



# The 2021 Situation Analysis of the Status and Well-Being of Children in Zambia

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for every child

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## FOREWORD



This *2021 Situation Analysis of the Status and Well-being of Children in Zambia* is the culmination of a joint effort by the Government of the Republic of Zambia and the United Nations Children's Fund (UNICEF) to take stock of the progress that has been made towards improving the welfare of children in Zambia, to better understand the vulnerabilities they still face, and the reasons and drivers behind the deprivations faced by many children which consequently impede the full enjoyment of their rights.

This analysis comes at an opportune time as Zambia develops its Eighth National Development Plan; as the United Nations in Zambia develops its next five-year Sustainable Development Cooperation Framework; and as UNICEF develops its five-year programme of cooperation with the Government. The common thread that runs through all these plans and frameworks is the shared commitment to promote the rights and well-being of Zambia's children, who make up over half of Zambia's population.

The following pages present an important snapshot and record of the status of child development and respect for child rights in Zambia. Behind each statistic is the story of Zambia's children, and the opportunities and obstacles they face through their life course. This report, therefore, provides insights into areas where the situation of children has improved, and where significant challenges remain.

This report is intended to inspire action towards stepping up efforts where evidence has presented poor outcomes for children, while also building upon the good lessons and doing more and better for Zambia's children, and in doing so – secure the future of Zambia by achieving the ambitious targets the country has set for itself.



**Permanent Secretary**  
Ministry of Finance and National Planning  
Mr. Trevor Kaunda



**Representative**  
UNICEF Zambia  
Ms. Noala Skinner

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# ABBREVIATIONS

7NDP	Seventh National Development Plan
AFDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
CMR	Child Mortality Ratio
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
CSRHE	Comprehensive Sexual and Reproductive Health Education
DHS	Demographic and Health Survey
ECD	Early Childhood Development
ECE	Early Childhood Education
FAO	Food and Agriculture Organization (of the United Nations)
FGD	Focus Group Discussion
FISP	Farmer Input Support Programme
FSP	Food Security Pack
GDP	Gross Domestic Product
GEI	Gender Equality Index
GEWEL	Girl Education Women Empowerment and Livelihoods
GII	Gender Inequality Index
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
ICCM	Integrated Community Case Management
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IYCF	Infant and Young Child Feeding
JMP	Joint Monitoring Programme
KGS	Keeping Girls in Schools
KII	Key informant interview
LCMS	Living Conditions Monitoring Survey
M&E	Monitoring and Evaluation
MCDP	First 1,000 Most Critical Days Programme



MCDSS	Ministry of Community Development and Social Services
MHM	Menstrual Hygiene Management
MLSS	Ministry of Labour and Social Services
MMR	Maternal Mortality Ratio
MNPD	Ministry of National Planning and Development
MoA	Ministry of Agriculture
MODA	Multiple Overlapping Deprivation Analysis
MoGE	Ministry of General Education
MPI	Multidimensional Poverty Index
MTCT	Mother to Child Transmission
MYSKD	Ministry of Youth, Sport and Child Development
NGO	Non-Governmental Organisation
NMR	Newborn Mortality Rate
NPF	National Planning Framework
NSPP	National Social Protection Policy
PHC	Primary Health Care
PWAS	Public Welfare Assistance Scheme
RMNCH	Reproductive, Maternal, Newborn and Child Health
SCTs	Social Cash Transfers
SDGs	Sustainable Development Goals
SRHR	Sexual Reproductive Health Rights
SUN	Scaling-Up Nutrition
U5MR	Under-five Mortality Rate
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
UNJPSP	United Nations Joint Programme on Social Protection
VNR	Voluntary National Review
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization
ZamStats	Zambia Statistics Agency
ZDHS	Zambia Demographic and Health Survey

# EXECUTIVE SUMMARY

This report examines the current national context and Zambia's progress in safeguarding the rights and improving the welfare of children and adolescents. It also identifies causes of shortfalls and inequities to directly address issues through risk-informed, equity-focused efforts. Findings and insights presented in the report are based on nationally endorsed data sources, such as the Zambia Demographic and Health Survey (ZDHS), Living Conditions Monitoring Survey, National Census, Vision 2030, the Seventh National Development Plan (7NDP), budget analyses, published scientific and grey literature, and sector-specific analyses and administrative data (e.g., the Health Management Information System and Education Management Information System). Furthermore, to investigate trends in the situation of children and adolescents in Zambia on the ground, field research was conducted across six provinces in Zambia: Luapula, Copperbelt, Southern, Western, Eastern and Central.

## **The national context**

Zambia has one of the world's fastest growing populations. The United Nations projects that the population will almost triple by 2050. If this is the case, then any economic growth under 2.7 per cent per annum (and thus below population growth) will lead to lower income per capita, and thus the country would end up being poorer by 2050. The economy needs to grow by significantly higher proportions and include the poorer strata of society to reduce poverty. While approximately 59 per cent of the population resides in rural areas, the trend is being reversed as urban population growth outstrips rural growth. With three quarters of its population estimated to be living on less than US\$1.90 per day, this lower-middle-income country has high levels of inequity in income distribution. About 54 per cent of the population lives below the poverty line. Inequality remains high and Zambia recorded a Gini coefficient of 49.50 in 2018: this points to significant room for wealth redistribution in addition to driving an agenda of inclusive growth for poverty reduction. Poverty in its multiple dimensions is also addressed by public social policies. However, increasing public debt together with inadequate budget allocations to social sectors have created constraints for social spending. Nearly three-quarters of Zambia's tax revenues go toward debt service. In 2019, Zambia had a budget deficit of 10.9 per cent of gross domestic product (GDP).

Zambia has a legal framework that guarantees equality between men and women. The extent to which these legislations have translated into outcomes for women can be deciphered through certain trends and data. The number of women who reported to have experienced physical violence has declined from 43.3 per cent in 2014 to 36 per cent in 2018. The proportion of seats held by women in the Parliament has remained low at 19 per cent since 2016. On a positive note, the proportion of local government seats held by women rose from 10 per cent in 2016 to 38 per cent in 2019. Challenges in translating policy and regulation to action include lack of gender-disaggregated data for planning, monitoring, and evaluation (M&E); difficulties in enforcing statutory law in a traditional setting and persistent low representation of women in leadership.

## **Early childhood development**

The crucial structural foundation for human and social development is laid in the first 1,000 days of a child's life. These early years represent a critical development phase of the parts of the brain that are responsible for physical and motor activities, thought, memory, social and emotional behaviours, perceptual and sensory faculties, and language. Holistic and integrated early childhood development (ECD) interventions in life—in health, nutrition, nurturing care, water and sanitation, early learning, and protection, therefore set a trajectory for lifelong good health and well-being.

The current situation analysis found the quality of early childhood education (ECE) to be wanting in Zambia: 40 per cent of teachers are untrained and those who are trained are not necessarily trained in appropriate pedagogy for early years education. Currently only 35 per cent of children have access to early learning,<sup>1</sup> especially in rural and hard-to-reach areas and this is widening the equity gap. The 2017–2021 Education Sector Plan identifies ECE as a key strategic priority with several strategies outlined to accelerate access to ECE and improve quality, equity, efficiency, and effectiveness. Parents in Zambia have limited knowledge about the importance of early stimulation and playful parenting and tend to focus on practical and physical care of young children, rather than the socioemotional care, early learning and development.<sup>2</sup>

In 2017, the Government launched the 2016 Early Childhood Development Lancet Series in Zambia, and thereafter adapted the Child's Healthy Growth and Development package to train frontline workers in key family and community care practices to promote family well-being and optimal child development. Following this, in 2018 the Government adopted the Nurturing Care Framework (NCF) for ECD and committed to scaling up Nurturing Care for ECD and Care for Child Development (CCD). Public information about ECD, particularly responsive caregiving and playful parenting, is still permeating Zambian society since the launch of the playful parenting campaign.

The different government line ministries have no one, unified policy or framework under which they can frame and align ECD interventions. While the current policy environment in which ECD programming is being delivered is aligned to international commitments and national policies, guidelines and strategic service delivery platforms, there is currently no national multisectoral ECD policy that guides delivery of nurturing care to children. This hinders progress towards the country's vision for accomplishing developmental goals for young children. There is also limited capacity among multisectoral structures at the national, provincial and district levels. National platforms like the Zambia ECD Action Network (ZECDAN) and the National ECD Technical Committee are promoting the multisectoral ECD agenda, but these structures currently need greater capacity to perform their functions. It is therefore recommended that an overarching National Multisectoral ECD Policy Framework is developed which will serve to improve ECD workforce capacity and intersectoral collaboration, strengthen data, indicators, and assessment of progress, and agree on a consistent, national definition of ECD.

## **Education**

The education sector in Zambia is guided by the Zambia National Education Policy 1996, the Education and Skills Sector Plan 2017–2021, and the National Higher Education Policy 2019. These policies are aligned with the 7NDP, which emphasises the development of quality human capital, including investment in quality education and skills development. A striking achievement of the education and skills sector is the attainment of gender parity in enrolment at primary school level. In 2016, 89 per cent of eligible girls and 90 per cent of eligible boys were enrolled in primary school. In 2019, enrolment declined slightly, but there were still more girls (89 per cent) enrolled than boys (85 per cent). In 2018, the national average dropout rate from Grade 1 to 7 was 1.7 per cent, compared to 1.2 per cent from Grade 8 to 12. ZDHS 2018 data shows that, in general, more boys than girls attend school in upper secondary than in primary and lower levels. Girls are more likely to drop out of upper secondary school: in fact, while less than a fifth of girls are out-of-school at primary-level, nearly half will have dropped out

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<sup>1</sup> Ministry of General Education (2018) Education Statistics.

<sup>2</sup> ECD KAP survey, 2020 by M&C SAATCHI, UNICEF Zambia.

of school by the upper secondary level. The official school entrance age into Grade 1 is seven years, and in 2018 the primary school net intake rate (NIR) was reported as being just 54.5 per cent of the total population of eligible children—the remaining children mostly began at an older age. This late school start and the insufficient access to ECE results in Zambian children losing age-appropriate education.

A major challenge that the education sector faces is the extremely low levels of attainment, especially in literacy and numeracy. The situation is possibly worse than the data suggests because many children, who are failing in school, may have dropped out before taking exams. Improving the quality of teaching is crucial, and both pre- and in-service teacher training at primary level needs to have a strong focus on appropriate pedagogy for the relevant age group, with an emphasis on teaching literacy and numeracy. It is recommended that the education sector prioritises education in budget allocation, strengthens focus on age-appropriate pedagogy, expands and develops flexible Alternative and Distance Education, reviews and strengthens the Grade 1 entry process, provides all 6-year-old children with at least one year of ECE, and focuses on and prioritises children and schools in the most disadvantaged and hardest to reach areas.

### **Health and HIV**

Maternal mortality has continued to decline from 591 deaths per 100,000 live births in 2007 to 398 deaths per 100,000 live births in 2013/2014 and 278 deaths per 100,000 live births in 2018. However, a recent analysis of Maternal and Perinatal Death Surveillance and Response (MPDSR) data for 674 maternal deaths at public health facilities in Zambia in 2018–2019 by Zambia National Public Health Institute highlights that Zambia is not on track to achieve the Sustainable Development Goal (SDG) 3 target for maternal mortality rate (MMR).<sup>3</sup>

There have been steady progresses in the reduction of under-five mortality rate (U5MR) and infant mortality rate (IMR). As per ZDHS 2018, the U5MR reduced from 75 in 2013–14 to 61.7 in 2018 and the IMR reduced from 45 in 2013–14 to 42 in 2018 per 1000 live births. However, it is of great concern that newborn mortality rate (NMR, the probability of dying within the first 28 days of life) increased from 24 deaths per 1,000 live births in 2013–14 to 27 deaths per 1,000 live births in 2018. The main causes of newborn deaths are reported as asphyxia, neo-natal sepsis, and prematurity. Mitigating all three, but especially asphyxia, depends on the technical skill of the birth attendant. According to the ZDHS, there has been an increase in the proportion of women whose delivery was attended by a skilled health worker from 64 per cent in 2015 to 80 per cent in 2018. The uptake of antenatal services also saw a surge, with the majority of women (97 per cent) aged 15–49 years had a live birth in the five years preceding the survey and received antenatal care (ANC) from a skilled provider during their most recent birth. However, the high newborn mortality rate reflects the inadequate quality of care (QoC), especially during the intrapartum period (during labour and delivery). The Ministry of Health (MoH) has produced Essential Newborn Care Guidelines, but this and capacity building, has not yet taken place across the whole country. The ZDHS 2018 reports that acute respiratory infection (ARI), predominantly pneumonia, is a major cause of childhood morbidity and mortality.

Knowledge and use of modern methods of family planning are an important determinant of empowering couples and particularly women in deciding when and how many children to have. Despite improved knowledge of modern methods of family planning, only 48 per cent of married women aged 15–49 years use modern methods of family planning. The country has, however,

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<sup>3</sup> Gianetti B, Musakanya KE, Ngomah Moraes A, Chizuni C, Groeneveld C, Kapina M, Hamoonga R, Mazaba ML, Mukonka V. Maternal mortality trends and correlates in Zambia. *Health Press Zambia Bull.* 2019; 3(4&5); pp 12–16.

recorded an improvement in the use of modern methods among married women aged 15–49 years over the years from 9 per cent in 1992 to 48 per cent in 2018.

The 2018 ZDHS results show improvements in basic vaccination coverage. The percentage of children aged 12–23 months who received all basic vaccines increased from 68 per cent in both 2007 and 2013–14 ZDHS to 75 per cent in 2018. However, high levels of invalid vaccination coverage (only 46 per cent valid full immunisation coverage as per ZDHS 2018), high drop-out rates (especially from Penta-1 to measles, which is over 20 per cent), wide range of inequities in coverage (especially between urban and rural, and by economic quintile) and outbreaks of vaccine preventable diseases (VPD), including measles and polio, are key concerns.

While Zambia has made significant progress towards achieving the 90:90:90 global targets for HIV epidemic control, Zambia's Mother to Child Transmission (MTCT) rate of HIV remains high at 11 per cent and far from the target for virtual elimination, which is set for less than 5 per cent by 2021.<sup>4</sup> Key recommendations include the need to investigate root causes of newborn deaths, and to identify and address barriers and bottlenecks in health facilities. Improvements are needed in several areas including coordination between health-related partners, in providing quality, equity and dignity in Reproductive Maternal Newborn Child Health (RMNCH) services, in human resources for health, and in data and evidence-informed programming. Primary health care (PHC) needs to be strengthened and referral linkages are to be built along with strengthening of systems for improved maternal, perinatal and neonatal health. Gains made with re-vitalising immunisation systems and services are to be sustained. Communities need to be empowered and community-based health services are to be strengthened, including efforts in public information and awareness raising, community participation, community health workforce enhancement, community-based supply chain management and financing of community health programme.

## **Nutrition**

Despite a gradual and steady progress in different nutritional outcomes in the country, based on the current nutrition situation, the country is not on course to meet the global nutrition targets established by the World Health Assembly. Malnutrition among women and children continues to be a challenge, impeding the overall socioeconomic development of Zambia. Chronic malnutrition, manifesting as stunting remains a serious problem. Even though the country has made incremental progress in the reduction of stunting, with stunting prevalence having declined nationally from 40 per cent in 2013 to 34.6 per cent in 2018, the persistent widespread prevalence rates are a key concern. Research shows the vast majority of babies in Zambia are not born stunted (chronically malnourished). Instead, most children under age five who become stunted do so between the ages of two months and two years.

The prevalence of stunting was higher among children in rural areas (36 per cent) than among children in urban areas (32 per cent). A regional comparison showed that in 2018, stunting levels were highest in Northern (46 per cent) and Luapula (45 per cent) and lowest in Western and Southern (29 per cent each) Provinces. The prevalence of stunting increases from 19 per cent among children aged 0–6 months to a peak of 46 per cent among children aged 18–23 months. This highlights the importance of optimal nutrition in the first 1,000 days of life.

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<sup>4</sup> UNAIDS HIV Epidemiological Estimates, Zambia data (July 2021). Key HIV epidemiology indicators for children and adolescents aged 0–19, 2000–2020. Available at <https://data.unicef.org/resources/dataset/hiv-aids-statistical-tables/> (accessed September 2021).

Underweight prevalence also showed a steady decline over the 2001 and 2018 period. In 2001, almost a quarter (23 per cent) of the children less than five years of age were underweight. The proportion declined to 15 per cent in 2013–2014 and 12 per cent in 2018. The prevalence of underweight was higher among children in rural areas (12.4 per cent) than among children in urban areas (10.8 per cent).

Dietary diversity in Zambia is another a major challenge. Children do not consume food from enough food groups, with only 22 per cent of children aged 6–23 months found to have sufficient dietary diversity according to infant and young child feeding (IYCF) guidelines. Households, particularly those in rural areas, are also vulnerable to shocks that affect their supply of food and have little ability to absorb the impact of negative shocks.

As with ECD and child health, addressing undernutrition requires a well-coordinated multisectoral, multistakeholder approach with each ministry or stakeholder contributing to the plan. Currently, there is inadequate clinical nutrition capacity in the health sector to effectively contribute towards acceptable nutrition therapy and practice. Specialised clinical nutrition care services are limited in the management of different health conditions at the health facility.

While the first 1,000 Most Critical Days Programme (MCDP-II) is having greater success than MCDP-I at implementing a harmonised, multisectoral delivery of services closer to communities, there remains the need ensure that equal attention and resources are invested in addressing social and economic constraints to nutrition. In addition, it is recommended that the nutrition sector strengthens the integration of nutrition with other key health sector interventions and the systems approach for coherence in formulation and implementation of policies. Capacities also need to be improved at the institutional level along with workforce capacity across sectors, including capacity strengthening at the MoH. There is need to invest in community systems for nutrition and to sustain investments in Integrated Management of Acute Malnutrition (IMAM). The sector should also strengthen the provision of an updated package of high-impact nutrition-direct interventions and employ new approaches to ensure climate change adaptations and to mitigate the effects on nutrition.

### **Water, sanitation and hygiene (WASH)**

In Zambia, 72 per cent of households have access to an improved water source, although access is more predominant in urban (92 per cent) than rural (58 per cent) households. One third of the population has access to basic sanitation services: 41 per cent in urban areas and 28 per cent in rural areas. Fifty-four per cent of households have access to an improved sanitation facility, with the most used facility being a pit latrine with a slab (37 per cent).

WASH conditions and services vary significantly within Zambia: urban areas outdo rural areas on every key WASH metric, indicating high inequality in access to WASH services. While the government has instituted several reforms to improve the performance of WASH in Zambia and increase WASH coverage throughout the country, significant access gaps persist. According to the 2018 ZDHS, approximately 36 per cent of Zambia's population lacks access to basic drinking water services with only 64 per cent of the population enjoying these services. Two-thirds of the population lack or suffer from limited use of basic sanitation services (33 per cent of the population use a basic sanitation service). In terms of open defecation (ODF), the country has registered a notable decline with only 10 per cent of the population practicing ODF, down from 21 per cent in 2005. Lastly, basic hygiene services, such as a handwashing facility with soap and water, are only available to about a quarter of the population, estimated at 24 per cent in 2018. Access to WASH services has strong linkages with prevailing cultural and social norms in Zambia that impose a burden on women and children, especially



girls, who are rarely in control of household finances. While disaggregated data was not available to show the inequities in the WASH situation in schools especially the rural-urban divide, it is evident that Zambia has made significant progress in enhancing WASH conditions in schools. According to the Joint Monitoring Programme (JMP) report, Zambia has greater than 75 per cent coverage of basic drinking water services in its schools, as of 2016. This makes the country one of 58 countries out of 92 to have that level of coverage.

Peri-urban areas faced some of the worst water supply and sanitation services. To address these challenges, the Government established the Devolution Trust Fund (DTF) to improve service provision in peri-urban areas. Since its establishment, the DTF has contributed significantly to increasing access to water supply services for the urban poor through water kiosks. However, water supply under the DTF is mostly through kiosks as opposed to the desired individual standpipes. Rural-urban inequities in access have remained. Other challenges include the adverse impact of climate change on water and sanitation, a relatively underdeveloped sanitation sub-sector and operational difficulties of urban and peri-urban supply programmes and reforms level.

A committed financing mechanism for the WASH sector is needed. The sector should also heighten commitment to promoting hygiene and build equity considerations into the supply of WASH services and infrastructure. Non-traditional private sector investments are to be leveraged. It will be important for Zambia to provide a climate resilient and emergency responsive financing strategy that prioritises the needs of children in times of crisis. The WASH sector also needs to strengthen systematic and regular collection of national WASH data, and national and sub-national capacity in planning, implementing and monitoring of programmes and projects. The implementation of the National Water and Sanitation Policy should also continue, including the development of a sector management information system.

## **Adolescence**

Policy instruments specific to adolescents are inadequate, although there are some national instruments and documents that include explicit priorities related to adolescents and youth. Adolescents account for over a quarter of the total population and have unique health concerns. Health risks for adolescents include early and unprotected sex, gender-based violence (GBV), teenage pregnancies, substance abuse, accidents and mental illness. Adolescents are particularly susceptible to both non-communicable and communicable diseases, such as sexually transmitted infections, including HIV and AIDS. Several interventions have been implemented to protect adolescents and to improve their health status. Among the major areas of concentration are efforts to reduce early marriages and teenage pregnancy. During the 2013/2014 and 2018 period, the country registered a decline in adolescent birth rate from 141 to 135 per 1,000 adolescent girls aged 15–19 years.

A key trend to highlight is the decline in adolescent childbearing from 34 per cent in 1992 to 29 per cent in 2013–14 and in 2018. By province, teenage pregnancy ranges from a low of 15 per cent in Lusaka to a high of 43 per cent in Southern Province. During focus group discussions (FGDs) conducted as part of this situation analysis, community members referenced poverty, deprivation and the cost of living as drivers of adolescent pregnancy. According to the ZDHS 2018 data, 98 per cent of the surveyed 3,000 women aged 15–19 years had heard of contraception. The contraceptive prevalence rate for modern family planning methods among adolescent girls aged 15–19 years is 12 per cent. The most common form of contraception used amongst young women is injectable, as this is used by 7.8 per cent of the 3,000 women surveyed. Some 87.9 per cent girls are not currently using any form of

contraception. The low rate of condom usage, 1.6 per cent of all women aged 15–19 years, indicates a higher risk of HIV and other sexually transmitted infections among the younger population.

Up-to-date information is limited on the nutritional status of adolescents. According to the latest ZDHS data, females between ages 15–19 years had a higher prevalence of anaemia compared to other age groups (33.4 per cent compared to 28.6 per cent for 20- to 29-year-olds). On average one third (31 per cent) of women aged 15–49 years are anaemic.

The Zambia Population based HIV Impact Assessment (ZAMPHIA) of 2016 showed that there were marked age differentials in progress towards 90:90:90 targets. For example, 2020 HIV estimates indicate that only 53 per cent of adolescents living with HIV aged 10–19 years are currently on anti-retroviral treatment (ART) compared to 80 per cent coverage among adults.<sup>5</sup>

There are significant gender differences related to risk and vulnerability among adolescents in Zambia: almost one in five adolescent girls are already married, compared to only one in 100 adolescent boys aged 15–19 years. Similarly, one out of every four girls aged 17 years, and six out of every 10 girls aged 19 years, have already started childbearing,<sup>6</sup> and new HIV infections are about four times higher among adolescent girls than in their male counterparts.<sup>7</sup>

High rates of substance abuse have been reported among youth in Zambia. Among 15- to 21-year-old Zambian youth, lifetime alcohol use has been found to be almost 50 per cent, whereas marijuana use was 86 per cent and inhalant usage was 47 per cent. Focus group discussions revealed that alongside alcohol consumption, marijuana is also a pervasive issue affecting adolescents. Street children, especially males and refugee youth, are particularly vulnerable to substance abuse due to mental health issues.

There is scarcity of data and validated mental health measures for assessing psychological well-being among adolescents, however, globally adolescents are the most vulnerable population for mental disorders. In Zambia, adolescents are more likely to suffer from mental disorders due to various vulnerabilities, including poverty and diseases.<sup>8</sup> This includes pregnant adolescents, those who have experienced abuse or trauma, orphans or those with learning difficulties. Field data demonstrates a link between adolescents and vulnerable living conditions, such as living on the street, and mental health disorders.

There is a need to build on the experience of the development and implementation of the Adolescent Development and Health Strategy 2017–2021. Currently, there are various sectoral policies, strategies, plans and guidelines that include, but do not exclusively focus on adolescents. There is need to advocate for greater resource allocation, and tracking of adolescent sensitive programming. There is no current data to understand prevalence rates for mental illness among adolescents or children in Zambia. The most current data for mental health was from a 2011 report by the MoH, and it is not clear how the MoH obtained this data, although some of the data was from reports by Mental Disability Advocacy Centre, Mental Health Users Network Zambia (2008) and by Mwanza et al. (2008), which used pooled data from

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<sup>5</sup> UNAIDS HIV Epidemiological Estimates, Zambia data. Available at <https://data.unicef.org/resources/dataset/hiv-aids-statistical-tables/>. (Accessed Sep 2021).

<sup>6</sup> Adolescent Health Strategy 2017–2021.

<sup>7</sup> UNAIDS (2018) Women and Girls and HIV.

<sup>8</sup> Ministry of Health (2011). Adolescent Health Strategic Plan 2011–2015. Directorate of Public Health and Research, Government of the Republic of Zambia.

hospital records. World Health Organization (WHO) and Non-governmental organisations (NGOs) mental health data rely on adult mental health and are not disaggregated by age, gender, location, etc. Therefore, it is recommended that the United Nations Children's Fund (UNICEF) commissions further research into adolescents and their mental health, and to understand mental health determinants, gender issues and mental health literacy levels amongst adolescent boys and girls living in both rural and urban areas.

### **Children and participation**

Child participation in Zambia remains low owing to, among other reasons, the country not having a framework to institutionalise and guide implementers of child participation in a way that would ensure standards which are safe, ethical and meaningful, considering the evolving capacity of children. A recent study Zambia's Young Voice Survey (2020) conducted by Save the Children highlighted that children have few opportunities for participation in public decision-making processes. The report also showed the inadequacies in recognising and appreciating children's rights to participation: 84 per cent of children reported that politicians and decision makers should listen to the opinions of children and young people. Focus group discussions (FGDs) with children found that children felt that this culture of non-participation harmed their relations with adults. On the other hand, adults were concerned that growing awareness of child rights to participation were a threat to community norms and the expected power balance between adults and children. While Zambia's Constitution provides for and promotes children's participation, some subsidiary laws claw back. The Public Order Act (1955) regulates meetings, assemblies, demonstrations, protests without prior police permission/notification. This law constrains children's participation in public affairs in a collective manner. For example, students taking collective action can be classified as holding an unlawful assembly and can be barred from free expression of their views.

It is recommended that child participation is defined to clarify the scope of participation and that Government leadership on and mainstreaming of child participation needs to be prioritised. Positive steps are needed to revive the National Children's Committee and ways in which the Children's Code Bill can underwrite child participation should be analysed; include a provision in the Children's Code Bill to articulate child participation. Regular and structured examination of children's participation is needed. It is imperative to understand the right to participate and how it affects the scope and quality of children's participation. Participation should also be embedded in institutions and organisations that directly interact with children. In addition, development of key child participation indicators needs strengthening and child participation in education, health and care services should be mainstreamed.

### **Disability**

Zambia is signatory to Convention on the Rights of Persons with Disabilities (2006) which was domesticated through the enactment of the Persons with Disabilities Act No. 6 in 2012, and the 2016 National Policy on Disability. The Social Cash Transfers (SCTs) benefits persons with severe disabilities, who are not involved in meaningful income generating activities. Furthermore, the Ministry of General Education (MoGE) has introduced a quota system, whereby 10 per cent of teacher recruitment is reserved for Persons with Disabilities. The Zambia Agency for Persons with Disability (ZAPD) registers and collects information on people with disabilities and the estimated disability prevalence is 10.9 per cent in Zambia. The ZAPD's medical model of disability is currently being revised in accordance with the rights-based approach. The 2021 Zambia Census will for the first time collect data on the six areas of activity limitations and levels of severity: seeing, hearing, walking, cognition, self-care and communication. This promises to provide a more accurate disability prevalence rate for Zambia.

Among children (aged 2–17 years), the prevalence of disability is estimated to be 4.4 per cent.<sup>9</sup> Prevalence varies across the provinces, with the highest estimates in Luapula and Copperbelt Provinces, among both adults and children. The National Disability Survey (2015)<sup>10</sup> found that among children with disability, 40 per cent of their disabilities are congenital in origin and 31 per cent are the result of disease/illness, which suggests that some forms of disability may be preventable. Furthermore, the survey looked at the differences between living conditions between children with and without disabilities and found significant gaps in services for children with disabilities. Of relevance, in UNICEF's advocacy and system strengthening role, is addressing the multiple barriers to accessing assistive devices and technology, educational services, vocational training, and appropriate health and rehabilitative services.

It is noted that women and girls with disabilities in general are at heightened risk of sexual and GBV, and of contracting HIV and AIDS.<sup>11</sup> Field data reveals that there is also a significant lack of knowledge and understanding of disabilities, which feeds stigma, fear and social isolation. This is noted in the Zambia Disability Survey (2015), in which 2.2 per cent of respondents stated witchcraft as being the reason for disability in children. The following recommendations are crucial in relation to issues of disability in Zambia: Awareness raising about disabilities to remove stigmatisation of disabilities. Education programmes and schools should be utilised as key in preventing negative attitudes towards children with disabilities. In Zambia, disabilities can be prevented or mitigated with good quality, developmentally supportive care. It is vital to monitor the health and development of all newborn babies to identify and respond with relevant services to disabilities, such as cerebral palsy, retinopathy of prematurity (a leading cause of preventable childhood blindness), auditory and visual impairments, and other developmental delays.

### **Child protection**

Zambia's laws prohibit violence against children, but gaps in the legal framework and a lack of clarity remain, which limits the scope of perceived protection in specific cases. There is a question of compatibility between international standards and Zambian laws on corporal punishment in the family setting. The Education Act prohibits the use of corporal punishment or degrading treatment in education institutions (Section 28). At the same time, the Juveniles Act (Section 46) permits caregivers and guardians to administer lawful punishment against children, without providing a definition of 'lawful punishment'. There are no mandatory child safeguarding policies in place to protect children from violence in other settings where children reside without being accompanied by a parent or carer (sports clubs, churches and hospitals).

However, Zambia has taken some important legal steps to establish reporting pathways for children, communities, and professionals regarding GBV. Zambia's Anti Gender-Based Violence Act requires public authorities and specific groups of professionals and community leaders (for example, medical practitioners and religious leaders) to report identified situations of GBV and trafficking of children. According to the Violence against Children Study 2014, 20.3 per cent of females and 10 per cent of males (aged 18–24) experienced sexual violence prior to the age of 18. Amongst experiences of sexual violence by 13- to 17-year-olds, 28.3 per cent of females and 6.8 per cent of males stated that their first experience of sexual intercourse was unwanted. The biggest concern is lack of access to services for

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<sup>9</sup> Central Statistics Office (ZamStats). 2018. National Disability Survey 2015. Lusaka  
<https://www.unicef.org/zambia/reports/zambia-national-disability-survey-2015>

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

child survivors of sexual abuse. Zero per cent of girls and 6.5 per cent of boys, who experienced sexual violence, had access to services (VAC 2014).

Birth registration process has been decentralised and all 10 provinces now have birth certificate printing centres. Furthermore, over 900 birth registration desks were established at district and sub-district levels. The 2018 ZDHS data shows that only 14 percent of children's births were registered with the civil authorities and 5.9 per cent of children had received a birth certificate. There are stark variations in birth registration rates between urban and rural children (25 per cent and 8 per cent), by wealth quintile (4 per cent in poorest wealth quintile WQ1 and 32 per cent in the richest wealth quintile WQ5) and between provinces (with Northern Province being at 3 per cent and Copperbelt at 29 per cent).<sup>12</sup>

To address the issue of child marriages, the Government is working with stakeholders to implement the National Strategy on Ending Child Marriage. In this regard, child marriages for girls declined only marginally from 31.4 per cent in 2014 to 29 per cent in 2018.

The Government has not taken action to create child-friendly reporting pathways in places frequented by children, including schools, community centres, alternative care institutions, sports clubs, churches and medical clinics. Child-friendly reporting pathways exist intermittently through civil society programming and other community-centric actions, but the Government does not maintain national policies that correspond to this. There is evidence that the current Zambian juvenile justice system is harmful to juveniles who come into conflict with the law. The system is punitive in nature, characterised with prolonged child detention, over prosecution of minor offences, lack of alternative sentencing and community-based rehabilitation services. Vulnerable children found in migration flows risk being placed in police detention and prisons if they are not identified and assessed for protection.

In 2018, Zambia made moderate advances with efforts to eliminate the worst forms of child labour. The Government developed national action plans on Child Labour and Anti-Human Trafficking in line with the 7NDP. It also significantly increased the number of labour inspections conducted, which identified 511 child labour law violations, and achieved five convictions for the crime of child trafficking.

A key challenge in tackling violence against children is lack of comprehensive and up-to-date information on violence against children, making it difficult to plan, implement, monitor, and evaluate appropriate policies and programming for child protection. This lack contributes to the inability of both the Government and other agencies to make informed programmatic decisions around violence against children. As a result, evidence to support advocacy, data to hold authorities accountable for action or non-action and systematised monitoring information to inform national planning and funding allocation violence against children is urgently needed.

In addition, recommendations for the child protection sector includes advancing legislation for child protection, improving birth registration, introducing quality assurance for the social work profession and child safeguarding policies for all organisations that directly interact with children, improving funding and resourcing policies, improving protection of child victims and witnesses, and providing psychosocial and recovery services. Data on children protection also needs to be strengthened and case management for early identification and response should be standardised and upscaled. Finally, social

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<sup>12</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

and behaviour change is needed to address the high levels of tolerance for violence against children including child marriage.

### **Social protection**

Zambia's social protection system consists of five pillars as outlined in the 2014 National Social Protection Policy (NSPP). These include Social Assistance, Social and Health Insurance, Livelihoods and Empowerment, Protection and Disability. A total of 30 programmes were mapped under the overall social protection ambit: 6 under social assistance, 11 in livelihoods and empowerment, 7 under social security and social health insurance, 7 under protection and 2 under disability. In all programmes, children are direct or indirect beneficiaries, although there are very limited programmes designed specifically and comprehensively for children. The current social protection system is inadequate to provide children their rights.

Zambia has a total of six social assistance programmes: the Public Welfare Assistance Scheme (PWAS), SCTs, Keeping Girls in Schools (KGS), Home-Grown School Meals (HGSM), bursaries for Orphans and Vulnerable Children and Nutrition Sensitive Social Protection (NSSP). Three of the five programmes, KGS, HGSM and bursaries for Orphans and Vulnerable Children, are specifically designed to benefit children from impoverished households. In terms of the budget, the National Social Protection Policy has registered steady growth towards Social Assistance allocations. Children make up a significant portion of beneficiaries in the SCT programme with the total number of children on the programme standing at 1,398,562 (in 887,759 beneficiary households), based on existing SCT-MIS figures (November 2021).

Child-sensitive social protection programmes need to be responsive to the multi-dimensional needs of children. For instance, while the KGS programme has increased access to education by paying children's school fees, but other restrictive costs may keep children from accessing education, and thus undermine the overall impact of the programme. While Zambia has made commendable progress in providing social insurance benefits to employees, there is still a considerable gap in the provision of maternity protection. Maternity protection is provided through the Employment Act (and Employment Code Act No. 3 of 2019), as sole employer liability (not through an insurance fund), thus benefiting only formal sector workers and disincentivising the recruitment of women in child-bearing age. No provisions for non-contributory maternity protection currently exist, and the International Labour Organization (ILO) Convention 183 has not yet been domesticated.

Social protection programmes, aimed at reducing vulnerability and poverty, need to be conscious of the demographic context, understand what drives inequality and what limits inclusion in the socioeconomic engine of the country and among children. Therefore, social protection that is designed to reach children should aim to eliminate the impacts of deprivation in both the present and the long run. Recommendations include strengthening the life cycle based social protection programming, providing social protection as a right to children, investing in a cost analysis of raising a child, embedding child and adolescent outcomes into programmes, amplifying the human capital investment of social protection by addressing multiple dimensions of poverty and continuing investments in social protection systems strengthening.



# CHAPTER 1. INTRODUCTION TO THE SITUATION ANALYSIS

## 1.1 Purpose of the 2021 situation analysis

The objective of the situation analysis is to provide an update on the situation of children in Zambia and identify recent patterns and trends in terms of inequalities. The ultimate objective is to understand how to continuously protect and promote the rights of every child, improve the lives and well-being of children and create opportunities for the full realisation of children's rights. All this lies within the four core principles of the United Nations Convention on the Rights of the Child (UNCRC): non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child.

In 2014, the United Nations Children's Fund (UNICEF) produced a situation analysis of Children and Women on the main issues related to these populations. The situation analysis contributed to discussions with the Zambian Government and partners. Since then, the Government and its partners have produced a series of updated data, surveys and analyses that have improved understanding of the situation of children and women and have guided the programming interventions. The country's programming environment has also changed in the intervening years as the country experienced droughts and cholera outbreaks, witnessed an increasing number of children in migration and refugee influxes, underwent economic investments, macroeconomic challenges and currency depreciation, and most recently the COVID-19 pandemic. This situation analysis focuses on the life cycle of the child and on child rights as set out in the UNCRC. The analysis is of children's needs and is gender and age specific. Thus, three age groups are considered: 0–4 years, 5–10 years and 11–17 years. The analysis of differing gender-specific needs and the underlying causes of gender inequalities are crucial to the well-being of both girls and boys. Therefore, this situation analysis incorporates a gender lens across all thematic areas. Where possible, the analysis also discusses inequalities based on geographic location.

## 1.2 Methodological framework of the situation analysis

This situation analysis adopted a human rights framework that assumes rights are interdependent and interrelated. The realisation of one right often depends, wholly or in part, on the realisation of others. For instance, realisation of the right to health services may depend, in certain circumstances, on the realisation of the right to water and sanitation, nutrition, education and information, and gender equality. Hence, it is impossible to disassociate the problems of one area from those of another. The methodological process for updating the situation analysis largely followed the steps indicated in UNICEF's 2019 *Core Guidance: New Generation Situation Analysis*. An assessment was conducted of the manifestations of child rights shortfalls and inequalities in child outcomes, based on the material available in the country. To fill in any gaps, to update information, and to understand the reasons and stories behind the data, research teams carried out key informant interviews (KIIs) with key stakeholder groups identified during the literature review. This included Government officials, UNICEF personnel, development partners and civil society organisations (CSOs). To collect the voices of primary stakeholders, especially children, focus group discussions (FGDs) and interviews were conducted with children, adolescents, community members and parents or primary caregivers, especially women and traditional leaders. For this primary research, provinces and districts were selected based on a set of indicators, including rural versus urban settings, poverty, gender, deprivation and education rates. The

aim of the 2021 situation analysis is to highlight the current challenges and to use the voices of the Zambian people to share their stories and challenges, including adolescents, children and women. The updated situation analysis uses a comprehensive approach and considers the complexities that influence the lived realities of children and women.

### 1.3 Issues and limitations

There are several issues and limitations to the study. The most pertinent one being the lack of current and accessible data on the majority of the key thematic areas to allow for a comprehensive assessment of the current situation of children in Zambia. Research, statistical analysis in most reports was conducted from older datasets. For instance, a report from 2018 would employ data from 2009, 2010 and 2013. Consequently, this would not be an accurate presentation of the current situation in Zambia. However, the team has triangulated data from various sources to overcome this issue, and where possible, included qualitative data to support findings.

The focus of the 2021 situation analysis is on the status and well-being of children, and it is based on the lifecycle of the child. The analysis does not include the status of issues solely affecting women, however gender relations and gender inequalities that impact the lives of girls and boys are explored, as are aspects of maternal health that affect children's ability to survive and thrive. A situation analysis focused solely on women merits an independent in-depth analysis, based on women's rights as set out in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW.) A limited number of field visits were conducted to gather qualitative data from districts that were purposefully selected to provide a sample of views from different regions of the country. Though not many in number, these voices and stories represent the lives of people met during the field research.

## CHAPTER 2. COUNTRY OVERVIEW

### 2.1 Zambia's progress towards sustainable development goals

The Government of the Republic of Zambia is committed to the implementation of the 2030 Agenda for Sustainable Development and to the integration of the Sustainable Development Goals (SDGs) into the National Planning Framework. The Seventh National Development Plan (7NDP) mainstreamed 86 per cent of the SDGs and targets and introduced a multisectoral approach. The country's first Voluntary National Review (VNR) in 2020 underscored this commitment and highlighted the following achievements:<sup>13</sup>

- reduction in Multidimensional Poverty Index (MPI) from 50 per cent in 2016 to 44 per cent in 2019 through a range of social protection mechanisms, such as Social Cash Transfers (SCTs in all 116 districts), the Public Welfare Assistance Scheme (PWAS) and the Food Security Pack (FSP) initiative;
- provision of Government and non-government organization (NGOs) bursaries to improve access to education, especially for girls;
- reduction in the maternal mortality ratio (MMR), which declined from 398 deaths per 100,000 live births in 2014 to 278 deaths in 2018;
- reduction in the child mortality rate (CMR) from 31 deaths per 1,000 live births in 2014 to 19 deaths per 1,000 live births in 2018;
- increase in immunisations coverage from 68 per cent in 2014 to 75 per cent in 2018;
- decline in the percentage of females aged six years or above with no education from 24 per cent in 1992 to 16 per cent in 2013–14 and remained at 16 per cent in 2018;
- reduction of stunting from 40 per cent in 2013–14 to 35 per cent in 2018 through coordinated and concerted multisectoral response for nutrition through the national flagship 1,000 Most Critical Days Programme (MCDP); and
- reduction in cumulative emissions by 39 per cent (14,846.9 Gg CO<sub>2</sub>) between 2015 and 2019. Diversification of energy from 99 per cent reliance on hydropower production in 2011 to 80.6 per cent in 2019. Zambia is promoting solar energy and climate smart agriculture, water harvesting techniques and green infrastructure.

However, the VNR and Government data from the 2018 Zambia Demographic and Health Survey (ZDHS) indicate the following key challenges, many of which are crucial for the survival, health and well-being of the nation's children and adolescents:

- Zambia ranks among the countries with highest levels of poverty and inequality globally. More than 54 per cent of 16.6 million people in Zambia earn less than the international poverty line of US\$1.90 per day; 48.3 per cent are classified as extremely poor and three quarters of the poor live in rural areas.<sup>14</sup>
- Sixty-four per cent of children are monetarily poor or deprived, with the greatest proportion of poor children living in rural areas.<sup>15</sup>

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<sup>13</sup> Government of the Republic of Zambia (GRZ). "Zambia Sustainable Development Goals: Voluntary National Review 2020." <https://bit.ly/2YsQ8Y3> (accessed on 8 October 2021).

<sup>14</sup> UNICEF & GRZ (2019) *End of Programme Evaluation: UN Joint Programme on Social Protection*. <https://www.unicef.org/zambia/reports/end-programme-evaluation-grz-un-joint-programme-social-protection>. Accessed on 8 October 2021.

<sup>15</sup> Ministry of National Development and Planning, and Government of Zambia & UNICEF (2018) *Child Poverty in Zambia: A Multiple Overlapping Deprivation Analysis*. <https://www.unicef.org/zambia/reports/child-poverty-zambia-report-2018>. Accessed on 8 October 2021.

- While 54 per cent of households have access to improved sanitation, only 33 per cent of the population has basic sanitation service: 41 per cent in urban areas and 28 per cent in rural areas.
- Despite improvement in rates of MMR over the past three decades, (from 729 deaths per 100,000 live births in 2001–02 to 398 deaths in 2013–14 and 278 deaths in 2018) maternal mortality remains high in Zambia as it accounts for 10 per cent of all deaths among women aged 15–49 years (Central Statistics Office now ZamStats, 2014). Early detection and registration of pregnancy during the first trimester is crucial for early detection of pregnancy related complications and management. However, as per ZDHS 2018, only 37 per cent pregnant women attend Antenatal Clinic (ANC) in the first trimester of pregnancy.
- Teenage pregnancies remain high in Zambia at 29 per cent and has not changed since the previous Demographic and Health Survey (DHS) of 2013–2014. Teenage pregnancies are high risk for maternal complication including maternal deaths, still births, newborn deaths as well as low birth weight and prematurity. Rural young girls are twice as likely to get pregnant than urban girls (37 per cent versus 19 per cent) and with geographical variations of 43 per cent in southern provinces to 15 per cent in Lusaka, highlighting equity related barriers that need to be addressed.
- Newborn mortality rate (NMR; 27/1000 live births) constitutes 62 per cent of the infant mortality rate (IMR; 42/1000 live births) in Zambia and 44 per cent of the under-five mortality rates (U5MR; 61/1000 live births). The NMR has increased over the course of last two surveys from 24/1000 live births to 27/1000 live births in Zambia. Prematurity, sepsis and birth asphyxia are the three leading causes of newborn deaths in Zambia. The child mortality indicators are favourable for girl child with NMR, IMR and U5MR being lower for girl child. Notably, the U5MR for urban areas is more than in rural areas. While illnesses and mortality in children under five years of age has decreased, this rise in newborn mortality is of great concern.<sup>16</sup>
- Child malnutrition rates are determined using three nutritional status indices: stunting is at 35 per cent, wasting at 4 per cent and underweight is estimated at 12 per cent. The progress is uneven across the country with marked inequity in stunting across provinces, where stunting rates have ranged from 45.8 per cent in Northern Province to 29 per cent in Western Province.
- 2018 ZDHS estimated 58 per cent of children under the age of five were anaemic, with the highest prevalence (77 per cent) amongst children who were less than 24 months old, thus highlighting the need for life-cycle approach for nutrition. About 31 per cent of women of reproductive age (15 to 49 years) were anaemic, ranging from 24 per cent in Central Province to 38 per cent in Western Province.
- Exclusive breastfeeding rate declined from 73 per cent to 70 per cent. Only 13 per cent children aged 6–23 months were fed with recommended Minimum Acceptable Diet (MAD), thus highlighting an urgent need to improve the quantity as well as quality of children’s diet in the country. Wide disparities exist in nutritional status and feeding practices across the socioeconomic gradient. ZDHS 2018 data shows that amongst the households in the lowest wealth quintiles, only 6 per cent of children were fed the recommended MAD, compared to 25 per cent children among highest wealth quintiles. Only 4.8 per cent children from Western Region were fed the recommended MAD compared to the national average of 12.5 per cent.
- While Zambia has made significant progress towards achieving the 90:90:90 global targets for HIV epidemic control, Zambia’s Mother to Child Transmission (MTCT) rate of HIV remains high at 11 per cent and far from the target for virtual elimination, which is set for less than 5 per cent by 2021.
- Rate of reduction in new HIV infections is low and pervasive gender disparities exist among all age groups, although this is more pronounced among adolescents and young people aged 10–25

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<sup>16</sup> Ibid.

years. Evidently, new HIV infections among adolescent girls (ages 10–19 years) are about 3.5 times more than among adolescent boys.

The 2020 VNR indicates the following structural challenges:

- Data limitations continue to be a huge constraint on SDG monitoring and evidence-based planning. Zambia has enacted the Zambia Statistics Act of 2018 to address data challenges.
- The expansionary fiscal policy driven by the need to invest in infrastructure development has resulted in a significant resource gap, which has hampered SDG financing and threatened the country's debt sustainability.
- Adverse effects of climate change and the recent COVID-19 pandemic pose major threats to achieving the SDG targets in Zambia.

## 2.2 International, regional, and national legal and policy framework

To date Zambia has signed the following international documents governing child rights and gender:

- The UNCRC in 1991;
- The CEDAW in 1985;
- The 1995 Beijing Declaration and Platform of Action;
- The United Nations 2030 Agenda on SDGs;
- The two International Labour Organization (ILO) Conventions on child labour— Convention No.138 on Minimum Age and Convention No. 182 on the Worst Forms of Child Labour; and
- The Convention on the Rights of Persons with Disabilities (CRPD) in 2010.

At a regional level, the Government is also a signatory to:

- The African Charter on the Rights and Welfare of the Child;
- An Addendum on the Prevention of Violence against Women and Children (1998);
- The African Union's Solemn Declaration on Gender Equality in Africa (2004), including an aim for gender parity in public sector and political representation;
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003); and
- The Southern Africa Development Community (SADC) Declaration on Gender and Development (1997) with the aim of achieving 30 per cent female representation in public decision making.

The 7NDP is aligned with several regional and global development priorities:<sup>17</sup>

- **Alignment with the (SADC) Regional Development Priorities**, which aim to deepen the integration agenda of the region through accelerating poverty eradication and attainment of other economic and non-economic development goals. The 7NDP priority pillars contribute to the attainment of the SADC Regional Indicative Strategic Development Plan 2020–2030. As such, the 7NDP is closely aligned to the SADC regional development agenda.
- **Alignment with the African Union Agenda 2063**. The African Union development priorities are contained in the Agenda 2063 document with seven aspirations, which are aimed at inclusive growth and sustainable development for Africa. The 7NDP Pillars and Result Areas are strongly aligned with the Agenda 2063 development aspirations.
- **Alignment with Sustainable Development Goals (SDGs): The 7NDP is relevant in its contribution to the attainment of the SDGs**. The 7NDP pillars correspond to the SDGs. The Rapid Integrated

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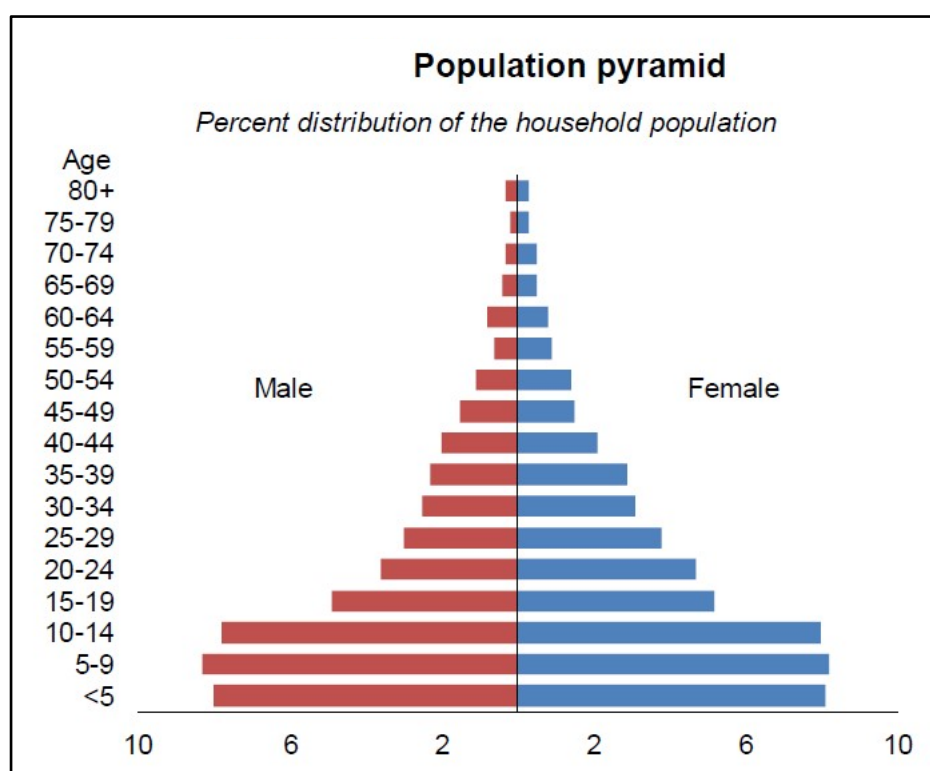
<sup>17</sup> The Seventh National Development Plan 2017–2021.

<https://www.lusakatimes.com/wp-content/uploads/2017/06/Final-7NDP-07-06-17.pdf>. Accessed on 8 October 2021. Pp 24–26.

Approach (United Nations' methodological approach) was used to measure the alignment of the 7NDP Pillars to the SDGs.

### 2.3 Demographic profile

With a total population of 17,885,422, of which 9,033,248 are females and 8,852,174 are males,<sup>18</sup> Zambia is experiencing a large demographic shift and is one of the world's youngest countries by median age. Almost half of the population (48 per cent) is aged 0–14 years, 49 per cent are aged between ages 15–64 years, while only 4 per cent are of ages 65 years or older. Life expectancy is 58.2 years for men and 62 years for women.<sup>19</sup> Although reducing over the past decade, Zambia remains among the top 12 countries in the world with respect to fertility rates, resulting in a rapidly growing population at 2.8 per cent per year.<sup>20</sup> This trend is expected to continue as the large youth population enters reproductive age, which will put even more pressure on the demand for jobs, health care, education and other social services.



Source : ZDHS 2018

<sup>18</sup> Zambia Statistics' Agency <https://www.zamstats.gov.zm/index.php>. Accessed on 19 February 2021.

<sup>19</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021. Accessed on 8 October 2021.

<sup>20</sup> World Bank, 2021. "Poverty and Equity Brief. Africa Eastern and Southern." [https://databank.worldbank.org/data/download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/AM2020/Global\\_POVEQ\\_ZMB.pdf](https://databank.worldbank.org/data/download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/AM2020/Global_POVEQ_ZMB.pdf)



Approximately 40 per cent of the population lives in urban areas.<sup>21</sup> In terms of parental survival and living arrangements, 16 per cent of children under the age of 18 years are not living with a biological parent, and 10 per cent of these children are orphans (i.e., one or both parents are dead).<sup>22</sup>

## 2.4 Political economy and governance

Zambia has had a strong foundation on which to build accountable and responsive systems of governance that advance the nation's long-term development priorities. It has a long history of democratic governance and peaceful transitions of power: In the most recent elections of August 2021, opposition leader Hakainde Hichilema won by a large majority. This is the third time, since independence in 1964, that an opposition party has come to power peacefully.<sup>23</sup> During the preceding national development plans, governance institutions were transformed to comply with international standards for modern democratic systems.<sup>24</sup> The 2016 Constitution amendment, during the current 7NDP, strengthened the mandates and functions of existing governance institutions, such as the Zambia Correctional Service, the National Prosecutions Authority and converted the Office of the Ombudsman into the Office of the Public Protector with enhanced powers and created new institutions including the Small Claims Court, Constitutional Court, Court of Appeals and Family Court. Despite these positive developments towards enhancing governance institutions, inadequacies and inconsistencies in the regulatory framework and policy environment remain. Delays also exist in access to justice, implementation of reforms to enhance transparency, accountability, democratisation and decentralisation.<sup>25</sup> In addition, the finalisation of the Children's Code is also delayed, which reinforces the rights stipulated in the CRC and strengthens the regulatory framework for child welfare and protection.

## 2.5 The macroeconomic context

After 15 years of significant socioeconomic progress towards achieving middle-income status in 2011, Zambia's economic performance stalled in recent years. Between 2000 and 2014, the annual real gross domestic product (GDP) growth rate averaged 6.8 per cent. The GDP growth rate slowed to 3.1 per cent per annum between 2015 and 2019, mainly attributed to falling copper prices and declines in agricultural output and hydro-electric power generation due to insufficient rains. The services sector remained the country's key driver of growth, growing by 3.5 per cent in 2019, but primary and secondary sectors decreased significantly, though 2020 growth was negative, compounded by the COVID-19 pandemic.<sup>26</sup> Public investment has severely strained public finances. Over-reliance on non-concessional external borrowing since 2012—to finance large-scale infrastructure projects—has resulted in large fiscal deficits since 2014 (going from 6.5 per cent of GDP in 2013 to 12.1 per cent in 2015, 10.5 per cent in 2018, and 7.7 per cent in 2019).<sup>27</sup> Large domestic payment arrears have also accumulated (9.7 per cent in 2019). The rapidly increasing public debt (80 per cent of GDP at the end of 2019, up from 35 per cent at the end of 2014) places Zambia at a high risk of debt distress.<sup>28</sup>

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<sup>21</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

<sup>22</sup> Ibid

<sup>23</sup> Mfula, Chris. "Zambia opposition leader Hichilema wins landslide in presidential election". 16 August 2021. Reuters.

<sup>24</sup> Seventh National Development Plan.

<sup>25</sup> Ministry of National Development and Planning (2020) *Mid-Term Review of the Seventh National Development Plan*.

<sup>26</sup> World Bank (2021) The World Bank in Zambia <https://www.worldbank.org/en/country/zambia/overview>

<sup>27</sup> Ibid

<sup>28</sup> AfDB (2020) *Zambia Economic Outlook*. <https://www.afdb.org/en/countries-southern-africa-zambia/zambia-economic-outlook>.

Over the past five years, there has been a decline in development assistance to Zambia from the Organisation for Economic Cooperation and Development-Development Assistance Committee member countries. In 2015, the total bilateral and multilateral aid fell to US\$572 million and US\$311 million, respectively. In 2017, grants amounted to Zambian Kwacha (ZMW) K466.62 million against a target of K2.23 billion and during the first half of 2018, grants at K212.63 million were below the budget target due to lower inflows, especially for project support. In 2019, grants stood at K840 million against the target of K1.92 billion. With this decline in development assistance, the role of the private sector and South-South Cooperation have become increasingly prominent as alternative sources of development finance. About 80 per cent of aid had been for the health and other social sector initiatives.<sup>29</sup> Zambia's economy was hit by drought in the southern and western parts of the country that lowered 2018/19 agricultural production and hydropower electricity generation considerably. Severe electricity rationing followed, and long periods of electricity load shedding dampened activity in almost all economic sectors.<sup>30</sup> Domestic revenue as a proportion of GDP has remained stagnant at around 18 per cent over the last five years, leaving the Government with no significant resource mobilisation space. The reduction in overseas aid, declining commodity prices, an unstable exchange rate, decreased production because of persistent droughts and power generation deficits have contributed to a period of worsening macroeconomic conditions, which has limited social expenditure, thereby threatening poverty reduction efforts.<sup>31&32</sup>

In 2020 the economy of Zambia fell into a deep recession due to the adverse impact of the COVID-19 pandemic. Real GDP contracted by an estimated 4.9 per cent in 2020 after growing by 4.0 per cent in 2018 and 1.9 per cent in 2019.<sup>33</sup> The output contraction is the result of an unprecedented deterioration in all the key sectors of the economy. Manufacturing output fell sharply as supply chains were disrupted, while service and tourism sectors were hurt as private consumption and investment weakened because of measures taken to contain the spread of COVID-19. The economy is projected to grow by 1.0 per cent in 2021 and 2.0 per cent in 2022, underpinned by recovery in the mining, tourism and manufacturing sectors. The recovery in international demand for copper is a positive development, while a reduction in COVID-19 cases will boost activity in both manufacturing and tourism. However, subsequent waves of COVID-19 and/or failure to effectively implement the Economic Recovery Programme, could pose a high risk to Zambia's economy. In the banking sector, the ratio of non-performing loans is expected to increase and the consequent reduction in bank liquidity will dampen private sector activity. Against this backdrop, poverty is expected to increase due to significant job losses in the service sector (on average 30.6 per cent), manufacturing (39 per cent), personal services (39 per cent) and tourism (70 per cent).<sup>34</sup> This will reduce funds available for social funding and will reverse the gains made on child welfare.

