the health and educational status of women is to elevate their position in Swazi society to one of equal standing with men. Although women are legally ensured of equality of opportunity for employment, they have limited access to managerial positions. Also, women's rights are not sufficiently protected regarding property ownership and inheritance. Furthermore, marriage laws classify women as minors who need the consent of their husbands regarding legal matters. Field observation suggests that a significant number of girls are street children or adolescent prostitutes.

Programme cooperation, 1991-1995

41. The 1991-1995 programme of cooperation focused mainly on increasing coverage of basic services by providing supplies, e.g., essential drugs and equipment, to strengthen service delivery systems, in particular MCH care services.

42. UNICEF supported MCH mainly through (a) training of health personnel and community volunteers on preventive, promotive and curative health; (b) social mobilization and advocacy; and (c) procurement of supplies. In 1991, UNICEF procured almost all of the country's supply of vaccines. However, in 1993 the Government began to procure 50 per cent of the national vaccine requirements. UNICEF support for communication and social mobilization helped to increase and sustain the commitment of political leaders and the demand for immunization services among mothers. The mid-decade targets of eliminating poliomyelitis and neonatal tetanus, therefore, appear achievable. As the immunization programme is integrated with other MCH activities, reaching the target for universal child immunization has also strengthened the entire system for health services.

43. With regard to the Baby-Friendly Hospital Initiative and the household food and income security programme, the Government developed a policy on infant feeding for all health centres based on the "ten steps to successful breast-feeding". There are six major hospitals in Swaziland, of which four were assessed as "baby-friendly" and another two received certificates of commitment. The country programme framework was adjusted, and UNICEF also supported hand-pump installation and pit latrine construction as part of a drought emergency intervention.

44. The basic education programme was discontinued because it was comprised of a disparate set of interventions with insufficient integration. However, as a result of the mid-term review, its elements were incorporated into a newly created social mobilization programme.

Lessons learned

45. The 1993 mid-term review of the country programme was seminal in that a new strategic approach emerged for both implementation of sectoral programmes and the UNICEF programme management role.

46. The assessment concluded that the country programme had too many projects (17) and that the activities were not sufficiently integrated within a comprehensive strategic framework. With the advent of the national programme of action in 1991, it became clear that Government-UNICEF cooperation should strengthen monitoring of progress towards achieving and sustaining the national programme of action goals as there was limited national capacity for the systematic monitoring of the situation of children. Furthermore, more viable programmatic approaches were needed for underserved areas.

47. The cooperation also needed to give greater attention to programme management systems rather than focus too heavily on a supply-oriented approach for increasing access to services as Tinkhundla, and the chiefdoms were becoming more actively involved in service delivery. The Tinkhundla can help to improve coordination between the central administrative regions and communities.

48. The population is scattered in homesteads, and the mountainous terrain makes some areas difficult to access. Although coverage for services such as immunization and ORT is already high, it is not universal. Therefore, more consistent and long-term efforts should be made to extend services to difficult to serve areas, including the urban poor.

49. Research suggests that although people's knowledge about children's and women's needs is often high, their behaviour is often at odds with promotive health norms. For example, knowledge about contraception and AIDS is relatively high, but the actual use of contraceptives and condoms is only 22 per cent. Over 96 per cent of pregnant women make at least one antenatal clinic visit, but only 56 per cent deliver in health facilities.

50. UNICEF assistance for service delivery is still necessary, primarily to fill clearly identifiable gaps on a short-term basis. A more long-term role for UNICEF in Swaziland will be to advocate with the Government for more effective mobilization of other service agencies, including non-governmental organizations and the private sector. UNICEF cooperation should evolve to focus more on policy advocacy as a means to expedite programme implementation at all administrative levels. For example, cost-effective ways to promote the Convention on the Rights of the Child need to be identified, such as the Convention providing a concrete ethical basis for achieving the decade goals and addressing other issues such as HIV/AIDS prevention.

51. It is important to strengthen strategies, e.g., self-sufficiency in vaccines, which will sustain the gains made in primary health care (PHC). Such strategies would include (a) additional government resources for the recurrent costs for vaccines and oral rehydration salts (ORS); (b) the promotion of community ownership of activities and community financing; and (c) increasing the capacity of local leadership to plan and manage projects.

