# Neighbourhood Care Point
# Strategic Plan

WFP
World Food
Programme

# Neighbourhood Care Point Strategic Plan

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# Table of Contents

**Acronyms** ... VI
**Definition of Terms** ... VII
**Foreword** ... X
**Preface** ... XI
**Executive summary** ... 1
**Introduction and Background** ... 2
Eswatini - Country Context ... 2
Situation of OVCs in Eswatini ... 3
Key existing external and internal children's rights frameworks ... 5
The Genesis and Evolution of the NCPs ... 6
Rationale for NCP strategic plan and strategic objectives ... 7
Current state of NCPs in Eswatini ... 7
Challenges ... 7
Successes ... 11
SWOT analysis ... 13
**CHAPTER 1 - NCP STRATEGY 2022-2027** ... 14
**NCP Vision, Mission, and Values** ... 14
Vision ... 14
Mission ... 14
Values ... 14
**THE NCP STRATEGIC DIRECTION** ... 15
**The Technical Pillar** ... 15
Health and Food Security Sub-Pillar ... 15
**Basic Health Care component** ... 15
**Food and Nutrition component** ... 15
**Water Sanitation and Hygiene component** ... 15
Education Sub-Pillar ... 17
**Early Childhood Education component** ... 17
**Linkages to Formal Education Component** ... 17
Social Pillar ... 18
**Psychosocial Support** ... 18

**Child Protection and Safety** ........ 18
**Life Skills Development** ........ 18
**Administrative Pillar** ........ 20
Coordination ........ 20
Performance of caregivers ........ 20
**Monitoring, Evaluation and Learning (MEL)** ........ 21
Monitoring ........ 21
Evaluation ........ 21
Learning ........ 22
NCP strategic plan results Framework ........ 22
The NCP strategic plan Logical framework ........ 25
**Strategic Plan Coordination Framework** ........ 33
Roles and Responsibilities of coordination structures ........ 33
**National Children Services Department** ........ 33
**National NCP TWG –** ........ 33
**Regional NCP TWG** ........ 33
**Inkhundla NCP Team** ........ 33
**NCP Management committee** ........ 34
**Development Partners** ........ 34
**Civil Society and Faith and community-based Organizations** ........ 34
**NCP Leads** ........ 34
**Caregivers** ........ 34
NCP Strategic Plan Coordination Structure ........ 35

# Acronyms

| | |
|---|---|
| **AIDS** | Acquired Immuno-Deficiency Syndrome |
| **CSO** | Civil Society Organisations |
| **ECCD** | Early Childhood Care and Development |
| **EUP** | Unintended Pregnancy |
| **DPMO** | Deputy Prime Minister's Office |
| **FBO** | Faith Based Organizations |
| **HIV** | Human Immunodeficiency Virus |
| **MEL** | Monitoring, Evaluation and Learning |
| **NCP** | Neighborhood Care Point |
| **NCSD** | National Children Service Department |
| **NPA** | National Plan of Action |
| **OVC's** | Orphaned and Vulnerable Children |
| **PPP** | Public Private Partnership |
| **SELDS** | Swaziland Early Learning Development Standards |
| **UN** | United Nations |
| **UNICEF** | United Nations Children's Fund |
| **WASH** | Water Sanitation and Hygiene |

# Definition of Terms

| | |
|---|---|
| **Basic Health Care** | These are services which a child might reasonably require in order to be maintained in good health. |
| **Caregiver** | This refers to anyone who provides care for and relieves burdens and supports a child in need |
| **Coordination** | This is the Organisation of the different elements of the NCP body or activities that enables them to work together effectively. |
| **Child Protection and Safety** | It is the safeguarding of children from violence, exploitation, abuse and neglect. |
| **Children with  Special Needs** | These are children with developmental disabilities, mental retardation, emotional disturbance and sensory or motor impairments |
| **ECCD Services** | This refers to the full range of health, nutrition, early education and social services that provide for the holistic needs of children, who are between the ages 0 to 8 and to promote their optimum growth and development. |
| **Food and Nutrition** | This is the process by which the body nourishes itself by transforming food into energy and body tissues, this process   begins with food. |
| **Holistic Services** | These provide support that focuses on the child as a whole, not just their mental health needs. The support considers their physical, emotional, social and spiritual wellbeing. |
| **Life Skills Development** | A set of basic development skills acquired through learning that enables children to effectively handle issues and problems commonly encountered in daily life. |
| **Neighborhood Care Point** | It is a safe place where the community's most vulnerable children can receive critical resources that are aimed at their   educational, physical, moral, and spiritual growth. |
| **Psychological  Fracture** | This is damage or injury to the psyche after living through an extremely frightening or distressing event. It may result in challenges in functioning or coping normally after the event. |

| | |
|---|---|
| **Psychological Support** | This is support that addresses a child's emotional, social, mental and spiritual needs, which are all essential elements of positivehumna develpment. |
| **Tinkhundla** | This refers to an administrative subdivision that is smaller than a district, but larger than an Umphakatsi or chiefdom. |
| **Umphakatsi** | A homestead of a Chief. Local communities are able to converge to a Chief's homestead to discuss issues that pertain to their livelihood. |
| **Unintended Pregnancy** | This is a pregnancy that is unwanted, such as a pregnancy that occurred when no children or when no more children were desired. |
| **Vulnerability** | This are children who are at greater risk of experiencing physical or emotional harm and/or experiencing poor outcomes because of one or more factors in their lives. |

# Foreword

Protecting children and promoting their welfare is a collective activity and responsibility enshrined in the Constitution of the Kingdom of Eswatini 2005 (29) and the Children Protection and Welfare Act 2012. The country is also signatory to International organizations such as the United Nations Convention on the Rights of the Child which also views the protection of children as a fundamental right to their wellbeing and survival.

Our aspiration for children in the Kingdom of Eswatini is that they fulfill their potential in every aspect of their lives. This vision can only be achieved with the cooperation of the relevant professions across all sectors of society, support services, and communities.

The country has survived a number of hard times including HIV/AIDS and recently COVID 19, which has negatively affected households where children live, with many surviving as orphans. In its effort, the Government of the Kingdom of Eswatini has continued to provide safety nets to cushion such children through programs such as the Child-Headed Household project, the Orphaned and Vulnerable Children Grant, the Free Primary Education, and many more.

I am pleased to commend this Neighborhood Care Point Strategy as another responsive and guiding document for delivering accountable and consistent services for children in the country. This strategy is designed as a quick reference document to help guide and create links between policy and grassroots levels. It sets out the key issues from a policy level, implementation, and monitoring. It has taken into account the recommendations made by all sectors of society together with international research and best practices with the view of pursuing the "Best Interest of The Child". The strategy is designed as another companion volume to complement the Children Protection and Welfare Act (2012) which is the full reference text for practitioners. It also supports policies, procedures, and legislation for children.

I believe that this strategy will feed to the goal of making Eswatini Fit for Every Child and when it comes to its end in 2027; the life of Emaswati children would have been improved for the better.

**SENATOR THEMBA NHLANGANISO MASUKU**

DEPUTY PRIME MINISTER

# Preface

The Deputy Prime Minister's Office is entrusted with the responsibility of coordinating children stakeholders in the country. Our vision is to be a social protection services facilitator of excellence. The realization of this vision lies partly on the availability of guiding documents such as this Neighborhood Care Points Strategy.

Forty-three percent (43%) of the total country's population are children. Statistics show that about 50% of these children face some form of vulnerability that compromises their wellbeing and protection. Through resource mobilization and intervention from different partners, a number of social protection activities are currently taking place to address the socio-economic situation of Emaswati children.

Neighborhood Care Points are a good example through which such activities are being carried out. It is from these centers that vulnerable children find a safety net. However, a coordination gap has existed in this area after the expiry of the last NCP strategic plan in 2017.

This strategy is a product of a collaborative consultation with multi-sectoral stakeholders. It seeks to migrate from the view that these are centers where young children only get food but to utilize them as centers for the delivery of Modern Early Childhood Care Development services and also provide other services such as counseling to adolescents.

I, therefore, like to commend all the stakeholders and those who participated in the formulation and finalization of this strategy for their invaluable support. I believe we will see the same dedication you applied during its formulation for the implementation of the set goals and targets.

**M.M. MASUKU**

PRINCIPAL SECRETARY

# Executive Summary

The development of this strategic plan follows a vigorous consultation with stakeholders from the Government, civil society organisations, faith-based organisations, the United Nations and all stakeholders. The Neighborhood Care Point (NCP) 2023-2027 strategy is developed as continuous work from the recently lapsed strategy. It focuses on making NCP centres places of holistic well-being and development for children. This has been a building block from previous accomplishments, including the challenges of this strategic plan. To effectively meet the needs of all children, there are required interventions from members of the community, parents and caregivers.

The strategic planning process is a result of a careful and thoughtful process that identified critical strategic issues and crafted creative strategies to address those issues. The strategic planning process focused on two (2) main pillars, the technical pillar and the administrative pillar. The Technical pillar provides a clear direction on the core mandate of the NCP, while the administrative pillar provides a clear administrative approach for the NCP to shape goals and objectives in the next five (5) years.

This strategy recognises the important roles of communities and parents when collaborating with caregivers and all stakeholders for the development and wellbeing of children. To achieve this outcome, the strategy identifies the following action plan: advocating for the rights of children at community level, facilitating children's access to health and social services, ensuring children's access to adequate and nutritious food and coordinating childhood care and development initiatives at community level. The implementation of strategy activities will ensure that the outcomes of this strategy are achievement. This strategy makes NCP a one-stop centre for the development and wellbeing of children, where every child is afforded a safe and nurturing environment to grow and develop.

Strategic plan implementation is not a "one and done" event, but a series of continuous dynamic activities implemented throughout. To maintain accountability and review the implementation of the strategy there shall be mid-term and end-term reviews. The mid-term review will be implemented at the end of 2025 while the end-term review will be implemented at the end of 2027.

# Introduction and Background

Literature postulates that if we ensure the well-being of children and assist them develop to their full potential, the benefits will last for decades. Be that as it may, pursuant to the realisation of benefits of children's social protection, there exists a vicious cycle of poverty and vulnerability that confronts them on a daily basis. Consequently, poverty in childhood has negative effects that can last a lifetime. In Africa as elsewhere in the world, the need to ensure children's social protection has throughout the past decades, been high on the agenda of governments. Understandably so, as a majority of developing countries including Eswatini, recognise the need to align their policies with the needs and rights of children. This is evidence that the United Nations Convention on the Rights of the Child has been ratified by most countries.