## 2.6 The poverty context

National poverty statistics for Zambia are available only up to 2015. The poverty rate at the national poverty line of K214 per adult equivalent per month remained largely unchanged at 54.4 per cent between 2010 and 2015. In rural areas, where 82 per cent of the poor live, poverty rose from 73.6 per

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<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

<sup>31</sup> Ministry of National Development and Planning. (2020). *Mid-Term Review of the Seventh National Development Plan*.

<sup>32</sup> UNICEF/ZIPAR. (2019). *Analytical Budget on the Social Sector Budget 2020: Sustaining social sector gains*. Lusaka: UNICEF

<sup>33</sup> AFDB. (2020). *Zambia Economic Outlook* <https://www.afdb.org/en/countries-southern-africa-zambia/zambia-economic-outlook>.

<sup>34</sup> Ibid.

cent to 76.7 per cent. In urban areas poverty fell slightly from 25.7 per cent in 2010 to 23.4 per cent in 2015.<sup>35</sup>

The 2020 mid-term review (MTR) of the 7NDP shows that the MPI declined from 28 per cent in 2014 to 25 per cent in 2018. The MPI measures acute poverty or poverty depth in which a household is considered poor if deprived in four of the total ten indicators. Acute poverty for rural areas declined from 39 per cent to 33 per cent between 2014 and 2018. Similarly, the urban MPI declined from 14 per cent to 10 per cent. At the provincial level, the multidimensional poverty rate had declined for all provinces except in the Western Province.<sup>36</sup> The MTR measures poverty levels by calculating headcount poverty, which focuses on three social dimensions of poverty: health, education and living conditions. The MTR assessment indicated a declining trend between 2014 and 2018 in which headcount poverty reduced from 50 per cent in 2014 to 44 per cent in 2018. Rural poverty dropped from 69 per cent to 59 per cent, while urban poverty declined from 25 to 18 per cent, representing declines of 10 and 7 percentage points respectively. Despite these gains, inequality between rural and urban areas continues to rise and affects girls and women disproportionately.<sup>37</sup> Shifting climatic conditions lead to disrupted crop production, food shortages and rising commodity prices, and make the poorest segments of the population, especially women and children, susceptible to shocks. Access to basic social services, such as health and education, becomes more difficult for vulnerable populations and perpetuates a vicious circle, thus further reducing their human capital. The links between inequality and poverty provide one of the greatest challenges currently facing the country. The economic growth the country has seen over the past two decades has not been inclusive. It has not trickled down to the overall population and therefore has not contributed to increasing the incomes of the poor rapidly enough to lift them out of poverty.<sup>38</sup> This is reflected in the Gini coefficient measure of income inequality. While the Zambia Gini coefficient decreased from 50.96 in 2017 to 49.50 in 2018, this still represents significant inequality with the poorest quintile holding 2.9 per cent of the income share, while the richest quintile in Zambia holds 61.3 per cent.<sup>39</sup> Moreover, the poorest households spend 66 per cent of their resources on food, with those better off spending only 34 per cent.<sup>40</sup> Data from the 2018 ZDHS indicates that households with no household head who had completed school, with no access to secondary education for their children, lacking information technology tools and with no electricity were more likely to be poor than those with access to these services, thereby also contributing to a multidimensional and complex vicious cycle of deepening poverty.

To address the multidimensional aspects of poverty and exclusion, the Government, through the National Social Protection Policy (NSPP) and with support from the United Nations Joint Programme on Social Protection (UNJPSP), has promoted coordinated multisectoral responses towards improving the livelihoods and welfare of those most vulnerable to potential environmental shocks. These include the SCT, the FSP and the PWAS. Social assistance programme administrative records show that 632,327 households (465,804 female-headed and 166,523 male-headed) were enrolled in the SCT programme as

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<sup>35</sup> World Bank. April 2021. "Poverty and Equity Brief. Africa Eastern and Southern." Zambia.

[https://databank.worldbank.org/data/download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/AM2020/Global\\_POVEQ\\_ZMB.pdf](https://databank.worldbank.org/data/download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/AM2020/Global_POVEQ_ZMB.pdf)  
[https://databank.worldbank.org/data/download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/AM2020/Global\\_POVEQ\\_ZMB.pdf](https://databank.worldbank.org/data/download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/AM2020/Global_POVEQ_ZMB.pdf)

<sup>36</sup> Ministry of National Development and Planning. (2020). *Mid-Term Review of the Seventh National Development Plan*.

<sup>37</sup> World Bank. (10 May 2021). *Empowering Rural Women to Move out of Poverty* World Bank News Feature.

<sup>38</sup> World Bank. (2021). *Macro Poverty Outlook Zambia*. <https://pubdocs.worldbank.org/en/248071492188177315/mpo-zmb.pdf>.

<sup>39</sup> Zambia Statistics Agency. (2015). *Living Conditions Monitoring Survey*.

<sup>40</sup> Ibid.

of June 2019 in all the 116 districts in the country. The 7NDP MTR findings indicate that at mid-term the SCT was benefiting 33.8 per cent (3,302,394) of the poorest individuals in the country.<sup>41</sup> Social cash transfers have been increasingly combined with social welfare community-based case management that has helped identify multiple deprivation, challenges in accessing services, child abuse and risk of child/family separation. The families are further referred to respective services. However, inadequate resources and coordination and poor targeting mechanisms have hampered the effective implementation of these programmes and projects. Moreover, while the UNJPSP support has helped build institutional capacity and commitment for social protection and political will remains strong, the sustainability of the SCT programme may be hampered by inadequate financing towards the social protection sector by the Government. The increased risk of environmental factors, such as climate change, could push more people into poverty.<sup>4243</sup>

## 2.7 Gender profile

Gender inequality is a significant barrier to providing an inclusive, equitable and enabling environment for the realisation of children's rights. The Zambian Constitution (2016) provides an institutional framework consistent with the CEDAW. The Anti Gender-Based Violence Act was passed in 2011 and the Gender Equity and Equality Act No. 22 of 2015 gives further implementation guidance to the Convention. Despite the policy and legal framework, the United Nations Development Programme (UNDP) Gender Inequality Index (GII) demonstrates high levels of gender inequality in the social, economic and political spheres in Zambia and points to the fact that men are still at a more advantaged position compared to women. The GII reflects three dimensions of gender-based inequality: i) reproductive health, ii) empowerment and iii) economic activity. The 2020 Human Development Report shows that in 2019 Zambia's GII value was 0.539, giving the country a rank of 137 out of 162 countries.<sup>44&45</sup> Significant concerns remain on issues of maternal and sexual health. Maternal mortality remains a major cause of death with 278 deaths per 100,000 live births.<sup>46</sup> The birth rate among adolescents (ages 15–19 years) is 120.1 per 1,000 population as of 2020, down from 140.7 per 1,000 population in 2010. With an average total fertility rate of 4.98 births per woman between ages 15–49 years, the population of Zambia is growing steadily.<sup>47</sup>

Adolescent pregnancy birth rates remain high. The 2018 ZDHS indicates that 29 per cent of girls aged 15–19 years had already had a birth or were pregnant with their first child, with no decline from the previous ZDHS. Adolescent pregnancy has demographic, health and social consequences for women. Adolescent mothers, especially those under the age of 18 years, have been shown to be more likely to suffer from pregnancy and delivery complications than older mothers, resulting in higher morbidity and mortality for both themselves and their children.<sup>48</sup> When compared with older women, adolescent and

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<sup>41</sup> Ministry of National Development and Planning. (2020). *Mid-Term Review of the Seventh National Development Plan (2017–2020)*.

<sup>42</sup> UNICEF and Government of the Republic of Zambia. (2019). *End of Programme Evaluation of the UN and GRZ Joint Programme on Social Protection*.

<sup>43</sup> United Nations Development Programme. (2020). Zambia Human Development Report.

<sup>44</sup> United Nations Development Programme. (2020). *Human Development Report: The Next Frontier: Human Development and the Anthropocene*. New York: UNDP <http://hdr.undp.org/sites/default/files/hdr2020.pdf>.

<sup>45</sup> Zambia Statistics Agency. (2018). *Zambia Demographic and Health Survey* see also Child Poverty section of the report and Ministry of National Development and Planning and UNICEF (2018) *Child Poverty Report: A multiple overlapping deprivation analysis* Lusaka: UNICEF.

<sup>46</sup> UNICEF Zambia. (2018). *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

<sup>47</sup> Ibid.

<sup>48</sup> Tembo, T., Koyuncu, A., Zhuo, H. *et al.* The association of maternal age with adverse neonatal outcomes in Lusaka, Zambia: a prospective cohort study. *BMC Pregnancy Childbirth* 20, 684 (2020).

young mothers (between ages 10–25 years) fare less well at various points along the prevention of mother-to-child transmission of HIV (PMTCT) continuum: high unmet demand for contraception, lower rates of retention in HIV care and treatment, higher new infections of HIV during pregnancy, and breastfeeding posing risks to health as it increases the likelihood of MTCT of HIV (UNICEF, 2020). Nutrition in adolescence have far-reaching influence on adult health and nutrition status and consequently on productivity and national economic growth of the country. Adolescent malnutrition is a problem in Zambia, where all forms of malnutrition co-exist among the group. As per the DHS 2013–14, 16.4 per cent adolescent girls were undernourished while 8.6 per cent were overweight and obese. One-third of adolescent girls were anaemic.<sup>49</sup>

Discriminatory, gendered social norms intersecting with poverty and location result in multifaceted barriers to girls' access to and achievement in education. Girls are particularly vulnerable during transitions from one stage of education to the next and from school into adulthood.<sup>50</sup> These multifaceted and intersecting barriers increase as girls reach adolescence and are compounded by issues of child marriage, sexual and physical exploitation and violence, and additional financial burdens in secondary school. While Zambia has a re-entry policy which encourages girls to return to school after delivery, only 56 per cent of the 15,724 girls who dropped out of school in 2019 due to pregnancy, returned to school.<sup>51</sup> In many communities and families, the gendered social norms and long-standing practices dictate that girls remain at home to undertake household chores and marry as children.

Child marriage is common in Zambia: 29 per cent of women aged 20–24 years were married before the age of 18. According to the ZDHS 2018, the median age of marriage for girls is 19 years and the median age for boys is 24.5 years. Underlying gender norms subjugate and disempower girls and women and elevate boys and men into a position of power. Harmful gender norms often restrict women's access to services and information and opportunities for their participation in decision-making. Both girls and boys are affected by child marriage, but girls are disproportionately affected.<sup>52</sup> Although there is some decline in the prevalence of child marriage, progress has been slow with the prevalence rate declining from 31 per cent to 29 per cent from the 2014 ZDHS to the 2018 ZDHS. Qualitative research carried out by the Government of Zambia and UNICEF provides a more nuanced viewpoint to the ZDHS data with parents and children stating that a range of factors contribute to child marriage, including poverty, being out of school, lack of opportunities, peer pressure and escape from a violent family home. Child marriage is thus seen as the best of bad options and is often a choice amongst adolescents.<sup>53</sup>

The ability to read is an important personal asset and critical when engaging the population with social and behaviour change communication interventions. Illiteracy is more common among women than men. Eighty-three per cent of women residing in urban areas are literate, as compared to only 54 per cent of rural women. Moreover, literacy increases with increasing household wealth, ranging from 38 per cent among women in the lowest wealth quintile to 93 per cent among those in the highest quintile.<sup>54</sup>

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<sup>49</sup> These issues are further explored in the Chapter 8: Adolescents.

<sup>50</sup> CAMFED. (2016). End line Qualitative Study.

<sup>51</sup> Education statistical Bulletin. (2019).

<sup>52</sup> UNICEF Zambia. (2018). *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

<sup>53</sup> UNICEF Zambia. (2018). *Child Marriage in Zambia: Situation Analysis 2018* and Mweemba, O., and G. Mann (2020) 'Young Marriage, Parenthood and Divorce in Zambia', Research Report, Oxford: Young Lives.

<sup>54</sup> ZamStats. (2015). Zambia.

Access to media and other engagement platforms is another factor that empowers girls and boys, men and women. The ZDHS 2018 reported that a slim 5 per cent of women and 13 per cent of men aged 15–49 years are being exposed to three types of mass media (newspaper, television, and radio) at least once a week. Forty-six per cent of women and 31 per cent of men are not exposed to any of these mass media on a weekly basis. The percentage of women aged 15–49 years with no weekly access to mass media increased from 33 per cent in 2007 and 34 per cent in 2013–14 to 46 per cent in 2018. Among men, the percentage increased from 19 per cent in 2007 and 22 per cent in 2013–14 to 31 per cent in 2018. Looking at the socio-demographic patterns, both men and women in urban areas are more likely to have accessed all three forms of mass media in the last week than those in rural areas (9 per cent versus 2 per cent among women and 22 per cent versus 5 per cent among men). Exposure to the three forms of mass media improves with increasing education. The proportion of women with exposure to all three forms of media rises from less than 1 per cent among those with no education to 29 per cent among those with a higher education. Among men, the corresponding increase is from less than 1 per cent to 45 per cent. The Internet World Statistics 2021 reported that as of December 2020 there were 9.8 million Internet users, including mobile phone users, or 59 per cent per cent of the country's 16.6 million population. In the same year, Facebook subscribers were at 2.5 million. The advent of digital technology in Zambia has revolutionised information seeking, sharing and exchange using mobile phones, computers and tablets. Particularly among young people access to the Internet and social media platforms like email, SMS, Facebook, Twitter, YouTube, etc., has made communication faster and easier and made it possible to access news and events in various formats.

According to ZDHS 2018, among all women and men aged 15–49 years, 12 per cent and 26 per cent have used the Internet in the last 12 months, respectively. Of those who have accessed the Internet in the past 12 months, a greater percentage of women (55 per cent) than men (47 per cent) used the Internet daily. Internet use in the last 12 months was more common in urban areas (22 per cent of women and 44 per cent of men) than in rural areas (3 per cent of women and 11 per cent of men). Internet usage among women and men increased with increasing education and household wealth. Seventy-nine per cent of women and 89 per cent of men with a higher education used the Internet in the past 12 months, as compared with 1 per cent of women and 6 per cent of men with no education. Similarly, 38 per cent of women and 65 per cent of men in the highest wealth quintile used the Internet during the past 12 months, compared with less than 1 per cent of women and 3 per cent of men in the lowest wealth quintile, showing an immense need to address such disparities in designing social and behaviour change communication interventions.

Access to equitable labour market is also skewed as women often face exploitation. For example, over half of female agriculture workers (73.2 per cent) contribute to family labour, which is usually unpaid, as compared to men (26.8 per cent). Available data also shows that most females are in low-paying and short-term contract jobs. Such jobs limit access to productive resources and social services and are associated with increased risks of losing income and falling into poverty.<sup>55</sup> In rural areas, women are still expected to look after all aspects of child rearing and household management, earning income in whatever form to support the family or contribute to agricultural production in the family, and taking care of others who are sick or needing help in the community and wider family. In the current context, many women find themselves caring for and feeding orphaned children as well as their own. Men on the other hand may earn income and participate in community political or leadership roles. While the actual situation is more complex and is related to asymmetrical power relations. What is clear is that women take on more roles in support of the family and work harder and longer than most men. Moreover, the

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<sup>55</sup> Government of the Republic of Zambia. (2016). *Zambia national Gender Knowledge, Attitudes and Practices Survey Report*.



number of female-headed households (either real or de facto, especially when the man has migrated for work) continues to grow. Of the total unemployment rate, female to male ratio is 1.15, and of the youth employment rate, female to male ratio is 1.08 indicating that younger females can access greater work opportunities.<sup>56</sup> In terms of access to finance, 40.3 per cent of Zambian women have an account at a financial institution or with a mobile money service provider (per cent of female population ages 15 years and older)—this has increased from 23.3 per cent in 2011.<sup>57</sup>

One of the drivers of inequality is women's low participation in governance and decision-making at all levels. These include women's comparatively low level of education, their lack of support from political parties, lack of financial and other resources, stereotypes that work against women, cultural norms and values, and violence against women during elections.<sup>58</sup> Women's political representation in the Parliament remains low at 14.6 per cent.<sup>59</sup> Financial resources are a key barrier to women's political participation, but education also plays a crucial role. Before the 2016 elections, an amendment to the constitution ruled that all candidates must have studied for 12 years and prove this with a Grade 12 certificate. In Zambia, the school dropout among girls, especially in rural areas, is common and boys are more likely to complete secondary education than girls.<sup>60</sup> Therefore, the requirement for the Grade 12 certificate hinders women's candidacy. With respect to education, a significant gender gap emerges at secondary school level: secondary school completion being at 31.6 per cent among girls and 40.4 per cent among boys. Moreover, there is also a marked geographical disparity in relation to girls' completion rates, which are as low as 26.5 per cent in Northern Province and 26.7 per cent in Southern Province<sup>61</sup>.

Gender dynamics are reflected in women's participation in household decision making, often resulting in married women not having sole decision-making power over their own healthcare (31.7 per cent), major household purchases (11.7 per cent), or visiting friends and relatives (20.6 per cent).<sup>62</sup> However higher numbers report joint decision making with husbands on these issues, at 42.4 per cent, 54.6 per cent, and 54.6 per cent respectively.<sup>63</sup> Regression analyses indicate that there are significant differences between urban and rural gender power relations. Data in Table 1 taken from ZamStats demonstrates the percentage of control between wife and husband over the women's cash earnings and who decides how it will be used.<sup>64</sup> In urban areas, married women had 41 per cent of control over their total earnings as opposed to 21.9 per cent in rural areas. Interestingly in rural areas, a higher proportion of women's cash earnings were controlled jointly by women and men compared to urban areas. However, gender power relations differ based on the socioeconomic background of households with 36 per cent of women in the highest wealth quintile having control over their earnings compared to 21 per cent in the lowest wealth quintile. This indicates the importance of socioeconomic factors in driving gender

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<sup>56</sup> United Nations Development Programme. (2020). *Human Development Report*, <http://hdr.undp.org/en/countries/profiles/ZM> B.

<sup>57</sup> Ibid.

<sup>58</sup> Nakray, K. & Kafukanya M.N. (2019). Gender mainstreaming in multi-level political governance in urban Zambia: A critical review of Millennium Development Goal (MDG) achievements, *Development Southern Africa*, 36:1, 111–126.

<sup>59</sup> National Assembly of Zambia. Available at:

<https://www.parliament.gov.zm/members/gender><https://www.parliament.gov.zm/members/gender>. Accessed on 6 October 2021.

<sup>60</sup> UNICEF 2015, 2018, 2016; CAMFED 2015.

<sup>61</sup> Education Statistical Bulletin. (2018).

<sup>62</sup> Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF. 2019. Zambia Demographic and Health Survey 2018: Key Indicators. Rockville, Maryland, USA: Central Statistical Office, Ministry of Health, and ICF.

<sup>63</sup> Ibid.

<sup>64</sup> ZamStats. Available at: <https://www.zamstats.gov.zm/index.php/publications/category/8-demography>.

equality.<sup>65</sup> Similar trends are evident in terms of ownership of assets: 21.9 per cent of urban women have their own name on their title/deed of their residence in contrast to 2.8 per cent of women in rural areas; 19.4 per cent have use of a bank account compared to 3 per cent of rural women and 75 per cent own a mobile phone compared to 33 per cent of women in rural areas. Despite prevailing harmful social, cultural and gender norms inhibiting women's full participation in the community, society and economy, there are nuances within gender power relations and organisations targeting gender equality should be mindful of these when considering gender related interventions. Another manifestation of gender inequality is the prevalence of sexual violence. In 2019, 45.9 per cent of women aged 15–49 years had experienced violence and were subject to physical and/or sexual violence by a current or former intimate partner.<sup>66</sup> Data shows socioeconomic background and residence has limited impact on the number of women experiencing sexual violence. Statistics from 2018 ZamStats (see Table 1) show 17 per cent of women in the two lowest wealth quintiles had ever experienced sexual violence in contrast to 11 per cent in the three highest quintiles.

*Table 1: Sexual violence experienced by women (percentage) by residence and wealth quintile*

Background characteristic	Experienced sexual violence	2018
<b>Residence</b>		
<b>Urban</b>	Ever	12.7%
	In the past 12 months	7 %
	Number of women	4,383
<b>Rural</b>	Ever	14.5%
	In the past 12 months	9.1%
	Number of women	5,120
<b>Wealth</b>		
<b>Lowest</b>	Ever	17%
	In the past 12 months	11.1%
	Number of women	1,704
<b>Second</b>	Ever	16.6%
	In the past 12 months	10%
	Number of women	1,667
<b>Third</b>	Ever	12.4%
	In the past 12 months	7.7%
	Number of women	1,751
<b>Fourth</b>	Ever	12.4%
	In the past 12 months	8.5%
	Number of women	2,076
<b>Highest</b>	Ever	11.2%
	In the past 12 months	4.5%
	Number of women	2,306

Source: ZamStats 2018.

<sup>65</sup> Ibid.

<sup>66</sup> UN Women (2020) *Zambia Fact Sheet*.

There is reason to believe that the gender inequality gap and age gap is compounded to create a power relationship gap. According to the Violence against Children (VAC) Study (2014) over a quarter of girls stated that their first sexual encounter was forced or coerced. Access to services for both girls and boys who experience sexual abuse is concerning. The VAC Study shows that 0 per cent of girls who had experienced sexual violence received services and the figure for boys was 7.2 per cent. According to the ZDHS (2018), 36 per cent of women aged 15–49 years have experienced physical violence since age 15, and 18 per cent experienced physical violence in the 12 months prior to the survey while 1 per cent of women aged 15–49 years had experienced sexual violence. This points to the need for much greater emphasis on social and behaviour change and gender transformative programming moving forward, including the empowerment of girls, positive parenting for adolescents, and working with traditional leaders and religious leaders as well as other community influencers (teachers, health workers) so that a culture of zero tolerance towards sexual abuse is strengthened.

Acceptance of violence against women is high and stagnant amongst both women and men. According to the ZDHS (2018) 46 per cent of women and 26 per cent of men agreed with at least one specified reason justifying “wife beating”. Different processes of initiation, intended to prepare young men and women for adulthood are widespread, although varying by area, gender and ethnic group. Research in both urban and rural areas in Lusaka and Copperbelt Provinces and rural Eastern Zambia has identified how boys learn sexually aggressive masculinities whilst girls receive mixed messages emphasising being sexually assertive, passive and yet chaste,<sup>67</sup> which can contribute to gender violence and HIV risk.<sup>68</sup> A UNICEF supported study of violence in boarding schools showed a high rate of violence against girls with just under 20 per cent of girls being victims of sexual violence and/or engaging in transactional sex; and perpetrators of violence often being male peers, current or ex-boyfriends, and even male teachers. Given the importance of secondary education for girls, in terms of future livelihoods and reduction of child marriage, it is important that significant emphasis is put on both access to secondary education and implementation of school protection policies and practices (child safeguarding in schools).

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<sup>67</sup> Heslop, J., and R. Banda. 2013. “Moving Beyond the ‘Male Perpetrator, Female Victim’ Discourse in Addressing Sex and Relationships for HIV Prevention: Peer Research in Eastern Zambia.” *Reproductive Health Matters* 21 (41).

<sup>68</sup> Ibid.

# CHAPTER 3. EARLY CHILDHOOD DEVELOPMENT

## 3.1 Introduction

Early childhood is defined as the period from conception to eight years of age,<sup>69</sup> including when the child enters education and the lower years of primary school. It is further divided into the following stages

- (a) Babies and toddlers (zero- to two-years-old): from conception and through the first 1,000 days of life;
- (b) Preschool (three- to six-year-olds): play-based learning and school readiness; and
- (c) Early school age (six- to eight-year-olds): transition to school and lower primary school.

Early childhood development (ECD) refers to the physical, cognitive, linguistic, social and emotional abilities attained with the support of nurturing care and positive parenting. Zambia has a youthful and rapidly growing population of 2.8 per cent per year, which is projected to double in the next 25 years.<sup>70</sup> Most of the Zambian population are sparsely distributed, living in rural areas, with 44 per cent concentrated in a few urban locations. Overall, 32 per cent of households are caring for foster or orphaned children.<sup>71</sup> A third of the population (35 per cent) is currently in the age range of 15–35 years, with 48 per cent under 15 years of age and 14 per cent under five years of age; giving a median age of 17.6 years. The youthful population presents a demographic dividend potential as it provides the required human capital base needed for the country to reap the social and economic benefits associated with this age group.

Harnessing human capital is a priority of the Government under the 7NDP, however the Government needs to nurture its young citizens through social and economic reforms to ensure no one is left behind; or else, the large population of young people might become a challenge in terms of demand for social services and employment, with severe implications for the already strained Government resources. Early childhood is also the period when sound nutrition forms the basis for future health and well-being. The promotion of ECD, as an intrinsic initial step to a positive life cycle approach and continuum of care, is widely endorsed in the global social and economic transformative agenda as being crucial in the enhancement of human capital. Despite this, compelling evidence has shown that over 43 per cent of children under the age of five years globally, and predominantly in Sub-Saharan Africa including Zambia, are at risk of not achieving their developmental potential. This is due to a complex and multidimensional set of factors, including poverty, poor nutrition, low levels of parental education, lack of access to health and sanitation services, and insufficient responsive caregiving and early stimulation; subsequently leading to an estimated 20 per cent loss in adult wages and productivity.<sup>72&73</sup>

### **Rationale for investing in the early years**

The crucial structural foundation for human and social development is laid in the first 1,000 days of a child's life. During these early years, the parts of the brain develop that are responsible for physical and motor activities, thought, memory, social and emotional behaviours, perceptual and sensory faculties,

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<sup>69</sup> ECD as defined by the United Nations.

<sup>70</sup> World Bank, March 2021.

<sup>71</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

<sup>72</sup> Lancet ECD series (2016). Grantham-McGregor, S., Y. B. Cheung, S. Cueto, P. Glewwe, L. Richter, & B. Strupp (2007). Developmental potential in the first 5 years for children in developing countries. *The Lancet* 369: 60 (70).

<sup>73</sup> Engle P.L., Black M.M., Behrman J.R., Cabral de Mello M., Gertler P.J., Kapiriri L., Martorell R., & Young M.E. (2007). Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world. *Lancet* 369:229–42.

and language.<sup>74</sup> To reach full potential, children need nurturing care, which includes good health, adequate nutrition, security and safety, early learning opportunities, early stimulation, and responsive caregiving. Without this, the child is at risk of severe negative consequences. For example, poor nutrition during the first 1,000 days of life directly affects neurodevelopmental processes, with permanent or irreversible consequences that compromise the long-term cognitive, motor and socio-emotional well-being of the child. Timely interventions early in life are critical as they can protect children from diseases and set them up for healthier lives. Children will thrive when they eat well, feel safe and secure, loved, stimulated through play and communication, and are provided with opportunities to learn at home and in their community. The holistic care of a child, to enable them to reach their developmental potential, is a human right as stipulated in the UNCRC and affirmed in the *General Comment No. 7 of 2005*,<sup>75</sup> which also emphasises the implementing of rights of children in early childhood.

Risk factors that impede development go beyond the individual's health and include low wages, high government spending on the social system, low productivity, and intergenerational transmission of poverty.<sup>76</sup> Early childhood development is seen as one of the most cost-efficient investments in human capital which leads to a country's sustainable development. For example, cost-benefit analysis in middle- and low-income countries shows that from an economic perspective, for every US\$1 spent on early childhood development interventions, the potential return on investment can be as high as US\$6–17 in reduced poverty; subsequently increasing prosperity and economic competitiveness,<sup>77</sup> with an increase in adult individual earnings by 25 per cent.<sup>78</sup>

### 3.2 Legal and policy framework

In addition to the global conventions to which Zambia is signatory to, and which define Zambia's commitments to the rights of the child, the Sustainable Development Goals provide the overarching framework to achieve a better and more sustainable future for all. This blueprint and its derivative, the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030 include multiple targets that relate to nurturing care and create the conditions for children to survive and to thrive; thus, transforming children's health and human potential. ECD is at the heart of the Government's Transformative Agenda and is key to attaining the 2030 Vision. The SDGs are essential to creating the environment in which all children can thrive,<sup>79</sup> thereby transforming not only individual lives, but also wider communities and societies. SDGs related to ECD are:

#### **Goal 1: Target 1.2 (Ending Poverty)**

- By 2030, reduce at least by half the proportion of men, women, and children of all ages living in poverty, in all its dimensions, according to national definitions. ECD is one of the most cost-effective strategies for poverty alleviation. Early brain development sets children up for the future and enables them to learn skills, be productive, and build the economy.

<sup>74</sup> Shonkoff, Jack P. and Deborah A. Phillips, Ed (2000); *From Neurons to Neighbourhoods: The Science of Early Childhood Development* Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families.

<sup>75</sup> General Comment No. 7 of the addendum of the CRC.

<sup>76</sup> van der Gaag, J. (2003) *From Child Development to Human Development*. Available at: [http://www.ecdgroup.com/pdfs/van\\_der\\_gaag\\_paper\\_CHILDDEV-20\\_05\\_2003-18\\_13\\_22.pdf](http://www.ecdgroup.com/pdfs/van_der_gaag_paper_CHILDDEV-20_05_2003-18_13_22.pdf)

<sup>77</sup> World Bank. (2016).

<sup>78</sup> Heckman, (2008) and World Bank Report, (2002).

<sup>79</sup> List based on Pia Britto's October 2015 UNICEF Connect blog: "Why early childhood development is the foundation for sustainable 12 development." <https://blogs.unicef.org/blog/why-early-childhood-development-is-the-foundation-for-sustainable-development/>.

**Goal 2: Target 2.2 (Nutrition)**

- By 2030, end hunger and ensure access for all people, including the poor, people in vulnerable situations, and infants, to safe, nutritious, and sufficient food all year round. Children who receive early stimulation with nutrition supplements have better outcomes than those who only receive nutrition supplements. ECD interventions buffer the negative effect of stress, thereby improving absorption of nutritional intake.

**Goal 3: Target 3.2 (Health)**

- By 2030, end the preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to, at least, as low as 12 in 1000 live births, and under five years mortality to, at least, as low as 25 in 1000 live births.

**Goal 4: Target 4.2 (Education)**

- By 2030, ensure that all girls and boys have access to quality early childhood development, care, and pre-primary education so that they are ready for primary education, with their ECD within target (4.2.1, 4.2.2, and 4.2.3).
  - Per cent of children developmentally on track (4.2.1)
  - Per cent of children participating in organised learning (4.2.2)
  - Per cent of children experiencing positive, stimulating home environments (4.2.3)

**Goal 16: Target 16.2 /16.9 (Child protection)**

- By 2030, end abuse, exploitation, trafficking, torture, and all forms of violence against children. The birth registration target is for 16.9 per cent of all children's births to be registered, and to have an identity and recognition of nationality and factored in National Planning.

In 2017, the Government launched the 2016 ECD *Lancet Series* in Zambia, and thereafter adapted the Child's Healthy Growth and Development package to train frontline workers in key family and community care practices, to promote family well-being and optimal child development. Following this, in 2018 the Government adopted the WHO/UNICEF Nurturing Care Framework (NCF) for ECD and committed to scaling up Nurturing Care for ECD, and Care for Child Development, which underpins the Playful Parenting campaign, was launched in 2021. The National Playful Parenting Campaign has been launched to promote responsive and positive parenting, and early learning opportunities for children as key elements, including caring for the caregiver, as this has been significantly absent from the childcare system. In alignment with the NCF, the Government has adopted a multisectoral approach to ECD and has integrated it in sector plans, programmes and services. Key line Ministries that have already commenced the integration of ECD into sector programmes are:

- (a) the Ministry of Health (MoH) focusing on the developmental life stage from conception to three years of age; and
- (b) the Ministry of General Education (MoGE) focusing on early learning and school readiness from three to six years of age and the transition period into school, targeting children of six to eight years of age.

Recently, Zambia's programming for ECD has increasingly been influenced by the NCF and driven by political commitment and a determination to support and empower parents, families, other caregivers, and communities in providing appropriate holistic care to young children and protect them from adversities. While the Ministry of Community Development and Social Services (MCDSS) has not yet included ECD in its child protection programmes, it is part of the National ECD Multisectoral Technical Committee and is fully engaged in ECD policy dialogue.

### 3.3 Levels, trends and differentials in key indicators

#### Components and status of the nurturing care framework in Zambia

Nurturing care comprises five essential, interrelated and indivisible components: good health, adequate nutrition, responsive caregiving, security and safety, and opportunities for early learning what the child's brain and body expects and needs, and what young children need to grow physically, cognitively, linguistically, and socio-emotionally. The key elements of the five components are summarised in the following NCF diagram and its corresponding alignment with the SDGs.



Source: World Health Organization 2018<sup>80</sup>

The following section summarises the nurturing care components and interventions as identified in the framework.

#### 1. Good health

ECD interventions early in life set a trajectory for good lifelong health. Among other things they can lead to lower incidence of cardiovascular and non-communicable diseases and can also increase well-being. The current MMR in Zambia is at (278/100,000);<sup>81</sup> 63.5 per cent of women received four antenatal care (ANC) visits; 83 per cent of pregnant women living with HIV received treatment; and 84 per cent of deliveries were assisted by a skilled health professional.<sup>82</sup> The under-five mortality rate was 61 per 1,000 live births, with low birth weight at 9 per cent, and preterm births at 13 per cent. Care-seeking for child pneumonia was at 70 per cent. Children between ages 12–23 months, who are fully immunised, was at 75 per cent.<sup>83</sup>

Even though 86 per cent of women are assisted in delivery by a skilled birth attendant, the 2018 ZDHS reports that while infant and under-five mortality decreased between 2014 and 2018, newborn

<sup>80</sup> WHO and UNICEF. (2018). Nurturing Care Framework.

<sup>81</sup> Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF. 2019. Zambia Demographic and Health Survey 2018: Key Indicators. Rockville, Maryland, USA: Central Statistical Office, Ministry of Health, and ICF. p 48.

<sup>82</sup> Ibid. p 134.

<sup>83</sup> Ibid. pp 122 & 155.

mortality (the probability of dying within the first 28 days of life) increased from 24 deaths per 1,000 live births in 2013–14 to 27 deaths per 1,000 live births in 2018. This indicates the need to train all birth attendants, including midwives in essential newborn care.

An additional concern in health service delivery in Zambia is the insufficient attention given to, and lack of data on maternal mental health, particularly during the perinatal period and for young teenage mothers. Maternal stress affects babies in the womb, can increase pre-term delivery, may result in low birth weight, and affect children's development. Mental health affects children and caregivers, and negatively impacts a caregiver's sensitivity and responsiveness to the child's needs and optimal caregiving. The results of a meta-analysis by Warnock et al<sup>84</sup> indicated an association of maternal depression with negative parental behaviours and disengagement. In Zambia COVID-19 has aggravated poor levels of mental health in parents who are struggling with their own well-being and the challenging task of childcare. Pregnant adolescents who are HIV positive have also been identified as needing mental health support.

There is growing evidence that poor water, sanitation and hygiene (WASH) conditions have an impact on ECD outcomes that is larger than previously recognised. Over 72 per cent of households have access to drinking water and 58 per cent have access to improved sanitation,<sup>85</sup> mostly in urban and less in rural areas. Baby WASH is a relatively new concept developed following a detailed evidence review examining the links between poor WASH conditions and early child development, particularly for babies and children under three years of age.<sup>86</sup> Baby WASH integrates WASH interventions into maternal, newborn and child health (MNCH), ECD and nutrition to have a profound impact on child health outcomes in the first 1,000 days of life. Open defecation is still at 10 per cent and Baby WASH is still poor in communities as parent leave their children to play on the ground. The effects of poor hygiene during the first 1,000 days of life can determine whether a child will reach his or her developmental potential.<sup>87</sup>

## **2. Adequate nutrition**

The nutritional status of the mother before and during pregnancy affects her health and well-being and that of her unborn child. After birth, the mother's nutritional status affects her ability to provide adequate care to her young child. Children who receive early stimulation with nutrition supplements have better outcomes than children who only receive nutrition supplements: 76 per cent of mothers conduct initial breastfeeding within the first hours of delivery. In Zambia, 73 per cent of children are exclusively breastfed for 0–6 months. Only 13 per cent of vulnerable and disadvantaged children between the ages of 6–23 months have a minimum acceptable diet and the food insecurity rate is 23 per cent. Over 58 per cent of 6- to 59-month-old children suffer from anaemia that has devastating mental consequences for the developing child. Child poverty is at 60 per cent.<sup>88</sup> Four in ten children are stunted (35 per cent) and that poses a risk of permanent and irreversible physical and cognitive consequences that can last a lifetime. The risk of poor development is estimated at 78 per cent using the composite indicator of under-five stunting and poverty.<sup>89</sup> The proportion of children aged 6–23 months

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<sup>84</sup> Warnock FF, Craig KD, Bakeman R, Castral T, Mirlashari J *BMC Pregnancy Childbirth*. 2016 Sep 7; 16():264

<sup>85</sup> *ibid*

<sup>86</sup> Ngure, F.M., Reid, B.M., Humphrey, J.H., Mbuya, M.N., Pelto, G., Stoltzfus, R.J. "Water, sanitation, and hygiene (WASH), environmental enteropathy, nutrition, and early child development: making the links." *Ann N Y Acad Sci* 2014 Jan; 1308:118–128.

<sup>87</sup> *The Lancet*. (2016).

<sup>88</sup> Ministry of National Development & Planning and UNICEF. (2018). *Child Poverty in Zambia Report: A multiple overlapping deprivation analysis*.

<sup>89</sup> *Ibid*.



receiving minimum adequate feeding is very low, at 11 per cent. In terms of caring practices for women and children, research shows that most babies in Zambia are not born stunted (chronically malnourished). Instead, most children under five years of age who become stunted do so between the ages of two months and two years.<sup>90</sup>

### **3. Responsive caregiving**

Responsive caregiving refers to the ability of the parent/caregiver to notice, observe, understand, and respond to children's movements, sounds, gestures, verbal requests in a timely and appropriate manner. Caregivers respond through cuddling, eye contact, carrying, smiling, mimicking, vocalising/talking and gesturing. Responsive caregiving is characterised by a home environment that is emotionally supportive, developmentally stimulating, and presents opportunities for play, exploration, and is sensitive to children's health and nutritional needs, and provides protection from threats.<sup>91</sup> Responsive caregiving is considered the foundational component of the NCF because it underpins the other four care components.

Most interventions and services to children in Zambia have been skewed towards health and nutrition neglecting the socio-emotional and development component. Mutually enjoyable interactions between the child and the caregiver creates an emotional bond, which not only helps young children to understand the world around them and to learn about people, relationships and language, but also stimulates the mind.<sup>92</sup> Yet parents in Zambia have limited knowledge about the importance of early stimulation and playful parenting. Parents tend to focus on practical and physical care of young children, rather than the socioemotional care, early learning, and development.<sup>93</sup> Cultural and traditional norms persist in communities throughout the perinatal period putting the health of the mother and child at risk.<sup>94</sup> Despite scientific evidence showing that early stimulation by spending quality time with the baby from the first months strengthens the child's brain,<sup>95</sup> parents are still sceptical about engaging children in structured traditional games and talking to their children, especially preschool children.<sup>96</sup> Public information about ECD particularly responsive caregiving and playful parenting is still in the process of penetrating Zambian society since the launch of the playful parenting campaign. Parents and primary caregivers are key actors in the adoption of family care practices. However, parental education programmes are scarce and, where they do exist, they lack diversity, a life course approach to ECD and the focus tends to be on health and nutrition, with no focus on responsive caregiving, and parental socio-emotional or psychosocial care of the child. Therefore, psychosocial care and how it affects child development needs to be prioritised in parenting education programmes and counselling for the family.

### **4. Safety and security**

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<sup>90</sup> Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. 2014.

Zambia Demographic and Health Survey 2013-14. Rockville, Maryland, USA: Central Statistical Office, Ministry of Health, and ICF International.

<sup>91</sup> Black and Aboud. (2011). *Responsive feeding is embedded in a theoretical framework of responsive parenting in The Journal of Nutrition*.

<sup>92</sup> Black MM, Walker SP, Fernald LCH, Andersen CT, DiGirolamo AM, Lu C, McCoy DC, Fink G, Shawar YR, Shiffman J, Devereceilli AE, Wodon QT, Vargas-Barón E, Grantham-McGregor S, *Lancet Early Childhood Development Series Steering Committee*. *Lancet*. 2017 Jan 7; 389(10064):77-90.

<sup>93</sup> ECD KAP survey, 2020 by M&C SAATCHI, UNICEF Zambia.

<sup>94</sup> RMNCH KAP 2015, Zambia.

<sup>95</sup> Including smiling, touching, talking, storytelling, listening to music, sharing, and reading books, and engaging in play.

<sup>96</sup> ECD KAP survey, 2020 by M&C SAATCHI, UNICEF Zambia.

Zambia ranks 146 out of 182 countries in the KidsRights Index score of 0.529, and 0.351 on the child protection score,<sup>97</sup> this means that Zambia has suboptimal child protection issues, which need to be addressed. Teenage motherhood (31 per cent) decreased the chances of children receiving responsive and appropriate care from young and inexperienced caregivers. The average age to marry in Zambia is 19 years with 9 per cent girls and 1 per cent boys marrying earlier than 19 years of age. This is more prevalent in rural areas. Throughout Zambia it is not uncommon for parents to use harsh forms of discipline, including corporal punishment, even for children as young as two years old. This poses a potential risk to the child's developing brain, trust and self-esteem.<sup>98&99</sup> Children living in extreme and stressful environments experience toxic stress, which has a negative effect on emotional and brain development.

Birth registration, a key indicator for safety and security, fulfils a basic right to identity. Birth registration is not compulsory in Zambia, and only 14 per cent of children's births are registered. Without registration, the child has no right to an identity, legal recognition as citizen and is unaccounted for in the provision of social services, national planning and budget allocation.

## **5. Opportunities for early learning**

ECD interventions have proved to be the foundation for later learning, academic success and productivity in life. Early Childhood Education (ECE) is identified by the Government as a foundational stage in the Zambian education structure and it was integrated into the MoGE education structure in 2011. The Government has established over 3,997 ECE centres through annexing classrooms at primary schools, but these classrooms have not been adapted for this purpose and do not provide an enabling environment for early years learning. With the population growth, classrooms are limited thereby increasing the number of out-of-school children at this school readiness age even before children start school. ECE still suffers from limited trained and qualified teachers in schools.<sup>100</sup> The first enrolment in Government funded ECE centres took place in 2013. The 2017–2021 Education Sector Plan identifies ECE as a key strategic priority with several strategies outlined to accelerate access to ECE and improve quality, equity efficiency and effectiveness. However, currently only 35 per cent of children have access to early learning, especially in rural and hard to reach areas and this is widening the equity gap.<sup>101</sup> The remaining 65 per cent children begin school often unprepared for learning. Furthermore, less than half of the Grade 1 students (49 per cent) start school at the Government-approved age of seven years. This is further analysed and explored in the chapter on Education.

The Government has identified three scale-up models for improving access to ECE: annex centres, standalone centres and hub-satellite centres. The Government's initial strategy to annex primary school classrooms made an initial 2,992 ECE centres across the 10 provinces. In the standalone model, the ECE centre operates as an independent entity under direct monitoring of the District Education Office. The hub-satellite model was recently introduced as a low-cost strategy where satellite centres are established at community level and where a respective primary school annex centre acts as a hub providing support for quality assurance and development. The hub-satellite model has demonstrated feasibility for expanding access to ECE with targeted interventions, including early learning and stimulation, health, nutrition, safety and security through strong partnerships across multiple sectors.

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<sup>97</sup> KidsRights Foundation (2021)—KidsRights Index, 2021.

<sup>98</sup> American Institute for Research (2017) Traditional Parenting Study.

<https://www.unicef.org/zambia/media/1341/file/Zambia-traditional-parenting-study-2018.pdf>

<sup>99</sup> University of Zambia (2020). Insaka baseline study.

<sup>100</sup> Ministry of General Education. (2018). Status of Early Childhood Education in Zambia.

<sup>101</sup> Educations Statistics, Ministry of General Education. (2018).

According to the ZDHS (2018) only 27.8 per cent and 5.8 per cent of children in the age group of zero to five years have attended ECE in urban and rural areas respectively. Additionally, the proportion of children with disabilities accessing ECD is exceptionally low and remains undocumented.

### 3.4 Challenges, shortfalls and inequities

The COVID-19 pandemic clearly is a serious set-back for the realisation of children's rights. Besides the deepening of poverty and structural inequalities many children during the pandemic have reduced their prospects of developing their full potential, particularly with key concerns on violence against children, vaccinations (non-COVID-19) for children, education and the related issue of school closures, mental health and well-being, and case management for children at risk. Psychosocial support and counselling for caregivers including public campaigns on playful parenting should be encouraged and implemented through national and community communication channels that operate according to MoH COVID-19 prevention guidance.

**Inconsistent ECD definitions:** There are inconsistencies in definitions and terminologies used for ECD across sectors; with each ministry using a definition in line with their mandate. Furthermore, this results in several different abbreviations being used interchangeably across different sectors: for example, ECD, Early Childhood Care Development and Education, Early Childhood Care Development and Education and ECE. The absence of national ECD definition may impact on policy implementation, practice, scope of programming, and potential outcomes for children and their families.

**Lack of an overarching national multisectoral ECD policy framework:** Every line Ministry has policies and a strategic plan that enables the delivery of services under their mandate. However, the current circumstance of fragmented policies has raised challenges to the multisectoral collaboration structure with different line ministries between the various policies to which each ministry is accountable.

**Siloed service delivery:** Service delivery to young children is fragmented and different sectors work in their own silos. Service delivery is skewed towards health and nutrition with responsive care, early learning opportunities and caregivers' mental health being limited in scope, coverage, and access. Responsive caregiving, early learning and caring for caregiver's mental health are key components related to socioemotional and psychosocial care and enhances the effectiveness of other nurturing care components.

**Weak coordination structures:** Weak coordination structures from national to subnational levels have contributed to the silo approach to programme implementation. This makes it difficult to provide coherent ECD services and support for children and families. The capacity of ECD coordinating structures need to be strengthened so that they can plan, coordinate, implement and monitor programmes for synergies and complementarities for optimal child development outcomes.

**Limited ECD workforce:** There are capacity gaps in NCF amongst key stakeholders across sectors, especially on responsive caregiving, early learning opportunities and caregiver's emotional availability for appropriate response to child's needs. Previously any capacity development for ECD has focused on the training of ECE teachers. While this is still needed, a wide number of professionals and volunteers across all relevant sectors need to be trained on all aspects of ECD.

**Insignificant visibility of nurturing care for ECD:** Nurturing care interventions are beginning to permeate Zambian society and the understanding of how it can be implemented to benefit child development is

growing. However, there remains limited awareness among parents, communities, and key stakeholders on the importance of ECD: what children need to develop their potential and how caregivers can support. Influencing social norms and behaviours for appropriate family and community care practices needs a behaviour change communication approach, which would use different touchpoints to reach children, caregivers and community groups and other actors, including influential people who can champion nurturing care for ECD. There is need for a mixed approach, including home visits, group sessions, community theatre, and mass and multimedia to reach different audiences, including the most vulnerable.

**Public finance for ECD (PF4ECD):** ECD is at risk of being overlooked when national financial decision makers allocate scarce public resources to policy priorities. Governments might recognize ECD as a priority but need to reflect it in national or subnational budgets and incorporate into national and District development plans.

**Weak ECD data, knowledge management and reporting for decision-making:** The ECD sector lacks a comprehensive, robust information management system to capture data for use in policy and programming. Most NCF indicators for international comparability are still lacking and most available data still lack disaggregation by gender, disability, geographical location, orphanhood and HIV/AIDs status. Data is in the different ministerial information systems and linked to sectoral indicators and paper-based at the facility and community level.

### 3.5 Stakeholder landscape and initiatives

The following provides a summary of the opportunities that currently exist for progressing ECD in Zambia:

- (a) compelling global and regional evidence of the high returns of investment in ECD;
- (b) high commitment of Government in the 2030 Vision and 7NDP with the Human Capital Development Pillar and social and economic reforms to improve the situation of deprived, disadvantaged, and marginalized population (*Leaving no one behind*). There is no better way of building human capital and workforce then investing the youngest citizens and building well-being and brains for future development;
- (c) the development of guidelines/frameworks and the launch of the *Lancet Series, Nurturing Care Framework*, and the *National Playful Parenting Campaign* are significant for Government commitment to ECD;
- (d) the establishment of national, provincial and district multisectoral ECD structures and platforms to drive ECD planning, coordination, implementation and monitoring;
- (e) the youthful population of Zambia is a great opportunity for the Government to harness and educate the young before they start reproduction so that children born can enjoy nurturing and holistic care for optimal development; and
- (f) partnership with technical assistance from United Nations agencies multilateral and bilateral donors, NGOs, CSOs, traditional authorities, academia, media, faith-based organisations, local leaders, communities and families for a multisectoral approach to optimise child development.

#### **Multisectoral coordination structures**

Key structures and platforms in the ECD space exist at national, provincial and district levels, albeit with weak capacities. The MoH is the national ECD lead with line ministries responding to their corresponding sectors and contributing to the synergies and complementarities for optimal child development. The key line ministries are MoH, MoGE, MCDSS, Ministry of Youth, Sports and Child development (MYSCD) and

Ministry of Agriculture (MoA). There is also the Zambia ECD Network Action (ZECDAN) which is an interagency platform of United Nations agencies (UNICEF and WHO), civil society organisations (CSOs) and stakeholders in the ECD space in Zambia. The ECD Multisectoral Technical Committee (ECD-MTC) provides the multisectoral inter-agency network. The inter-ministerial coordination has a corresponding multisectoral structure at provincial and district levels that are currently being strengthened with support from UNICEF. Multisectoral coordination with strong community engagement is currently being piloted in Chipata, Chongwe, Katete and Petauke Districts.

A National Integrated ECD Policy Framework is vital for the operationalisation of the NCF for ECD services with a costed Action Plan that includes timelines, responsibilities and progress indicators. Its absence currently hinders the country's vision for accomplishing developmental goals for young children. The Government is in the process of addressing this policy gap by putting in place a National ECD Multisectoral Policy and Strategic Framework 2022–2026, which will help articulate the country's vision, strategies and monitoring system for ECD. The *National Playful Parenting Campaign* has been launched and there are high-level champions to drive increase in the political will for increased resources and for the visibility of ECD. The Parliament and the media community have been oriented on the scientific evidence for ECD, its potential and practice.

### **Health initiatives**

The primary ECD ministry in the health and nutrition sector is the MoH operating with the department of Public Health and department of Health Promotions, Environment and Social Determinants. ECD related services under the two departments focus on maternal, reproductive health, neonatal, and child health and nutrition (through the Child Health and Nutrition Units) health promotion and education, community health, environmental health and food security, water and sanitation as well as pollution prevention. The Integrated Management of Newborn and Child Illnesses (IMNCI) initiative focuses on community health outreach services provided to reach children aged 0–59 months in target communities in Chipata and Chongwe with integrated ECD services and stimulation and play spaces for children at health facility level.

Given its strategic position in maternal and child health services, the MoH is playing a leading role in integrating responsive caregiving in existing programmes. Key to this programme is integration of the *Care for Child Development* intervention package into health and nutrition delivery. ECD has been incorporated into the Maternal and Child Health Handbook being piloted in Katete and Petauke. Nurturing care for ECD has been incorporated as a unit into the National Pediatric Registered Nursing curriculum and in Community Health Management Information System. The United States Agency for International Development (USAID) is providing a platform for early learning and responsive caregiving for children admitted in paediatric wards and a total of 14 centres have since been established in health facilities in Central, Copperbelt and Southern Provinces.

### **Nutrition initiatives**

Different line ministries in collaboration with UNICEF, WHO, Food and Agriculture Organization (FAO) and United Nations Development Programme (UNDP) are working through the Scaling-Up Nutrition (SUN) MCDPII to reduce rates of malnutrition and stunting. Other partners, including Right to Care, GSI, PATH and Catholic Relief Services (CRS) are contributing to scaling up ECD nutrition initiatives in different districts through community engagement. This programme takes a life cycle approach in addressing issues related to feeding of infants and young children as well as meeting the biological and nutritional needs of adolescents and mothers. Initiatives on nutrition include the following:

- (a) Growth Monitoring Promotion (GMP);

- (b) Baby Friendly Hospital Initiative (BFHI);
- (c) The First 1,000 MDPII-SUN II;
- (d) Maternal, Adolescent, Integrated Management of Acute Malnutrition (IMAM and IMSAM);
- (e) Infant and Young Child Nutrition (IYCN);
- (f) Integrated Management of Severe Acute Malnutrition (IMSAM); and
- (g) Training nutrition support groups and Community Based Volunteers (CBVs) to support home visits and Maternal Adolescent Infant and Young Child Feeding (MA-IYCF) counselling and food demonstrations in the multisectoral districts with support from UNICEF.

### **WASH initiatives**

These are aimed at delivery of improved WASH in institutions, in ECD Centres, preschools and primary schools, as well as at the community level. Services are focused on community mobilisation and sensitisation on improved WASH, COVID-19 prevention and the practice of baby WASH. The WASH sector is contributing to creating an enabling environment for ECD, highlighting the need for cross-programme collaboration between WASH, nutrition and MNCH. (See Chapter 7 on WASH for further detail and analysis).

### **Child protection initiatives**

Child protection initiatives include family social protection, birth registration, case management of families and referral, protection of children from violence. ECD is incorporated into the alternative care and family-based foster care programme. There are trainings on child safeguarding and Protection against sexual exploitation and abuse (PSEA), initiatives to stop early marriage. Social services are also focused on Social Assistance Social Cash Transfer, Service Efficiency and Effectiveness for Vulnerable Children and Adolescents, the Livelihood and Empowerment Support Scheme, Community Skills Development, Functional Literacy programme and psychosocial counselling. This Ministry of Home Affairs (MoHA) and the Birth registration department, MCDSS, and CSOs are partners working in this area.

### **Early Childhood Education (ECE) initiatives**

This initiative is provided by the MoGE with other line ministry departments working on water and nutrition and health. Other partners/funders working on ECE include GPE, World Bank, UNICEF, Save the Children and VVOB. The initiative focuses on the promotion and delivery of play based early learning and has included community/parental ECD interventions in the GPE/WB Zambia Enhancement of Early Learning (ZEEL) programme. Services are focused on the delivery of play based early learning to children aged 3–6 years in preparation for school. The MoGE trains ECD teachers to provide ECE. ‘Master’ ECD trainers provide training for caregivers to help them develop parenting skills to enhance their ability to support early learning opportunities, such as through household play materials and storytelling.

### **Adolescent Development and Participation (ADAP) initiatives**

ADAP supports the delivery of adolescent protection and safety. Through mentoring programmes, they provide health and parenting education to adolescent girls and boys. Adolescence is a critical window or opportunity for interventions to improve knowledge before they start childbearing. Many adolescents support younger sibling with childcare, and it is important for them to understand the concept and importance of play as they enter parenting or adulthood with knowledge of key optimal practices on childcare.

## Communication

A multi-pronged communication and outreach strategy was introduced to parents during the pandemic to support parents in the provision of playful parenting and nurturing care. Three million caregivers were reached in multiple languages. The strategy included various channels: TV spots in National ZNBC; billboards across 20 cities and towns with local proverbs in seven languages; radio spots in local radios featuring key messages; social media posts showcasing nurturing care with quotes from caregivers; print media, including press releases from the MoH, newspaper articles to raise awareness; and newspaper and press releases on ECD, nurturing care and playful parenting. “Parenting Month” included a media and digital campaign including stories photos and videos highlighting importance of co-parenting, the involvement of fathers and what they can do to support nurturing care.

## Partnerships, key entities and structures in the ECD landscape

The multisectoral components of ECD cannot be implemented by one sector thus there is a critical need for partnership in the ECD space. With the scarce resources at hand, the Government on its own cannot implement the programme on a scale. Strategies to implement ECD must be implemented in partnership complementing the efforts of the government. The available resources combined with technical expertise, logistics, data and coverage can provide added benefit for out-reach and advocacy to reduce poverty, especially in the districts that are lagging in human and economic development. Currently those resources include:

- The Joint Core Coordinating Committee: National, Provincial and District Multisectoral ECD Team, Multisectoral SUN II/National Nutrition Committee, Zambian ECD Action Network (ZECDAN) and the National ECD-MTC.
- Within Government multisectoral collaboration is also critical for the success of ECD. Government, at HQ and at subnational levels, works through the National ECD structures, along with the line ministries, with similar structures at district and community level: MoGE, MCDSS, Ministry of Chiefs and Traditional Affairs (MOCTA), MoA, MoYSCD and SUN II (coordination and policy decisions, advocacy, and resource mobilisation).

## 3.6 Sector specific recommendations

**Develop an overarching National Multisectoral ECD Policy Framework.** Every line ministry has policies, strategic plans and budget that enable the delivery of services under their mandate. However, it is critical to develop and implement a National Multisectoral ECD Policy and strategy framework with costed Action Plan encompassing the five NCF components with a clearly defined Theory of Change and nationally defined young children’s outcomes to foster implementation of nurturing care for ECD across sectors and from a life cycle approach.