Recommendation for additional general resources for the approved country programme, 1991-1995

52. The country programme for Swaziland for the period 1991-1995 was approved by the Executive Board in 1991 with available general resources of $2,500,000 (E/ICEF/1991/P/L.20). In 1994, the Executive Board approved an additional $919,340 from general resources for the programme period (E/ICEF/1994/P/L.30). The Executive Board is being requested to approve an additional amount of $100,000 from general resources for 1995 to accelerate activities for achieving the remaining mid-decade goals as well as to maintain and improve on the achievements made thus far. The focus will be on maintaining high levels of immunization coverage (89 per cent), with particular emphasis on eradicating poliomyelitis, eliminating neonatal tetanus and reducing the incidence of measles. The use of ORT, currently estimated at 84 per cent, will be increased to 90 per cent by 1995. To combat the high morbidity and mortality rates, UNICEF will continue to provide essential drugs, including vaccines and ORS, support refresher training of health staff and promote health education. Another priority will be to strengthen the decentralization of health services and to build regional capacity for effective preventive, curative and health promotion services. Safe motherhood will be addressed more vigorously in order to improve the quality of prenatal and maternity care services, especially with respect to emergency interventions. Malnutrition, reflected in the high rate of stunting of children under five years old, will continue to be a major concern. UNICEF will support activities for promoting breast-feeding and improved young child-feeding practices through community-based initiatives.

Annual funding requirements

(In thousands of United States dollars)

Current programme cycle	Approved general resources funding a/	Additional funding proposed 1995	Total
1991-1995	650	100	100

a/ The amount shown here includes the actual balance carried over from the previous programme cycle.

Recommended programme cooperation, 1996-2000

Estimated annual expenditure

(In thousands of United States dollars)

	1996	1997	1998	1999	2000	Total
General resources						
Social policy development	75	80	90	90	105	440
Health and nutrition	375	320	340	290	300	1 625
Water supply and environmental sanitation	105	120	95	105	90	515
Basic education	80	115	95	115	105	510
Programme support	115	115	130	150	150	660
Subtotal	750	750	750	750	750	3 750
Supplementary funding						
Social policy development	95	90	110	95	50	440
Health and nutrition	205	230	245	245	275	1 200
Water supply and environmental sanitation	100	120	100	90	110	520
Basic education	150	110	95	120	115	590
Subtotal	550	550	550	550	550	2 750
Total	1 300	1 300	1 300	1 300	1 300	6 500

Country programme preparation process

53. The strategy meeting, which produced a programme framework, was followed by a programme formulation process, based on intensive Government-UNICEF consultations, including comments from some UNICEF Executive Board member countries. The 1996-2000 programme of cooperation builds on the likelihood of Swaziland achieving and sustaining the mid-decade goals and on the lessons learned during the previous country programme. The achievement of the mid-decade goals will be used as a springboard for achieving the major national programme of action goals for the year 2000.

54. The two country programme objectives, which will serve as a catalyst for achieving the national programme of action goals, provide a role for UNICEF cooperation that is complementary to the roles of other United Nations agencies involved in social development. In all programme sectors, UNICEF Swaziland will apply three approaches: (a) building capacity by providing financial and technical support to implementing partners for local-level planning, monitoring and programme implementation; (b) reinforcing support services by developing programme communication, advocacy and social mobilization; and (c) maintaining the provision of supplies for deprived rural and urban areas.

55. The first objective is to promote implementation of the national programme of action goals nationwide through advocacy and social mobilization. The second objective is to contribute and support the major national CSD goals, especially for children most at risk, in selected rural and urban areas. In these selected locations, UNICEF cooperation will help to achieve the following national programme of action goals, or their equivalents, based on targets developed by local government administrations: to reduce IMR from 98 to 75 per 1,000 live births; to reduce U5MR from 141 to 110 per 1,000 live births; to reduce MMR from 110 to 75 per 100,000 live births; virtually to eliminate iodine deficiency disorders (IDD) and vitamin A deficiency; to increase to 90 per cent the proportion of all primary schools, clinics and outreach sites with access to safe drinking water and sanitary means of excreta disposal; and to increase the primary school completion rate to 85 per cent within the areas of programme implementation.