Globally, the impact of poverty on children is still devastating, despite countless efforts in mitigating poverty and vulnerabilities among them. The United Nations Children's Fund (UNICEF) reports that, a staggering one (1) billion children worldwide are multi-dimensionally poor. They are without access to education, health, housing, nutrition, sanitation or water, while almost one in five (356 million) children are living in extreme poverty, forced to survive on less than $1.90 a day and notably an estimated 153 million children worldwide are orphans.[1] In Sub-Saharan Africa, the rise of orphans and vulnerable children is said to be due to the spread of HIV/AIDS. Estimates of the World Bank indicate that twenty percent (20%) of children in Sub-Saharan Africa are OVCs.[2] A staggering fifty-eight percent (58%) of the Kingdom's children are orphans and vulnerable children, largely due to the impact of HIV/AIDS. One in four (4) children has lost one or both parents and at least thirty-eight percent (38%) of rural households care for at least one orphan.[3] The observation is that the majority, if not all the OVCs live in absolute poverty.

## I. Eswatini - Country Context

The Kingdom of Eswatini is a small landlocked country in Southern Africa, it is nestled between South Africa and Mozambique. Eswatini is classified as a lower-middle-income country by the World Bank. Eswatini has the tenth highest income inequality in the world, with fifty-nine percent (59%) living below the poverty line and twenty percent (20%) considered extremely poor.[4]

Eswatini has a population of about 1. 1 million, with 36.6 % of the population under the age of fifteen (15) years.[5] This means that children constitute a significant proportion of the population. The economic growth rate is as low as 2.8% and a national unemployment rate of twenty-eight percent (28%). Seventy-seven percent (77%) of the country's population resides in rural areas and twenty-three percent (23%) in urban settlements.[6] The summary of the age and sex distribution of Eswatini's population is presented in the figure below.

1 https://www.unicef.org/social-policy/child-poverty
2 Toolkit for Programming Assistance to Orphans and Vulnerable Children (OVC) in Sub-Saharan Africa. Social Safety Nets Primer Notes; No. 17. World Bank, Washington, DC.
3 https://reliefweb.int/report/eswatini/country-orphans
4 WFP Eswatini Country Brief July 2021
5 https://eswatini.unfpa.org/en/topics/population-trends-0
6 https://eswatini.unfpa.org/en/topics/population-trends-0

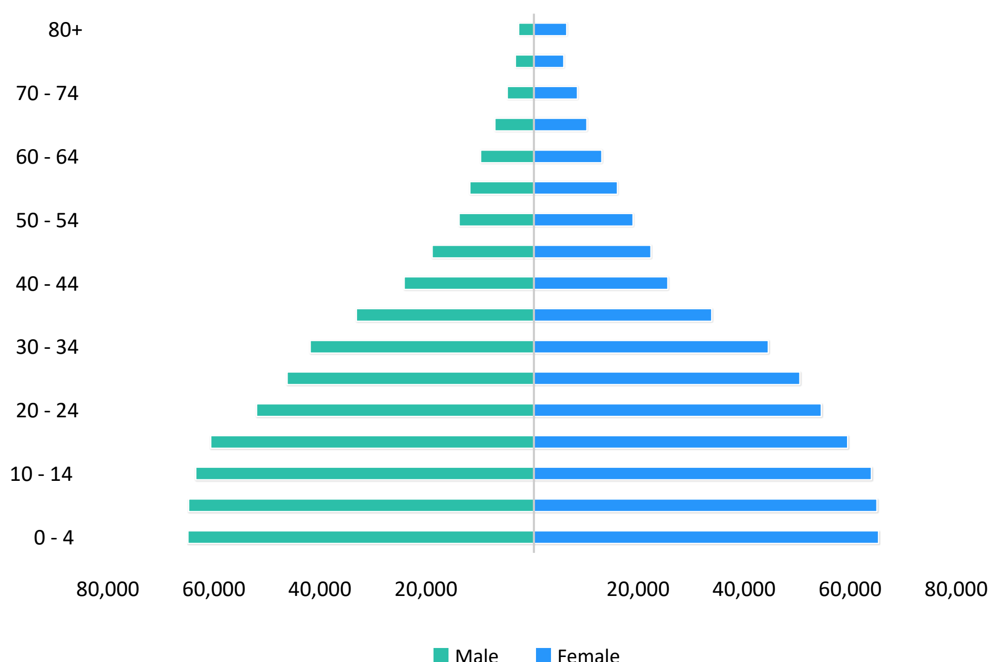


**Figure 1:** Eswatini Population Pyramid. Source Central Statistics Office and UNFPA (2017). Kingdom of Swaziland Population and Housing Census. Ministry of Economic Planning and Development, Mbabane.

## II. The Situation of OVCs in Eswatini

For the past three (3) decades, HIV/AIDS has contributed significantly to the high morbidity and mortality rates in the country. In fact, HIV is still among the top five (5) causes of mortality in the country. This has resulted to unprecedented proportions of children with no parents and those with no siblings and a strong family background. Consequently, children are left with no one to care for them with love and guidance to achieve sound health and physical development. As such, the health and well-being of children remains a call for concern. There is no doubt therefore, that children were greatly impacted by these shocking developments as their mothers developed AIDS and died, hence the concept of OVCs quickly gained attention.

It is important to note that there is no universally accepted definition of the OVC category. Although UNICEF defines an orphan as any "child under 18 years of age who has lost one or both parents," individual countries set the definitions of "vulnerability" based on HIV-status, socioeconomic status, parental abandonment or a combination of all in their National Plans for Action (NPAs).[7]

In the context of Eswatini, the National Plan of Action for Orphans defines an orphan as a child (less than 18 years) who has lost one or both parents. A vulnerable child is defined as a child under the age of 18 years who satisfies one or more of the following criteria:

a. Parents or guardians are incapable of caring for him/her.
b. Physically challenged, staying alone or with poor elderly grandparents.
c. Lives in a poor sibling-headed household.
d. Has no fixed place of abode.
e. Lacks access to healthcare, education, food, clothing, and psychological care and/or has

no shelter to protect from the elements, exposed to sexual or physical abuse including child labour.

All things being equal, the challenges faced by Eswatini with reference to orphan and vulnerable children are not so different from those of other developing countries. An observation would be that, the situation in Eswatini has been greatly intensified by a very high rate of HIV infection with 27.2 percent of the population being infected with HIV.[8] Females are particularly at risk because; thirty-five percent (35%) of women and adolescent girls between the ages of fifteen (15) and fort-nine (49) years are HIV-positive, compared to nineteen percent (19%) percent of boys and men. This has resulted to about fifty percent of (58%) children in Eswatini are orphaned and vulnerable children (OVC).[9]

In Eswatini, the prevalence of OVCs varies with geographic location. This is to an extent is due to harsh weather conditions in some parts of the country, leading to droughts and other life-threatening environments especially in the Lowveld. Accordingly, the Shiselweni Region has twenty-six percent (26%) of orphaned children which is a slightly higher percentage, while the Lubombo Region has the highest percentage of vulnerable children thirty-seven percent (37%).[10]

Available evidence suggests that malnutrition is more prevalent among OVCs compared with non-OVCs. Nationally, thirty-nine percent (39%) of OVCs under five (5) years of age are stunted, compared with twenty-eight percent (28%) condition for non-OVCs. For underweight children, the comparable figures are eight percent (8%) for OVCs and five percent (5) for non-OVCs. Such findings speak volumes about the insufficient access to food and other factors which impact the health and malnutrition of OVCs in the country.[11]

Undoubtedly, orphanhood has shaped the future of children in Eswatini as it impacts negatively on their social development. Part of the evidence is the percentage of children aged fifteen (15) to seventeen (17) years who had sex before age fifteen (15), which is marginally higher among OVCs than non-OVCs. This in itself contributes to high rates of HIV. It is truly a vicious cycle. This differential is driven primarily by female children; 4.3 percent of orphaned females had sex before age fifteen (15), while 2.4 percent of females who are not orphaned or vulnerable had sex before age fifteen (15).[12] This best demonstrates the long-lasting impact of being an OVC in Eswatini, given that growing up in an environment of vulnerability decreases the opportunity of children to exhibit positive behaviour. It leads to early sexual debut hence Early and Unintended Pregnancy (EUP).

The life situation of children in many communities puts excessive demand on caregivers and members of extended families who are often not equipped to respond to these particular needs. In addition, one of the appalling challenges facing children is the lack of identity. This is so because most OVCs are reported to have no birth certificates. A child with no documents of birth registration may result in denial of public services (State, 2019).[13]

In the case of Eswatini, children require a birth certificate to access formal schools and to be eligible for the free primary education among other basic services.

In the wake of the HIV pandemic, a high number of young children were left in the care of other children. These child-headed families are confronted by poverty which negatively impacts on their access to health services as they lack

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[7] Smart, R. (2003). Policies for Orphans and Vulnerable Children: A Framework for Moving Ahead: POLICY.

[8] Swaziland 2016 Country factsheet". UNAIDS. Retrieved 14 February 2022.

[9] WFP Eswatini Country Brief July 2021

[10] Swaziland Multiple Indicator Cluster Survey SUMMARY REPORT 2010

[11] Swaziland Multiple Indicator Cluster Survey SUMMARY REPORT 2010

[12] Swaziland Multiple Indicator Cluster Survey SUMMARY REPORT 2010

[13] United States Department of State, 2016 Country Reports on Human Rights Practices: Swaziland, 3 March 2017

resources to overcome barriers to service utilisation.

Furthermore, OVCs are facing challenges with shelter in Eswatini. Most OVCs are living in deplorable conditions. In fact, they are not living in decent houses that can afford them an arena for privacy, dignity and peace. The right to shelter is an important element in ensuring children's safety. Without proper shelter, the safety of children is not guaranteed.

The lived experiences of OVCs are even made worse by the fact that most OVCs are either child-headed or living with old parents who are sometimes sickly and are not able to provide for the children. The majority of OVCs therefore, do not have adequate clothing since their grandparents have no means to provide for the children. The experience of having to care for sick adults deepens even further the psychological harm to children as they do not have time to socialise and play with their peers.

Additionally, it is difficult to discuss issues of OVCs in Eswatini without mentioning HIV/AIDS although (Foster, 2010) argues that this focus on children orphaned by AIDS has put the sufferings of orphans of other reasons in the shadow. However, there is no doubt that most parents developed AIDS and died, leaving children homeless, without the taste of parental love and in the process, children faced abuse and exploitation from their caretakers. Abuse such as discrimination and child labour, resulting to serious irreparable psychological fracture. Furthermore, exposure to extreme poverty among OVCs in Eswatini has paraded an expedient risk to inequality and extensive marginalisation. Such has led to improper methods of discipline and other social ills among OVCs. Affected children had no support systems to cope with the emotional impact of a traumatic event and that has led to a countless number of psychosocial needs among OVCs.

