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Government of Zimbabwe

WORLD FIT FOR CHILDREN

MID-DECADE PROGRESS REPORT

ZIMBABWE 2002-2006

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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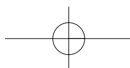
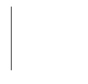

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MID-DECADE PROGRESS REPORT

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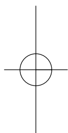
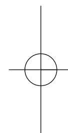

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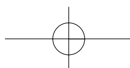

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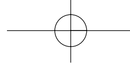

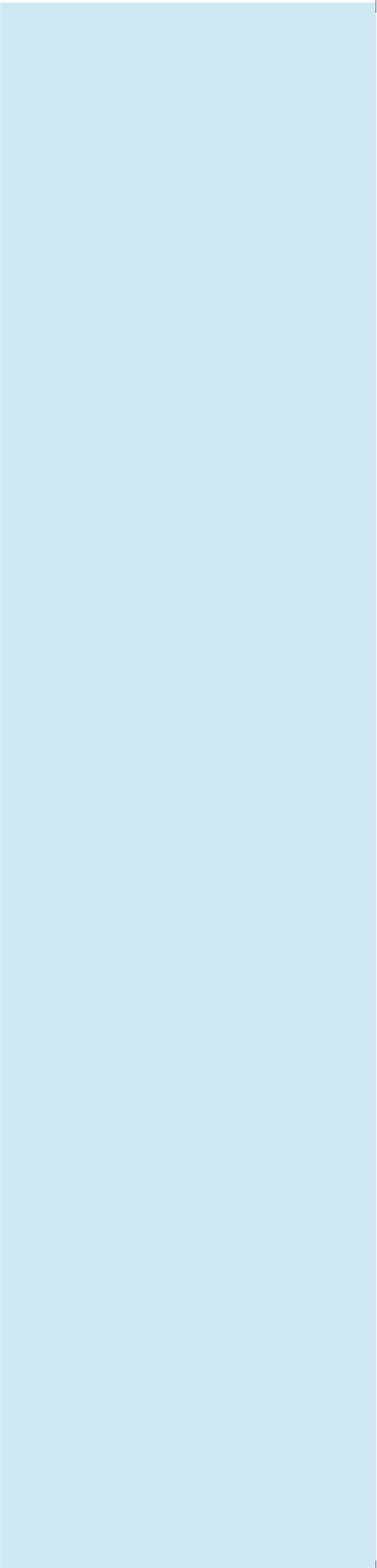

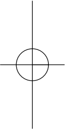

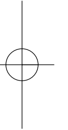

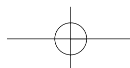

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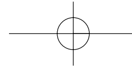


Foreword

The United Nations General Assembly Special Session (UNGASS) on Children was held in New York from 8th to 10th May 2002. At this memorable event, Zimbabwe committed herself to uphold the rights of the child to life and good health. These commitments are consistent with the UN Convention on the Rights of the Child (CRC), the African Charter on the Rights and Welfare of Children (ACRWC) and the Millennium Development Goals (MDGs).

Strong support to the Declaration and Plan of Action is contained in the outcome document of the 27th Special Session of the General Assembly on children, entitled 'A world fit for children'. At its Fifty-eighth session, the General Assembly decided to convene a commemorative plenary meeting in 2007, devoted to the follow-up to the outcome and the progress made in implementing the Declaration and the Plan of Action towards a World Fit for Children.

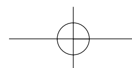
Ensuring the realization of children's rights set out in the Convention on the Rights of the Child, African Charter on the Rights and Welfare of the Child and the Millenium Development Goals will require dedication and commitment from all stakeholders. It is our hope that the information contained in this report will serve as a rallying point for scaling up of on going programmes for children in Zimbabwe. We hope that the mid decade reporting process will pave the way for more comprehensive assessment and analysis of the situation of children for the betterment of children in Zimbabwe.

The report contains the statistical details on the current situation of children and women in Zimbabwe with focus on progress made since 2002, major policy actions taken, resource trends and the challenges met. Further the report highlights some of the key priority actions to be undertaken in the next five years.

The preparation of this report would not have been possible without the commitment and dedication of various Ministries, government deparments, UN agencies, Civil Society partners and last but not least children themselves.

Dr Mabiza
Permanent Secretary
Ministry of Health and Child Welfare

Dr F P Kavishe
Representative
UNICEF Zimbabwe



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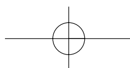

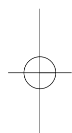

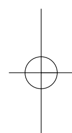

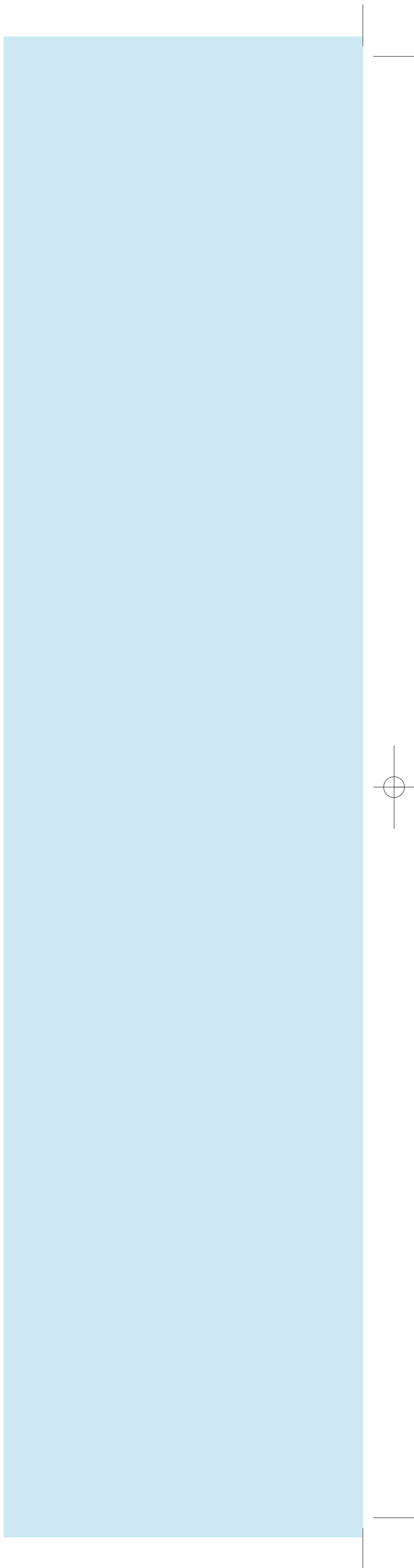

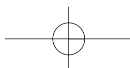

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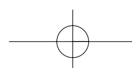
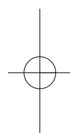
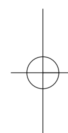
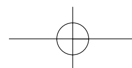


ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALS	Agricultural and Livestock Survey
ANC	Antenatal Clinic
ART	Acute Respiratory Infections
ARV	Anti-Retroviral (drugs)
BEAM	Basic Education Assistance Module
CBO	Community Based Organization
CDC	Centre for Disease Control Prevention
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CIDA	Canadian International Development Authority
CRC	Convention on the Rights of the Child
CSFP	Child Supplementary Feeding Programme
CSO	Central Statistical Office
DAAC	District AIDS Action Committee
DFID	Department for International Development (British)
ECD	Early Childhood Development
ECEC	Early Childhood Education and Care
EDC	Epidemiology and Disease Control
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EMIS	Education Management Information System
EPI	Expanded Programme of Immunization
EU	European Union
FAO	Food and Agriculture Organization
FBO	Faith Based Organization
FP	Family Planning
FPL	Food Poverty Line
GAPWUZ	General Agricultural and Plantation Workers Union of Zimbabwe
GCN	Girl Child Network
GDP	Gross Domestic Product
GEM	Girls Education Movement
GFATM	Global Fund for AIDS, TB and Malaria
GMB	Grain Marketing Board
GoZ	Government of Zimbabwe
HBC	Home-based Care







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HF	Health Facility
HIV	Human Immuno-Deficiency Virus
IEC	Information, Education and Communication
IGPs	Income Generating Projects
IMCI	Integrated Management of Childhood Illnesses
ICDS	Inter-Census Demographic Survey
IOM	International Organization for Migration
ITN	Insecticide Treated (mosquito) Net
LFS	Labour Force Survey
M & E	Monitoring and Evaluation
MDG	Millennium Development Goals
MERP	Millennium Economic Recovery Programme
Mid	Middle
MMR	Maternal Mortality Ratio
MOESC	Ministry of Education, Sport and Culture
MOHCW	Ministry of Health and Child Welfare
MPSLSW	Ministry of Public Service, Labour and Social Welfare
NAC	National Aids Council
NAC	National Aids Council
NAP	National Action Plan
NATF	National Aids Trust Fund
NatPharm	National Pharmaceutical Company
NDTPC	National Drugs and Therapeutics Practice Committee
NEDPP	National Economic Development Priority Programme
NERP	National Economic Revival Programme
NGO	Non- Governmental Organisation
NHIS	National Health Information System
NMRL	National Microbiology Reference Laboratory
NZAid	New Zealand Aid
OAK	Foundation
OI	Opportunistic Infections
ORS	Oral Rehydration Solution
OVC	Orphans and Vulnerable Children
PAAC	Provincial AIDS Action Committee
PASS	Poverty Assessment Study Survey
PCN	Primary Care Nurse

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PESSA	Cabinet Committee on Poverty Eradication and Social Services Delivery
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PoS	Programme of Support
PSI	Population Services International
RBM	Roll Back Malaria
RBZ	Reserve Bank of Zimbabwe
RDC	Rural District Council
RG	Registrar General's Office
SDC	School Development Committee
TB	Tuberculosis
TBP	Time Bound Programmes
TCPL	Total Consumption Poverty Line
UN	United Nations
UNAIDS	United Nations Joint Programme for HIV and AIDS
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Fund for Children
USAID	United Nations Agency for International Development
VFU	Victim Friendly Unit
VHW	Village Health Worker
WFFC	World Fit For Children
WFP	World Food Programme
WHO	World Health Organization
ZDAWU	Zimbabwe Domestic Allied Worker's Union
ZDHS	Zimbabwe Demographic and Health Survey
ZNFPC	Zimbabwe National Family Planning Council
ZNPP+	Zimbabwe Network of People Living Positively with HIV and AIDS
ZNSC	Zimbabwe National Security Council
ZTV	Zimbabwe Television
ZVITAMBO	Zimbabwe Vitamin A for Mothers and Babies (Programme)

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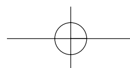


1. INTRODUCTION

A World Fit For Children (WFFC) is one in which children get the best possible start in life, having access to education and an opportunity to develop their individual capacity in a safe and supportive environment (UN General Assembly Special Session on Children (UNGASS), May 2002). A child in Zimbabwe is any person below the age of 18 years. The WFFC targets cover five broad priority areas of the Millennium Development Goals (MDGs) which is also a strategy in the world's endeavour to fulfil the Rights of the Child as outlined in the UN Convention on the Rights of the Child.

i. Promoting Healthy Lives

Promoting healthy lives for children is achieved through the attainment of MDG 1 'Eradicate extreme poverty and hunger', MDG 4 'Reduce child mortality', MDG 5 'Improve maternal health', MDG 6 'Combat HIV and AIDS, malaria and other diseases, MDG 7 'Ensure environmental sustainability'.

ii. Promoting Quality Education

Promoting quality education for children depends on the country's realization of MDG 2 'Achieve universal primary education' and MDG 3 'Promote gender equality and empower women' and MDG 8 'Develop global a partnership for development'.

iii. Combating HIV and AIDS

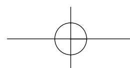
Combating HIV and AIDS in children is determined by achievements in MDG 6 'Combat HIV and AIDS, malaria and other diseases', MDG 3 'Promote gender equality and empower women' and MDG 8 'Develop a global partnership for development.'

iv. Protecting Children against Abuse, Exploitation and Violence

Child protection depends on achievements made by the country in implementing the Millennium Declaration Section 6 on Protecting the Vulnerable.

v. Resource Mobilization

Overall, MDG 8 'Develop a global partnership for development' is critical for the achievement of both MDG and WFFC targets in Zimbabwe. However, the efficient utilization of available national resources, remains the back-borne of progress and sustainable development.



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Background

Zimbabwe developed a National Plan of Action for Children covering the decade 1990-2000 and produced both the Mid Decade report submitted in 1995 and the End-Decade Report submitted to UNGASS in 2002. Even though a follow-up plan for children for the decade 2002-2012 was not developed, many of the programmes on children are still guided by the earlier plan (1990-2000). A Programme of Action for Children covering the remaining five years of this decade will be developed to enable a better end decade assessment.

However, in 2004, a National Action Plan for Orphans and Other Vulnerable Children[1] (NAP for OVC), was developed to re-emphasise the urgent attention required for orphans and children made vulnerable especially by the AIDS scourge. In this regard, the Mid-Decade Progress Report on Children is a follow-up to the 1990-2000 End-Decade Report, and it therefore not only reports on progress made to date but also serves as a basis for the formulation of the National Programme of Action for Children for the remaining half-decade. It is important to note that whilst the MDG targets were translated into national targets, this was not specifically done for the WFFC targets. In the absence of a comprehensive National Programme of Action for Children, the WFFC targets were therefore adopted as presented at the international level. As a Third World country Zimbabwean children continue to suffer and die of diseases of poverty and under development as reflected in the top ten causes of morbidity and top five causes of mortality.

1.1 Summary of Zimbabwe's Progress in Meeting WFFC and MDG Targets

Box 1 summarises Zimbabwe's progress made in meeting WFFC and MDG targets during the period under review.

Box 1: Summary of Zimbabwe's Progress in Meeting WFFC and MDG Targets

Promoting Healthy Lives

Zimbabwe has made progress in meeting the 2010 WFFC 'Promoting Healthy Lives' targets in the following areas:

- Low birth weight (below 2.5kg) prevalence: decreased from 11.4% (1999) to 2.3% (2003)
- Total Fertility Rate decreased from 4.0(1999) to 3.8 (2005/6)
- Age Specific Fertility Rate of women aged 15 to19 years: decreased from 112 (1999) to 99 (2005/6)
- Contraceptive prevalence rate: increased from 53.5% (1999) to 60.2 % (2005/6)
- Antenatal care: increased from 81.1% (1999) to 94.5% (2005/2006)
- Births attended by skilled health personnel: increased from 72.5% (1999) to 79.7% (2005/6)
- Pregnant women who received tetanus toxoid: increased from 78.9% to 80.8% (2005/6)
- Use of ORT: increased from 69.2% (1999) to 75.6% (2005/6)

[1]The Zimbabwe National Orphan Care Policy (1999) defines orphans as those children who have lost one or both parents while vulnerable children (including orphans) are those children with unfulfilled rights such as: children with disabilities; children affected and/or infected by HIV and AIDS; abused children (sexually, physically and emotionally); working children; destitute children; abandoned children; children living on the streets; married children; neglected children; children in remote areas; children with chronically ill parent(s); child parents; children in conflict with the law etc. These children in the decade 1990-2000 were referred to as children in difficult circumstances.

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Box 1: Summary of Zimbabwe's Progress in Meeting WFFC and MDG Targets cont'd

- Under-Five Mortality Rate per 1,000 live births: decreased from 102 (1999) to 82 (2005/6)
- Maternal Mortality Ratio, per 100,000 live births: decreased from 695 (1999) to 555 (2005/6)
- Infant Mortality Rate per 1,000 live births: decreased from 65 (1999) to 60 (2005/6)

However, the following basic indicators remain a cause for concern:

- Coverage of all vaccinations for children aged 12-23 months (vaccinated by 12 months of age) : decreased from 67.3% (1999) to 41.0% (2005/6)
- Exclusive breast feeding rate: 38.9% for less than 4 months and 7.2% for 4-6 months (1999), 24.1% for less than 4 months and 22.2% for less than 6 months (2005/6)
- Vitamin A supplementation in children (6-59 months): 61.4% (2003) according to PASS and 47.1% (2005/6) according to ZDHS
- Stunting prevalence for under fives (<-2SD height-for-age)): increased from 26.5% (1999) to 29.4% (2005/6)
- Underweight prevalence for underfives (<-2SD weight-for-age): increased from 13% in 1999 to 16.6% in 2005/06.
- Wasting prevalence for under fives (<-2SD height-for-weight): 6.4% for 1999 and 2005/6
- Iron supplementation to pregnant mothers: decreased from 59.7% (1999) to 42.9% (2005/6)
- Households without access to safe drinking water: increased from 24.9% (1999) to 33.5% (2004) for rural households, but decreased from 0.4% (1999) to 0.3% (2004) for urban households
- Households without access to safe sanitation: slightly increased from 55.4% (1999) to 55.7% (2004) for rural households and 1.2% (1999) to 1.3% (2004) for urban households

Promoting Quality Education

Zimbabwe has made progress in meeting WFFC 'Promoting Quality of Education' and MDG 2 on 'Achievement of Universal Primary Education' targets as reflected below:

- Primary school net enrolment ratio: increased from 96% (2002) to 97% (2004)
- Gender ratio, improved from 97% (2000) to 98% (2004) for primary, and from 89% (2000) to 91% (2004) for secondary
- Literacy rates for the age group 15-24: slightly increased from 98.0% (1999) to 98.3% (2004)
- Literacy gender parity: improved from 91.9% (1999) to 93.2% (2004)
- Secondary school net enrolment ratio: increased from 47% (2002) to 50% (2004)
- Secondary school transition rate (Form 4 to 5): increased from 10 % (2001) to 16% (2003)

However, the following areas related to quality of education remain a challenge:

- Primary school completion rate (Grade 7): decreased from 73% (2001) to 68% (2004)
- Primary school specialist classrooms shortfall: increased from 65% (2001) to 68% (2004)
- Secondary school completion rate (Form 4): decreased from 78% (2001) to 73% (2004)
- Primary (Grade 7) pass rate: decreased from 49% (2001) to 39% (2003)
- Secondary (O level) pass rate: decreased from 24% (2001) to 23% (2003)
- Primary school transition rate (Grade 7 to Form 1): decreased from 76% (2001) to 67% (2003)

Combating HIV and AIDS

Zimbabwe is experiencing a general reduction in HIV and AIDS prevalence with progress recorded in provision of PMTCT services at health facilities.