**Improve ECD workforce capacity.** There are capacity gaps on NCF for key stakeholders across sectors especially on responsive caregiving, early learning opportunities and caregiver’s emotional availability for appropriate response to child’s needs. There is a need to build competencies in pre- and in-service training for ECD workers and volunteers, and with the provision of mentorship and supervision as well as clear outline of standards and guidelines for service delivery. Attention should be paid to investing in training of National Master Trainers and District Trainers of Trainers (ToTs) for a multisectoral workforce reaching children families and communities.

**Improve intersectoral collaboration.** Service delivery to young children is fragmented across different sectoral silos. There is need for clear multisectoral service delivery mechanisms for a defined package of interventions for implementation. Sectoral collaboration with clearly defined roles and responsibilities is

strategic for improved efficiency of service delivery and timely services to young children during the early years window of opportunity. There is need to support efforts to implement the NCF across platforms reaching young children and caregivers. Most importantly, interventions beyond ECD/ECE need to be noted and linkages should be made to the adolescence period.

**Strengthen data, indicators and assessment of progress.** There is need for the compilation of a comprehensive data collection tools and system. An ECD-Management Information system (ECD-MIS) that will systematically measure child development outcomes across the different developmental domains and indicators that will be critical for planning, decision making and budgeting. This will support the use of indicators for monitoring progress and impact to support institutionalisation of the use of indicators across sectors and allow within and across country comparisons. It is essential that all data collected for ECD purposes be disaggregated by gender, age, disability etc.

**Agree on a consistent, national definition of ECD.** The absence of an agreed national ECD definition may impact policy implementation, practice, scope of programming, and potential outcomes for children and their families. There is a need for a common or harmonised definition of Early Childhood and ECD as a multifaceted and an all-encompassing definition is fundamentally important in stimulating a multisectoral approach and a continuum of care from a life course perspective. An agreed national definition of ECD will ensure consistency among policy makers and implementation partners and for measurement of progress and comparability of indicators.



# CHAPTER 4. EDUCATION

## 4.1 Introduction

*All children are entitled to education (CRC Article 28); the goals of education are to develop a child's personality, talents and abilities to the fullest (CRC Article 29); and children are entitled to access to information and mass media (CRC Article 17).* The education of all children is widely acknowledged as a strong driver of social mobility and key catalyst for national development. Moreover, access to quality and relevant learning is the right of every child, as set out in the CRC. For these reasons, education and skills are firmly rooted in the national visions and plans and are a priority for the current Government of the Republic of Zambia. However, the challenges in the Zambian education system are many and are identified in the Education Skills Sector Plan (ESSP) of 2017–2021: “Various system distortions [exist] in the provision of education opportunities across sub-sectors, issues of curriculum relevance, teachers’ skills and their supply across regions and subject matter, the weak development of foundational learning skills, and negative incentives that demotivate the effective management of education delivery.”<sup>102</sup> There is a notable gap between the Government’s ambitious policies and plans for education on the one hand and the inadequate financial resources for the Government’s response to the multiple challenges to an equitable education system on the other hand. The ESSP goes on to explain that innovative strategies and efficiency gains will be required to affect any lasting change.

## 4.2 Legal and policy framework

The education sector in Zambia is guided by the Zambia National Education Policy 1996, the ESSP and the National Higher Education Policy 2019. These policies are aligned with Zambia’s 7NDP. Education in all its forms is expected to produce an efficient and inclusive labour force which can resolve mismatches in workforce supply and demand and can enable all citizens to participate in and benefit from the nation’s economic growth (7NDP). The 7NDP is situated within Zambia’s Vision 2030 and presents five priorities for the 2017–2021 period, including reducing developmental inequalities, enhancing human development, economic diversification and job creation, poverty and vulnerability reduction, and creating a conducive governance environment for a diversified economy. These priorities are aligned with regional and global initiatives, such as the SADC Regional Indicative Strategic Development Plan, the African Union’s Agenda 2063, the Common Market for Eastern and Southern Africa protocols, and the SDGs. SDG 4, which “ensure[s] inclusive and equitable quality education and promote[s] lifelong learning opportunities for all”, focuses specifically on education. All the SDG4 targets reflect global standards for education, but four stand out as having the greatest impact on the situation of children:

- **SDG 4.1** calls for ensuring that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes by 2030.
- **SDG 4.2** ensures that all girls and boys, by 2030, have access to quality early childhood development, care, and pre-primary education so that they are ready for primary education.
- **SDG 4.5** aims to eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples, and children in vulnerable situations, by 2030.
- **SDG 4.7** aims to ensure that all learners acquire the knowledge and skills needed to promote sustainable development and sustainable lifestyles. SDG 4.7 also ensures that learners will be educated in human rights and gender equality, the importance of a culture

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<sup>102</sup> Education Skills Sector Plan (ESSP) of 2017–2021. p. 1.

of peace, non-violence, and global citizenship, and that an appreciation of cultural diversity and the role culture plays in sustainable development is fostered in learners by 2030.

The 2011 Education Act domesticates the CRC in relation to education. It also regulates the provision of accessible, equitable and qualitative education, and provides for the establishment, regulation, organisation, governance, management and funding of educational institutions. The 1997 Re-entry Policy mandates schools to allow girls back to school after pregnancy and the 2002 Free Primary Education Policy provides for all children to access primary education free of charge. To promote quality teaching and learning, in 2013 the Government enacted the Teaching Profession Act, which facilitated establishment of the Teaching Council of Zambia. The Act aims to enhance professionalism in the teaching service, and to regulate teacher training institutions. In addition to the human rights aspect of education, the Government of Zambia's Vision 2030 and 7NDP highlights the importance of improved education and skills development as being instrumental in "creating societies that are better able to respond to social and economic development challenges they face." The ambitions of the policies and laws are translated in the ESSP, soon to be revised, which sets out the roadmap, pragmatic strategies, and actions to re-establish education as the key catalyst for national development, throughout the duration of the plan, and to help the country attain its long-term development vision of "Quality and relevant lifelong education and skills training for all" (ESSP). The strategic focus of the MoGE and Ministry of Higher Education (MoHE) combines the policy aspirations outlined in *Educating Our Future*, the Science, Technology, and Innovation Policy and Vision 2030. An integral part of the strategic approach is ensuring relevance in education that is provided across all levels of learning, to equip children with skills and to contribute to national development. The MoGE has also developed a National Assessment Framework and metrics to measure progress towards learning across all levels.

### Structure of the education system

The structure of the education system changed in 2015 from a 9-3-4 system with nine years of basic education, to a 7-5-4 system with seven years of primary and five years of secondary education. ECE covers students aged three to six years, in two grades—a lower grade for the three- to four-year-olds age group, and a higher grade for the five- to six-year-olds age group. The education sector is governed by two ministries, each with distinct responsibilities. MoGE manages ECE, primary, secondary, and youth and adult learning education (YALE). The MoHE is responsible for University Education, Technical Vocational Education, Science, Technology, and Innovation. The responsibility of providing pre-service and in-service teacher training falls to the MoGE, who collaborate with teacher training institutions that are under the management of the MoHE.

The MoGE has made progress in building the institutional frameworks for a comprehensive expansion of access to quality ECE for children aged three to six years old, but this is currently being guided by the 25-year-old *Education our Future* policy (1996). This inadequate and somewhat out-of-date policy direction, compounded by insufficient funding, has seriously impacted ECE provisions and aspirations. The Government is the main provider of education services in all parts of the country, but NGOs including communities are also playing prominent roles in relation to increasing access, especially to ECE and secondary education. Table 2 shows an aggregated increase of Private, Church, or Community schools at secondary level, from 101 schools in 2017 to 121 in 2018, representing a 19.8 percentage increase.

*Table 2: Supply of primary and secondary schools 2009–2018*

#### Number of Primary Schools by Agency 2009–2018

	Year										Av. Annual Growth	%. Change
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018		
<b>Government/GA</b>	4709	4903	5016	5219	5420	5474	5669	5670	5859	5983	2.7%	5.5%
<b>Private/Church</b>	354	739	709	498	485	616	699	673	659	696	7.8%	3.4%
<b>Community/ Unknown</b>	2576	2851	2637	2642	2896	2664	2406	2480	2325	2371	-0.9%	-4.4%
<b>Total</b>	<b>7639</b>	<b>8493</b>	<b>8362</b>	<b>8359</b>	<b>8801</b>	<b>8754</b>	<b>8804</b>	<b>8823</b>	<b>8843</b>	<b>9050</b>	<b>1.9%</b>	<b>2.6%</b>
<b>Number of Secondary Schools by Agency 2009–2019</b>												
	Year										Av. Annual Growth	%. Change
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018		
<b>Government/GA</b>	447	498	487	501	522	616	664	707	908	996	9.3%	9.7%
<b>Private/Church/ Community</b>	97	148	144	162	161	178	168	144	101	121	2.5%	19.8%
<b>Total</b>	<b>544</b>	<b>646</b>	<b>631</b>	<b>663</b>	<b>683</b>	<b>794</b>	<b>832</b>	<b>851</b>	<b>1009</b>	<b>1117</b>	<b>8.3%</b>	<b>10.7%</b>

Source: Education Statistical Bulletin 2018.

As shown in Table 2, the supply (number) of primary and secondary schools has increased year on year since 2009, with an annual growth rate of 1.9 per cent for primary schools and 2.6 per cent for secondary schools. The increase in the number of secondary schools is attributed to the upgrading of some primary schools to include secondary grades, in all provinces, and the provision of greater support to Community Schools. Most schools in the country are in rural areas (where 65 per cent of the population lives): 81.7 per cent of all primary and 69.5 per cent of all secondary schools are in rural areas. All provinces, except the urbanised of Lusaka and Copperbelt, have more primary and secondary schools in rural than in urban areas.

Table 3: Supply of primary and secondary schools by location

	Primary Schools						Secondary Schools					Total Schools
	Urban	Rural	% Rural	Total	% of Total		Urban	Rural	% Rural	Total	% of Total	
<b>National</b>	<b>1,654</b>	<b>7,396</b>	<b>81.7%</b>	<b>9,050</b>	<b>100%</b>		<b>341</b>	<b>776</b>	<b>69.5%</b>	<b>1,117</b>	<b>100%</b>	<b>10,167</b>
<i>Provinces</i>												
Central	152	1,019	87.0%	1,171	12.9%		29	95	76.6%	124	11.1%	1,295

Copperbelt	537	453	45.8%	990	10.9%		93	43	31.6%	136	12.2%	1,126
Eastern	52	968	94.9%	1,020	11.3%		18	107	85.6%	125	11.2%	1,145
Luapula	60	583	90.7%	643	7.1%		12	68	85.0%	80	7.2%	723
Lusaka	506	282	35.8%	788	8.7%		76	46	37.7%	122	10.9%	910
Muchinga	39	649	94.3%	688	7.6%		10	80	88.9%	90	8.1%	778
North-Western	42	708	94.4%	750	8.3%		25	109	81.3%	134	12.0%	884
Northern	60	827	93.2%	887	9.8%		26	110	80.9%	136	12.2%	1,023
Southern	149	986	86.9%	1,135	12.5%		37	72	66.1%	109	9.8%	1,244
Western	57	921	94.2%	978	10.8%		15	46	75.4%	61	5.5%	1,039

### 4.3 Levels, trends and differentials in key indicators

#### Access and enrolment

Zambia has made strides towards universal primary education, with an increase in participation rates up to 2016; by which time almost all children were able to gain access to primary school. A key challenge now remains in participation rates across education levels, as measured by the Net Enrolment Rates (NER) and the Net Intake Rate (NIR).<sup>103</sup> The official school entrance age into Grade 1 is seven years, and in 2018 the primary school NIR was reported as being just 54.5 per cent of the total population of eligible children; the remaining children mostly began at an older age. This late school start, and the insufficient access to ECE, results in Zambian children losing a lot of age-appropriate education. Lusaka Province recorded the lowest NIR of 26.6 per cent, followed by Eastern Province with 39.2 per cent, while the highest NIR was recorded in Western Province with 73.9 per cent and was followed by North-Western and Central at 60.5 per cent.

With the population increase of children of school-going age, over-age learners occupying the places in the system, creating inefficiency in the system, and a reduced spending on education, there remains a crucial supply issue of places available in primary schools for learners at the official intake age. In urban areas this gives rise to Grade 1 places being allocated to older children, who were unable to gain a place in previous years. In addition to then preventing some seven-year-olds from starting school, this also causes some relatively mature adolescents to be in the same classes as much younger children, with some girls reaching the age of menstruation while being in the lower years. In rural areas, the issues stem from there being greater distances to some primary schools, coupled with the parents' concern about their seven-year-olds, especially girls, walking so far; while these parents may value education, they may choose to send their children to school when they are older.<sup>104</sup> In contrast to the NIR, the primary NER reflects the total percentage of primary-aged learners (7–13 years old) who are enrolled in primary school (Grades 1 to 7) as a ratio of the total population number of 7- to 13-year-olds. Although the NER has declined since 2014, 83.6 per cent of children still receive some education at primary level, even though the insufficient number of places leads to many of them being over-age for their school

<sup>103</sup> The Net Intake Rate for Grade 1 is the percentage of seven-year-olds who enter school for the first time, expressed as a percentage of the total number of 7-year-olds in the population. A high NIR indicates a high degree of access to primary education for the official primary school entrance age children. An 'NIR of 100% is a necessary condition for the policy goal of universal primary education' (MOGE 2018 Education Sector Data – Education Statistical Bulletin).

<sup>104</sup> Interviews with district education officials and ZOCS representatives.

year. The picture of secondary-level education is less positive, even though the MoGE has taken action to increase capacity by building new schools, transforming a selected number of primary schools to ‘all-through’ schools (incorporating Grades 1 to 9), double shifting and by supporting community schools. The secondary level NER in 2018 remained at 20.2 per cent. The pressure for Grade 8 (and Grade 10) places is immense and it is hard to keep up with the growing demand. One of the ESSP goals of the Government is to increase enrolment and Grant Aided secondary schools from 0.7 million in 2015 to a range of 1.3–1.5 million by 2022. However, according to the World Bank and Government of Zambia’s Public Expenditure Review (PER),<sup>105</sup> the current number of secondary schools can

“There are high school fees especially from Grades of 8 to 12. Although primary school is free, parents/guardians are expected to purchase uniforms, shoes, books and other requirements. As a result, most parents/guardians fail to sustain their children’s education needs.

There is also a practice of migration of parents/guardians to fishing camps and children accompany them into the fishing camps from March to November annually resulting in the children missing classes for such a long period.”

—Local NGO member

accommodate, at most, 30 per cent of the current students in Grades 1–5, indicating that there is a very long way to go. Barriers to education, relating to both the supply and demand, are multidimensional and include direct and indirect costs of education, parental attitudes to the education of boys and girls, caregivers’ level of education, and the history of successful education in the family and wider community. Multidimensional child poverty is also part of the education causal pathway. Various forms of child poverty, such as hunger, can negatively impact a child’s experience within the education system, and ultimately their school performance. Other adverse factors include:

- direct and indirect costs of education. While the Government has capped school fees, they are still unaffordable to some parents or caregivers;
- multiple overlapping deprivations in girls and boys from resource-poor homes, especially those headed by single parents, with many dependents, and those from rural areas;
- history of unsuccessful education at home and the attitude of the parents or caregivers towards education, especially when considering access to education for girls;
- child pregnancy and marriage, and longstanding gendered beliefs and practices in families and communities;
- insufficient places in both primary and secondary schools, leading to many over-age children in classes; and
- family migration for seasonal agriculture and fishing, which require children’s participation.

### **Tertiary**

The 7NDP proposes the need for investment in education and skills development to overcome the challenges of low progression rates to higher education levels, as well as gender disparities in participation rates, and variations in participation rates across the rural-urban dichotomy. It also emphasises the need for action to broaden access to and participation in higher education for disenfranchised populations; those most often found in remote places and overcrowded urban areas.

### **Gender parity**

With respect to the Gender Parity Index (GPI), there is near parity at primary school as for every 100 boys enrolled there are 99 girls, and there are higher rates of girls at primary-level in Grades 7 and 8,

<sup>105</sup> World Bank. (2015). *Education Public Expenditure Review in Zambia*.

<https://documents1.worldbank.org/curated/en/431421468000590726/pdf/103870-PUB-PUBLIC-Education-Public-Expenditure-Review-in-Zambia.pdf> (accessed 31 October 2021).

although this is reversed in Grades 9 and 10. At secondary school level, the GPI drops to 84 girls for every 100 boys. These disparities are evident across the urban-rural regional divide.

### Out-of-school children

The number of out-of-school children increased from 343,609 in 2011 to 411,506 in 2012. Between 2012 and 2014 the number decreased by 51.9 per cent to 197,757. In 2015 the number increased sharply to 249,416. However, it has again reduced between 2016 and 2018. Interestingly, from 2012 onwards, the number of boys out of school has exceeded that of girls. In 2018, the out-of-school children accounted for 5.3 per cent of the total primary school enrolment. Dropout rates are significantly higher for orphans and vulnerable children, students from poorer families and those attending schools in rural areas.

Table 4: Out-of-school children from 2014–2018

	Year				
	2014	2015	2016	2017	2018
<b>Male</b>	109,692	134,115	133,888	129,029	119,029
<b>Female</b>	88,065	115,301	115,698	104,407	103,407
<b>Total</b>	<b>197,757</b>	<b>249,416</b>	<b>249,586</b>	<b>233,436</b>	<b>222,436</b>

As children move up through the system, the number out-of-school girls and boys increases. DHS data was used to check the proportion of out-of-school girls and boys of secondary age, considering both dropouts and those who may never have attended. A total of 22,427 children and adolescents, between the ages of seven years and 18 years, were considered for this analysis. The table below shows their respective participation in education.

Table 5: Status of school-going children

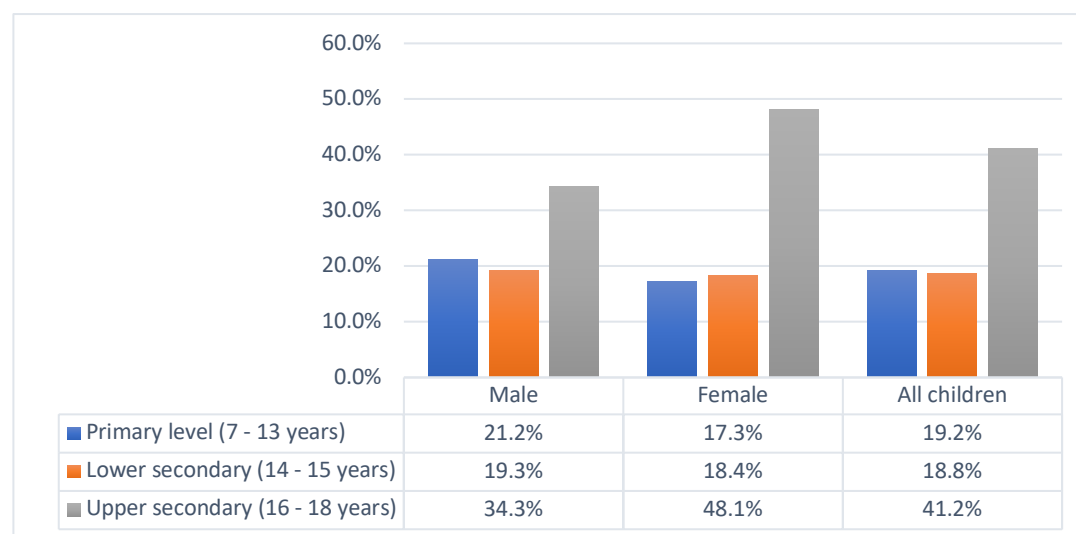
		Male	%	Female	%	Total	%
<b>Primary level (7–13 years)</b>	Out of school	1,536	21%	1,337	18%	2,873	19%
	In school	5,840	79%	6,098	82%	11,938	81%
	Total	7,376		7,435		14,811	
<b>Lower secondary (14–15 years)</b>	Out of school	331	20%	316	18%	647	19%
	In school	1,334	80%	1,447	82%	2,781	81%
	Total	1,665		1,763		3,428	
<b>Upper secondary (16–18 years)</b>	Out of school	719	34%	964	47%	1,683	40%
	In school	1,401	66%	1,104	53%	2,505	60%
	Total	2,120		2,068		4,188	
<b>Total</b>	Out of school	2,586	23%	2,617	23%	5,203	23%
	In school	8,575	77%	8,649	77%	17,224	77%
	Total	11,161		11,266		22,427	

Source: DHS 2018 dataset.

ZDHS 2018 data shows that, in general, more boys than girls attend school in upper secondary than in primary and lower levels. Girls are more likely to drop out of upper secondary school, in fact, while less

than a fifth of girls are out-of-school at primary-level, nearly half will have dropped out of school by the upper secondary level. This is elaborated in the figure below:

Figure 1: Proportion of out-of-school children and adolescents in Zambia (weighted)



Source: DHS 2018 raw data

## Transition

According to the Education Statistical Bulletin of 2018, 64.5 per cent of students made the transition from Grade 7 to Grade 8. The goal is that all primary school students should have the chance to enter secondary education. Government policy is that there should be an automatic progression between grades, including Grades 7 to 8, but there is insufficient space in Grade 8 to accommodate all students. In the last few years, the Government has tried to increase the capacity of secondary education by building new schools and by transforming a selected number of basic schools into secondary schools.

Table 6: Transition rate by gender and province

	Grades 7–8			Grades 9–10		
	Male	Female	Total	Male	Female	Total
<b>National</b>	<b>68.2%</b>	<b>70.0%</b>	<b>69.1%</b>	<b>50.7%</b>	<b>49.2%</b>	<b>50.0%</b>
<i>Provinces</i>						
Central	62.5%	66.5%	64.4%	44.5%	42.5%	44.6%
Copperbelt	86.4%	86.4%	86.4%	60.7%	64.3%	60.5%
Eastern	63.1%	62.0%	62.6%	43.7%	32.5%	39.7%
Luapula	66.2%	66.0%	66.1%	45.6%	35.8%	45.0%
Lusaka	84.9%	84.4%	84.6%	59.0%	53.7%	55.7%
Muchinga	49.7%	51.2%	50.4%	54.8%	46.2%	55.0%
North-Western	69.5%	68.9%	69.2%	53.8%	48.4%	54.1%
Northern	48.4%	54.1%	50.9%	69.9%	56.1%	67.2%



Southern	62.3%	64.0%	63.1%	35.9%	33.6%	36.4%
Western	73.5%	72.1%	72.8%	42.8%	40.1%	43.2%

### Children's voices

"I am 10 years old and in Grade 1. I like school and doing house chores. I don't like arguing, insults/disrespecting others and gossiping. I want to be a nurse to help my family when they are sick, as well as earn money to take care of their needs. I also want to help my mother pay for school fees."

"The challenges I am facing are that I do not go to school because my parents cannot pay my fees, if I go to school I am sent back [for not paying my fees]. I have to walk a long distance from home to school, and when I get home from school, I am sent to sell maize ... My dream is to become a soldier, so that I can earn money to look after my mother. This will be possible if I can complete my education."

"The good thing about my school is that they teach us well. I like writing and playing. I also like playing hide and seek and playing football. What I do not like about my school is that teachers beat pupils who make noise in class."

Table 6 further illustrates links between gender and spatial transition rates: girls have higher rates of transition at primary-level than boys, including in Grades 7 and 8, but this is reversed in Grades 9 and 10. Children from predominantly urban provinces are more likely to transition than those from predominantly rural provinces, and the transition rate to upper secondary education continues to fall. Copperbelt had the highest transition rate at Grades 7 to 8, followed by Lusaka, Western, North-Western, Luapula, Central, Eastern, Southern, Muchinga and Northern Province.

### Learning Outcomes

Despite Zambia's recent improvements in expanding access to primary and secondary education, achievement of targets in the learning outcomes remains poor. Zambia is placed at the bottom, in terms of academic achievement, of countries measured by the Southern and Eastern Africa Consortium for Monitoring Educational Quality assessment. National assessment results for Grade 5 show students consistently scoring below the

minimum desired achievement of 40 per cent in English, mathematics, life skills, and Zambian languages. Poor performance during the middle stage of primary education is of particular concern as it suggests learners are not grasping key foundational skills and will subsequently have challenges at higher levels.<sup>106</sup> In terms of results at lower levels, the 2015 Early Grade Reading Assessment and Early Grade Mathematics Assessment (EGMA)<sup>107</sup> show considerably low attainment of learning achievements in literacy and numeracy for Grade 2 pupils.<sup>108</sup> Similarly, for older students, the Programme for International Student Assessment–Development, a 2015 study by the OECD, and the Examination Council of Zambia revealed that 15-year-old Zambian students achieved only 5 per cent and 2 per cent of the minimum international level of proficiency in reading and mathematics respectively.<sup>109&110</sup>

<sup>106</sup> Joseph Wales, Chipoma, C. and Cummings, C. (2016) *The political economy of poor learning outcomes in Zambia: Finding accountability solutions to collective action problems* ZAP International.

<sup>107</sup> RTI International. 2015. National Assessment Survey of Learning Achievement at Grade 2 Results for Early Grade Reading and Mathematics in Zambia. <https://earlygradereadingbarometer.org/files/EGRA%20in%20Zambia.pdf> RTI International. 2015. National Assessment Survey of Learning Achievement at Grade 2 Results for Early Grade Reading and Mathematics in Zambia. <https://earlygradereadingbarometer.org/files/EGRA%20in%20Zambia.pdf>.

<sup>108</sup> The average oral reading fluency rate for the local languages ranged from 1.84 to 8.40 words per minute, indicating that the typical Grade 2 pupil could recognize a few words but struggled to read a coherent sentence. In mathematics, the percentage of pupils scoring zero was 49.5% for addition and 60.7% for subtraction.

<sup>109</sup> UNICEF, 2019 Education Budget.

<sup>110</sup> Kaffenberger, M. 2019. "Pisa-D Reveals Exceptionally Low Learning." Blog, September 21, 2020. [https://www.riseprogramme.org/blog/PISA-D\\_low\\_learning](https://www.riseprogramme.org/blog/PISA-D_low_learning).



In 2018 less than 15 per cent of teachers in Zambia held a degree, with the majority holding a diploma,<sup>111</sup> and approximately 13 per cent of instructors in primary schools were unpaid volunteer teachers;<sup>112</sup> suggesting that teacher quality may be a concern. Worryingly, progress made in strengthening the pre-service teacher education system has not translated into gains in learning achievement. The reasons for the poor access, attendance, and low achievement rate of learning outcomes are complicated and multi-dimensional, with a range of factors in both the supply and demand of education. Some of the identified issues include:<sup>113</sup>

- inadequately qualified teachers;
- high absenteeism for both students and teachers, with teacher absenteeism of approximately 20 per cent being observed. In 2017, 23.5 per cent of 15-year-olds reported having missed school for more than three months in a row, with the most frequent reasons being health problems (their own, or those of family members), and inability to pay school fees;<sup>114</sup>
- inadequate teacher skills and preparedness, with less than 40 per cent of teachers routinely preparing lesson plans;
- poor oversight of teaching and learning, and inadequate teacher support and supervision, related to poor school leadership, lack of accountability, and inadequate district support;
- lack of access to and low ECE enrolment resulting in a poor foundation for learning;
- limited space that results in large class sizes, which are beyond the capacity of instructors to teach effectively;
- shortage of textbooks. The pupil-book ratio for primary school, for example, is 1.02 but this falls to only 0.83 for secondary school pupils; and
- poor access to libraries. Even when libraries exist, they may be difficult to access for many children.

#### 4.4 Challenges, shortfalls and inequities

Zambia's current fiscal constraints have affected social sector spending more than any other function of Government. The education budget nominally reduced from K13.2 billion in 2019 to K13.1 billion in 2020. The relative share of the education sector budget is at its lowest level in five years, from a peak of 20.2 per cent in 2019 to 12 per cent in 2020; significantly lower than the international benchmark for education spending at 20 per cent of total Government expenditure. These reductions risk compromising the education sector's ambitions to enhance access and improve the quality of education.<sup>115</sup> A major challenge that the education sector faces is the extremely low levels of attainment, especially in literacy and numeracy. The situation is possibly worse than the data suggests because many children, who are failing in school, may have dropped out before taking exams. Improving the quality of teaching is crucial, and both pre- and in-service teacher training at primary level needs to have a strong focus on appropriate pedagogy for the relevant age group, with an emphasis on teaching literacy and numeracy.

The quality of ECE is suboptimal: 40 per cent of teachers are untrained and those who are trained are not necessarily trained in appropriate pedagogy for early years education. Infrastructure and furniture are often not suitable for the age group. Furthermore, a lack of teaching and learning materials, adequate playground equipment, and WASH facilities, does not provide an appropriate environment for

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<sup>111</sup> MoGE, 2018.

<sup>112</sup> World Bank, 2015b.

<sup>113</sup> Identified by the 2018 ESSP and through interviews with children, parents, education officials, NGOs and other stakeholders.

<sup>114</sup> Programme for International Student Assessment for Development (PISA-D) (2017) Zambia Study.

<sup>115</sup> UNICEF/ZIPAR (2020) *Analytical Brief on the 2020 Social Sector Budget*.

young children. Monitoring, regulation and quality assurance systems are also substandard.<sup>116</sup> Lack of places in both primary and secondary schools leads to many over-age children in classes. At primary level this may have a serious negative impact on girls, who are more likely to drop out when they reach puberty. Boys may also drop out if they see an opportunity to work and realise that there will be no secondary school places or skills development opportunities available to them. It is important to ensure that initiatives to keep girls in school begin while they are still in primary school, before they reach puberty. Despite the MoGE's and partners' efforts to improve learning opportunities, there remains a high level of inequity in the education systems and structures. The data reveals that it is the children from the most resource-poor homes, headed by single parents with many dependents from rural areas that are likely to have less access to education. The 2018 ESSP identified a "grave concern" for the high rate of dropout, and the absence of learning opportunities for those that were "pushed out" of the system at either Grade 7 or Grade 9; this situation persists. A wide range of supply and demand constraints negatively affect the enrolment, attainment, and progression of many girls and boys. These include limited access to secondary education, long distances to school, an inadequate availability of school places, financial challenges to meet school fees (including boarding facilities costs), early pregnancies, and child marriages.

#### 4.5 Stakeholders, initiatives and opportunities

World Bank provides a soft loan to the Government for the Zambia Education Enhancement Project. This is to facilitate quality of teaching, especially in Maths and Science, by training teachers and providing teaching and learning materials. This is now to be rolled out across all 10 provinces. One of the most successful initiatives of the past few years has been the Catch-Up programme, designed to directly address the low levels of literacy and numeracy. Based on similar programmes in India and elsewhere, this was originally an initiative of the Government and supported by UNICEF, and is now managed by the Belgian NGO, VVOB. It has operated in 634 schools in Southern and Eastern Provinces, reaching 160,968 Grade 3 to 5 pupils who have challenges with learning in classrooms. Through this initiative they have been taught at their level of ability, giving them an opportunity to acquire basic literacy and numeracy skills. Findings from the 2019 end-line assessment revealed that the percentage of learners at beginner literacy level dropped from 33 per cent before intervention to 9 per cent afterwards, and that the percentage of learners who could do basic subtraction increased from 27 per cent to 51 per cent (UNICEF 2019).<sup>117</sup> Several interventions have been introduced to mainstream and achieve gender equality, and to eliminate gender disparities. These interventions include the Re-Entry Policy (which allows female learners to return to school after giving birth), the promotion of female education through sensitisation campaigns with traditional leaders, the 'Go Girls' campaign initiative, bursary support, and the promotion of girl child-friendly school interventions through the concept of Care and Support for Teaching and Learning. The MoGE is also implementing the Keeping Girls in School initiative (KGS) in 27 districts. The programme pays school fees for secondary school girls from SCT households. By the end of 2019 the project had exceeded its target by supporting over 16,500 girls out of the targeted 14,000 girls, of which 3,800 girls successfully completed Grade 12. The World Bank Funded Girls' Education and Women's Empowerment and Livelihoods (GEWEL) project provides funding for NGO's, such as Campaign for Female Education (CAMFED) to support girls' education, life skills, and livelihood development in selected districts across Zambia. UK-AID and Sweden's Government agency for development cooperation (SIDA) have also now provided additional finance for the project. CAMFED also provides support for girls' education across five provinces; operating in 47 districts in total, they provide a whole school approach as well as bursaries for girls. As a component of GEWEL, the KGS is being implemented

<sup>116</sup> MOGE (2019) *Early Childhood Education in Zambia*. Lusaka.

<sup>117</sup> UNICEF RAM 2019.

in 27 districts. The programme pays school fees for secondary school girls from SCT households. By the end of 2019 the project had exceeded its target by supporting over 16,500 girls out of the targeted 14,000 girls, of which 3,800 girls successfully completed Grade 12. At the tertiary level, the Technical Education Vocational and Entrepreneurship Training (TEVET) Bursary Scheme and a Higher Education Student Loan Scheme supports females in education. An affirmative admissions policy exists for girls whereby 30 per cent of new admissions to public universities are reserved for them. Zambia Open Community Schools, which has operated in Zambia for the past 30 years, fills gaps in Government provision by supporting communities to provide education for the most vulnerable children, especially those from remote rural areas. ZOCS supports over 1,000 community schools in 76 districts, with an estimated population of 172,680 learners, comprised of 46,800 boys and 70,200 girls. The learners are taught by over 2,340 volunteer teachers (936 male and 1,404 female), who have dedicated their time to ensuring access to education for all children in their communities.

#### 4.6 Sector specific recommendations

**Fill gaps and prioritise education in budget allocation.** It is recommended that all possible avenues are explored to fill these gaps and that education is given greater priority in budget allocation to invest in the social and economic future of the country.

**Strengthen focus on age-appropriate pedagogy.** It is recommended that both pre- and in-service teacher training at primary level has a strong focus on appropriate pedagogy for the relevant age group with a strong focus on teaching literacy and numeracy. In addition, it is suggested that MoGE considers expanding the Catch-Up programme.

**Expand and develop flexible Alternative and Distance Education.** The flexible Alternative Education should serve as alternative pathways that allow learners to advance to the next level of education or training.

**Review and strengthen the Grade 1 entry process.** The MoGE is working to address this, but it requires continued effort and priority targeting to improve opportunities in the country. There is a need to review and strengthen the Grade 1 entry process and orient all schools to ensure full enrolment at right age and to develop a strategy to support over-aged children in the system to improve internal efficiency and create space for right-age learners.

**Provide all six-year-old children with at least one year of ECE.** This is to support timely transition from ECE to Grade 1, and progressively increase ECE access to other age group.

**Focus on and prioritise children and schools in the most disadvantaged and hardest to reach areas.** Addressing the high levels of inequity in the education systems and structures requires a multisectoral strategy to break the cycle of marginalisation. One such action could be to progressively achieve free secondary education, by working towards removing school fees for the children from SCT target households. The package of support might include addressing family poverty through social protection mechanisms, free school places, and school feeding, as well as operating grants to the schools (to mitigate low levels of fee payment), in-service training and support for teachers, and possible incentives for teachers to work in such schools. A national campaign that promotes the strategy would mobilise a wider range of resources from, for example, the private sector, whilst mitigating any backlash from privileged schools and parents, and increasing public understanding of how the strategy will contribute to inclusive economic growth of the country.

# CHAPTER 5. HEALTH

## 5.1 Introduction

Recognising that health is a key socio-economic and development investment, the Government has embarked on a national health sector transformation agenda, as outlined in the 2017–2021 National Health Strategic Plan (NHSP). The aim is to build a robust and resilient health system enshrined in a primary health care (PHC) approach, across the continuum of care and to deliver high-impact cost-effective interventions package towards universal health coverage (UHC) as close to the family as possible. The Plan emphasises the facilitation and creation of an environment that enables individuals and families to maintain and improve their own health. It is aimed at the development of community health, which includes supportive mechanisms for community participation in organisation, coordination, and financing.

## 5.2 Legal and policy framework

The 2012 National Health Policy is anchored in Vision 2030 and is implemented through successive NDPs and NHSPs. The policy also takes into consideration various Regional and International Instruments, Protocols and Commitments, which will ensure that Zambia's health programmes are integrated with the regional and global health system. The policy underscores the Government's commitment to provide equitable access to cost effective and quality health services as close to the family as possible in a caring, competent, and clean environment. It prioritises PHC services, hospital referral services, human resource development and management, medical supplies and logistics, infrastructure development, legal framework, quality of care standards, and health care financing. The 2017–2021 NHSP is formed from the 2012 National Health Policy and provides the implementation framework for the policy. The goal of the strategic plan is "to improve the health status of people in Zambia in order to contribute to increased productivity and socio-economic development". The Plan details the direction the health sector will take, the achievements and outcomes that will be attained, and the interventions that will be undertaken to ensure targets are met. It also specifies the roles and responsibilities that all stakeholders involved in the health sector will have to perform, the implementation challenges that must be overcome, the monitoring and evaluation (M&E) required, and the financial resources needed.

The strategic plan was developed in line with the National Transformative Agenda, which recognises the importance of the health sector in improving national productivity. Further direction for the strategic plan was provided through key international and national policies and goals, which include the SDGs, the Abuja Declaration, Zambia Vision 2030, 7NDP and the National Health Policy. The outcomes and targets in the plan are consistent with the targets and goals in these policies. In particular, the NHSP specifically includes strategies and high impact interventions which aim to speed up the achievement of the health-related SDGs.

## 5.3 Levels, trends, and differentials in key indicators

### **Maternal, newborn, infant and child survival**

Information on maternal, infant and child mortality is an important indicator of the country's socioeconomic development and quality of life. It can also help identify children who may be at higher risk of death and lead to strategies to reduce this risk, such as promoting birth spacing.

## Maternal mortality

The pregnancy-related maternal mortality has declined steadily over the past two decades in Zambia from 729 deaths per 100,000 live births in 2001–02 to 398 deaths in 2013–14 and 252 deaths in 2018. However, it must be noted that the confidence interval of ZDHS 2013–14 and ZDHS 2018 overlap, which indicates a possibility that MMR has not changed over the course of last seven years in Zambia. Furthermore, the MMR in Zambia in previous rounds of surveys included deaths due to violence and accidents, hence the comparable indicator is pregnancy related mortality ratio (PRMR). The MMR as per the definition of WHO stands at 252/100,000 live births, which has been measured for the first time in ZDHS survey in 2018. A recent analysis of Maternal and Perinatal Death Surveillance and Response (MPDSR) data for 674 maternal deaths at public health facilities in Zambia in 2018–2019 by Zambia National Public Health Institute highlights that Zambia is not on track to achieve the SDG 3 target for MMR.<sup>118</sup> Thirty-nine per cent deaths were due to obstetric haemorrhage; 28 per cent deaths were due to indirect causes, such as HIV, TB, Malaria, Neoplasm etc; 13 per cent deaths were due to hypertensive disorders; 6 per cent deaths were due to pregnancy related infections; and 6 per cent deaths were due to abortions. The remaining unknown, undocumented, obstructed labour related deaths were 0.4 per cent. Three quarters of all maternal deaths were reported from hospitals: district, central and general hospitals, while 10 per cent deaths were reported at health posts and centres and 9 per cent were reported from community centres. Primigravida constituted 17 per cent with 39 per cent deaths attributed to indirect causes. Indirect causes were also the lead cause of death in ages 10–19 years old and ages 20–29 years. In the age group of 30–39 years and 40–49 years obstetric haemorrhage was the main cause of death and constituted 51 per cent of death in grand multipara.

Zambia still has a long way to go in achieving the SDG target of MMR of 70/100,000 live births and U5MR target of 25/1,000 live births. Human resource constraints are one of the biggest challenges in achieving maternal and child health results in Zambia. A baseline assessment of regulatory framework for maternal and newborn health services under the EU commissioned MDGi project in Zambia revealed that only 24 per cent facilities offered Emergency Obstetric and New-born Care (EmONC) services while only 17 per cent facilities had mother birth waiting shelter.<sup>119</sup> Forty-seven per cent of the population did not have a health facility in vicinity of 5km (NHSP 2017–21); only 67 per cent of human resource positions were filled leaving almost one-third positions vacant. Zambia has 0.07 per cent doctors and 0.06 per cent of nurses per 1,000 population, which is far below the recommended WHO norms.

## Under-five and infant mortality

The 2018 ZDHS results show that the Government has had considerable success in reducing IMR (the probability of dying between birth and the first birthday) and U5MR (the probability of dying between birth and the fifth birthday). The U5MR of Zambia fell gradually from 179.9 deaths per 1,000 live births in 1970 to 61.7 deaths per 1,000 live births in 2018. This is confirmed by the independent analysis of ZDHS data. The proportion of children under five years of age who died decreased steadily from 2007 (9.0 per cent) to 2019 (3.4 per cent). This indicates a nearly threefold reduction in the number of children who died and shows improvements in health outcomes. The ZDHS indicates that from 2013–14 to 2018 infant mortality decreased from 45 to 42 deaths per 1,000 live births, while under-five mortality decreased from 75 to 61 deaths per 1,000 live births in the same period. These results signify that over two-thirds of the deaths (69 per cent), which occurred during the first five years of life, took place between birth and the first birthday. A closer examination of which children died was undertaken, and

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<sup>118</sup> Gianett B, Musakanya KE, Ngomah Moraes A, Chizuni C, Groeneveld C, Kapina M, Hamoonga R, Mazaba ML, Mukonka V. Maternal mortality trends and correlates in Zambia. Health Press Zambia Bull. 2019; 3(4&5); pp 12–16.

<sup>119</sup> MDGI Assessment of Regulatory Framework for MNCH Zambia – EU MDGI project supported by UNICEF and UNFPA.

the following table disaggregates between infants (zero to one years) and those between one and five years of age. The IMR (per 1,000 live births) for Zambia is 42.4118. Factors such as small size at birth and short birth intervals are associated with higher new-born mortality. This analysis of ZDHS data from 2007, 2013–2014 and 2018 includes both de facto and de jure resident children under five years and is sorted to analyse the factors associated with mortality. Analysis was carried out to check the proportion of children who died under one year of age and was compared to those who died between one and five years of age.

*Table 7: Comparison of mortality in children under one year and children between ages one and five years*

Survey	Sample considered			Children who died below the age of 1 year		Children who died between 1–5 years	
	Number	Number of children who died	% of children who died	Number	%	Number	%
2007	6,178	557	9.02%	453	81.30%	104	18.70%
2013 /14	13070	743	5.68%	624	83.98%	119	16.02%
2018	9578	475	4.96%	414	87.16%	61	12.84%

The 2018 ZDHS reports the following patterns exhibited by the data:

- Infant mortality is slightly higher in urban areas (44 deaths per 1,000 live births) than in rural areas (41 deaths per 1,000 live births). A similar pattern is observed for under-five mortality (64 deaths per 1,000 live births in urban areas and 58 deaths per 1,000 live births in rural areas).
- By province, under-five mortality is highest in Luapula (110 deaths per 1,000 live births) and lowest in North-Western (26 deaths per 1,000 live births).
- Under-five mortality is higher among children born to women with no education (69 deaths per 1,000 live births), or a primary education (66 deaths per 1,000 live births), than among children born to women with a secondary (62 deaths per 1,000 live births) or higher (47 deaths per 1,000 live births) education.
- Mortality rates are lower among female children than among male children, with differences of at least 10 deaths per 1,000 live births for all three indicators; newborn mortality (22 NMR in female children versus 33 NMR in male children), infant mortality (36 versus 48), and under-five mortality (53 versus 67).
- The IMR is higher (58 deaths per 1,000 live births) among infants born to women under the age of 20 than among infants born to women in other age groups.
- Both infant and U5 mortality rates are higher when the reported previous birth interval is less than two years (86 and 116 deaths per 1,000 live births, respectively).
- Under-five mortality is highest among the first children born to a mother (73 deaths per 1,000 live births), and in the children born seventh or later to the same mother (70 deaths per 1,000 live births).

### **Newborn mortality**

While infant and under-five mortality decreased, it is of great concern that newborn mortality (the probability of dying within the first 28 days of life) increased from 24 deaths per 1,000 live births in 2013–14 to 27 deaths per 1,000 live births in 2018. The main causes of newborn deaths are reported as asphyxia, neo-natal sepsis and prematurity. Mitigating all three, but especially asphyxia, depends on the technical skill of the birth attendant. As 80 per cent women in Zambia are delivered by skilled providers,

this high NMR is a concerning reflection of the poor quality of care (QoC), especially during the intrapartum period (during labour and delivery). MoH has produced Essential Newborn-Care Guidelines, but this, and capacity building, has not yet taken place across the whole country. To explore the patterns related to newborn deaths, an analysis was undertaken using newborn mortality data from the 2007, 2013/14 and 2018 ZDHS. Over the 10-year period (2008–2018), newborn deaths accounted for 44.8 per cent of the under-five deaths (see table below for more detailed results). Newborn mortality was checked against several variables across the three different DHS periods. The variables considered included: birth weight, sex of the child, mother's occupation, husband or partner's highest level of education, mother's highest level of education, mother's age and religion. Based on birth weight, across the 10-year period (2008–2018), most of the newborn deaths had an expected birth weight of >2500 grams (35.3 per cent), and about 12.3 per cent of the newborn deaths had low birth weight (<2500 grams). It is worth noting that this proportion increased by 6 per cent, from 9.2 per cent in 2007 to 15.2 per cent in 2018. Considering gender, a greater number of the neonates who died were males (56.7 per cent) in comparison to females (43.3 per cent).

*Table 8: Newborn deaths over a ten-year period*

DHS period	Gender	Newborn deaths					
		Yes		No		Total	
		Count	Row N %	Count	Row N %	Count	Row N %
2008	Male	107	34.5%	203	65.5%	310	100%
	Female	99	40.1%	148	59.9%	247	100%
	Total	206	37.0%	351	63.0%	557	100%
2013/14	Male	188	46.4%	217	53.6%	405	100%
	Female	133	39.3%	205	60.7%	338	100%
	Total	321	43.2%	422	56.8%	743	100%
2018	Male	156	60.0%	104	40.0%	260	100%
	Female	113	52.6%	102	47.4%	215	100%
	Total	269	56.6%	206	43.4%	475	100%
Total	Male	451	46.3%	524	53.7%	975	100%
	Female	345	43.1%	455	56.9%	800	100%
	Total	796	44.8%	979	55.2%	1775	100%

The data shows that over the 10-year period, 51.3 per cent of newborn deaths were experienced by mothers who were currently working. Considering the level of education attained by the mother, 41.6 per cent of the newborn deaths were experienced by mothers with a primary level education, however when looking at DHS periods, the proportion reduced from 43.3 per cent in 2007 to 37.1 per cent in 2018. Looking at the mother's age, newborn deaths were most common in young mothers who were less than 29 years of age (60.9 per cent). For more detailed results, see the table below:

*Table 9: Factors associated with newborn deaths*

	2007		2013/14		2018		Total	
	N	%	N	%	N	%	N	%
Birth weight								



Low birth weight (< 2500 grams)	19	9.2%	38	11.8%	41	15.2%	98	12.3%
Expected birth weight (> 2 500 grams)	65	31.6%	108	33.6%	108	40.1%	281	35.3%
Not weighted at birth	101	49.0%	130	40.5%	74	27.5%	305	38.3%
Birth weight not known	13	6.3%	37	11.5%	46	17.1%	96	12.1%
Missing birth weight	8	3.9%	8	2.5%	0	0.0%	16	2.0%
Total	206	100%	321	100%	269	100%	796	100%
Sex of child								
Male	107	51.9%	188	58.6%	156	58.0%	451	56.7%
Female	99	48.1%	133	41.4%	113	42.0%	345	43.3%
Total	206	100%	321	100%	269	100%	796	100%
Mother's occupation								
Not working	106	51.5%	143	44.5%	139	51.7%	388	48.7%
Currently working	100	48.5%	178	55.5%	130	48.3%	408	51.3%
Total	206	100%	321	100%	269	100%	796	100%
Husband/partner highest level of education								
No education	22	11.7%	18	6.1%	19	9.3%	59	8.6%
Primary	89	47.3%	121	41.2%	76	37.1%	286	41.6%
Secondary	62	33.0%	129	43.9%	92	44.9%	283	41.2%
Higher	11	5.9%	19	6.5%	13	6.3%	43	6.3%
Don't know	4	2.1%	7	2.4%	5	2.4%	16	2.3%
Total	188	100%	294	100%	205	100%	687	100%
Mother highest level of education								
No education	29	14.1%	38	11.9%	27	10.0%	94	11.8%
Primary	134	65.0%	170	53.1%	133	49.4%	437	55.0%
Secondary	36	17.5%	101	31.6%	97	36.1%	234	29.4%
Higher	7	3.4%	11	3.4%	12	4.5%	30	3.8%
Total	206	100%	320	100%	269	100%	795	100%
Mother matrimonial status								
Never married	18	8.7%	27	8.4%	34	12.6%	79	9.9%
Married	165	80.1%	249	77.6%	203	75.5%	617	77.5%
Living together	1	0.5%	2	0.6%	2	0.7%	5	0.6%
Widowed	8	3.9%	6	1.9%	5	1.9%	19	2.4%
Divorced	12	5.8%	23	7.2%	17	6.3%	52	6.5%
Not living together	2	1.0%	14	4.4%	8	3.0%	24	3.0%
Total	206	100%	321	100%	269	100%	796	100%
Mother's age								
≤ 29 years	128	62.1%	190	59.2%	167	62.1%	485	60.9%
≥ 30 years	78	37.9%	131	40.8%	102	37.9%	311	39.1%
Total	206	100%	321	100%	269	100%	796	100%
Religion of the household head								



<b>Catholic</b>	31	15.0%	47	14.6%	38	14.1%	116	14.6%
<b>Protestant</b>	167	81.1%	264	82.2%	227	84.4%	658	82.7%
<b>Muslim</b>	1	0.5%	1	0.3%	1	0.4%	3	0.4%
<b>Other</b>	2	1.0%	8	2.5%	3	1.1%	13	1.6%
<b>Missing data</b>	5	2.4%	1	0.3%	0	0.0%	6	0.8%
<b>Total</b>	206	100%	321	100%	269	100%	796	100%

A separate analysis was carried out for the most recent DHS survey of 2018. The results show that the newborn deaths were most common in mothers between the ages 20–24 years (32.7 per cent), followed by ages 25–29 years (20.4 per cent), and ages 30–34 years (18.6 per cent).<sup>120</sup> Considering household wealth, most newborn deaths occurred in the poorest wealth quantile (30.9 per cent). Based on regions, newborn mortality was found to be most common in Luapula (14.1 per cent), followed by Eastern (12.6 per cent) and Muchinga (12.3 per cent), and when considering rural/urban divide, newborn deaths were found to be most common in a rural setting (68.4 per cent) than in an urban setting (31.6 per cent).

Table 10: Newborn deaths and mothers' characteristics

Newborn deaths						
	Yes		No		Total	
	Count	Column N %	Count	Column N %	Count	Column N %
<b>Mothers age in five-year groups</b>						
<b>15–19</b>	24	8.9%	20	9.7%	44	9.3%
<b>20–24</b>	88	32.7%	61	29.6%	149	31.4%
<b>25–29</b>	55	20.4%	42	20.4%	97	20.4%
<b>30–34</b>	50	18.6%	35	17.0%	85	17.9%
<b>35–39</b>	26	9.7%	28	13.6%	54	11.4%
<b>40–44</b>	23	8.6%	14	6.8%	37	7.8%
<b>45–49</b>	3	1.1%	6	2.9%	9	1.9%
<b>Total</b>	269	100%	206	100%	475	100%
<b>Wealth index</b>						
<b>Poorest</b>	83	30.9%	62	30.1%	145	30.5%
<b>Poorer</b>	49	18.2%	55	26.7%	104	21.9%
<b>Middle</b>	60	22.3%	34	16.5%	94	19.8%
<b>Richer</b>	38	14.1%	31	15.0%	69	14.5%
<b>Richest</b>	39	14.5%	24	11.7%	63	13.3%
<b>Total</b>	269	100%	206	100%	475	100%
<b>Region</b>						
<b>Central</b>	26	9.7%	16	7.8%	42	8.8%
<b>Copperbelt</b>	20	7.4%	15	7.3%	35	7.4%
<b>Eastern</b>	34	12.6%	18	8.7%	52	10.9%
<b>Luapula</b>	38	14.1%	51	24.8%	89	18.7%

<sup>120</sup> UNICEF. (2021). 2018 Zambia Demographic and Health Survey Secondary Data Analysis. Lusaka.

Lusaka	30	11.2%	19	9.2%	49	10.3%
Muchinga	33	12.3%	25	12.1%	58	12.2%
Northern	30	11.2%	21	10.2%	51	10.7%
North-Western	9	3.3%	10	4.9%	19	4.0%
Southern	26	9.7%	13	6.3%	39	8.2%
Western	23	8.6%	18	8.7%	41	8.6%
Total	269	100%	206	100%	475	100%
<b>Type of place of residence</b>						
Urban	85	31.6%	64	31.1%	149	31.4%
Rural	184	68.4%	142	68.9%	326	68.6%
Total	269	100%	206	100%	475	100%
<b>Owns a house alone or jointly</b>						
Does not own	156	58.0%	119	57.8%	275	57.9%
Alone only	16	5.9%	20	9.7%	36	7.6%
Jointly only	80	29.7%	57	27.7%	137	28.8%
Both alone and jointly	17	6.3%	10	4.9%	27	5.7%
Total	269	100%	206	100%	475	100%
<b>Owns land alone or jointly</b>						
Does not own	181	67.3%	146	70.9%	327	68.8%
Alone only	19	7.1%	14	6.8%	33	6.9%
Jointly only	63	23.4%	40	19.4%	103	21.7%
Both alone and jointly	6	2.2%	6	2.9%	12	2.5%
Total	269	100%	206	100%	475	100%
<b>Domestic violence</b>						
Does not agree	137	50.9%	91	44.2%	228	48.0%
Agrees that a beating of woman is justified	132	49.1%	115	55.8%	247	52.0%
Total	269	100%	206	100%	475	100%

### Perinatal deaths and stillbirths

Not only is there a stagnation and recently increasing trend of neonatal mortality but also challenges of high rates of perinatal death and stillbirth. There is an urgent need to comprehensively review, analyse and identify the root causes behind stillbirth, perinatal and neonatal deaths, and based on this design an evidence-based, well-resourced programme that provides live-saving comprehensive early essential newborn care. This will also require developing and updating perinatal and neonatal care standards, protocols and tools to enhance the system's capacities in line with global standards. As per ZDHS 2018, Perinatal Mortality Rate for Zambia is 33/1,000 pregnancies. As per the United Nations Interagency Group of Child Mortality Estimates (IGME) 2019, stillbirths in Zambia declined by 28.6 per cent over 2000–2019 from 20.7 still births/1,000 total births to 14.8 /1,000 total births. However, only 3.6 per cent decline was observed in absolute numbers from 9,952 (in 2000) to 9,597 (in 2019).

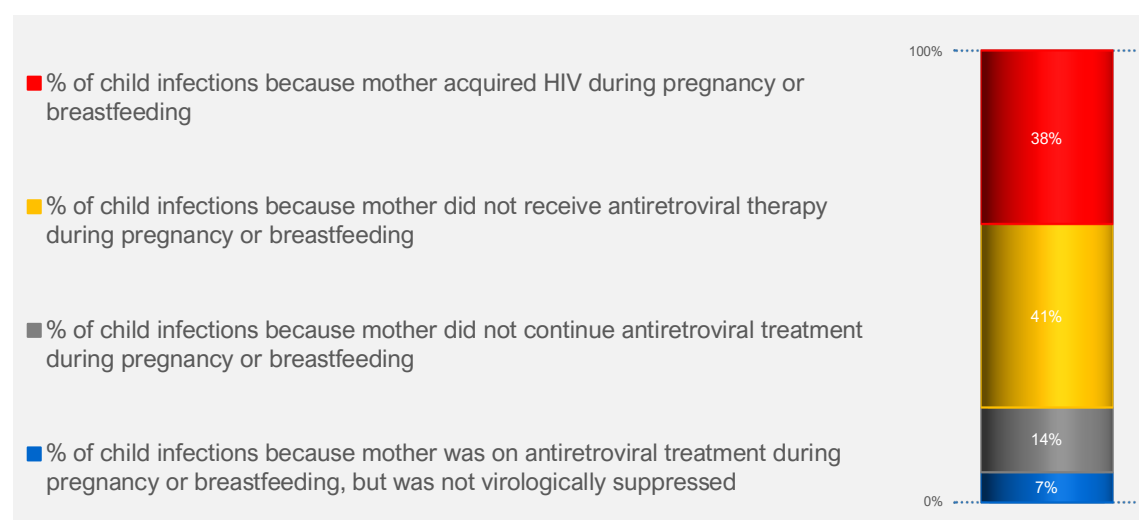
### Antenatal care and delivery

Early childhood care begins before birth, and the health and well-being of the mother is fundamental to the early development of the child. Effective, well-managed ANC not only supports well-being but also

reduces maternal and newborn mortality and morbidity. At least four visits for ANC are recommended, with the first occurring in the first trimester of pregnancy. Yet in most Sub-Saharan African countries, Zambia inclusive, insufficient ANC coverage coexist with high maternal and newborn mortality. An assessment by Kyei et al shows that the quality of ANC services is low in Zambia.<sup>121</sup> It is reported that only 3 per cent fulfilled desirable criteria for optimum ANC service, while 47 per cent of facilities provided adequate service, and the remaining 50 per cent offered inadequate service. The report also indicated that only 8 per cent of mothers received good quality ANC and attended ANC in the first trimester. While more women are taking up ANC services, it seems that the quality remains low, therefore, newborn mortality is not reducing. The drive to take up ANC and other reproductive health services should, therefore, be matched by improvements in quality of service. Early detection of pregnancies in the first trimester is extremely important for timely diagnosis and management of pregnancy-related complications. However, as per DHS 2018, only 37 per cent of women had their ANC check-up during the first trimester.