## III. Key Existing External and Internal Children's Rights Frameworks

The above scenarios resulted to the adoption of different frameworks, which seek to uphold and promote the rights of children at all levels. The figure below presents some of the frameworks adopted at the different levels.

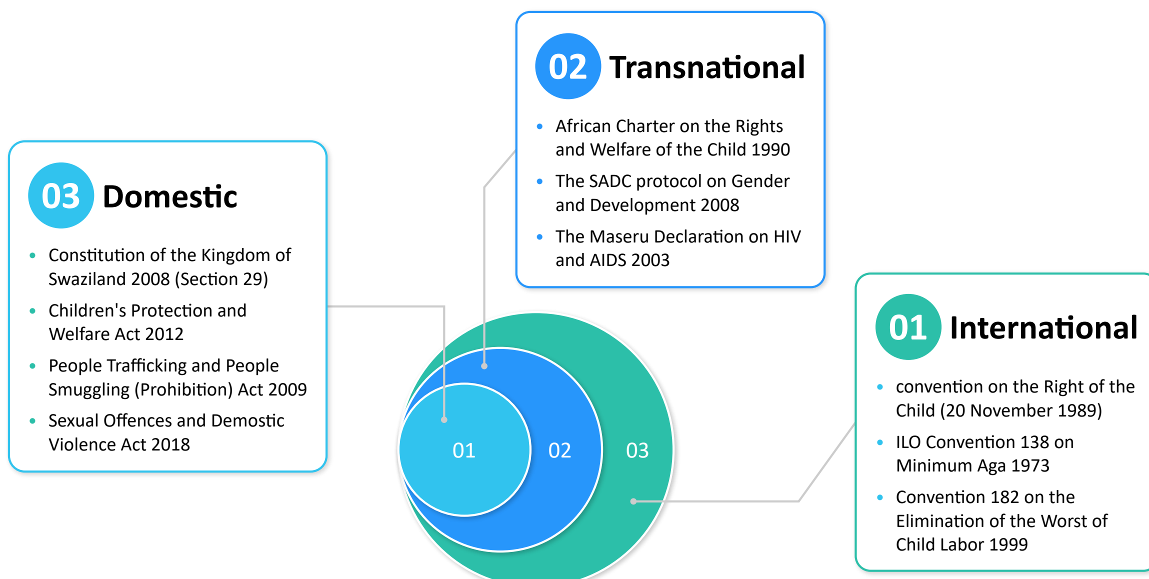



**Figure 2**: Children's' Rights - Frameworks Adopted at Varying Levels

**UN** - The Convention on the Rights of the Child is a legally binding international instrument for guaranteeing the protection of Human Rights. Its objective is to protect the rights of all children in the world. The convention is naturally founded on four principles which are to consider: the best interest of a child, their right to life, respect for views of a child as well as right to life, survival, and development.

**AFRICA -** Governments across the Continent have accelerated efforts and tried to provide adequate funding to ensure that all children can enjoy their right to an education. The implementation of the Africa Charter on the Rights and Welfare of the Child has tried to alleviate discriminatory barriers caused by pregnancy, parenthood, or child marriage among tens of thousands of girls in Africa. Yet, millions of children are already faced with financial, social, and discriminatory barriers and are at high risk of being excluded from a quality education – especially children with disabilities

**ESWATINI-** From a legal and policy perspective, Eswatini has reaped the fruits of Public Private Partnership (PPP) and spared no effort when it comes to addressing the needs of children. Even though due to inadequate resources to support the design and implementation of sectoral policies, strategies, national laws and regulations aligned to the needs of children. Some of these policies and laws crafted for meeting the needs of children are not yet operationalised.

Among many existing children's framework in Eswatini, is the comprehensive National Plan of Action for Children (NPA) for the period 2011–2015. It is a review of the previous 2006-2011 plan of action which was specifically developed to support government-wide planning and evaluation as measured against national child rights priorities. Notably, the NPA 2011-2015 does not only cater for HIV and AIDS orphans and vulnerable children but also considers the wide range of their needs.

The coordination structure and function of the children and welfare department has since been strengthened and systematised into government operations through the establishment of the National Children Services Department (NCSD) within the Deputy Prime Minister's Office (DPMO) in the year 2002. Today unlike in the past, children's rights policies and coordination mechanisms make provision for the systematic representation and participation of civil society organisations in the planning, implementation and monitoring of children's right and well-fare.

## IV. The Genesis and Evolution of the NCPs

The staggering proportion of OVCs has led to the Government, through the Ministry of Tinkhundla Development and Administration to come up with a strategic plan on how to care for these children. The Government of Eswatini, in collaboration with civil society actors and communities have been supporting orphans and vulnerable children through various community-based programs. One such initiative was the establishment of Neighborhood Care Points (NCPs). NCPs were conceived in 2002, as a community response to support vulnerable children. In fact, the initial community capacity gap--analysis had indicated an urgent need to protect children from all forms of vulnerability and these children were not accessing education, nutrition, basic health care and psychosocial support. To curb the gap, NCPs were established to:

a. Provide care and support for orphans and vulnerable children, by mitigating the impact of HIV and AIDS, poverty, food insecurity, sexual exploitation.
b. Serve as a community-based care and support system especially for vulnerable children at the chiefdom level.
c. Provide children with nutritious meals, non-formal learning and recreational activities and basic health care and psychosocial support.

As such, NCPs have become the foundation of the quest to find a lasting and sustainable solution to the protection of children from six (6) months to six(6) years in communities. They are still relevant even today, given that they serve as a community level initiative representing local practices that protect children and their developmental programs.

To direct efforts by stakeholders in providing services in NCPs, the Ministry of Tinkhundla and Local Administration, which was the coordinating Ministry for NCPs, developed the first national Neighborhood Care Point Strategy of 2012 – 2016 which was aimed at promoting holistic multi-sectoral services for children in communities.

# V. Rationale for NCP Strategic Plan and Strategic Objectives

Orphans and vulnerable children (OVC) are among the most vulnerable population groups. Without support and protection, they are exposed to the risk of abusive labour, lack of education, malnutrition, disease and death. Accordingly, there is a need to improve and develop the new strategic plan in a way that will guide the operations of the NCPs to ensure that it yields the intended results in a standardised, systematic, cost-effective and sustainable manner. The strategic plan is used as a reference point for implementing NCP interventions by government and partners (CSO, FBO, UN) and all stakeholders.

The strategic plan considers the resolution taken by representatives of broader cross-sectional stakeholders that NCPs will not only provide early childhood care services but will also include early childhood developmental activities. They will be open to all children (0-18 years) who need them – not just OVCs – and will offer high-quality, full-spectrum early childhood development services, not just emergency/survival interventions, but also to prepare children for schooling and ultimately for a productive adulthood

Based on the review of the previous strategic plan and lesson learnt, as well as being cognisant of the rights and resolutions taken in the best interest of children, the main objective of the new strategic plan is to improve the quality of life for children through promoting community driven initiatives and encouraging meaningful partnership and collaboration at all levels ensuring sustainability in an effective and efficient manner.

Therefore, the specific objectives of this new strategy are to:

1. Guarantee the delivery of NCP holistic services (minimum package) in line with National Minimum Standards.
2. Invest in strengthening the local capacity to deliver these services in a cost effective and sustainable way

# VI. Current State of NCP in Eswatini

Since 2019, Government stakeholders agreed that the coordination of NCPs program at a national level was to rest with Deputy Prime Minister’s Office (DPMO) for the simple reason that the Office had established the National Children’s Services Department, a coordinating structure for children’s issues in the country. The NCPs have been faced with challenges and have also had some successes during the implementation of the previous strategic plan.

## Challenges

The challenges that were encountered by implementers of the strategic plan from institutions to caregivers at community level included the following: the poor-quality infrastructures of the NCPs, lack of specific ownership of the NCP structures, unmet needs of

the caregivers, inconsistent food supply and limited capacity of the caregivers to provide the services required by the children at the NCP.

### 1. Quality of NCP Structures

Stakeholders who were engaged in the review of the previous strategic plan, reported that most of the NCPs are poorly constructed, they are made of informal material such as stick and mud and some are also made of wood and corrugated iron. Respondents further categorised the NCP structures into formal and informal NCPs, with the latter being the NCPs constructed of poor-quality materials like the stick and mud and the corrugated iron. They further reported that the informal NCPs were mainly in rural areas than in urban areas. In some cases, stakeholders mentioned that there are no structures and NCP business is carried out under a tree.

To this effect one stakeholder stated that:

> *"They [NCPs] are different. We have some NCP's that do not have a structure at all, actually it is most NCP's. There are some that operate under a tree, some have tried to put up an informal structure using corrugated iron. We have some that operate in Gogo centres. We then have NCP's that have proper formal structures, and in most cases, they have these formal structures because there is another partner that helps them"-*
>
> ***CSO key informant***

> *"We have a hybrid of permanent structures and temporal structures and by temporal structures I mean those that have been constructed using wood and corrugated iron sheets. There are those that are operating under trees and are still NCP's"-*
>
> ***CSO key informant***

The implication of these different structures and categories of NCPs is that some NCPs are non-functional on days of unfavorable weather conditions such as, high temperatures and rainy days. According to the stakeholders, these NCPs are mainly located in rural areas. Furthermore, the formal structures of NCPs are associated with some institutional partnerships, which could be an NGO involved in the affairs of the NCP or the NCP is entirely managed by the NGO.

> *"The only properly built structures are where the church has linked with an NGO"-*
>
> ***FBO key informant***

### 2. Lack of specific ownership of the NCP structures

The respondents highlighted that there is no clear ownership of NCPs between Government, community and in some cases, the civil society organisations. This was viewed as the main challenge of the NCPs in the country. The implication of this lack of clear ownership was mentioned as the ineffective operations of NCPs. This was stated due to the unavailability of a budget to operationalise the NCPs. One stakeholder stated that:

> *"The communities do not want to admit that the NCP's are theirs and they do not want to contribute anything. If you are an NGO working with the caregivers, the NCP becomes your burden. So, I think for the strategy to work properly, ownership of the NCPs by the communities should be promoted-*
>
> ***CSO key informant***

> *"The church interfered with the NCPs a lot. They feel like the children from the church should be the only ones reaping the benefits of the NCPs yet that should not be happening. All children should benefit even if they affiliate to other religions rather than Christianity since the NCPs belong to the community as opposed to the church"-*
>
> ***FGD participant***

There was also some sort of conflict regarding the ownership where some institutions then claim ownership of the NCPs after they have provided some form of assistance. This also result in the institutions stipulating who will benefit or not benefit from the NCP. The resulting issue with the latter is that the children who benefit from the NCPs are those who meet the criteria set by the institution providing the support, for example the church. The caregivers during their FGD mentioned that: The poor collaboration of the community and the NCPs is also reflected by the fact that the caregivers bear some of the burdens associated with the operationalisation of NCPs. These burdens include, collecting firewood to cook the food that is eaten by the children when they visit the NCPs and also individually planting, weeding and harvesting the fields that are planted to provide food to the NCPs.