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Box 1: Summary of Zimbabwe's Progress in Meeting WFFC and MDG Targets

- Estimated adult HIV prevalence among the 15 to 49 year olds: decreased from 24.6% (2003) to 20.1% (2005) based on antenatal sentinel surveillance, and according to Zimbabwe Demographic and Health Survey (ZDHS) 18.1% (2005/6) based on population survey.
- Number of sites offering PMTCT: increased from 1 382 (2005) to 1 412 (2006)

Despite the significant progress in the fight against HIV and AIDS, the pandemic continues to fuel high morbidity (particularly TB) and the OVC burden, and exacerbating poverty levels.

- Reported prevalence of TB : increased from 438 (2001) per 100,000 population to 471 (2004)
- Orphanhood prevalence for under 18 age group: 22.3% (2003) according to Poverty Assessment Study Survey 2003 and 23.9% (2005/6) according to ZDHS

- **Protecting Children Against Abuse, Exploitation and Violence**

  Zimbabwe has many policies and laws that protect children against abuse, exploitation and violence. However, as a result of poverty and orphanhood which increased the vulnerability of children, reported assault of children and reported juvenile rape cases are on the increase. The presence of abandoned children and children on the streets is relatively significant. The negative attributes have been exacerbated by the economic hardships and the impact of the HIV and AIDS pandemic and the mistaken belief that sexual intercourse with a virgin girl child cures AIDS or increases harvest yields or business performance.

  - Child labour[2] : 37% (2004)
  - Reported cases of indecent assault of children: 1541 (2005)
  - Reported rape cases of children under 16 years: 2990 (2005)

- **Resource Mobilization**

  Zimbabwe remains committed to financing child rights programmes in pursuit of the 2010 WFFC and 2015 MDG targets. The government social protection programmes, being complimented by resources from development partners like the UN, faith based organizations, community based organizations and NGOs have provided assistance to a sizeable proportion of children. Various partnerships and alliances for children in all thematic areas have been forged, the most significant being assistance to the National Action Plan for OVC, immunization, malaria control, TB, AIDS, education and supplementary feeding.

1.2 Process of Compiling Report

The compilation of this Mid-Decade Report on Children would not have been possible without the participation of many representatives from Government Ministries and departments, UNICEF, WHO, NGOs and children (see Appendices: Table C). The input of children into this process came through a parallel advocacy campaign on Millennium Development Goals (MDG) led by young people. The broad consultative process was facilitated by the following sector Ministries who coordinated and chaired the various Thematic Groups under the overall chairmanship of the National Programme of Action for Children Secretariat in the Ministry of Health and Child Welfare with technical support from UNICEF.

[2] According to the International Labour Organization (ILO) definition, a child who spends at least one hour per week on any economic activity is taken to be in economic child labour. For Zimbabwe three major variations were introduced; namely (a) a cut off of three hours or more per day in relation to economic activities; (b) provision to allow for involvement of children aged 15 and above in some form of work as per national law; and (c) a cut off of five hours or more per day for children involved in housekeeping activities as constituting child labour

Table 1.1:
Thematic Groups and Process Coordinating Ministries and Departments, Zimbabwe Mid-Decade Progress Report on Children, 2002-2006

Thematic Group	Coordinating Ministry
Process Coordination	Ministry of Health and Child Welfare (MOHCW) and UNICEF
Promoting Healthy Lives	Ministry of Health and Child Welfare (MOHCW)
Promoting Quality Education	Ministry of Education, Sport and Culture (MOESC)
Combating HIV and AIDS	National AIDS Council (NAC) and AIDS and TB Unit MOHCW
Protecting Children against Abuse, Exploitation and Violence	Ministry of the Public Service, Labour and Social Welfare (MPSLSW)

The five thematic Groups reported on: status and trends; policy and legal developments; resource mobilization; opportunities or supportive environment; challenges and priority actions for the next five years. This national report was compiled and validated using these thematic group inputs.

This Mid-Decade Progress Report on Children is presented according to WFFC thematic areas. Under each thematic area the following issues are considered: A summary of progress related to MDGs and 2010 WFFC Targets and Indicators; Status and Trends; Challenges in Achieving the WFFC Goal; National Action Plans towards WFFC Targets; National Resource Trends; Partnerships and Alliances including Global Resource Mobilization, Lessons Learnt and Thematic Priorities for the next five years. The thematic area analysis is preceded by a socio-economic contextual analysis of the country. The structure of the report is designed to enable the reader to understand the context within which progress towards WFFC targets is being achieved in Zimbabwe. In addition to presenting progress on 2010 WFFC targets, the report also provides the progress on MDG 2015 targets in the Status and Trends section under each thematic area. The report also contains the statistical table to show progress through key indicators in Annex.

2. ZIMBABWE'S SOCIO-ECONOMIC AND HISTORICAL CONTEXT

Zimbabwe is experiencing a complex interplay of structural chronic poverty[3] combined with transient poverty[4]. Structural chronic poverty in Zimbabwe has its roots in the pre

[3]Structural chronic poverty is rooted in socio-economic, political and cultural dynamics and institutions and is experienced over the long term and is often transferred inter-generationally.

[4]Transient poverty is due to cyclical or temporary factors and is experienced over shorter periods of time. Typical examples include poverty induced by macro-economic policy shifts such as under economic reform programmes, natural disasters, cyclical unemployment, inflation, technological changes etc. It is important to note that structural chronic and transient poverty often co-exist and are not mutually exclusive.

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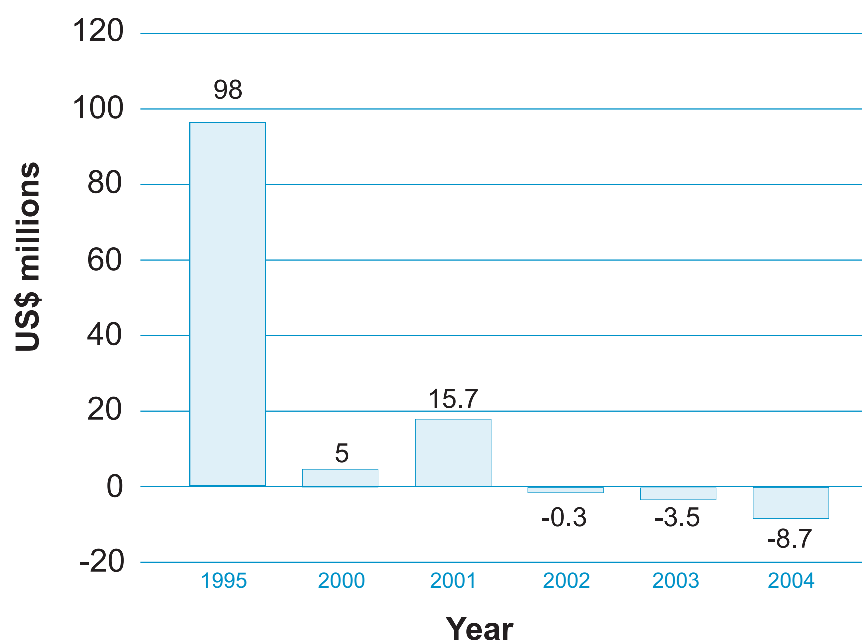
independence period. At independence in 1980, Zimbabwe inherited a dual economy characterized by a relatively well-developed modern sector which enjoyed support co-existing with a highly marginalized, largely poor rural sector, now called communal lands. This rural sector accounted for 80 percent of the population and provided cheap labour to the modern industrial sector particularly commercial agriculture and mining. This historical structural poverty and vulnerability template largely exists to this day and remains a foundational cause of structural chronic poverty and vulnerability.

Zimbabwe is experiencing unprecedented economic challenges, with the economy having shrunk cumulatively by about 40 percent since 1999, a four digit year on year hyper inflation of 1 070 percent in October 2006 which has severely eroded the purchasing power of incomes, a severe shortage of foreign currency and high unemployment levels. These together with the perennial droughts and HIV and AIDS pandemic, declining Foreign Direct Investment (see Figure 2.1) and low Overseas Development Assistance (ODA) have left the population vulnerable to poverty and food insecurity, which is adversely affecting children.

Women and children are disproportionately affected by both poverty and the HIV and AIDS pandemic. The HIV and AIDS pandemic is undermining food production systems. In 2003, rural households reported having experienced agricultural labour shortages, sale of agricultural and non-agricultural assets, reduced area planted, agricultural input shortages, increased indebtedness and looking after increasing numbers of orphans. The poverty, HIV and AIDS and gender nexus has become the greatest development challenge in Zimbabwe in particular and the Southern African region in general.

Figure 2.1: Net Foreign Direct Investment, US$ million, Zimbabwe 1995 and 2000-2004

Source: Reserve Bank of Zimbabwe, 2005



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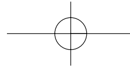


In response to the economic challenges various economic blueprints such as the “Millennium Economic Recovery Programme (MERP)”, August 2001; the “National Economic Revival Programme (NERP): Measures to address the current challenges”, February 2003; the “Macroeconomic Policy Framework 2005-2006”; the “Monetary Policy Statement, 2003-2008” were formulated. In March 2006, the “National Economic Development Priority Programme (NEDPP)” was launched to further put in place measures for economic recovery. Sustaining economic growth and development is key to ensuring a ‘World Fit For Children’.

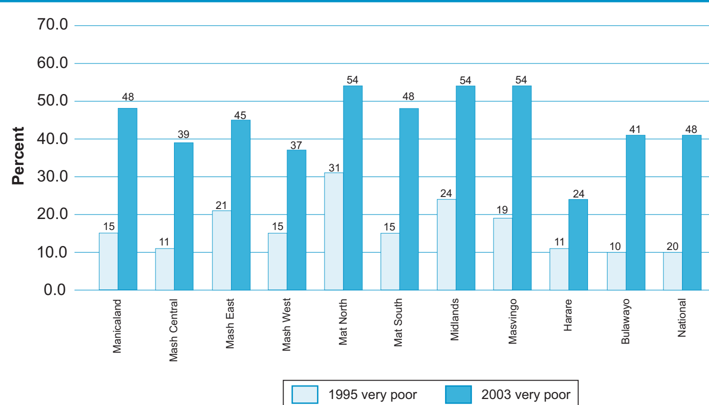
A notable feature of Zimbabwe’s overarching policy framework during the reporting period is the official national launch of the Millennium Development Goals Report (MDGR) in 2004 as the nation’s 2015 development vision. Five out of the eight goals directly impact on children. While Zimbabwe is working hard to achieve the eight goals, three priority goals which underlie the country’s achievement in the MDG agenda were prioritized as follows: MDG 1: ‘Eradicate extreme poverty and hunger’; MDG 6 ‘Combat HIV and AIDS, malaria and other diseases; and MDG 3: ‘Promote gender equality and empower women’. These three priority goals also underlie the country’s progress towards the achievement of the World Fit For Children 2010 Targets.

2.1 Household poverty

The poverty status of a household has implications on the well-being of children as measured in all the WFFC thematic areas. The Poverty Assessment Study Survey (PASS, 2003) found that the proportion of households below the Total Consumption Poverty Line (TCPL)[5] had increased from 42 percent in 1995 to 63 percent in 2003, while the proportion of households below Food Poverty Line (FPL)[6] more than doubled from 20 percent (1995) to 48 percent (2003).

In some provinces such as Manicaland, Mashonaland Central, Matabeland South and Bulawayo the proportion of very poor households more than tripled as illustrated in Figure 2.2 below.

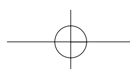
Figure 2.2: Percentage of the Households below the FPL by Province, Zimbabwe 1995 and 2003



Source: Zimbabwe 2003 Poverty Assessment Study Survey (PASS II), MPSLSW 2006

[5]The total Consumption Poverty Line (TCPL) reflects the minimum monthly income required by an individual to meet both basic food and basic non-food requirements.

[6]To determine the level of monthly income required for an individual in a household to meet basic food requirements a Food Poverty Line (FPL) is derived.



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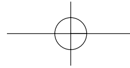


Although the poverty increase was slightly higher among male-headed households, poverty has remained higher in female-headed households as illustrated in Figure 2.3. Deepening poverty has increased vulnerability to shocks like food price increases and other forms of instability. While broad social indicators do not provide evidence of large scale effects of such increased vulnerability, the PASS 2003 found that the Human Poverty Index (HPI), a combined measure of deprivation in longevity, knowledge and overall economic provisioning, had deteriorated from 22 percent in 1995 to 33 percent in 2003.

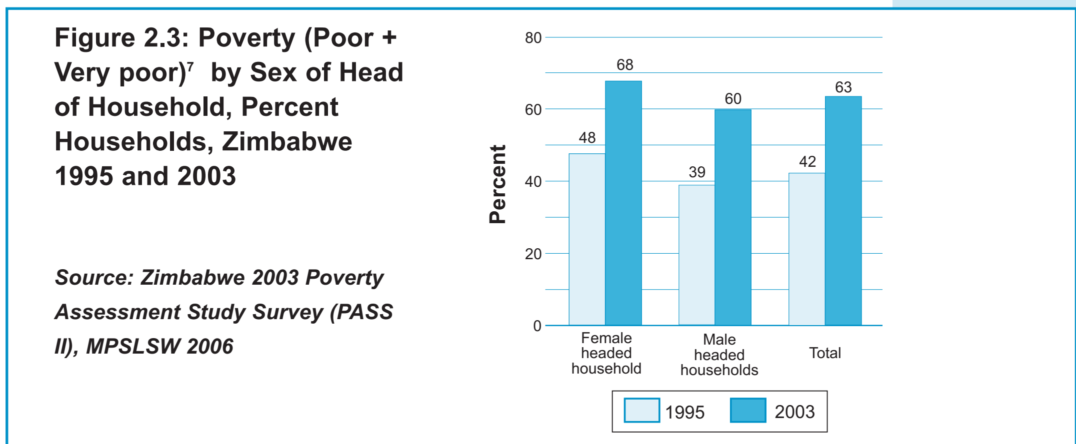


Figure 2.3: Poverty (Poor + Very poor)[7] by Sex of Head of Household, Percent Households, Zimbabwe 1995 and 2003

Source: Zimbabwe 2003 Poverty Assessment Study Survey (PASS II), MPSLSW 2006

Nutrition

As depicted in Figure 2.4, Zimbabwe Demographic and Health Surveys (ZDHS) show that under-weight prevalence for under fives increased from 13 percent in 1999 to 16.6 percent in 2005/6; the prevalence of stunting, the chronic form of under nutrition rose from 26.5% in 1999 to 29.4% in 2005/6, and the prevalence of wasting, the acute form of under nutrition stayed stable at about 6 percent. Malnutrition in women as measured by the prevalence of a Body Mass Index (BMI) of less than 18.5 points increased from 5 percent in 1999 to 9.2 percent in 2005/06 an indication of increasing chronic food insecurity.

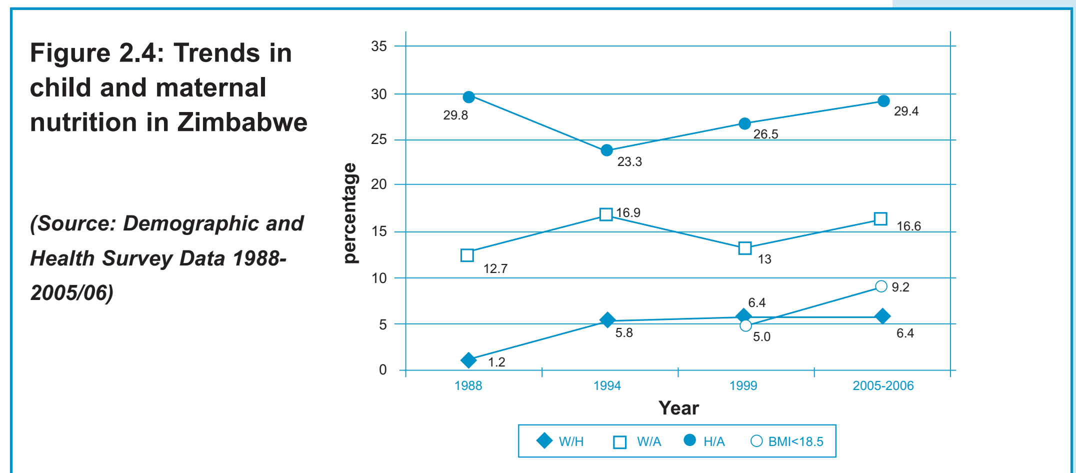
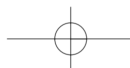


Figure 2.4: Trends in child and maternal nutrition in Zimbabwe

(Source: Demographic and Health Survey Data 1988-2005/06)

[7]Very Poor - Households/persons whose per capita monthly expenditure was below the Food Poverty Line (FPL); Poor – Households/persons whose per capita monthly expenditure is equal and or above the FPL but below the TCPL.



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The MDG goal for nutrition is to achieve an underweight prevalence rate of 7 percent. The increasing levels of undernutrition are explained mainly by food insecurity, inadequate child care practices and the impact of HIV and AIDS.