Objectives and strategies

56. The main goal will be to move beyond increasing coverage of basic services to achieve a more positive impact on child survival, development and protection. The objectives of the national programme of action will be pursued in the geographical areas designated for UNICEF cooperation. The country programme strategy employs the following three main interrelated types of strategies: (a) sustaining and increasing the coverage of social services; (b) strengthening the quality of service delivery and social planning; and (c) empowering Swazi citizens, particularly women, for greater participation in the development process. The structure of UNICEF cooperation includes improving the quality and impact of direct services (e.g., safe motherhood) and more systematic support services (e.g., social policy developments for children and women). The country programme will also have two mutually supportive components: (a) sectoral cooperation, with an emphasis on delivering inputs for direct services through ministries and departments, primarily on a national basis (e.g., health, water

supply and education); and (b) cross-sectoral support services (advocacy, social mobilization, communication, planning and monitoring), with a focus on local-level capacity-building and community empowerment. The phasing of programme implementation will include an additional 11 Tinkhundla per year for a total of 55 Tinkhundla, or about 20 per cent of the population. However, UNICEF will assist virtual universal immunization coverage of infants and universal consumption of iodized salt. Advocacy and social mobilization activities will be nationwide. There are four strategies themes which permeate the country programme.

57. Responsiveness to community initiatives. Development of more effective local-level participatory mechanisms will promote more productive collaboration between governmental and customary governance (e.g., chieftainships). In addition, there will be an ongoing dialogue between the providers of basic services and organized groups of beneficiaries from communities.

58. Sustaining survival achievements. Strengthening the sustainability of service delivery for successful national programmes, such as EPI, will focus on five interrelated factors: long-term political support; financial resources; managerial competence; technical expertise; and cultural acceptance.

59. Disparity reduction. The relatively high levels of child malnutrition and under-five mortality indicate that many children have not benefited from the economic boom of the 1980s. Therefore, disparity reduction will be an overarching concern in itself and essential to achieving the national programme of action goals. UNICEF cooperation will target children at high risk in both rural and urban areas.

60. Information, advocacy and social mobilization for policy development. Government-UNICEF cooperation will engage in high-level and national-level advocacy with policy makers, legislators and other donors for improving the social and legal environment for children and women. Social mobilization in all regions and communities, combined with the provision of technical assistance for programme planning and management and better utilization of national resources, will strengthen implementation of national policies as they are adapted to local conditions. Through more targeted communication and training, the country programme will improve the impact of information dissemination and strengthen the motivation and abilities of communities and families to provide leadership for and support initiatives.

Social policy development

61. This programme aims at strengthening government-wide programme planning and advocacy for children and women so that children’s needs and gender equity become higher priorities on Swaziland’s development agenda. The programme will establish a policy and legislative framework based on the Convention on the Rights of the Child for safeguarding the basic rights of children and women. Strategies for decentralization and community participation should empower communities to promote government accountability for children and women’s rights.

62. Programme communication activities will be included in all programmes. Activities will help to build government and NGO capacities to undertake communication initiatives considered essential for achieving the country programme objectives. There will be an emphasis on standardizing messages and coordinating information dissemination through all governmental, NGO and donor parties involved in the programmes. Advocacy and social mobilization for child protection and gender equity will address gaps in legislation and the need for behavioural changes. A special concern will be the protection and development of children and women in difficult circumstances, e.g., the impact on children whose parents die from AIDS and the right of these children for care. The planning, evaluation and goals monitoring components will strengthen these capacities at national, regional and community levels.

63. An integrated monitoring and evaluation plan has been designed to cover all sectoral programme plans of operation. A mid-programme review is planned for 1998 and an impact evaluation for the year 2000. Systematic data collection and analyses will be undertaken annually at community and regional levels by various governmental institutions and organizations, including non-governmental organizations and rural health motivators. A national programme of action monitoring and evaluation group will promote and coordinate periodic analyses of the situation of children and women and suggest improvements for supervision, monitoring and evaluation systems. Allocations to human development priorities will also be monitored, together with per capita spending on basic services. External resources for the national programme of action will be mobilized through an emphasis on private sector fund-raising. Regional action plans will be prepared annually as part of the rolling, three-year national budgeting and planning process.