> *"...but the burden is just too much on the caregivers because they must sow and weed the fields and at the same time still need to cook for the children-*
>
> ***CSO key informant***

Care givers echoed the above sentiments by stating that they are not in good terms with some of the community members. The main bone of contention was reported to be community members also wanting to benefit from the services provided to the children at the NCPs, especially the food.

> *"People in the community feel they are entitled to the food because it belongs to the NCP and therefore, we are in a bad space as we are labelled as greedy since we do not give them the food-*
>
> ***FGD participant***

> *"Our main challenge is community participation. This aspect is very poor in the sense that there are still constituencies that still do not know that NCP's belong to the community, they are still of the mentality that NCP's belong to the caregivers. So you find that even when community support is needed, the leadership in the community fails to mobilise the community leaders to support. For instance, in light of the recent rains the same caregivers had to come and do the groundwork in the NCPs because people have this assumption that the NCPs belong to the caregivers"*
>
> ***CSO key informant***

### 3. Stakeholders are not aware of the strategic plan

Stakeholders at all levels and from all type of stakeholders reported not to be aware of the NCP strategic plan.

> *No, I don't think they are aware of it. We are also at fault because we did not give ourselves time to read it and know it. We just continued running the social centres with the basic knowledge we had on how to run social centres, but then it worked-*
>
> ***CSO key informant.***

### 4. Unmet Needs of the Caregivers

Caregivers are typically older women with their own children and families. In fact, some of them are widowed and unemployed with poor education. Despite that, caregivers reported that

their needs are not met, while they meet the needs of the children who receive the services they provide at the NCPs. These unmet needs of caregivers included: financial incentives, capacity and working tools. This resulted to caregivers not prioritising their work working at the NCP

> *"People do not want to work at the NCPs because there is no money. No one wants to come and help us from the time we started until now"*
>
> ***FBO key informant.***

> *"Not getting anything hinders our work because we do not even have work clothes. They say we must be clean, yet we do not get money for soap. We do not even get safety shoes"*
>
> ***FGD participant.***

### 5. Inconsistent Food Supply

One of the services provided by all NCPs to their clients (children) is food. However, the number of meals that should be received by the children per day vary between the caregivers and other stakeholders. Caregivers state that children receive one (1) meal per day while the strategic plan states that children should receive at least two (2) meals every weekday including during school holidays. The respondents reported that there has been no consistency in the availability of food in the NCPs. This is attributed to two (2) main reasons by the respondents. The reasons are: decrease in donor funding for the NCPs and decreased funding and poor coordination of funding by Government. The inconsistency of food supply to the NCPs is one of the major issues given that, the Food and Nutrition Pillar of the NCP programming is one of the most required services by the children.

> *"The life situation at home is also very bad for most children as they do not have food. Parents send the children to the NCP's because they also have nothing to give them as well"*
>
> ***FGD participant.***

> *"The food is the biggest challenge. If we do not get the food from WFP, where will we get it from? For instance, the social centres in towns do not have land that can enable them to grow their own food, so where else can they get the food?*
>
> ***CSO key informant***

### 6. Limited Capacity of the Caregivers

The provision of all the NCP related services requires some level of capacity from the caregivers. However, the capacity of the caregivers remains a challenge in providing the comprehensive package of the services that ought to be provided by the NCPs. As such, capacity building for the caregivers remain one critical area of intervention if the objective is to operationalise the NCPs fully and effectively. Capacity building remains fundamental. For an effective NCP, the caregivers need to be capacitated on the issues around the needs of children. A notable challenge is in the area of Early Childhood Care and Development (ECCD) and psychosocial support. Caregivers tend to deliver content that is not age-specific, hence fracturing with the developments of the children. Regarding psychosocial support, the scope of caregivers needs to be strengthened to accommodate the needs of children.

*"We usually have a challenge with the content they teach we are not expecting a child to be able to write at pre-school level because they should be coloring only. When it comes to reading, they do read, but it should only be picture reading failing which it conflicts with their developmental milestones leading to school dropouts"*

***Government key informant.***

*The one who teaches should also undergo a certain level of training on what they should teach at the pre-school and at what age of children. So, I recommend that there should be capacity building and also the level of education to be the right one because we cannot do a capacity building for a person who has a primary level of education"*

***CSO key informant.***

## Successes

The successes of the previous strategic plan include, improving children's health, improved children's access to education and integrated children with disabilities in health services as well as education.

### 1. Improved Children's Health and their Access to Food

Despite falling short of providing at least two (2) meals a day and the inconsistent supply of food in NCPs, the NCPs and the caregivers made the most of resources that were available. This in turn improved the health status of affected children. This was achieved through the Food and Nutrition pillar of the strategic plan. Meals in the NCPs are reported to be provided once a day to children aged 0-5 years. Due to this intervention, the respondents believe that the nutritional standard in the country has improved. Children are reported to be more nourished and resistant to diseases such as scabies and kwashiorkor.

*"I don't want to lie to you, Food, and nutrition, ECCD and Caring and Support are our leading packages, and I can safely say we are the best"*

***CSO key informant.***

*"We have seen a decline on the number of street kids' children no longer eat from dustbins anymore compared to the past"*

***CSO key informant.***

### Improved children's access to ECCD services

Children have benefitted from the implementation of the early learning play and recreation pillar of the NCPs, especially those who do not afford pre-school education. The NCPs have been of great assistance in meeting the educational needs of Orphaned and Vulnerable Children in communities. According to the caregivers, the children visit the NCPs not just for the food but also to learn.

*"The children now come to school not only to just eat but to also learn and this has been such a tremendous change"*

***FGD participant.***

The quality of the ECCD services provided by some of the NCPs is confirmed by the civil society respondents who stated that NCPs provide the children with solid foundation and introduction to formal education.

*"The NCPs provides a solid foundation and proper introduction to formal schools such that children no longer run away from school because they have a background from the care point"*

***CSO key informant.***

### 2. Identified and Integrated Children with Special Needs

Through the use of the local caregivers, the NCPs are reported to be of great assistance in identifying and integrating the children with disabilities in education and in social assistance interventions. Given that the caregivers are based in the community and engage in other community development activities as well as that all children are expected to go to the NCP for their meals, an opportunity to discover children living with disabilities avails itself.

> *"The NCPs are a good initiative because we have discovered a lot of disabled children through the NCP's and have been able to help them. Seriously speaking, we wouldn't have known some of these children"*
>
> ***FBO key informant.***

> *"We have also picked up a lot on the children's needs and we are able to refer them to institutions that can help them. The children also learn a lot of skills at the NCP's"*
>
> ***FGD participant.***

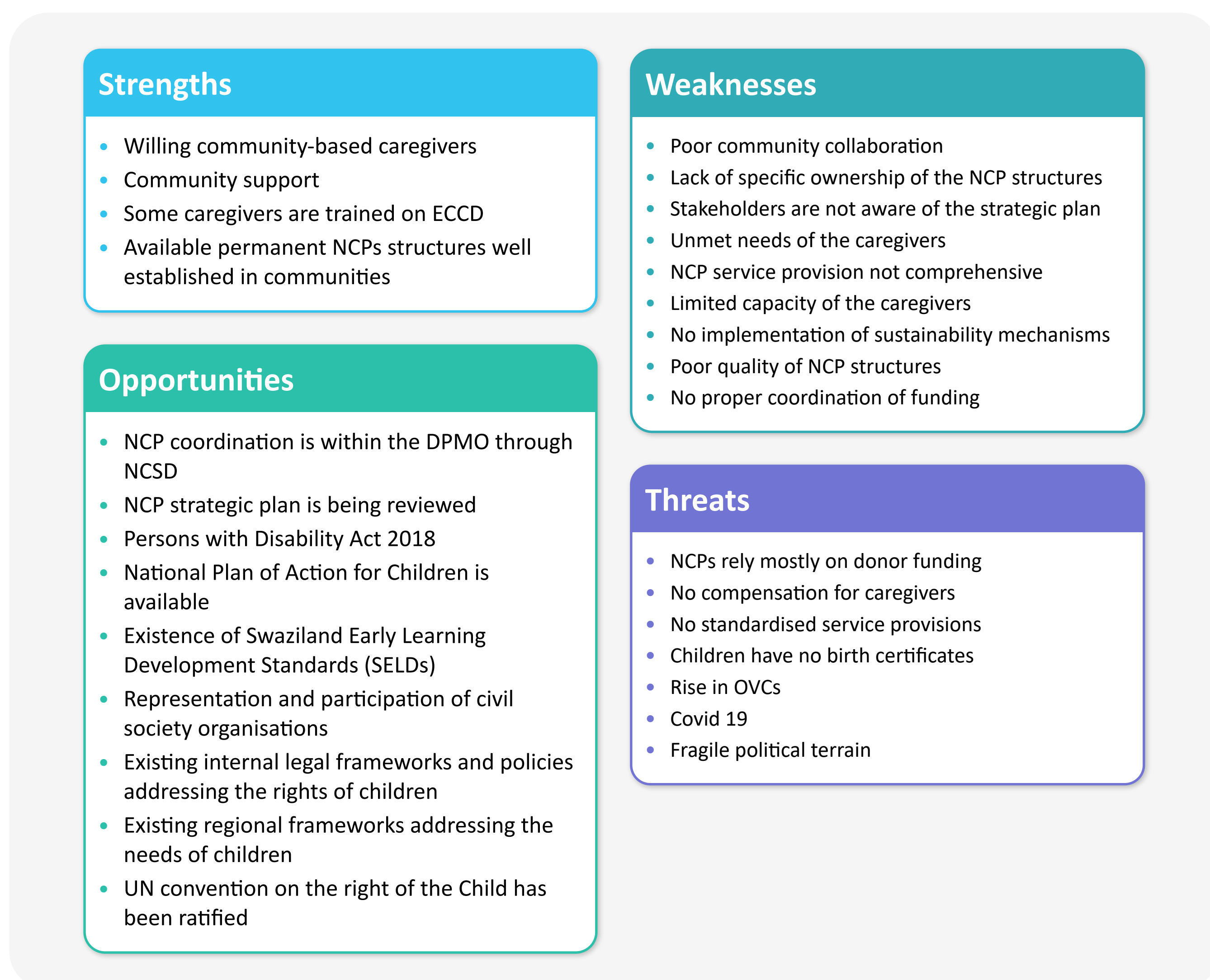
> *"I would say we have seen more assistance to children with disabilities. Children who would have not been able to continue with their education are now able to because of our intervention by going to the community centres and identifying children with a condition and then trying to refer the person to the institutions who can support them"*
>
> ***CSO key informant***

In the context of the successes and challenges mentioned above, the NCPs have inherent strengths, weaknesses, opportunities and threats which are presented below

# VII. The Strategic Plan's SWOT Analysis

The results of the investigative work described above can be summarised in a statement of the NCP's internal strengths and weaknesses as well as the external opportunities and threats it faces, as presented in the figure below. The implementation of this strategic plan is faced with more opportunities than threats and weaknesses as it is evident in the analyses.