A tragic outcome of the HIV and AIDS pandemic is the growing orphan crisis. HIV and AIDS has left over one million children without parents resulting in increased vulnerability to neglect and abuse. Following the UNGASS on HIV and AIDS in 2001, Zimbabwe developed a National Action Plan for Orphans and Other Vulnerable Children (NAP for OVC) in 2004, with the target of making social services accessible to at least 25% of the OVC by 2010.

Despite the challenging operating environment in Zimbabwe, a lot of development work in the form of policies, programmes and legislation for children was undertaken since 2002. There is urgent need to scale up and widen these initiatives in an effort to achieve both the 2010 WFFC and 2015 MDG targets

2.2 Resource Requirements to Meet WFFC and MDG Targets

Meeting the WFFC and MDG targets calls for huge investment of resources. As per Table 2.1 it was estimated in the Zimbabwe Millennium Development Goals, 2004 Progress Report that meeting the MDG targets requires an estimated budget of US$ 2.2 billion. Zimbabwe therefore requires extensive support from partners in order to fulfill her obligation to uphold the rights of all her children and provide a nation that is truly fit for its children.

Table 2.1: Estimated Expenditures Required to Meet the Key MDG Targets, US$, Zimbabwe 2000-2015

Source: Zimbabwe Millennium Development Goals 2004 Progress Report.

Primary Education (with quality improvement)	$447.8m
Health	$43.2m
Water	$48.6m
Housing	$71.0m
HIV and AIDS	$38.0m
Anti -Retroviral Drugs	$1.5b
Total	$2.2b
Average spending per year	$143.2m

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Table 2.2 presents the estimated costs for the implementation of the NAP for OVC, Zimbabwe 2005-2008. Given the resource magnitude of over US$ 270 million for the four year OVC Programme dealing only with the segment of children in need of care, there is no doubt therefore that global partnerships for resource mobilization are an absolute necessity.

Table 2.2: Summary of Estimated Costs for the Implementation of the NAP for OVC, US$, Zimbabwe 2005-2008 ***Source: NAP for OVC, Zimbabwe October 2005***

NPA Strategic Objective	2005	2006	2007	2008
Education	16 215 062	21 815 056	33 386 141	41 294 959
Food, Health, Water and Sanitation	6 284 696	10 641 192	16 381 557	21 024 723
Education on Nutrition, Health, and Hygiene	200 000	243 200	250 226	263 835
Healthy Family Environment/Protection from Abuse	7 302 028	7 896 421	9 623 233	10 557 323
Birth Registration	775 000	775 000	775 000	775 000
Child Participation	2 346 552	3 434 625	5 190 415	6 550 120
Coordination	2 081 600	2 719 600	3 011 600	3 011 600
Administration	3 524 094	4 752 510	6 861 817	8 347 756
M & E	1 762 047	2 376 255	3 430 909	4 173 878
Total	**40 527 079**	**54 653 860**	**78 910 897**	**95 999 194**

3. WFFC THEMATIC AREA 1: PROMOTING HEALTHY LIVES

Zimbabwe has made progress in meeting the 2010 WFFC 'Promoting Healthy Lives' targets in the following areas:

- Low birth weight (below 2.5kg) prevalence: decreased from 11.4% (1999) to 2.3% (2003)
- Total Fertility Rate decreased from 4.0(1999) to 3.8 (2005/6)
- Age Specific Fertility Rate of women 15 to19 years: decreased from 112 (1999) to 99 (2005/6)
- Contraceptive prevalence rate: increased from 53.5% (1999) to 60.2 % (2005/6)
- Antenatal care: increased from 81.1% (1999) to 94.5% (2005/2006)
- Births attended by skilled health personnel: increased from 72.5% (1999) to 79.7% (2005/6)
- Pregnant women who received tetanus toxoid: increased from 78.9% to 80.8% (2005/6)
- Use of ORT: increased from 69.2% (1999) to 75.6% (2005/6)
- Under-Five Mortality Rate per 1,000 live births: decreased from 102 (1999) to 82 (2005/6)
- Maternal Mortality Ratio, per 100,000 live births: decreased from 695 (1999) to 555 (2005/6)
- Infant Mortality Rate per 1,000 live births: decreased from 65 (1999) to 60 (2005/6)

However, the following basic indicators remain a cause for concern:

- Coverage of all vaccinations for children aged 12-23 months (vaccinated by 12 months of age) : decreased from 67.3% (1999) to 41.0% (2005/6)

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- Exclusive breast feeding rate: 38.9% for less than 4 months and 7.2% for 4-6 months (1999), 24.1% for less than 4 months and 22.2% for less than 6 months (2005/6)
- Vitamin A supplementation in children (6-59 months): 61.4% (2003) according to PASS and 47.1% (2005/6) according to ZDHS
- Stunting prevalence for under fives (<-2SD Height-for-age)): increased from 26.5% (1999) to 29.4% (2005/6)
- Underweight prevalence for underfives (<-2SD weight-for-age): increased from 13% in 1999 to 16.6% in 2005/06.
- Wasting prevalence for under fives (<-2SD height-for-weight): 6.4% for 1999 and 2005/6
- Iron supplementation to pregnant mothers: decreased from 59.7% (1999) to 42.9% (2005/6)
- Households without access to safe drinking water: increased from 24.9% (1999) to 33.5% (2004) for rural households, but decreased from 0.4% (1999) to 0.3% (2004) for urban households
- Households without access to safe sanitation: slightly increased from 55.4% (1999) to 55.7% (2004) for rural households and 1.2% (1999) to 1.3% (2004) for urban households

3.1 Status and Trends

The Statistical Annex presents status and trends in the WFFC 'Promoting Healthy Lives' thematic area indicators.

MDG 1: Eradicate extreme poverty and hunger

Poverty reduction remains a key priority in Zimbabwe. According to PASS 2003, poverty increased considerably between 1995 and 2003. The proportion of population below the Food Poverty Line increased from 29% in 1995 to 58% in 2003 (see Figure 3.1). The proportion of population below the Total Consumption Poverty Line also rose from 55 percent in 1995 to 72 percent in 2003. If this trend continues, Zimbabwe is highly unlikely to meet its target of halving the poverty levels.

Gender analysis shows that at national level the poverty incidence (percentage households below the TCPL) was higher among female-headed households: 68% of female-headed households were classified as poor compared to 60% of male-headed households. This figure shows that women are still disproportionately represented among the poor.

Figure 3.1 Percentage of Total Population Below the Food Poverty Line Zimbabwe 1995 to 2003 and 2015 MDG Target.

Source: Ministry of Public Service, Labour and Social Welfare, Poverty Assessment Study Survey (1995) and II.

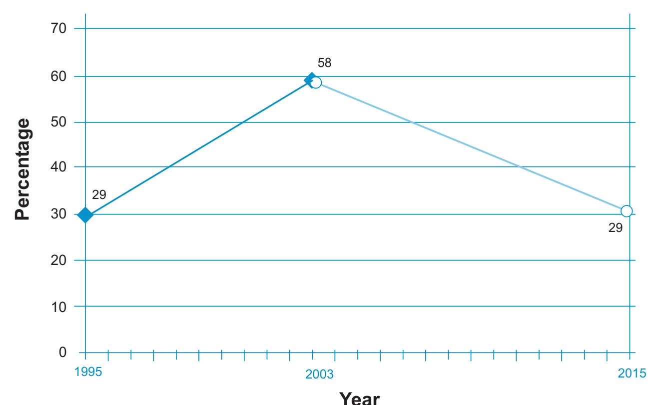

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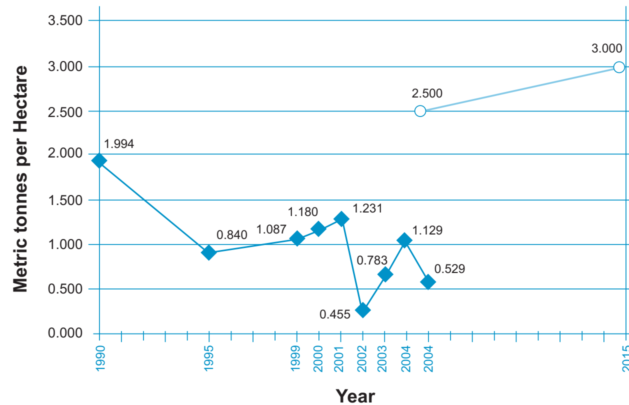
Figure 3.2 Maize Productivity (Yield per Hectare), Metric Tonnes, Zimbabwe 1990 to 2005 and 2015 MDG target.

Source: Ministry of Lands Agriculture and Rural Ressetlement (1990 and 1995) and Central Statistical Office.



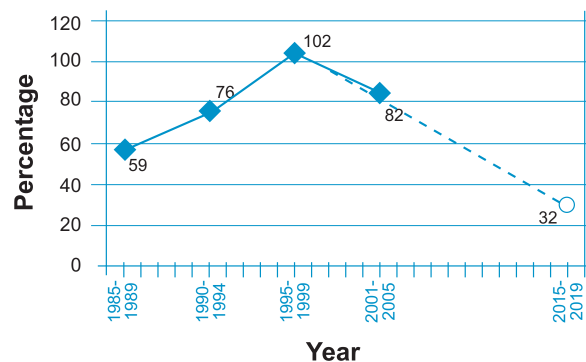
Children experience poverty differently than adults: child poverty is therefore experienced as both material and developmental deprivation. The exclusion resulting from poverty has lifelong impact on children. Poverty and HIV and AIDS are among the greatest threats to childhood. Human development as a whole shows an alarming trend: Human Development Index for Zimbabwe declined from 0.591 in 1995 to 0.505 in 2003.

MDG 4: Reduce child mortality

Statistics shows that the rise in child mortality may have reached a peak and have started to decline, following a similar peak and decline in HIV and AIDS incidence and prevalence. According to ZDHS, infant mortality rate declined from 65 deaths per 1 000 live births in 1999 to 60 in 2005/6. Consequently, if current trends continue, the infant mortality rate may be on target for both the 2010 WFFC target of 36 per 1 000 live births and the 2015 MDG target of 18. At the same time, under-five mortality has also declined from 102 deaths per 1 000 live births in 1999 to 82 in 2005/6 (Figure 3.3). The nation is on target to eradicate polio and the elimination of neonatal tetanus and iodine deficiency disorders.

Figure 3.3 Under Five Mortality, Zimbabwe 1985 to 2005 and 2015 MDG target

Source: Central Statistical Office, Zimbabwe Demographic and Health Surveys.



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The challenge is to sustain this declining trend in the face of resource constraints in the health sector and the effects of HIV and AIDS in order to meet the WFFC 2010 target and 2015 MDG target. In Zimbabwe 73 percent of the under five deaths occur before a child's first birthday and 29 percent during the first month of life. Table 3.1 below shows main causes of under five morbidity.

Table 3.1: Top Ten Causes of Morbidity for Under 5 Years Old, 2006

Source: Ministry of Health and Child Welfare

Rank	Condition/Diseases	Number of cases	Percent
1	ARI	934,544	40
2	Malaria	342,076	15
3	Skin diseases	307,242	13
4	Diarrhoea	193,974	8
5	Eye diseases	79,361	3
6	Injuries	70,828	3
7	Nutritional deficiencies	16,043	1
8	Dysentery	14,657	1
9	Dental	3,432	0
10	Bilharzia	3,430	0
	All other remaining diseases	361,538	16
	Total	**2,327,125**	**100**

According to ZDHS, coverage of measles immunization (vaccinated by 12 months of age) dropped from 71.4% in 1999 to 55.9% in 2005/6. Although the routine EPI monitoring report indicates that 85% of children received full immunization, the ZDHS 2005-06 shows a decline from 67.3 percent in 1999 to 41.0 percent in 2005/6. If this trend continues, the 2010 WFFC and 2015 MDG targets of 90 percent immunisation may not be achieved.

Vitamin A supplementation in children (6-59 months) was 61.4 percent in 2003 (Poverty Assessment Study Survey) and 47.1% in 2005/6 (ZDHS). Vitamin A deficiency elimination is crucial for effective immune system functioning where even moderate deficiency increases the child's risk of mortality and severe infection.

Breast feeding

ZDHS indicated high levels of timely complimentary feeding for the 6 to 9 month olds at 79 percent in 2005/6. However, a major challenge still remains in exclusive breastfeeding for the first 6 months. The rate remains low at 22 percent in 2005/6 which shows an alarming signal.

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Child care practices

A child's heath status is also a result of the care the child receives from the family/household and community. UNICEF and WHO in the Integrated Management of Childhood Illness (IMCI) and the key practices identified 17 key family practices which improve the child health status. Practices are not optimal because of household resource constraints such as lack of income, food insecurity, shortage of insecticide treated mosquito nets (ITNs), lack of access to safe drinking water and sanitation and inadequate child care knowledge of care givers.

MDG 5: Improve maternal mortality

According to ZDHS, the maternal mortality ratio (MMR) was 695 per 100 000 live births in 1999 and 555 in 2005/6. Meanwhile, Census data shows 1 068 in 2002. ZDHS 2005/6 concludes that the difference between those two figures (1999 and 2005/6) are not statistically significant and it is not possible to conclude that there have been any changes in maternal mortality in Zimbabwe. The current decline in HIV prevalence might result in a decrease in maternal mortality if combined with a well resourced health delivery system with an efficient referral system, trained personnel and essential equipment, drugs and other supplies.

The quality of care a mother receives in the prenatal and postnatal periods has implications on the survival and well being of the newborn. Seventy two percent of pregnant women were attended to by skilled health personnel, namely doctors and nurses in 2003. According to ZDHS, home deliveries were 23 percent in 1999 and PASS showed 30 percent in 2003. Escalating health care costs including maternity fees and transportation may be contributing to such high mortality figures.

The health system has seen the highest erosion of human resources through the "brain drain" and high morbidity caused by AIDS. The vacancy rate for doctors and nurses are 50 percent and 32 percent respectively (MOHCW 2006). Restoration of the country's human resource base to optimum capacity is, therefore, a critical challenge. With high HIV and AIDS prevalence the strain on health services is enormous. In addition to orphaning and loss of caregivers, lack of access to essential services and increased risk of missing out on education, HIV and AIDS also threatens the very survival of the infected and affected children who are unable to access pediatric antiretrovirals.

Zimbabwe has achieved high antenatal care coverage (percent of women attended by a health professional; doctor, nurse, midwife or auxiliary midwife) with 95 percent in 2005/6 rising from 81 percent in 1999. Also 81 percent of the pregnant women received tetanus toxoid in 2005/6, increasing from 79 percent in 1999.

Meanwhile, iron supplementation in pregnant women is still low at 43 percent in 2005/2006 having fallen from 60 percent in 1999.

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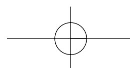


MDG 7: Ensure environmental sustainability

Adequate safe water, sanitation and hygiene are essential for the prevention of diarrhoeal disease, skin and eye infections. According to the Labour Force Survey (LFS), the proportion of rural households with access to safe water declined from 75.1% in 1999 to 66.5% in 2004. In 2006, government support to the water and sanitation programme covered 17 districts out of 58 rural districts due to resource constraints. The current efforts to develop a National Policy on Domestic Water Supply and Sanitation will go a long way in addressing challenges in the provision of safe water and sanitation in the rural areas.

Also planned are an Environmental and Public Health Policy and a 10 year environmental health plan to meet the MDGs. Without accelerated efforts, the WFFC 2010 target and the MDG 2015 target may not be achievable.

Access to safe sanitation in Zimbabwe's rural areas remains low at 44 percent in 2004(LFS). This reflects lack of investment in sanitation programmes by key players in the sector. Consequently, the country is way below the WFFC 2010 safe sanitation target of 61 percent and the MDG 2015 target of 73 percent.

Decent shelter is important for promoting healthy lives for children. Provision of adequate urban accommodation remains a major challenge in Zimbabwe. Following Operation Restore Order (2005) which saw the demolition of illegal structures, in both urban and rural areas, the Government has since launched an extensive programme 'Operation Garikai/Hlalani Kuhle' to improve the housing situation. In rural areas the challenge is to improve the quality of housing. In this regard, the Government has embarked on a Rural Housing Programme and the provision of social amenities like roads, clinics or dispensaries beginning with the most remote areas of the country.

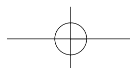
3.2 Challenges in Achieving Goal

A number of challenges were encountered in promoting healthy lives as reflected below:

- **Economic turnaround, sustained growth and development** remain the biggest challenge for Zimbabwe in its endeavor to achieve the WFFC and MDG targets.

- **HIV and AIDS pandemic:** The health system is overwhelmed by the high rates of morbidity and mortality as a result of the impact of the HIV and AIDS pandemic.

- **Household food insecurity:** Improvement in household food security is imparative to prevent malnutrition and improve the general health of children. Child and maternal malnutrition are increasing, mostly due to national and household food insecurity and increasing poverty. Exclusive breastfeeding is remaining low



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and decreasing. The feeding of the 0-6 month orphans is a daunting challenge as formula preparations are very expensive even for the well off sections of the population let alone the grandmothers who have now become the principal care givers to these orphans.

- **Inadequate maternity care:** Quality maternity care has the biggest potential to prevent the majority of neonatal morbidity and mortality and maternal mortality. It also has the biggest potential to prevent child disability and requires concerted effort from all stakeholders.

- **Decreasing resources to the health sector:** Paradoxically, the resources available to the health system have decreased at the same time as the burden it has to address has increased. All types of resources have been affected.

- **Increasing dependence on donors, particularly for commodities:** Because of the foreign currency shortage, preventive programmes are relying more and more on donations for essential supplies such as vaccines for expanded programme on immunization (EPI) and food for child supplementary feeding Programme (CSFP) thus posing a threat to their long-term sustainability.