Additionally, ANC is an important service delivery platform for Prevention of Mother-to-Child Transmission (PMTCT) of HIV, and provides an entry point for HIV care, treatment and support for women living with HIV; especially those who know their HIV status, through testing undertaken in ANC as per policy in Zambia. The proportion of pregnant women counselled and tested for HIV during ANC has increased significantly from 37 per cent in 2007 to 82 per cent in 2018 (DHS, 2007; 2018). More recent estimates indicate that HIV testing coverage for pregnant women is at 89 per cent; although high, this falls short of the 95 per cent target as enshrined in the national plan for the elimination of MTCT of HIV and syphilis (2019–2021). Furthermore, over the past four years, new maternal HIV infections during pregnancy and breastfeeding periods and pregnant and breastfeeding women living with HIV who are not on Anti-Retroviral Treatment (ART) account for major reasons for MTCT of HIV (see Figure 2 below; UNAIDS, 2021). Consequently, the rate of MTCT of HIV for Zambia remains high at 10 per cent: far below the elimination of MTCT target of less than 5 per cent by 2021.

Figure 2: New HIV infections among children due to gaps in PMTCT



Source: UNAIDS Spectrum Estimates 2021.

<sup>121</sup> Kyei, N. N., Chansa, C., & Gabrysch, S. (2012). Quality of antenatal care in Zambia: a national assessment. *BMC pregnancy and childbirth*, 12(1), 1-11.

### **Safe delivery**

According to the ZDHS 2018, 84 per cent of all births were delivered at a health facility; a significant improvement since 2007 where only 52 per cent of all births were at a health facility. The survey highlights how the percentage of births delivered in a health facility decreases with the increasing age of a mother: the more children delivered, the less likely a woman will deliver at a health facility. While delivery at the health facility is likely to be safer than at home, it is the presence and care of a skilled health professional that should make the greatest difference, especially in relation to managing complications which may arise during childbirth and reducing maternal and neonatal mortality. The ZDHS 2018 reports that 80 per cent of births were delivered by a skilled professional: 71 per cent by a nurse or midwife, 8 per cent by a doctor, 9 per cent by a friend or relative, 1 per cent by a community health worker, and 2 per cent by no-one. The survey also found the following correlations:

- The percentage of births attended by a skilled provider decreases in relation to the mother's age at birth, from 84 per cent births among women who are less than 20 years old, to 76 per cent births among women aged 35–49 years.
- The percentage of deliveries attended by a skilled provider decreases in relation to birth order; 89 per cent of first-order births are delivered by a skilled provider, compared to 71 per cent of sixth- or higher-order births.
- Women with no ANC visits are less likely to be assisted by a skilled provider than women with one or more visits.
- Births delivered somewhere other than a health facility are less likely (4 per cent) to be attended by a skilled provider than births delivered in a health facility (95 per cent).
- Women in urban areas are more likely to be assisted by a skilled provider (93 per cent) than women in rural areas (73 per cent).
- By province, the percentage of births delivered by a skilled provider range from 70 per cent in Northern to 91 per cent in Copperbelt and Lusaka. Women in Luapula and North-Western are more likely to be assisted by a traditional birth attendant (18 per cent and 17 per cent, respectively) than women in other provinces.
- The more highly educated a woman is, the more likely she will be assisted by a skilled provider during delivery: from 66 per cent of births to mothers with no education to 99 per cent of births to mothers with a higher education.
- Women in the highest wealth quintile are more likely (96 per cent) to be assisted by a skilled provider during delivery than those in the lowest quintile (67 per cent).
- The percentage of health facility deliveries increases with increasing household wealth, from 73 per cent births in the lowest wealth quintile to 96 per cent births in the highest quintile.

### **Child spacing and family planning**

Policies and strategies on fertility are aligned with allowing women to be able to decide when to have a child, which includes: the age at which the woman begins childbearing, limiting the number of children she has and the spacing between children. The Reproductive Health Policy guarantees free contraceptives in public health facilities in Zambia to enable women or couples to decide birth spacing or limiting births. Furthermore, the Government through the National Youth Policy and the National Plan of Action of 2015 aims to create an enabling environment that promotes the rights and obligations of adolescents and youth to foster their participation in national development. Knowledge and use of modern methods of family planning are an important determinant of empowering couples and women to decide when and how many children to have. Despite the increase in the knowledge of family planning, only 48 per cent of married women aged 15–49 years use modern methods of family planning.

The country has, however, recorded an improvement in the use of modern methods among married women aged 15–49 years over the years from 9 per cent usage in 1992 to 48 per cent usage in 2018.<sup>6</sup> According to ZDHS 2018, the use of any contraceptive rises with age, peaking at 54 per cent among currently married women aged 25–29 years and 30–34 years, and then declining to 37 per cent among women aged 45–49 years. It also shows that it is not very common to use contraception until couples have had at least one child.<sup>122</sup> There has been significant progress in the provision of family planning services. Contraceptive prevalence rate for modern family planning methods were estimated to have increased from 33 per cent to 45 per cent, and ‘unmet need’ reduced from 27 per cent to 21 per cent in 2007 and 2013, respectively. Despite the nearly universal knowledge of family planning, the total fertility rate is still high (5.3), with rural areas reporting a higher rate of 5.8 than urban areas at 3.4. Furthermore, teenage pregnancy is also high at 29 per cent. The rate of teenage pregnancy remains largely inequitable with huge urban-rural difference: urban at 19 per cent and rural at 37 per cent. Forty-two per cent of young women with no education have begun childbearing compared to 23 per cent of women with secondary education.

## **Childhood illnesses**

### *Acute Respiratory Infection*

The ZDHS 2018 reports that acute respiratory infection (ARI), predominantly pneumonia, is a major cause of childhood morbidity and mortality. Two per cent of children under the age of five had ARI symptoms in the two weeks prior to the survey. Advice or treatment was sought for 76 per cent of children with ARI symptoms; however, advice or treatment was sought the same or next day for only 40 per cent of children. Among children under the age of five with symptoms of ARI, for whom advice or treatment was sought, the vast majority (89 per cent) received advice or treatment from the public sector, including 66 per cent who were taken to a government health centre.

### *Fever*

Fever is a symptom of malaria but is also associated with other childhood illnesses that may contribute to high levels of malnutrition, morbidity and mortality. Sixteen per cent of children under the age of five had a fever in the two weeks preceding the ZDHS. The prevalence of fever among children is highest in Luapula (30 per cent) and lowest in Lusaka (9 per cent). Patterns of care-seeking are similar to those for ARI symptoms: 77 per cent of children were taken for advice or treatment, and 48 per cent were taken for advice or treatment the same or next day. One-third (34 per cent) of children with a fever received antibiotics.

### *Diarrhoea*

Mothers reported that 15 per cent of children under the age of five years had a diarrhoeal episode in the two weeks before the survey (ZDHS 2018). Advice or treatment was sought for 69 per cent of these children, and 62 per cent were taken for advice or treatment within two days of the onset of the diarrhoea. The prevalence of diarrhoea peaks among children aged 6–23 months (28–30 per cent). This corresponds with the time when children start losing protection from maternal antibodies through breastfeeding, begin to walk, and are at increased risk of becoming ill because of environmental contaminants. Other findings were as follows:

- The prevalence of diarrhoea is slightly higher among children in households with an unimproved drinking water source (17 per cent) than among those in households with an improved drinking water source (14 per cent). The prevalence is also slightly higher among children whose

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<sup>122</sup> UNICEF. (2021). *2018 Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka.

households engage in open defecation (17 per cent) or use an unimproved facility (16 per cent), than among those in households who use improved toilet facilities (14 per cent).

- By province, the prevalence of diarrhoea among children is highest in Western (23 per cent) and lowest in Central (11 per cent).
- Children from the highest wealth quintile are least likely to have diarrhoea (13 per cent); however, they are also least likely to be taken for advice or treatment within two days of the onset of diarrhoea (55 per cent).<sup>123</sup>

## Immunisation

Zambia has conducted routine childhood immunisations since the inception of the Expanded Programme on Immunisation in 1975 and has been actively implementing the Universal Childhood Immunisation Programme since 1984. To strengthen and scale-up immunisation efforts, the country has developed the *Strengthened Expanded Programme on Immunisation Vaccination Manual*. When linked to the integrated management of childhood illnesses (IMCI) it ensures that whenever a child encounters a health worker, the child's immunisation status is checked, and they are given necessary vaccines. In Zambia, routine childhood vaccines include BCG (tuberculosis), DPT-HepB-Hib or pentavalent (diphtheria, tetanus, pertussis, hepatitis B, and Haemophilus influenzae type B), oral polio vaccine or OPV (poliomyelitis), PCV (pneumococcal), rotavirus or RV, and measles and rubella (MR). Other interventions include Vitamin A supplementation, IYCF counselling, sustained coverage of traditional and new vaccine immunisations, and improved management of common childhood illnesses, including IMNCI and integrated community case management (iCCM). Historically, an important measure of vaccination coverage has been the proportion of children receiving all 'basic' vaccinations.<sup>124</sup> The 2018 ZDHS results show improvements in basic vaccination coverage. The percentage of children aged 12–23 months who received all basic vaccines increased from 68 per cent in both 2007 and 2013–14 to 75 per cent in 2018. The percentage of children aged 12–23 months with no vaccinations decreased from 6 per cent in 2007 to 2 per cent in 2013–14, and to 1 per cent in 2018. Data from the 2018 ZDHS also shows that by province, basic vaccination coverage is highest in Copperbelt (83 per cent) and lowest in Luapula (67 per cent), and that basic vaccination coverage improves with increasing levels of education in mothers; for example, 66 per cent of children born to mothers with no education received all basic vaccinations, as compared to 88 per cent of those born to mothers with a higher education.

Despite recent progress, the vaccine-preventable diseases (VPDs) are still the major cause of child deaths. This is because invalid coverage, and dropout rates are high (especially from Penta-1 to measles which is over 20 per cent) and because of a wide range of inequity in coverage (especially between urban and rural; and by economic quintile). Outbreaks of preventable diseases, including measles and polio, are because of poor coverage and protection, which leads to continued high mortality due to VPDs. The national immunisation programme is also facing challenges of vaccine insecurity, poor cold chain capacity, inadequate social mobilisation and community engagement, and inadequate technical, managerial, and operational capacities, especially at provincial and district levels. The introduction of COVID-19 vaccines has further stressed the country's health system's capacity to sustain the gain of

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<sup>123</sup> UNICEF. (2021). *2018 Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka.

<sup>124</sup> Children are considered to have received all basic vaccinations if they have received the BCG vaccine, three doses each of the DPT and polio vaccines, and a single dose of the measles vaccine. In Zambia, the BCG vaccine is usually given at birth or at first clinic contact, while the DPT vaccine is given in combination with HepB and Hib (DPT-HepB-Hib) at approximately the age of 6, 10, and 14 weeks. A first measles vaccination (which has been given in combination with rubella since June 2017) is given at, or soon after, the age of 9 months.

national immunisation programme as well as need for expanding the immunisation systems and service delivery capacity.

### **HIV burden among children**

Whilst PMTCT of HIV interventions has increasingly averted new HIV infections, however, new infections still pose a clinical and public health challenge. Recent HIV estimates indicate that there are about 82,000 children aged 0–14 years living with HIV and new HIV infections in 2020 were estimated at about 9,000 (UNAIDS 2021). Only two thirds of children born to mothers with HIV in Zambia receive a HIV test by the time they are two months of age. Undiagnosed and without treatment, these children have less than 50 per cent chance of surviving past their second birthday. Low testing rates contribute to a significant treatment gap for children and adolescents in Zambia as compared to adults. In 2020 only 58 per cent of children <14 years, and 53 per cent of adolescents were accessing lifesaving treatment, while the rate for adults (ages 15 years and above) was 80 per cent. Various shortcomings in health sector have led to the coverage in HIV testing rates for HIV-exposed children and in treatment for children living with HIV. Challenges include staff shortages; inadequate capacity of some health workers in management of HIV among children; long distances to health facilities compounded with lack of funds for transport; pill burden (frequent daily intake of drugs and some taste bitter); weak linkages across the HIV testing, care and treatment continuum, particularly in terms of receiving the results of diagnostic tests; and missed opportunities in following up on HIV-exposed infants. Among adolescents, stigma and discrimination associated with an HIV diagnosis remains a significant barrier to HIV testing and treatment among adolescents.<sup>125</sup> Evidence suggests the impact of HIV in children and on other circles of child survival and development. These include high educational risk compared to their uninfected counterparts (Sherr et al, 2018),<sup>126</sup> poorer nutritional outcomes, especially if living with HIV and not on treatment (Chamla et al, 2015)<sup>127</sup>, and HIV as one of the underlying risk factors for death resulting from diarrhoea, sepsis, and ARIs among others.

### **Community participation and accountability for health**

Zambia developed the National Community Health Strategy (NCHS) 2019–2021, the Community Health Worker Strategy (2010) and the Neighbourhood Health Committees (NCHs) which aims to reposition, expand and institutionalise the community health system responsiveness and accountability to the participating community. However, the operationalisation of these strategies has not yet been fully in effect with development of various guidelines, tools and protocols as envisioned in the strategy. The operationalisation of these strategies is expected to yield both economic and societal gains, such as reduced risk of preventable conditions, reduced out-of-pocket payments for healthcare and increased employment opportunities for community members.

## **5.4 Challenges, shortfalls and inequities**

Whilst noting the positive strides made in improved health outcomes, data from the 2018 ZDHS and programme reviews shows that there are persistent challenges which need to be addressed:

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<sup>125</sup> UNICEF. (2021). *Understanding and Improving Viral Load Suppression in Children with HIV in Eastern and Southern Africa*. Source: <https://www.unicef.org/esa/reports/understanding-and-improving-vls> (accessed on 31 October 2021).

<sup>126</sup> Sherr, L., Hensels, I. S., Tomlinson, M., Skeen, S., & Macedo, A. (2018). Cognitive and physical development in HIV-positive children in South Africa and Malawi: A community-based follow-up comparison study. *Child: care, health and development*, 44(1), 89–98.

<sup>127</sup> Chamla, D., Luo, C., Adjorlolo-Johnson, G., Vandelaer, J., Young, M., Costales, M. O., & McClure, C. (2015). Integration of HIV infant testing into immunization programmes: a systematic review. *Paediatrics and international child health*, 35 (4), 298–304.

**Concern about QoC:** The quality of care determines its effectiveness in terms of demand, uptake, and continued utilisation of services. The WHO QoC framework highlights the importance of quality being not just about provision of care, but also about the experience of care by beneficiaries. There are gaps and concerns in the public sector health services. Key challenges are infrastructural: old buildings and improper old designs not supporting quality service provision; far few facilities per population compared to set standards; WASH infrastructure and power challenges; and access to transport and referral services. Human resource challenges include critical shortages in nurses, medical doctors, specialists including anaesthetists at all levels, lack of key maternal newborn health services including blood storage and blood banking services, and critical QoC and gaps in respectful maternity care, which remains to be adequately quantified.

**COVID-19** has aggravated the situation of low access to and utilisation of Reproductive Maternal Newborn and Child Health (RMNCH) services. Communities' care-seeking from health facilities has reduced due to the fear of contracting COVID-19. Furthermore, there has been significant reduction in outreach and community-based health services due to the COVID-19 necessitated movement restrictions. Global supply chains have also been affected leading to poor and inadequate stock of essential health commodities, including life-saving vaccines and essential medicines. A recent second round of national pulse survey across 135 countries including Zambia on continuity of essential services during COVID-19 pandemic reveals that over the course of past one year, 94 per cent countries reported at least one essential service continuity disruption, and 35 per cent countries reported disruption across all service delivery channels and across all sectors of health, thereby indicating the far-reaching impact of COVID-19 on health system.<sup>128</sup> More than one third of countries reported disruptions to immunisation services, highlighting the need for new and sustained approaches to improving routine immunisation coverage and uptake. In Zambia, the COVID-19 context has resulted in a significant downward trend in the supply and uptake of RMNCH services as shown in Table 11.

*Table 11: Downward trend of RMNCH services*

	2018 ZDHS	30 November 2020 District Health Information Systems 2 (DHIS-2)
Infants receiving Penta3 vaccination	92%	69%
Women receiving ANC once (one visit) (ANC-1)	97%	82%
Women receiving ANC four times (four visits) during pregnancy (ANC-4)	64%	67%
Women delivering by a skilled health care provider	80%	37%
Women delivering at health facilities	84%	63%
Mothers receiving a post-natal visit within two days of delivery	70%	26%

This downward trend of coverage of essential RMNCH services is due to poor care-seeking behaviours in the context of the COVID-19 pandemic. Partial lockdown and restricted movement that hindered economic activity and the Government's fiscal hardship, which led to decreased allocations to the health sector budget (which declined from 9.5 per cent in 2018 to 8.8 per cent in 2020) are all factors that contributed to poor care-seeking behaviours.

<sup>128</sup> World Health Organization: Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: January-March 2021, Interim Report 22<sup>nd</sup> April 2021.



**Inequitable access to health services:** In urban areas, 99 per cent of households are within 5 km of a health facility compared to only 50 per cent of households in rural areas. The inequitable access to health services increases mortality and morbidity, particularly among the poor and vulnerable. Long distances to health facilities and low-quality health care delivery, especially for antenatal and postnatal care, are the key factors that lead to high maternal and infant mortality. These inequities remain a key challenge in the quality of maternal care, newborn care and child health services across various service delivery platforms in Zambia. Given that 80 per cent of women give birth in the presence of a skilled professional, there is clearly a need to increase the capacity and capability of skilled birth attendants along with implementing MNCH QoC standards across all health facilities, with regular checks and balances in place.

While Zambia has made significant progress in Emergency Obstetric and Newborn Care (EmONC), women and children are still dying from preventable causes, which indicates inadequate access and quality of EmONC services. Many EmONC facilities are partially functional, as they provide limited signal functions, due to shortage of human resources and basic supplies for delivering signal functions. Zambia reported a shortfall of 18.4 per cent recommended versus actual EmONC facilities in a national level assessment carried out by the Government with United Nations Population Fund (UNFPA).<sup>129</sup> Of the 118 hospitals assessed, less than half (48.3 per cent, n=57) had fully functioning comprehensive EmONC facilities, and of the 266 health centres assessed, only two (0.8 per cent) had fully functioning basic EmONC facilities. Most health facilities were partially functional with basic EmONC facilities. The signal functions performed most often were parenteral oxytocin (96.5 per cent) and parenteral antibiotics (79.5 per cent). There are prevailing equity gaps in healthcare access as lesser number of women in rural areas give birth in health facilities compared to their urban counterparts (79 per cent in rural areas compared to 93 per cent in urban areas). Such gaps pose risks to mothers and newborns because of inadequate quality of care, due to limited or partial EmONC services. Zambia has a shortage of trained EmONC providers—doctors (obstetricians/gynaecologists and general practitioners), associate clinicians, anaesthetists, midwives, and nurses—all of whom are necessary for quality EmONC services. Nationally of the 3,119 doctors needed, only 1,514 were available: a shortfall of 51 per cent. Similarly, of the 6,322 midwives needed, 3,141 were employed, a shortfall of 50 per cent. Of 18,484 nurses required, only 11,666 were employed, a shortfall of 37 per cent.<sup>130</sup> Newborns delivered in a health facility are four times more likely to receive postnatal health check during the first two days after birth than those delivered elsewhere (80 per cent versus 20 per cent). Distance to a health facility (29 per cent) was the most mentioned problem in accessing care by women, while permission to visit health facility (4 per cent) was the least. Women in rural areas (62 per cent) reported at least one problem in accessing health care for themselves compared to 39 per cent in urban areas.

**Gender, disability and healthcare:** There are specific gendered risk factors and barriers to health care both attributed to masculinity and femininity norms respectively. However, women, young and adolescent girls continue to face multiple layers of gender-based vulnerabilities, across stages along the continuum of care. The specific needs for and barriers faced by people with disabilities continue to be largely unaddressed without sufficient data to inform the reforms. The COVID-19 pandemic has added another layer of vulnerability to these groups through loss of livelihoods or risk of contracting the virus while making ends meet. The importance of mainstreaming gender and disability in planning,

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<sup>129</sup> Zambia Ministry of Health, UNFPA, Population Council. 2018. National Emergency Obstetric and Newborn Care (EmONC) Needs Assessment 2014–2015 Policy Brief: Status of EmONC Services in Zambia. Lusaka, Zambia.

<sup>130</sup> Ministry of Health. (2016). Table 4, National Health Strategic Plan 2018–2024 Zambia.

implementation and evaluation of policies and programmes for health and beyond remains critical for equitable distribution of health and opportunities.

**External shocks and health emergencies:** As in globally and regionally, Zambia is increasingly facing the brunt of external shocks (biological, environmental, ecological, and man-made disasters) leading to the repeated threats of Public Health Emergencies (PHEs), such as the disease outbreaks of polio (cVDPV2), cholera, measles and currently the COVID-19 pandemic. In addition, Health in Emergencies (HiEs) caused by disasters, an influx of refugees and migration also pose threats to public health. A key challenge is therefore how to keep the fragile health system resilient and prepared towards such external shocks.

**Mother to Child Transmission:** While there has been good progress in reducing MTCT of HIV over the past decade, in recent years MTCT rate has been reducing at a lower rate than is optimal to achieve the elimination of MTCT of HIV target of less than 5 per cent. This is due to several reasons:

- While coordination of all partners working on health has improved, there remains a need to have better coordination between health and social sector partners.
- Medical staff are distributed unevenly across the country, leaving rural facilities under-staffed.
- Insufficient and inadequate transport hampers staff's ability to provide services to rural areas.
- Weak programming, resourcing and support for community participation, and engagement to increase demand for and utilisation of newborn care and child health services. This often results in lack of ownership of child health services at the community level.
- An inadequate referral system has adversely affected service delivery at the community level. The weak inter-sectoral collaboration at the district level has also limited the effectiveness of community health interventions.
- Weak systems to collect, collate, analyse and use community and facility-level data for programme management, especially at the point of data collection.

**Malnutrition continues to be a major contributor of child mortality:** Malnutrition is an underlying cause for up to 40 per cent of children's deaths. Stunting rates has declined from 40 to 35 per cent in children under-five, wasting from 6 per cent to 4 per cent, and underweight rates have declined from 15 per cent to 12 per cent. However, prevalence of stunting is still particularly high in some age bands: it increases from 19 per cent among children aged 0–6 months to a peak of 46 per cent among children aged 18–23 months, highlighting the importance of optimal nutrition in the first 1,000 days of a child's life.

## 5.5 Stakeholders, initiatives and opportunities

The Government of the Republic of Zambia (GRZ), through the leadership of MoH, coordinates and works with health sector partners and stakeholders under various platforms such as the Annual Consultative Meeting (ACM) chaired by the Minister of Health; the Quarterly Health Policy Meeting chaired/led by the Permanent Secretaries; the TROIKA meeting chaired/led by the Permanent Secretary (Technical Services) and represented by the Chair and Co-Chair of Health Cooperating Partners (HCP) Group, and a permanent member of the HCP group. Furthermore, the health emergencies and epidemic / pandemic responses are coordinated by the National Epidemic Preparedness, Prevention, Control and Management Committee (NEPPC&MC) chaired/led by the Minister of Health and represented by all stakeholders including NGOs, civil society, UN and multi-lateral agencies, bilateral donors, faith-based organisations, and private sector. The United Nations agencies are active members of all these platforms and the coordinating mechanisms including the Health Cooperating Partners, which meets regularly to discuss health-related issues. The United Nations provides support in line with the Sustainable Development Partnership Framework, comprising of three pillars and 11 results groups through annual work plans.

Various health sector agencies and partners (including NGOs and research institutions) that are supporting reproductive, maternal, neonatal, child and adolescent health and nutrition (RMNCAH&N) services are coordinated under the platform of Interagency Coordinating Committee (ICC). The ICC was originally constituted to provide policy and strategic oversight to coordinate and leverage partnerships and resources towards strengthening of routine immunization systems and services, primarily supported by Gavi, the global alliance for vaccines. GRZ/MoH also closely work with the Global Polio Eradication Initiative (GPEI), a partnership of WHO, UNICEF, Bill & Melinda Gates Foundation (BMGF), and the Rotary International, to achieve the global goal of polio-free world.

Zambia has embarked on the integrated life course continuum approach of programming through developing an integrated RMNCAH&N roadmap and investment case under the platform of Global Financing Facility (GFF) led by the World Bank and in collaboration with UN agencies and other health cooperating partners. Thus, the Zambia MoH has expanded the scope of ICC to address the broader RMNCAH&N programming issues to promote better coordination, synergies, and integration in service delivery of high impact health services package. Zambia has also endorsed the WHO led initiative of attaining the Universal Health Coverage (UHC) through revitalising Primary Health Care (PHC) in line with Alma-Ata 40 Declaration and the institutionalising community health as a member of global initiative of Community Health Roadmap, led by UNICEF and USAID.

A wide range of stakeholders including United Nations agencies, bilateral donors, multilateral agencies, and civil society organisations support Zambia to achieve its health sector results for both on the routine health and development services, and the public health emergencies (PHEs) responses including the on-going COVID-19 pandemic. The major partners are USAID, the United Kingdom's Foreign, Commonwealth and Development Office (FCDO), Swedish International Development Agency (SIDA), Federal Government of Germany through German Development Bank (KfW), Government of Japan, the European Union (EU), the CDC, the African Union, the World Bank, the Global Fund and Gavi.

Zambia is a participating country to the global initiatives and partnerships of COVAX (a partnership of WHO, UNICEF, Gavi and CEPI) and African Union's Africa Vaccine Acquisition Trust (AVAT) facilities on the introduction and roll out of COVID-19 vaccination programme. Zambia also work closely with United Nations agencies (WHO, UNICEF, UNFPA, UNAIDS, UNDP, UNHCR), US Centre for Disease Control (CDC), the Centre for Infectious Disease Research in Zambia (CIDRZ), the Churches Health Association of Zambia (CHAZ), NGOs and the private sectors on preparedness and response to COVID-19 pandemic as well as continuation of essential health services.

Zambia adopted the Integrated Management of Childhood Illness (IMCI) strategy developed by UNICEF and WHO in the early 1990s, which provides a holistic approach for child health. In addition to IMCI implementation, the Child Health Unit at the Ministry of Health launched several other child survival interventions, which have contributed to the improved health of children, but more attention is needed to focus on improving the prevention and management of diarrhoea. The review of the IMCI strategy 2013–2017 has been used to inform development of the IMCI Plan 2018–2022. As a result, Early Childhood Development has been integrated into the IMCI Strategy. Zambia has now moved from accelerated burden reduction to elimination of malaria, as set out in the 2017–2021 National Malaria Elimination Strategy.

## 5.6 Sector specific recommendations

**Investigate root causes of newborn deaths.** A harmonised and multisectoral plan is needed to address the causes of newborn deaths. The investigation should include a critical examination of the social determinants of health, in addition to other factors. Further investigation is also needed to understand what specifically is causing higher mortality rates among boys than girls and come up with specific measures of intervention.

**Identify and address barriers and bottlenecks related to health facilities.** Community interface, social norms, and sub-optimal practices that compromise newborn health and survival should be tackled by providing additional training for birth attendants.

**Empower communities.** The Government is taking a community health approach, which includes supportive mechanisms for community participation in organisation, coordination, and financing. As such, community members, especially volunteers, form an essential part of the health system and are a critical link between service provision to facilities, and individual community members. It is therefore recommended that efforts be made to empower communities, provide capacity strengthening support, and remuneration for volunteers, so that they are at least not out-of-pocket.

**Improve coordination.** While coordination between health-related partners working on child health has improved, there remains a need to improve coordination with social sector agencies and departments.

**Improve quality, equity, and dignity of RMNCH services.** There is a need to take action to create a more equitable health system by creating incentives to attract qualified health professionals to work in rural areas. It is also important to keep in mind that high degree of inequity in health outcome, quality of service provisions and access to health care services exists in Zambia. This is evidenced by indicators disaggregated for gender, education, vulnerable groups and between and within provinces. Identifying the deprived areas and vulnerable population groups (including special groups) through disaggregated data is an important step to address the existing inequities in health outcomes between and within provinces and districts in Zambia.

- It is important to prioritise high impact evidence-based interventions for improving maternal, newborn and child survival.
- Focus not only on quality assurance of services but also on quality provision, thereby building in the beneficiary perspective of quality of services. Ensure respectful care with dignity including staff behaviour, consent, information, communication and by providing infrastructure that promotes privacy and dignity.
- Make provision for equitable distribution of services in terms of reaching the most marginalised and vulnerable populace, geographically remote areas, migrants, peri urban settlements, youth, women and children.
- Build technical capacities—human resource for health (HRH), which is motivated, skilled and rationally distributed; standardise guidelines and Standard Operating Procedures (SOPs), reporting and recording mechanisms, mentorship and supportive supervision.
- Ensure availability of essential infrastructure, commodities and supplies for RMNHC services; develop strong referral linkages and transportation mechanisms along with tele medicine services and improve use of technology.
- Strengthen MIS systems—reporting mechanism, data for action, gender and age disaggregated data, end to end data solutions and real time monitoring.

- Address the inequities in burden of maternal deaths as well as overall access to maternal health services integrated with new-born and child health and overall RMNCH+A services from a “leaving no one behind” equity lens and gender lens.
- Scale up integrated monitoring and supportive supervision mechanism and strengthen measures like hands on training, pre- and in-service education using mentoring approaches.
- Undertake strategic partnerships for improving mental health services with community as key strategic partners and empowering women and adolescents.

**Improve HRH** to promote health care. As per Zambia NHSP plan 2017–21, though significant achievements were made in HRH during 2011–2016, at present 67 around one third of posts in the health sector are vacant. The doctors and nurse’s ratio per 10,000 population is also below the WHO norms. There is need to strengthen human resource policies and appointment, retention of nurses (particularly the public health nurse) and midwives who are crucial for providing the PHC services. There is need to increase numbers and capacity of training institutions and introduction of new training programmes for various cadres of health staff. COVID-19 has shown how e-learning platforms can be used efficiently to undertake rapid capacity building, these can be further utilised for routine health trainings and programmes. Training needs assessment, HR policies, strengthening in-service trainings, creating web-based HRH systems, budget allocation, strengthening collaboration with faith-based organizations, private service providers are some of the strategic actions required to improve utilisation of existing staff.

**Strengthen primary health care.** In line with the Zambia’s development vision of 2030, health is an economic investment and key vehicle for driving the social and economic agenda of development.<sup>131</sup> Promotion of PHC is central to the national plan which prioritises providing PHC including community health close to the people for attainment of UHC towards realisation of SDG goals. PHC is also key to the realisation of UHC goals reaffirmed in the Asthana Declaration.

**Strengthen systems for improved perinatal and neonatal health.** Zambia is one of the few countries in the world experiencing high perinatal and neonatal deaths. There is an urgent need to have focused policy and programmatic attention with a comprehensive review and analysis to identify root causes, design an evidence-based programme and mobilise resources to ensure that most vulnerable are protected with the provisions of live-saving essential newborn care through life-course approach. The MoH needs to develop and update the perinatal and neonatal care standards, protocols, tools and to enhance the systems capacities in line with the global standards.

**Sustain Gains made with re-vitalising Immunisation Systems and Services.** Immunisation is one of the most cost-effective public health interventions tools to combat VPDs, as the VPDs are still one of the major causes of mortality, morbidity and disability in all contexts and settings. The recent COVID-19 pandemic and other VPDs compel the needs for even stronger and resilient health systems that are adequately equipped to design and deliver immunisation services to all population. Zambia’s gain with sustained high coverage of routine immunisation services has been threatened by many external shocks including disease epidemics and pandemic, economic stress and de-prioritisation of domestic resources leading to essential medicines and vaccines insecurity. The Government’s and MoH’s leadership with support from the cooperating partners is paramount in ensuring the essential health commodities security to continue life-saving services like immunisation, a sustainable vaccine security plan with domestic financing, and innovative approaches of immunisation services financing.

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<sup>131</sup> 7NDP 2017–2021 Zambia.

**Build strong referral linkages.** Building capacity, resilience and reach of PHC would entail investment in strengthening the first level institutions (Health Posts, Health Centres and District Hospitals) across the 110 districts in Zambia. The first level institutions are the health centres that provide PHC including preventive, promotive, rehabilitative, palliative and curative care with strong referral linkages with second level (provincial) and third level (national) health facilities.

**Strengthen community health services:** Community health is intrinsically linked to PHC, as it pertains to the health of a community or specific group of people and thereby expands and completes the scope of preventing and promoting actions required for UHC. The strengthening of referral services and linkages between community health service and PHC at institutions should be an important 9<sup>th</sup> pillar of PHC in Zambia:

- **Community participation:** Involve community in planning and monitoring of community-based services, thereby ensuring identification and prioritisation of context specific needs, diversity, inclusion and developing ownerships. The Neighbourhood Health Committees (NHCs) need to be empowered and capacities are to be built along with local volunteer and support groups.
- **Community health workforce:** Support prioritisation of enrolment, capacity building and supportive supervision and regulatory framework for community-based HR, such as Community Health Assistants (CHAs) and CBVs, thus creating a national CBV database. As per Zambia's National Community Health Strategy 2019–2021, there are approximately 2,000 CHAs trained against the target of 5,000 and 10,000–100,000 CBVs in Zambia.<sup>132</sup> However, the community-based system is fragmented: >20 per cent CHVs are working at health facilities without skilled supervision. Formalising the roles of community HR including incentive mechanisms, job responsibilities, service spectrum, trainings, SOPs, reporting, certification are critical steps required.
- **Community based supply chain logistic management:** timely availability of quality and sufficient community-based supplies needs to be strengthened for ensuring distribution of preventive, promotive and curative services at community platforms.
- **Health financing for community health programme:** proper process and systems to be laid down including accountability mechanism for fund allocation, tracking, utilisation and reporting expenses. Clear guidelines and fund management SOPs for guiding community intervention delivery. Building the capacity up to the bottom most level to manage funds including providing standardised tools.

**Strengthen the humanitarian–development nexus with systems resilience.** MoH's high-level commitment and leadership of tackling the outbreaks and pandemic needs a concerted multisectoral approach of adequately resourced longer-term public health emergencies prevention, preparedness and response strategic plans and programmes in place. The lessons from the 2015 outbreak of Ebola in West Africa, the ongoing COVID-19 pandemic, the predicted increase in outbreaks, and disasters predicated on the climate change behoves the Government and partners to adopt a risk-informed programming of Humanitarian-Development Nexus (HDN) with emphasis on building resilient systems that can stand extreme shocks.

**Strengthen health sector supply chain management systems.** Tangible steps taken to strengthen public health supply chain system with recent shift of all related functions to Zambia Medicines and Medical Supplies Agency (ZAMMSA) allowing for end-to-end visibility of all functions under one umbrella. This

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<sup>132</sup> Zambia National Community Health Strategy 2019–2021.

needs to be translated into actions aimed at systems strengthening for supply chain management aligned with global standards of supply chain maturity model responsive and effective to accountable public sector supply chain management.

**Improve data and evidence-informed programming.** Real-time credible data are critical of continued advocacy for every woman, young people, adolescents, newborns and children's right to health and well-being using evidence to engage partners to strengthen policies, resources and partnerships. Digitisation of health information management systems across the continuum including community-based data and information system is critical to support evidence-based policymaking and financing thus scaling-up of high-impact interventions and innovations. The use of digital platforms to promote Real Time Monitoring (RTM) using the successful experience of polio outbreak response, would also be useful and effective in improving the monitoring of routine health services including the continuity of life-saving critical health services in view of the COVID-19 pandemic.

# CHAPTER 6. NUTRITION

## 6.1 Introduction

Undernutrition is one of the world's most serious but least addressed challenges. The human and economic costs are enormous and fall hardest on the very poor, particularly on women and children. Nutrition problems are often unnoticed until they reach severe levels. Globally, nearly 200 million children are chronically malnourished and annually 35 per cent (nearly 3 million) of all deaths among children under 5 years of age and roughly 20 per cent (nearly 1 million) of all maternal deaths are due to malnutrition.<sup>133</sup>

In 2020, globally, 149.2 million children under the age of 5 years of age were stunted, 45.4 million wasted, and 38.9 million overweight.<sup>134</sup> The number of children with stunting is declining in all regions except Africa. Chronic malnutrition (stunting) affects approximately 195 million or about one in three children under 5 years of age in the developing world. Chronically malnourished children can become locked in a cycle of recurring illnesses and are more likely to be shorter adults and to give birth to low-birth-weight offspring. Undernutrition can create irreversible damage to growth, development and cognitive abilities.<sup>135</sup> Chronic undernutrition is largely irreversible if not corrected in the first two years of life, but it is preventable. The factors that contribute to malnutrition are complex, and tackling malnutrition requires the involvement of all sectors.<sup>136</sup> The COVID-19 pandemic has exacerbated Zambia's socioeconomic vulnerabilities and further shrunk the fiscal space. The number of vulnerable households are on the rise, further limiting access to essential services that are necessary for human survival, such as food security, health, education, water and sanitation. Poor nutrition, resulting from food insecurity in households, further erodes the country's human capital potential. The disruption in health and food systems, coupled with the effect of COVID-19, have increased risk of food and nutrition insecurity, especially among vulnerable groups in Zambia.

Zambia has also experienced adverse impacts on its agriculture sector because of climate change. The country experienced drought during the 2018/2019 season resulting in food insecurity in 58 districts, affecting 2.3 million people. The drought came on the heels of the el Niño occurrence in the 2017/2018 rainy season, which and accompanying caused floods. In Zambia, the impacts of climate change also include occasional extended dry spells, increased temperatures in valleys, flash floods, increase in frequency and severity of seasonal droughts, and changes in growing seasons. Smallholder farmers are the country's largest population of food producers, and they are responsible for up to 90 per cent of the food produced in Zambia, with 80 per cent being women farmers accounting for about 80 per cent. Agriculture is a major source of livelihood for majority of the rural population in Zambia. Since most of the vulnerable population rely on agriculture for their livelihoods, improving agriculture and food systems is key to achieving food and nutrition security in the country.

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<sup>133</sup> Malnutrition. April 2021.

<https://data.unicef.org/topic/nutrition/malnutrition/><https://data.unicef.org/topic/nutrition/malnutrition/>

<sup>134</sup> Ibid.

<sup>135</sup> Bhutta, Z. A., Das, J. K., Rizvi, A., Gaffey, M. F., Walker, N., Horton, S., Maternal and Child Nutrition Study Group. (2013). Evidence-based interventions for improvement of maternal and child nutrition: What can be done and at what cost? *Lancet*, 382, 452–477.

<sup>136</sup> Brudevold-Newman A., Dias, P., Ring, H., Roopnaraine, T., Seidenfeld, D. and Tembo, G. (2018) *Final Evaluation Report: Evaluation of Zambia's First 1000 Days Programme* Washington: AIR



## 6.2 Legal and policy framework

Passed in 2020, the Food and Nutrition Act of Zambia provides for guides the implementation of a national food and nutrition programme. It also strengthens the functions of the National Food and the Nutrition Commission coordinate the regulations through the Food and Nutrition Coordinating Committee. Other legislation in place to support nutrition programmes includes the Food Safety Bill of 2019, Food and Drugs Regulation of 2001 that cover elements of monitoring food fortification. In addition, Statutory Instrument No. 48 of 2006 on Regulating marketing of Breastmilk Substitutes and Employment Code Act, No. 3 of 2019, which covers Maternity Protection that supports promotion and protection of recommended IYCF practices.

The Zambian Food and Nutrition Policy is an overarching document that provides framework for supporting implementation of nutrition interventions across sectors. Review of the policy is underway to align to updated global and local evidence for effective interventions and service delivery strategies. To accelerate the reduction of malnutrition, the Government of the Republic of Zambia has prioritised nutrition in national development policies and plans. Nutrition and is linked with all the development outcomes of the 7NDP. The National Food and Nutrition Strategic Plan (NFNSP) 2018–2022 highlights multisectoral solutions for nutrition problems through strengthening governance, enhancing planning and monitoring through a *Common Result Framework*.

Recognising the need to address different faces of malnutrition including inequity in nutrition outcomes, UNICEF has developed a Global Nutrition Strategy 2020–2030 for Maternal and Child Nutrition that aims to support five systems namely: food, health, water and sanitation, education and social protection that are important for reducing under nutrition.<sup>137</sup> The system approach aims to make these five systems equipped and accountable to deliver nutritious diets, to strengthen essential nutrition services, and to improve positive nutrition practices for children, adolescents and women. In 2010, Zambia joined the SUN, a global movement that advocates for multisectoral, multi-stakeholder responses to nutrition improvement; the MCDP 1. While the programme recorded some successes, levels of malnutrition remained high. The programme focused on improving the provision and /delivery of nutrition services for 14 priority interventions (PIs) in 14 priority districts. It operated through bringing together line ministries, the United Nations agencies and NGOs, promoting harmonisation among key cooperating partners and stakeholders, thereby aiming to avoid duplication of efforts and reduce transaction costs for all players addressing nutrition interventions. One of the challenges for MCDP1 was that while there was coordination at national level, this did not translate into sufficient coordination or impact at community level.<sup>138</sup> The follow-on five-year stunting reduction programme, MCDP II was launched by the Government in 2018 and plans to run until 2023. The programme operates in 42 out districts of the 116 districts in Zambia. MCDP II has been based on lessons learnt from MCDP I and updated with national and global evidence. Key features of MCDP II that incorporated lessons learnt from the first phase include a simplified package of high impact, multisector interventions converging at household level; greater investment in a robust M&E component; greater concentration of effort at district level, including increased capacity building, financial and technical support; and increased engagement at community level. Furthermore, sustained advocacy at national level attracted additional donors and the second phase is now the largest multisector and multi-donor funded programme in Zambia.<sup>139</sup>

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<sup>137</sup> WHO and UNICEF 2017. Discussion Paper: The extension of the 2025 Maternal, Infant and Young Child nutrition targets to 2030.

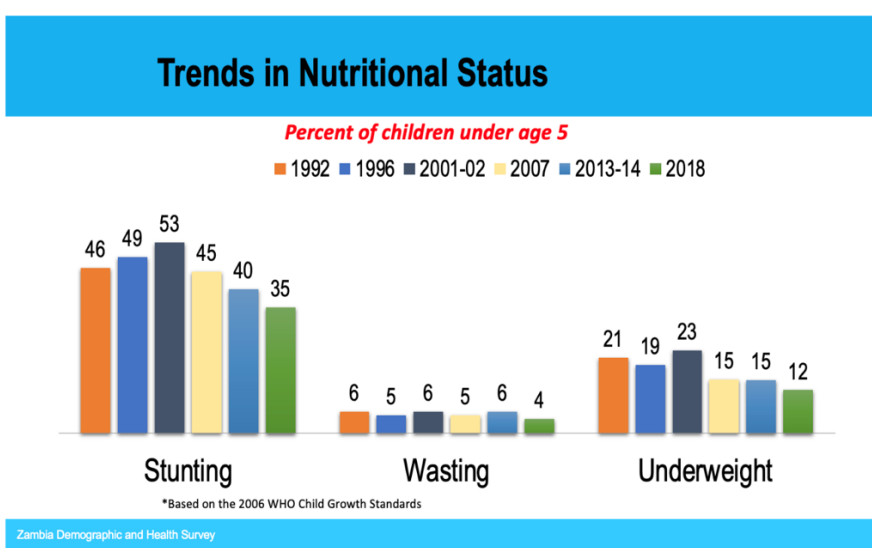
<sup>138</sup> Andrew Brudevold-Newman, Dias, P., Ring, H., Roopnaraine, T., Seidenfeld, D. and Tembo, G. (2018) *Final Evaluation Report: Evaluation of Zambia's First 1000 Days Programme* Washington: AIR.

<sup>139</sup> Ibid.

### 6.3 Levels, trends and differentials in key indicators

Despite gradual and steady progress in different nutritional outcomes in the country, based on the current nutrition situation, the country is not on course to meet the global nutrition targets established by the World Health Assembly. Malnutrition among women, adolescents and children continues to be a challenge, impeding the overall socio-economic development of Zambia. Chronic malnutrition, manifesting as stunting remains a serious problem, even though the country has made incremental progress in the reduction of stunting: the stunting prevalence has declined nationally from 40 per cent in 2013 to 34.6 per cent in 2018.<sup>140</sup> There were however, widening disparities across provinces, regions (rural and urban), gender and other socioeconomic gradients. The 2018 ZDHS report indicates reports that off the 35 per cent children who are stunted, that there are more boys (38 per cent) compared to girls (31 per cent) who are stunted. Children whose mothers have no education have a higher prevalence of stunting (38 per cent) than those whose mothers have a higher education (15 per cent). Stunting prevalence between provinces ranged from 45.8 per cent in Northern Province to 29 per cent in Western Province. As with all forms of undernutrition, causal factors for chronic malnutrition (stunting) in Zambia are complex and caused by multiple factors. Acute malnutrition, manifesting as wasting, a result of short-term inadequacy of dietary intake and/or acute illness, stands at 4 per cent among children under five years of age. Twelve per cent of children were underweight (thin for their age) and 5 per cent were overweight (heavy for their height). This wasting rate often time increases during recurrent droughts, which affects almost 50 per cent of the 116 districts in Zambia.

Figure 3: Trends in nutritional status



According to the ZDHS 2018, only 12.5 per cent of children were receiving the adequate number and diversity of meals recommended, as measured by the Minimum Acceptable Diet, a standard indicator to measure IYCF practices in children 6–23 months old. Less than 1 in 4 children were fed a MAD: 6 per cent in the lowest wealth quintile households compared to 25 per cent among the highest wealth quintiles. The percentage of children aged 6–23 months who consumed foods rich in Vitamin A had

<sup>140</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

decreased from 84 per cent in 2007 to 79 per cent in 2018. Over the same period, the percentage of children consuming foods rich in iron decreased from 63 per cent to 54 per cent. Though there is lack of data, dietary diversity among women and adolescents also seems to be poor.

The prevalence of anaemia in children aged 6–59 months was 58 per cent. The prevalence of anaemia was higher among younger children (aged 6–23 months) than in older (aged 24–59 months) children, with a peak prevalence of 77 per cent among children aged 9–11 and 12–17 months highlighting the need to address the problem in the first 1,000 days group. The prevalence of stunting increases increased from 19 per cent among children aged 0–6 months to a peak of 46 per cent among children aged 18–23 months. This highlights the importance of optimal nutrition in the first 1,000 days of life. Conversely, the prevalence of wasting peaks at 7 per cent among children aged 9–11 months. The prevalence of stunting was higher among children in rural areas (36 per cent) than among children in urban areas (32 per cent). Stunting was higher in boys (38 per cent) than in girls (31 per cent).<sup>141</sup> Furthermore, studies indicate that most of the population in Zambia, especially in rural areas, survives on diets that are deficient in a variety of micronutrients. Micronutrient deficiencies, including deficiencies in Vitamin A, Iron and Iodine, are also prevalent in Zambia. Anaemia, a proxy of iron deficiency is a severe public health problem, with no significant reduction in anaemia among children aged 6–59 months over the past two decades (estimated prevalence of 60 per cent in 1998, 53 per cent in 2003, 49 per cent in 2009, and 55 per cent in 2012 and, 60 per cent in 2015).<sup>142</sup> The proportion of households consuming adequately iodized salt remains low at 53 per cent.<sup>143</sup> Twenty-six per cent of children under 5 years of age are vitamin A deficient (National Food and Nutrition Commission, NFNC, 2014). Anaemia is a severe public health problem and boys are more likely to be anaemic than girls (60 per cent and 57 per cent, respectively). Anaemia prevalence of children varies by province: from 50 per cent in Central Province to as high as 71 per cent in Luapula Province. In addition, overall, 31 per cent of women (ages 15–49 years) in Zambia suffer from anaemia according to DHS 2018. Pregnant women were found to be more likely (41 per cent) to suffer from anaemia than breastfeeding mothers (28 per cent) and non-breastfeeding/non-pregnant women (31 per cent). By province, the prevalence of anaemia among women ranges from 24 per cent in Central to 38 per cent in Western.

The 2014 Zambia Food Consumption and Micronutrients Survey (conducted in Northern and Luapula Provinces), revealed that the prevalence of inadequate intake of the various vitamins and minerals can vary widely, as do the prevalence among provinces.<sup>144</sup> For the two provinces, the dietary patterns were generally found to be highly inadequate for vitamin A, vitamin B-12, folate, iron, zinc, and calcium. The dietary profile also featured low levels of consumption of milk, meat, fish, and dairy products. Almost all the children were deficient in vitamin B-12, with many others also being deficient in folate.<sup>145</sup> For pregnant women, the lack of essential vitamins and minerals can be catastrophic, increasing the risk of low birth weight, birth defects, stillbirth, and even death.<sup>146</sup> The control of vitamin and mineral deficiencies is an essential part of the overall effort to fight hunger and malnutrition.<sup>147</sup> Actions that

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<sup>141</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

<sup>142</sup> Ministry of Health. 2015. Zambia national malaria indicator survey 2015. Lusaka, MoH.

<sup>143</sup> National Food and Nutrition Commission. 2011. Iodine deficiency disorder impact survey. Lusaka, NFNC.

<sup>144</sup> Alaofè H., Kohler L., Taren D., Mofu M.J., Chileshe J. & Kalungwana N. (2014). *Zambia Food Consumption and Nutrition Survey Report*. Zambia National Food and Nutrition Council. <https://www.nfnc.org.zm/research-reports/> (accessed on 28 October 2021).

<sup>145</sup> Ibid.

<sup>146</sup> UNICEF. 2015. Micronutrients. Available at: [https://www.unicef.org/nutrition/index\\_iodine.html](https://www.unicef.org/nutrition/index_iodine.html)

<sup>147</sup> Bhutta ZA, Salam RA, Das JK. 2013. Meeting the challenges of micronutrient malnutrition in the developing world. *British Medical Bulletin*; 106: 7–17

promote an increase in the supply, access, consumption and utilisation of an adequate quantity, quality and variety of foods for all populations groups should be supported. Policy and programme responses include food -based strategies, such as, dietary diversification and food fortification, as well as nutrition education, public health and food safety measures, and finally supplementation.<sup>2,148</sup>

In Zambia, adolescents make up a substantial 25 per cent of the population, majority of whom live in rural areas. The country has one of the highest adolescent fertility rates in the region. High prevalence of child marriage and teenage pregnancy has contributed significantly to high fertility and population growth. As a result, adolescent population in Zambia is expected to increase from current 3.7 million to 9.8 million in 2050. Adolescent malnutrition is a problem in Zambia, where all forms of malnutrition co-exist amongst this age group. As per the DHS 2013–14, 16.4 per cent adolescent girls were undernourished while 8.6 per cent were overweight and obese. One-third of adolescent girls were anaemic. There is a dearth of adolescent-focused nutrition programmes with multisectoral interventions using different service delivery platforms (school, health facility and community) to address all forms of malnutrition, including support to enhancing their diet. However, there is a need to reach to adolescents especially those out-of-school adolescent girls with an integrated package of interventions.

Dietary diversity in Zambia is a major challenge. Children do not consume food from enough food groups: only 22 per cent of children aged 6–23 months found to have had sufficient dietary diversity according to infant and young child feeding guidelines.<sup>149</sup> The COVID-19 pandemic has had a serious negative impact on the price and availability of food and therefore on the food choices of families. The impact of COVID-19 goes beyond the environment but also impacts the health of the people especially children aged below five 5 years. The Lancet suggests an estimated increase of 14 per cent in moderate or severe wasting due to COVID-19 pandemic.<sup>150</sup> The paper also estimates a 30 per cent overall reduction in coverage for essential nutrition services, reaching up to 75–100 per cent in fragile countries. Given the complete lack of Government funding for the IMAM Programme, the case of acutely malnourished children is expected to increase in Zambia.

Given the established relation between wasting and stunting, it will be imperative for UNICEF to continue treating Severe Acute Malnutrition (SAM) in children as this would indirectly exonerate the food system and contribute to stunting reduction. Therefore, the proposed scale-up of IMAM Programme will prevent many deaths of children who might have fallen through the cracks of preventive actions in those districts during the pandemic. Research shows most babies in Zambia are not born stunted (chronically malnourished). **Instead, most children under age five years who become stunted do so between the ages of two months and two years.** Breastfeeding rates are high, but so are incidences of related diseases such as diarrhoea, which can be linked to early separation from exclusive breastfeeding. The prevalence of diarrhoea peaks among children aged 6–23 months (28–30 per cent). This corresponds to the time when children start losing protection from maternal antibodies through breastfeeding, begin to walk, and are at increased risk of becoming ill because of environmental contaminants. The proportion of children aged 6–23 months receiving minimum adequate feeding is very low, at 11 per cent across all Zambia and 7 per cent in the lowest wealth quintile.

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<sup>148</sup> WHO/FAO. 2006. Guidelines on food fortification with micronutrients. Geneva, WHO.

<sup>149</sup> Save the Children Fund (2016) *Malnutrition in Zambia: harnessing social protection for the most vulnerable*.

<sup>150</sup> Bhutta, Z. A., Das, J. K., Rizvi, A., Gaffey, M. F., Walker, N., Horton, S., Maternal and Child Nutrition Study Group. (2013). Evidence-based interventions for improvement of maternal and child nutrition: What can be done and at what cost? *Lancet*, 382, 452–477.

With regards to health services and environment, poor water and sanitation are concerns. In rural areas, 19 per cent of the population uses surface water for drinking. Similarly, 16 per cent of the rural population practices ODF, leaving them vulnerable to infections transmitted by faeces.<sup>151</sup> Lack of access to clean water is a key factor in the persistence of chronic malnutrition in Zambia. While the Zambia Child Grant Programme, a cash transfer programme, was found to reduce stunting rates by 9 percentage points in households that had access to clean water, it did not reduce stunting at all in those households without access to clean water.<sup>152</sup>

#### 6.4 Challenges, shortfalls and inequities

As with ECD and child health, addressing undernutrition requires a well-coordinated multisectoral, multi-stakeholder approach with each ministry or stakeholder contributing to the plan. MCDP-I was instrumental in establishing nutrition as a key component of the national development agenda, and in establishing the multisector, multi-partner coordination structures at all levels of governance from central to ward level, yet the coordination still proved to be inadequate. Such a multisectoral approach requires sufficient financial and HR allocation to address all forms of malnutrition effectively, yet currently allocation is insufficient. Other than the nutrition-specific interventions under the health sector, nutrition is still given a low priority by non-health sectors. Lack of an effective system or mechanism for sectoral accountability for nutrition, combined with inadequate institutional and human resource capacity restrict the possibility of multisectoral nutrition planning, implementation and evaluation.<sup>153</sup>

Coordination at community and household levels is key to a successful nutrition programme but, as demonstrated in MCDP-I, the service delivery structures lacked coherence and convergence for multisectoral nutrition interventions at the household and community levels. Currently, there is inadequate clinical nutrition capacity in the health sector to effectively contribute towards acceptable nutrition therapy and practice. Specialised clinical nutrition care services are limited in the management of different health conditions at the health facility level. This is compounded by the limited numbers of qualified dietitians/clinical nutritionists to provide comprehensive nutrition therapy. Furthermore, there is limited available equipment, guidelines and protocols, supplies, and commodities to provide specialised nutrition services.<sup>154</sup>

Zambia adopted an IMAM approach to treat acute malnutrition, ensuring a continuum of care including both severe and moderate acute malnutrition. The IMAM programme is organised into four components: a) Community Outreach and mobilisation: for early identification, referral and follow up of acutely malnourished children, b) Supplementary Feeding Programmes (SFP): to treat moderately malnourished children, c) Outpatient Therapeutic Programme: to treat severely malnourished children without complication and good appetite and d) Inpatient Therapeutic Program: to treat severely malnourished children with complication. The programme has experienced several challenges. These include limited community mobilisation systems, uncoordinated and ineffective supply chain management, sub-optimal quality of IMAM services, limited volunteer engagement and support for outreach services, lack of a proper follow-up system, unstructured monitoring and evaluation system, insufficient funding, and a weak enabling environment for IMAM implementation. Following the 2018–

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<sup>151</sup> Save the Children Fund (2016) *Malnutrition in Zambia: harnessing social protection for the most vulnerable*.

<sup>152</sup> Handa, S., Seidenfeld, D., Davis, B., Tembo G., and the Zambia Cash Transfer Evaluation Team, 2014. Are Cash Transfers a Silver Bullet? Evidence from the Zambian Child Grant, Innocenti Working Paper No.2014-08, UNICEF Office of Research, Florence.

<sup>153</sup> Government of the Republic of Zambia. Health Strategic Plan 2017–2021.

<sup>154</sup> Ibid.

2019 drought that affected 58 districts, UNICEF raised funds and supported the implementation of IMAM programme in 58 drought affected districts out of the 116 districts in Zambia. This programme was aligned with the MoH's National Health Strategic Plan and aimed to increase coverage and quality of IMAM services and contributed to strengthening the IMAM system to respond to challenges, but this the emergency funding is coming to end by 2021.

## 6.5 Stakeholder landscapes and initiatives

The Government's First 1,000 MCDP, is the national flagship programme for stunting reduction. MCDP-II, with support from key partners, such as Scaling Up Nutrition Technical Assistance (SUN-TA), United Nations agencies, Netherlands Development Organisation (SNV) and German Corporation for International Cooperation (GIZ) are reinvigorating a harmonised approach to multisectoral nutrition actions in high priority districts of the country. To date, the Government has identified 42 priority districts which are being targeted for stunting reduction programmes under the MCDP-II through various cooperating partners to receive comprehensive, integrated, harmonised, large-scale multisectoral nutrition-specific and nutrition-sensitive interventions using common approaches for service delivery.

The SUN-TA, a USAID funded programme based on the same design, is being implemented in 13 districts, while the GIZ, through KfW funding is implementing the Food and Nutrition Security, Enhanced Resilience (FANSER) programme in six districts. The SNV, with FCDO funding implements in three districts (three overlapping with SUN-II), and WFP with funding from SIDA, is implementing in three districts (Mazabuka, Nyimba and Chisamba). UNICEF, in partnership with other United Nations agencies (FAO, WHO and WFP), is supporting 17 districts through the SUN-II programme, jointly funded by FCDO, SIDA, KfW, Irish Aid and the EU.

Programme response to micronutrient deficiencies include Child Health Weeks (CHWs) for delivering a package of services to children under 5 years of age and pregnant and lactating mothers. This is the key strategy adopted by the Government for vitamin A supplementation, implemented twice yearly since 1999.<sup>155,156</sup> Fortification of foods in Zambia started in the 1970s' when salt and margarine were mandatorily fortified with Iodine and Vitamin A, respectively. In 1998, Zambia embarked on the fortification programme targeting sugar, which is consumed by 50 per cent of the population. Currently all sugar for human consumption is required by law to be fortified with Vitamin A.<sup>157</sup> In 2006, concrete plans were advanced for fortification of breakfast and roller maize meals with multiple micronutrients. The process led to the drafting of a statutory instrument, a roadmap for fortification, and a framework for determination of fortification levels to be calculated once population-based data on micronutrient intakes are available.<sup>158</sup> The use of bio fortified maize and sweet potatoes introduced in 2013 is expanding.