## Figure 3: **Neighbourhood Care Point SWOT Analysis**



# NCPs Strategic Plan Vision, Mission and Values

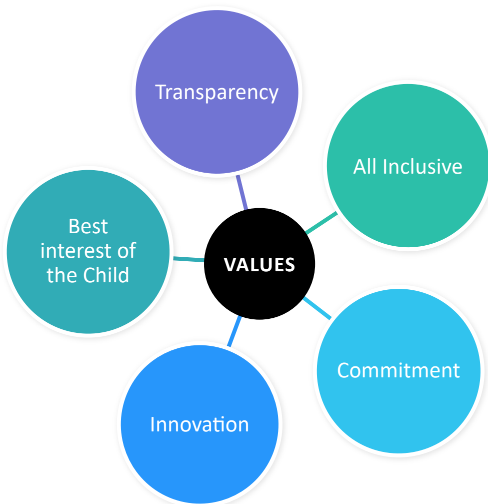



**Figure 4:** The Values of Neighbourhood Care Points

## Vision

The Vision of NCPs is to be a community level one stop shop for holistic wellbeing and development of children where every child is afforded a safe and nurturing environment to grow and develop.

## Mission

The Mission of NCPs is to improve the holistic well-being of OVCs deliver early childhood care and development interventions in the country at community level through:

- Advocating for the rights of children at community level.
- Facilitating children access to health and social services.
- Ensuring children access to adequate and nutritious food.
- Coordinating childhood care and development initiatives at community level.

## The Values of Neighbourhood Care Points

- **Transparency and accountability** – This refers to expressing accountability through the transparency of all NCP processes to encourage community engagement and improve government responsiveness, thereby strengthening and enriching the NCP.
- **All inclusive** –This is about providing the whole NCP package to all children and meeting the minimum requirements of getting support from an NCP.
- **Best Interest of the Child** – Having the best interests of the child should be a primary consideration in all actions undertaken by all NCP stakeholders.
- **Innovation** – This entails introducing new ideas and methods as practice to aid in the bettering of the NCP program.
- **Commitment** – This calls for helping with sticking to set goals during the good times and the bad times, when barriers get in the way.

# The Neighbourhood Care Points' Strategic Direction

The strategic plan is made up of two main pillars, the Technical Pillar and the Administrative Pillar. The Technical Pillar provides a clear direction on the core mandate of an NCP while the Administrative Pillar provides a clear administrative approach for the NCP for the next five (5) years. Furthermore, monitoring and evaluation has been provided as a cross-cutting strategy for the strategic plan given its significance in both the technical and administrative perspectives of the NCPs.

The goal of the strategic plan is to improve the holistic wellbeing and development of children in the country. This will be achieved through the attainment of the specific objectives of the technical and administrative pillars of the strategic plan that are listed below:

### The Technical Pillar

The technical pillar is characterised by the health and Food security, education and social development sub pillars. Each sub-pillar has its feeding components

### Health and Food Security Sub Pillar

The main objective of the health and food security pillar is to facilitate the improvement of the holistic health status of children and not just ensuring the absence of diseases. As such, this pillar is made up by three (3) main components of basic health care and they are; Food and Nutrition, Water Sanitation and Hygiene.

1. **Basic Health Care component**
   The main objective of Basic Health Care is to increase children's access to and utilisation of basic healthcare services that seek to prevent and treat diseases as well as maintain good health status.

2. **Food and Nutrition Component**
   The food and nutrition component of the health pillar seek to improve the continuous availability of at least two (2) high quality nutritious meals a day for children, regardless of the days and months.

3. **Water Sanitation and Hygiene Component**
   Hygienic behaviours and effective management of child-friendly sanitation services as well as potable water sources are the key focus areas of the Water Sanitation and Hygiene (WASH) component of the strategic plan.

# Table 1: **The Health and Food Security Sub-Pillar**

**Main objective:** To improve the holistic health status of children and not just the absence of diseases among them.

## 01 BASIC HEALTH CARE

**Objective:** To increase access of all children at NCPs to basic healthcare services that seek to prevent and treat diseases as well as maintain good health status.

| Strategies | Key Activities |
|---|---|
| **Capacity building for caregivers, NCP committees and communities** | Train caregivers, NCP committees and communities on identifying key health issues on children |
| **Strengthen and establish effective partnerships at all levels** | Develop and formalise partnerships between health facilities, Community health volunteers and NCPs at community level. |
| **Service provision** | Provide services to children in NCPs as according to their needs |

## 02 FOOD AND NUTRITION

**Objective:** To improve the continuous availability of high quality adequate nutritious food for children at NCPs regardless of the days and months

| Strategies | Key Activities |
|---|---|
| **Capacity building** | • Provide skill and knowledge to caregivers on meal preparation, presentation, and preservation.<br>• Train caregivers, NCP committees and communities on food production<br>• Train caregivers, NCP committees on stock management<br>• Train caregivers, NCP committees and communities on the implementation of Climate Smart agricultural techniques |
| **Integrate food production through climate smart agriculture in the operations of NCPs** | • Institutionalise back yard gardens in NCPs<br>• Integrate food production through climate smart agriculture techniques / technology in the operations of NCPs<br>• Institutionalise water harvesting in NCPs<br>• Institutionalise livestock farming in NCPs |
| **Advocacy** | • Advocate for the explicit budget for NCPs<br>• Advocate for participation and ownership in food production of NCPs |
| **Food provision** | Cook and provide food for children at NCPs |

## 03 WATER SANITATION AND HYGIENE

**Objective:** To promote the adoption of Hygienic behaviors and effective management of sanitation practices as well as potable water sources

| Strategies | Key Activities |
|---|---|
| **Infrastructure development** | Construct and maintain key relevant WASH infrastructure in NCPs vicinities |
| **Community mobilisation** | • Conduct WASH educational sessions for children and community members<br>• Develop and disseminate information, communication, and education material on WASH |
| **Capacity building** | • Train caregivers on hygienic behaviours and effective management of portable water sources and sanitation infrastructure<br>• Capacitate NCPs, NCP committees and communities on water harvesting, water purification and water source management |

## The Education Sub Pillar

### 1. Early Childhood Education Component

The Early Childhood Care and Development component is aimed at improving the nurturing of children for their physical, emotional, and mental development and to prepare them for schooling with right attitudes and habits.

### 2. Linkages to Formal Education Component

The main objective of linking children to formal education is to ensure that all children of school-going age receive support to be integrated and or retained in formal education. Care givers and nearby school administrators need to establish a common working relationship that will make it possible for children who are ready for school in the following year to be registered in schools.

## Table 2: **The Education Sub-Pillar**

**Main objective:** To increase access to education for all children at community level

### 01 EARLY CHILDHOOD CARE AND EDUCATION

**Objective:** To improve the nurturing of children for their physical and mental development and to prepare them for schooling with right attitudes and habits.

| Strategies | Key Activities |
|---|---|
| **Capacity building** | Train, certify, pay, and monitor caregivers on providing ECCE related interventions |
| **Infrastructure development and resourcing** | • Develop the necessary and required infrastructure for effective implementation of ECCE interventions<br>• Procure and distribute the required resources for the provision of ECCE related services |
| **Advocacy** | • Advocate for policies conducive for the implementation of ECCE services at NCPs<br>• Advocate for adequate budget for supporting and implementing ECCE services at NCPs |

### 02 LINKAGES TO FORMAL EDUDUCATION

**Objective:** To increase the access to formal education by OVCs through integration and or retention in formal education

| Strategies | Key Activities |
|---|---|
| Advocacy | • Advocate for the formalisation of NCP operations<br>• Advocate for the provision of payment for caregivers |
| Establishment or strengthening partnerships at all levels | • Formalise partnerships between NCPs and caregivers with other educational &social institutions<br>• Strengthen community involvement and participation in the NCPs |
| Linkage of children to other social services | • Conduct outreach activities to NCPs by other social service providers<br>• Document the needs of children and Caregivers in NCPs |

## The Social Sub Pillar

The Social Pillar aims to improve the children' social competence and also strengthen their safety and protection. As such, the sub pillar is characterised by: Psycho-social Support; Child Protection and Safety and Life Skills Development components.

1. **Psychosocial Support**

   The main objective of the psycho-social support component is to facilitate the children' psychosocial well-being and resilience.

2. **Child Protection and Safety**

   The child protection pillar is aimed at preventing violence, abuse, and exploitation of the children as well as ensuring that displaced children access protection services.

3. **Life Skills Development**

   The objective of Life Skills Development component is to improve the adoption of positive behaviour by the children to ensure their effective navigation of their life experiences.

# Table 3: **The Social Sub-Pillar**

**Main objective:** To improve the children' social competence and also strengthen their safety and protection.

## 01 PSYCHOLOGICAL SUPPORT

**Objective:** To improve the psychosocial well-being and resilience of the OVCs.

| Strategies | Key Activities |
|---|---|
| **Capacity building** | • Train caregivers and parents on comprehensive PSS and needs of children<br>• Develop and or routinely update training curriculum and materials including caregiver training manual |
| **Information sharing** | • Conduct awareness sessions on violence for the community, parents and also for the children<br>• Provide continuous awareness platforms for children and caregivers |
| **Advocacy** | • Advocate for the adequate resources for effective implementation of PSS interventions in NCPs |

## 02 CHILD PROTECTION AND SAFETY

**Objective:** To prevent violence, abuse and exploitation among the OVCs as well as ensuring that displaced children access protection services.

| Strategies | Key Activities |
|---|---|
| **Capacity building** | • Train caregivers on effective GBV reporting, prevention, and response<br>• Train health care providers on providing child friendly health services<br>• Provide child friendly community-based para-legal services and counselling |
| **Service provision** | • Provision of safety and protection services as provided by national documents especially the Child Protection and Welfare Act of 2012<br>• Develop training manuals for effective service provision.<br>• Provide income generating life skills for families of children and children |
| **Strengthening and development of strategic partnerships** | • Set up and operationalise stakeholder participation platform |

## 03 LIFE SKILLS DEVELOPMENT

**Objective:** To improve the adoption of positive behaviours by the OVCs for effective navigation of their life experiences.

| Strategies | Key Activities |
|---|---|
| **Capacity building** | Train caregivers on Life Skills education |
| **Life Skills Education implementation** | Conduct Life skills education sessions in NCPs with children |

## The Administrative Pillar

The Administrative Pillar of the strategic plan is aimed at improving the efficiency and effectiveness of the NCPs. The pillar, therefore, focuses on effective coordination of the NCPs and performance of the caregivers at the NCP level. Implied by these two (2) components is a robust monitoring and evaluation and learning component of the strategic plan.