- **Inadequate support to village health workers (VHWs):** Zimbabwe's experience is that VHWs are an essential component of improving the health delivery system, hence the revival of the VHW programme. Unfortunately, as volunteers, VHWs are however de-motivated due to poor working conditions.

- **Decent and affordable shelter:** Provision of affordable decent shelter in urban areas and improving the quality of rural housing remains a challenge.

Despite the challenging operating environment in Zimbabwe, significant development work in the form of policies, programmes and legislation for children is on-going in the area of promoting healthy lives for children as shown in Table 3.2. It is important to note that key policies and programmes such as the launch of the MDG process as a 2015 national development vision and the development and implementation of several macro-economic policies in an effort to turn around the economy and achieve sustained economic growth and development for poverty reduction are overall key national actions for promoting healthy lives of children. Therefore, these have been discussed at length in the socio-economic context section above. The next section highlights some of the key national actions taken in the area of promoting healthy lives for children.

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3.3 Major National Policies and Programmes Undertaken for Children Towards the World Fit For Children (WFFC) Targets, 2001-2006

Table 3.2: Promoting Healthy Lives: Selected Policies, Programmes and Legislation for Children, Zimbabwe 2001-2006

National Action Undertaken	Brief Comment
Cabinet Committee on Poverty Eradication and Social Services Delivery (PESSA)	The Cabinet Committee on Poverty Eradication and Social Services Delivery (PESSA) was established to monitor the social services delivery system and advise Cabinet on timely interventions. One such key intervention was the endorsement of the National Action Plan for Orphans and Vulnerable Children (NAP for OVC) and the mobilization of resources to ensure its implementation.
National Action Plan for Orphans and Other Vulnerable Children (NAP for OVC)	The NAP for OVC has programmes which support all the four thematic areas highlighted in the WFFC. The National Action Plan for Orphans and Other Vulnerable Children was formulated following UNGASS on HIV and AIDS with the objective of making social services including education accessible to 25 percent of the OVC between 2007 and 2010. It has enabled further resource mobilization to ensure proper targeting and assistance to children in need of care.
Nutrition Programmes	The child supplementary feeding programme (CSFP) has been almost continuous since 2002 given the prolonged droughts of the 2000s. Therapeutic feeding was introduced at district health facilities. A Nutrition and HIV Programme has been established for the ART rollout programme following research to find suitable complementary foods for HIV exposed children at 6 months of age.
Immunization Days	Conducted to improve coverage in addition to routine immunization.
The Land Reform – Assistance with inputs to farmers	To increase food security and economic growth
Roll-back Malaria Programme	Under this programme insecticide treated mosquito nets (ITNs) are free for all children under five years and pregnant and lactating women in the Roll Back Malaria (RBM) supported districts.
Safe Water and Environmental Sanitation Programme	A Draft National Policy on Domestic Water Supply and Sanitation has been finalized and is being considered for approval.
Village Health Workers (VHW) and Primary Care Nurse Programmes	VHWs were re-introduced in 2001 to carry out community health work. The nursing profession has been able to reduce staff attrition through the introduction of the Primary Care Nurse (PCN) programme as well as other measures such as bonding immediately after basic training.
The Health Services Board and the Public Service Skills Retention Fund	The Health Services Board was created in 2005 to develop more conducive conditions of service for health workers which are responsive to the specific needs of the health service delivery system. The Public Service Skills Retention Fund established in 2006 is intended to curb the brain drain particularly in the social services sectors such as health and education. This is expected to have a positive impact on the wellbeing of children.
Clinics in resettlement areas	Establishment of clinics in newly resettled areas is ongoing to widen access to primary health care services.
Amendment of the Criminal Procedures and Evidence Act	Now enables Nurses to also examine child victims of sexual abuse as doctors are not always available in districts and rural health facilities.
Hospital Fees	Under fives and pregnant women receive free treatment.

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Other initiatives include the Integrated Management of Childhood Illnesses (IMCI) which approved drugs such as amoxicillin to be available at the primary care level. IMCI implementation started in 1999 covering reference districts. By 2005, the first two components of IMCI (training of health workers and health system improvement) had expanded to 21 districts. Implementation of the community component remains as a challenge.

3.4 Resource Trends for promoting healthy lives

Financial Resources

Notwithstanding current economic hardships, government allocations to health increased in both nominal and real terms between 2002 and 2005 as shown in Figure 3.4.

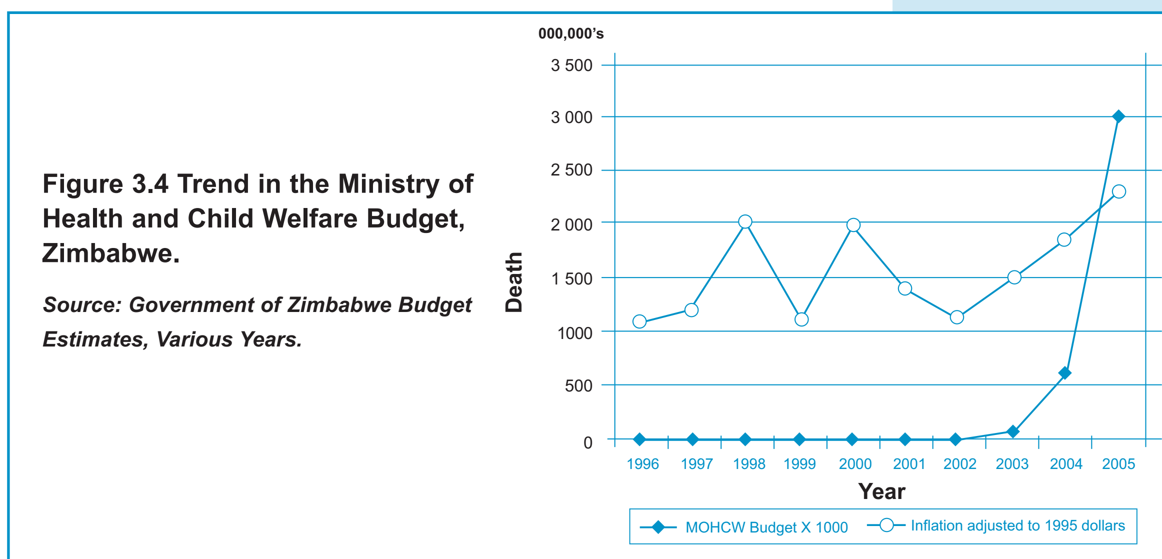

Figure 3.4 Trend in the Ministry of Health and Child Welfare Budget, Zimbabwe.

Source: Government of Zimbabwe Budget Estimates, Various Years.

However, this increase was not sufficient to match the demands on the health sector as a result of the impact of the HIV and AIDS pandemic which has also compounded the burden of diseases of poverty and under development such as under nutrition and malaria.

Human resources

Zimbabwe is well endowed with highly trained health professionals who are in high demand in the region and beyond. Since 2000, staff attrition mainly due to the brain drain has increased within the public health sector. Staff vacancies have increased since 2001 for pharmacists, environmental health officers, doctors and nurses as shown in Figure 3.5 below. The causes include low remuneration and poor working environment. The Health Services Board was created in 2005 to improve cconditions of service which are responsive to the specific needs of the health service.

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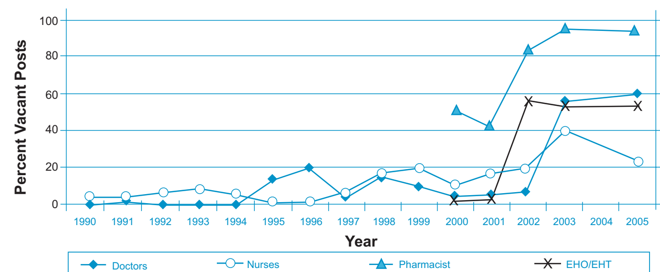
Figure 3.5 Trend in Staff Vacancies in MOHCW: Zimbabwe

Source: Human Resources (Staffing) Dept. MOHCW Headquarters, Various Years.



Medicines and other supplies

Availability of medicines and other supplies has been severely compromised (Table 3.3) by the significant shortage of foreign currency, and the inability of the MOHCW budget to keep up with the hyperinflationary environment. The local pharmaceutical industry is failing to adequately support the health system due to foreign currency shortages as most of the medicines have a foreign currency component.

The Reserve Bank of Zimbabwe (RBZ) availed US$106 thousand dollars in 2006 for the five months up to May out of the pledged US$2.5 million per month for the purchase of medicines made in 2004. Though the funds allocated for drugs and supplies in the 2005 MOHCW budget were 30 percent higher than the previous year, they fell far short of the year-on-year inflation for that year of 585.8 percent in December 2005. Total foreign exchange allocated in 2005 was US$3 166 231, which was only 10 percent of the pledged amount.

Table 3.3: Availability of drugs and supplies at NatPharm, 2004 and 2005 (percent) ***Source: Ministry of Health and Child Welfare, 2006***

	2004 (percent)	2005 (percent)
All drugs	65	41
Vital drugs	72	63
Essential drugs	56	21

Transport, Communication and Equipment

Emergency referrals, supervision and support to lower level health facilities as well as the outreach mobile services particularly to commercial farms and the resettlement areas which still have few static clinics have been compromised by the shortage of vehicles, vehicle spares and erratic fuel supplies.

3.5 Partnerships and Alliances

There are varied partnerships and alliances for children in the thematic area on ‘Promoting Healthy Lives’ which have been pivotal in helping to sustain previous gains in the health sector. Some of the major partnerships are highlighted in Table 3.4 below.

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Table 3.4: Promoting Healthy Lives: Selected Partnerships and Alliances for Children, Zimbabwe 2001–2006

Activity	Partnerships and Alliances
National Millennium Development Goals (MDGs), Taskforce 2002 to date.	The Millennium Development Goals taskforce is a broad partnership which brings together Government, the UN systems, Civil Society, Private Sector, Academic and Research Institutions, Youth. The Taskforce spearheads MDG monitoring as well as localisation to ensure that planning and decision making is aligned with MDGs.
Programme of Support (PoS) (for the implementation of the NAP for OVC),	The approval in 2004 of the National Action Plan for OVC has given the necessary framework for action and resource mobilization for OVC. In 2005-2006, under this framework UNICEF together with other stakeholders developed a pooled donor funding mechanism, with a double objective: to mobilize increased, multi-donor and more predictable funding for OVC and ensure that those resources are channeled down to communities, families and children.
Country Coordinating Mechanism	Given the international isolation Zimbabwe is facing, including the pool out of the IMF/World Bank macro-economic policies are funded from national resources. Major economic policies are formulated with the wide consultation of private sector, civil society and support from UNDP given the absence of the IMF and low profile of the World Bank in Zimbabwe during the reporting period. As a result whatever little support international partners are providing is being channeled through the UN agencies like UNICEF, WHO, etc e.g. the combating of environment threats to the health of children, pediatric ARVs and the care protection of orphans and other vulnerable children, immunization drug supplies etc.
Roll Back Malaria	The major partners in the Malaria programme are the Global Fund for AIDS, TB and Malaria which funds ITN purchasing equipment and other interventions.

3.6 Lessons Learnt and Priority Actions for the Next Five Years

Lessons Learnt

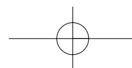
- Despite of the current socio-economic difficulties, it is still possible to make positive contributions to improve child health if resources are targeted at the right interventions and the most vulnerable. There is urgent need to invest in high impact interventions.

Given the above mentioned lessons learnt and the challenges still being experienced in the area of promoting healthy lives for children, the following priority actions have been set for the next five years.

Priority Actions for the Next Five Years

- **Develop and implement a broad-based, pro-poor macroeconomic strategy** for economic recovery, sustained growth and development for the realization of children's rights.

- **Enhance the implementation of agrarian reform** through a comprehensive support package to agriculture particularly inputs,



research and extension and efficient food marketing to ensure increased agricultural productivity to achieve national and household food security.

- **All child health and welfare programmes** to be strengthened and better coordinated to reduce duplication and wastage of scarce resources.
- The Primary Nurse Care (PCN) programme needs to be strengthened and expanded through **training and deployment of more primary care nurses** to the rural areas and better incentives for village health workers.
- **Improving access to decent shelter** and other social amenities.
- **Global Duty Bearers:** To ensure that children in Zimbabwe are not denied their right to life and the highest standard of health obtainable.

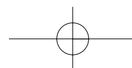
4. WFFC THEMATIC AREA 2: PROMOTING QUALITY OF EDUCATION

Zimbabwe has made progress in meeting WFFC 'Promoting Quality of Education' and MDG 2 on 'Achievement of Universal Primary Education' targets as reflected below

- Primary school net enrolment ratio: increased from 96% (2002) to 97% (2004)
- Gender ratio, improved from 97% (2000) to 98% (2004) for primary, and from 89% (2000) to 91% (2004) for secondary
- Literacy rates for the age group 15-24: slightly increased from 98.0% (1999) to 98.3% (2004)
- Literacy gender parity: improved from 91.9% (1999) to 93.2% (2004)
- Secondary school net enrolment ratio: increased from 47% (2002) to 50% (2004)
- Secondary school transition rate (Form 4 to 5): increased from 10 % (2001) to 16% (2003)

However, the following areas related to quality of education remain a challenge:

- Primary school completion rate (Grade 7): decreased from 73% (2001) to 68% (2004)
- Primary school specialist classrooms shortfall: increased from 65% (2001) to 68% (2004)
- Secondary school completion rate (Form 4): decreased from 78% (2001) to 73% (2004)
- Primary (Grade 7) pass rate: decreased from 49% (2001) to 39% (2003)
- Secondary (O level) pass rate: decreased from 24% (2001) to 23% (2003)
- Primary school transition rate (Grade 7 to Form 1): decreased from 76% (2001) to 67% (2003)



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4.1 Status and Trends

The Statistical Annex presents status and trends in the WFFC 'Promoting Quality Education' thematic area.

The following section presents the narrative and graphical presentation of progress towards 2015 MDGs and 2010 WFFC targets. Promotion of quality of education is pursued under MDG 2 'Achieve universal primary education' and MDG 3 'Promote gender equality and empower women'.

Primary Education

Since independence in 1980, Zimbabwe has registered success in the expansion of school infrastructure with the number of primary schools increasing by 51 percent from 3 160 schools in 1980 to 4 779 in 2004 excluding the many satellite schools set up to cater for the recently resettled population under the land reform programme. Tremendous expansion in teacher training was realized including the introduction of the Zimbabwe Integrated Teacher Education Course Programme. Zimbabwe with the net enrolment ratio of 97 percent in 2004 has achieved the 2010 WFFC universal primary education target of 90 percent. Further, a notable achievement is the gender parity at primary school level (Figure 4.1). However, the quality of education remains problematic as reflected, for example, in the pupil-teacher ratios (See Figure 4.3).

Figure 4.1: Gender disparities in the Net enrolment Ratio, Primary Education, 1994 to 2004 and 2015 MDG Target.

Source: Ministry of Education, Sports and Culture 2001 and 2005.

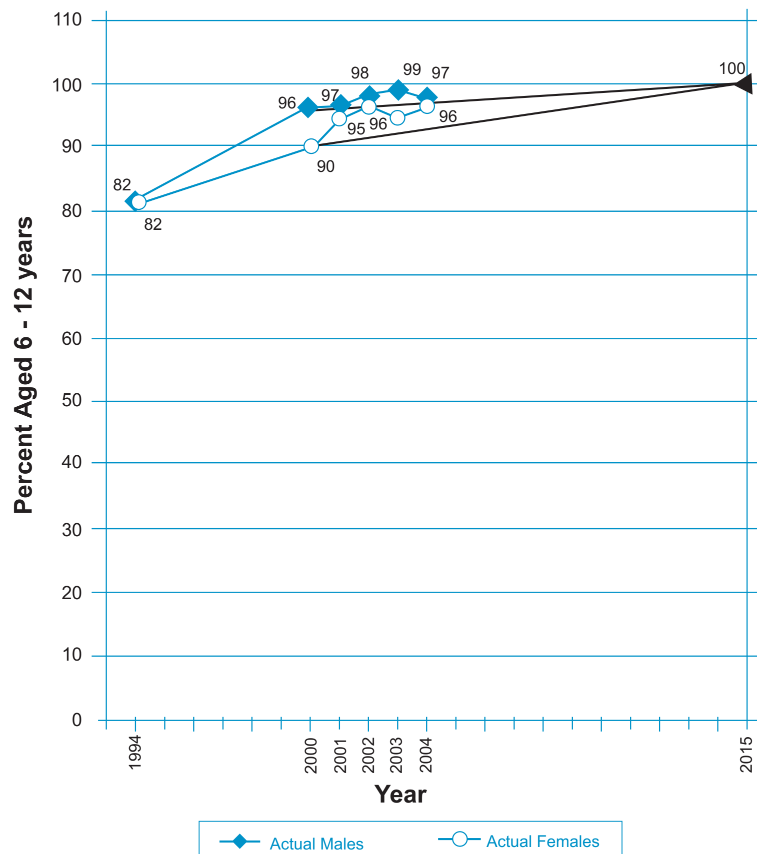

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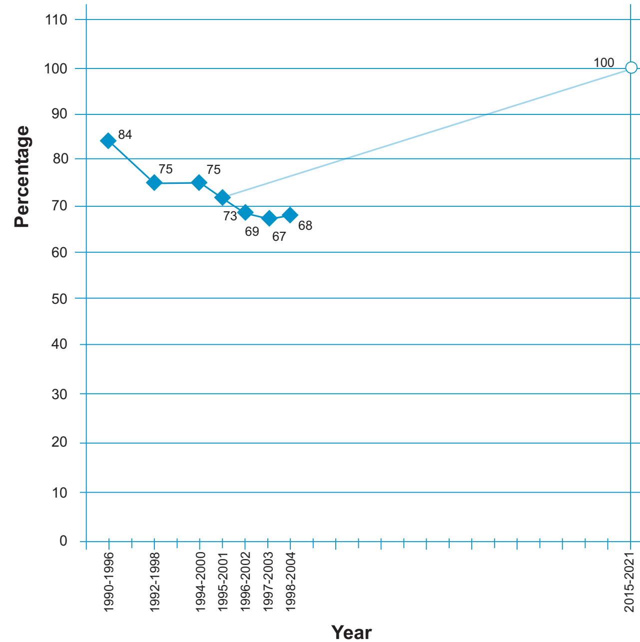
Figure 4.2: Completion Rate, Primary Education, Zimbabwe 1990-1996 to 1988-2004 and 2015 MDG Target

Source: Ministry of Education, Sports and Culture 2001 and 2005.