While multiple interventions are implemented over years to address micronutrient deficiencies throughout the country, there are considerable knowledge gaps in the coverage and effects of those interventions. Provincially, representative data for micronutrient status has never been collected in Zambia although there are several micronutrient programmes being implemented in all Provinces.

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<sup>155</sup> Fiedler et al. 2012. Child Health Week in Zambia: costs, efficiency, coverage and a reassessment of need. Health Policy and Planning; 1–18.

<sup>156</sup> UNICEF. 2017. Zambia Child Health Days: Lessons learnt in improving children's lives. Nairobi, UNICEF/ESAR.

<sup>157</sup> National Fortification Alliance. 2010. Concept paper on maize meal fortification. Lusaka, NFNC.

<sup>158</sup> UNICEF / NFNC. 2013. A Road Map for Maize Meal Fortification in Zambia: A Proposal. Lusaka, UNICEF.

Representative, population-based survey data are necessary to inform policy makers and programme managers on the scope and quality of programme coverage and the potential impact of programmes on reducing micronutrient deficiencies in the country. UNICEF has supported a national food consumption and micronutrient surveys that was undertaken in 2020–2021 and data analysis is ongoing, and the report is expected by the end of 2021. Four main areas of information gap will be addressed through this survey: the development of micronutrient control strategy, the updating of the Zambia Food Composition Tables, and the development of a national dietary guidelines, and contribution to regional and global reports on micronutrient deficiency and the programme coverage to address the gaps. There is unprecedented attention and commitment to address malnutrition using multisectoral approaches but one of the most frequently mentioned problems in Zambia is the lack of the right nutrition data to characterise the situation, allocate resources, monitor implementation and evaluate progress.<sup>159</sup>

UNICEF supports MoH to collect reliable and timely nutrition and health data through national health management information systems, as part of its approach to close the equity gaps in maternal, newborn, child and adolescent health and nutrition, and strengthen effort towards Universal Health Coverage. Strong and effective Nutrition Information Systems (NIS) provides timely and reliable nutrition and health information that supports the development of health-related policies, strategies, plans and budgets at national level and improves decentralised capacity for management. Further, it provides the necessary information for tracking country's progress of global targets, evidence-based prioritisation, resource allocation, and monitoring & evaluation (M&E) for programme improvement.

A landscape analysis of the NIS in the eastern and southern region carried out in 2019 by the UNICEF Regional Office in Eastern and Southern Africa identified several gaps in the NIS and provided recommendations to strengthen NIS specific to each country, Zambia included. There are both needs and gaps with the indicators currently used: quality issues exist with current indicators while some critical indicators are still missing. Furthermore, nutrition data if collected is not regularly analysed to inform decision-making for nutrition programming. A need to integrate data from multisectoral sources (agricultural, markets, climatic, health, WASH, social protection) to make useful programmatic decisions was identified. To address these challenges, UNICEF, with funding from EU from 2020–2022, is working with MoH to strengthen the NIS for a greater use of nutrition information by policy makers and programme managers by improving the capacity of MoH staff in monitoring programmes and reporting on country and international/global nutrition targets. While for SUN II, a multisectoral M&E systems is being developed by strengthening the capacity of all relevant sectors including MoH in data collection, and collation, and reporting for programme monitoring and decision making.

## 6.6 Sector specific recommendations

While MCDP-II is having greater success than MCDP-I at implementation in a harmonised, multisectoral delivery of services closer to communities, there remains the need to ensure that equal attention and resources are invested in addressing social and economic constraints to nutrition. Other sector specific recommendations are the following:

**Strengthen the integration of nutrition with other key health sector interventions**, such as ECD maternal and adolescent health, HIV care, TB, IMCI, and NCDs - as well as social interventions, such as ECD, social protection and poverty reduction.

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<sup>159</sup> Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.



**Strengthen the systems approach for coherence in formulation and implementation of policies,** programmes and investment among food, health, social protection, WASH, and education system for nutrition.

**Enhance capacities** to develop policies, adopt practices, increase investments, and implement innovative actions across the food system for healthy diets.

**Strengthen the institutional as well as workforce capacity across sectors,** especially the frontline workers to promote diets and to deliver essential nutrition services and positive nutrition practices.

**Invest in community systems for nutrition** and develop the capacities of community workers across systems for effective nutrition services, practices, and promotion of diets.

**Promote sustainable investment in IMAM** including enhanced institutional capacity, procurement of essential nutrition commodities including for emergency preparedness and response.

**Strengthen capacity and commitment for effective and inclusive multisectoral nutrition governance** and accountability, and promote use of technology, data and innovation.

**Introduce capacity strengthening for the MoH** to deliver services for children with moderate and severe acute malnutrition using a health systems approach. This will include support for programme guidance, increased financial allocation from Government and cooperating partners, capacity building of service providers, strengthened supply chain and improved information management system. The NHSP must prominently integrate IMAM services, including the allocation of funds at all levels from national level to district level.

**Strengthen provision of an updated package of high-impact nutrition-direct interventions,** such as maternal, infant adolescent, and young child nutrition; IMAM; GMP; micronutrient deficiency control; nutrition in HIV; and clinical nutrition and dietetics.

**Employ new approaches to ensure climate change adaptations and mitigation.** This will include strengthening community resilience for nutrition and adoption of climate smart technologies and related innovations. Involvement of private sector in such innovations will go a long way in adoption of such measures at scale.



# CHAPTER 7. WATER, SANITATION AND HYGIENE

## 7.1 Introduction

Accessible safe drinking water and sanitary and hygienic conditions are a precursor to good health and wellbeing especially for children, girls and women. In spite of the various measures taken in terms of improving access to basic drinking water service (64 per cent coverage in 2018) and sanitation (33 per cent coverage in 2018), Zambia was not able to reach the Millennium Development Goal (MDG) 7 target for water and sanitation which intended to halve the proportion of people without sustainable access to safe drinking water (61.3 per cent coverage in 2015) and basic sanitation (39.7 per cent coverage in 2015) by 2015. As a result, Zambia was already behind in its target at the onset of the SDGs. SDG 6 targets the achievement of access to adequate and equitable WASH for all; and to end open defecation (ODF), paying special attention to the needs of women and girls and those in vulnerable situations by 2030 (UNICEF 2017).<sup>160</sup> SDG 6 is ambitious with the six outcome-oriented targets aiming to ensure safe and affordable drinking water; end ODF; provide access to sanitation and hygiene; improve water quality, wastewater treatment and safe reuse; increase water-use efficiency and ensure freshwater supplies; implement Integrated Water Resource Management (IWRM); and protect and restore water-related ecosystems. The two means of achieving the targets are to expand water and sanitation support to developing countries, and to support local engagement in water and sanitation management.

Growing up in a clean and safe environment is every child's right. Access to clean water, basic toilets, and good hygiene practices not only keeps children thriving, but also gives them a healthier start in life. This is even more urgent in the current context where COVID-19 has highlighted the importance of water supply and good hygiene to control its spread. In the case of Zambia however, COVID-19 has exposed the many years of underinvestment in WASH, resulting in a weakened COVID-19 defence. Stay home orders become particularly less effective when the homes lack the facilities to practise good hygiene and where toilets and water points are meagre and often shared by several households. With hand hygiene being one of the central ways to curb the spread of not only COVID-19, but other diseases too, its importance has come to the fore. However, this becomes particularly challenging when the sector shows low coverage of these services especially in urban informal settlements and in rural areas. Pre-COVID-19 data suggests that 40 per cent of non-hospital healthcare facilities (HCFs) that did not have water and soap, at points of care.<sup>161</sup> This is also closely associated to the high rate of urbanisation in Zambia, as Zambia is the third most urbanised country in Southern Africa. In these urban populations, up to 40 per cent reside in informal urban and peri-urban settlements, with limited basic WASH services and facilities. In many communities, basic services such as toilets and water points are inadequate and often shared by several households. Children residing in these settings are denied their rights to drinking water and sanitation. This has serious implications for their survival, growth and development.

## 7.2 Legal and policy framework

WASH services require strong national policies and legislative frameworks, financial systems, communication and monitoring to be sustainable, resilient and accountable. The legal and policy framework for water and sanitation in Zambia is comprehensive with the amended constitution of 2016 providing for water resource management (WRM). In Article 147(2), the amended Constitution spells out "the concurrent and exclusive functions of the national, provincial and local government levels" in

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<sup>160</sup> UNICEF 2017, *Strategy for Water, Sanitation and Hygiene 2016–2030*, UNICEF, Available at: < <https://www.unicef.org/media/91266/file/UNICEF-Strategy-for-WASH-2016-2030.pdf> >.

<sup>161</sup> WaterAid 2020, *Wash Matters*, WaterAid, Available at: < <https://www.wateraid.org/where-we-work/zambia> >

relation to WASH. It assigns water resources management to the state, making it an exclusive national function. “Water and sanitation services limited to potable water supply systems and domestic wastewater and sewage disposal systems,” “refuse removal, refuse dumps and solid waste disposal,” and “licensing and control of undertakings that sell food to the public” are exclusively local authority functions. Article 255 provides for the “principles of environmental and natural resources management and development.” Article 256 provides for the “protection of environment and natural resources.” Article 257 provides for the “utilization of natural resources and management of environment.”

The Water Supply and Sanitation (WSS) sector is implemented through the National Rural Water Supply and Sanitation Programme (NRWSSP) and the National Urban Water Supply and Sanitation Programme (NUWSSP). Both the NRWSSP and the NUWSSP contribute to the Government’s constitutional obligations and the achievement of Vision 2030, the 7NDP, and the SDG 6 WASH targets. These instruments underpin the Zambian Government’s commitment to universal and equitable access to WASH services, with due regard to environmental issues. In Vision 2030, Zambia, has a development objective to provide secure access to safe, potable water sources and improved sanitation facilities for the entire population in both urban and rural areas by 2030. The specific sector vision for water and sanitation is “clean and safe water supply and sanitation for all by 2030” and the targets include:

- improved access to appropriate, environmentally friendly sanitation by all Zambians;
- attainment of 80 per cent access to clean water supply for all by 2015 and 100 per cent by 2030;
- attainment of 68 per cent access to sanitation for all by 2015 and 90 per cent by 2030;
- 80 per cent of waste collected and transported; and
- 80 per cent of unplanned settlements upgraded and the residents have access to clean drinking water and sanitation facilities.

Several international declarations have led the foundation for the recognition of the right to water. These include the United Nations Water Conference (1977), the Global Consultation on Safe Water, Water and Sanitation for the 1990s, Plan of Action – World Summit for Children (1990), Dublin Statement (1992), Agenda 21(1992), Convention on the Rights of the Child – Article 24(1989), World Water Forum Commitments (2000). In 2010, Resolution 64/292 of the United Nations General Assembly explicitly recognized the human right to water and sanitation and acknowledged that clean drinking water and sanitation are essential to the realisation of all human rights. The main WASH legislative enactments in Zambia include: (a) The local Government Act, (b) The Water Resources Management Act and (c) The Water Supply and Sanitation Act. The Water Resources Management Act of 2011 is the supreme law on WRM in Zambia. The WRM Act repealed and replaced the Water Act of 1949 and established the Water Resources Management Authority (WARMA), defining its powers and functions (WARMA replaced the then Water Board). WARMA’s core objective is to manage, develop, conserve, protect and preserve water resources both surface and groundwater. The Water Supply and Sanitation Act of 1997 is an Act to establish the National Water Supply and Sanitation Council and define its functions and powers; to provide for the establishment by local authorities, of water supply and sanitation utilities; to ensure efficient and sustainable supply of water and sanitation services under the general regulation of the service.

The Local Government Act of 1991 places local authorities in charge of the provision of water supply, sanitation and hygiene services, the decentralization policy (2002) aimed at decentralizing government responsibilities and functions, among which include rural water and sanitation to lower-level government through devolution; and the National Water Supply and Sanitation Policy (2020). The Water Supply and Sanitation Policy espouses nine key principles that include:

- i. Basic need, recognising that all life is dependent upon water

- ii. Equity: which gives primary consideration to equitable access to water given that safe water and sanitation is a basic need
- iii. Health: placing emphasis on community driven clean, safe and healthy environments
- iv. Efficiency: using technology to optimize efficient and cost-effective provision of services, conditions and environmental benefits
- v. Sustainability: focusing on conservation and protection of ecologically sensitive areas, habitats, species, and other strategic areas
- vi. Integration: of services to optimize socio-economic benefits
- vii. Private sector and community participation: in the implementation of the policy
- viii. Values: both cultural values and social practices that promote respect for men and women in the provision of WSS
- ix. Cross-cutting issues: including HIV/AIDS, gender, disability, special groups, environment and climate change, nutrition, water security and disaster risk management. The vision of the National Water Policy is “a population that has sustainable and equitable access to safe water supply, adequate sanitation and improved services”.

In many cases, WASH services are planned without timely or accurate data. Budgets are set based on historical patterns rather than the needs of the population. Government budgets for financing WASH, especially WASH infrastructure, and for expanding services to those in need remain low. Private sector investment is also insufficient, given the low returns in the water and sanitation business. As a result, one of the greatest barriers to achieving WASH-related targets is the large funding gap.

### 7.3 Levels, trends and differentials in key indicators

#### National Indicators

WASH conditions and services vary significantly within Zambia: urban areas outdo rural areas on every key WASH metric, indicating high inequality in access to WASH services. While the Government has instituted several reforms to improve the performance of WASH in Zambia and increased WASH coverage throughout the country, significant access gaps persist. According to the ZDHS 2018,<sup>162</sup> approximately 36 per cent of Zambia’s population lacks access to basic drinking water services. Two-thirds of the population lack or suffer limited use of basic sanitation services (33 per cent of the population use a basic sanitation service). In terms of open defecation, the country has registered a notable decline with only 10 per cent of the population practicing open defecation, down from 21 per cent in 2005. Lastly, basic hygiene services, i.e., a handwashing facility with soap and water, are only available to about a quarter of the population, estimated at 24 per cent in 2018.

In rural areas, the WASH context is significantly more constrained than the urban regions. Typically, rural populations have lower access to safe WASH services. Access to basic drinking water services in rural areas is estimated at around 50 per cent compared to nearly 90 per cent in urban areas. The situation for sanitation is worse, with only 28 per cent of the rural population having access to basic sanitation services while urban areas stand at 41 per cent. Open defecation is higher in rural areas than in urban areas to only 1 per cent. Equally, basic hygiene services are available to only 15 per cent of the rural population against 36 per cent in urban areas (UNICEF 2020).<sup>163</sup>

<sup>162</sup> Zambia Statistics Agency, Ministry of Health (MOH) Zambia, and ICF. 2019. *Zambia Demographic and Health Survey 2018*, Zambia Statistics Agency, Ministry of Health, and ICF, Available at: <https://dhsprogram.com/pubs/pdf/FR361/FR361.pdf>

<sup>163</sup> UNICEF 2020, *Water, Sanitation and Hygiene*, UNICEF, Available at: <https://www.unicef.org/zambia/water-sanitation-and-hygiene>

The lack of access to basic amenities including clean water and safe sanitation is among the key factors contributing to widespread poverty among the rural population. There is a relatively high incidence of water and sanitation related diseases, particularly diarrhoea, which results in high health costs to individuals and communities. Access to WASH services has strong linkages with prevailing cultural and social norms in Zambia that impose a burden on women and children, especially girls, who are rarely in control of household finances. This further impacts their ability to access key WASH services. In general, although there has been increased focus on women's WASH needs, Zambia is still lagging in addressing these fully. Further, the responsibility for collecting water for many households, which falls disproportionately on women and girls, especially in rural and peri-urban areas, implies not only an additional physical and health burden, but also significantly lessens the time available for education, play or economic and other activities.

### **WASH in Schools**

Improved WASH is fundamental for achieving equity between the genders especially in schools. The SDG targets recognise that building safe, inclusive and effective learning environments is fundamental to increasing children's access to education and improving learning outcomes. But nearly one third of schools around the world still lacked basic water, sanitation and nearly half lacked basic hygiene services in 2016.<sup>164</sup> For girls, appropriate WASH facilities are a particularly important part of ensuring their safe and healthy participation in school. WASH facilities have both 'push' and 'pull' factors for girls' education. Girls can struggle to attend and stay in school if they do not have safe, single-sex and hygienic facilities, which are essential for menstrual hygiene management (MHM). Although there is still little evidence, reports have recognised that the introduction of appropriate water and sanitation facilities has been associated with improved girls' attendance. In addition, Water Aid notes that "girls are particularly at risk of sexual violence when using unsafe facilities at school."

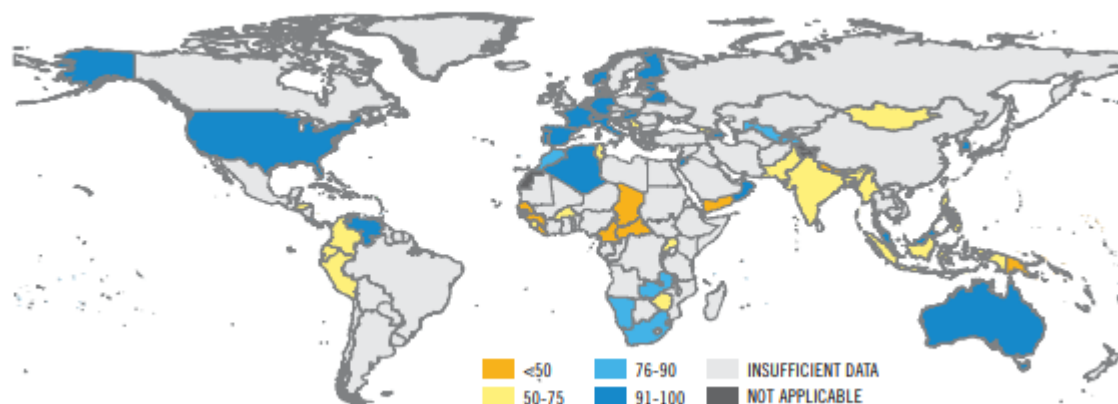
Conversely, learning about menstrual hygiene and pubertal changes can encourage girls to come to school during their menstruation. WASH facilities in schools and the wider community can also free girls from having to collect water, allowing them to have more time in education as young girls and adolescents particularly because women and girls bear the responsibility of fetching water for household use, where this is not readily available. Other than that, the glaring inequities between urban and rural areas as well as the urban poor can be reduced considerably if access to WASH was improved. These inequities affect children disproportionately as they are exposed to higher likelihood of water-borne illnesses and malnutrition resulting from inadequate WASH facilities and services. While disaggregated data was not available to show the inequities in the WASH situation in schools, especially the rural-urban divide, it is evident that Zambia has made significant progress in enhancing WASH conditions in schools. According to the UNICEF and WHO Joint Monitoring Programme (JMP) report,<sup>165</sup> Zambia has greater than 75 per cent coverage of basic drinking water services in its schools, as of 2016. This makes the country one of 58 countries out of 92 to have that level of coverage. The JMP further indicates that rural schools had lower coverage of basic drinking water services than urban schools in almost all countries with disaggregated data.

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<sup>164</sup> United Nations Children's Fund (UNICEF) and World Health Organization, 2018. Drinking Water, Sanitation and Hygiene in Schools: Global Baseline Report 2018. New York: Licence: CC BY-NC-SA 3.0 IGO.

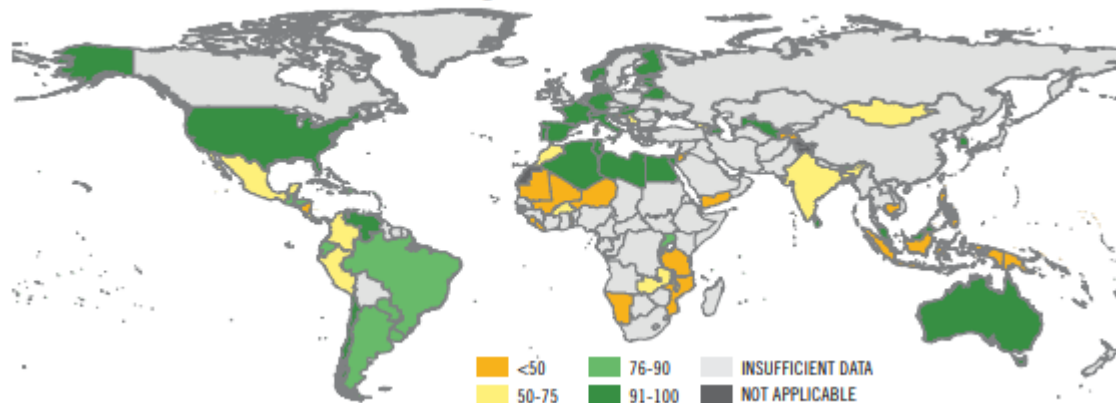
<sup>165</sup> <https://washdata.org/reports>

**58 out of 92 countries had >75% coverage of basic drinking water services in schools in 2016**



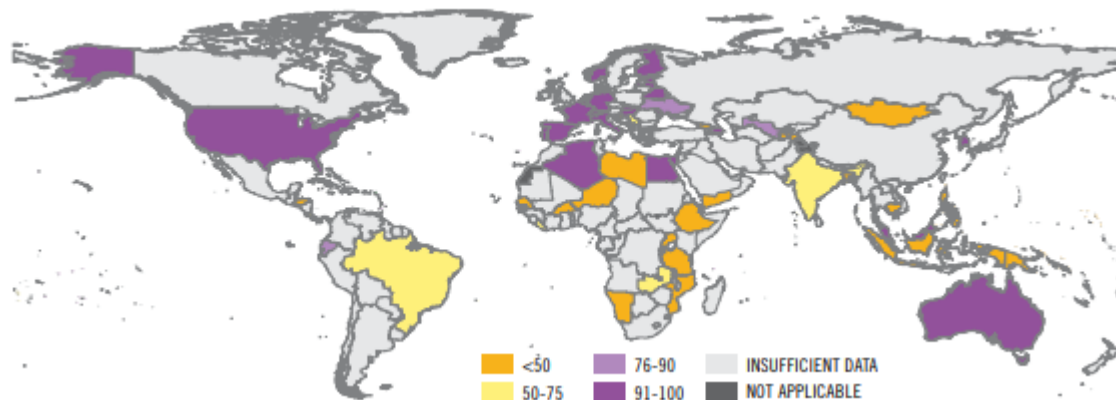
In terms of sanitation in schools, Zambia was still falling behind on this metric with a sanitation coverage of between 50–75 per cent. This focused on schools with a basic sanitation service, defined as an improved single-sex facility that is usable.

**67 out of 101 countries had >75% coverage of basic sanitation services in schools in 2016**



Similarly, basic hygiene coverage in Zambian schools stood at between 50–75 per cent, defined as a handwashing facility with water and soap available at the time of the survey.

**48 out of 81 countries had >75% coverage of basic hygiene services in schools in 2016**



## WASH in healthcare facilities

WASH in HCFs is essential for the provision of quality care. This should be accompanied by adequate WASH infrastructure for HCFs to have safe and accessible water supply; clean and safe sanitation facilities; hand hygiene facilities at points of care and at toilets; and appropriate waste disposal systems.

HCFs in Zambia have limited data on essential WASH and healthcare waste services. According to the JMP (2019), Zambia estimates for basic healthcare waste management services stood at 40 per cent while the remaining 60 per cent indicated insufficient data. In terms of basic water services, nationally, according to the JMP report (2019), 2,842,596 (16 per cent) out of a catchment population of 17,861,034, people do not enjoy access to basic water services in HCFs while 84 per cent had insufficient data to allow complete analysis. In terms of Sanitation, 93 per cent of HCF users had access to improved sanitation in Healthcare Facilities.

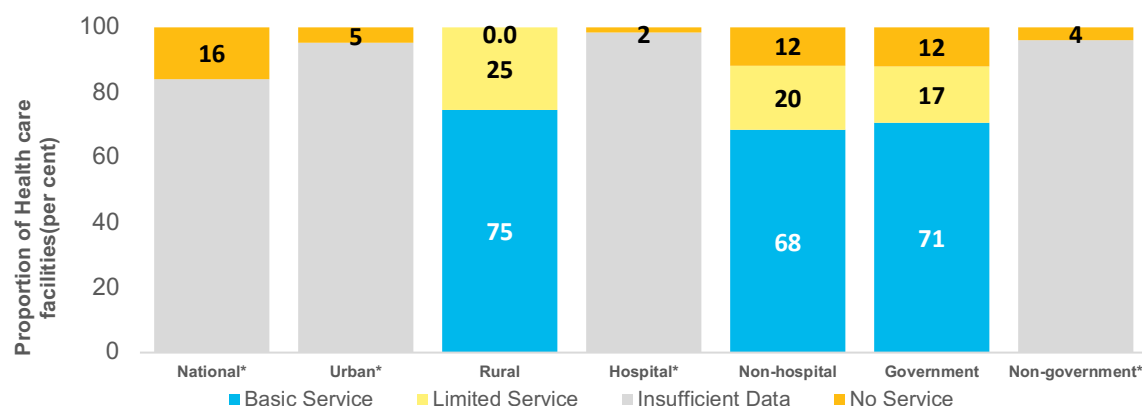
Table 12: Health facilities' access to WASH

Year	Service Type	Service Level	Coverage	Residence / Facility Type	Population
2019	Water	Insufficient data	84.08	total	15,018,438.46
2019	Water	No service	15.92	total	2,842,595.54

Source: Joint Monitoring Programme.

Other than that, rural areas had either basic service (75 per cent of HCFs) or limited service of water (25 per cent of HCFs). According to 2019 findings, no rural areas had completely no service compared to 5 per cent of HCF in urban areas that had no service. See figure below.

Figure 4: Healthcare facilities' access to services



Source: WHO/UNICEF JMP (2020/1).<sup>166</sup>

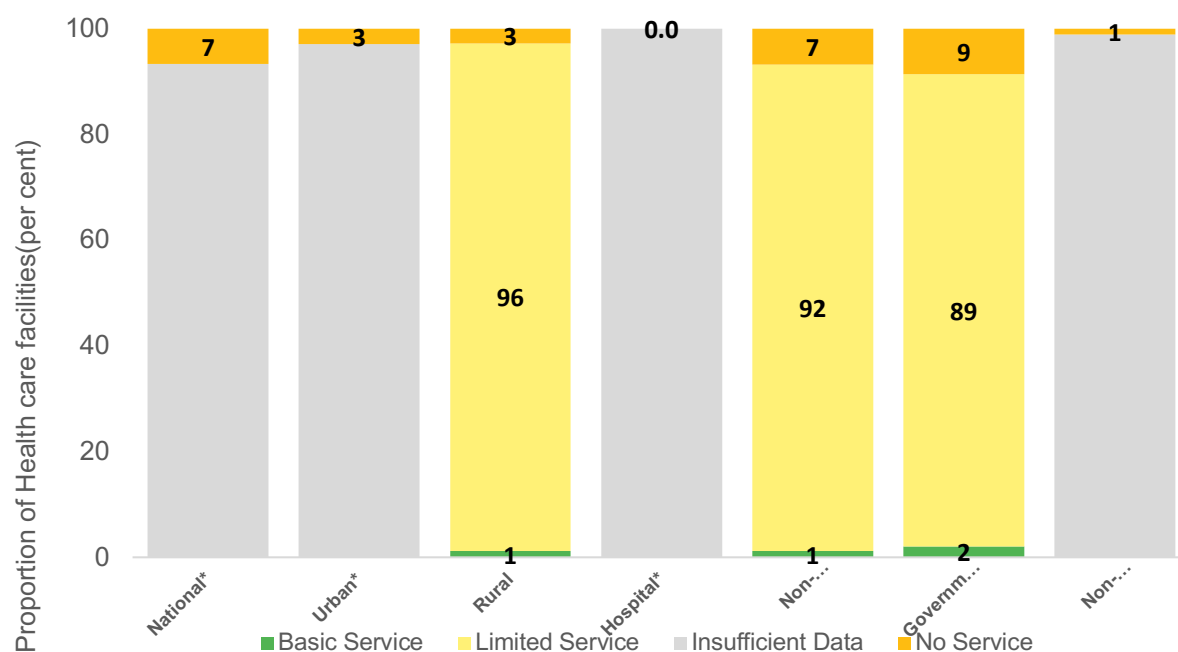
According to a WaterAid report, 60 per cent of HCFs provide less than a 'basic service' of water while some facilities have no water, sanitation or hygiene (WASH) services at all—and approximately 7 per cent of HCFs have no toilet (WaterAid, 2020).<sup>167</sup> The Zambia DHS does not systematically collect data on sanitation in HCFs. Available statistics show that across the board, there is limited services for sanitation

<sup>166</sup> WHO UNICEF 2021, *JMP 2021 progress report on WASH in households*, WHO/UNICEF, 22 July, Available at: <https://washdata.org>

<sup>167</sup> WaterAid 2020, *Wash Matters*, WaterAid, Available at: < <https://www.wateraid.org/where-we-work/zambia>

in the country. For rural, non-hospital and government HCFs presenting data, about 90 per cent and above have limited services while only between 1 per cent and 2 per cent have basic sanitation services. Government HCFs have the highest incidence of no service at 9 per cent, followed by non-hospital at 7 per cent and rural HCF at 3 per cent.

Figure 5: WASH services in healthcare facilities



Source: WHO/UNICEF JMP (2020/1).<sup>168</sup>

The Government of Zambia has set targets by 2022 for WASH in HCFs; aiming for 90 per cent of facilities to have basic water and basic sanitation and 80 per cent to have adequate health care waste management and hand washing facilities at critical points.

### WASH at household level

Disparities between urban and rural areas in access to improved water sources persist at household level. According to the Zambia (DHS 2018)<sup>169</sup>, 72 per cent of households had access to an improved water source, although access is more predominant in urban (92 per cent) than rural (58 per cent) households. The most common sources of drinking water in urban households are water piped into the household's dwelling, yard or plot (41 per cent); water from a public tap or standpipe (16 per cent); and water piped to a neighbour (15 per cent). In contrast, rural households rely predominantly on tube wells or boreholes (36 per cent), followed by protected dug wells (14 per cent). Forty-two per cent of rural households obtain their drinking water from an unimproved water source, as compared to 8 per cent of urban households. The percentage of households with an unimproved source of drinking water decreases with increasing wealth. This creates significant inequities for children in rural households who mostly bear responsibility for fetching or pumping water, creating time poverty for rural children and

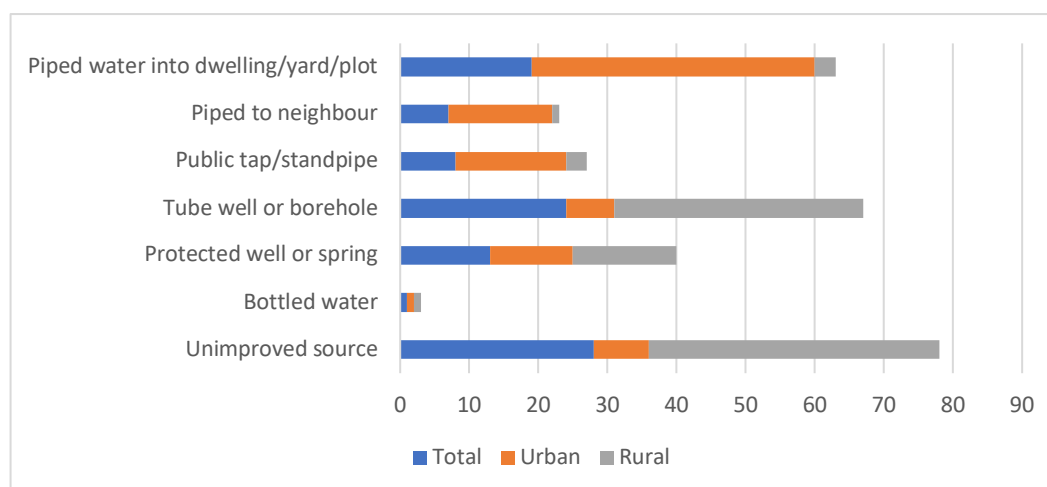
<sup>168</sup> WHO/UNICEF 2021, *JMP 2021 Progress Report on WASH in Households*, WHO UNICEF, Available at: <https://washdata.org>

<sup>169</sup> Zambia Statistics Agency, Ministry of Health (MOH) Zambia, and ICF. 2019. *Zambia Demographic and Health Survey 2018*, Zambia Statistics Agency, Ministry of Health, and ICF, Available at: < <https://dhsprogram.com/pubs/pdf/FR361/FR361.pdf> >



depriving them of free time for education and leisure. See figure below distribution of households by source of drinking water.

Figure 6: Percentage distribution of households by source of drinking water



Source: Authors' construction based on (DHS 2018)<sup>170</sup> data

Sixty-four per cent of Zambia's population has basic drinking water service, while 6 per cent has limited drinking water service. Access to basic drinking water service varies widely by province, from 36 per cent in Northern to 91 per cent in Lusaka. Access to basic drinking water service increases with rising wealth; however, there is no clear association between household wealth and limited drinking water service.

### WASH in emergencies

Historically, Zambia has been a stable and peaceful country. Nevertheless, Zambia records recurring emergencies because of changing weather patterns (droughts and floods) and public health threats (such as COVID-19 and Cholera). In some cases, emergencies are spurred by spill over effects from neighbouring countries in armed conflict and violence. With no potable water or adequate sanitation and hygiene facilities, children, especially those already suffering from malnutrition and weakened immune systems, become even more susceptible to water-borne diseases. To prevent the outbreak of a PHE, WASH services must be prepared to support children and their communities in times of crisis – including during armed conflict and other fragile contexts.

In 2017, Zambia suffered a cholera outbreak in the country's capital. Cholera cases increased rapidly, from several hundred cases in early December 2017 to approximately 2,000 by early January 2018. One of the key responses in the multifaceted public health response was water-related preventive action, which included: increased chlorination of the Lusaka municipal water supply; provision of emergency water supplies; and water quality monitoring and testing. The water-related preventive actions cholera cases sharply in January 2018. However, in mid-March, heavy flooding and widespread water shortages occurred, leading to a resurgence of cholera. By May 2018, the outbreak had affected seven of the 10 provinces in Zambia, with 5,905 suspected cases and a case fatality rate of 1.9 per cent.<sup>171</sup>

<sup>170</sup> Zambia Statistics Agency, Ministry of Health (MOH) Zambia, and ICF. 2019. *Zambia Demographic and Health Survey 2018*, Zambia Statistics Agency, Ministry of Health, and ICF, Available at: < <https://dhsprogram.com/pubs/pdf/FR361/FR361.pdf> >

<sup>171</sup> Sinyange N, Brunkard JM, Kapata N, et al. Cholera Epidemic — Lusaka, Zambia, October 2017–May 2018. *MMWR Morb Mortal Wkly Rep* 2018;67:556–559. DOI: <http://dx.doi.org/10.15585/mmwr.mm6719a5>.



While the Government and partners instituted rapid response water-related preventive measures that managed to control the outbreak, stakeholders have raised concerns about efforts to sustain these preventive measures. A Multisectoral Cholera Elimination Plan was developed in 2019, with more than 60 per cent focus on WASH. Targeted investments for implementation of the plan and tracking progress are required to ensure that the targets are achieved. Similarly, COVID-19 has underscored the importance of WASH in managing the spread of the disease, with especially increased emphasis on hand hygiene and water supply. Handwashing is an effective way to prevent the transmission of diseases, including COVID-19. The challenge is how to make changes in hygiene behaviour lasting and impactful on disease prevention and quality of life when WASH services are badly lacking. Recognising this deficit and the loss of revenue created by COVID-19, UNICEF, with funding from the Government of the Federal Republic of Germany through the KfW Development Bank and in partnership with the Ministry of Water Development, Sanitation and Environmental Protection (MWDSEP), provided water treatment supplies to 11 commercial water utilities to support the provision of continuous safe water supply, in both the first and second waves, to urban and peri-urban areas to over 6 million people served by the commercial utilities. Furthermore, the presence of large numbers of refugees in Zambia (over 94,000) has generated substantial humanitarian needs and has had great socioeconomic impact on host areas, which are in remote parts of the country and lack adequate access to WASH services.

## Sanitation

In Zambia, the MWDSEP has set out to strengthen the implementation of National Urban and Rural Water Supply and Sanitation Programmes. This involves WSS infrastructure development, water quality monitoring, and sanitation and hygiene promotion. The target of these efforts is to provide access to basic sanitation to 70 per cent of the urban population and 55 per cent of the rural population by December 2021 (MWDSEP 2018).<sup>172</sup> The likelihood of this target being met is high for urban areas as JMP data shows that 69.55 per cent of households have access to improved sanitation in urban areas up from 41 per cent in 2018 recorded in the ZDHS. However, the rural target is only likely to be met at the basic level with portions of the population living with limited (improved and shared), basic (improved and not shared) and improved sanitation, which stand at 5.9, 18.9 and 24.8 per cent, respectively. By province, the proportion of the population with improved sanitation facilities varies from a high of 80 per cent in Lusaka to a low of 6 per cent in Western. The proportion of the population engaging in open defecation is highest in Western (50 per cent) and lowest in Copperbelt, Lusaka, and Northern (1 per cent each). The 2018 ZDHS results show that 18 per cent of the population in the lowest wealth quintile has basic sanitation service, as compared with 65 per cent of the population in the highest wealth quintile. The proportion of the population with access to improved sanitation increased from 27 per cent in 2013–14 to 54 per cent in 2018 and is currently estimated at 66 per cent in 2020.<sup>173</sup>

## 7.4 Challenges, shortfalls and inequities

The key WASH sector challenges include funding gaps; low access to WASH services, especially in rural and peri-urban areas; lack of a comprehensive sector management information system leading to limited use of data for planning, targeting and management; and capacity gaps at the national and sub-national levels.

<sup>172</sup> Ministry of Water Development, Sanitation and Environmental Protection 2018, *Zambia Joint Water, Sanitation and Environment Sector Review Report 2018* Ministry of Water Development, Sanitation and Environmental Protection, Available at: < [https://www.mwdsep.gov.zm/?wpfb\\_dl=1213](https://www.mwdsep.gov.zm/?wpfb_dl=1213) >

<sup>173</sup> Zambia Statistics Agency, Ministry of Health (MOH) Zambia, and ICF. 2019. *Zambia Demographic and Health Survey 2018*, Zambia Statistics Agency, Ministry of Health, and ICF, Available at: < <https://dhsprogram.com/pubs/pdf/FR361/FR361.pdf> >

## Water supply

Water supply challenges in Zambia differ significantly between urban and rural areas. This also presents unique challenges for children based on where they reside. In general, access to clean water in the country is highly unequal, with 92 per cent of urban households having access to safe water in contrast to 58 per cent of rural households (UNICEF, 2019).<sup>174</sup> In urban areas, water supply challenges include water quality issues, aging infrastructure and increasing water scarcity. In industrial and mining towns, water pollution risks are also a major challenge, all of which have a significant bearing on children's, quality of life, wellbeing as well as health and time poverty. The continuing trend in mining activity, industrial emissions and urbanisation will place further pressure on the country's sources of water supply unless appropriate corrective action is taken.

In peri-urban settlements, water scarcity is mainly a result of unchecked usage, largely because water points are shared within communities, in majority of the cases. If current usage continues to go unchecked, it could place a strain on availability of economically usable underground water resources. While providing communal water facilities does reduce the drudgery of water sourcing for domestic use, it still takes time away from children to study, play and rest. Aging water infrastructure is a fundamental point of weakness in water supply in both urban and rural areas. In rural and peri-urban areas, where water supply initiatives emphasised borehole drilling to supply clean underground water, communities have reverted to the use of shallow wells for their water supply as the boreholes have become unusable, due to their state of disrepair. While statistics are not available to show the waste resulting from ageing and leaking infrastructure, this poses a profound challenge for access to water which ultimately impacts children in the immediate and threatens water security for the future. The problem is most intense in the capital city of Lusaka, where water and sanitation infrastructure built in the 1960s and 1970s for a population of 300,000 is insufficient to meet the needs of the current population of approximately two million. A study on peri-urban water sources in Lusaka found that 90 per cent of domestic water sources were from piped water divided into 65 per cent communal taps and 25 per cent piped water within the house. The second source was groundwater; representing 10 per cent. This included protected open wells (1 per cent), public borehole (6 per cent) and a borehole within the yard (3 per cent).<sup>175</sup>

## Coverage

While Zambia has made significant progress in WASH coverage, it is still not sufficient to meet the ambitious targets of the SDGs, with less than 9 years to their deadline. On all key metrics for WASH, Zambia is making slow progress and risks missing the 2030 milestone. With only an estimated average of 72 per cent of Zambian households having access to an improved water source, and only about 54 per cent to an improved sanitation facility (World Bank, 2020) coverage is lagging in targeted levels.<sup>176</sup> To make matters worse, disparities between rural and urban areas mean that rural populations are disproportionately uncovered by essential WASH services. Access to improved water in rural areas is at 51 per cent, whereas urban is 89 per cent. Sanitation access in rural areas is at 19 per cent, whereas

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<sup>174</sup> UNICEF 2019, *Progress on household drinking water, sanitation and hygiene, 2000-2017*, UNICEF Data, Available at: < <https://data.unicef.org/resources/progress-drinking-water-sanitation-hygiene-2019/> >

<sup>175</sup> Lillian Mutesu Silavwe, Kunda Ndashe, Edgar Mulwanda, Allan Mbewe and Bornwell Sikateyo 2018, *An Assessment of the Quantity and Microbiological Quality of Domestic Water Supplied to Residents of Peri-Urban Townships of Lusaka District, Zambia*, Journal of Preventive and Rehabilitative Medicine, Vol. 1, No. 1, 2018, pp. 32-38, Available at: < [https://www.unza.zm/sites/default/files/article\\_files/2018-08/An\\_Assessment\\_of\\_the\\_Quantity\\_and\\_Microbiological\\_Qality.pdf](https://www.unza.zm/sites/default/files/article_files/2018-08/An_Assessment_of_the_Quantity_and_Microbiological_Qality.pdf) >

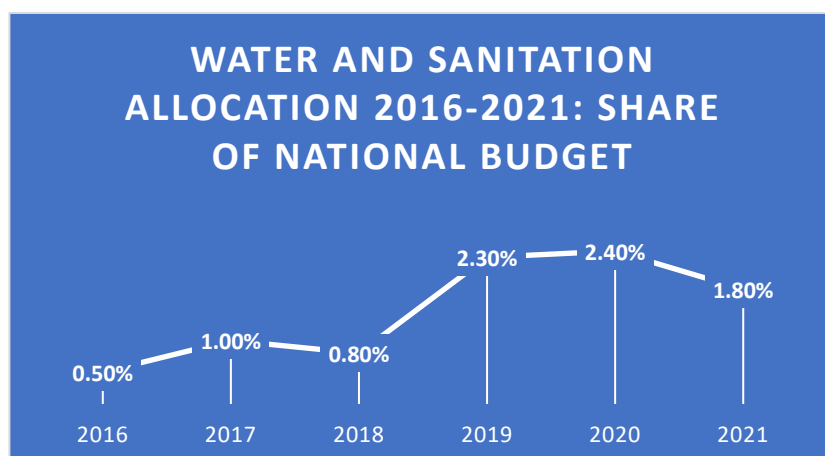
<sup>176</sup> World Bank (2020) Zambia Water Supply and Sanitation Sector Diagnostic Narrowing the Gap between Policy and Practice. Available at: <https://openknowledge.worldbank.org/bitstream/handle/10986/34067/Zambia-Water-Supply-and-Sanitation-Sector-Diagnostic-Narrowing-the-Gap-between-Policy-and-Practice.pdf?sequence=6>

urban is 49 per cent. Approximately 19 per cent of Zambians practice open defecation. Access rates have remained almost stagnant over the past 15 years. In addition, increased urbanisation is placing a strain on WASH services and infrastructure as this results in growing unplanned peri-urban settlements. As a result, data shows not only limited availability of WASH services, but poor quality of service in small rural towns and peri-urban areas.

### WASH financing

As Zambia continues to edge towards the achievement of SDG 6 and the Vision 2030 ambitions for WASH, the need for greater expenditure, becomes inevitable. Over the years, Zambia's WASH sector budget registered a reducing trend in allocations both in nominal and real terms, which has perilous implications on achieving sector outcomes. WaterAid Zambia's assessment of WASH financing found that WASH has not been prioritised. For ten successive years up to 2018, the sector was allocated 0.1–0.3 per cent of GDP. Less than 40 per cent of what was allocated was disbursed. In total, an allocation of K2.1 billion was set aside in 2021 towards WASH programmes and projects. Through the implementation of the National Urban and Rural Water Supply and Sanitation Programmes, Zambia continues to make progress in improving coverage, quality and efficiency of water supply and sanitation. The developments include water supply projects focusing on provision of piped water and drilling and rehabilitation of boreholes as well as drainage provision. The projects are envisaged to reach over 1,200,000 people or about 7 per cent of the population. While this is commendable, a Zambia Council for Social Development 2021 Budget Analysis, shows that the allocation towards the WASH sector in 2021 reduced from 2.4 per cent in 2020 to 1.8 per cent (Wakunuma and Chewe, 2020). This speaks to the deprioritisation of the WASH sector, at a critical time for the Public Health context and the trajectory towards achieving the WASH goals in the SDGs (see Figure 7).

Figure 7: A trends analysis of budget allocation to WASH



The reduced allocation to WASH could have serious implications for the public health situation in the country. WASH is essential to prevention of key public health outbreaks. For instance, one of the key preventive measures against the spread of COVID-19 is frequent handwashing with soap and running water. Also, the likely outbreak of Cholera requires enhanced WASH infrastructure and services to adequately deal with it. Another gap identified in the 2021 Budget is the failure to provide innovative means of mobilizing resources for the WASH sector. This, along with the poor budget performance of WASH budgets over the years, threaten the sustainability of the sector.

### **Comprehensive WASH sector management information system**

To effectively plan, finance, target and manage WASH programmes, services and their performance, consolidated data and monitoring becomes important. Several initiatives have been implemented to support Management information systems., However, these have been piecemeal and focused on specific themes. The lack of a comprehensive sector Management Information System leading to limited use of data for planning, targeting and management

## **7.5 Stakeholder landscape and initiatives**

Understanding the stakeholder environment is important for ensuring greater coordination between government, donors, other development partners and communities at all stages of resourcing, implementation and accountability. In the absence of effective coordination, neither government, donors, development partners nor communities can be held accountable. In Zambia, WASH services are the responsibility of central and local government. However, many other stakeholders support the efficient delivery of these services in the country. The stakeholders can be categorised broadly into public (government), international, NGO and private sector stakeholders. These stakeholders support the sector in a whole range of ways across the water and sanitation supply chain. Stakeholders have also mobilised themselves to contribute in different ways to the key WASH themes that government has identified as priority for the period of the SDGs. Further, the Government has also designed region responsive strategies with a specialised focus on rural, urban and peri-urban to ably respond to the unique needs of the different regions.<sup>177</sup>

Zambia has three main regulators in the WASH sector. The National Water Supply and Sanitation Council (NWASCO), established under the Water Supply and Sanitation Act No. 28 of 1997 to regulate the provision of WSS services. NWASCO is responsible for regulation of water supply and sanitation service providers, with a mission of ensuring sustainable service delivery balancing commercial orientation and social consideration and increasing access to affordable safe water and acceptable sanitation, while also enhancing public awareness. The WARMA is Zambia's independent regulator responsible for Water Resource Management. It was established through the Water Resources Management Act No. 21 of 2011 with the purpose of serving as the regulatory body for the management and development of water resources in the whole country and ensuring equal access to water for the various stakeholders. Zambia Environmental Management Agency (ZEMA) is responsible for environmental protection. The agency works with relevant authorities to develop standards and guidelines relating to the protection of air, land, water and other natural resources.

The key government ministries working in WASH and related sectors include the Ministry of Water Development, Sanitation and Environmental Protection (MWDSEP) which is responsible for the development and management of water resources, provision of water supply and sanitation as well as environmental management. The mandate of the Ministry is to provide policy guidance in the water and environment sectors. Ministry of Local Government and Housing (MLGH), the Ministry of Lands and Natural Resources. Other than that, the MoH is responsible for water quality regulation. Other Line Ministries include the MOCTA, the Ministries responsible for Education, the Ministry of Finance (MoF) and Ministry of National Development Planning (MNDP). These Ministries play the primary functions of providing policy leadership, resourcing, coordination and oversight. A range of Cooperating Partners and United Nations Agencies work in the WASH sector providing support to the Government to deliver on its WASH ambitions. These partners include UNICEF, the Department for International Development (DFID), African Development Bank (AfDB), Habitat for Humanity, the European Union (EU), German

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<sup>177</sup> Regions here refers to urban, peri-urban and rural areas

Development Cooperation (GIZ), Japan International Cooperation Agency (JICA), KfW, the World Bank and USAID. The partners are particularly involved in providing finance, capacity development and technical assistance to the sector. Their assistance in capacity development covers policy, legal, institutional, organisational and skills development. Other key stakeholders include International NGOs such as World Vision, Water Aid, SNV, Oxfam, Plan International, Save the Children, CRS, Child Fund and Care International. INGOs provide advice, engage in policy dialogue and supplement government efforts through service delivery and project implementation. NGOs have also come together under the NGO WASH Forum. The NGO WASH forum includes both international NGOs and local NGOs such as Environment Caretakers Organisation, Volunteer for Zambia (V4Z), Zambia Green Building Association, Village Water Zambia, Enviro San Zambia and Youth Environmental Education Organisation. These provide checks and balances as well as platforms for information sharing and policy advocacy. The private sector's current participation is mainly through provision of consultancy services, service delivery, development of infrastructure and supply of tools and equipment.

## 7.6. Sector specific recommendations

**Adopt a more committed financing mechanism for the WASH sector** to enable a sustained and proactive implementation of preventive measures and investment in WASH infrastructure and maintenance for the continuous and sustained supply of clean and sufficient WASH in homes and underserved communities as well as in schools and healthcare facilities.

**Heighten commitment to promoting hygiene** at legislative, policy, planning, programming and financing levels. Government, local government, international development partners, NGOs and the private sector need to cooperate effectively to scale up and sustain hygiene promotion, including hand hygiene, as well as trigger and sustain demand for sanitation at household, community and district levels.

**Build equity considerations into the supply of WASH services and infrastructure** to ensure that gender needs and those of other vulnerable groups, such as persons with disabilities, children and adolescents are met. This can be informed by understanding the implications of WASH deficits on these different groups and the foregone cost to national development.

**Leverage non-traditional private sector investment** to contribute to the provision of WASH infrastructure, communication and commodities to reach excluded households and communities. This should be driven by child-sensitive and gender-transformative programmes and measures that support the national urban, peri-urban and rural WASH Programmes.

**WASH financing to respond to emergencies resulting from both public health and climate shocks**, such as COVID-19 and Cholera or droughts and floods remains a huge area of concern with the repeated failure to ensure financing for the Multisectoral Cholera Elimination Plan over the years. It will be important for Zambia to provide a climate resilient and emergency responsive financing strategy that prioritises the needs of children in times of crisis.

**Strengthen systematic and regular collection of National WASH data** at different levels to ensure the provision of appropriate and adequate child-sensitive WASH services and commodities distinguishing between needs of different age groups of children, adolescents as well as their communities and public institutions that children access regularly.

**Strengthen national and sub-national capacity** in planning, implementation and monitoring of WASH programmes and projects.

**Continue to implement the National Water and Sanitation Policy** and the sector regulatory frameworks and monitoring their implementation to ensure coordinated and effective WASH sector interventions. This includes development of a sector management information system.

# CHAPTER 8. ADOLESCENCE

## 8.1 Introduction

Adolescents account for over a quarter of the total population and have unique health concerns. Health risks for adolescents include early and unprotected sex, GBV, teenage pregnancies, substance abuse, accidents and mental illness. Adolescents are particularly susceptible to both non-communicable and communicable diseases, such as sexually transmitted infections, including HIV and AIDS. Several interventions have been implemented to protect adolescents and to improve their health status. Major efforts are being made to reduce early marriages and teenage pregnancy.

## 8.2 Legal and policy framework

The CRC does not draw a distinction between ‘children’ and ‘adolescents’, however, the Constitution of Zambia (Amendment Act, No. 2) of 2016 defines a child as being a person aged 18 years and defines a young person as “a person who has attained the age of fifteen years but is below the age of nineteen years”. Thereby covering all the bracket ages of adolescence. Young persons are protected from exploitation under the following legal policy and framework:

- The Constitution of Zambia (Part III) contains provisions that protect the fundamental rights and freedoms of the individual; Article 24 specifically protects children’s rights (Constitution, 1991);
- The Penal Code protects children from exploitation and related vices (partial domestication of the CRC);
- Anti-Gender Based Violence Act, and now the Anti-GBV and Fast Track Courts;
- Employment of Young Persons and Children Act;
- Anti-Human Trafficking Act;
- Sections 17 and 34 of Zambia’s Marriage Act, which require parental consent if either party involved in a marriage is under the age of 21 years and prevents anyone married under the Act from engaging in further customary law marriages;
- National Child Policy (NCP); and
- National Youth Policy.

### **The policy and legal framework relating to juvenile justice**

- a. The National Child Policy and Plan of action
- b. The Legal Aid Policy
- c. The National Diversion Framework
- d. The Education Policy
- e. The Social Protection Policy
- f. National Youth Policy

### **The following are the statutes:**

- a. The Constitution
- b. The Penal Code Act
- c. The Narcotic Drugs and Psychotropic Substances Act 35 of 2021
- d. The Juveniles Act Cap 53 of the laws of Zambia
- e. The Criminal Procedure Code Act
- f. Affiliation and maintenance of Children Act
- g. Anti-Human Trafficking Act
- h. Adoption Act

- i. Education Act
- j. Day Nurseries' Act
- k. Birth and Deaths Registration Act, Cap 51
- l. Employment of Young Persons and Children Act

There is a notable scarcity of policy instruments that are specific to adolescents, although some national instruments and documents include explicit priorities related to adolescents and youth. The 2015 National Youth Policy and National Prevention and Response Plan on ending Violence against children (2021–2025) includes adolescents as well youths: classifying a youth as a person aged 15–35 years. A critical area of policy intervention includes empowering youths through skills development, health and education, and there is also a need to ensure a distinction between adolescents and older youths (according to the United Nations, adolescents are defined as females and males aged 10–19 years). Adolescent stage is characterised by a time of transition that is a gateway to adulthood. During adolescence, gendered roles and responsibilities often create opportunities for males but curtail opportunities for females. As described in earlier chapters, adolescents are a key demographic group in Zambia and make up 34 per cent of the population. This is expected to more than double in the coming decades: from 3.7 million to 9.8 million in 2050, thus adding challenges for society to provide health, education and job training services to prepare adolescents for a productive future.

*Table 13: Population of adolescents by gender*

Year 2017	Female		Male	
Age Group	Number	Percentage of total female population	Number	Percentage of total male population
10–14 years	1,116,288	13%	1,127,971	13.3%
15–19 years	966,116	11.2%	970,964	11.4%
20–24 years	802,867	9.3%	801,441	9.4%

Source: Global Revision of the World Population Prospects 2017.

### 8.3 Levels, trends and differentials in key indicators

In Zambia, gender inequalities are present across people's lives, however the gender divide is particularly prominent starting in adolescence. As observed in previous situation analyses, there is also tremendous regional variation in data available on adolescents.

#### Adolescent fertility

In Zambia, the Age of Consent for sexual intercourse is 16 years for both boys and girls. There are no legal age restrictions on access to contraceptive services and commodities per se. The Government has developed several policies to ensure access to family planning for young people to improve their health status. However, as the Age of Consent to sexual intercourse is 16 years, access to any form of contraceptive, including barrier methods, is denied to any person under this age unless there is parental consent.<sup>178</sup>

#### Policy initiatives on contraception and commodities

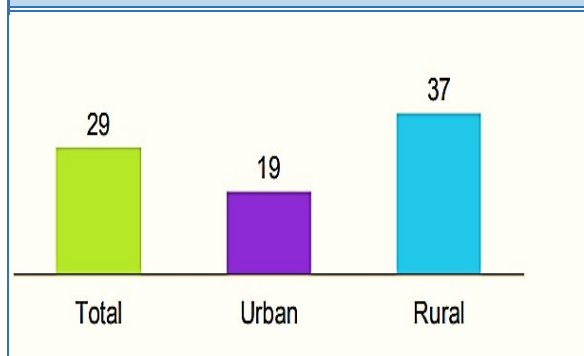
Family Planning Services Integrated Family Planning Scale-up Plan 2013–2020 states that youth-friendly Service points will be established in each district in existing government buildings, such as sports complexes and administrative blocks. The rooms will be refurbished with family planning materials and necessary supplies. Peer educators, who are trained to dispense pills and condoms, will staff the service points.



In 2018 the ZDHS collected data on pregnancy in late adolescence (ages 15–19 years) showing that 29 per cent of adolescents had begun childbearing at the time of the survey, whilst 24 per cent had given birth, and a further 5 per cent were pregnant with their first child. Figure 8 illustrates the variation in adolescent pregnancy by urban and rural location of women, aged 15–19 years, who have begun childbearing, with such pregnancies in rural areas standing at 37 per cent, and in urban areas at 19 per cent of all pregnancies.<sup>179</sup>

Although sexual intercourse with a person under the age of 16 years is illegal, the 2018 ZDHS indicates that adolescents are engaging in sexual behaviour before this age. Among the older adolescent population (ages 15–19 years), 13 per cent of girls and 16 per cent of boys had sexual intercourse by the age of 15 years.<sup>180</sup> However, an exception to the Age of Sexual Consent is made if the couple is married under customary law. Teenage pregnancy in many settings is a precursor to child marriage, as parents would prefer the adolescents to get married to formalise the relationship and to avoid community shame.