1. **Coordination:** The aim of the coordination component of the strategic plan seeks to ensure improved efficiency and standardise the operations of the NCPs in the different constituencies.
2. **Performance of Caregivers:** This component of the administrative pillar is aimed at improving the effectiveness of the NCPs in improving the quality of life of children at the community level.

## Table 4: **The Administrative Pillar**

**Main objective:** To improve the efficiency and effectiveness of the NCPs.

### 01 COORDINATION

**Objective:** To improve efficiency of the NCPs and standardize the operations of the NCPs in the different constituencies.

| Strategies | Key Activities |
|---|---|
| **Coordination** | • Strengthen the NCP coordination framework based on experiences from strategic plan implementation<br>• Set up and operationalise NCP coordination structures at all levels<br>• Develop ToRs for all the NCP coordination structures at all levels<br>• Orientation sessions for all coordinating structures. |
| **Advocacy** | • Advocate for adequate resources for effective NCP coordination.<br>• Advocate for collaboration among stakeholders to enable holistic interventions for PSS interventions.<br>• Advocate for support at community level |

### 02 PERFORMANCE OF CAREGIVERS

**Objective:** To improve the effectiveness of the NCPs in improving the quality of life of children at the community level.

| Strategies | Key Activities |
|---|---|
| **Creation of performance focused culture within NCPs** | • Develop and disseminate caregiver ToRs<br>• Train, certify and pay and monitor caregivers on performance management and measurement<br>• Set up and operationalise caregiver appraisal system<br>• Develop translated and easy to understand SOP's for use by caregivers<br>• Develop and implement NCP strategic plan MEL system<br>• Disseminate the strategic plan to all stakeholders including caregivers |
| **Capacity building** | • Train caregivers on monitoring, evaluation, and reporting<br>• Train Care givers on performance management and measurement |

# Monitoring, Evaluation and Learning (MEL)

The Monitoring, Evaluation and Learning (MEL) and reporting will be formulated based on targets and indicators outlined in the strategic plan. The implication here is that there is a need for the DPMO to effectively document and disseminate/ communicate results from the monitoring, evaluation and learning activities of the strategic plan. The results will be presented in the form of reports and case studies, where applicable. The findings of the MEL-related activities will be used to facilitate continuous improvements on the technical and administrative issues of the NCP as enshrined in the strategic plan.

## Monitoring

There is need to develop a robust monitoring and evaluation system of the strategic plan. The monitoring of the strategic plan will produce periodic up-to-date information on the implementation of the strategic plan. The monitoring system will also provide data on the enabling and constraining factors of implementing the strategic plan at all levels. Jointly, these will facilitate timely evidence-based decision making during the implementation of the strategic plan. The monitoring system will detail the following:

- Indicators that will be routinely monitored.
- Monitoring tools.
- The indicator protocol and their analysis methodology.
- Data utilisation approach to facilitate evidence-based decision making throughout the implementation of the strategic plan.
- Platforms and approaches of report dissemination.

The effective monitoring of the strategic plan will be ensured through institutionalising the development and reviews of annual work plans which will be drawn from the strategy. This process will also facilitate the review of the relevance of the strategic plan.

The output of the strategic plan monitoring exercise will be the routine progress reports, activity reports and management reports. The development of these reports will be guided by the standards, targets and key performance indicators that will be outlined in the monitoring and evaluation system of this strategic plan.

## Evaluation

Two (2) external evaluations will be implemented for this strategic plan. The midterm review will be implemented at the end of 2025, while the end term review will be implemented at the end of 2027. The midterm evaluation aims to highlight programme performance against the comprehensive strategic plan as well as to measure progress towards the achievement of the outcomes and objectives set in the strategic plan. Hence, through the midterm review, DPMO will be able to: identify potential areas for improvement in the implementation of the strategic plan and produce actionable and realistic recommendations for the implementation of the strategy moving forward. The evaluation guiding questions are:

- Has the context of implementing the strategic plan changed?
- Are there any new opportunities for the improvement of NCPs?
- Is the strategic plan still relevant to the context of the NCPs?
- Is the implementation of the strategic plan still feasible?
- What progress has been made towards the achievement of the set targets/outcomes; is it relevant to the implementation time

available?

- What are the challenges faced during the implementation of the strategic plan?
- Are there sections of the strategic plan that need to be revised?

The evaluation of the strategic plan will be based on the OECD evaluation criteria of relevance, coherence, efficiency, sustainability, effectiveness and impact. An additional criterion of lessons learnt will be added to the evaluation criteria. The end line evaluation will also analyse the process of implementation (Implementation fidelity) and a benchmark for the subsequent strategic plan. Similarly, for the end line evaluation, lessons learned will also be documented to inform future planning and programming.

### Learning

This is a crosscutting component of the MEL, and it will be used to guide performance management planning by setting knowledge and information priorities. The learning plan will be part of the Monitoring and Evaluation and Learning system of the NCP strategic plan. It is characterised by:

- A set of learning questions designed to address existing knowledge gaps.
- A set of associated activities on how the learning questions will be answered.
- Products and strategies outlining how the findings will be disseminated and utilised.

The learning part of the MEL will ensure that:

- Scientific tests and exploration of assumptions and hypotheses are implemented throughout the life of the strategic plan.
- Knowledge gaps are filled from actual experiences of implementing the strategic plan.
- Informed decisions are made that results in more effective and efficient work.

## The NCP Strategic Plan Results Framework

The results of the strategic plan will be tracked using the below results framework. This framework presents the expected results of the strategic plan from the outcome level to the impact level. The outcome results are presented by objectives.

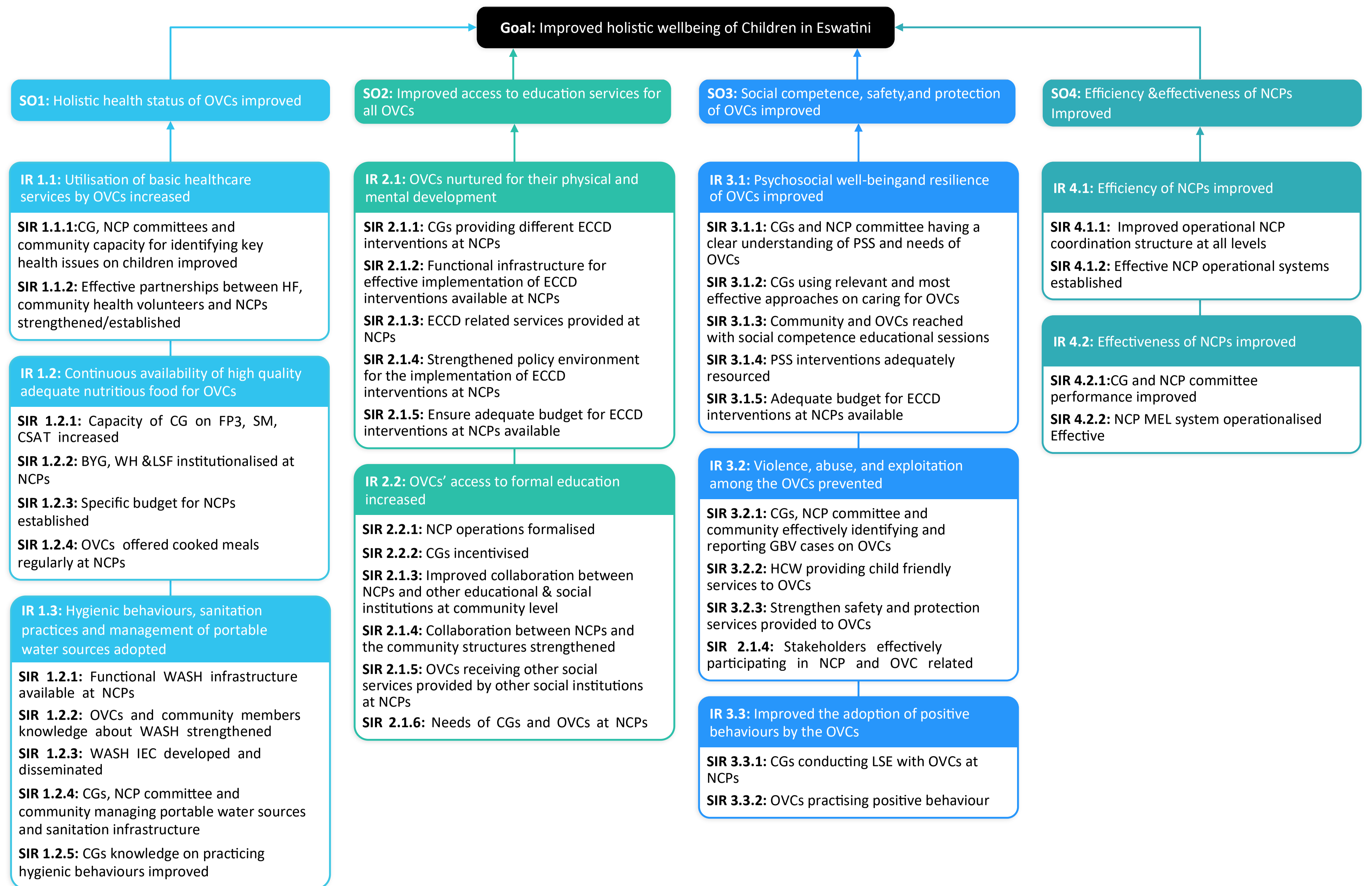



Figure 5: **The NCP Strategic Plan Results Framework**

Notes:

# The NCP Strategic Plan Logical Framework

The implementation of the strategic plan will follow the logical framework presented in the Table 5 below. Table 5 presents the implementation chronology of the main activities while also outlining the main outcome indicator and indicators for the main activities. The stakeholder responsible for the implementation has also been identified in the last column of the framework. It is however critical to note that the stakeholders have only been identified by group save for the Government ministries and departments.