The completion rate for the primary school level has been falling since the 1990's owing, in part, to financial constraints. As illustrated in Figure 4.2, the 2004 primary school completion rate of 68 percent is well below the 2010 WFFC target of 90 percent and the 2015 MDG target of 100 percent. Of concern too, are the dropout rates for girls which increase with grade, showing the vulnerability of girls due to varied reasons including care role.

The quality of primary education has been declining due to the severe strain on household and national budgetary resources. The primary level pass rate is very low and has decreased from 49 percent in 2001 to 39 percent in 2003. Girls had a higher pass rate (41 percent) than boys (37 percent) in 2003. Zimbabwe's primary school pupil-teacher ratio of 38:1 in 2004 is way above the agreed international standard of the MDG international target of 28:1 (Figure 4.3). Some remote districts such as Binga had a pupil teacher ratio as high as 161:1 for primary schools in 2004. This has negative implications on the quality of education to the individual pupils.

Pre-school attendance gives a good education foundation and has positive implications on quality of education. According to Education Management Information System (EMIS, 2004), Early Childhood Education Care (ECEC) (the proportion of grade ones who have pre-school background) has increased from 55% in 2002 to 57% in 2004. The recent policy on the provision of early childhood education at all primary schools, "the zero grade," will further improve access to pre-school education.

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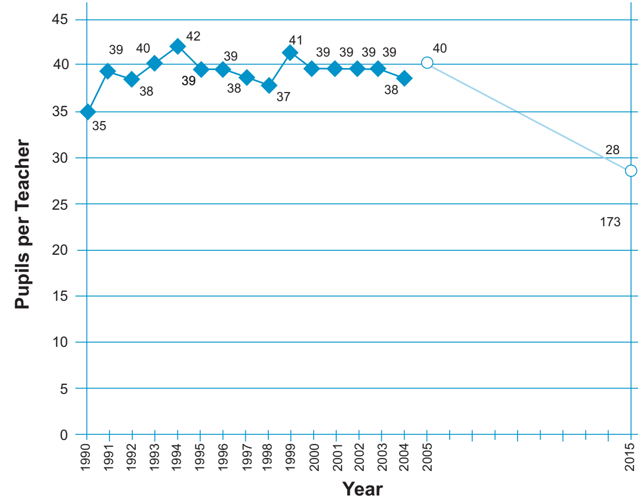
Figure 4.3: Pupil/teacher ratio, primary schools, Zimbabwe, 1990 to 2004 and 2015 MDG target

Source: Ministry of Education, Sports and Culture 2001 and 2005.



More attention in infrastructure especially the provision of specialist classrooms, furniture, proper sanitation and safe drinking water particularly in satellite schools is required. Notwithstanding these challenges, Zimbabwe has highly trained teachers with 91 percent trained primary school teachers in 2004. The challenge, however, is to retain them at a time when large numbers of professionals are leaving the sector for the neighboring countries and overseas.

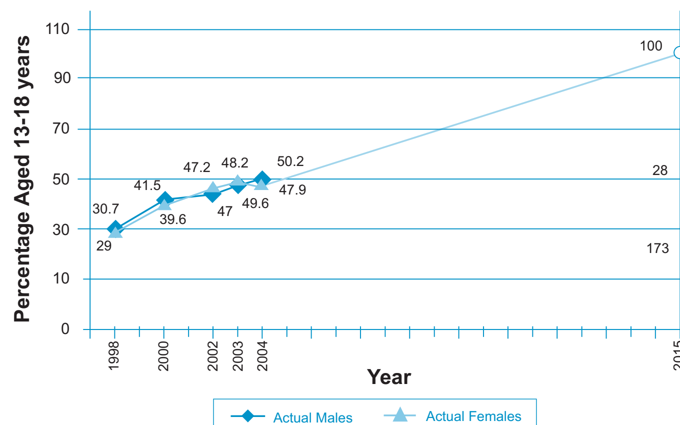
Secondary education

To match the massive enrolment in primary schools, secondary school infrastructure was also expanded from 200 schools in 1980 to 1 567 in 2004, excluding satellite schools. At secondary level there is an acute shortage of specialist classrooms. Major challenges continue to be the AIDS scourge which has claimed the lives of a sizeable number of teachers and the financial constraints the nation is facing.

Net enrolment in secondary education has been increasing although it was still low at 50 percent in 2004 in comparison to the 2010 WFFC target of 90 percent and the 2015 MDG target of 100 percent (Figure 4.4). Gender disparity is, however, minimal at 91% in 2004.

Figure 4.4: Net Enrolment Ratio, secondary (Form 1-4) education, Zimbabwe, 1998 to 2004 and 2015 MDG target

Source: Ministry of Education, Sports and Culture 2001 and 2005.



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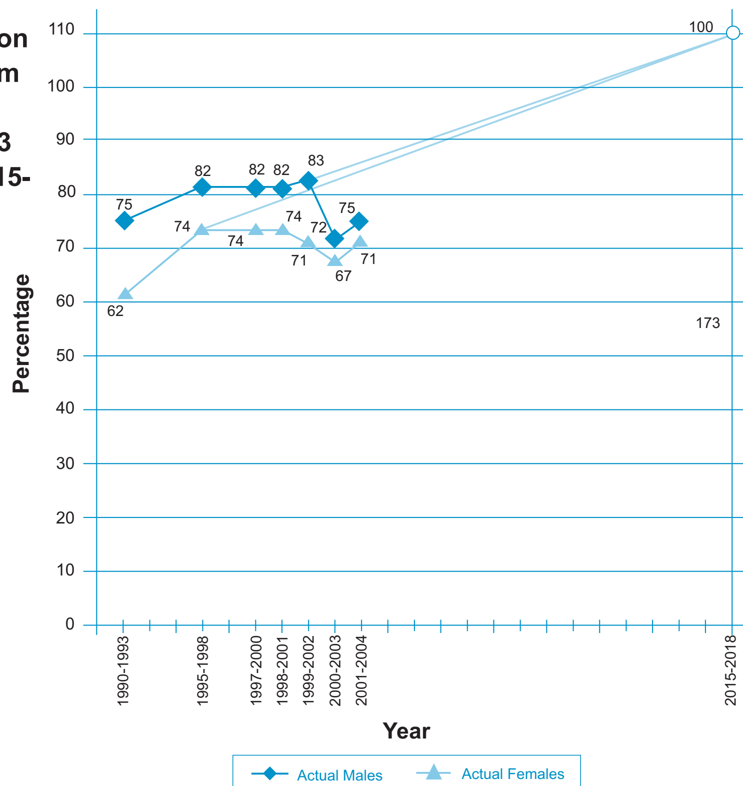
According to the EMIS (2004), Zimbabwe's 'O' level completion rate has decreased from 77 percent in 2002 to 73 percent in 2004. Girls had a lower completion rate of 71 percent compared to 75 percent for boys in 2004. Completion rates for secondary education fell from 83 percent in 2002 to 72 percent in 2003 and recovered to 75 percent in 2004 for boys. Whilst that of girls fell from 71 percent in 2002 to 67 percent in 2003 and recovered to 71 percent in 2004 (Figure 4.5). Without accelerated efforts the MDG target of 100 percent completion rate will not be achieved.

Figure 4.5: Completion rate, secondary (Form 1-4) education, Zimbabwe, 1990-1993 to 2001-2004 and 2015-2018 MDG target

Source: Ministry of Education, Sports and Culture 2001 and 2005.



The quality of education at secondary level is equally problematic. The pass rate at 'O' level was 23 percent in 2003 with boys having a higher pass rate of 25 percent than girls at 20 percent. The transition from form 4 to 5 increased from 10 percent in 2001 to 16 percent in 2003. In 2003 males had a higher transition rate of 18 percent than that of 14 percent for girls.

Notwithstanding these challenges Zimbabwe has maintained a very high literacy rate (completed Grade 3 level of education) for the 15-24 years of age of 98.3 percent in 2004

The education sector is facing major challenges from the HIV and AIDS pandemic. Consequently, schools have lost both children and teachers whilst absenteeism due to sickness of both teachers and pupils has also increased.

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4.2 Challenges in Achieving Goals

- **The impact of poverty** continues to hinder substantive progress in achieving the MDG on Universal Primary Education. Whereas education is one of the ways of ensuring that orphans escape from poverty, the same poverty leads to their erratic school attendance and in some cases dropping out due to lack of fees and learning materials among others. Constant monitoring and targeting of these poor children is required to ensure all children have access to the required assistance.
- **Quality of education:** Improving the quality of both primary and secondary education remains a challenge in Zimbabwe with attention required in the following: pupil teacher ratios, Grade 7 and O level pass rates, Grade 7 to Form 1 transition and training of secondary school teachers.
- **Ever increasing cost of education:** The cost of education especially school fees, and indirect costs like uniforms and books which continue to escalate, make it difficult for many children to access and complete a full course of primary and secondary education. The Basic Education Assistance Module (BEAM) that is meant to assist poor children to access education has inadequate resources given the growing demand for social protection.
- **The inflationary environment** characteristic of the economy is making it difficult to operate. For the NGOs that are providing education assistance, this has meant that less children are supported with the same budget. Inflation has also eroded household incomes.
- **The HIV and AIDS pandemic** has led to an increased number of orphans and other children who have been made vulnerable and need urgent assistance which the nation cannot fully provide with the current economic hardships. School attendance is affected when children have to assume caring roles for sick parents. Their school achievement becomes limited even if they are academically gifted due to the psychosocial effects of loosing parents as well as the stigma and discrimination, attached to HIV and AIDS.
- Like other professionals **qualified teachers continue to leave** the teaching profession for better remuneration elsewhere.

Despite the challenging operating environment in Zimbabwe, notable development work in the form of policies, programmes and legislation for children was undertaken in the area of promoting universal quality education for children as shown in Table 4.1.

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4.3 Major National Policies and Programmes Undertaken for Children Towards the World Fit For Children (WFFC) Targets, 2001-2006

Table 4.1: Promoting Quality Education - Selected Policies, Programmes and Legislation for Children, Zimbabwe 2001-2006

National Action Undertaken	Brief Comment
National Strategic Plan for the Education of Girls	Plan was formulated to address gender issues in education such as gender violence in schools. It was launched in October 2006.
Draft Basic Education Policy	Existing basic education policies were reviewed; grassroots consultations were held throughout the country (all ten provinces) reaching 800 key stakeholders, including children and young people. Key inputs into the policy development process are a study on the Cost and Community Co-financing of basic education (2005-2006).
The Education Amendment Act 2006	The Act was enacted to regulate the national school fees system to reduce discrimination in the educational system on grounds of economic status of parents.
Early Childhood Education and Care (ECEC)	In 2005, preschool popularly known in Zimbabwe as the zero grade, was introduced in the educational system as a compulsory component of primary education. Zero grade teachers are undergoing training. This is a big step in expanding and improving comprehensive early childhood education and care. Zimbabwe is the first country in Africa to introduce the ZERO GRADE in its educational system.
Basic Education Assistance Module (BEAM) Programme	BEAM was established in 2001 for the education assistance of orphans, the poor and other vulnerable children. By 2005 approximately one million children annually benefit from BEAM assistance. BEAM is funded through the national budget, the National AIDS Trust Fund and now from NGO's.
Schools Expansion Programme	New schools (including satellite schools) are being established in the newly resettled areas to increase accessibility to education for children in resettlement areas.
Rural Schools Computers Programme	As the rural electrification programme continues to expand to rural schools and clinics, the Rural Computers Programme has been introduced in rural schools to enable rural children to also become computer literate.

4.4 Resource Trends in Promoting Quality Education

Public expenditure on education

The Ministry of Education Sports and Culture and the Ministry of Higher and Tertiary Education are the biggest beneficiaries of the national budget. Between 2000 to 2005 education as a share of GDP increased from 5.9 percent in 2001 to 11 percent in 2005. Education share of total government spending also rose from 22.2 percent in 2001 to 27 percent in 2005.

However, the bulk of the total expenditure on education is absorbed by recurrent spending (salaries and staff allowances). On average recurrent expenditure constitutes close to 98 percent and 97 percent of the total expenditure for primary and secondary levels of education respectively, leaving inadequate amounts for non-salary expenses, such as provision of books and pedagogic inputs, construction, maintenance, and furnishing of classrooms. Most investment activities in the education sector used to be undertaken jointly with significant donor contribution. Lately, reduced direct donor funding towards the education sector has resulted in a decline in resources for school maintenance and construction.

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Government contributes to social protection in the education sector through the BEAM programme. The BEAM Programme assists orphans and vulnerable children by paying for their school fees, levies and examination fees. The amount allocated to BEAM has increased between 2001 and 2005 as shown in Table 4.2. However, the increase in the amount allocated is not matched by a proportionate increase in the number of children eligible for assistance.

Table 4.2: Total BEAM allocation, total number of children assisted and percent boys and girls, Zimbabwe 2001 to 2005. *Source: MPSLSW, 2006*

Year	Total BEAM Allocation, Z$	Girls assisted, % of total children	Boys assisted, % of total children	Total No. of Children Assisted
2001	$ 300 000	49.70	50.30	593 298
2002	$ 580 000	49.40	50.60	865 761
2003	$ 1 billion	49.80	50.20	588 817
2004	$ 3, 5 billion	49.70	50.30	310 363
2005	$190 billion	49.02	50.98	969 962

Private, Public Partnerships in Education

Government has partnerships with the private sector in improving access to education. Major players in education financing in Zimbabwe comprise the formal private sector, families and communities, churches, non-governmental organization and other philanthropic organizations.

The study on Cost and Community Co-financing of Basic Education in Zimbabwe (UNICEF, 2006) indicated significant community contribution towards education. On average household contribution was 85 percent of the average unit cost of primary education and 80 percent for secondary whilst government was contributing the remainder. This means that an improvement of household incomes offers great potential in ensuring sustained access to education.

There are various partnerships and alliances for children in thematic area on 'Promoting Quality Education'. Major partnerships and alliances in education are between government, UN agencies, communities and households, private sector, civil society and NGOs. Some of the major partnerships are highlighted in Table 4.3.

4.5 Partnerships and Alliances

Table 4.3: Promoting Quality Education - Selected Partnerships and Alliances for Children, Zimbabwe 2001 – 2006

Initiative	Partnerships and Alliances
Education Working Group	Education Working Group, composed of MOESC, UN and various NGOs is the major partnership forum for players in the education sector.
Joint Programme on Livelihoods	Brings together Ministry of Education, Sport and Culture, Ministry of Agriculture, UNICEF and FAO to improve livelihoods in selected districts where the programme will be implemented.

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4.6 Lessons Learnt and Priority Actions for the Next Five Years

Lessons learnt

- **Political commitment:** The political commitment in financing education as reflected in budgetary allocation for education and social protection programmes have helped to ensure access to education for the children. However, the benefits of these initiatives have been eroded by the general economic challenges which have resulted in, for example, the loss of teachers to greener pastures.
- **Public and private partnership:** There is strong and viable partnership between Government, communities, households, private sector and civil society in education provision which has resulted in the high quality of education in the country and the impressive literacy rates.
- **Targeted interventions:** Targeted interventions such as the Child Supplementary Feeding Programmes and block grant schemes have turned out to be effective in keeping the targeted children in school.

Given these lessons learnt and the challenges still being experienced in the area of promoting quality education for children, the following priority actions have been set for the next five years.

Priority Actions for the Next Five Years

- Expansion and improvement of Early Childhood and Education Care (ECEC) programmes, to include orphans and other vulnerable children.
- Capacity development for ECEC para-professionals and teacher pre-service training.
- Reform of learning curricular in line with current context and needs.
- Expansion of HIV and AIDS programme in the education sector for the benefit of both staff and pupils.
- Improve school infrastructure for both children and teachers as well as improve working conditions for teachers to ensure retention of trained and experienced staff.
- Better targeting of OVC to increase their access to school through programmes such as BEAM, NAP for OVC intervention and NGO and private sector initiatives.
- Improve quality of education by reducing pupil book and teacher pupil ratios.
- Sustain gender parity in education at both primary and secondary school level.
- Access to free and compulsory primary education for minority groups and vulnerable children.
- Access to appropriate learning and life skills programmes for all youths and adults.

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5. WFFC THEMATIC AREA 3: COMBATING HIV AND AIDS

Zimbabwe is experiencing a general reduction in HIV and AIDS prevalence with progress recorded in provision of PMTCT services at health facilities.

- Estimated adult HIV prevalence among the 15 to 49 year olds: decreased from 24.6% (2003) to 20.1% (2005) based on antenatal sentinel surveillance, and according to Zimbabwe Demographic and Health Survey (ZDHS) 18.1% (2005/6) based on a population survey.
- Number of sites offering PMTCT: increased from 1 382 (2005) to 1 412 (2006)

Despite the significant progress in the fight against HIV and AIDS, the pandemic continues to fuel high morbidity (particularly TB) and the OVC burden, and exacerbating poverty levels.