*Figure 8: Percentage of women aged 15–19 years who have begun childbearing by residence*



According to the 2018 ZDHS, only 2 per cent of girls and less than 1 per cent of boys aged 15–19 years were married by the age of 15 years. Since 2001–02, there has been a slight decrease in the percentage of teenagers who have given birth or are pregnant; 5.9 per cent in 2001, compared with 4.7 per cent in 2018.<sup>181</sup> The fieldwork investigated factors associated with adolescent pregnancy and early motherhood in Zambia, in addition to the data from the 2018 ZDHS. The analysis demonstrates that adolescent pregnancy rate reduces as education levels of the adolescents increases. A study by the Population Council and UNFPA in 2015 identified where adolescent pregnancy and early motherhood is most likely to occur in Zambia.<sup>182</sup> The study suggested that 45 per cent of the girls aged 15–19 years from the lowest wealth quintile had been pregnant, compared to 10 per cent girls in the highest wealth quintile—indicating that being poor and living in rural areas predisposes adolescents to pregnancy and early motherhood, and that teenagers in rural areas are much more likely than their urban counterparts to have begun childbearing. By province, teenage pregnancy ranges from a low of 15 per cent in Lusaka to a high of 43 per cent in Southern.<sup>183</sup>

<sup>179</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory - UTH-VL, and ICF. 2020. Zambia Demographic and Health Survey 2018. Lusaka, Zambia: ZSA, MOH, UTH-VL and ICF. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>. P.112.

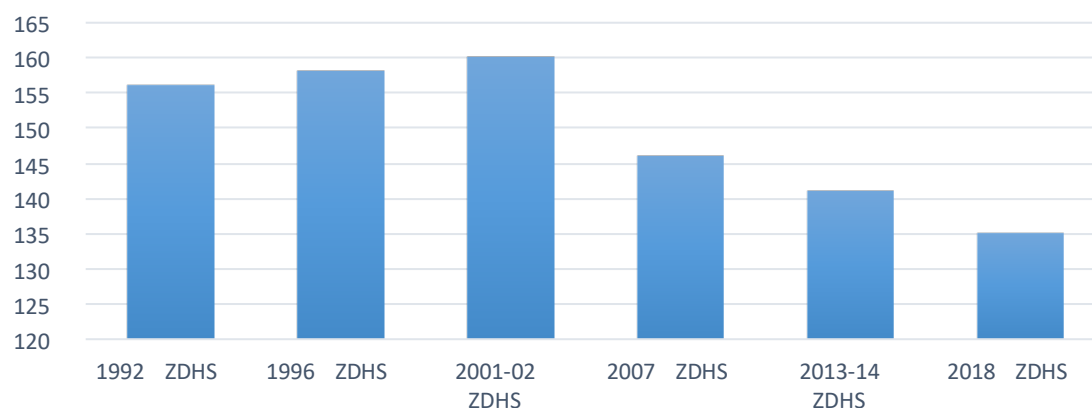
<sup>180</sup> Ibid.

<sup>181</sup> Ibid.

<sup>182</sup> Population Council and UNFPA, 2017, Adolescent Pregnancy In Zambia. Available at [https://www.popcouncil.org/uploads/pdfs/2017RH\\_AdolPregnancyZambia\\_brief.pdf](https://www.popcouncil.org/uploads/pdfs/2017RH_AdolPregnancyZambia_brief.pdf).

<sup>183</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory, and ICF. 2020. Zambia Demographic and Health Survey 2018. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>. P. 112.

Figure 9: Trends in age-specific and total fertility rates per 1,000 births for 15- to 19-year-olds (ZDHS 2018)



During FGDs, community members referenced poverty, deprivation and the cost of living as drivers of adolescent pregnancy.<sup>184</sup>

“And what is causing this [teenage pregnancy] is that the cost of living is hard, to the extent that households are only able to provide only one meal a day. That is why the young girls are taking to having relationships with men in the hope that these men will provide for their needs. When the father is unable to provide for a daughter’s school needs, yet there is a young man who is promising to look after her if she becomes his girlfriend, the young girl is enticed and ends up pregnant. In my neighbourhood alone I have seen about 15 to 20 girls, this [early pregnancy] is happening and that’s why the government has introduced the re-entry policy because this [early pregnancy] is happening in communities.”

Teenage pregnancy can have multi-generational effects, for example, the Young Lives Longitudinal Study showed that a child born to a stunted adolescent mother had a 15 per cent increased chance of being stunted themselves.<sup>185</sup> Furthermore, early motherhood is also associated with adverse neonatal outcomes. In one study,<sup>186</sup> it was found that the risk of experiencing obstructed labour, premature rupture of membranes and postpartum haemorrhage was higher among adolescents (aged 10–14 years) than in women aged 20–24 years. The study further shows that adolescents are 1.36 times more likely to have a low-birth-weight baby and were also at risk of preterm birth. Similarly, UNICEF’s (2014) comprehensive analysis of adolescents in Zambia states that “unplanned adolescent pregnancy is a major health concern because of its association with higher morbidity and mortality for both mother and child.”<sup>187</sup>

### Adolescent health

Zambia has prioritised adolescent health because of the demographic dividend opportunity this presents and has done so by expediting progress towards socioeconomic development, in line with Vision 2030 and the 2030 SDGs. The Adolescent Health Strategy 2017–2021 developed with the support of UNFPA-

<sup>184</sup> FGD with Community Members, District Kitwe, Copperbelt Province.

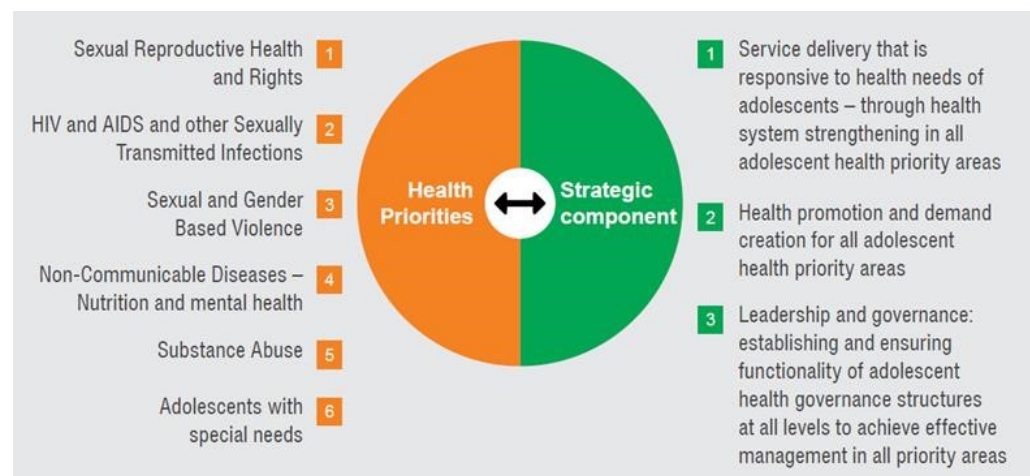
<sup>185</sup> Benny, L. et al. 2017. *Maternal Under-nutrition and Childbearing in Adolescence and Offspring Growth and Development in Low- and Middle-Income Countries: Is adolescence a critical window for interventions against stunting?* Working Paper 165.

<sup>186</sup> Tembo, T., Koyuncu, A., Zhuo, H. et al. “The association of maternal age with adverse neonatal outcomes in Lusaka, Zambia: a prospective cohort study.” *BMC Pregnancy Childbirth* 20, 684 (2020). <https://doi.org/10.1186/s12884-020-03361-5>

<sup>187</sup> UNICEF 2014. “The report card on adolescents in Zambia”. Available at <https://www.unicef.org/zambia/media/786/file/Zambia-adolescents-report-card-2014.pdf>.

UNICEF Global Programme to End Child Marriage, is working in tandem with the NHSP 2017–2021 and has prioritised health system strengthening as a pathway to attain UHC, using the PHC approach. The Adolescent Health Strategy outlines measures to mitigate incidences of teenage pregnancy and unsafe abortion. Reflecting the priorities of the Adolescent Development and Health (ADH) Strategy 2017–2021, the National Operational Plan 2017–2021 sets out the roadmap for achieving the adolescent health objectives. The diagram below highlights the strategic components of the operational plan for service delivery, health promotion and demand creation, and leadership and governance.

*Figure 10: National Operational Plan 2017–2021: Six priority areas and delivery modalities for promotion of adolescent health and well-being.*



The MoH has a RMNCAH and Nutrition Communication and Advocacy Strategy 2018–2021. A key objective of this strategy is “to more effectively target and serve adolescents and youth with quality accessible sexual and reproductive health (SRH) information and services in and out of school.”<sup>188</sup> According to the ZDHS 2018 data, 98 per cent of the 3,000 women aged 15–19 years surveyed had heard of contraception, and the contraceptive prevalence rate for modern family planning methods among adolescent girls aged 15–19 years was 12 per cent.<sup>189</sup> The most common form of contraception used amongst young women is injectable, as this is used by 7.8 per cent of the 3,000 women surveyed. The unmet need for family planning among sexually active unmarried adolescents aged 15–19 years was high at about 59 per cent.<sup>190</sup>

### Adolescent nutritional status

With the focus on maternal and child nutrition, there is limited up-to-date information around adolescent nutritional status. Adolescence is a critical window of opportunity for interventions to improve nutritional status. As noted in the chapter on nutrition, there are a myriad of nutrition-related strategies, guidelines and plans that include adolescents as one of many target population groups. Those of relevance to adolescents include:

- School Health and Nutrition Policy
- National Food and Nutrition Policy, 2006

<sup>188</sup> MoH (2018) Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Communication and Advocacy Strategy 2018–2021. [https://www.moh.gov.zm/?wpfb\\_dl=111](https://www.moh.gov.zm/?wpfb_dl=111). P. 17.

<sup>189</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory, and ICF. 2020. *Zambia Demographic and Health Survey 2018*. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>. P. 152.

<sup>190</sup> Zambia Demographic and Health Survey 2018 data. Accessed through Statcompiler.com/eng.

- School Health and Nutrition Programme (SHN)
- ADH strategy 2017–2021

Adolescent nutrition includes both under and over nutrition, which is frequently unnoticed by families or the individual themselves. Negative effects of malnutrition persist throughout the reproductive life and are passed on to offspring; subsequently affecting health and productivity. In the 2004 Zambia Global School Health Survey, 31 per cent of the females and 27 per cent of the males reported that they had gone hungry most of the time during the previous 30 days due to not having enough food at home (based on a sample of 2,257 learners from grades 5 to 7).<sup>191</sup> Twelve years later, another study conducted in Mongu and Mumbwa districts among 410 adolescent girls aged 14–19 years found that only 42 per cent had breakfast regularly, and only 41 per cent reported easy access to food at any time.<sup>192</sup> The latest ZDHS (2018) also indicates that 16 per cent of adolescent girls aged 15–19 years are underweight, while about 9 per cent of the girls in the same age group are obese.<sup>193</sup>

Research findings highlight that when separated by place of residence, education and wealth index, differences between adolescents became apparent, for example, those in rural areas were more likely to be underweight. In addition, adolescents with primary education, and from the poorest, or poorer and middle-income households were more likely to be underweight. A positive correlation is present between diet diversity score and the adolescents' nutritional status, however, an independent sample t-test revealed that differences exist between urban and rural adolescents in terms of dietary intake.<sup>194&195</sup> The 2021 SUN National Conference in Zambia reported COVID-19 has also exacerbated these nutritional issues: mean number of food groups consumed by children is in decline; there is also an overall decline in proportion of women achieving the minimum dietary diversity diet, and incidences of hunger have increased.<sup>196</sup> More households reported to have experienced moderate and severe hunger in March 2021. This is also an indication that more households were sliding into poverty. Field data from CSO's indicates that adolescents, especially in urban areas, suffer more from food poverty because of decline in household income; adolescent mothers were especially at risk and less likely to receive COVID-19 Government assistance. According to the 2018 ZDHS data, adolescent females had a higher prevalence of anaemia compared to other age groups (33.4 per cent compared to 28.6 per cent in 20- to 29-year-olds).<sup>197</sup> On average one third (31 per cent) of women aged 15–49 years were anaemic. Anaemia is a serious concern for children because it can impair cognitive development and is associated with long-term health and economic consequences (STC 2016).<sup>198</sup> This also affects young mothers, as adolescents are most likely to get pregnant before their growth is completed, thus increasing nutritional demands, and leaving them prone to nutritional deficiencies. According to the Adolescent Health Strategy and National Operational Plan for Adolescent Health Strategy 2017–2021, improvement in adolescent awareness and knowledge around nutrition is a critical factor in addressing the cross-cutting issues around HIV/AIDs, Sexual and reproductive health and rights (SRHR), SGBV and mental health. Integrated nutrition packages are to be implemented within ANC/PMTCT for adolescent mothers in all

<sup>191</sup> MOH 2017, Adolescent Health Strategy 2017–2021.

<sup>192</sup> World Food Programme, 2016. The Barriers to HIV Prevention and Adequate Nutrition among Adolescent Girls.

<sup>193</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory, and ICF. 2020. *Zambia Demographic and Health Survey 2018*. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>.

<sup>194</sup> Bwalya, Bupe. (2015). "Nutritional Status Among Female Adolescents Aged (15–19 years) in Zambia: Why it Matters." 1

<sup>195</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory, and ICF. 2020. *Zambia Demographic and Health Survey 2018*. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>.

<sup>196</sup> Mofya-Mukuka (2021). IAPRI Monitoring Household Food Security and Nutrition During COVID-19.

<sup>197</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory, and ICF. 2020. *Zambia Demographic and Health Survey 2018*. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>.

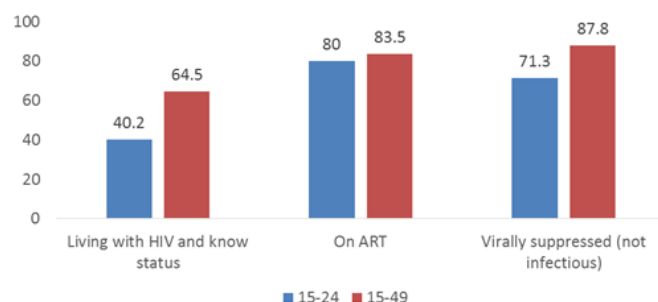
<sup>198</sup> Save the Children, 2019 Malnutrition in Zambia: Harnessing social protection for the most vulnerable.

targeted districts by 2021.<sup>199</sup> The National Food and Nutrition Commission (NFNC) supports youth friendly corners in government health facilities to provide technical guidance and nutrition Information, Education and communication materials to healthcare workers. The NFNC is also a partner of the School Health and Nutrition Program, offering technical backstopping for the implementation of school health and nutrition activities, for both primary and secondary school going children of disadvantaged backgrounds. However, there is a scarcity of programmes that explicitly address adolescent nutrition, even though adolescent nutrition is reflected in national strategies and plans.

### Adolescence and HIV

While Zambia has made great strides in attaining the 90:90:90 targets for the overall population of people living with HIV, some important subpopulation groups, such as adolescents, lag. For example, the Zambia Population based HIV Impact Assessment (ZAMPHIA) of 2016 showed that there were marked age differentials in progress towards 90:90:90 targets as illustrated by Figure 11. However, selected indicators from facility-based data show that the situation is unlikely to have changed although improvements have been noted across all age groups. For example, 2020 HIV estimates indicate that only about 53 per cent of adolescents living with HIV aged 10–19 years are currently on ART compared to 80 per cent coverage among adults.<sup>200</sup>

Figure 11: Progress towards 90:90:90 targets in 2016 in percentages



Furthermore, new HIV infections are declining at a slower rate among adolescents and young people and the burden of HIV is increasing in this age group. At present, adolescents and young people 15–24 years contribute to 40 per cent burden of new HIV infections and yet they account for only 20 per cent of the population (NAC, 2020). Lack of HIV prevention knowledge, low uptake of essential HIV interventions by adolescents and young people are among factors leading to new HIV infections. For example, the percentage of young people aged 15–24 years with comprehensive knowledge about HIV is 43 per cent among young women and 41 per cent among young men.<sup>201</sup> The percentage of young men aged 15–24 years with comprehensive knowledge about HIV rose from 37 per cent in 2007 to 47 per cent in 2013–14, before decreasing to 41 per cent in 2018. Among young women, the percentage increased from 34 per cent in 2007 to 42 per cent in 2013–14, and 43 per cent in 2018. In 2018, the prevalence of HIV among adolescent girls aged 15–19 years was 2.6 per cent compared to 1.2 per cent for boys of the same age.<sup>202</sup> A study examining risk factors (i.e., community, family and peers) for HIV

<sup>199</sup> No data to show if this is being done now.

<sup>200</sup> UNAIDS HIV Epidemiological Estimates, Zambia data. Available at <https://data.unicef.org/resources/dataset/hiv-aids-statistical-tables/>. (Accessed Sep 2021).

<sup>201</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory, and ICF. 2020. *Zambia Demographic and Health Survey 2018*. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>.

<sup>202</sup> Ibid.

among 250 street youth aged 14–24 years in Lusaka revealed, in terms of HIV knowledge, that though the youth can correctly identify some of the ways in which HIV can be transmitted, they still have many misconceptions: a sizeable number of youths were unaware that a pregnant woman can pass HIV to her child. It was found that HIV knowledge varies by gender and age.<sup>203</sup> Results show that two variables were statistically significant: those who do not have a home to return to (i.e., homeless youth) were significantly more likely to be HIV positive (31.3 per cent), compared to youth who have a home to return to; and youth who reported that a parent or caretaker misused drugs were significantly more likely to be HIV positive (12.5 per cent) compared to youth whose parents did not have a drug problem.<sup>204</sup> It was noted that parents who misuse drugs are more likely to convey to their child that drug use is acceptable, which may result in higher drug abuse among the youth, and yet drug abuse is a known risk factor for HIV transmission.

Given that being homeless was significantly related to HIV status—youth who did not have a home to return to were over three times more likely to be HIV positive, it is therefore prudent for governmental strategies to include orphans and children most at risk of being homeless as part of Government aid strategy. It is plausible that, for survival reasons, this group of youth engages in high-risk behaviours, one of which may be trading sex (as noted during FGD discussions). Findings around street youth and HIV underscores the fact that, though education about HIV is increasing, there is still room for further improvement as many youths still incorrectly answered questions about how HIV is transmitted and prevented. Education targeting street youth regarding HIV knowledge, as well as potential risks for HIV and its link with substance abuse and sexual risk behaviour, is warranted. Moreover, future studies should include measures of sexual risk-taking behaviour (e.g., trading sex) along with substance use and HIV testing so that the government can more accurately determine the prevalence rate of HIV among Zambian street youth. Additionally, future research may wish to examine positive elements offer protective behavioural strategies against using alcohol and drugs, which may serve to lower the risk for HIV infection.

### **Substance abuse**

High rates of substance use have been reported among youth in Zambia. This is particularly concerning given that substance use is one of the biggest risk factors placing young people at risk for HIV infection and for being in conflict with the law. However, there is limited up-to-date quantitative data available disaggregated by age, gender and location. Among 15- to 21-year-old Zambian youth, lifetime alcohol use has been found to be almost 50 per cent, marijuana use was 86 per cent and inhalant usage was 47 per cent.<sup>205</sup> Field data highlights young people, who persistently abuse substances, often experience an array of problems: academic difficulties, health related problems (including mental health), poor peer relationships, and involvement with the juvenile justice system. Alcohol and drug abuse led adolescents to being disruptive in school or to them dropping out.<sup>206</sup> Community FGDs revealed that alongside alcohol consumption, marijuana is also a pervasive issue affecting adolescents, as outlined by a traditional leader:

“Also marijuana consumption is a real and rampant problem among the young people. Now we fear it will even be worse after the legalisation of its cultivation, and its being

<sup>203</sup> Tyler, Kimberly A et al. “Risk Factors for HIV among Zambian Street Youth.” *Journal of HIV/AIDS & social services* vol. 15,3 (2016): 254-268. doi:10.1080/15381501.2016.1138178.

<sup>204</sup> Ibid.

<sup>205</sup> Nkowane MA, Rocha-Silva L, Saxena S, Mbatia J, Ndubani P, Weir-Smith G. Psychoactive substance use among young people: Findings of a multi-center study in three African countries. *Contemporary Drug Problems*. 2004. 31: 329–356.

<sup>206</sup> Samuel Hall (2019). Dropping Out? A Participatory Exploration of Adolescent School Journeys in Zambia - Lusaka: District Highlights, commissioned by UNICEF Zambia.



grown even in the villages and the children know where to access it. This has also affected the children in secondary and primary schools who sneak out to buy drugs, including the boarding schools and children from other provinces accessing school here. When intoxicated they return to school and insult the teachers. This demoralises teachers and protest by refusing to teach misbehaving children and that is what leads to the child dropping out.”

In addition, marijuana use increases youths’ chances of engaging in sex, as found in a study of Zambian in-school adolescents.<sup>207</sup> There is a shared concern amongst adults and adolescents of the notable levels of juvenile delinquency in schools caused by alcohol and drug abuse by both male and female pupils. During one FGD with adolescents in Chipata, it was identified that “drug abuse amongst pupils, who come to school intoxicated” was a key challenge, which was often linked back to a “lack of recreational facilities for children.” Most adults talked about adolescents engaging in increasingly risky behaviour, such as alcohol brewing, alcohol drinking, smoking and drug-taking. There is a consensus that those who engage in risky behaviour and substance abuse are primarily boys, though there is a growing sense the young girls are also becoming involved in substance abuse, which may also have tentative links to the rise in child pregnancy. However, the ZDHS (2018) data documented no self-reported use of tobacco, of any kind, amongst females aged 15–19 years, while only 2.9 per cent of males aged 15 to 19 years self-reported tobacco use.<sup>208</sup> The 2018 World Health Organization’s (WHO) Global status report on alcohol and health revealed the prevalence of heavy episodic drinking (HED) in Zambia, with 16.5 per cent of males and females between ages 15–19 years engaging in HED: males being 23.9 per cent and females at 9 per cent.<sup>209</sup> In Zambia specifically, 40.8 per cent of adolescents (36.7 per cent of boys and 45.2 per cent of girls) have drunk alcohol.<sup>210</sup>

## Mental health

There is a scarcity of data and validated mental health measures for assessing psychological well-being among adolescents, however, globally adolescents are the most vulnerable population for mental disorders. WHO 2020 data reveals that mental health conditions account for 16 per cent of the global burden of disease and injury in people aged 10–19 years. Suicide is the third leading cause of death in 15- to 19-year-olds globally, and depression is one of the leading causes of illness and disability among adolescents.<sup>211</sup> Multiple physical, emotional and social changes, including exposure to poverty, abuse or violence can make adolescents vulnerable to mental health problems. Promoting psychological well-being and protecting adolescents from adverse experiences, and risk factors that may impact their potential to thrive is critical for well-being during adolescence and for their physical and mental health in adulthood.

In Zambia, adolescents are more likely to suffer from mental disorders due to various vulnerabilities, including poverty diseases.<sup>212</sup> This also includes pregnant adolescents, those who have experienced abuse or trauma, orphans or those with learning difficulties. Field data demonstrates a link between

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<sup>207</sup> Siziya S, Muula AS, Kazembe LN, Rudatsikira E. “Harmful lifestyles’ clustering among sexually active in-school adolescents in Zambia.” *BMC Pediatrics*. 2008. 8, 6–13.

<sup>208</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory, and ICF. 2020. *Zambia Demographic and Health Survey 2018*. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>.

<sup>209</sup> World Health Organization (2018), *Global status report on alcohol and health 2018*. Geneva.

<sup>210</sup> Swahn, M. H., Ali, B., Palmier, J., Tumwesigye, N. M., Sikazwe, G., Twa-Twa, J., & Rogers, K. (2011). Early alcohol use and problem drinking among students in Zambia and Uganda. *Journal of public health in Africa*, 2(2).

<sup>211</sup> WHO 2020 <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>.

<sup>212</sup> Ministry of Health (2011). *Adolescent Health Strategic Plan 2011-2015*. Directorate of Public Health and Research, Government of the Republic of Zambia

adolescents with vulnerable living conditions, such as those living on the street, and living with mental health disorders; for example, boys who experience abuse and are raped are more likely to experience mental health difficulties, and to suffer from substance abuse and depression.<sup>213</sup> Interviewees with CSO's and NGOs working with children and street children stated there were limited, if any, mental health services specific to youth or adolescents, and that “the infrastructure or even the understanding around mental health and wellbeing does not exist [in the] mainstream...community's still see mental health as a taboo.” This is consistent with other interviews on mental health perceptions in Zambia, which show people still consider mental disorders or illness taboo diseases due to a pervasive culture of denial, myths and negative perceptions that marginalise and ostracise people believed to have mental illnesses. Limited Zambian studies on mental health in youth and adolescents highlight the connections between mental health and HIV/AIDs. A study by Degun et al (2011) found that female adolescents with HIV and AIDs aged 11–15 years were particularly susceptible to developing a mental health disorder.<sup>214</sup> Substance abuse is also a key indicator of mental health and well-being. Risk-taking behaviours can be both an unhelpful strategy to cope with poor mental health and can also severely impact an adolescent's mental and physical well-being.<sup>215</sup>

#### 8.4 Challenges, shortfalls and inequities

A five-percentage point decline in almost two decades (i.e., from 34 per cent in 1992 to 29 per cent in 2018) shows little progress in reducing early childbearing and reflects some shortcomings in uptake of essential SRHR services. Consequently, adolescent fertility in Zambia remains one of the highest globally. Interviews with key informants suggests that adolescent pregnancy and early motherhood were more common in traditional rural communities because of limited access to health facilities with quality and preferred contraceptive services, and because of the distance to health facilities. Another barrier to contraception access for adolescents is religious and cultural beliefs, which do not support provision of these services to young people on the belief that they promote promiscuity.

Various factors have been cited to contribute to low utilisation of SRH services, including contraceptive use, among adolescents and these include: negative and judgmental attitudes of health workers, stigma and discrimination associated with use of services like family planning for adolescents, legislative barriers pertaining to age of consent for contraceptive services, limited finances for transport to access health services, and perceived lack of privacy and confidentiality at health facilities.<sup>216</sup> The low rate of condom usage at 1.6 per cent of all women aged 15–19 years indicates a higher risk of HIV and other sexually transmitted infections among the younger population.

Knowledge of the correct fertile period is also extremely low amongst adolescents. Out of the 3,000, women aged 15–19 years who were surveyed, only 13.2 per cent had correct knowledge. Interestingly, despite the high number (98 per cent) of women aged 15–19 years who were aware of contraception, 83 per cent had no exposure to family planning messages from radio, television, newsprint and mobile phones.<sup>217</sup> This suggests that some other means, such as social media, may be influential in communicating messages to adolescents and young women. The coverage and quality of adolescent-

<sup>213</sup> FGDs with NGOs, Lusaka & Samfya.

<sup>214</sup> Degun, S., Menon, A., McPherson, A. et al. “Factors Influencing Mental Health in Zambian Adolescents with HIV and AIDS.” *Pediatr Res* 70, 444 (2011). <https://doi.org/10.1038/pr.2011.669>.

<sup>215</sup> WHO. 2020 <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>.

<sup>216</sup> UNICEF and MoH (2019) Knowledge and use of Sexual Reproductive Health and HIV services among adolescent girls and young women in Central and Western provinces: A qualitative Knowledge Attitudes and Practices study.

<sup>217</sup> Zambia Statistics Agency, Ministry of Health, University Teaching Hospital Virology Laboratory, and ICF. 2020. *Zambia Demographic and Health Survey 2018*. Available at <https://www.dhsprogram.com/pubs/pdf/FR361/FR361.pdf>. P. 152.



friendly health services, and SRH services, is extremely limited. In addition to this, adolescents often face challenges within their households and communities due to the lack of a protective and enabling environment that promotes positive behavioural development and encourages access to, and utilisation of, relevant health services.<sup>218</sup> A UNICEF supported Knowledge Attitudes and Practices (KAP) study found that health system factors; such as long distances to health facilities, negative attitudes of health workers, unavailability of essential health commodities and supplies; and psychosocial factors, such as stigma and discrimination (including for those with HIV), low socioeconomic status and illiteracy, deterred access to essential integrated SRH/HIV and Sexual and Gender-based violence (SGBV) services for adolescent girls and young women.<sup>219</sup>

Given the context of mass awareness campaigns on HIV prevention over the years, progress remains dismal. This low knowledge has negative implications on behaviour change and uptake of other HIV prevention interventions. To this end, a geospatial analysis of interventions targeting adolescents and young people in Zambia posited that key HIV indicators, such as comprehensive knowledge of HIV are not improving optimally. This is because Social Behaviour Change and Communication (SBCC) programmes are not responsive to the information and service needs of adolescents, hence they are not as impactful in knowledge retention and behaviour change. This is largely due to lack of engagement of adolescents and young people in design and implementation of SBCC and other programmes; and because many programmes are implemented at small geographical levels as pilots and are not scaled up hence may show positive impact at implementation sites but with no national level impact. From 2010 to 2019, there was a 40 per cent decline in new infections among children aged 0–14 years, compared to a decline of only 10.3 per cent among women aged 15 years and above, and only 9.5 per cent decline among men aged 15 years and above (NAC & UNAIDS 2020). The low rate of decline in new infections is of concern, more so given ongoing gender-related disparities that particularly disadvantage adolescent girls and young women.

Adolescents also experience other problems, including mental health issues, trauma, physical and sexual violence, non-communicable diseases (which are nutrition related), and alcohol and substance abuse. Most planning and policies on adolescent health tend to overlook mental health, which is critical given some of the devastating consequences of COVID-19 on families. Qualitative data from KII's attribute some of the anxiety and depression experienced by adolescent females to sexual harassment, risks of sexual violence and child marriage, which is subsequently associated with early pregnancy. There are significant gender differences related to risk and vulnerability among adolescents in Zambia; almost one in five adolescent girls are already married, compared to only one in 100 adolescent boys aged 15–19 years. Similarly, one out of every four girls aged 17, and six out of every 10 girls aged 19, have already started childbearing,<sup>220</sup> and new HIV infections are about four times higher among adolescent girls than in their male counterparts.<sup>221</sup> Adolescent boys seem more predisposed to alcohol and substance use and abuse,<sup>222</sup> suggesting socialisation is a critical factor in the adolescent's life pathways. Boys are also vulnerable to sexual abuse, especially adolescent boys living on the streets. One member of a CSO working with children on the streets stressed that “all the boys I have come into contact with have some form of mental health issues; they have experience trauma; most have been sexual abused and suffered

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<sup>218</sup> MoH 2017, Adolescent Health Strategy (2017–2021). P. 11.

<sup>219</sup> UNICEF & MOH, 2015 KAP study on RMNCH on the Copperbelt, Zambia, Available at: <https://www.unicef.org/zambia/media/626/file/Zambia-KAP-RMNCH-2015.pdf>

<sup>220</sup> MoH 2017, Adolescent Health Strategy 2017–2021.

<sup>221</sup> UNAIDS (2018) Women and Girls and HIV.

<sup>222</sup> MoH 2017, Adolescent Health Strategy 2017–2021.

rape or groomed”.<sup>223</sup> However, there is a notable paucity of data and interventions targeting adolescent boys and children on the streets as advocacy and strategies primarily prioritise girls and young women.

Several suggestions are made for factors influencing substance abuse, ranging from social media pressure and exposure, especially in urban areas, to other environmental factors, such as deprivation and poverty, lack of education and employment, and available recreational activities. Street children, especially males and refugee youth, are particularly vulnerable to substance abuse due to mental health issues. A clearer understanding of multi-level risk and protective factors for young people’s alcohol and marijuana use could lead to better intervention strategies to reduce this behaviour among Zambian street youth.

The previous discussion on substance abuse highlights the need for a mental health intervention and approach to tackle these challenges. Mental health literacy was identified as limited amongst adolescents, with little or no understanding around mental health disorders, access to care or coping strategies. There is no current data to understand prevalence rates for mental illness amongst adolescents or children in Zambia. The most current data for mental health was from a 2011 report by the MoH, and it is not clear how the MoH obtained this data, although some of the data was from reports by MDAC and MHUNZ (2008) and by Mwanza et. al. (2008), which used pooled data from hospital records. WHO and NGO mental health data rely on adult mental health reports.

## 8.5 Stakeholder landscape and initiatives

Partners working in Adolescent Development and Health (ADH) include some private sector organisations, CSOs and Cooperating Partners (CP). The private sector and civil society are involved in the implementation of ADH related programmes, while the CPs are mainly involved in providing financial and technical support. Currently, the CSOs that are significantly involved in ADH include the Planned Parenthood Association of Zambia (PPAZ), Child Fund (CF), CIDRZ, Marie Stops and Afya Mzuri. The PPAZ stands out strongly among those actively involved in providing ADH services to the youth and adolescents and it has established Adolescent Friendly Spaces in Lusaka, Livingstone and Kitwe. The CPs have played a very important role in supporting ADH services in Zambia, particularly the establishment of the pilot YFCs. The Undikumbukire Project Zambia (UP Zambia) works with various stakeholders in the criminal justice system, such as the law enforcement officers, courts and prosecutors to ensure that juveniles in contact with the law are given space to be heard, for example, by cross-examining the witness or the complainant in the matter. UP Zambia has worked to support juveniles in giving their views in judicial proceedings without undue influence on matters that concern them. Among the United Nations agencies, UNICEF, WHO and UNFPA are mainly involved in ADH programming and contribute assistance to the national programme.

## 8.6 Sector specific recommendations

**Build on the development of the ADH strategy 2017–2021** as there are various sectoral policies, strategies, plans and guidelines that include, but do not exclusively focus on, adolescents. Advocate for greater resource allocation and tracking of adolescent sensitive programming.

**Explore how social protection schemes and private sector can explicitly contribute** to outcomes related to adolescents (e.g., ending child marriage, completing at least a secondary school education,

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<sup>223</sup> FGD with Street Children Charity, Lusaka.

acquiring skills for employability, facilitating adolescent civic participation and addressing mental health needs).

**Utilise HIV combination prevention**, which entails a strategic mix of biomedical, socio-cultural and structural interventions. Differentiated programming for adolescents is needed to improve HIV testing and treatment for those that are positive and targeted programming for pregnant and breastfeeding adolescents, and young women living with HIV and their children

**Target substance abuse in educational settings.** This may involve upskilling child protection officers or social workers.

**Commission further research into mental health** to understand mental health determinants, gender issues, and mental health literacy levels amongst adolescent boys and girls living in both rural and urban areas.

**Support legal structures and settings** in which hearings take place to influence the important participation of adolescents and/or juvenile defendants, victims and witnesses of crime. United Nations agencies should encourage and support government to substantiate the practical implementation of the right to be heard in all judicial and administrative matters concerning adolescents. This should entail building the capacity of criminal justice system to engage with adolescents, involving them in programme design and implementation, undertaking research to understand adolescents' needs and contexts, ensuring adaptive, relevant and responsive programming.

# Chapter 9. CHILDREN AND PARTICIPATION

## 9.1 Introduction

Definitions on child participation may vary, but there is broad consensus on the key features of child participation in decision making processes. First, the child has information to understand what the context of decision making is about and what the available options are. Second, the child has an opportunity to express her or his wishes and views. Third, the child's opinions are considered and have an impact on the decisions being made. Child participation is one of the key principles of the CRC. The CRC stipulates that children have the right to freely express their views on all matters and decisions that affect them, and to have those views taken into account at all levels of society. It is the right of every child, without exception. Article 12, paragraph 2, specifies that opportunities to be heard must be provided, in particular "in any judicial and administrative proceedings affecting the child". Typical administrative proceedings include, for example, decisions about children's education, health, environment or protection. To this end, it is critical to strengthen mainstreaming of child participation in education, health and care services, community leisure and skills building activities, religious activities and sports activities.

It must be noted that child participation is a way to create social capital and mutual trust in society, which in turn provides a societal or community framework for realising children's capabilities. Consequently, the society becomes dynamic and government structures do not stand alone in the protection and realisation of child rights. Therefore, participation of children in decision-making is vital and any government must create an enabling environment for the participation of children in the national discourse. The participation of children and young people may include several activities. For example: children expressing the desire to learn even at a very young age; seeking information; expressing ideas and opinions; taking part in activities and processes; being informed and consulted in decision-making; initiating ideas, proposals or projects; and respecting others. Children's participation is one of the main principles of the UNCRC, which should be considered and applied when asserting other rights.

Additional participation rights for children articulated in the UNCRC include freedom of expression (Article 13), access to appropriate information (Article 17), freedom of association and peaceful assembly (Article 15), freedom of thought, conscience and religion (Article 14), and protection of privacy (Article 16). Furthermore, Article 23 emphasises the importance of creating conditions which facilitate the active participation of children with disabilities in the community; and Article 29 encourages education which prepares the child for responsible life in a free society promoting peace, tolerance and equality. The Committee emphasises that this provision applies to all relevant judicial proceedings affecting the child, without limitation, including separation of parents, custody, care and adoption; children in conflict with the law; child victims of physical or psychological violence, sexual abuse or other crimes; health care; social security; unaccompanied children, asylum-seeking and refugee children; and victims of armed conflict and other emergencies.

Child participation is paramount in decision-making that takes place by authorities entrusted with the custody and care of children. This has special importance for children without parental care (without adequate parental care) or for children whose parents are going through divorce proceedings and a decision needs to be made on who the child will live with. In addition, the social welfare system oversees the well-being of children living in child-care facilities and children's participation in the

management of activities implemented in these facilities is also central. Finally, for children leaving care and transitioning to independent living or returning to their family, having been in alternative care—the child’s views and opinions need to be considered. Children, especially the most marginalised, are better able to protect themselves, to fulfil their rights to survival and development and to hold adults accountable, when given opportunities to express their views, to access information, to form associations, to participate in decisions that affect them and to take action.

## 9.2 Legal and policy framework

The right to participate in the conduct of public affairs is enshrined under Article 21 in the Universal Declaration of Human Rights and under Article 25 of the International Covenant on Civil and Political Rights (ICCPR), including treaty bodies and their general comments. The ICCPR is legally binding for the countries that have ratified the covenant. Zambia is a party to several human rights mechanisms that provide for the right for public participation including the ICCPR (ratified in 1984), the International Covenant on Economic, Social and Cultural Rights (ratified in 1984), the CEDAW (ratified in 1985) and the African Commission on Human and Peoples' Rights (1984). It is generally agreed that the extent to which children’s rights are addressed within a country’s legislative and policy framework, to a large extent, reveals the way children are perceived within that society.

At international and continental levels, Zambia is signatory to two instruments governing the rights of the child: the UNCRC and ACRWC. Zambia has ratified both the UNCRC and the ACRWC and formed a foundation for local legislative and policy frameworks and ensure that children’s rights are fully compatible with national priorities. Ratification of these instruments is also an acknowledgement that Zambia agrees to be held accountable on an international platform about the fulfilment of these rights by providing necessary opportunities for children’s participation in decision-making. The Zambian Constitutional provision on the freedom of association is deeply rooted in international law. Zambia is a State Party to several international instruments that guarantee participation of children. Though international instruments are not legally enforced per se in Zambia, they provide the basis for the country’s laws that enshrine human rights.

Zambia is also a signatory to the African Union Charter on Democracy, Elections and Governance (ACDEG). The Charter was adopted in 2007 and came into force on 15 February 2012, and Zambia signed the Charter on 27 June 2019. Article 2 (10) of ACDEG seeks to “promote the establishment of the necessary conditions to foster citizens’ participation, transparency, access to information, freedom of the press and accountability in the management of public affairs.” Article 2 (1) seeks to “promote adherence, by each State Party to the universal values and principles of democracy and respect for the rule of law.” With this commitment, Zambia is obliged to secure press freedom and access to information by children and necessary legislation must be put in place. This will accord opportunity for all citizens including children to participate in decision-making processes at all levels of society including the resource allocation, budget execution, monitoring and evaluation and part of social accountability mechanisms. At a country level, Zambia has a range of legislative and policy instruments in place to underpin children’s participation. The constitution is the starting point for child participation: The Constitution of Zambia in Article 11–23 guarantees a range of civil and political rights and freedoms for everyone in Zambia, including children. The Constitution of Zambia provides for freedoms of expression, assembly and association in Articles 19, 20 and 21. As regard to Freedom of Expression, the Republican Constitution is the most defining legislative framework on expression. Article 20(1) accordingly provides that “Except with his own consent, a person shall not be hindered in the enjoyment of his freedom of expression, that is to say, freedom to hold opinions without interference, freedom to receive ideas and

information without interference, freedom to impact and communicate ideas and information without interference, whether the communication be to the public generally or to any person or class of persons, and freedom from interference with his correspondence.” Children have the Constitutional right to freely express their opinions on affairs affecting them and to receive any information on the same. They have the constitutional right to communicate amongst themselves or with the general public including influencing decision-making in public policy.

In attempting to domesticate international instruments, Zambia has faced a challenge of synthesising common, civil and customary laws, and overhauling outdated statutes affecting children. The upcoming Children’s Code Bill attempts to harmonise and consolidate these existing laws to advance the rights of children. Several laws already passed have a bearing on children’s participation; notable among them are the Public Order Act (POA), Cap 113 of the laws of Zambia, the newly enacted Cyber Security and Cyber Crimes Act of 2020 and the Penal Code. These are however argued to be restrictive to effective participation. The POA has affected the children’s engagement in public discourse, especially when children mobilise themselves and stage, demonstrations and protests; and this contravenes the POA. On the other hand, the newly enacted Cyber Security and Cyber Crimes Act of 2020 would affect engagement in cyber space. At the policy level, the 2015 National Child Policy (NCP) has, among its four pillars, child participation as a pillar, which the Government will focus on during the policy period. The current 2015 NCP has a vision to build a society where children survive, thrive and reach their full potential. Under the child participation rights pillar of the policy, the policy objective is to coordinate and facilitate the participation of children in national programmes to enhance child development programme.

### 9.3 Levels, trends and differentials in key indicators

Children’s participation is a goal, a principle and a means. Participation is every child’s right. Children have civil rights to information, expression, participation and association which should be upheld. Children’s participation is a means to secure other rights to survival, development and protection. However, child participation in Zambia remains low owing to, among other reasons, the country not having a framework to institutionalise and guide implementers of child participation in a way that would ensure standards which are safe, ethical and meaningful, considering the evolving capacity of children. A recent study, Zambia’s Young Voice Survey (2020), conducted by Save the Children highlighted that children have few opportunities for participation in public decision-making processes. The report also showed the inadequacies in recognising and appreciating children’s rights to participation and their ability to influence public decision-making processes, with 84 per cent of children reporting that politicians and decision makers should listen to the opinions of children and young people.

On the ground, FGDs with children found that they had limited opportunities to participate in decision-making, and children felt that this culture of non-participation harmed their relations with adults. On the other hand, adults were concerned that growing awareness of child rights to participation (an “imposition” as one caregiver said in an interview) were a threat to community norms and the expected power balance between adults and children.

In the education system, children are included in school governance as class monitors, school prefects and other forms of leadership positions that are designed specifically for children’s engagement. In addition, the 2011 Education Act deliberately provided space for children to be part of the school governance structure, through spaces such as Parent Teacher Associations (PTAs) and School Governance Boards. In the leadership roles assigned to children, there is a deliberate design to have gender balance among the school prefects, which assures girls an opportunity to participate equally in decisions at that level. At secondary level, pupils are also part of school boards which are responsible for

setting school fees and providing oversight in school activities including budget approval and expenditure reports. In general, adolescents and children at secondary school level had greater chances of being involved in decision-making than younger children in primary schools. Children were seen to abuse their right to participation when they were aware of them. Therefore, teachers preferred that children were not given rights to decision-making, as this right seemingly risked abuse in teacher's view. Children's participation was thus relegated to club participation, and in events and other engagements rather than in key decision-making processes. Additionally, many children in Zambia both in school and at community level participate in various sports and art. It is believed that "participation in sport improves children's educational attainment and skills development including empowerment, leadership and self-esteem—contributing to their overall well-being and future prospects".<sup>224</sup> In some cases, children use sport and art, such as music and performance arts. These arts are used to express themselves on issues affecting them at community or national levels.

Participation in healthcare decision-making is an important right of minors and is highlighted in international legislation. However, despite the legal recognition of children's rights to participation and the benefits that children experience by their involvement, there is evidence that legislation is not always translated into health care practice. There are several factors that may impact the ability of the child to be involved in decisions regarding their medical care. Participation in medical decision-making is more complex and are subject to several reservations and restrictions.

Areas where there are good practice examples of child participation in health-related decision making include: a) participation in design of public health campaigns, information and communication; b) participation in decision making where a number of possible options are in play, especially if there is a mental health concern; c) the right of the child to understand his/her health circumstances and the treatment required; d) the right of children to confidential medical counselling where they can express their opinion and be heard, without an imposition of age limitations to access; e) when the age of sexual consent in a country is 16 years (like in Zambia) children have the right to access information and advice on establishing healthy intimate relationships; and f) physicians and HCFs should provide clear and accessible information to children on their rights concerning participation in paediatric research and clinical trials.

In Zambia, cultural and religious beliefs and practices are key consideration in child participation. Children, in their familial, community and public life roles, are often relegated to being passive recipients of programmes, activities and benefits that are directed at them. Mindsets that support exclusion of children are often backed by cultural practices and beliefs that do not create a supportive environment for children. For example, in Zambia, expressive children can be labelled as unruly. On the other hand, children are exposed to various platforms of participation. Notable among many platforms is the media. Currently, children are participating in decision-making (direct or indirect) through web-based platforms, such as social media and other mainstream media platforms. Most radio and TV stations, especially the public media, have included children programmes. Unfortunately, children in rural areas may not have the opportunity or the exposure to participate through radio or TV programmes. Additionally, the way media is accessed and consumed by children adds to the weakened participation of children in key processes, critical conversations and in decision-making. This systemic exclusion of children, except for special days, lessens children's ability to add their voice to matters that are of concern to them. In Zambia, the participation of children and adolescents in decision making is weak. According to children that participated in the FGDs, children were not adequately consulted on

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<sup>224</sup> Barça Foundation and UNICEF, (28 March 2019).



issues concerning them. Since children are not consulted enough, their needs are less likely to be fulfilled which leads to a proliferation of problems. Even when children's voices are heard they are not properly considered.

#### 9.4 Challenges, shortfalls and inequities

##### **Cultural and social barriers to participation of children in Zambia**

Culturally, adults perceive children to be secondary players in the affairs of the country. Most adults are imbued with the belief that children cannot make rational and informed decisions. In a study by the University of Zambia (UNZA) on Child Labour, it was revealed that adult attitudes towards children discourage children to participate.<sup>225</sup> Certain idioms, adages and expressions reinforce stereotypes that suggest that children do not know as much as adults do. These serve to create adult attitudes that do not see value in children's views or voice. For instance, there is a proverb in Bemba *Inama yabaice tainona* meaning that the meat cooked by children is not tasty. This means that whatever children would do may not be appreciated by the adults. There is also a saying among the Tonga of Southern Province which states that, "an elderly person can only be surpassed in running not in wisdom". Such sayings show that elderly people "know better", have the wisdom and are superior in decision-making as compared to children. The Zambian culture has always provided platforms for children participation, without this ever being turned into meaningful and active participation. Many of these platforms (which adults have provided) are focused on training children to become responsible adults or developing masculinity or femininity as responsible husbands or wives. For example, the Mukanda and Nyau Initiations of Luvale and Chewa people of Northwestern and Eastern Provinces, respectively train boys to have more respect for adults and learn how to look after wives. It is also through these initiation ceremonies that negative masculinities are often passed on, which have a bearing on unequal gender relations at family and societal level. On the other hand, girls in many cultures undergo initiation ceremonies, which are designed to transition them into adulthood and prepare them exclusively for their wifely and motherly roles. These cultural rites, administered to both boys and girls in Zambia, but predominantly in rural areas, have a large bearing on the extent to which boys and girls participate and engage in public discourse. In most settings where initiation for boys and girls is carried out, 'participation' in the public space is limited to those that have been initiated. Furthermore, it is through these ceremonies that girls are taught to be subservient to men—this has a bearing on gender relations at household level. It is necessary therefore to understand the lack of participation as being a result of structures and processes that militate against participation.

##### **Economic barriers to participation of children in Zambia**

Historically, Zambia's development model has been characterised by economic and social exclusion, driven primarily by a concentration on peasant agricultural land ownership while macroeconomic growth has been largely dependent on mining. Lately, cross border trade and micro-businesses in both rural and urban areas have been more prominent. The Labour Force Survey (2020) also confirms that more than 76 per cent of the labour force is in the informal sector.<sup>226</sup> Under these circumstances, many children have had little to no access to pre-primary and primary schooling, and worse still to secondary education, which requires payment of school fees. This therefore deprives children from poor households the opportunity not only to access education but also to participate in various decision-making platforms.

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<sup>225</sup> University of Zambia. April 2015 "Child Labour" vol. 11. Published by European Scientific Journal.

<sup>226</sup> Zambia Statistics Agency and Ministry of Labour and Social Security (2020). 2019 Labour Force Survey. <https://www.zamstats.gov.zm/phocadownload/Labour/2019%20Labour%20Force%20Survey.pdf>



Gender inequality, household poverty and the expansion of peri-urban populations are some of the systemic challenges to realising the rights of children. Economic and social inequalities seriously limit the options and opportunities of the rural population and of women and children to participate in public policy decision-making platforms. Therefore, poverty is one of the drivers of poor citizens' participation in development processes. Poverty inhibits children participation in decision-making. As Tess (2006) notes, poverty can have a profound impact on participation, excluding children from social experiences available to other more affluent children, and encroaching on their capacity to develop and maintain satisfactory social relationships.<sup>227</sup> Studies have also shown that education and information can help enhance participation and equity in democracy. It is therefore important to note that one of the biggest obstacles impairing progress towards poverty reduction is the lack of participation of women and children in decision-making processes relevant to public policies. This gives rise to a vicious cycle where poverty not only harms child participation but also reinforces poverty across the generations because of the lack of participation. The *2000 UNDP Human Development Report* states that equitable economic and social policies are directly linked to the preservation of civil and political freedoms and these, in turn, foster social and economic growth and abate poverty and inequality at the economic and social levels. UNDP proposed that it is the duty of public institutions and relevant stakeholders in human rights to pursue policies that favour the poor and to apply processes that ensure the rights of the poor to participate in policymaking.

### **Legislative barriers to participation of children in decision-making in Zambia**

While countries have laws to ensure public order and to maintain security, some of these laws, especially in the hands of tyrants, can be subverted to impose limits on participation. The concern is that countries introduce limits on participation in the name of some other goal, such as security. Several legislative instruments in Zambia elicit similar concern and potentially provide a basis to restrict citizens' participation. Notable among them are the Public Order Act, Cap 113 of the laws of Zambia, and the Penal Code.

While Zambia's Constitution provides for and promotes children's participation, some subsidiary laws claw back. As indicated earlier, the Public Order Act (1955) regulates meetings, assemblies, demonstrations, protests without prior police permission/ notification. This law constrains children's participation in public affairs in a collective manner. For example, students taking collective action can be classified as holding an unlawful assembly and can be barred from free expression of their views. Like other citizens, the Constitution empowers children to engage with policy makers and implementers in social and economic decision-making that could help improve the well-being of children. One of the key political and economic tools that children can engage leaders in is the budget formulation and execution processes. Because Zambia has signed and ratified child rights treaties (UNCRC and the ACRWC), it also has a legal obligation to set resources aside for the realisation of children's rights. From the perspective of Zambia's children, it is imperative that the national budgeting process is inclusive and effectively opens space for child participation.

## **9.5 Stakeholder landscape and initiatives**

Various stakeholders work in child participation. NGOs both local and international as well as CSOs have been instrumental in advancing children participation. NGOs operate in different legal, economic, social and political settings, which results in varied modalities of work and impacts on children's participation. CSOs are instrumental in fostering good governance and play a vital role in child welfare, especially by

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<sup>227</sup> Ridge, Tess. (2006). *Childhood Poverty: A barrier to social participation and inclusion*. 10.1332/policypress/9781861346629.003.0002.

providing platforms in various areas of development. This is because children are affected by any action of the State, including when not directed at them. Agricultural, environmental and land policies, for example, have significant impacts on children's livelihoods and enjoyment of their rights. Areas which are traditionally within the governance realm are therefore of critical relevance to children. Issues as diverse as the impact of taxation on the household income, the effect of corruption on the accessibility and quality of social services, privatisation of some sectors, such as water, and business practices including respect for the well-being of communities and family life, are all core elements of governance which have major consequences for the realization of children's rights. Civil society therefore creates spaces for participation of children in influencing policies.

## 9.6 Sector specific recommendations

**Define child participation with all stakeholders will be useful to clarify the scope of participation expected** to ensure children's right to participate is guaranteed. It would be useful, in doing so, to develop tools and guidelines to guide stakeholder understanding and inclusion of children in planning and decision-making.

**Take positive steps to revive the National Children's Committee** under MYSCD, including a Technical Working Group on child participation to provide strategic and policy direction in child participation.

**Analyse ways that the Children's Code Bill should underwrite child participation.** This will help define how children's participation can become more structural within certain Government systems.

**Conduct regular and structured examination of children's participation** using tools, such as the ladder of participation and other tools, to better understand the position children and young people when participating in different spaces.

**Understand the right to participate and how it affects the scope and quality of children's participation** as well as its acceptability. Once this understanding has been achieved, it will be important to ensure the consistent and meaningful participation of children in different spaces.

**Go beyond the informal model of child participation and ensure participation is embedded** in institutions and organisations that directly interact with children and make decisions that impact their well-being. These most commonly include schools and health centres and hospitals. In addition, child participation is crucial when social welfare and judicial authorities are making decisions about a child's care and custody. By mainstreaming participation into the statutes and procedures of schools, health facilities, and social welfare, court care and custody decision-making, children will be involved on many aspects of decision making that significantly affect their lives.

**Include a provision in the children Code Bill to articulate child participation** to ensure that each administrative authority, institutional entity, NGO, religious or sports organization that directly interacts with children must implement procedures for securing the participation of children in all matters that directly impact on the advancement of child rights and child welfare.

**Strengthen development of key child participation indicators** framework and reporting mechanisms.

# CHAPTER 10. DISABILITY

## 10.1 Introduction

Disability is defined in the Persons with Disabilities Act (2012) as "permanent physical, mental,

intellectual or sensory impairment that alone, or in a combination with social or environmental barriers, hinders the ability of a person to fully or effectively participate in society on an equal basis with others". This definition moves away from the traditional, medical model, which focuses on physical defects, to a social model that encompasses the attitudinal, environmental and institutional barriers that limit or exclude persons with impairments from effectively and fully participating in social, educational and livelihood activities. This approach was adopted by the 2015 National Disability Survey, which used the Washington Group's International Classification of Functioning and Disability (ICF), to learn about the situation of persons with disabilities and to compare living standards between people with and without disabilities.

The National Disability Survey (2015) found the prevalence of disability in Zambia to be 7.7 per cent across the overall population, with 10.9 per cent among adults and 4.4 per cent among children.<sup>228</sup> This is slightly lower than the estimate of 10 per cent by WHO 2010 and higher than the 2010 Population Census of 2 per cent.<sup>229&230</sup> However, it is important to note that the 2010 Census used a medical model, focusing on severe physical impairments, which explains the lower estimate. The 2021 Census, which is delayed partly due to COVID-19, has transitioned to using the ICF approach. Detailed analysis of the National Disability Survey (2015) revealed that the prevalence estimates vary across the 10 provinces, with the Copperbelt and Luapula having the highest estimates for both adults and children. There is a higher proportion of persons with disabilities in rural areas (58 per cent) than in urban areas (42 per cent). The report suggests that a significant proportion of disability in Zambia could be preventable since disease is the most common cause of disability, followed by accidents, falls and congenital disability.

## 10.2 Legal and policy framework

The Government of Zambia has several legislations and policies that advance the rights of people with disabilities. In addition to ratifying the United Nations's CRPD, CRC and CEDAW, and the ACHPR, the Government has also committed to the East African Policy on Persons with Disabilities (2012). This outlines joint policy commitments that are in line with the CRPD and country-level recommendations. In terms of national laws and policies, there are three key documents which guide the Government's responsibilities to persons with disabilities: the Persons with Disabilities Act (2012), the National Policy on Disability (2013), and the National Implementation Plan on Disability (2013). In addition, the Zambian Vision 2030 recognises the need to streamline service delivery for people with disabilities, to achieve the SDGs. Other policies and legalisation that include the rights and entitlements of persons with disabilities:

- The Technical Education, Vocational and Entrepreneurship Training (TEVET) Act (1998), which states that "special needs of people with disabilities will be taken into consideration";
- The Workers Compensation Act (1999) provides for the compensation of workers who become disabled as a result of their work;
- The National Policy on Education (1996) includes recognition of the right to education for all children regardless of their personal capacity and places responsibility on the MoGE for the education of children with disabilities;
- The National Youth Policy (2006) includes youth with disabilities in mainstream programmes and projects targeting youth; and

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<sup>228</sup> Central Statistics Office, Ministry of Community Development and Social Services. 2018. *National Disability Survey 2015*. Lusaka.

<sup>229</sup> World Health Organization and World Bank: World Report on Disability 2011.

<sup>230</sup> Central Statistics Office, 2012. *2010 Census of Population and Housing: National Analytical Report*, Central Statistics Office, Lusaka, Zambia.

- The Adolescent Health Strategy 2017–2021 emphasises a rights-based and disability inclusive approach.

### 10.3 Levels, trends and differentials in key indicators

#### **Data systems on persons with disabilities**

The Persons with Disabilities Act (2012) established the Zambia Agency for Persons with Disability (ZAPD), which is responsible for registering and collecting information on people with disabilities. Thus, a Disability Management Information Management System (DMIS) was established, which to date has a caseload of about 9,000, which is below the estimated prevalence of 10.9 per cent in Zambia.<sup>231</sup> ZAPD is the only organisation authorised for identifying and registering persons with disabilities and issuing them with disability identity cards. The Agency delegates the disability assessment process to the MoH; while the ZAPD retains the authority to classify and register in the DMIS. A medical officer is required to rank the person's "degree of disability" caused by their impairment which are listed as: "mild, moderate, severe and profound." The medical model of disability is currently being revised in accordance with the rights-based approach, with the intention of strengthening the validity of DMIS by combining functional assessments using the Washington Group's questions in combination with a physical assessment. However, this revision requires institutional and administrative changes, which take time. In the interim unregistered persons with disabilities are not identified and assessed in terms of need for goods, services and assistive devices.