# Table 5: **NCP Strategic Plan Logical Framework**

| Strategy | Key Activities | Implementation | | | | | | | | | | | | | | | | | | | | Outcome Indicator | Responsibility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Year 1 | | | | Year 2 | | | | Year 3 | | | | Year 4 | | | | Year 5 | | | | | |
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | | |
| **Technical Pillar** | | | | | | | | | | | | | | | | | | | | | | | |
| NCP KEY STRATEGIC AREA: **HEALTH AND FOOD SECURITY**<br>**Main Objective:** To improve the holistic health status of children in NCPs and not just the absence of diseases among the children in NCPs | | | | | | | | | | | | | | | | | | | | | | | |
| **01 BASIC HEALTH CARE**<br>**Objective:** To increase access of all children at NCPs to basic healthcare services that seek to prevent and treat diseases as well as maintain good health status.<br>**Outcome:** Access to health services for all children leading to a decline in child mortality. | | | | | | | | | | | | | | | | | | | | | | | |
| **Capacity building** | Train caregivers on identifying key health issues on children | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | % Of caregivers correctly identifying key health issues on children | DPMO |
| **Strengthen and establish effective partnerships at all levels** | Develop and formalise partnerships between health facilities and NCPs at community level. | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | • % of children utilizing health services from local health facilities<br>• # of children who received health services at an NCP | DPMO and stakeholders |
| **Service provision** | Provide services to children in NCPs as according to their needs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of children utilizing health services at NCPs | MoH and DPMO and Stakeholders |

## 02 FOOD AND NUTRITION

**Objective:** To improve the continuous availability of high quality adequate nutritious food for children at NCPs regardless of the days and months
**Outcome: Children** have access to at least two nutritional meals per day for all 7 days of the week

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Capacity building** | Train caregivers on meal preparation, presentation, and preservation. | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | % of NCPs adhering to meal preparation, presentation and preservation standards | DPMO and stakeholders |
| | Train caregivers on stock management | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | % of NCPs with effective stock management practices | DPMO |
| | Train caregivers on the implementation of Climate Smart agricultural techniques | | | Q3 | | | | Q3 | | | | Q3 | | | | Q3 | | | | Q3 | | % of NCPs implementing climate smart agricultural techniques | DPMO and MoA and stakeholders |
| **Integrate food production through climate smart agriculture in the operations of NCPs** | Institutionalise back yard gardens in NCPs | | | | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of NCPs with functional backyard gardens | DPMO and MoA stakeholders |
| | Institutionalise water harvesting in NCPs | | | | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of NCPs with functional water harvesting infrastructure | DPMO and MoA stakeholders |
| | Institutionalise livestock farming. | | | | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of NCPs practicing live-stock farming | DPMO and MoA stakeholders |
| **Advocacy** | Advocate for the explicit budget for NCPs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of DPMO budget dedicated to NCPs | CSO/FBOs and Caregivers |
| **Food provision** | Cook and provide food for children at NCPs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | # of children accessing food at NCPs | Caregivers |

## 03 WATER SANITATION AND HYGIENE

**Objective:** To promote the adoption of Hygienic behaviors and effective management of sanitation practices as well as potable water sources
**Outcome:** Increased number of NCPs with improved sanitation and hygiene practices

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Infrastructure development** | Construct and maintain key relevant WASH infrastructure in NCPs vicinities | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of NCPs with functional WASH infrastructure | DPMO and MPWT stakeholders |
| **Community mobilization** | Conduct WASH educational sessions for children and community members | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | # of community members practising proper WASH | Caregivers and CSOs/ FBOs |

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| **Community mobilization** | Develop and disseminate information, communication, and education material on WASH | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of community members with at least 70% knowledge on WASH | Caregivers and CSOs/ FBOs |
| **Capacity building** | Train caregivers on hygienic behaviors and effective management of portable water sources and sanitation infrastructure | | | Q3 | | | | Q3 | | | | Q3 | | | | Q3 | | | | Q3 | | % of caregivers practicing hygienic behaviours | DPMO and stakeholders |
| | | | | Q3 | | | | Q3 | | | | Q3 | | | | Q3 | | | | Q3 | | % of NCPs effectively managing portable water sources | |
| | | | | Q3 | | | | Q3 | | | | Q3 | | | | Q3 | | | | Q3 | | % of NCPs effectively managing sanitation infrastructure | |

NCP KEY STRATEGIC AREA: **EDUCATION**

**Main Objective:** To increase access to education for all children at community level

## 01 EARLY CHILDHOOD CARE AND EDUCATION

**Objective:** To improve the nurturing of children for their physical and mental development and to prepare them for schooling with right attitudes and habits.

**Outcome:** Number of NCPs with ECCE equipment and ECCE materials and at least one ECCE accredited caregiver.

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| **Capacity building** | Train caregivers on providing ECCE related interventions | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | % of NCPs with optimal adherence to National ECCE standard | MoET and DPMO |
| **/Infrastructure development and resourcing** | Develop the necessary and required infrastructure for effective implementation of ECCE interventions | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of NCPs meeting the minimum standards of providing ECCD services | MoET and DPMO |
| | Procure and distribute the required resources for the provision of ECCE related services | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % Of NCPs meeting the minimum requirements of providing ECCE services | MoET and DPMO |
| **Advocacy** | Advocate for policies conducive for the implementation of ECCE services at NCPs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Policy environment conducive for the provision of ECCER services at NCPs | DPMO, CSO/FBOs |
| | Advocate for adequate budget for supporting and implementing ECCE services at NCPs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of ECCE required budget at NCP level available | DPMO, CSO/FBOs |

## 02 LINKAGES TO FORMAL EDUDUCATION

**Objective:** To increase the access to formal education by OVCs through integration and or retention in formal education
**Outcome:** Increased number of school-going age children referred from NCPs to formal schools

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| **Advocacy** | Advocate for the formalization of NCP operations | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of NCPs with formal operating systems | CSO/FBOs and caregivers and other stakeholders |
| | Advocate for the provision of incentives for caregivers | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of caregivers financially incentivized for the services they provide | Caregivers, CSOs/ FBOs and other stakeholders |
| **Establishment or strengthening partnerships at all levels** | Formalize partnerships between NCPs and caregivers with other social institutions | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | # of children benefiting from the partnership of NCPs and other social institutions | Caregivers, CSOs/ FBOs |
| | Strengthen community involvement and participation in the NCPs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Implementation rate of the NCP community involvement strategy | Caregivers, CSOs/ FBOs |
| **Linkage of children to other social services** | Conduct outreach activities to NCPs by other social service providers | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | # of children reached through outreach to NCPs by other social service providers | Caregivers, CSOs/ FBOs |
| | Document the needs of children and Caregivers in NCPs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of the needs of children met | Caregivers, CSOs/ FBOs, DPMO, MoET |

NCP KEY STRATEGIC AREA: **SOCIAL**
**Main Objective:** To improve the OVCs' social competence and strengthen their safety and protection.

## 01 PSYCHOLOGICAL SUPPORT

**Objective:** To improve the psychosocial well-being and resilience of the OVCs.
**Outcome:** Psychosocial well-being and resilience of OVCs improved

| | | | | | | | | | | | | | | | | | | | | | | | |
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| **Capacity Building** | Train caregivers on PSS and needs of children | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | % of CGs having a clear understanding of PSS and needs of OVCs | DPMO, CSOs and FBOs |

| Capacity Building | Train caregivers on PSS and needs of children | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % CGs utilising the latest manual implementing interventions at NCPs | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Information sharing | Conduct educational sessions for children and for the community | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Community and OVCs reached with social competence educational sessions | Caregivers, CSOs/ FBOs |
| | Provide continuous educational sessions and platforms for children and caregivers | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | | DPMO, CSOs/FBOs |
| Advocacy | Advocate for the adequate resources for effective implementation of PSS interventions in NCPs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of NCPs reporting to have received adequate budget for interventions | Caregivers, CSOs/ FBOs |

## 02 CHILD PROTECTION AND SAFETY

**Objective:** To prevent violence, abuse and exploitation among the OVCs as well as ensuring that displaced children access protection services.
**Outcome:** Violence, abuse, and exploitation among the OVCs prevented

| Capacity building | Train caregivers on effective GBV case registering, signs and symptoms of violence and the reporting of any form of child abuse. | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | % of CGs effectively identifying and reporting GBV cases on OVCs | DPMO, MoH, CSOs, and other stakeholders |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Train health care providers on providing child friendly health services | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | % of HCW providing child friendly services to OVCs | |
| Service Provision | Provision of safety and protection services as provided by national documents | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of OVCs utilizing services | Caregivers, CSOs and FBOs |
| | Develop training manuals for effective service provision. | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | Q1 | Q2 | | | | DPMO, Caregivers, CSOs and FBOs and other stakeholders |
| | Strengthening development of strategic partnerships | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Stakeholders effectively participating in NCP and OVC related issues at community level | |

NCP KEY STRATEGIC AREA: **ADMINISTRATION**

**Main Objective:** To improve the efficiency and effectiveness of the NCPs

## 01 COORDINATION

**Objective:** To improve efficiency of the NCPs and standardize the operations of the NCPs in the different constituencies

**Outcome:** Efficiency of NCPs improved

| | | | | | | | | | | | | | | | | | | | | | | | |
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| **Coordination** | Compile and disseminate NCP coordination framework and strategy | Q1 | Q2 | Q3 | | | | | | | | | | | | | | | | | | # of NCP stakeholders aware of the NCP coordination framework | DPMO |
| | Set up and operationalise NCP coordination structures at all levels | | | | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | # of NCP coordination structures operational | DPMO and other stakeholders |
| | Develop ToRs for all the NCP coordination structures at all levels | Q1 | Q2 | | | | | | | | | | | | | | | | | | | # of NCP coordination structures adhering to their ToRs | DPMO |
| | Conduct orientation sessions for all coordinating structures. | Q1 | Q2 | | | | | | | | | | | | | | | | | | | # of NCP coordinating structures fully aware of their ToRs | DPMO and other stakeholders |
| **Advocacy** | Advocate for adequate resources for effective NCP operations. | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of NCPs with at least 80% of their annual budget | Caregivers, CSOs/ FBOs |
| | Advocate for collaboration among stakeholders to enable holistic interventions for PSS interventions | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | # of PSS interventions at NCP level implemented collaboratively with other stakeholders | Caregivers, CSOs/ FBOs |
| | Advocate for NCP support at community level | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | # of collaborative activities implemented by NCPs and community structures | Caregivers, CSOs/ FBOs |