- Reported prevalence of TB : increased from 438 (2001) per 100,000 population to 471 (2004)
- Orphanhood prevalence for under 18 age group: 22.3% (2003) according to Poverty Assessment Study Survey 2003 and 23.9% (2005/6) according to ZDHS

5.1 Status and Trends

The Statistical Annex presents status and trends in the WFFC 'Combating HIV and AIDS' thematic area.

MDG 6: Combat HIV and AIDS, Malaria and other diseases

HIV and AIDS pose one of the greatest national challenges. The exceptionality of HIV and AIDS requires accelerated action not only in health and education, but also in economic and social development policies and strategies, allocation of resources and use of progress on HIV and AIDS as a critical indicator of national development. According to the Zimbabwe National HIV and AIDS Estimates 2005 (Ministry of Health and Child Welfare), Zimbabwe's estimated HIV adult (15-49 years) prevalence rate declined from 24.6 percent in 2003 to 20.1 percent in 2005. Substantial declines in HIV prevalence in the 15-44 years-old (from 32% to 24%) and 15 -24 years old (from 29% to 20%) in the antenatal clinic surveillance system between 2000 and 2004 is also documented by UNAIDS ('Evidence for HIV decline in Zimbabwe', November 2005). However, the number of new AIDS cases and AIDS related deaths continues to be high. In 2005, an estimated 1.61 million adults (1 in 5) lived with HIV and AIDS.

The 2005-06 ZDHS that provided the first population based HIV testing showed a prevalence rate of 18.1 percent in the age group 15-49 years with more women affected (21.1 percent) compared to men (14.5 percent). This confirms the continued HIV burden borne by women. HIV prevalence is higher for women than men in all age groups from 15-39 but higher for men than women in ages above 40 years. This indicates the intergenerational sexual relations between older men and younger women putting the girl child at higher risk of HIV infection. Among people aged 15-19 years, the proportion of HIV positive women and men was 6 percent and 3 percent respectively. The HIV prevalence for those aged 15-19 years is 5 percent in 2005/6. The prevalence for girls (6 percent) is double that of boys (3 percent).

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The ZDHS 2005-06 showed virtually universal knowledge of HIV and AIDS in all sub-groups with 98 percent of women and 99 percent of men having ever heard of HIV and AIDS though there is a slight gap in the percentage of women(86 %) and men(90 %) who believe there is a way to avoid HIV and AIDS. This offers a window of opportunity in the sustained fight against HIV and AIDS.

Prevention of Mother to Child Transmission of HIV Infection

Tremendous gains have been in expansion of PMTCT services throughout the country. As presented in Table 5.1, as of 2006 more than 500 sites are providing comprehensive PMTCT services in the country (MoHCW 2006). Although the national PMTCT programme has rapidly expanded into rural areas in recent years, major constraints have been low uptake of services: counseling, testing, receiving test results and taking nevirapine. Additional challenges remain in follow-up of babies born to HIV positive women on the programme. According to the National Survey of HIV and Syphilis Prevalence Among Women Attending Antenatal Clinics in Zimbabwe (2004), HIV prevalence among women ANC attendees (15-24 years) has declined from 20.8 % in 2002 to 17.4 % in 2004.

Table 5.1 Number of sites offering PMTCT services

Source: Miinistry of Health and Child Welfare, 2006

Sites	2005	2006
Comprehensive PMTCT sites (on site HIV testing, ARV prophylaxis and ART)	394	547
Minimum PMTCT sites (ARV prophylaxis but refer for testing)	988	875
Total no. of PMTCT sites	1382	1412

Access to treatment

Of the 340,000 people requiring antiretroviral therapy (national ART roll out plan), only 23,000 (6 percent) received it in 2005, with children aged 0-14 years accounting for 7 percent. In 2004, only 7 percent of all HIV positive pregnant women received antiretroviral (ARV) prophylaxis to prevent mother to child transmission (PMTCT) of HIV with a modest improvement to 9 percent in 2006 (Ministry of Health and Child Welfare, 2005). Furthermore, home based care is reaching only a small fraction of those in need. As of August 2006, only about 48,000 or 16 percent of the 300,000 in need were accessing home based care services with only 11,000 (4 percent) accessing home based care kits (NAC, 2006).

However, it should be noted that the number of those on ART has improved. In August 2006 about 36,000 people (10 percent of those in need) were on public ART with an additional 6,000 accessing ART through government partners and 3,000 through private means (Ministry of Health and Child Welfare 2006). The target for 2006 was to reach 70,000 people by end of year. Achievement of this target and in general that of universal access to prevention, treatment and care will depend on availability of resources, particularly the drugs.

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Although the National AIDS Trust Fund generated through a 3 percent tax levy provides predictable local resources at national level for HIV and AIDS response through the National AIDS Council and continues to be a significant source of funding for OVC and ART, its effect has been diminished by the erosion of the value of the local currency. External resources in 2005 for Zimbabwe including the global fund were a mere US$4 per person living with HIV and AIDS compared to a regional average of US$74.

Orphan challenge

A tragic outcome of the HIV and AIDS pandemic is the growing orphan challenge. According to the Poverty Assessment Study Survey, orphan prevalence was 22.3 % in 2003 and according to ZDHS, it was 23.9% in 2005/6. The 2002 Census found that 48,223 households were headed by a child under 18 years. Most of the orphans are cared for by the extended family system and especially grandmothers whose livelihoods are also precarious. The erosion of livelihoods and poor coping mechanisms resulting from increasing poverty makes orphans particularly vulnerable. The impact on children of this double burden, high HIV and AIDS prevalence coupled with high poverty levels are multi-dimensional. Children orphaned and made vulnerable by HIV and AIDS are often at greater risk of numerous and adverse outcomes. The most direct effects are both emotional and economic. Beyond the emotional and economic effects, orphans and vulnerable children (OVC) can be stigmatized and discriminated against. This can result in further poverty, making OVC more vulnerable to exploitation and abuse, and at greater risk of contracting debilitating diseases such as HIV and AIDS.

5.2 Challenges in Achieving Goal

- **Resource constraints** particularly for ARVs including pediatric drugs.
- **High staff turnover** in the health sector.
- **Providing equitable service** in both rural and urban areas, such as voluntary counseling and testing, and comprehensive PMTCT facilities.
- **High poverty levels** combined with high HIV prevalence increase vulnerability.
- **Food insecurity** undermining interventions particularly mitigatory interventions for people living with HIV.
- **Capacity development** for health sector on how to deal with pediatric HIV and AIDS
- **Sustainable alternative feeding** for orphans and babies aged 0-6 months born to HIV positive mothers.

In spite of the challenging operating environment in Zimbabwe, significant development work in the form of policies, programmes and legislation is on-going in the area of combating HIV and AIDS.

5.3 Major National Policies and Programmes Undertaken for Children Towards the World Fit For Children (WFFC) Targets, 2001-2006

Table 5.2: Selected Policies, Programmes and Legislation for Children, Zimbabwe, 2000-2006

National Action Undertaken	Brief Comment
National HIV and AIDS Strategic Framework (2000-2004, 2006-2010)	The National HIV and AIDS Strategic Framework guides national response in a coordinated manner. The Strategic Framework 2006 – 2010 focuses on Home Based Care Standards, Behavior Change Strategy and National Aids Council Monitoring and Evaluation System
National AIDS Trust Fund (NATF) (commonly referred to as the AIDS levy)	Introduced in 1999 to mobilize resources for the prevention and care of the infected and affected by the HIV and AIDS pandemic through the collection of income tax of all formally salaried employees. The funds are managed by the National AIDS Council (NAC), which started operating in 2000. The 2007 budget requires that 70 percent of the AIDS Levy should go towards the provision of antiretroviral drugs.
Anti-Retroviral Therapy (ART) Programme	Treatment and management of patients, including children, with AIDS started in 2004 and by the end of that year about 6 000 patients were on treatment. The ART programme has been expanded with support from the Global Fund on HIV, AIDS, Malaria and TB and the Clinton Foundation with the aim of reaching more of those needing the therapy including pediatric ART. At least 20 percent of patients on ART should be children.
Prevention of Mother-to-Child-Transmission (PMTCT) Programme	There has been a rapid scaling up of PMTCT so that by the end of 2005 over 95 percent of health facilities (HF) with ANC services were providing PMTCT services. In order to ensure that PMTCT is truly integrated into maternal and child health services, both the Child Health Card and the Women's Card (and ANC cards) were updated to include pertinent information useful for PMTCT. Both include the HIV status of the mother or baby and reminders for testing the child at 18 months. A comprehensive plan for rolling out PMTCT and pediatric HIV prevention, care, treatment and support for the period 2006 to 2010 has been prepared, which will consolidate the work already in progress.

5.4 Resource Trends for Combating HIV and AIDS

The National AIDS Trust Fund (NATF) commonly known as the AIDS Levy was introduced in 1999 and collects 3 percent of taxable income of all formally salaried employees to increase resources for the prevention and assistance for the infected and affected by the pandemic including the purchase of ARVs. The purchase of ARVs is, however, hampered by the lack of foreign currency due to the economic challenges. The Fund has over the years collected a substantial amount of national resources for the fight against HIV and AIDS. The allocation of resources to Provincial AIDS Action Committees (PAAC) and District AIDS Action Committees (DAAC) and other organizations increased from 46.3% in 2002 to 94.7% in 2004, but dropped to 75.2% in 2005 (Figure 5.2).

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Figure 5.1: Trends in donor support to HIV and AIDS

Donor support in US$ by three main initiatives on HIV and AIDS, 2004

***The US President's Emergency Plan for AIDS Relief. The World Bank Multi-Country HIV and AIDS Program for Africa, and The Global Funds for AIDS, TB & Malaria (Last includes support for TB/Malaria)**

Source: http//www.worldbank.org/afri aids/map_docs.htm

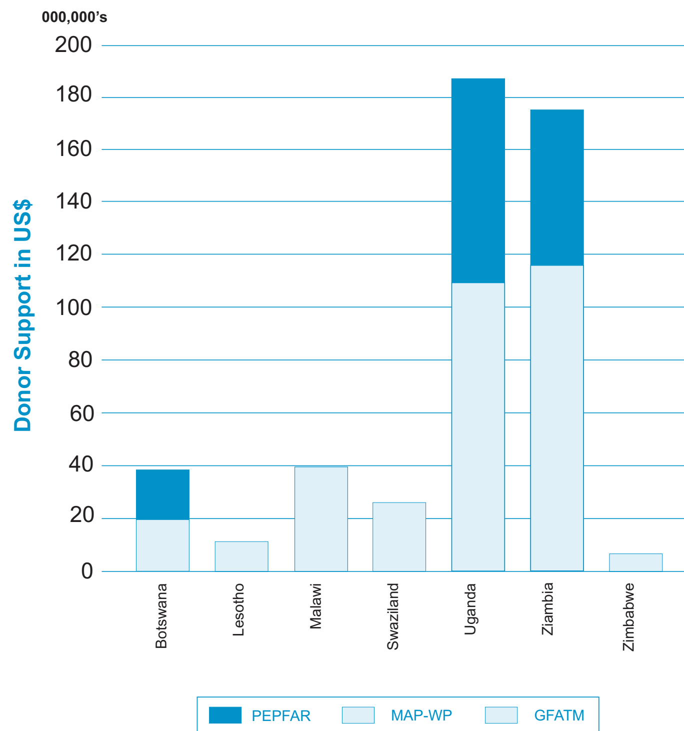
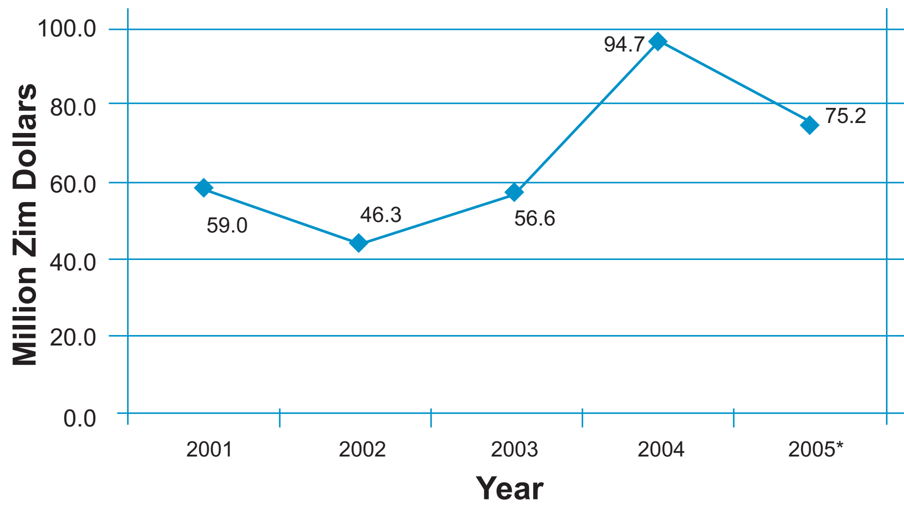


Figure 5.2: AIDS Levy 2001-2005, Zimbabwe $ million (1990 prices)

Source: Compiled from NAC Annual Report 2005 (*2005 is Jan-Dec)



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5.5 Partnerships and Alliances

Table 5.3 presents major partnership and alliance for tackling HIV and AIDS for children.

Table 5.3: Combating HIV and AIDS - Selected Major Partnerships and Alliances for Children in , Zimbabwe 2001 – 2006

Activity	Partnerships & Alliances
Global Funding Initiative	Funding partnerships are critical in combating HIV and AIDS. Although Zimbabwe's HIV and AIDS response remains greatly under-funded in comparison with other countries in the region, there has been a significant inflow of funds since 2002. This includes access to the Global Fund against HIV and AIDS, TB and Malaria. Global resource partnerships include Rounds One (USD14 million) and Five (USD62 million) of the Global Fund to Fight AIDS, TB and Malaria to fund the purchase of ARVs, TB drugs and malaria insecticides. Since 2002 European Union (EU) has been providing about one third of all medicines (and about 60 percent of the vital drugs) and surgical supplies requirements for the public sector through NATPHARM. EU also supports Tuberculosis (TB) and Opportunistic Infection (OI) drugs. UN agencies have facilitated purchase of essential drugs including ARVs and vaccines. World Food Programme (WFP) provides child supplementary feeding Private pharmaceutical companies play a critical role in the production of ARVs and other essential drugs, although hampered by shortages of foreign currency to procure the raw materials.
The Clinton Foundation HIV and AIDS Initiative	It has provided funding to treat 1,000 children with ART at 11 pilot sites in 2006. There are plans to scale up this treatment to 10,000 children by 2007.
Zimbabwe National Network for People Living Positively with HIV and AIDS (ZNNP+)	The establishment of ZNNP+ and groups affiliated to it in 2004 marked great progress in the fight against the stigma associated with HIV and AIDS on the national level, and enabled the establishment of a Meaningful involvement of people living with HIV and AIDS (MIPA) within NAC in 2004.
National Partnership Forums in HIV and AIDS	A number of national partnership forums established since 2002 are helping to ensure better coordination among government, civil society and development partners. These include the National Partnership Forum, co-chaired by NAC and the UN, the PMTCT Partnership Forum, the Care and Treatment Partnership Forum (which includes a sub-committee on pediatric AIDS), the Behaviour Change Technical Support Group, and the Counseling and Testing Partnership Forum.
Expanded Support Programme (ESP)	The Expanded Support Programme brings together Government, the UN, donors and civil society in efforts to accelerate HIV and AIDS response.

5.6 Lessons Learnt and Priority Actions for the Next Five Years

Lessons learnt

- **Global and local partnerships with all stakeholders:** Global, private sector, NGOs, other civil societies and communities are key to combating HIV and AIDS. Communities, households and individuals need to be empowered to play a critical role in combating HIV and AIDS. The private sector should be supported to scale up their role in combating HIV and AIDS.

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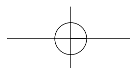


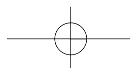
- **Targeted interventions:** Investment in high impact interventions offers great potential even in resource constrained situations.
- **Coordination of resource mobilization:** Working within the context of the Three Ones; one strategic framework, one programme and one Monitoring & Evaluation system has yielded positive results.
- **The focus on integration of service delivery** has made it easier to address new issues even in the current difficult economic environment. For instance, PMTCT has been added on to maternity services, while vitamin A supplementation was added on to the EPI.
- **It is critical to address gender inequality** as a whole as it is one of the root causes of vulnerability to both poverty and HIV and AIDS.

Given these lessons learnt and the challenges still being experienced in combating HIV and AIDS, the following priority actions have been set for the next five years

Priority Actions for the Next Five Years

A number of important national strategic plans have been drawn up to incorporate many of the priority areas that the Zimbabwe national programmes will tackle over the next five years. These include: National HIV and AIDS Strategic Plan; Draft National PMTCT and Pediatric HIV and AIDS plan and National Action plan for OVC. Resource mobilization to enable implementation of these plans is at different stages at the time of this mid-decade review. Thus, priorities include:

- **Coordination, implementation and fundraising for children:** Coordination of strategic plans and ensuring planned activities are implemented. MOHCW and NAC will continue to advocate and mobilize more resources to cover gaps in the funding mechanisms to ensure continued progress in all areas.
- **Scaling up of pediatric HIV treatment:** Support the scaling up of treatment for not only HIV positive children including infants but also strengthen links to adult ART and HIV services. The focus of the national efforts will be on ‘family-centered’ treatment practices that encompass a holistic approach to health care provision. Integration of services going beyond simply treatment and strengthening of psychosocial support services provided to both HIV positive children, OVC and their families will be an important area to address over the coming years.