Little information is available on the socio-demographic characteristics of people and children with disabilities and on their quality of life, particularly in terms of participation in activities and use of services. This is due to a paucity of data on the characteristics of those with disabilities, limited comprehensive knowledge, and lack of understanding of the issues faced by people with disabilities in terms of their participation in day-to-day activities and their access to basic social services. These issues include poverty, stigma and discrimination, and accessibility to public services, such as education and health systems. As part of the data collection process for the situational analysis, the CIDT and the Zambia Council for Social Development and Development Data conducted interviews with key stakeholders. Zambia Council led field consultations with rights-holders: children, adolescents, women and community members. FGDs and interviews were held in Luapula, Copperbelt, Southern, Western, Eastern and Central Provinces. Children with disabilities and parents of children with disabilities were included in all districts that were visited by the researchers. The following information in this chapter is based on some of their experiences, challenges and needs identified during consultations.

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<sup>231</sup> Zambia Central Statistics Office, Ministry of Community Development and Social Services. 2018. *National Disability Survey 2015*. Lusaka.

### **Stigma, shame and exclusion associated with disabilities**

Field data reveals that there is a significant lack of knowledge, which gives rise to stigma, fear and social isolation. This is noted in the Zambia disability survey 2015, where 2.2 per cent of respondents stated witchcraft as being the reason for boys' and girls' disability. The Zambia Disability and Education report indicates similar findings and that "such lack of knowledge also affected people's perspective of what persons with disabilities' participation in society should entail."<sup>232</sup> In Samfya, FGDs highlighted the barriers experienced by persons with disabilities, including children, due to stigma and shame. After giving birth to a child with a disability, mothers are often abandoned by their husbands. Mothers may also face social and economic exclusion, which leads to their children being hidden or placed in an institution and possibly neglected by caregivers. Parents of children with disabilities lacked knowledge on how to access specialised services, including respite care. There was also an impression amongst the discussants that persons with disabilities are not included in national development processes, that they are often excluded from decision making and that they are not included in the Council chambers. Furthermore, field observations identified environmental barriers to mobility and full participation in society.

### **Children with disabilities in Kitwe from field data**

Kitwe is the third largest city in Zambia, located in the Copperbelt Province, a business hub which attracts people, including those with disabilities. Adults and children with disabilities, particularly visually impaired, are frequently found begging in the markets and at the traffic lights. This situation exposes the visually impaired to other vulnerabilities, such as exploitation, abuse and physical accidents. Another concern expressed by respondents is the tendency for children with disabilities to be marginalised and excluded by their peers and family, in addition to these children's struggles with access to education.

### **Disparities in access to basic services for children with disabilities**

Since the DMIS does not comprehensively reflect the numbers and conditions of persons (including children) with disabilities, this report relies on the National Disability Survey (2015) as a lens to children's access to education and health services. Children with disabilities are much less likely to attend school than those without a disability: 15.6 per cent of children with disabilities are in school compared to 32.9 per cent of children without disabilities. This has obvious implications on their rates of literacy and their ability to gain the qualifications needed to enter formal labour market. School was either not accessible or not available to three out of 10 children with disabilities. More children without disabilities than with disabilities were literate, had accessed formal education, had studied as far as they had planned, or were still studying. The highest level of education attained by most persons with disabilities was primary education.<sup>233</sup> The 2015 National Disability Survey also identified and measured gaps in access to services as a proportion of those who needed a service but did not access it. Empowerment programmes, welfare services and legal aid had the largest gaps, while the lowest gaps were in health services and health information. Almost half of all children with disabilities who needed educational services did not receive them. In those services that enjoyed relatively small gaps (e.g., health information and health services), larger gaps in access were found among children with disabilities. These results indicate that health and welfare services need to be improved substantially to cater adequately for children with disabilities.

<sup>232</sup> CSO & MCDSS, 2018 Disability and Education, p. 5.

<sup>233</sup> ZAPD, The Strategic Plan 2017–2021: Promoting inclusive and Sustainable Development.

A qualitative study on the barriers to and facilitators of life-long learning that was published in 2018 provided some insight to how and why access to education is challenging.<sup>234</sup> Education sector lacks a coordinated effort or systems in place to ensure life-long learning for children with disabilities, and that children with disabilities do not undergo educational assessment before they begin school. This is worsened by the low teacher-to-student ratio, which means children with disabilities are unable to get the extra support they need from teachers in some cases.

Crucially, gender differences are also relevant: in both categories (disabled and non-disabled), more girls had ceased to study, and more boys were still studying, suggesting that attitudes towards girls also plays a role in their ability to continue with their education. Traditionally Zambia has established schools for people with disabilities, for example, the University Teaching Hospital (UTH) Special Needs School and Munali Secondary School (both in Lusaka), and Magwero Secondary School in Chipata, Eastern Province; all are currently under the MoGE. Supported by UNICEF, ILO and other partners, MoGE now plans to invest in developing inclusive schools, a process where all students with and without disabilities are taught together. Currently there are five vocational schools in Zambia that have served as pilots for inclusive education: Ndola Vocational Rehabilitation Centre, and Luanshya Trades (both in Copperbelt Province), Kaoma Trades (in Western Province), Mansa Trades (in Luapula Province), and Lusaka Business and Technology College. These vocational schools are the responsibility of the Department of Vocational Education and Training, MoHE in line with the 1996 TEVET policy. The recommendations of the Disability and Education Report (2018) are to improve resources for education, enhance capacities of responsible ministries, improve cooperation with ZAPD and train teachers for inclusive education. Data from the field research reveals that there is a significant lack of disability friendly infrastructure and poor accessibility to information. NGOs in Samfya reported scarcity of assistive services in the district—one must travel long distances to apply for assistance, which is costly and not possible for some forms of disabilities.

#### 10.4 Challenges, shortfalls and inequities

Lack of training and awareness on disability from health care professionals was identified as a challenge, which in some cases resulted in further ill health and the worsening of disabilities. One parent from Samfya mentioned that when her child with a disability suffered from meningitis and jaundice, she was not given much information on the disease and the effects it had on the child. She was later referred to Mansa Hospital, which is about 75km from her home. The reason for the transfer was because the hospital in Samfya is Level 1 and it does not have any specialised treatment or skilled personnel. Even the drug stores did not stock the type of medicines that were needed by the child. Another parent mentioned:<sup>235</sup>

“My son was born with club foot (foot twisted out of shape). Since his birth, I have faced a lot of challenges as there is nowhere to buy appropriate shoes or sandals called ‘clubfoot brace’ that can help correct the situation. There are also no special chairs or standing frames to help him learn how to sit or stand properly. I have experienced negative attitude and negligence by health personnel. Currently, we have been referred to Lusaka at Beit Cure hospital for an operation as there are no specialised health personnel for club foot. However, the challenge is finances for transportation and funds to use when in Lusaka.”

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<sup>234</sup> Central Statistics Office, Ministry of Community Development and Social Services. 2018. *Disability and Education. Qualitative Study on Barriers to and Facilitators of access to Life-Long Learning* (Summary of Results).

<sup>235</sup> FGDs with parents in Samfya.



Despite the adoption of the National HIV and AIDS Strategic Framework 2011–2015, which identified persons with disabilities as one of the key populations in the national HIV and AIDS response, in practice the Government has been unable to make such response accessible to adults and children with disabilities, particularly those with sensory impairments and persons with psychosocial disabilities.<sup>236</sup> The prevalence of HIV among persons with disabilities is high due to their vulnerability.<sup>237</sup> One respondent from an NGO in Samfya noted that “in the district (Samfya) just looking at the number of people living with disabilities that are currently on Anti-retroviral Therapy, we can deduce that HIV prevalence rate is high among the persons with disabilities. The persons with disabilities are also left alone to fend for themselves, hence become more vulnerable to abuse”.<sup>238</sup> Women and girls with disabilities in general are at heightened risk of sexual and gender-based violence,<sup>239</sup> and of contracting HIV and AIDS, perhaps owing to the myth that having sexual intercourse with a person with disability—who are often viewed as being virgins and asexual—can cure the virus.

### **Case study on children with disabilities in Samfya**

According to Government interviewees in Samfya the following disabilities are common in the district: visual impairment, hearing impairment, physical disabilities and mental disabilities. Samfya district has four schools that are implementing the inclusive education programme in schools. These are Samfya, Kasanka, Anweshiba and Kasoma schools. A big challenge for children with physical disabilities is getting to school. At times, given the long distances to schools, parents also face financial challenges.

Children related to adults with disabilities are often used as guides and are involved in begging. Children who lose their parents at a tender age fail to cope when they are left alone. Other challenges include stigma from parents, guardians and friends. Poverty levels are also very high among families who raise children with disabilities.

In addition, high school fees and insufficient teachers, who are trained to teach children with disabilities, diminish motivation for schooling. Children with disabilities, especially those who are hard of hearing, also lack sponsorship to hearing aids. The children have challenges communicating with health personnel as there are no provisions for sign language interpreters in health facilities.

### **Poverty and households headed by persons with disability**

According to the 2015 Living Conditions Monitoring Survey (LCMS), the poverty rate among households headed by people with disabilities was 76 per cent (87 per cent in rural areas and 45 per cent in urban areas), compared to an overall poverty rate of 54.4 per cent. Similarly, the UNICEF (2018) Child Poverty report found that 75 per cent of children aged between zero to four years with a disability were deprived in three to six dimensions or more;<sup>240</sup> compared to children with no disability (54 per cent).<sup>241</sup> This declined to 58.9 per cent for ages 5–13 years, and 36.2 per cent for children without disabilities in the same age cohort. The gap narrows further when looking at the multidimensional headcount for 14- to 17-year-olds; 48 per cent of those with disabilities and 40 per cent of those without disabilities were deprived in three to six dimensions or more.<sup>242</sup>

People with disabilities also suffer from nutritional deficits and often experience stigma, discrimination and abuse (sexual, physical and verbal). Some disabilities depend on human support, which may be constrained during COVID-19 due to social distancing requirements, and some disabilities make it more

<sup>236</sup> ZAPD 2017 Strategic Plan 2017–2021.

<sup>237</sup> ZAPD 2017 Strategic Plan 2017–2021 & CSO & MCDSS, 2018 Disability and Education.

<sup>238</sup> FGDs with NGOs in Samfya.

<sup>239</sup> ZAPD 2017 Strategic Plan 2017–2021.

<sup>240</sup> Multidimensional Deprivation Headcount by Age Group for all Possible Profiling Variables Using a Deprivation Threshold of  $k=3$ .

<sup>241</sup> UNICEF 2018, Child Poverty Report.

<sup>242</sup> Ibid.

difficult to access critical information on COVID-19 precautions. Most people with disabilities rely on informal and unpaid family support—this puts them in a difficult situation if either they or their usual support persons get infected or are at risk.

### 10.5 Stakeholder landscape and initiatives

Currently, the welfare of persons with disabilities is the responsibility of the Ministry of Community Development and Social Services (MCDSS). The 2021 Zambia Census will for the first time collect data on the six areas of functional limitations and levels of severity: seeing, hearing, walking, cognition, self-care and communication. This promises to provide a more accurate disability prevalence rate for Zambia. At the national level, the Zambia Federation of Disability Organizations (ZAFOD) is an umbrella organisation representing several national organisations of persons with disabilities. Its main activities include advocacy and awareness-raising. It also provides small loans to people with disabilities and training in small-scale business management.

### 10.6 Sector specific recommendations

**Raise awareness to remove stigmatisation and shame** through schools and public media about disabilities.

**Improve ante and neo natal care** to prevent congenital disabilities.

**Increase rehabilitation and recreational facilities** for persons with disabilities.

**Increase sign language interpretation** in basic services, such as health and education.

**Produce and disseminate Braille version** of The Persons with Disabilities Act (2012).

**Make accessible** the education syllabi, materials and facilities for persons with disabilities.

**Improve quality and quantity of disaggregated data** on persons with disabilities, with granular detail on barriers to effective participation and inclusion in society and life-long learning.

**Improve general knowledge on causes and types of disability** and what participation of persons with disabilities would look like. This could also reduce stigma and shame associated with disabilities, which is experienced in some communities.

**Increase knowledge on policies** (e.g., relating to inclusive education and assistive devices) particularly for persons with disabilities to improve their agency to claim rights and entitlement.

**Improve cooperation amongst ministries and the ZAPD** to improve delivery of basic services and assistive devices.

**Train teachers** for inclusive education.



# CHAPTER 11. CHILD PROTECTION

## 11.1 Introduction

Until recently, child protection focus has mostly been on individual protection problems, such as child trafficking, child labour, juvenile offending and sexual abuse. The focus on different issues has contributed greatly to the protection of children and much has been learnt about what makes good child protection work. However, this approach has not been without its drawbacks. Many children face multiple protection problems and child protection approaches need to tackle the multi-layered protection issues that children face rather than one issue at a time. UNICEF's comprehensive child protection approach considers the multifaceted and interlinked

### Defining Child Protection

The report adopts UNICEF'S definition of child protection which refers "to prevention and response to violence, exploitation and abuse of children in all contexts. This includes reaching children who are especially vulnerable to these threats, such as those living without family care, on the streets or in situations of conflict, (including refugee and migrant children) or natural disasters."<sup>243</sup>

nature of violence and is built on the recognition that each system has distinct roles and responsibilities with the social welfare system being the central protection pillar. Children experience violence in a wide variety of settings, ranging from home and school to institutions and the judicial system. Being exposed to different types of violence, be it physical, emotional, sexual or neglect, is painful and can be traumatic. This also includes children living in care, migrants, refugees as well as those living on the streets.

## 11.2 Legal and policy landscape

Article 266 of Zambia's Constitution, which is the interpretative provision, defines a 'child' as a person who has not yet reached, or is below, the age of 18 years. The problem arises because of the conflicting definitions of 'child' in other provisions:

- a. The Penal Code Act, Chapter 87 of the Laws of Zambia, under section 131 A defines a child as '**a person below the age of sixteen years.**' This definition relates to the protection of the child against the offence of defilement.
- b. The Marriage Act, Chapter 50 of the Laws of Zambia, under section 17 defines a child as one who is **below the age of 21 years of age.** Thus, for the purposes of protecting children from marriages, any person below that age can only marry with the written consent of his or her parents or guardians.
- c. The Juveniles Act, Chapter 53 of the Laws of Zambia, under section 2, defines a child as '**a person who has not attained the age of sixteen years.**' Thus, all delinquents below that age are protected from issues, such as imprisonment and other degrading punishments.
- d. The Adoption Act, Chapter 54 of the Laws of Zambia, under section 2, defines 'infant' to mean '**a person who has not attained the age of twenty-one years, but does not include a person who has been married.**' In this regard, an infant or child is one who is below 21 years provided that they are not married. This threshold is above the constitutional threshold of 21 years. Thus, all persons below that age cannot be adopted without meeting certain requirements under the Act.
- e. Section 3 of the Interstate Succession Act, Chapter 59 of the Laws of Zambia defines a minor as '**a person who has not attained the age of eighteen years.**' Thus, a child's inheritance is protected under this provision as double administration is favoured to shield their assets until the child or minor reaches the age of majority, which in this case is 18 years.

<sup>243</sup> UNICEF 2015. "Child Protection Overview" <https://data.unicef.org/topic/child-protection/overview/> (accessed on 29 October 2021).

- f. The Affiliation and Maintenance of Children Act, Chapter 64 of the Laws of Zambia, under section 2 defines a child as **‘a person below the age of eighteen years, whether a marital or non-marital child.’** In this case, persons below that age are entitled to maintenance from their fathers (or mothers).
- g. The Employment Act, Chapter 268 of the Laws of Zambia, under section 12, states in part that **‘no person shall, except under conditions to be prescribed, employ or cause to be employed, any person under the age of fifteen years.’**

Zambia’s laws prohibit many types of violence against children, but legal framework gaps and a lack of clarity remain, which limits the scope of perceived protection in specific cases. The Zambian Bill of Rights mandates general provisions that prohibit mental violence (Article 11) and any form of torture or other cruel, inhumane, or degrading treatment or punishment (Article 15) against children and citizens alike. Zambian laws also tackle gender-based violence and violence by caregivers and guardians against children, which includes physical assault, ill-treatment, neglect and mental harm. However, there is a question of compatibility between international standards and Zambian laws on corporal punishment in specific settings. The Education Act prohibits the use of corporal punishment or degrading treatment in education institutions (Section 28). At the same time, the Juveniles Act (Section 46) permits caregivers and guardians to administer lawful punishment against children, without providing a definition of ‘lawful punishment’. The Government outlawed the performance of an assault on a child, which applies to all settings (Section 248a of the Penal Code Chapter 87 of the laws of Zambia as amended by Act No. 15 of 2005). The offence carries a minimum sentence of five years imprisonment with hard labour. There are concerns that the differentiation between severe/consistent assault leading to significant consequences on child development and the use of corporal punishment, which does not require draconian penal measures, are not differentiated in the law. The application of this in the court of law has not been uniform. Given the prevalence of violent discipline in Zambia and current competing legal provisions, it is necessary to amend contradicting provisions, clarify the definition and raise awareness on the legislative provisions around tackling corporal punishment to fortify community values against this act of violence.

Zambia’s Anti Gender-Based Violence (GBV) Act protects victims of gender-based violence, whether it is the infliction of physical, sexual or mental injury. It also names female genital mutilation as a form of abuse under the law. Laws forbidding child labour are also strong. The Employment of Young Persons and Children Act forbids hazardous labour and identifies specific work and circumstances as being hazardous. The law forbids labour that interferes with a child’s education, is harmful to a child’s health or their physical, mental, spiritual, moral or social development, and which involves cruel, inhuman or degrading treatment. This same law prohibits the sale of children or servitude of children, and activities in which a child performs legally punishable criminal acts, such as trafficking in drugs or prohibited goods. Zambia’s Section 10 of the marriage Act, Cap 50 of the laws of Zambia sets the minimum age for marriage at 21 years but provides an exception that allows children to marry with parental consent. In addition to this legislative framework being problematic, the country has a dual legal system: it recognises both constitutional and customary law and the latter does not ascribe any minimum age for marriage with an understanding that girls can enter marriage when they reach puberty.

Policies to prevent GBV are also present in schools. Zambia’s Education Policy creates mechanisms to report all GBV, and clear measures are in place to respond to GBV. Again, these policies do not encompass other forms of violence in schools. These policy measures should include anti-bullying and safe school policies, mechanisms to report all types of violence, and standardised training and capacity building for teachers to recognise and respond to violence appropriately. In addition, protection from

violence in schools is not implemented accordingly and corporal punishment is still common. The Study on GBV in boarding schools commissioned by UNICEF demonstrated concerns over high rates of emotional abuse, physical and sexual violence, which was often performed by peers but also by adults in the community and school staff.<sup>244</sup> There are no child safeguarding policies in place to protect children from violence in other settings where children reside without being accompanied by a parent or carer (sports clubs, churches and hospitals).

Zambia has established some reporting pathways for children, communities and professionals regarding GBV. Zambia's Anti GBV Act requires public authorities and specific groups of professionals and community leaders (e.g., medical practitioners and religious leaders) to report identified situations of GBV and trafficking of children. Despite a mandatory duty to report cases of GBV, the law does not assign a penalty in cases where duty bearers do not report cases of alleged abuses. Mandatory reporting requirements do not extend to other forms of violence against children; Zambia's Juveniles Act (Article 10) only conveys a 'discretionary' duty to report other acts of violence against children. To establish the reporting requirement in cases of GBV, the Government provides reporting and referral protocols to police, health services, educators and social workers. Again, there are no reporting and referral protocols in cases of other types of violence against children.

The Juvenile's Act is key for child protection because it regulates the area of juvenile offending as well as the Government's role when it comes to the children in need of care and protection. The District Social Welfare Officers have a gazetted role in custody and care decision making in cases of juvenile offending, placement of children in care and addressing cases of violence against children, when children have been exposed to significant harm. District Social Welfare Officers are also licensed Juvenile Inspectors, which means they can visit any institution where children reside to inspect their well-being. Although the law does not recognise the term "statutory case management" it is clear from the legislation that this government body is responsible for the management of cases of children that have been exposed to violence. The Juvenile's Act does not limit the placement of children in institutional care (children's homes), even though institutionalisation of children should only be used as a measure of last resort according to international standards (United Nations Guidelines on Alternative Care). For this reason, placement of children in children's homes remains the predominant form of alternative care and fostering is under-developed. The protection of all the specific vulnerable groups of children defined below are the responsibility of the social welfare system, as prescribed by the Juvenile's Act. The lack of recognition of the social work profession and practice by actors designing child protection programmes has often created a lot of confusion when it comes to the clearly differentiated roles of social welfare, police, prosecution and justice service providers – when protecting children. One of the reasons may be that the legislation is not fully operationalised through statutory instruments or guidance notes that would help practitioners implement provisions in a uniform manner. For communities and individuals, the Government co-sponsors a national helpline and GBV line with civil society partners and mobile companies. At the local level, communities and individuals have access to Victim Support Units (VSU) at police stations (Zambia Police Amendment Act No. 14 of 1999). VSU officers receive reports on violence, follow gender-sensitive and child-friendly protocols, and ensure referrals to needed services and specialists. The policy on VSUs provides assistance related to GBV. The NGO Childline/Lifeline offers toll-free lines for children and parents to provide mental health support and enabling an avenue for reporting abuse. However, although the service is recognised as important by Government counterparts, it has failed to receive sustainable Government financial support. The Government has not

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<sup>244</sup> UNICEF 2014. "Violence against Children in Zambia. Findings from a national survey 2014."

taken action to create child-friendly reporting pathways in places frequented by children, including schools, community centres, alternative care institutions, sports clubs, churches and medical clinics. Child-friendly reporting pathways exist intermittently through civil society programming and other community-centric actions, but the Government does not maintain national policies that correspond to these instances.

### Legal and policy challenges

When it comes to juvenile justice administration, the Constitution creates two Juvenile Justice sub-systems: the statutory and customary sub-system. The Zambian juvenile justice system is not significantly different from the criminal justice system applicable to adults. With the statutory Juvenile Justice sub-system, the substantive law is primarily the Penal Code Act (PC) supplemented by other specific criminal statutes. The Criminal Procedure Code (CPC) provides the procedures for implementing the substantive laws, while the Juveniles Act provides specific procedures relating to juveniles. The legislation defines the age of criminal responsibility at eight years age.<sup>245&246</sup> International Standards (General Comment on the CRC on juvenile justice, 2019) define the age of criminal responsibility at 14 years. There are also no legislative provisions defining diversion or mandating authorities to prioritise community solutions for juvenile offending. With respect to the customary law in the juvenile justice sub-system, the substantive laws are set out in the various customary laws in Zambia. The institutions responsible for administering substantive customary laws are the Local Courts, Chiefs and other traditional institutions. The procedural laws for implementing the substantive customary laws are determined not only by the customary laws, themselves but also the customary by-laws.

“Reason being is that there is no one definition that defines a child, if it comes to defilement a minor is someone who is 16 [years of age] but when you come to my department a minor is someone who is 18 [years old]. Depending on what section of the law you are looking at, [the age of] a minor varies. If you look at the employment act you are allowed to employ someone who is 15 years [old]. It doesn’t really coordinate so that is why you find issues to do with child labour are being promoted, this person is old enough this person is 16 but I would define that as child labour yet under the employment act someone can be employed at that age [16]. So, this person is going out with someone who is 17 years old, for the police them its fine, she is above 16, for me it’s a problem. For me it’s a crime for the police it’s not a crime.”

— A Government official

The Government had finalised a draft Children’s Code Bill in April 2021 and the document passed the Internal Legislative Review of the Ministry of Justice as well as the first Cabinet review. However, the second cabinet review was postponed, and the document did not reach the National Assembly before it was dissolved in mid-May, prior to the General Elections. The Social Work Association Bill had the same fate: This Bill was crucial for introducing an independent quality assurance system for social work and for the recognition of social workers as the single most important profession for responding to and preventing violence against children. The adoption of the Bill would introduce licensing procedures,

<sup>245</sup> For all children under 12 years of age who have committed offences, the judge needs to confirm that the child is mature enough to stand trial. This caveat limits the number of children, between ages 8–12 years, that are prosecuted. Given that the procedure leaves the decision-making on whether a child can stand trial if they are between 8 and 12 years of age to a judge (rather than making it illegal; according to international standards definitions), the age of criminal responsibility in Zambia is 8 years of age.

<sup>246</sup> UN Human Rights Committee and OMCT. “Human Rights Violations in Zambia. Part III: Child rights’ situation. Shadow Report.” 90<sup>th</sup> session. July 2007. [https://www2.ohchr.org/english/bodies/hrc/docs/ngos/omct\\_zambia2.pdf](https://www2.ohchr.org/english/bodies/hrc/docs/ngos/omct_zambia2.pdf) P. 17.

provide quality assurance, and create space for systematic development of the profession. This would bring social workers on par with teachers, doctors and nurses, who are all key to ensuring children's access to services. Nevertheless, the biggest challenges in child protection lie in the lack of enforcement of existing legislation and policies. Implementation is too often reliant on donor funds, leading to patchy and unsustainable implementation. Application is not uniform across the country, and it is unclear how authorities are held accountable for its implementation and what the repercussions are for not taking action when children are at significant risk of harm. The lack of nationally available administrative data makes it extremely difficult to track progress. Nevertheless, data available through the ZDHS shows that progress is dismal in areas of birth registration, access to services for child victims of violence, attitudes towards domestic violence, prevalence of violence and so on.

In addition, operationalisation of child protection heavily relies on community volunteers, and this includes access to information, identification of vulnerability and referral to services as well as implementing social and behaviour change activities that can address barriers in attitudes and practices. Many donor-supported initiatives rely heavily on engagement of volunteers to implement community-based case management and connect the most vulnerable families to services. Such interventions are key in permeating isolated communities and addressing vulnerability. Community Welfare Assistant Committees (CWACs) are part of the formal structure of the MCDSS and are recognised in the PWAS<sup>247</sup>. However, CWACs role is not regulated in any manner. Efforts are underway, by the MCDSS to ensure that CWACs apply a uniform approach across the country so that this does not depend on the donor in question. Nevertheless, there is no accredited training programme for CWACs, no registration of CWACs in the system, no provision of registration cards and no regular provision of supportive supervision (Study on Community-based Case Management completed by UNICEF, 2020, unpublished). It is clear from the draft Volunteer Policy that efforts were underway to introduce such quality assurance systems for government volunteers, but the policy has still not been adopted.

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<sup>247</sup> Guidelines as such  
(<https://bettercarenetwork.org/sites/default/files/Zambia%2020Basic%20Facts%20About%20the%20Public%20Welfare%20Assistance%20Scheme.pdf>)

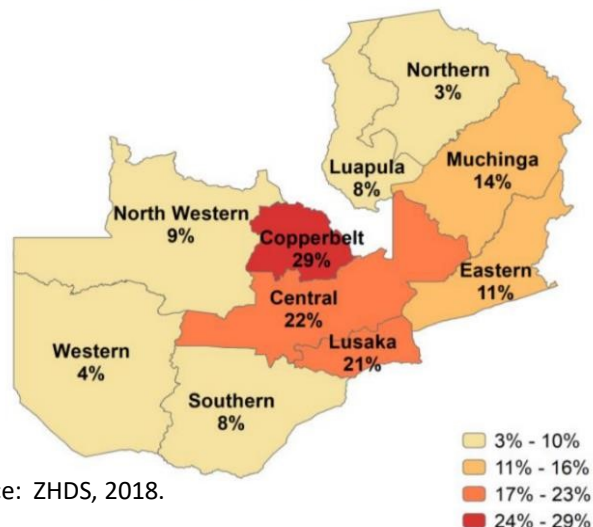
### 11.3 Levels, trends and differentials in key indicators

#### Birth registration

The right to a name and a nationality belongs to every child, as enshrined in the Convention on the Rights of the Child and other international treaties, yet only 14.2 per cent of children under the age of five years in Zambia have their births registered, only 5.9 per cent have birth certificates.<sup>248</sup> There is no variation by age or sex in the percentage of births registered. However, 25 per cent of urban children are registered, in comparison to only 8 per cent of rural children. Furthermore, the percentage of registered births rises with increasing wealth, from 4 per cent in the lowest wealth quintile to 32 per cent in the highest wealth quintile.<sup>249</sup> However, there is slight improvement in registration of children under the age of five: from 11 per cent in 2013–14 to 14 per cent in 2018.

Figure 12: Birth registration by province

Percentage of de jure children under age 5 whose births are registered with the civil authorities



Source: ZHDS, 2018.

With fewer than one in five births registered, Zambia has one of the lowest birth registration rates in Africa, which can mainly be attributed to a general lack of awareness of the value of birth registration. Figure 12 shows large variations by province in birth registration. Copperbelt (29 per cent) has the highest percentage of registered births, while Northern (3 per cent) has the lowest. UNICEF has worked closely with the Government through the Department of National Registration, Passports and Citizenship (DNRPC) to develop evidence-based interventions that support the strengthening of the National Civil Registration System generally, and particularly birth registration. For instance, the DNRPC was supported by UNICEF to conduct a comprehensive review of the National Civil Registration and Vital Statistics system upon realising that birth registration is part of the bigger civil registration agenda. Resulting from the Comprehensive assessment was the development of the 2015–2019 Civil Registration and Vital Statistics National Strategic Plan.

UNICEF has recognised that legal provisions for birth registration have been relatively strong, with the existence of the birth and death registration Act CAP 51 since 1973, whilst enforcement lagged. The Zambian Government working with UNICEF, with financial support from European Union managed to decentralise Birth Registration.<sup>250</sup> This has encouraged its partnership with Government through the MoH and EU to establish 806 registration desks in health facilities across the country.<sup>251</sup> In less than two years, the EU-UNICEF programme saw birth registration coverage almost double in the focus districts,

<sup>248</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

<sup>249</sup> Ibid.

<sup>250</sup> Lusaka Times 2017 <https://www.lusakatimes.com/2017/11/24/government-decentralises-issuance-birth-death-certificates/>

<sup>251</sup> Chisamba, Nkole Nkole. 7 August 2018. "Birth registration: Right of every child" <http://www.daily-mail.co.zm/birth-registration-right-of-every-child/>

from 68,000 in 2017 to 134,500 in 2019.<sup>252</sup> A UNICEF Evaluation showed that birth registration services in health facilities are largely seen as an add-on service and not part of the mandatory responsibilities of paid health professionals.<sup>253</sup> Services of birth notification are largely provided by community health volunteers and there is a disconnect with the birth notification system used for health purposes. More recently efforts are underway to amalgamate the two systems, with a single birth notification procedure to be put in place, both for health and civil registration purposes.

### Child justice

Literature reviewed revealed several challenges in the system and indicates that the current Zambian juvenile justice system is not adequately serving its intended purpose of providing a child-friendly and child-sensitive justice system. The current juvenile justice system is punitive in nature, characterised with prolonged child detention, over prosecution of minor offences, lack of alternative sentencing and community-based rehabilitation services. The age of criminal responsibility is eight years, with some restrictions in place to prosecute a child under the age of 12 years. There have been repeated calls for the reform of Zambia's juvenile justice system. The most notable literature includes the 2015 'Bottleneck Analysis' on child detention in Zambia conducted by the Human Rights Commission, the Auditor General's Performance report for the years 2014–17 released in 2018, and the MCDSS Report on Children Deprived of Liberty in Detention and Correctional Facilities in Zambia released in 2018. This literature highlights several shortcomings in the implementation of national, international, and regional standards for treating children who are in conflict with the law in Zambia. According to the 2015 National Child Policy (NCP), children who are in conflict with the law must be treated with dignity and compassion, while respecting their legal rights and implementing legal safeguards in all processes. Several of these recommendations have not yet been implemented, which leaves the challenges unresolved and therefore, the need for reform has been recognised as a priority. A UNICEF supported nationwide child detention monitoring mission that took place in 2018 found over 1,000 children, including migrant and circumstantial children, in prisons or police cells. Many of the children in conflict with the law were in detention for minor offences.

#### The forgotten and uncouned children in "incarceration"

During a visit to Kabwe Maximum Female section of the Correctional Facilities, researchers were able to interact with female prisoners. However, within these walls were children below the age of five years. At the time of the visit, there were six circumstantial children living with their mothers, three boys and three girls aged between three months to four years. These children are not counted because according to the prison system only offenders are to be listed and counted. Because of this, the team of researchers were further informed that these children are not budgeted for in terms of their food and other needs, such as clothing, diapers, medicines, educational and health needs. These uncouned children share their breastfeeding mother's food ration or rely on well-wishers. On probing about whether the facility gives the parents a little extra food to cater for their child, the response given was that providing additional food to mothers would allegedly result in an audit query.

### Child labour

In 2018, Zambia made moderate advances with efforts to eliminate the worst forms of child labour. The Government developed national action plans on Child Labour and Anti-Human Trafficking in line with Zambia's 7NDP. It also increased the number of inspectors and significantly increased the number of

<sup>252</sup> Singizi, T. April 15, 2020. "The birth certificate that skipped a whole generation". <https://www.unicef.org/esa/stories/birth-certificateskipped-whole-generation> (accessed on 29 October 2021).

<sup>253</sup> Ibid. p10.



labour inspections conducted: It identified 511 child labour law violations, and achieved five convictions for the crime of child trafficking.<sup>254</sup> During a FGD with community members in the Copperbelt Province, it was confirmed that the Ministry of Labour provides labour inspectors who check on child labour.<sup>255</sup> Another respondent suggested that there is a plan underway to conduct inspection of companies and small-scale companies to check and monitor the level of child labour. UNICEF child protection statistics show child labour prevalence was 23 per cent in 2018, down from 40.60 per cent in 2016; male child labour accounted for 22.90 per cent in this time, down from 41.60 per cent in 2016.<sup>256</sup> Available data for 2016 showed child labour is more prevalent in rural areas (at 56 per cent) compared to urban areas (at 9 per cent).<sup>257</sup>

#### **Findings on child labour from field research**

Field visits to Samfya observed children engaged in street hawking of fresh produce and at times covering long distances on foot (e.g., from Musaila to Town, a distance of 10km). Some children start fish farming activities between the ages of 5 and 10 years. These children are taken to fishing camps during crucial schooling years. Further discussions revealed that children with disabilities are especially at risk of child labour and child exploitation: “child labour is rampant among children with disabilities who are used in begging for alms in the communities.” NGOs noted that child labour had increased following the outbreak of COVID-19, as parents struggled with costs of household goods, food and sent their children to sell in the streets at the expense of children’s schooling.

Traditional leaders from Chipata asserted similar claims around child labour and added that there are consequences for girls involved in child labour: “The other problems are alcohol drinking and child labour, there is need to curb Kachasu (local highly potent alcoholic beverage) brewing. Child labour is still rampant while parents/guardians or other elders send children to sell things at marketplaces where bars are found, and there, the children like to spend time watching TV found in these places. In these spaces, they are introduced to illicit activities and girls fall pregnant.”

Adolescents also identified this as a challenge: “Children are being used as labour by parents and guardians. You will find children being sent to the markets carrying heavy loads of goods to sell or the children are asked to do difficult chores, when they should be in school.”

The implications of child labour on the educational outcomes of children have not been consistently tracked or monitored, but respondents have pointed out that children’s livelihood and positive outcomes are impacted due to lack of education, lack of socialization with peers at school, lack of opportunities for personal development and the linkages between illicit activities, drug abuse and child labour. Further research and data are required for targeted interventions.

In 2018, the Government and UNICEF published studies on child poverty and violence against children. The study on child poverty reports that adolescents (aged 14–17 years) are three times more likely to be engaged in child labour than children aged 5–13 years.<sup>258</sup> The study on violence against children reports that girls aged 13–17 years are engaged in commercial sexual exploitation.<sup>259</sup> Although the Government has conducted regular Labour Force Surveys and published the results in 2011, 2014 and 2016, it has yet

<sup>254</sup> Bureau of International Labor Affairs. 2019 Findings on the Worst Forms of Child Labour: Zambia.

[https://www.dol.gov/sites/dolgov/files/ILAB/child\\_labor\\_reports/tda2019/Zambia.pdf](https://www.dol.gov/sites/dolgov/files/ILAB/child_labor_reports/tda2019/Zambia.pdf) (accessed on 29 October 2021).

<sup>255</sup> FGD with respondents from the Copperbelt.

<sup>256</sup> UNICEF child protection statistics 2020.

<sup>257</sup> Ibid.

<sup>258</sup> Ministry of Youth, Sport and Child Development, Ministry of Community Development and Social Services, University of Zambia, United Nations Children’s Fund, Save the Children International and United States Centers for Disease Control and Prevention. (2018). *Violence against Children in Zambia: Findings from a national survey, 2014*. Lusaka. <https://www.unicef.org/zambia/sites/unicef.org.zambia/files/2018-11/> (accessed on 29 October 2021).

<sup>259</sup> Ibid 17.



to collect and release child labour data. To address this, in 2018 the Government included a specific child labour module in the Labour Force Survey, however the data is yet to be released. Discussions with NGOs, community members and government officials revealed similar findings. In Kitwe and surrounding areas, there are many mining dumpsites from the Zambia Consolidated Copper Mines. It has been discovered that the heaps contain minerals like chrome, so children are used by adults to do scrape, dig and load trucks. This was echoed by one respondent who said, “A good example is of the sink hole in Chamboli, the only people that could manage to go down were the children, and when we [adults] tried to go it was very difficult and it was steep and from the assessment of one of the miners he said it [the sink hole] was only about a 100m from the haulage or tunnel under ground, which was very dangerous. So, the children are the ones being used to transport the materials from down to up, so there are risks of child labour because for them [children] they see it as means of income not knowing they being used as labour”.<sup>260</sup> Social and gender norms are key drivers of child labour patterns, with an expectation for boys and girls to contribute to economic activities. Child labour is most prevalent in areas of agriculture, mining and commercial sexual exploitation, which is sometimes because of human trafficking. However, there is a need for community awareness around the understandings of child labour, as parents, community members and officials in both urban and rural districts indicated that they did not understand what constituted child labour. As one community member noted “It is difficult to define what constitutes child labour and differentiate it from the cultural practices that encourages teaching house chores to the children. When is it child labour and at what age?”<sup>261</sup> In another case community members raised concerns that chores around the house and in the fields or tending to livestock were a way of ensuring that “children had responsibility” and was a way of making children respectable and accountable. Greater guidance on what constitutes child labour would be a major step towards combating it at a community level. In 2018, the Government funded and participated in programmes that included the goal of eliminating or preventing child labour. However, gaps exist in these social programmes, including the adequacy of programmes to address child labour in all relevant sectors. See Annex 3 on the role and description of each coordinating body on child labour.

### **Children in migration flows**

Zambia is a country of origin, transit and destination for migrants mainly from the Democratic Republic of the Congo (DRC), eastern Africa and the Horn of Africa. Children on the Move include children who are stranded, at risk, are stateless, are victims of trafficking or child labour, are unaccompanied or separated as well as displaced children fleeing violence or conflict and rejected child asylum seekers. Traditional entry points have been through the borders with DRC in the North and Tanzania in the North-east. However, new entry points in the East, where Zambia borders Malawi and Mozambique were found in 2020. These new entry points can be attributed to an increased monitoring of traditional entry points, where a rapid upsurge in cases of COVID-19 was recorded and there was an implementation of restrictive entry measures for non-nationals by the Government. The COVID-19 pandemic has seen an increase in the numbers of vulnerable migrants, including undocumented migrants and victims of trafficking or smuggled individuals, being identified in the country. Mixed migration flows through the Eastern route have become more prominent leading to the identification of at least 500 Ethiopian nationals along that route in the last nine months. International Organization for Migration (IOM)-supported field profiling of these migrants has shown a general reduction in the age of the flows; where previously the lowest age range was about 15–17 years; last year’s reports have indicated that child migrants between ages 12–14 years move independently, without a parent or

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<sup>260</sup> FGD with Community Members, Kitwe 2021.

<sup>261</sup> Ibid.

guardian, and in the company of other older migrants who are not related to them, with most of these migrants, including the child migrants, not being in possession of any legal identity documents.<sup>262</sup>

### Street Children

Street-connected children represent a particular subcategory of orphans and vulnerable children that typically lacks regular family support. Studies conducted in 1991 and 2013 estimate that the number of street-connected children in Zambia more than doubled, from approximately 35,000 to 75,000.<sup>263,264&265</sup> This increase is attributed to poverty (rural and urban), large scale unemployment and the HIV/AIDS epidemic<sup>266</sup>. Zambia currently does not have a specific policy on street children; however, there is a National Child Policy that aims to “improve the standards of living in general and the quality of life for the Zambian child in particular”. Evidence on the causes and drivers of this phenomenon remains scant. The lack of quantitative evidence in this area stems from the difficulty of collecting micro-level data on street-connected children, and especially on their families of origin, as well as limited governmental attention on embedding street children into policies and strategies<sup>267</sup>. Lusaka alone has around 2000 street children, of which 1,300 are male.<sup>268</sup> The second and third cities with highest rate of street children are Kitwe and Ndola. Data suggests that children end up on the streets for varied reasons. There are those whose parents have passed away, those from broken homes where a parent has remarried and the child cannot get along with either the stepfather or mother, those who have been neglected, and some that have just ended up on the streets because they either travelled to the city out curiosity or have been influenced by their friends, who falsely persuaded them that they can make easy money. The most common feature is around poverty drivers and family breakdown. There are also some children who have been abused and needed to escape their home.<sup>269&270</sup> During discussions with respondents, the family situation was identified as a key driver and risk factor for street children: “If you go to the city, you find that most of them are not coming from Kitwe, most of them are coming from Chingola and Mufulira and if you go there and ask why they prefer to be on the streets rather than at home, they will tell you that the situation at home is not okay. They don’t eat or they eat once in a day, that has driven them to the streets is poverty so already that shows, if the economic situation were better they wouldn’t be on the streets.”<sup>271</sup> Available studies show the profile of street children is most likely between 15 and 18 years old and the majority are double or single orphans.<sup>272&273</sup> In one World

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<sup>262</sup> International Organization for Migration (IOM). <https://www.iom.int/covid-19-and-transformation-migration-and-mobility> (accessed on 29 October 2021).

<sup>263</sup> Tacon, P., & Lungwangwa, G. (1991). *Reap a Hundred Harvests: A Study on Street Children in Three Urban Centres of Zambia*. Unpublished. (1991b). *Survey on Street Children in Three Urban Centers of Namibia*. Unpublished. (1992). *Marco Jemuse and the Malevolent Monsters: A Program for Children in Especially Difficult Circumstances in Africa*, 3993–2000.

<sup>264</sup> Muntingh, L., Elemu, D., & Moens, L. (2006). Report on survey and analysis of the situation of street children in Zambia. Zambia Ministry of Community Development and Social Services and Zambia Ministry of Sport, Youth and Child Development: Zambia.

<sup>265</sup> Strobe et al (2013) *Breaking the Net: Family Structure and Street-Connected Children in Zambia* World Bank Open Knowledge Network available at <https://openknowledge.worldbank.org/handle/10986/13367?show=full> (accessed on 29 October 2021).

<sup>266</sup> Ibid.

<sup>267</sup> FGD with NGOs, Lusaka.

<sup>268</sup> Musika, C. 2018 <http://www.daily-mail.co.zm/lusaka-street-kids-grow-to-2000/> (accessed 29 October 2021).

<sup>269</sup> FGD with NGOs, Lusaka in 2021

<sup>270</sup> Strobe et al (2013) *Breaking the Net: Family Structure and Street-Connected Children in Zambia* World Bank Open Knowledge Network available at <https://openknowledge.worldbank.org/handle/10986/13367?show=full> (accessed on 29 October 2021).

<sup>271</sup> FGD, Government offices in Kitwe, Copperbelt Province.

<sup>272</sup> Strobe et al. (2013) *Breaking the Net: Family Structure and Street-Connected Children in Zambia* World Bank Open Knowledge Network available at <https://openknowledge.worldbank.org/handle/10986/13367?show=full> (accessed on 29 October 2021).

<sup>273</sup> Muntingh, L., Elemu, D., & Moens, L. (2006). Report on survey and analysis of the situation of street children in Zambia. Zambia Ministry of Community Development and Social Services and Zambia Ministry of Sport, Youth and Child Development: Zambia.

Bank study on Street Children out of a sample of 102 street children, 40 per cent indicated a lack of food and money as their primary reason for leaving home. Food is also the most common item (68 per cent) purchased by street children after their daily earnings from child labour or begging. They have extremely low school attendance and less 15 per cent actually attend school.<sup>274</sup> The secondary reason was ‘abuse in the home.’ These findings are consistent with field research, a Zambia NGO working with Street Children identified sexual and physical abuse, and family break down as causes behind the increase in street children. Crucially, boys were more often likely to run away from home and face specific gender-based challenges: “all the boys I have encountered and taken into my shelter have been sexually abused, some are raped on the street, others are exploited and prostituted out for money”.<sup>275</sup> As a result most are likely to contract HIV/AIDs and be chronically ill; awareness around HIV/AIDs and other sexually transmitted diseases and use of contraception is extremely low.<sup>276,277&278</sup>

### **Child trafficking**

Children trafficked within Zambia (internal migration) are primarily trafficked from rural to urban areas for domestic work and forced labour in agriculture. Most trafficking occurs within the country’s borders and involves traffickers exploiting women and children from rural areas in cities, in domestic servitude or forced labour in agriculture, textile production, mining, construction, small businesses, such as bakeries, and forced begging. Some children in Zambia are forced by Jerabo gangs, which are illegal mining syndicates in the Copperbelt Province, to load trucks with stolen copper ore. Along Zambia’s borders, the commercial sexual exploitation of children is common.<sup>279</sup> Respondents, during community consultations mentioned that the influx of traders and truck drivers poses serious risks to children and women. Truck drivers allegedly exploit Zambian children in sex trafficking in towns along the Zimbabwean and Tanzanian borders, and miners exploit children in Solwezi. Sex trafficking and coerced labour between Zambia and neighbouring states is believed to be taking place. While orphans and street children are perceived to be most vulnerable, children of affluent village families appear to be at risk of trafficking because sending children to the city for work is perceived as a way to confer status.

### **Child marriage**

Data from the ZDHS highlights that in Zambia, women marry earlier than men. The median age for first marriage is 19.1 years among women and 24.4 years among men ages 25 to 49 years. Nine per cent of women were first married by the age of 15, compared with less than 1 per cent of men. By the age of 18, the percentage of women who are married increases to 39 per cent. By the age of 25 years, four in five women (81 per cent) are married.<sup>280</sup> Girls in the poorest 20 per cent of households are three times

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<sup>274</sup> Strobe et al. (2013) *Breaking the Net: Family Structure and Street-Connected Children in Zambia* World Bank Open Knowledge Network available at <https://openknowledge.worldbank.org/handle/10986/13367?show=full> (accessed on 29 October 2021).

<sup>275</sup> FGD with NGO in Lusaka.

<sup>276</sup> Strobe et al. (2013) *Breaking the Net: Family Structure and Street-Connected Children in Zambia* World Bank Open Knowledge Network available at <https://openknowledge.worldbank.org/handle/10986/13367?show=full> (accessed on 29 October 2021).

<sup>277</sup> Muntingh, L., Elemu, D., & Moens, L. (2006). Report on survey and analysis of the situation of street children in Zambia. *Zambia Ministry of Community Development and Social Services and Zambia Ministry of Sport, Youth and Child Development: Zambia*.

<sup>278</sup> Ibid.

<sup>279</sup> United States Department of State, *2018 Trafficking in Persons Report – Zambia*, 28 June 2018, available at: <https://www.refworld.org/docid/5b3e0a36a.html> [accessed 25 June 2021] FGD with Community, Government and NGOS, Copperbelt.

<sup>280</sup> Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. 2014. *Zambia Demographic and Health Survey 2013-14*. Rockville, Maryland, USA: Central Statistical Office, Ministry of Health, and ICF International.

more likely to be married before the age of 18 years than those in the richest households.<sup>281&282</sup> In 2014, the Government commissioned a qualitative study through UNICEF on the dynamics leading to child marriage. The study found that child marriage is a manifestation of socioeconomic disparities<sup>293</sup>. Interestingly despite widespread assumptions across global literature on the causes of child marriage and the determinant factors including parent roles, the study found that the practice itself is not monolithic. The Government of Zambia and UNICEF (2015) study found six different ‘types’ of child marriage. Some of these involved girls and men, others, women and boys. However, the most common unions are those that take place between peers—girls (from the age of 12 or 13 years) and boys (from the age of 14 years), usually with an age difference of about two to three years. Most marriages involving children do not adhere to traditional processes. A significant finding here is that children often decide on their own to marry. Interviews with community members suggest that children, especially girls, are ‘willing’ to marry earlier to escape from the ‘hardships’ and poverty situation at home. Further evidence is required around the influencing factors. This also has implications on the Eighth National Development Plan and activities to tackle child marriage; the presumption that parent, traditional beliefs, and practices play a driving force as opposed to understanding the agency of children in child marriage. Key trends and patterns in child marriage arise from the literature review: those more likely to marry include children living in rural areas, those not attending school, pregnant girls and their boyfriends, orphans, and stepchildren, difficult or ‘hard to manage’ children, and children without adequate supervision or support. While both globally and in Zambia, girls are statistically at a much greater risk of child marriage than boys (DHS 2018), this study found significant numbers of boy husbands and fathers.<sup>283,284&285</sup> Several studies also highlight the after-effects of child marriage, which predominantly result in:

- **Increasing Poverty:** Child brides tend to drop out of school. As a result, any opportunities they may have had at getting a good job, and helping their families out of poverty, disappear.
- **Health Risks:** Child brides are more likely to suffer from depression or PTSD due to abuse from their spouses or the fast-paced way they are forced to grow up. Also, child marriage in Zambia is often correlated with pregnancy, which can lead to higher death rates for the mother or child because the mother is not developmentally mature enough to carry a baby. Additionally, data shows married girls in Zambia are 75 per cent more likely than their unmarried sexually active peers to contract HIV.
- **Risk of Violence:** Child brides are more likely to deal with domestic violence including physical, sexual and emotional abuse.

## Violence against children

According to the 2018 ZDHS, 4.2 per cent of women aged 20–24 years experienced sexual violence as children and 10 per cent of men aged 18–24 years experienced the same. The Government launched the Violence against Children Survey (VACS) in 2018 with support from The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), Centers for Disease Control and Prevention (CDC), UNICEF, UNZA and other

<sup>281</sup> Plan International 2013. “A girl’s right to say no to marriage. Working to end child marriage and keep girls in school.” <https://plan-uk.org/file/a-girls-right-to-say-no-to-marriage/download?token=rW2qmh-7> (accessed 29 October 2021).

<sup>282</sup> UNICEF & Government of Zambia (2015). *Qualitative Study of Child Marriage in Six Districts of Zambia*. <https://www.unicef.org/zambia/media/621/file/Zambia-child-marriage-research.pdf> (accessed on 29 October 2021).

<sup>283</sup> Misunas, C., Gastón, C. M., & Cappa, C. (2019). Child marriage among boys in high-prevalence countries: an analysis of sexual and reproductive health outcomes. *BMC international health and human rights*, 19(1), 1–16.

<sup>284</sup> UNICEF & Government of Zambia (2015). *Qualitative Study of Child Marriage in Six Districts of Zambia*. <https://www.unicef.org/zambia/media/621/file/Zambia-child-marriage-research.pdf> (accessed on 29 October 2021).

<sup>285</sup> Human Rights Watch. (2016). *World Report*. [https://www.hrw.org/sites/default/files/world\\_report\\_download/wr2016\\_web.pdf](https://www.hrw.org/sites/default/files/world_report_download/wr2016_web.pdf) (accessed on 31 October 2021).

partners. Results show that violence against children is a problem and is rife in Zambia. The co-occurrence of violence overall and of different types of violence, sexual abuse, sexual, emotional and physical violence is prominent. Half of females and males experienced at least one type of violence in their childhood. Of the 1,819 individuals aged 13–24 years (891 females and 928 males) interviewed; female respondents aged 18–24 years were more likely to report experiencing sexual abuse than males in the same age group. Females were also more likely to experience physically forced sex in childhood compared to males. One in three females and two in five males aged 18–24 years experienced physical violence prior to age 18. A quarter of male and female respondents aged 13–17 years experienced physical violence in the 12 months prior to the survey.<sup>286</sup> Findings from the survey show that one in five females and one in six males aged 18 to 24 experienced emotional violence<sup>287</sup>. Amongst experiences of sexual violence by 13- to 17-year-olds, 28.3 per cent of females and 6.8 per cent of males stated that the first experience of sexual intercourse was unwanted. Physical violence among 13- to 17-year-olds by a parent, adult caregiver or other adult relative in the last 12 months was 14 per cent for females and 11.3 per cent for males. Numerous studies support these findings, showing that VAC is a significant problem in Zambia in both home and school.<sup>288</sup> Respondents from the research districts concurred that violence in their childhood was often a precursor for experiencing violence later in life (FGDs with parents, community, Government officials in Luapula and Copperbelt Provinces).

### Gender based violence

GBV is widespread in Zambia, with girls and women, particularly those in rural areas, facing high rates of GBV, including sexual exploitation and abuse/sexual harassment (SEA/SH). GBV is defined as any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering among women, including threats of such acts and coercion or arbitrary deprivations of liberty, whether occurring in public or in private life. However, GBV-related indicators were not included in Demographic and Health (DHS) Surveys until 2013–14. In addition to ratifying international and regional conventions on women's rights, gender equality, and social inclusion, Zambia has implemented the Anti-Gender-Based Violence Act of 2011, and enacted the National Gender Policy of 2014. Available data from the ZDHS 2018 and VAC survey reveals that:

- 33.8 per cent of women and 40.1 per cent of men aged 20–24 years experienced physical violence before the age of 18 years; and 20.3 per cent and 10.0 per cent, respectively, experienced sexual violence.<sup>289</sup>
- 31.4 per cent of women aged 20–24 years were married before the age of 18 years.<sup>290</sup> Approximately 58.9 per cent of girls aged 15–19 years were pregnant or had already delivered a baby, as of 2013.<sup>291</sup>

According to the 2018 ZDHS, more than one-third (36 per cent) of women aged 15–49 years have experienced physical violence at least once since the age of 15 years, and 18 per cent experienced physical violence within the 12 months prior to the survey. Forty-seven per cent of ever-married women

<sup>286</sup> Ministry of Youth, Sport and Child Development, and UNICEF et al. (2018). *Violence against Children in Zambia: Findings from a national survey, 2014*. Lusaka.  
[https://www.researchgate.net/publication/325246966\\_Addressing\\_School\\_Related\\_Gender\\_Based\\_Violence\\_in\\_Zambia\\_A\\_Scoping\\_Study](https://www.researchgate.net/publication/325246966_Addressing_School_Related_Gender_Based_Violence_in_Zambia_A_Scoping_Study)

<sup>287</sup> Ibid.

<sup>288</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

<sup>289</sup> H-Well (aka VACS) Data Brief <https://www.unicef.org/zambia/media/1066/file/Zambia-HWell-Policy-Brief-2015.pdf>.

<sup>290</sup> United Nations Children's Fund (UNICEF) Zambia 2018 *Zambia Demographic and Health Survey Secondary Data Analysis*. Lusaka: UNICEF, 2021.

<sup>291</sup> Ibid

have experienced physical, sexual or emotional violence by their current or most recent husband or partner. Among ever-married women who had experienced spousal physical violence in the past 12 months, 35 per cent reported having sustained physical injuries. Similarly, according to the 2014 Zambia Health & Wellbeing Survey,<sup>292</sup> young people expressed having experienced emotional violence by a parent or caregiver under two conditions:

- Prior to the age of 18 years, emotional violence was reported by 15.9 per cent of girls and 20 per cent of boys, aged 18–24 years.
- Within the past 12 months, emotional violence was reported by 17.7 per cent of girls and 12.5 per cent of boys, aged 13–17 years.

In terms of trends in data, the percentage of women who have experienced physical violence since the age of 15 years is higher in rural areas (37 per cent) than in urban areas (34 per cent). Also, rural women (18 per cent) are slightly more likely than urban women (17 per cent) to have experienced physical violence often or sometimes in the last 12 months. This is consistent from evidence emerging from field reports. Respondents mentioned how attitudes around violence towards women are still very much prevalent and pose a challenge to girls' rights.<sup>293</sup> The percentage of women who have experienced physical violence since age 15 years declined from 47 per cent in 2007 to 36 per cent in 2018. The percentage of women who experienced physical violence in the 12 months prior to the survey declined from 32 per cent to 18 per cent over the same period.

## 11.4 Challenges, shortfalls and inequities

### **Birth registration**

Findings from the assessments showed that Zambia has low civil registration coverage due to three main reasons: geographic factors, centralised supply or service delivery system, and thirdly, low demand by communities. The MoH established that a specific challenge, which is keeping birth registration numbers low in Zambia, is the wide acceptance of alternative user documents, such as the birth record which is often taken to be the birth certificate. Hence the demand for birth registration certificates is low.

### **Child justice and detention of migrant children**

A UNICEF-supported nationwide child detention monitoring mission that took place in 2018 found over 1,000 children, including migrant and circumstantial children, in prisons or police cells. Many of the children in conflict with the law were in detention for minor offences. The Government has taken steps towards the reformation of the juvenile justice by developing a National Diversion Framework, establishing specialised family courts and children's Division of the High Court, and putting in an order for this reform to be sustainable and to address the multi-faceted and complex nature of juvenile delinquency. The reform must be conducted in a coordinated, concerted, comprehensive, consultative and sustainable fashion to build a system for dealing with juveniles separately from the adult criminal justice system. The area of access to justice for child victims/witnesses is emphasised in other chapters of the Situation Analysis. Zambia criminalises illegal entry into and stay in the country. Vulnerable children found in migration flows risk being criminalised if they are not identified and assessed for protection. Children on the move are also at risk of immigration detention for illegal entry into the country. Once identified, children on the move have been reported as being held in detention, often for prolonged periods of time, with high exposure to ill health conditions and violence in detention. Support has been provided by the United Nations in Zambia in the development of the National Referral Mechanism for vulnerable migrants and Best Interest Determination Guidelines for Vulnerable Child

<sup>292</sup> H-Well (aka VACS) Data Brief <https://www.unicef.org/zambia/media/1066/file/Zambia-HWell-Policy-Brief-2015.pdf>

<sup>293</sup> FGD with NGOs Luapula, Copperbelt and Chipata.