Health and nutrition

64. The integrated health and nutrition programme aims to increase quality, access and coverage of basic health services for at least 150,000 underserved rural and urban children and women. The strategy is to reinforce the present integration of maternal health, EPI, the control of diarrhoeal diseases (CDD), ARI and nutrition activities into a comprehensive PHC service package, whose management will be strengthened at regional and community levels. Activities will focus on building the capacity of regional health management teams and strengthening the working relationships between them. Clinic nurses and community extension workers will be critical to the integration process. Regional health management teams will improve communication services with families. Special attention will be given to the development of interpersonal skills of health and family planning workers who work directly with families. UNICEF support to the health sector will be closely coordinated with assistance from several other donors such as WHO, the United States Agency for International Development (USAID), UNFPA and various non-governmental organizations.

65. EPI will add additional activities as a "plus component" and will (a) distribute vitamin A capsules to both children under five years of age and lactating mothers; (b) increase and sustain present immunization coverage levels; (c) expand the focus from mainly immunization coverage to disease reduction; (d) strengthen disease surveillance capacity; and (e) further develop

a sustainable vaccine supply and financing system by focusing on local government support. These will be achieved by identifying the underserved areas, maintaining advocacy at all administrative levels and strengthening management and supervision responsibilities at regional levels. Health staff in all 55 Tinkhundla will be trained in improved disease surveillance for the eradication of poliomyelitis and neonatal tetanus and the further reduction of measles morbidity and mortality.

66. The major strategy for safe motherhood and family planning will be to promote and improve access to prompt and competent emergency obstetric services. The quality of emergency care for obstetric complications will be improved through ensuring the availability of basic equipment and decentralizing the management system. Other related interventions will include the training of 500 traditional birth attendants, creating awareness and promoting action with communities for improved maternal care, and supporting the establishment and upgrading of other maternal health services at district and regional levels. The problem of adolescent reproductive health will be addressed through expanding family life education so as to reduce the risks of unwanted pregnancies and sexually transmitted diseases, including HIV infections in girls aged 15-19 years.

67. HIV/AIDS education for youth is aimed primarily at achieving a change in the sexual behaviour of Swazi adolescents in all 500 primary schools. Culturally compatible and novel teaching and learning materials, including gender-sensitizing topics and life skill modules, will be developed to promote sexually responsible attitudes and behaviours. Furthermore, children will be supported as "knowledge carriers" so that they are able to transmit what they have learned in school into their homes and communities. The mobilization and support of head teachers, teachers, parents, members of school committees and traditional leaders will also be a priority.

68. CDD and ARI services will focus on the prevention of diarrhoeal diseases and on correct standard case management of watery, bloody and persistent diarrhoea and ARI. This will be done through the training of 1,000 health staff and social mobilization and communication activities. Hard-to-reach areas, including peri-urban zones, will be identified and targeted where households may not have sufficient access to information about ORT or sufficient quantities of ORS sachets. Home therapy for the treatment of diarrhoeal episodes, coupled with emphasis on continued feeding and early recognition and appropriate referral of ARI cases to health facilities, will be promoted.

69. The promotion of breast-feeding and appropriate weaning practices is aimed at improving the proportion of exclusively breast-fed babies from 8 to 50 per cent and promoting appropriate weaning practices for children under three years of age. This will be achieved by promoting breast-feeding through non-formal education, communication and social mobilization channels. The target groups will be girls and women 15-25 years of age who account for more than 50 per cent of all deliveries. Support will be continued to the Swaziland Infant Nutrition Action Network to strengthen the Baby-Friendly Hospital Initiative in six hospitals and to expand it to other health facilities (public and private) with maternity services.

70. An initiative on the elimination of micronutrient deficiencies is aimed at improving the nutritional status of children under five years of age and women of child-bearing age. As all salt for human consumption comes from South Africa, IDD will be eliminated by enforcing legislation on the importation of iodated salt and advocacy with the public on the importance of the consumption of iodated salt. Constant monitoring of IDD indicators in high-risk areas will be carried out systematically by health workers. Vitamin A and iron deficiencies will be addressed by (a) encouraging the home production and consumption of vitamin A- and iron-rich foods; (b) providing iron and vitamin A capsules to high-risk children and women; and (c) sensitizing the public and mothers, in particular, on the importance of providing a healthy diet for young children.