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- **Integration of HIV and AIDS Services:** Attention will be given to embedding HIV services into other health and community initiatives e.g. EPI Services, Family Health Centres, Nutritional Programmes.
- **Development of child friendly services:** The development of 'child friendly' services, educational materials targeted for and at children infected or affected by HIV and AIDS; behaviour change strategies that encourage greater male participation in child orientated HIV services including PMTCT programmes and OVC strategies.
- **Prevention strategies including specific target groups such as adolescents and orphans:** Prevention strategies, targeting all levels of society and all age groups, remain the cornerstone of fighting the HIV and AIDS epidemics. Innovative programmes that specifically target adolescents, OVC and prevention of HIV transmission in newborns will continue to remain high on the agenda.
- Addressing gender disparities and development of strategies that address inequalities is an urgent national priority: Behaviour change strategies should focus on encouraging greater male participation in all family orientated HIV services.
- Greater participation of children: The development of policies that ensure greater participation from children and for children will become an area of engagement over the next half decade.

6. WFFC THEMATIC AREA 4: PROTECTION AGAINST ABUSE, EXPLOITATION AND VIOLENCE

Zimbabwe has many policies and laws that protect children against abuse, exploitation and violence. However, as a result of poverty and orphanhood, reported assault of children and reported juvenile rape cases are on the increase. The feature of displaced children and children on the streets is relatively significant. The negative attributes seem to have been exacerbated by the economic hardships and the impact of the HIV and AIDS pandemic and the mistaken belief that sexual intercourse with a virgin girl cures AIDS or increases harvest yields or business performance.

- Child labour[8]: 37% (2004)
- Reported cases of indecent assault of children: 1541 (2005)
- Reported rape cases of children under 16 years: 2990 (2005)

[8]According to the International Labour Organization (ILO) definition, a child who spends at least one hour per week on any economic activity is taken to be in economic child labour. For Zimbabwe three major variations were introduced; namely (a) a cut off of three hours or more per day in relation to economic activities; (b) provision to allow for involvement of children aged 15 and above in some form of work as per national law; and (c) a cut off of five hours or more per day for children involved in housekeeping activities as constituting child labour

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The Statistical Annex presents status and trends in the WFFC 'Protection Against Abuse, Exploitation and Violence' thematic area.

6.1 Status and Trends

Poverty, HIV and AIDS, inequality and discrimination have negative consequences for children through fostering conditions that heighten the risk of children being exploited, neglected or abused. Children orphaned or made vulnerable by the HIV and AIDS are not only at greater risk of missing out on education, they also face stigmatization and neglect in their communities. ('State of the Worlds Children, 2006'). Consequently, orphaned children are more vulnerable to violation of their right to be protected from abuse since death of a parent, in a situation where no adequate alternative care systems are in place, opens up protection gap.

Protecting children from all forms of abuse, neglect and exploitation and violence includes the following; combating child labour; promoting a protected from abuse healthy family environment; elimination of trafficking and sexual exploitation of children; protection from harmful traditional practices; general protection focusing on systems, policy and legislation (including birth registration).

Birth registration

Every child is entitled to formal identity including birth registration. Without formal registration at birth children may find themselves excluded from access to vital services such as education, health care, and social security ('State of the Worlds Children Report 2006'). Without proof of birth, children are especially vulnerable to exploitation and abuse. In Zimbabwe, a birth certificate is a requirement to participate in Grade 7 exams. In 2002, the Census reported that 64.4 % of children under 18 years were registered. This leaves more than 30% of children without registration and therefore at risk of exclusion. 2004/5 OVC Baseline Survey found that many are registered rather late. Among those surveyed OVC (under five years old), only 50% were found to be registered.

Abuse, neglect and exploitation and violence

According to the Victim Friendly Unit (VFU) reports from January to August 2006, there were 3,717 reported cases of sexual abuses ranging from rape, sodomy and incest. Over 70 percent of reported sexual abuse cases were committed against the girl child. Many cases, particularly those involving long term abuse of young children result in psychological trauma for the victims. (Situation Assessment and Analysis of Children in Zimbabwe, 2002). Of concern too is the increase in reported cases of domestic violence. Children are often the silent victims in cases of gender based violence. The recent passing of the Domestic Violence Act aimed at addressing gender based violence provides a promising legislative framework. The Domestic Violence Act seeks to address, among others, traditional and cultural practices that fuel abuse.

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Zimbabwe has many laws that protect children against abuse, exploitation and violence. However, there is a need to continue strengthening implementation of the laws for the benefit of the children. It is within this context that the victim/child friendly court system has been established. There are also efforts to extend the Cross Border Child Care Centre Model to other border posts in addition to the Beitbridge one in order to provide temporary shelter for deported children before they are reunited with their families and communities.

Combating child labour and street children

According to the 2004 Child Labour Survey, 37% of children were reported to be in economic labour reflecting the economic hardships being faced by households (Child Labour Survey, 2004). Other literature indicate that the activities children are involved in include picking tea, picking coffee, picking cotton, picking worms off the tobacco plants, hanging tobacco to dry in the barns, watering the gardens, weeding, spraying chemicals onto crops, assisting with building and vending. Some children are engaged in labour activities that can be detrimental to their healthy development, such as gold panning, mining and chemical spraying of crops without protective clothing[9]. It is not only injury and sickness that children risk when involved in hazardous labour. They also miss out on education that would provide the foundation for future employment. Children who are engaged in domestic work without contract especially for their relatives, work long hours without much time for themselves.

The exact number of street children in Zimbabwe is not known. According to the Situation Assessment of Children in Zimbabwe Report (2002), an estimated 12,000 children were on the streets. Various reasons lead children to the streets namely abandonment by guardians, family breakdown and abusive conditions at home. On the other hand, the majority of children working on the streets are in contact with their families and work to contribute towards household income. With the increasing economic hardships and the high HIV and AIDS prevalence the numbers of children on the street is likely to be going up. Children living and working on the streets are vulnerable to all forms of exploitation and abuse.

Promoting healthy family environment

Families have the primary responsibility for caring for and protecting children. For various reasons like loss of parents, separation, abandonment, domestic violence and abuse, children are deprived of a family environment. Children who are not enjoying a healthy family environment include those living under residential care, living and working on the streets and those deported unaccompanied from neighboring countries. According to the Study on Children in Residential Care in Zimbabwe (2004), there are 56 residential institutions for children with a registered capacity of 3279 children.

[9]A Situation Analysis of Orphans and Vulnerable Children and Adolescents in Zimbabwe (UNICEF 2001)

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Three thousand and eighty (3080) children are currently in care, including 67 children in unregistered orphanages. These figures represent a more than 100% increase in the number of children in residential care since the last study in 1994. Twenty four new homes have been built during this period.

The orphan status of inmates has also changed significantly since the last study. The number of children with no contactable relatives has increased from 25% to 41%. The number of children with both parents alive had decrease from 22% to 7%. These figures probably reflect a maturing AIDS pandemic but might also indicate more selective admission policies. However as in 1994, the majority of children in Zimbabwean institutions have contactable relatives and therefore have the potential of re-integration with their families.

Lack of access to identity documents remains a major problem for children in care. Despite aggressive advocacy campaigns by Child Welfare Organisations, more than half (60%) of institutionalised children remained without birth certificates. This proportion is identical to that in 1994.

Deported and unaccompanied children

Movement of children to neighboring countries has come under the spotlight in view of protection concerns for children without family, community and support networks. Although reliable data is difficult to compile, it is estimated that on average, 442 children have been deported from South Africa to Beitbridge monthly between January and May 2006. About half of these children were unaccompanied (Beitbridge Zimbabwe Republic Police, 2006). The majority of unaccompanied children deported from South Africa were boy children aged between 13 and 17 who crossed the border illegally in search of economic opportunities.

6.2 Challenges in Achieving Goal

Zimbabwe has a well defined policy and legislative system with well-established government programmes to care and support children in difficult circumstances. These government programmes are complemented by programmes implemented by over 400 registered civil organizations providing services to children. However, several challenges still exist and these include:

- **HIV and AIDS and poverty nexus:** As both the HIV and AIDS pandemic and poverty negatively impact on the unity of the family, an increasing number of children are being affected by family breakdowns.
- **The participation of children and young people in decisions that affect them** remains limited and the challenge to shape and build processes for their involvement continues. Young people have been brought into dialogue in design of interventions, through ad hoc inputs with inadequate sustained research, consultation or reflection on the issues at stake. Even where

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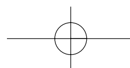


institutions like the child parliament or youth council exist, it is not clear how these provide for wider consultation and feedback to youth at large. Children, particularly OVC have limited opportunities to participate in decisions that affect their lives.

- **Insufficient financial and human resources:** Although there are policies and laws establishing the legal framework for the coordination and implementation of OVC programmes and services, insufficient resources limit full implementation and enforcement of policies and legislation that protect children's rights.

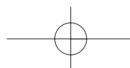
- **Advocacy and resource mobilization for the full implementation of existing laws and policies and scaling up programmes to national level** and where possible reviewing legislation and policy in light of the current situation and the new HIV and AIDS challenges. This should be complimented by a well defined and functional National Monitoring and Evaluation System to track resources mobilized for the OVC and also the numbers of children reached and by type of service.

- **The extent of the orphan problem and the new phenomenon of households headed by grandparents and children** were not anticipated when the laws were framed, and therefore gaps are evident which need rectification.

- **Lack of early warning system:** All the efforts aimed at supporting orphans and other vulnerable children at the community level can be said to be preventive measures against family separation. The challenge, however, is to implement more focused preventive efforts through early identification of those most at risk of separation from their families or living without primary care givers and subsequently providing timely and effective support while they are still in the community.

- **Lack of support systems at the community level:** Upon reunification of a child, it is often found that structures aimed at child protection at the community level are functionally weak, thus leaving reunified children without a safety net which is committed and capable of supporting the child. Improving the capacity of local communities to provide care to vulnerable children is critical as some double orphans simply do not have any relative who is willing to take them in.

- **Uncoordinated approach:** Lack of child care standards in residential care institutions and guidelines for family reunification of unaccompanied children often leads to an uncoordinated approach in providing care and protection to children outside of the family environment.



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- **Poverty and economic hardships forcing children to engage in labour activities** Children continue to work for various reasons. One of the challenges is to create an environment where the children's need to work in order to survive and their rights to schooling and healthy social and physical development are balanced.
- **Lack of data:** Key data on child protection issues such as child abuse, trafficking and street children are largely scarce as these activities are in the criminal arena.

In spite of the challenging operating environment in Zimbabwe, significant development work in the form of policies, programmes and legislation is also going on in the area of protection of children against abuse, exploitation and violence as shown in Table 6.1.

6.3 Major National Policies and Programmes Undertaken for Children Towards the World Fit For Children (WFFC) Targets, 2001-2006

Table 6.1: Protection Against Abuse, Exploitation and Violence - Selected Policies, Programmes and Legislation for Children, Zimbabwe, 2001-2006

National Action Undertaken	Brief Comment
The Zero Tolerance Campaign	Civil society, UNICEF and Government Ministries have raised awareness on the prevention of sexual exploitation and abuse. In 2002, the Victim Friendly Units (VFU) initiative was decentralized nationwide leading to the establishment of the Unit at Provincial, District and station level.
National Residential Care Standards Initiative, 2006	The purpose of this initiative was to develop a the minimum standard of care for children living in residential care institutions in the country. The standard is expected to place an emphasis on the importance of appropriate support for family reunification and community reintegration of children. Importance of child care plans in the institution and beyond.
Cross Border Child Care Centre	The centre was established by the MPSLSW, UNICEF, Save Children Norway, and International Organization for Migration at Beitbridge Border Post and has gone a long way in protecting the cross border unaccompanied children. This centre is a temporary place of safety, pending re-unification of children with their parents and communities.
Child Protection Legislation	The following legislation was enacted during the period to protect children: Sexual Offences Act , Domestic Violence Act, 2007, amendment of the Criminal Procedures and Evidence Act 2006.
Pilot pre-Trial Diversion Programme	This programme seeks to address the situation of children in conflict with the law. The piloting of the programme will start in 2007 in selected provinces.

There is also an Inter-ministerial Committee on Human Rights and Humanitarian Laws. The formation of the Inter-ministerial Committee on Human Rights and Humanitarian Laws to coordinate all the human rights functions and activities of all government ministries is important in monitoring the rights of children. The broadening of the functions of the office of the ombudsman to include violations to human rights, including children's rights.

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6.4 Resource Trends for protection against abuse, exploitation and violence

National resources for child protection are allocated under the social protection programmes budget lines. Public education on the prevention and management of child sexual abuse continue. Rehabilitation clinics continue to be established until all hospitals in the country are covered. The Criminal Procedures and Evidence Act has been amended to allow for nurses to also examine and manage these cases as doctors are not always available especially in the rural areas.

There are various partnerships and alliances for children in thematic area on 'Protecting Children Against Abuse, Exploitation and Violence'. Major partnerships and alliances in this area are between government, UN, private sector, civil society, NGOs, communities and households. Some of the major partnerships are highlighted in Table 6.2.

6.5 Partnerships and Alliances

Table 6.2: Protecting Against Abuse, Exploitation, and Violence - Selected Partnerships and Alliances for Children, Zimbabwe 2001 – 2006

Activity	Partnerships and Alliances
Working Party of Officials for National Action Plan for OVC	There has been increased coordination and collaboration among service providers working for children in the area of child protection as shown by the establishment of the Working Party of Officials comprising government key line ministries, UN bodies, NGOs, FBOs, Donors and Child Representatives to coordinate efforts for the protection of children, the WPOs subcommittees, Child Protection Working Groups, Provincial and District Child Protection Committees, and the Donors Reference Group.
NGOs consortiums for joint programming	A number of NGOs are forming consortiums for joint programming and joint resource mobilization. This minimizes competition while maximizing use of resources. There has been an improvement and strengthening of collaboration among service providers directly working with children on the streets in different regions in the country (Harare, Mutare, Bulawayo and Masvingo), especially in referrals of cases and sharing good practices.
Child Centre for unaccompanied cross-border children	In 2006, MPSLSW, International Organization of Migration (IOM), UNICEF and Save the Children Norway, started working in partnership to provide an interim care, protection and reunification services for unaccompanied children deported from South Africa in Beitbridge. Unaccompanied children are receiving basic needs, temporary accommodation, counseling and reunification services from the Child Centre located within the premise of Beitbridge Reception and Support Centre run by IOM.
Child Protection against Exploitation, GOZ and UN Initiatives	With regards to child protection against exploitation, Zimbabwe is a signatory to both the ILO Convention No.135 on the Minimum Age Convention and No. 182 on the Elimination of the Worst Forms of Child Labour. The country's ratification of the Convention No. 182 and its interest in implementing the stated commitment specifically provides an opportunity to protect children. The government has requested the financial and technical assistance from ILO to compliment their efforts to take urgent and effective measures to eliminate worst forms of child labour through Time Bound Programs (TBP). ILO is currently working with other agencies (UNICEF, UNDP, IOM and UNESCO) to develop a comprehensive proposal.

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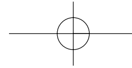


Participation of Children

Activity	Partnerships and Alliances
Youth Programmes and Youth Clubs	A number of structures are in place to support and promote child participation. The Junior Parliament and the Junior Council are well established national structures that strive to capture the voices of the children feeding the information to the Parliament of Zimbabwe. A number of youth programmes and youth clubs are also supported by the civil society promoting a number of activities from Income Generating Projects (IGPs), Sports, HIV and AIDS information dissemination through dramas and PSS activities through the Kids Clubs and other Children' clubs. Girls Education Movement (GEM) clubs are a vehicle for child participation.

6.6 Lessons Learnt and Priority Actions for the Next Five Years

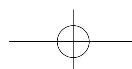
Lessons Learned

- Broad partnerships with stakeholders: Broad partnerships with Government, Private sector, Civil society, NGOs, the UN and communities, households and the media have raised awareness concerning the protection of children against child abuse, exploitation and violence resulting in more cases being officially reported and appropriate action being taken.
- Targeted advocacy: Following wide awareness campaigns and advocacy on children's rights, targeted programmes such as the Victim Friendly Units have been formed in police, health and legal institutions.
- Existence of laws does not guarantee realization of children's rights: Sustained legal literacy and implementation of laws are critical for the realization of childrens' rights in particular and human rights in general.
- Meaningful participation of children: Broad and meaningful participation, buy in and ownership by communities and children is critical to realize the protection of children against abuse, exploitation and violence.

Given these lessons learnt and the challenges still being experienced in the area of protecting children against abuse, exploitation and violence, the following priority actions have been set for the next five years.

Priority Actions for the Next Five Years

- Strengthening the capacity of families and communities to care for and protect children.
- Mobilization of financial and human resources for child protection.
- Setting up and implementing a National Monitoring & Evaluation System for child protection (to track resources



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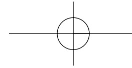
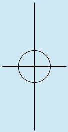
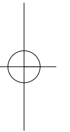
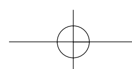


mobilized for children, abuse trends, and the numbers of children reached by type of services, etc.). Particularly, strengthening the stakeholders' capacity in recording incidence and nature of child protection abuses is the area which requires imminent action and resource allocation. Systematic efforts to collect and analyze child protection data should be mobilized to inform decision makers to reach those invisible.