## 02 PERFORMANCE OF CAREGIVERS

**Objective:** To improve the effectiveness of the NCPs in improving the quality of life of children at the community level.
**Outcome:** Effectiveness of NCPs improved

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| **Creation of performance focused culture within NCPs** | Develop, disseminate and implement caregiver ToRs | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of caregivers adhering to their ToRs | DPMO, community leadership and CSOs/FBOs |
| | Recruit and capacitate caregivers | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | • % of required caregivers recruited<br>• % of recruited caregivers achieving the minimum performance standards of caregivers | DPMO, community leadership and CSOs/FBOs |
| | Set up and operationalise caregiver appraisal system | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | A functional caregiver appraisal system | DPMO and other stakeholders |
| | Develop translated and easy to understand SOP's for use by caregivers | Q1 | Q2 | | | | | | | | | | | | | | | | | | | % of caregivers adhering to SOPs | DPMO and other stakeholders |
| | Develop and implement NCP programme MEL system | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Implementation rate of the NCP programme MEL system | DPMO and other stakeholders |
| | Disseminate the strategic plan to all stakeholders including caregivers | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | % of stakeholders aware of the strategic plan | All stakeholders |
| **Capacity building** | Train caregivers on monitoring and reporting | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | % of NCPs effectively compiling their routine reports | DPMO, CSO/FBOs |
| | Train Care givers on performance management and measurement | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | Q1 | | | | % of NCPs achieving at least 80% of their annual targets. | DPMO, CSO/FBOs |

# Strategic Plan Coordination Framework

The effective implementation of this strategic plan is largely depended on the operationalisation of the attached coordination structure. Each of the different stakeholders identified by the coordination structure have been assigned key roles and responsibilities to ensure the effective coordination of the strategic plan implementation. The stakeholders identified in the coordination structure are: the National Children Services Department, the National NCP TWG, the Regional NCP TWG, the Inkhundla NCP team, NCP management Committee, Development Partners; Community Based Organisations (CBOs) Faith Based Organisations (FBOs), Civil Society Organisations (CSOs), NCP leads and the Caregivers at NCP level. Other contributing partners include the Lihlombe Lekukhalela, Rural Health Motivators, Parents and Community Police.

## Roles and Responsibilities of coordination structures

Below are roles and responsibilities of the various coordinating structures.

### National Children Services Department

The National Children Services Department's role is to:

1. Ensure effective national coordination through compiling and disseminating NCP coordination framework and strategies.
2. Lead the implementation of the NCP strategic plan at all levels.
3. Advocating for child friendly policies and legislation in the country at all levels.
4. Advocating for a specific NCP budget that will support the implementation of comprehensive NCP services.
5. Lead the monitoring and evaluation of the NCPs and NCP strategic plan at all levels.
6. Ensure availability of data for children receiving NCP services and types of services being offered by the NCPs in the country.
7. Ensure effective collaboration across all levels and sectors to support the operation of the NCP.
8. Secretariat of all the NCP coordination structures at all levels Inform all stakeholders on the progress of the NCPs in the country.
9. Advocating for community ownership of the NCPs.

### National NCP TWG

The National NCP TWG's role is to:

1. Ensure multisectoral stakeholder collaboration in providing quality NCP services.
2. Support the development and dissemination of caregivers training manuals and curriculum.
3. Provide technical assistance to government as well as to other NCP stakeholders

### Regional NCP TWG

The Regional NCP TWG's role is to:

1. Coordinate NCPs at regional and community level.
2. Ensure regular reports on the implementation of NCP services.
3. Support initiatives to identify children with special needs.
4. Register NCPs and the type of services they provide for submission to the national level.
5. Collect and maintain regional data for children receiving services in the NCPs.

### Inkhundla NCP Team

The Inkhundla NCP Team's role is to:

1. Ensure availability of data for children accessing services in the NCPs at Inkhundla level.
2. Coordinate NCPs at community level and promote community ownership.
3. Lead the implementation of the strategic plan at Inkhundla level.
4. Lead Inkhundla level advocacy on NCPs.

### NCP Management Committee

The NCP Management Committee's role is to:

1. Oversee that NCPs operate in line with the values of this strategic plan which are accountability and transparency, all inclusive, best interest of the child, innovation, and commitment.
2. Monitor the services that are provided in the NCP to ensure that quality services are rendered.
3. Inform Inkhundla NCP team and the community leaders about the NCP activities.
4. Ensure that NCP leads compile and submit regular reports.
5. Promote collaboration between NCP leads and caregivers as well as other community NCP stakeholders.
6. Ensure that the community participates effectively in the operations of the NCP.
7. Be responsible for the appraisal of caregivers and NCP leads.

### Development Partners

The Development Partners' role is to:

1. Support policy and research, formulation, monitoring of the situation of children and situational analysis to inform the development of NCP programmes;
2. Support the government and CSOs, FBOs and other CBOs with financial and technical resources to support the establishment and running of NCPS.
3. Advocate for conducive legislative to meet children's rights in the country.

### Civil Society and Faith and Community-Based Organisations

The Civil Society, Faith and Community-Based Organisations' role is to:

1. Provide technical as well as financial resources to support quality service delivery at the NCP.
2. Support the monitoring and evaluation of NCP activities.
3. Capacitate caregivers on the issues of children to enhance quality service delivery.
4. Establish partnership at all levels to lobby for children's issues.
5. Support, supervise, monitor, and evaluate community initiates designed for children.

### NCP Leaders

The NCP Leaders' role is to:

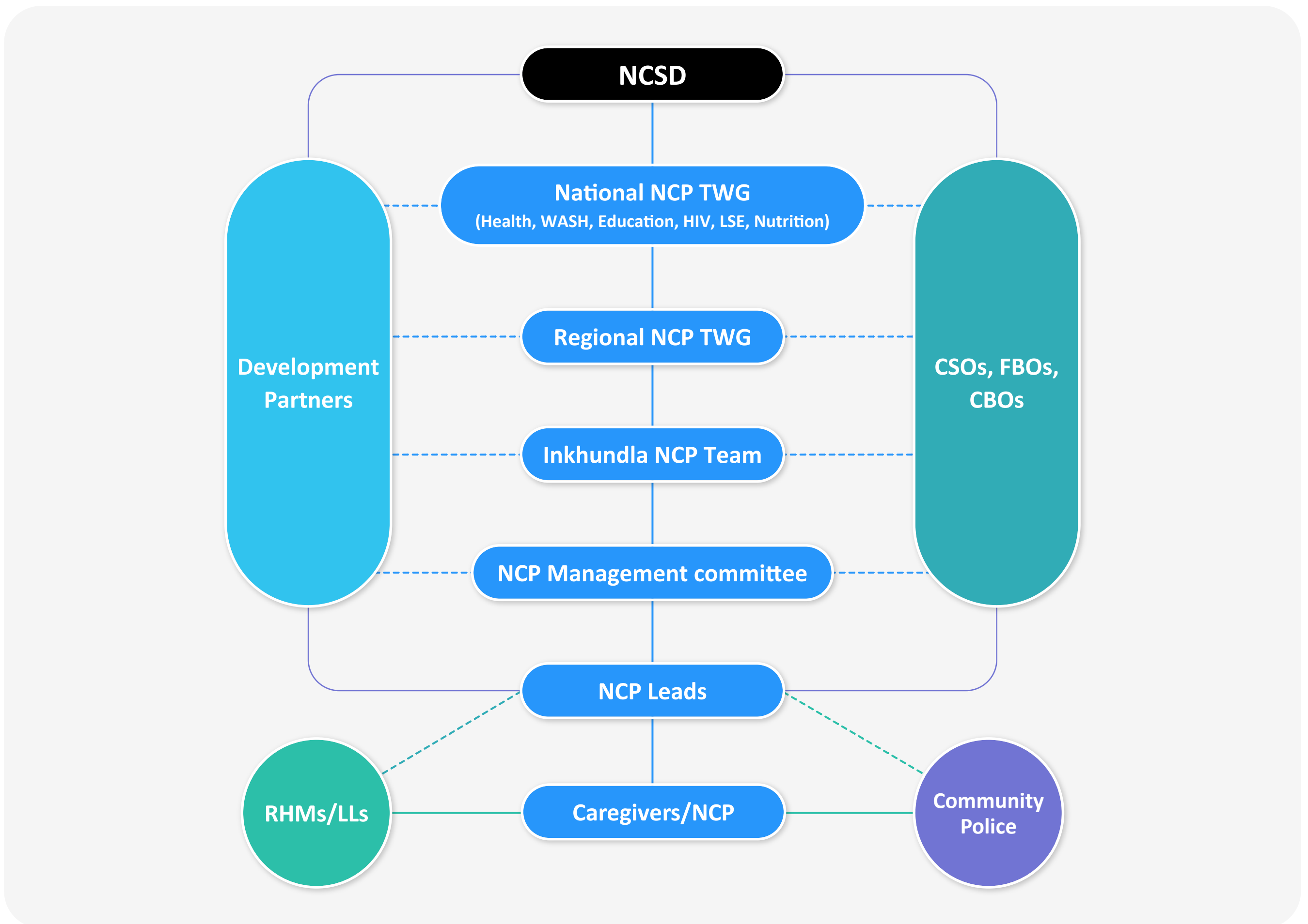
1. Prepare and submit reports to NCP committee.
2. Liaison with NGOs, Development partners and government to mobilise resources and technical expertise for the benefit of the children in the NCP.
3. Ensure caregivers submit timely reports on data collected at the NCP.
4. Ensure the needs of caregivers are met through establishing technical and financial empowerment for caregivers.

### Caregivers

The Caregivers' role is to:

1. Collaborate with CP, RHM and LL in comprehensive implementation of the strategic plan.
2. Ensure that the rights and needs of children are met at the NCP.
3. Effective reporting and responding to GBV needs.
4. Compile daily and weekly reports for submission to the NCP leads.
5. Collaborate with the Ministry of Health through RHMs in providing comprehensive basic health care to children.
6. Collaborate with RHMs in meeting the needs of the children in terms of health by making referrals to health facilities.
7. Monitor situation of children at NCPs and follow up cases of survivors of children abuse or children at risk of abuse, exploitation, and trafficking through home visits.
8. Provide support to survivors of child abuse.
9. Raise awareness for children's rights and needs.

# Figure 6: **Strategic Plan Coordination Structure**

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Written by Lungelo Vukile Bhembe from The Reaserch Company
Designed by the Publications Team @ Mbowa Design Lab

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