Migrants. The guidelines aim to support the various state and non-state actors to provide comprehensive services to migrants in need of protection. Implementation of these provisions by the various frontline officials have highlighted issues which require a concerted whole of government and whole of society approach. These issues pertain to age determination of child migrants and alternatives to detention for vulnerable child migrants.

### **Child labour**

Despite the enactment of the Employment of Young Persons and Children (Amendment) Act No.10 of 2004, the regulation allows children aged 13–15 years to engage in light work. With limited initiatives to combat child labour, there is concern that ‘light work’ might be real work and can interfere with children’s education. It can also be misconstrued in many ways. In 2018, the Ministry of Labour and Social Security (MLSS) increased the size of the inspectorate to 155 labour inspectors, and in 2019 this was increased to 160.<sup>294</sup> However, the number of labour inspectors likely remains insufficient for the size of Zambia’s workforce, which includes approximately 6.9 million workers. According to the ILO’s technical advice of a ratio of 1 inspector for every 40,000 workers in less developed economies; Zambia would employ about 172 inspectors.<sup>295</sup> Insufficient budget, insufficient office space, inadequate training, and a lack of transportation and fuel have prevented MLSS from adequately conducting inspections countrywide.<sup>296</sup> The MLSS conducts labour inspections in registered private institutions only; it does not conduct investigations, allowed by law, in unregistered institutions where child labour is more likely to be found. In 2018, the MLSS removed 2,787 children from child labour.<sup>297</sup> A referral mechanism exists through District Child Labour Committees that allows labour officers to refer cases to district social welfare officers who have the legal mandate to complete a risk assessment and make decisions.

### **Street children**

Given the importance of family and household dynamics, and the linkages with street children, it is recommended that further research is conducted to obtain updated profiles of street children and suggest early household intervention strategies and mitigation measures. It is also recommended to look at reintegration and reunification measures, where possible, and where it does not jeopardise the safety of the child. Suggestions for socio-psychological support and social workers to be trained in mental health and conflict management were also raised by NGOs. Many street children are placed in children’s homes, that is institutional care settings, which violates a child’s right to grow up in a family environment. Most children placed in care in Zambia are placed in children’s homes and no infrastructure is in place to operationalise alternatives, such as foster care. Reintegration of children into their birth families or kinship care is the mandate of social welfare, but lack of adequate resources means that such efforts are dependent on donor funds.

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<sup>294</sup> Bureau of International Labor Affairs, *2019 Findings on the Worst Forms of Child Labor: Zambia*. [https://www.dol.gov/sites/dolgov/files/ILAB/child\\_labor\\_reports/tda2018/Zambia.pdf](https://www.dol.gov/sites/dolgov/files/ILAB/child_labor_reports/tda2018/Zambia.pdf) (accessed on 29 October 2021).

<sup>295</sup> United States Department of State, *2018 Trafficking in Persons Report - Zambia*, 28 June 2018, available at: <https://www.refworld.org/docid/5b3e0a36a.html> (accessed 25 June 2021).

<sup>296</sup> United States Department of State, *2018 Trafficking in Persons Report - Zambia*, 28 June 2018, available at: <https://www.refworld.org/docid/5b3e0a36a.html> (accessed 25 June 2021).

<sup>297</sup> Bureau of international Labor Affairs, *2019 Findings on the Worst Forms of Child Labor: Zambia*. [https://www.dol.gov/sites/dolgov/files/ILAB/child\\_labor\\_reports/tda2018/Zambia.pdf](https://www.dol.gov/sites/dolgov/files/ILAB/child_labor_reports/tda2018/Zambia.pdf) (accessed on 29 October 2021).

**One NGO member's experience of working with street children**

"There is the lack of cooperation and coordination between the different sectors of Government dealing with children and family programmes. We work with street children, which is under the Ministry of Youth and Sports. Then we have to get an admission letter from the Ministry of Community Development and Social Welfare. Then to get someone to make a home assessment with you, you have to pay 100 Kwacha to each Government worker that you take with. Then to get a health assessment, you have to pay at a Government hospital and pay for the medical report, which is required by social welfare to be in the child's file. Then finally, when you get a child into school, you have to pay the Government school to educate the child from the streets that the Government placed with you to begin with. As a Children's NGO, it is nearly impossible to keep up with all the Government players involved. Even if you finally get to court for a committal order, you have to pay the court fees and social welfare officer. I once was arrested and the children removed from Salvation Home for operating illegally and feeding the children in the streets by officers from the Ministry of Community Development and Social Welfare, even though I had full and legal authority from the Ministry of Youth and Sports and every child I had was from the streets. There needs to be greater transparency and accountability for how the funds are spent. Someone needs to be accountable for producing results and affecting change in the children's lives. There is real harm to the children if nothing is done to change things."

The example above demonstrates the lack of clarity when it comes to mandate for addressing the issue of street children. Whilst MCDSS has the mandate for the protection and care of vulnerable children, the MYSCD has been given a discretionary mandate regarding street children. The main role of MYSCD is one of child policy coordination and as such, the Ministry does not have any staff at district level nor a role to employ gazetted social welfare officers who make decisions regarding the care of children without parental care or with inappropriate parental care. There have been several challenges identified specific to working with street children: firstly, around lack of understanding of what constitutes street children, secondly the lack of integration of street children in national or local policies and finally the lack of resources and coordination around efforts. Most of the actors involved in working with street children are either international or local NGO's.

**Child marriage**

Although the drivers of marriage and pregnancy are increasingly well understood, there is a dearth of evidence on how the children who marry, cohabit, or have children navigate their new roles and relationships, including experiences of parenting, separation, and divorce, and the types of support and services that are available to them. Moreover, little is known about how the choices, opportunities, experiences and relationships of those children who marry, cohabit or have children are shaped by age, gender and the changing social, cultural and structural contexts in which they and their families are living.

**Violence against children**

The biggest concern raised by the VAC study was lack of access to services for child survivors of sexual abuse. Zero per cent of girls and 6.5 per cent of boys, who experienced sexual violence, had access to services. A key challenge when it comes tackling VAC is lack of comprehensive and up-to-date information on violence against children, making it difficult to plan, implement, monitor, and evaluate appropriate policies and programming for child protection. This lack of sufficient and reliable data contributes to the inability of both the Government and other agencies to make informed programmatic decisions around VAC. As a result, evidence is urgently needed to support advocacy, inform national



planning and funding allocation, and monitor the impact of all forms of violence. These observations culminated in specific action points, which are included in the sector specific recommendations for Government action.

#### Violence against Children: Views from the community, adolescents, NGOs and Government officials

Field respondents from several sectors and age groups expressed concern about the level of abuse and exploitation in their communities, which emanated from the following experiences and observations: (a) widespread incidents of sexual violence in a range of settings including within families, public institutions and detention centres; (b) lack of data on sexual abuse cases, and the reluctance of family and the general public to acknowledge the existence of sexual abuse; (c) violence appears to be socially tolerated in the family and in society and is accompanied by a culture of impunity that contributes to high levels of underreporting; (d) low rate of convictions for reported incidents of rape and defilement; and (e) lack of information on the Government's provision of psychosocial support to child victims of rape and their families.

Some parents found distance to school to be challenging and a risk to children: "Security is bad, in the case of distances children in rural area walk to get to school are too long, and this is also contributing to early child pregnancies. It would be good if the children walked short distances, so they can get to and from school in the shortest time."<sup>298</sup>

Others identified stepchildren and foster children as being particularly vulnerable to violence at home: "Step children are being subjected to verbal, physical and sexual abuse by step parents or guardians." Others raised the concern over justice as there have been many examples provided during the interview of instances of rape, cases of defilement, but the police had not taken any significant action; there was a notable grievance that justice was reserved for those "with money." Respondents agreed that there are some key changes are required to address these issues:

"I think one of the major contributing factors is failure to enforce the existing laws and corruptness of law enforcers. Secondly, we need laws to guide conduct of citizens in the area of alcohol consumption and other issues. Thirdly organisations or government ministries are not doing enough to sensitize citizens. They are not on the ground, in the communities instead they focus on making appearances in TV and radio. Lastly there is need for recreational facilities in the communities, this reduces the danger we have spoken about."

### 11.5 Stakeholder landscape and initiatives

Many development partners and CSO partners have supported child protection initiatives. Development partners include USAID, GHR Foundation (alternative care programme), FCDO (global child marriage programme) and the EU (birth registration programme; developing programme on addressing GBV). This support is complemented by the work of NGOs, such as Save the Children (focusing on alternative care and child justice); Zambia Rising (USAID funded under SCI- focusing on SEEVCA and alternative care); Plan Zambia focusing on child marriage, the Civil Society Network on ECM (secretariat: Plan Zambia; Chair: WiLSA) and Expanded Church Response (partnering with SEEVCA). World vision is a key stakeholder and is working with Government on several initiatives around birth registration and tackling child marriage and child pregnancy. Many of the stakeholder initiatives focus on a single type of vulnerability and, whilst working closely with the Government, often create disjointed pocket-holes of

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<sup>298</sup> FGD with Community Members, District Kitwe – Copperbelt/Luapula Provinces.

good practice that do not “add-up” into a single systematised social welfare system or an integrated child protection system across sectors.

Whilst UNICEF is working closely with a range of cooperation partners on addressing different types of vulnerability, it is trying to do so in a way that puts efforts into a single umbrella that builds on existing laws and advancing their implementation. The vision is a uniform/single statutory social welfare case management system that can make informed decisions for children experiencing different types of vulnerability and then a strong prevention system that combined early identification/response with social and behaviour change initiatives and relies on social welfare community-based volunteers whose work is regulated by the MCDSS. A strong and robust statutory social welfare system would comprise of a Handbook assisting District Social Welfare Officers to operationalize the law with thematic guidance notes for different types of vulnerability, an accompanying database for managing cases which is implemented in a uniform manner. Emphasis on prevention that includes early-identification and reliance on community-based volunteers as well as social and behaviour change initiatives that increasingly follow robust mechanisms of implementation (influenced by the nudge theory) are key directions for way forward. In addition to strengthening the social welfare system itself, there is a recognition of the paramount roles of other systems including police, prosecution, judiciary and health when cases of violence against children are being addressed and response services are provided. The education and health systems are key strategic partner for prevention and for referral of cases of violence to social welfare and/or police when action needs to be taken regarding the childcare or when action needs to be taken against a perpetrator. Robust referral mechanisms with clear accountability for the different roles and responsibilities are therefore key.

The Zambia Civic Education Association which coordinates many local human rights organizations, including a cluster of child rights organizations, has played a key role in bringing key issues to the attention of the Government, Parliament and the media. A similar role has been played by the Children in Need Network (CHIN) and both umbrella organizations have advocated for the adoption of the Children’s Code Bill. In 2015/16 the Civil Society Network on Ending Child Marriage (linked to the global Girls not Brides network) was launched, with the aim of catalysing a social movement. Composed of over 35 members spread throughout the country, they have implemented many small-scale initiatives, which have had good results. Despite being a potential strong resource, not all network members are abreast of the new child marriage focus and limit their work to awareness-raising activities only. Several local NGOs working with street children have sustainable and successful initiatives around reintegration and supporting street children, which have the possibility to be scaled up. Shelter for Street Children is based in Lusaka, and Chisomo has three main programmes which address the issue of street children in Lusaka through prevention, intervention and rehabilitation. It would be valuable for UNICEF and the Government to understand the rate of success of these local initiatives at a local level and how they can further upscale and support them.

#### 11.6 Sector specific recommendations

**Advance legislation for the protection of children.** There is uniform recognition that the Juvenile’s Act needs to be aligned with international and regional standards, and a Children’s Code would need to be re-aligned with provisions from the Act and other related legislation (Maintenance Act, Adoption Act, parts of Probation Act related to children). This has been on-going for a decade. The Government needs to expedite the finalisation and adoption of the Children’s Act so that the above related issues concerning mandates and accountability are addressed and that standards endorsed through the

ratification of international conventions are domesticated (primarily the CRC, but also CEDAW and the CRPD).

**Improve birth registration.** Government has started piloting the new birth to death integrated national registration and information system (INRIS). As the unique identity number will now be issued during birth registration, the demand for birth registration is expected to rise. To achieve this, there is a need for national roll out. Given that 84 per cent of births in Zambia occur in health facilities, Government also needs to expedite the linking INRIS to the MoH's SmartCare information system to ensure that birth notifications in health facilities are transmitted electronically to the civil registration office for efficient registration and certification purposes. This in line with the MoU that was signed between the MoHA and MoH in 2019.

**Introduce quality assurance for the social work profession.** It is clear from the above analysis that there is a lack of understanding of the central role social workers and the District Social Welfare Officers should play in addressing the cases of children who are at significant risk of harm. By and large, the work is guided by provisions of the law and there are insufficient statutory instruments or policy guidance notes that can assist social workers and welfare officers in operationalising key child rights principles when dealing with individual cases. Statutory instruments or handbooks describing mandatory procedures need to be developed and should include correlated data management systems that are key for ensuring accountability. The Social Welfare Association Bill that introduces a quality assurance system for social work had passed the legislative review but was not adopted by the Cabinet for further submission to Parliament. Such legislation is key, as it puts the social work profession on par with other child-focused professions (such as teachers, doctors, nurses) which have well defined roles and professional licensing procedures. The Juvenile's Act necessitates action from diverse sectors including police, social welfare, prosecution and judiciary. Social welfare plays a key role in ensuring decisions are made taking the best interests of the child into account. Although the legislation does not recognize the term "statutory case management" the responsibility of this sector is to manage individual cases and engage with the police, health services, prosecution and judiciary. The gap identified in the above analysis needs to be addressed through the adoption of more explicit statutory case management procedures. In addition to this, a single child relevant referral framework that clearly differentiates the roles and responsibilities of all actors in the process of addressing protection issues needs to be developed and endorsed as mandatory procedure for all sectors involved. At present referral mechanisms are in place for GBV cases and for cases of migrant children, but their application is not mandatory.

**Introduce child safeguarding policies for all organizations that directly interacting with children.**

The above analysis details efforts made to introduce protection in schools and the challenges that still exist in this area. It also points to the lack of any protection procedures for other organizations that directly interact with children without presence of parents/carers. These include health facilities, sport clubs and other children's or youth clubs and churches. The Government can require mandatory child safeguarding procedures to be implemented by all public, private or NGO actors who are registered to work directly with children.

**Improve funding and resourcing policies.** To prepare for policy implementation, Zambian Government must provide budgets to fund services, personnel and trainings, to implement laws and policies to end violence against children. These resources are hard-won, given competing political and funding interests, however, funding from official development assistance budgets coupled with partnerships from civil society can amplify state budgets. Governments must create a detailed budget for national

action plans, current laws and policies; budgets must identify activity-related costs and implementation. Priority needs to be given to adequate resources for the full implementation of the Anti Gender-Based Violence Act to address comprehensive measures to address such violence.

**Improve protection of child victims and witnesses of sexual abuse and other types of violence against children.** The above analysis shows that children who have experienced violence do not have access to services and that such cases are not being processed. For this to change, there must be key accountability of all key actors involved, from the police to social welfare, health, prosecution and judiciary personnel. If perpetrators are not brought to justice and cases go unreported, the problems of violence against children will persist in society. It is recommended that mechanisms, procedures, and guidelines to ensure a) mandatory reporting of cases of child sexual abuse and exploitation are established and implemented, b) criminalise marital rape and c) strengthen training for the judiciary and law enforcement personnel and health-service providers. The Children's Code Bill is a good opportunity to legislate protection of child victims/witnesses to make sure that any child giving a statement is interviewed in a manner responding to his/her age and maturity, that the interview reaches the required standards of forensic interviewing and can be used as evidence against the perpetrator, and that the child is protected from secondary trauma caused by a judicial procedure. Access to support services, including psychosocial support, facilitation of kinship care arrangements or foster care must be provided.

**Manage data.** The Government must ensure that systems with clear mandates for the protection of children strengthen data management so that it is appropriately age disaggregated and provides information on whether the respective systems are performing as per the law. The systems that need to be strengthened are: police data systems that record cases of arrested and detained children, social welfare systems with data on all cases of children addressed (including children in need of care and protection, juvenile offenders and child victims in justice processes, child sexual abuse cases), prosecution databases that show the number of cases in which children were victims of crime or children who have committed a crime processed by the prosecution, and data from the judiciary on both criminal and civil proceedings where children were either offenders/victims or an interested party in a civil proceeding. Better administrative data acts as a pre-condition for advancing enforcement mechanism and professional accountability of all civil service staff across sectors that play an important role in responding to cases of violence against children and these include the police, prosecution, social welfare and the judiciary. Response data on action taken needs to permeate down to individuals who have taken such action or have failed to do so.

**Provide psychosocial and recovery services.** The Government must take all necessary measures to ensure a) that the prevention, protection, recovery and social reintegration of child victims are in accordance with the resolution documents adopted at the World Congress against Commercial Sexual Exploitation of Children, b) that child victims of violence receive psychosocial and recovery services, and c) that children are aware of reporting procedures and are encouraged to report cases of domestic violence, in particular child sexual abuse, and that appropriate counselling mechanisms are in place.

**Address social and behaviour change.** The situation analysis points to high levels of tolerance of violence against children. This tolerance exists at different levels including at home, school, community as well as amongst civil service practitioners who are responsible for protecting children (teachers, police authorities, social workers, health workers, prosecutors and judges). To achieve a shift in attitudes and behaviours, efforts are needed on continuous campaigning on violence against children through diverse media outlets and community mechanisms, with each sector playing a role. Shifts in

attitudes and behaviours must also come at the level of civil service and NGO practitioners who can take responsibility in addressing cases of violence and referring them to the authorities. The Government can build on existing networks of social welfare volunteers who play a key role at the community level. Social welfare volunteers can conduct awareness-raising activities to combat stigmatisation of victims of sexual exploitation and abuse, including incest, and ensure accessible, confidential, child-friendly, and effective reporting channels and referral pathways for such violations.

**Standardise and up-scale community-based case management for early identification and response.** A key part of prevention includes the identification of vulnerability and social exclusion at an early stage so that children and parents can be supported to access necessary services. This particularly pertains to addressing school drop-out, access to medical treatment, including for HIV, and access to services for parents and children where domestic abuse has taken place. CWACs have played a key role in providing this service across projects and programmes. Recognition and soft regulation of CWAC role would ensure a quality assurance system and that such support is provided in a uniform manner across districts and donor interventions.

# CHAPTER 12. SOCIAL PROTECTION

## 12.1 Introduction

Social protection policies are essential for tackling inequities and driving progress towards equal opportunities and access to services for children. Investments in children's lives (i.e., addressing social and economic vulnerabilities) during their growing years, yield huge returns. Missed investments, on the other hand (i.e., failing to address social and economic vulnerabilities), come with considerable losses with life-long consequences in terms of opportunities/life chances that they will have later in life. Because of this, children should be prioritised in social protection policy, considering that they are in a period in their lives that is characterised by rapid development. In the past decade, social protection has played a crucial role in reducing child poverty and in improving the lives of children around the world. In many countries, social protection systems have prioritised children by designing and implementing transfers targeted at children or households with children. A rapidly expanding evidence base indeed shows that social protection makes an important contribution to children's lives, ranging from poverty reduction to improved education and health outcomes. Human rights approaches have, in many instances, been used effectively at the international and domestic level to push states to improve social protection programmes. For Zambia to effectively tackle child poverty and vulnerability, an integrated social protection system, becomes essential. According to UNICEF, elements of a social protection system for children include social transfers; programmes to ensure access to services; social support and care services; and legislation and policies to ensure non-discrimination in access to services, employment and livelihoods. Overall, Zambia's social protection system consists of five pillars as outlined in the 2014 National Social Protection Policy. These include Social Assistance, Social and Health Insurance, Livelihoods and Empowerment, Protection and Disability. Within these pillars, the Government implements a range of programmes that are either contributory or non-contributory to certain sub-groups of the population. A total of 30 programmes are mapped under the overall social protection ambit including six under social assistance, eleven in livelihoods and empowerment, seven under social security and social health insurance, four under protection and two under disability (see Table 14 below).

Table 14: Current social protection by pillar

Social Assistance	Livelihood and Empowerment	Social Security and Social Health Insurance	Protection	Disability
Social Cash Transfer (SCT) Programme	Farmer Input Support Programme (FISP)	Public Service Pension Fund (PSPF)	National Referral Mechanism for vulnerable migrants (NRMVM)	Promotion of Disability Inclusion (Disability mainstreaming)
GEWEL - Keep Girls in School (KGS)	Youth Development Fund	National Pension Authority (NAPSA)	Places of Safety	National Trust Fund for Persons with Disabilities (NTFPD)
Home-Grown School Feeding (HGSF)	Women Economic Empowerment Fund	Local Authorities Superannuation Fund (LASF)	Child Protection	
Public Welfare Assistance Scheme (PWAS)	Village Banking	Workers Compensation Fund (WCF)	Protection Against HIV	

Bursaries for Orphans and Vulnerable Children	Youth Innovation Fund	Occupational Pension Schemes (OPS)		
Nutrition sensitive Social Protection Sector (NSSP)	Emergent Farmers Support Fund	Social Health Insurance Scheme		
	FSP	Weather Index Insurance (WII)		
	Empowerment in Aquaculture (EIA) Fund			
	Youth Empowerment			
	GEWEL - Supporting Women Livelihood (SWL)			
	Livestock Pass-On Scheme (LPOS)			

In all these programmes, children are direct or indirect beneficiaries, although only limited programmes are designed specifically and comprehensively for children. The current social protection system is inadequate to provide children their rights and it is not sufficiently oriented towards providing children's benefits to address the multidimensional poverty that they suffer from, the different contexts and situations in which they live as well as to respond to the unique challenges and needs of children and adolescents in Zambia. Presently, there is no universal child grant that is targeted to all children in whatever circumstances they live, to ensure an adequate living standard.

## 12.2 Legal and policy framework

The United Nations legal framework on human rights contains several provisions spelling out various rights of children that form part of their right to social protection. These comprise the right to social security, taking into consideration the resources and the circumstances of the child and persons having responsibility for their maintenance; the right to a standard of living that is adequate for children's health and their well-being; and the right to special care and assistance. The International Covenant on Economic, Social and Cultural Rights (ICESCR) further requires States to give the widest possible protection and assistance to the family, particularly for the care and education of dependent children (ILO, 2015). The Government, through the Ministry of Community Development and Social Services (MCDSS), has developed policies and strategies to aid the implementation of the social protection programmes. Various instruments characterise the policy and legal framework of Zambia's social protection sector. The National Social Protection Policy (NSPP) is the overarching policy that provides for the legislation currently guiding the sector. The NSSP presents various pieces of legislation to provide for advancements in social protection. In terms of legislation, the Government has initiated the drafting of the Social Protection Bill, a draft overarching law for social protection, which spells out Zambians' social protection entitlements covering a range of lifecycle contingencies. Once effected, the bill will harmonise contributory and non-contributory programming to clarify institutional arrangements and overall social protection regulation. The main pieces of legislation listed according to the policy are:

### **National legislation**

- Day Nurseries (Repeal) Act CAP 313 of 2011
- Employment of Children and Young Persons Act CAP 274 of 1933
- Anti-Gender Based Violence Act No. of 2009
- Anti-Human Trafficking Act No. 1 of 2011
- NGOs Act No. 16 of 2009

Another key Act for the sector is the National Health Insurance Act of 2018 which was envisioned in the 2014 NSPP. The Act provides for sound financing for the national health system; provides for universal access to quality insured healthcare services; establishes the National Health Insurance Scheme; establishes the National Health Insurance Fund and provides for contributions to and payments from the Fund; and lays out institutional and operational arrangements. If implemented well, the Act will help the country realise key universal health coverage goals, including equity, financial protection and access.

### **International and regional legislation (protocols and instruments)**

- The United Nations CRPD of 2006 (signed 2008, ratified 2010)
- African Union Social Policy Framework of 2008
- Universal Declaration of Human Rights of 1948 (signed 1983, ratified 1984)
- Declaration on Social Progress and Development of 1969
- CEDAW of 1979 (ratified 1985)

The lead agency for social protection is the MCDSS, although social protection programme implementation falls under a number of different ministries. Therefore, while the MCDSS is the custodian of the NSPP, other ministries are responsible for delivering on certain programmes under the social protection ambit. The roles that the different line ministries play have been harmonised in the framework of the 7NDP Poverty and Vulnerability Reduction Cluster. This has provided a level of horizontal coordination that is essential to attaining the NSPP policy objectives. Zambia has had several social protection programmes, some of them pre-dating its independence in 1964, although its first NSPP was only developed in 2014, bringing together programmes that had historically operated in silos. The NSPP provided a comprehensive sectoral vision and led the path for an integrated social protection system. The 7NDP developed in 2017 provided greater impetus for integration of social protection. The 7NDP introduced the cluster approach to national development, aiming to have greater coordination in implementation of programmes. Social protection was recognised as a key instrument in the poverty and vulnerability reduction cluster. To ensure the effectiveness of social protection in reducing poverty and inequality, three key strategies were outlined that focused on enhancing coordination and systems, expanding coverage and implementing pension reform. Some of the initiatives to ensure successful translation of strategies into successes included extension of coverage to informal economy, the single window initiative, integration of information systems, increased coverage of social assistance and livelihood and empowerment programmes, indexation of benefits and setting benchmarks for spending in proportion to GDP. In 2018, to further harmonise the implementation of non-contributory social protection programmes, MCDSS developed the Integrated Framework of Basic Social Protection Programmes (IFBSPP). The IFBSPP systematised the relation between NSPP pillars, showing how programmes could be integrated across pillars. The IFBSPP distinguished programmes by developmental progression and introduced the Floor and Ladder concept as a graduation pathway.



### 12.3 Levels, trends and differentials in key indicators

Social protection programmes aimed at reducing vulnerability and poverty in Zambia need to be conscious of the demographic context, understand what drives inequality and what limits inclusion in the socioeconomic engine of the country and among children. This requires the development of child-sensitive social protection systems to reduce child poverty in the country. A UNICEF Multiple Overlapping Deprivation Analysis (MODA) of child poverty in the country revealed that children aged 0–17 years suffer high and severe child deprivation: as high as 41 per cent of children suffering from at least three deprivations at a time and experiencing four deprivations on average.<sup>299&300</sup> These multiple overlapping deprivations have long-lasting effects on children. Therefore, social protection that is designed to reach children should aim to eliminate deprivation in both the present and in the long run. It is important to understand the extent to which policies, programmes and spending on existing social protection is delivering positive child outcomes whether directly or indirectly.

#### **Policy responsiveness**

The 2014 NSPP provided elaborate social protection programming, built on the back of the Transformative Framework. However, several key programming and coverage gaps remain evident, essentially because the policy was not designed based on a comprehensive lifecycle framework. Because of this, certain categories of the population are not comprehensively covered and certain contingencies that are expected at different stages of the lifecycle are not covered. IFBSPP addresses this challenge and details specific gaps and recommendations, such as priority social assistance coverage for the first 1,000 days of life, secondary education support for boys and UHC. As it stands, there is no universal child benefit that covers all children in Zambia regardless of socioeconomic status. Several children in different situations are therefore left uncovered under any form of social protection.

#### **Social assistance**

Zambia has a total of six social assistance programmes: the Public Welfare Assistance Scheme (PWAS), Social Cash Transfers (SCT), Keeping Girls in Schools (KGS), Home-Grown School Meals (HGSM), Bursaries for Orphans and Vulnerable Children, and Nutrition Sensitive Social Protection (NSSP). Three out of the five programmes, KGS, HGSM and bursaries for Orphans and Vulnerable Children, are specifically designed to benefit children from impoverished households. PWAS and SCT also deliberately target children in their design, although they are not child-only programmes. Children make up a significant portion of beneficiaries in the SCT programme with the total number of children on the programmes standing at 977,164 based on existing SCT-MIS figures.<sup>301</sup> Estimates by the World Bank suggest that the five social assistance programmes covered around 23 per cent of Zambia's population (UNICEF and World Bank, 2021). One of the major gaps identified is the lack of adequate programming for pregnant and lactating mothers. In terms of the budget for social assistance, since 2011 and over the period that the country has been implementing the NSPP, the sector has registered steady growth towards social assistance allocations. The highest allocation within social protection is directed towards social assistance, which is the pillar dedicated to poverty reduction and vulnerable groups with up to 64 per cent of the allocation to social protection going towards social assistance programmes.

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<sup>299</sup> UNICEF MODA 2018, *Child Poverty in Zambia report (2018): A multiple overlapping deprivation analysis*, UNICEF, Available at: < <https://www.unicef.org/zambia/reports/child-poverty-zambia-report-2018#:~:text=MODA%20analysis%20for%20children%20age,areas%20of%20residence%20are%20significant.>>

<sup>300</sup> Four deprivations indicate a damaging lack of material benefits considered to be necessities in a society.

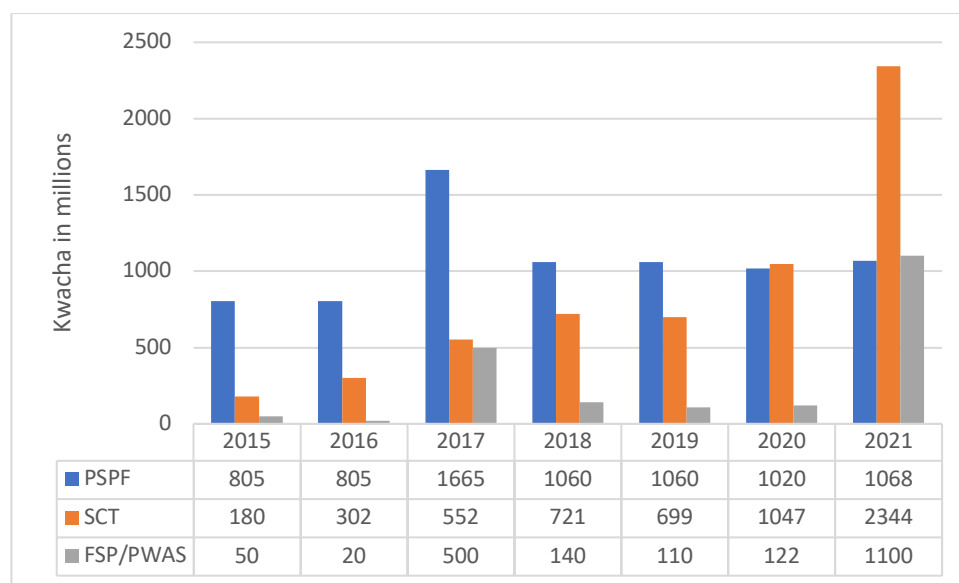
<sup>301</sup> Based on SCT-MIS data provided on June 24, 2021.

Table 15: 2021 budget allocation to MCDSS

2021 Budget allocation to MCDSS	Amount allocated in Kwacha	% Share of min. allocation
Total ministerial budget allocation	3,667,952,200	100.00
Social assistance	2,345,736,854	63.95
Social welfare	42,331,222	1.15
Community development	1,238,444,613	33.76
Non-governmental regulation and standards	5,545,643	0.15
Management and Support Services	35,893,868	0.98

Social assistance spending is significantly skewed towards SCTs. SCTs consume approximately 80 per cent of the social assistance budget, leaving the remaining four programmes to split the 20 per cent. The next major consumer under social assistance is the KGS followed by the HGSM. The graph below shows the growth in allocation to the SCT between 2015 and 2021.

Figure 13: Trends in allocation of SCT 2015–2021



In 2018, the SCT budget consumed 79 per cent of the total social assistance allocation, while KGS received 15 per cent. HGSM received 5 per cent of the social assistance budget while PWAS and the bursaries for Orphans and Vulnerable Children received only 1 per cent of social assistance expenditure (UNICEF & World Bank, 2021). Another rising concern is budget execution. An analysis of the budget conducted by UNICEF in 2019 showed that social protection programmes, namely SCT, Public Service Pensions and the FSP had a five-year average budget execution rate of 60 per cent, 71 per cent and 57 per cent respectively compared to execution rates of over 100 per cent for roads, strategic food reserve

and the FISP (UNICEF, 2019).<sup>302</sup> The main inequity in the programming under social assistance is that all programmes designed to benefit children are linked to schooling. Considering the MODA results, this means that other deprivations that children face may not be sufficiently taken care of. Programmes that cover other contingencies are also not universal and therefore only reach a segment of the total population of children in the country. For instance, the SCT programme, which includes children among the target categories, whether in child-headed households, female-headed households or in households with high dependency ratios, etc., does not offer universal child benefits and thus excludes more children than it covers. As UNICEF notes, despite the proven impacts of social protection programmes, coverage of children and families remains extremely low. Globally, two out of three children currently have no access to child or family benefits, and coverage is lowest where child poverty is highest (UNICEF, 2019). UNICEF goes on to argue that insufficient financing is a major barrier to comprehensive child-sensitive social protection systems. On average, countries spend only 1.1 per cent of GDP on social protection for children, although the amounts vary greatly across countries and regions: while Europe and Central Asia, as well as Oceania, spend more than 2 per cent of GDP on child benefits, regional estimates for Africa, the Arab States and Southern and South-East Asia show expenditure levels of less than 0.7 per cent of GDP (UNICEF, 2019).

### **Social insurance**

A second core pillar in the NSPP is social insurance. Under social insurance, Zambia has three contributory pension schemes including the PSPF, the NAPSA and the LASF. These are mandatory for all workers in formal employment including civil servants, local authority employees and others in formal employment. Until recently, informal economy workers were excluded from social security coverage. However, efforts to extend coverage to the informal economy have led to the inclusion of 18,000 informal economy workers including, domestic workers, casual sawmill workers and public transport drivers. Assuming an average house size of five, an additional 90,000 individuals have been covered by social security. In 2019, NAPSA also created a new scheme for self-employed informal workers that requires lower contributions and would include not only pension cover but also access to maternity benefits, funeral benefits and access to micro-loans (UNICEF and World Bank, 2021). In a traditional pension scheme, children are covered through survivor benefits in the event of a member's death. Biological and legally adopted children are eligible to receive a survivor's pension as a lump sum. The amount payable is divided as two shares for a spouse and one share per child covering a child under the age of 18 years, a child under the age of 25 years who is still in formal education, an unborn child and a child of any age physically or mentally incapacitated by the age of 18 and at the death of the member. Other than the pension schemes, Zambia has a recently enacted National Health Insurance Scheme overseen by the National Health Insurance Management Authority (NHIMA). NHIMA was established to achieve equity in access to cost-efficient quality health services that are close in proximity to the family. While the scheme is still in its nascent stages, the intention is to cover all Zambians regardless of their social, economic or employment status and thereby protect households from the burden of catastrophic health costs through risk pooling. This coverage will benefit children too although it is yet to be rolled out to have universal reach and meet the ambitions of quality and proximity. Amid all extension of social security efforts, coverage of social insurance programmes remains low with only 32 per cent of the employed population being covered by a pension scheme in 2019. This implies an exclusion rate of nearly 70 per cent of the work force with the predominant share of this being informal workers.

Zambia also has the WCF, a social insurance scheme that provides compensation to workers who suffered an accident, or an occupational disease contracted in the course of employment; this is in

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<sup>302</sup> UNICEF. (2019). Zambia Social Protection Budget Brief.

accordance with the provisions of the Workers' Compensation Act No. 10 of 2000. Essentially, the WCF has five primary types of benefits. The benefits include cover for medical costs, temporary disability benefits, permanent disability benefits, supplemental job displacement benefits and death benefits. These are key benefits in the event of disability and for survivors. While Zambia has made commendable progress in providing social insurance benefits to employees, there is still a considerable gap in the provision of maternity insurance. Children represent the future for any nation and therefore the financial support of women during their maternity leave period should be seen as a worthwhile investment for society. Zambia has shown commitment to protecting maternity in the employment context through its 2016 Constitution, which affirms the importance of the family, of children and of women's maternal role. In addition, several laws and policies on maternity protection are in place in the country. The current labour laws provide for maternity leave and benefits. Maternity leave and remuneration are provided for by the Employment Act, minimum wage legislations and various collective agreements. Presently, the law allows for 12 weeks with full pay upon completion of two years of continuous service or in cases where two years have elapsed since the last maternity leave. Meaning that employees that have not accumulated two years of unbroken service become ineligible to take maternity leave.

In terms of employer liability, previously the burden of financing maternity protection was shared between the employers and the social security scheme. The Zambia National Provident Fund (Maternity Grant) Regulations provided support for maternity leave. However, since the repeal of the said regulations, there is no longer any provision or public support in Zambia for maternity leave benefits. Maternity protection is currently provided by individual employers, who are subject to a liability mandate under the Employment Act. In addition, there is no non-contributory maternity protection which would be instrumental in reaching the uncovered informal economy workers. Consequently, the ILO Maternity Protection Convention 183 (of 2000) has not yet been domesticated. This has resulted in a lack of protection for children during their first 1,000 days of life. In budgetary terms, public expenditure on social insurance has continued to fluctuate, year on year since 2015. Most of the public social insurance spending is channelled towards the PSPF, a fund for civil service pensioners. It is also anticipated that the NHIMA, which will equally function as a funding modality, will also help supplement the traditional tax-based and donor-funded mechanisms.

### **Livelihoods and empowerment**

Zambia has a total of eleven programmes under the livelihoods pillar of the NSPP designed to reach the category of vulnerable populations that have some productive capacities and assets. The programmes include the FISP, Youth Development Fund, Women Economic Empowerment Fund, Village Banking, Youth Innovation Fund, Emergent Farmers Support Fund, FSP, Empowerment in Aquaculture Fund, Youth Empowerment, GEWEL- SWL and LPOS. Of the 11 programmes, five are agriculture support programmes, with the remaining programmes focusing on youth empowerment and the women empowerment. The main beneficiaries under this pillar are thus agricultural households, although, in general, livelihoods and empowerment programmes have very low coverage. As of 2019, programmes under this pillar covered only 6 per cent of the country's population (UNICEF and World Bank, 2021b). Under this pillar's spending, the FISP far outstrips spending on other programmes, with contention remaining about its classification as a social protection programme. Stakeholders are not always agreeing on FISP being a social protection programme with some proponents using the stated objectives of the programme to disqualify it from fitting into the spectrum of social protection. Other than the FISP, the main programme spending under this pillar goes towards the SWL and the FSP. Figures for the total number of children that benefit under these programmes are difficult to derive as programmes mainly aim at enhancing agricultural productivity and empowerment of women and youth (aged between 18

and 35 years).<sup>303</sup> Nonetheless, it is expected that children in beneficiary households benefit from enhanced household food security and improved household incomes. By implication, these programmes predominantly benefit children in households in the subsistence economy. The difficulty in assessing child sensitivity is acknowledged by UNICEF (2019) which recognises that determining the child-sensitivity of these structures is extremely challenging. A qualitative assessment by UNICEF colleagues suggests children have received some consideration in systems development, but in only a minority of cases where they were assessed as ‘highly considered’ (UNICEF, 2019).

## 12.4 Challenges, shortfalls and inequities

On many fronts, Zambia has made commendable progress in social protection. However, much more needs to be done to ensure a sustainably financed rights-based, shock-responsive, child-sensitive social protection system for the country.

### Child programming

Programmes designed specifically for children and those that benefit children as part of their targets face numerous challenges. These include irregular financing; low coverage; inadequacy of benefits to protect children and families effectively and sustainably against socioeconomic vulnerability; and lack of programmes that target pregnant and lactating women, which affects predictability of the transfers and limits or reverses the positive impacts of the programmes. As the field work revealed, the SCT did make a significant difference in beneficiary households in relation to children’s school attendance, negative coping strategies and children’s nutrition. Some negative coping strategies employed by households have included selling assets, keeping children out of school, selling children into child prostitution or early marriages and skipping meals. This has also been revealed in several evaluations conducted on the programme. SCT is a critical contributor to household income, especially for poor households with limited income earning potential. Case studies conducted by Save the Children revealed that poor households use SCT to support their children’s education. However, when SCT is irregular, school going children increasingly face the risk of dropping out of school.<sup>304</sup>

### Responsiveness of programme design

Child-sensitive social protection programmes need to be responsive to the multi-dimensional needs of children. Where programmes fail to consider the multiple overlapping needs and vulnerabilities, the likelihood of overall failure increases. Thus, programme design should be intuitive and responsive to the nuances within children’s circumstances. For instance, while the KGS programme has increased access to education for children from some of the poorest households by paying children’s school fees. However, paying school fees alone is not enough. Other costs restrict and still affect school attendance by children on the KGS when they fail to cover the required expenses. Children opt to drop out of school or abscond when their caregivers cannot put up enough money to ensure they have all the requirements for school. This reveals the need for the programme to cover more than just the school fees. Efforts to remedy this are the adjustments made to cater for such issues by adding a lump sum to all KGS households. The lump sum is meant to enable households to make investments that will not disrupt children’s access to education. Programmes designed for children or that target children should be able to respond in such a way so as to not undermine the full impacts of programmes.

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<sup>303</sup> We use the criteria for eligibility to the youth empowerment fund.

<sup>304</sup> Sitambuli, Emma. (2021). *Falling Through the Cracks: The impact of inconsistent Social Cash Transfers on children in Lufwanyama district, Zambia*. Save the Children Zambia, Save the Children International, Save the Children Finland.

### **Consistency in budgets**

Although Zambia has increased domestic financing for social protection, severe budget inconsistencies in year-on-year allocations and failure to match releases to allocations means that the Government continually falls short in meeting its obligations to various programmes. This inconsistency in budgets has also not spared programmes that benefit children. The risk of this inconsistency heightening is even greater now with the advent of the COVID-19 pandemic and its impacts on the fiscal space. The lack of child-sensitive social protection budgets is also a huge concern as it makes it more difficult to account for children's share of overall social protection budgets.

### **Shock-responsive social protection system**

Shock-responsive social protection systems will have a higher capacity to support children and their families in different risk contexts and contribute to maintaining children's human capital development regardless of the type and duration of the crisis they may be facing.<sup>305</sup> The recent shock of the COVID-19 pandemic provided opportunity to test Zambia's social protection system's shock responsiveness. In general, the country was able to galvanise stakeholders to deliver a successful response. One of the major lessons to have emerged from the crisis of the COVID-19 pandemic was the extent to which the social protection system was not prepared to respond swiftly to the crisis. As the COVID-19 Recovery Needs Assessment shows the delivery of the social protection response package was delayed, relative to the arrival of the shock. While pandemic containment measures started at the end of March 2020, the COVID-19 Emergency Cash Transfers (C-ECT) were only announced four months later, on 28 July 2020. The first payments in some districts followed shortly after, in August 2020. However, in other districts the delivery of the first payments only started in October 2020, over six months after the start of containment measures. The top-up for the SWL Cohort three beneficiaries was not delivered until the first and second quarters of 2021. As Beazley et al. 2021 note, the objective of a social protection response to a shock, such as COVID-19, is to mitigate the impact that the shock has on poor and vulnerable households. For this purpose, it is necessary that the response (i) expands coverage to those made (more) vulnerable by the crisis and (ii) provides them with adequate benefit levels. In addition, any response must be delivered in a timely and predictable manner to ensure that households have support when they need it and do not have to resort to negative coping strategies. Finally, responses should involve comprehensive benefits (beyond subsistence support) to support longer-term recovery and to address the full range of risks households may face because of the shock.<sup>306</sup>

Zambia has faced a growing number of shocks, whether induced by climate variability, public health shocks or price volatility, which have had lasting socioeconomic impact on families and children. More and more children in Zambia, along with their families are increasingly vulnerable to shocks. These shocks also promise undeniable catastrophic impacts on children and their childhoods. Despite the extended history of shocks in the country, Zambia is yet to develop a shock responsive social protection system, creating a gap in the system's ability and readiness to respond to crises. Having now had opportunity to implement a nationwide response to an emergency and seeing the important role that social protection should play in such emergencies to safeguard the welfare of the population, it will be important that shock-responsiveness becomes an integral part of the Zambian social protection system.

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<sup>305</sup> *ibid*

<sup>306</sup> Beazley, R., Solórzano, A., & Barca, V. (2021). Study on Shock Responsive Social Protection in Latin America and the Caribbean Summary of key findings and policy recommendations.

## Data systems

Data systems for social protection have historically been fragmented along programme lines and, in several cases, still remain paper based. In recent years, with strong Government leadership, the need for a unified system has emerged. Attempts to set up such a system have resulted in the creation of different systems at the programme level, such as the Social Cash Transfer Management Information System (SCT MIS) or the Keeping Girls in School Management Information System (KGS MIS). Attempts at a unified system began with the creation of the Single Registry of Beneficiaries and now the Zambia Integrated Social Protection Information System (ZISPIS). At present, the Social Protection MIS comprises of fragmented systems that serve different needs of social protection programmes. These systems are not always comprehensive, although recent efforts and investments are shifting towards greater integration. ZISPIS is envisaged to be the system for sector-level integration. The ZISPIS is a product of the Government initiative to roll out e-governance for public service delivery. This was primarily because the Government anticipated that e-governance would enhance efficiency and promote transparency and inclusion in public service delivery.

The MCDSS houses a MIS for the SCT programme, which at present provides the following services: household data management, generation of a basic dashboard report, payment lists and orders. However, an ideal system should provide payment tracking, logging of case management events on beneficiary households, logging and linking of grievance redress and an M&E platform i.e., generation of detailed reports for purposes of payment tracking. This will be built into the new ZISPIS. In general, while Zambia has made tremendous progress towards unification of data systems for social protection, they remain weak. Zambia, with the renewed impetus for e-government, is making significant headways in developing MIS, which can aid in making data available for programming on children's issues and child outcomes, however there are still severe shortfalls in building fully developed systems, let alone child-sensitive systems.<sup>307</sup> Child-sensitive MIS can aid in comprehensive planning, programming and reporting for children's social protection programmes. With the increasing focus on case management in child-sensitive programming, developing such systems can support a case management approach by incorporating child-related data in social and beneficiary registries for cross-referrals and social care.

## 12.5 Stakeholder landscape and initiatives

The MCDSS is the lead ministry that coordinates and implements the NSPP, with direct oversight responsibility for non-contributory programmes. Within MCDSS, two directorates are responsible for three of the NSPP pillars, with the Department of Social Welfare overseeing the social assistance and protection pillars and the Department of Community Development overseeing the livelihoods and empowerment pillar. Some programmes within these pillars are implemented through (jointly or by), other line ministries, departments and agencies. For instance, the ZAPD is the key government agency overseeing disability programming. Stakeholder involvement has been facilitated through several key forums and decision making working groups, such as the Social Protection Sector Advisory Group which was discontinued after 2016 to become the Poverty and Vulnerability Cluster Advisory Group in line with the 7NDP. Other forums include the Social Protection Joint Annual Review; Government of Zambia and UNJPSP; the Tripartite Consultative Labour Council; the NGO Board and the Council of NGOs at the national level. At subnational level, Provincial Development Coordinating Committees and District Development Coordinating Committees are the main avenues through which stakeholder participation was achieved. United Nations agencies provide technical support to the sector through the UNJPSP. The

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<sup>307</sup> Child sensitive data systems involve upholding the Convention on the Rights of the Child in this current data age, by developing and utilising responsible approaches for handling data for and about children and avoiding unintended negative consequences on data subjects and beneficiaries and, in turn, ensuring the effective use and positive impact of data (conversation.com).

UNJPSP is designed to provide technical assistance to different line ministries in implementing the NSPP to ensure effective delivery of social protection programmes in Zambia. Institutions that participate in the UNJPSP include UNICEF, ILO, IOM, WFP, FAO, UNDP, MCDSS, MLSS, MoHA, MoH, MYSCD, MoGE, MoA, MoFL, Gender department, MoF, the NFNC and ZAPD. Through the Poverty and Vulnerability Reduction Cluster, a total of 24 institutional stakeholders participate in social protection governance: comprising 11 Government line ministries and 13 United Nations agencies, cooperating partners, CSOs and the academia. All these forums and the implementation of the 7NDP resulted in increased stakeholder participation. Funding stakeholders for the SCT and the GEWEL programmes have now come together under the SCT Multi-Donor Trust Fund. This structure creates a financing pool with financing of US\$142 million credit from the International Development Association (IDA) and US\$35 million in co-financing grants from the UK DFID and the SIDA, which are jointly funding the programme under a Bank-administered Multi-Donor Trust Fund. The support provided through the Multi-Donor Trust Fund and the additional Financing packages (AF1 and AF2) augments the existing GEWEL Project, worth USD\$65 million, which has supported more than 28,000 girls from poor households by covering their secondary school costs and 75,000 poor women in Zambia with livelihood packages. The project brings together a collaboration between three ministries—Gender, Community Development and Social Services, and General Education—to support Zambia’s poorest citizens.

## 12.6 Sector specific recommendations

**Strengthen life cycle based social protection programming** by effectively weaving together social protection programmes. For the country to fully utilise social protection in preventing and reducing poverty for children and transmitting it inter-generationally, Zambia will need to simultaneously address poverty, inequality and vulnerability while strengthening inclusive socioeconomic development. This can be achieved through programme layering and sequencing, greater programme and policy integration and scaling-up interventions to enhance coverage. This will enable the country to cover all the gaps in providing social protection for children and yield greater impacts.

**Provide social protection as a right to children.** The provision of social protection as a right for children will be necessary to provide comprehensively for the well-being of children. Zambia will need to progressively move towards providing social protection to all children as a right. This should include universal child benefits, parental benefits and other necessary support, taking into consideration the resources and the circumstances of the child and persons having responsibility for their maintenance.

**Invest in a cost analysis of raising a child** to inform the potential cost of the universal provision of social protection to children, considering the multiple overlapping deprivations of different children in different circumstances across the country to reach every child without prejudice.

**Embed child and adolescents’ outcomes into programmes.** This will enable programmes to contribute to the reduction of children’s multi-dimensional poverty and drive important child and adolescents’ outcomes that, if left unabated, continue to reinforce intergenerational poverty, such as child marriage, teenage pregnancies and incomplete secondary and tertiary education.

**Continue investments in social protection systems strengthening** to support greater programme integration, stakeholder collaboration and shock-responsiveness of the system. This will ensure that the M&E Framework and MIS support comprehensive, child-sensitive social protection outcomes.



## ANNEX 1

### ECD relevant legislations and policies at a glance

#### Global Legislative Frameworks and Guidelines

- Convention on the Rights of the Child, (CRC), 1990
- Convention of the Elimination of All Forms of Discrimination Against Women, (CEDAW) 1979
- Education for All (EFA), 2000
- Convention of the Rights of People with Disabilities, 2006
- Sustainable Development Goals-SDGs (2015-2030)
  - GOAL 1: End Poverty (Target 1.2)
  - GOAL 2: Zero Hunger (Target 2.2)
  - GOAL 3: Good Health and Well-being (Target 3.2)
  - GOAL 4: Quality Education (Target 4.2, 4.2.1, 4.2.2, 4.2.3)
  - GOAL 16: Peace, Justice and protection of children (Target 16.2 & 16.9)
  - (other ECD related Goals other related goals such as 5, 6, 10 and 17)
- Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)- 'Survive, Thrive, Transform'
- Nurturing Care Framework, 2018
- Improving Early Childhood Development guidelines, WHO, 2020

#### Regional legislation/Vision

- African Charter on the Rights and Welfare of the Child
- African Union 2063 Agenda

#### National legislations, Policies and Strategic Plans

##### Cross-cutting

- The Constitution of Zambia
- 7<sup>th</sup> National Development Plan 2017-2021- (Human Development Pillar)
- Vision 2030 (2006)

##### Ministry of Health (Health and Nutrition) and National Food and Nutrition Committee (NFNC)

- National Food and Nutrition Policy 2006
- National Health policy 2012
- National Agriculture Policy 2012-2030
- Zambia Nutrition Advocacy Plan 2017-2019
- Zambia National Health Strategic Plan 2017-2021
- National Food and Nutrition Strategic Plan 2018-2022
- National Agriculture Policy 2012-2030

##### Ministry of General Education (Early Learning opportunities)

- Education Policy document, Educating Our Future, 1996
- National School Health Nutrition Policy 2006 (MoH NFNC)
- Education Act No. 23 of 2011
- Draft Early Childhood Education Policy- 2015
- Education and Skills Sector Plan (ESSP) 2017-2021
- National School Health Nutrition Policy 2006

**Ministry of Community Development and Social Services, Ministry of Youth, Sports and Child Development, Ministry of Water Development, Sanitation and Environmental Protection**

**(Security and Safety)**

- Anti-Gender Based Violence Act No 1 of 2011
- National Social Protection Policy 2014 (MoCDSS)
- National Child Policy -2015 (MoYSCD)
- National Action Plan for Children, 2015 (MoYSCD)
- National Policy on Disability 2016 (MoCCSS)
- Social Cash Transfer Guidelines 2018
- Employment Code Act of 2019
- Water Supply and Sanitation Act of 1997
- Water, Sanitation and Hygiene in Schools (WINS) National Strategy 2019-2030, (2020)
- National Advocacy and Communication Strategy on the Promotion of Family-Based Care for the Children in Zambia (MoYSCD)

## ANNEX 2

### Key stakeholders in fostering child rights and development

S/N	Name of the Stakeholder	Sector	Primary Focus Area
1	Action Aid Zambia (AAZ)	International NGO	Education and health, gender including policy advocacy
2	Alliance for Community Action		Social accountability and public finance
3	Campaign for Female Education (CAMFED)	Local NGO	Girl child education and sponsorship
4	Caritas Zambia	Local NGO	Education and environmental protection
5	Center for Trade and Policy Development (CTPD)	Local NGO	Tax justice
6	Civil Society for Poverty Reduction	Local NGO	Social protection, education and national development planning
7	Human Rights Commission	Government	Child rights promotion, protection and defending
8	Ministry of Agriculture	Government	Nutrition
9	Ministry of Community Development and Social Services	Government	Child Protection
10	Ministry of Finance	Government	Resource planning/ allocation
11	Ministry of Gender	Government	Child protection through anti-GBV policy formulation and implementation contributing keeping girl child education
12	Ministry of General Education	Government	Providing primary and secondary education and providing social protections facilities to vulnerable children
13	Ministry of Health	Government	Child health and nutrition
14	Ministry of Higher Education	Government	Provision of tertiary and University education
15	Ministry of Home Affairs	Government	Child protection and through prosecution and victim support
16	Ministry of Information	Government	Child participation in media
17	Ministry of Justice	Government	Domestication of regional, continental and international law, treaties and charters and child protection through judicial system
18	Ministry of Labour and Social Security	Government	Child labour

<b>19</b>	Ministry of Youth, Sport and Child Development	Government	Child development and youth empowerment
<b>20</b>	National Assembly	Government	Legislation
<b>21</b>	Non-Governmental Gender Coordination Council (NGOCC)	Local NGO	Keeping girls in school
<b>22</b>	Oxfam Zambia	International NGO	Education, agriculture and gender and public finance
<b>23</b>	Panos Institute of Southern Africa	Regional (SADC) NGO	Child participation through media
<b>24</b>	Plan International	International NGO	Education and water and sanitation support
<b>25</b>	SAVE the Children International	International NGO	Education, health, child protection, policy and advocacy, emergency response and child sponsorship
<b>26</b>	UNICEF	Intergovernmental Institution	Child protection, climate, HIV/AIDS
<b>27</b>	Water Aid	International NGO	Water and sanitation
<b>29</b>	World Bank	Intergovernmental Institution	Funding – Currently funding Keeping the Girl Child in School in partnership with Ministry of Community Development and Social Services and the Ministry of General Education (MoGE)
<b>30</b>	World Health Organisation (WHO)	Intergovernmental Institution	Child health including funding
<b>31</b>	World Vision-Zambia	International NGO	Education, health, child protection, policy and advocacy, emergency response and child sponsorship
<b>32</b>	Young Men Christian Association	Local NGO	Child protection focusing on boys
<b>33</b>	Young Women Christian Association	Local NGO	Child protection focusing on boys
<b>34</b>	Young Women in Action	Local NGO	Girl child capacity building
<b>35</b>	Zambia Civic Education Association	Local NGO	Civic education on child participation in decision-making and local and international legislative and policy advocacy
<b>36</b>	Zambia Council for Social Development (ZCSD)	Local NGO	Special and pre-education policy advocacy
<b>37</b>	Forum for Women Educationists of Zambia (FAWEZA)	Local NGO	Girl child education and sponsorship

<b>38</b>	Media Network on Child Rights and Development (MNCD)	Local NGO	Media and child rights
<b>39</b>	Zambia National Education Coalition (ZANEC)	Local NGO	Education policy including policy advocacy
<b>40</b>	Zambia Open Community Schools (ZOCS)	Local NGO	Policy advocacy on community education, pre-education and child sponsorship
<b>41</b>	Reformed Open Community Schools (ROCS)	Local NGO	Policy advocacy on community education, pre-education and child sponsorship
<b>42</b>	Zambia National Men Network	Local NGO	Boy child protection and responsible parenting

### ANNEX 3

#### Coordinating bodies on child labour

Coordinating Body	Role & Description
<b>MLSS-Child Labour Unit</b>	Coordinates with District Child Labour Committees (DCLCs) in Zambia's 114 districts to increase local awareness and mobilise communities against child labour, including its worst forms. In 2018, the child labour unit educated communities on the dangers of child labour and identified, and withdrew victims of child labour in the town of Kaoma, in Western Province. In addition, it coordinated the commemoration of the June 12 World Day Against Child Labour at district and community levels.
<b>Inter-Ministerial Committee on Anti-Human Trafficking</b> Leads efforts to address human trafficking.	In 2018, updated the National Action Plan on Human Trafficking, Mixed and Irregular Migration to strengthen the implementation of the Anti-Human Trafficking Act and better respond to cases of human trafficking.
<b>DCLC</b>	Responds to child labour complaints at the local level, files complaints to MLSS, and serves as the main referral mechanism for social welfare services. Comprises the Zambia Police Service; MLSS; the Ministry of Community Development, Mother, and Child Health; and civil society stakeholders. In 2018, 40 DCLCs were active, including in areas where child labour in tobacco production is prevalent.
<b>National Steering Committee on Child Labour (NSCL)</b>	Advises and oversees child labour matters, including implementation of the Hazardous Work Statutory Instrument. It comprises of government representatives, employers, trade unions, and civil society members. In 2018, NSCL developed the National Action Plan for Child Labour (2018– 2022) and conducted awareness raising activities.