Water supply and environmental sanitation

71. The programme comprises two components: (a) the provision of safe water and Blair ventilated improved pit latrines to primary schools and clinics; and (b) the promotion of environmental health education. The overall objective of the programme is to increase the proportion of the rural population with access to safe water and adequate sanitation, to reduce the incidence of diarrhoeal diseases for about 50,000 schoolchildren and to treat in-patients and out-patients in 50 clinics and outreach health stations. A principal focus is on improving family awareness of environmental health issues. The regional health management teams will be the principal agents to reinforce health education in primary schools and clinics. An intersectoral approach will be developed to involve primary schools, women's organizations, mass media and community leaders in reinforcing hygiene education.

72. UNICEF will advocate for a country-wide water supply and sanitation programme based on affordable, appropriate technology for hand-pumps and Blair latrines. This option would keep the per capita cost within the accepted global norm of $10-$20. Community training and participation in the management, operation and maintenance of a safe water supply is an integral part of the programme. As Swaziland has a high per capita cost for rural water supply, UNICEF advocacy for the hand-pump option would help to accelerate rural water supply coverage.

Basic education

73. The emphasis of basic education will be on improving the overall quality of primary education by doubling the number of children who graduate through reducing drop-out and repetition rates by 50 per cent. UNICEF assistance will cover 150 out of a total of over 500 primary schools. These schools will be selected according to criteria including equitable geographic representation, achievement scores, repetition and net enrolment rates and the strength of the school committees. To maintain high enrolment rates and to address gender issues, priority will be given to sensitizing communities on the development needs of children and the importance of primary education. Implementation will be mainly at the subnational level, with a strong emphasis on involving communities in managing educational activities.

74. At the national level, UNICEF will assist in improving the primary school curriculum through continuous assessments and incorporation of health education. Primary school teachers will be trained in monitoring and assessment techniques. Hard-to-reach youth will be attracted and retained by developing alternative and more creative strategies for both formal and non-formal education. Efforts will also be made to increase access and make the educational system more flexible and efficient. Moreover, a policy advocacy component will address various costs and financing issues related to improving the quality and relevance of primary education and giving more attention to impoverished children and especially the girl child.

Cooperation with other organizations

75. UNICEF will work closely with other United Nations agencies, donors and national non-governmental organizations to further develop cooperation in operational research, supervision, monitoring, training and enhanced information exchange. A technical working group is planning and overseeing implementation of a decentralized, "Health for All" package. UNICEF, WHO and UNFPA have been cooperating effectively on this initiative since 1993 to promote the active involvement of regional structures and communities in MCH programmes. Other coordination activities are planned to sustain MCH achievements and, at the same time, strengthen interventions pertaining to EPI, AIDS prevention, the safe motherhood initiative, improved nutritional practices and environmental care. Many donors, including UNICEF, are working with the Government to formulate a national development strategy. With respect to the country strategy note, UNICEF will strengthen its cooperation with United Nations agencies, the World Bank and the Overseas Development Administration (United Kingdom) on poverty alleviation, with a focus on reducing disparities in coverage of basic social services. During the first two years of the country programme, UNICEF will cooperate with USAID in the education sector to strengthen capacity for assessment and information management systems in primary schools.

Programme support and management

76. To respond to the new programmatic needs and to meet the requirements of the new strategies of decentralization, the management and staffing structure of the UNICEF office will need a realignment of responsibilities, including for management and monitoring of decentralization and social mobilization activities. Staff will assume additional tasks, including more frequent field visits to monitor implementation.

77. A genuine devolution of central government management responsibilities to regional and Tinkhundla levels is essential for the successful implementation of the country programme. At the national level, the Ministry of Economic Planning and Development, jointly with the Central Office for Tinkhundla, will be responsible for the overall coordination of the programme of cooperation. They will ensure that adequate support is given to regional and Tinkhundla level structures in terms of supplies, manpower, finances and coordination.

78. The responsibilities of the regional governments for the implementation of various programmes will be specified in annual regional project plans of action. Within this management framework, one of the unique funding approaches to be

developed will be the identification and use of community and regional resources, which could increase the organizational and operational efficiency of the Tinkhundla. Continued support from donors and the private sector will be essential.