- Establishment of community level early warning system to detect child abuse, exploitation and violence so that corrective action can be taken.
- Empowering children and young people through life skills programmes and information to protect themselves from abuse and exploitation.
- Strengthen the vital registration system (Information Communication and Telecommunication, human resources, transport, etc) to ensure all children have right to identity.
- Effective coordination of activities of the various stakeholders on the protection of children against abuse, exploitation and violence.







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STATISTICAL ANNEX

Promoting Healthy Lives: Targets and Indicators in Mid-Decade Selected Years

Goal and Indicator	2001	2002	Latest	Data Source
1. By 2010 reduction in the infant and under-five mortality rate at least one third, in pursuit of the goal of reducing it by two thirds by 2015				
Under-five mortality rate, per 1 000 live births	102 (1999)	–	82 (2005/6)	CSO-DHS
Infant mortality rate, per 1 000 live births	65 (1999)	–	60 (2005/6)	CSO-DHS
2. By 2010 reduction in the maternal mortality ratio by at least one third, in pursuit of the goal reducing it by three quarters by 2015;				
Maternal Mortality Ratio, deaths per 100 000 live births	695 (1999)	1 068 (2002)	555 (2005/6)	CSO-DHS, /Census
3. By 2010 reduction of child malnutrition among children under five years of age by at least one third, with special attention to children under two years of age, and reduction in the rate of low birth weight by at least one third of the current rate.				
Under weight prevalence for under fives, %, (<2SD)	13.0 (1999)	–	16.6 (2005/6)	CSO-DHS
Stunting prevalence for under fives, % , (<2SD)	26.5 (1999)	–	29.4 (2005/6)	CSO-DHS
Wasting prevalence for under fives, % , (<2SD)	6.4 (1999)	–	6.4 (2005/6)	CSO-DHS
Low birth weight, %	11.4 (1999)	2.3 (2002)**	–	MOHCW-NHIS
4. By 2010, reduction in the proportion of households without access to hygienic sanitation facilities and affordable and safe drinking water by at least one third.				
Households without access to safe drinking water in rural/ urban areas, % households	24.9 (rural) 0.4 (urban) (1999)	–	33.5 (rural) 0.3 (urban) (2004)	LFS
Households without access to safe sanitation in rural/urban areas, % households (Blair and flush only)	55.4 (rural) 1.4 (urban) (1999)	–	55.7(rural) 1.2 (urban) (2004)	LFS
5. Development and implementation of national early childhood development policies and programmes to ensure the enhancement of children's physical social emotional , spiritual and cognitive development.				
Pre-school development, % of grade ones with preschool background	–	55	57 (2004)	MOESC-EMIS, 2004
6. Development and implementation of national health policies and programmes for adolescents, including goals and indicators, to promote their physical and mental health.				
Fertility rate of women 15 to 19 years (live births per 1 000 women)	112 (1999)	–	99 (2005/6)	CSO-DHS
Total Fertility rate ,15-49 years, average number of children per woman	4.0 (1999)	–	3.8 (2005/6)	CSO-DHS

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Goal and Indicator	2001	2002	Latest	Data Source
7. Access through the primary health-care system to reproductive health for all individuals of appropriate ages as soon as possible and no later than 2015.				
Contraceptive prevalence rate, % married women aged 15-49 years	53.5 (1999)	–	60.2 (2005/06)	CSO-DHS
Fertility rate of women 15 to 19 years (live births per 1 000 women)	112 (1999)	–	99 (2005/6)	CSO-DHS
Total Fertility rate,15-49 years, average number of children per woman	3.96 (1999)	–	3.8 (2005/6)	CSO-DHS
8. Ensure reduction of maternal and neonatal morbidity and mortality; Ready and affordable access to essential obstetric care, maternal health-care services, skilled attendance at delivery, emergency obstetric care, post-partum care and family planning				
Antenatal care, % of women attended by a health professional (doctor, nurse, midwife or auxiliary midwife)	81.1 (1999)	–	94.5 (2005/6)	CSO-DHS
% of births attended by skilled health personnel (doctor, nurse/midwife including non professional midwives)	72.5 (1999)	–	79.7 (2005/6)	CSO-DHS
Obstetric care , number of facilities providing comprehensive essential obstetric care per 500 000 population	–	–	–	CSO-DHS
Home deliveries ,%*	23.3 (1999)	–	31.1 (2005/6)	CSO-DHS
9. By 2010 full immunization of children under one year of age at 90 percent nationally, with at least 80 percent coverage in every district of equivalent of administrative unit; • **Reduce deaths due to measles by half by 2005;** • **Eliminate maternal and neonatal tetanus by 2005; and** **Extend the benefits of new improved vaccines and other preventative health interventions to children in all countries**				
All vaccinations, % of children aged 12-23 months who received all vaccinations including DPT 4 and Polio 4 (Vaccinated by 12 months of age)	67.3 (1999)	–	41.0 (2005/6)	CSO-DHS
DPT3 immunization coverage , % children aged 12-23 months (Vaccinated by 12 months of age)	77.5 (1999)	–	55 (2005/6)	CSO-DHS

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Goal and Indicator	2001	2002	Latest	Data Source
Measles immunization coverage, % children aged 12-23 months (Vaccinated by 12 months of age)	71.4 (1999)	–	55.9 (2005/6)	CSO-DHS
Polio 3 immunization coverage (Vaccinated by 12 months of age)	77.6 (1999)	–	59.1 (2005/6)	CSO-DHS
Neonatal tetanus, % pregnant women who received tetanus toxoid	78.9 (1999)	–	81 (2005/6)	CSO-DHS
Reported under five measles cases, number*	169 (1999)	53	–	MOHCW-NHIS
Reported under five deaths from measles, number*	6 (1999)	3	–	MOHCW-NHIS
Reported Neonatal Tetanus cases (<28 days)*	2	5	–	MOHCW-NHIS
10. Certify by 2005 the global eradication of poliomyelitis				
Reported Polio cases, 0-14 years	15	–	123	MOHCW-NHIS
11. By 2010 eradicate guinea worm diseases				
Guinea worm cases	N/A	N/A	N/A	
12. By 2010 intensify proven, cost effective actions against diseases and malnutrition that are the major causes of child mortality and morbidity including; • **Reducing by one third deaths due to acute respiratory infections;** • **Reducing by one half deaths due to diarrhea among children under age five** • **Reducing by one half tuberculosis deaths and prevalence;** • **Reducing the incidence of intestinal parasites, cholera, sexually transmitted infections, HIV and AIDS, and all forms of hepatitis,** • **Ensure that effective measures are affordable and accessible, particularly in high marginalized areas of populations.**				
Diarrhea prevalence, under five years of age	–	–	12.4 (2005/6)	CSO-DHS
ORT use, % of under fives who were sick with diarhoea two weeks preceding the survey, who were treated with ORT	69.2 (1999)	–	75.6 (2005/6)	CSO-DHS
Reported ARI incidence rate for under fives, per 1 000 population	485	408	–	MOHCW –NHIS
Reported under-five deaths from acute respiratory infections, number	1 288	1 583	–	MOHCW –NHIS
Care seeking for acute respiratory infections, % who sought treatment	–	–	29.4 (2005/6)	CSO-DHS

Goal and Indicator	2001	2002	Latest	Data Source
13.By 2010 reduce by one half the burden of disease associated with malaria, and ensure that 60 percent of all people at risk of malaria, especially children and women, sleep under insecticide-treated bed nets.				
Clinical Malaria prevalence, per 1 000 people	122 (2 000)	93.7	–	MOHCW-NHIS
Reported Malaria In-patient deaths, number	2 201 (1999)	1 512	–	MOHCW-NHIS
Insecticide treated bed nets, % of children under five who slept under a net on the night before the survey*	–	–	47 (2006)	MOHCW-Malaria Rapid Assessment, April 2006.
Percentage of households with at least one mosquito net (treated or untreated)*	–	–	61 (2006)	MOHCW-Malaria Rapid Assessment, April 2006.
Malaria treatment, among children under five with fever in the two weeks preceding the survey, % who took antimalarial drugs*	–	–	81 (2006	MOHCW-Malaria Rapid Assessment, April 2006
14. Protect, promote and support exclusive breastfeeding of infants for six months and continued breastfeeding with safe, appropriate and adequate complementary feeding up to two years of age or beyond. • **Provide infant-feeding counseling for mothers living with HIV and AIDS so that they can make free and informed choices.**				
Exclusive breastfeeding rate, % less than 4 months for 1999 data and less than 6 months for 2005/6 data	38.9 (1999)	–	22.2 (2005/6)	CSO-DHS
Timely complementary feeding rate, % 6-9 months	–	–	78.7 (2005/6)	CSO-DHS
Continued breastfeeding rate,% 12-15 months who are breastfeeding	–	–	89.9 (2005/6)	CSO-DHS
Number of baby friendly facilities	–	42	–	MOHCW
Children receiving Vitamin A supplements, % of children 6-59 months	–	61.4 (2003)	47.1 (2005/6)	MPSLSW-PASS, CSO-DHS
Mothers receiving Vitamin A supplements, % mothers who received before infant was 8 weeks old	–	–	–	
Mothers who received iron tablets, % live births, 5 years preceding the survey*	59.7 (1999)	–	42.9 (2005/6)	CSO-DHS

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PROMOTING QUALITY EDUCATION: TARGETS AND INDICATORS IN MID-DECADE SELECTED YEARS

Goal and Indicator	2001	2002	Latest	Data Source
To meet the Dakar goals and ensure that by 2015 all children have access to and complete primary education that is free, compulsory and of good quality.				
1. Expand and improve comprehensive early childhood care and education for girls and boys, especially for the most vulnerable and disadvantaged children.				
Grade ones with ECEC background, %	–	55	57	MOESC-EMIS
Number of children enrolled in ECEC programmes regardless of age, expressed as a percentage of the total population of the official pre-school age group.	–	–	–	
2. By 2010, reduce the number of primary school –age children who are out of school by 50 percent and increase net primary school enrolment or participation in alternative, good quality primary education programmes to at least 90 percent.				
Gross/apparent intake rate, % (new entrants in primary grade one as a percentage of the population of official primary school entry age)	–	139	141 (2004)	MOESC-EMIS
Net intake rate, % (new entrants in primary grade one who are of the official primary school entrance as a percentage of the corresponding population)	–	52	53 (2004)	MOESC-EMIS
Gross enrolment ratio, % (Number of children enrolled in primary school regardless of age expressed as a percentage of the total official primary school age population)	–	113	113 (2004)	MOESC –EMIS
Net enrolment ratio, % (Number of children enrolled in primary school who belong in the relevant age group expressed as a percentage of the total number of people in that age group)	–	96	97 (2004)	MOESC –EMIS
Primary completion rate to (Grade 7), (percentage of pupil who enrolled in the first grade of primary education in a given school year and who eventually reach grade seven)*	73	69	68 (2004)	MOESC –EMIS

Goal and Indicator	2001	2002	Latest	Data Source
3. Eliminate gender disparities in primary and secondary education by 2005;achieve gender equality in education in 2015; with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality.				
Gender ratio, primary education, % (ratio of girls to boys in primary education)	97 (2000)	97	98 (2004)	MOESC-EMIS
Net enrolment ratio (Secondary)	–	47	50 (2004)	MOESC-EMIS
Secondary completion rate (Form 4), (percentage of pupil who enrolled in the first form of secondary education in a given school year and who eventually reach form 4)	78	77	73 (2004)	MOESC-EMIS
Gender ratio, secondary education, % (ratio of girls to boys in secondary education)	88 (2000)	89	91 (2004)	MOESC-EMIS
Primary school pupil teacher ratio, (pupils per teacher)*	39:1	39:1	38:1 (2004)	MOESC-EMIS
Primary school pupil book ratio, (number of pupils per book)*	–	–	8:1 (2003)	MPSLSW-PASS
Secondary school pupil book ratio (number of pupils per book)*	–	–	6:1 (2003)	MPSLSW-PASS
Primary school pass rate (Grade 7), % children*	49	41	39 (2003)	MOESC-EMIS
Secondary school pass rate (O level), % children*	24	24	23 (2003)	MOESC-EMIS
Secondary school pass rate (A level), % children*	70	79	79 (2003)	MOESC-EMIS
Primary school transition rate (Grade 7 to Form 1), % children*	76	71	67 (2003)	MOESC-EMIS
Secondary school transition rate (Form 4 to 5), % children*	10	12	16 (2003)	MOESC-EMIS
Primary schools libraries, % shortfall of requirement*	84	94	94 (2004)	MOESC-EMIS
Secondary schools science laboratories (Biology, Chemistry, Core- Science and Physics), % average shortfall of requirement*	60	62	63 (2004)	MOESC-EMIS
Secondary schools libraries, % shortfall of requirement*	–	–	63 (2004)	MOESC-EMIS
Primary school trained teachers, %*	92	92	91 (2004)	MOESC-EMIS

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Goal and Indicator	2001	2002	Latest	Data Source
Primary school teacher accommodation, % shortfall of requirement*	38	41	42 (2004)	MOESC-EMIS
Secondary school teacher accommodation, % shortfall of requirement*	–	33	36 (2004)	MOESC-EMIS
Primary school specialist classrooms, % shortfall of requirement*	65	64	68 (2004)	MOESC-EMIS
Primary school dropout rate, % (average Grade 1 to 6)*	10.17	8.74	6.12 (2003)	MOESC-EMIS
Secondary school dropout rate, % (average Form 1 to 3)*	14.32	13.65	0.13 (2003)	MOESC-EMIS
4. Improve all aspects of the quality of education so that children and young people achieve recognized and measurable learning outcomes especially in numeracy, literacy and essential life skills.				
Basic learning competencies, percentage of pupils having reached at least grade 4 of primary schooling who master a set of nationally defined basic learning competencies	–	–	–	
Literacy rates 15-24 year olds, percentage who completed grade 3	98.0 (1999)	–	98.3 (2004)	LFS
5. Ensure that learning needs of all young people are met through access to appropriate learning and life skills programmes.				
Percentage of schools with appropriate learning and life skills programmes*	–	–	–	
6. Achieve a 50 percent improvement in levels of adult literacy by 2015, especially for women.				
Adult literacy, percentage of population aged 15 years and above	87.8 (1999)	–	90.5 (2004)	LFS
Literacy Gender Parity Index, % (ratio of the literacy rate of 15 years and above females to male literacy rate)	91.9 (1999)	–	93.2 (2004)	LFS

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COMBATING HIV AND AIDS: TARGETS AND INDICATORS IN MID-DECADE SELECTED YEARS

Goal and Indicator	2001	2002	Latest	Data Source
1. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 percent and by 25 percent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV and AIDS, encouraging the active involvement of men and boys.				
HIV prevalence among 15-24 years old pregnant women, %	–	20.8 (2002)	17.4 (2004)	National Survey of HIV & Syphilis prevalence among women attending antenatal clinics in Zimbabwe (2004)
Estimated adult HIV prevalence, % population aged 15 to 49	–	24.6 (2003)	20.1 (2005)	MOHCW
Adult HIV prevalence, % population aged 15 to 49 years of age*	–	–	Total- 18.1 Female-21.1 Male -14.5 (2005/6)	CSO- DHS
Reported TB prevalence rates, per 100 000 people	438	–	471 (2004)	MOHCW-NHIS
Contraceptive prevalence rate	53.5 (1999)	–	60.2 (2005/06)	CSO- DHS
2. By 2005, reduce the proportion of infants infected with HIV by 20 percent, and by 50 percent by 2010, by ensuring that 80 percent of the pregnant women, accessing ante-natal care have information, counseling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV infected women, and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as effective interventions for HIV infected women, including voluntary and confidential counseling and testing, access to treatment, especially antiretroviral therapy and, where appropriate breast milk substitutes and the provision of a continuum of care.				
HIV prevalence among infants	–	–	–	
Sites offering PMTCT*, number	–	1 382 (2005)	1 412 (2006	MOHCW
HIV and AIDS knowledge, percent of population that has ever heard about HIV and AIDS*	Female-97 Male -99 (1999)	–	Female- 98 Male -99 (2005/6)	CSO- DHS
Knowledge of ways to avoid HIV and AIDS , percent of population (15-49 years old)*	Total -88 Female-83 Male -93 (1999)	–	–	CSO- DHS

Goal and Indicator	2001	2002	Latest	Data Source
3. By 2003 develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV and AIDS including by providing appropriate counseling and psycho-social support ; ensuring their enrolment in school and school and access to shelter, good nutrition, health and social services on an equal basis with other children, to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.				
Orphanhood prevalence, under 18 years old, %	–	22.3 (2003)	23.9 (2005/6)	MPSLSW-PASS and CSO-DHS

PROTECTION AGAINST ABUSE, EXPLOITATION AND VIOLENCE: TARGETS AND INDICATORS IN MID-DECADE SELECTED YEARS

Goal and Indicator	2001	2002	Latest	Data Source
1. Protect children from all forms of abuse, neglect. Exploitation and violence				
Child labour, % of 5 to 14 year olds*	49.2	–	37 (2004)	CSO-LFS
Birth registration, % under 18 years*	–	64.4 (2002)	–	Census
Reported indecent assault of children, cases*	1 530	1 355	1 541 (2005)	Police
Attempted indecent assault of children, cases*	–	–	–	Police
Juvenile justice	–	–	–	
Children deprived of liberty, by age, sex, type of offence if any*	–	–	–	
2. Protection of children from the impact of armed conflict and ensure compliance with international humanitarian law and human rights and law.				
Displaced children (on the streets)*	–	12 000	–	UNICEF- Situation Assessment of Children in Zimbabwe Report , 2002.
3. Protect children from all forms of sexual exploitation including pedophilia, trafficking, and abduction;				
Commercial sexual exploitation of children	–	–	–	
Reported rape cases (Juvenile under 16 years)*	2 631	2 608	2 990 (2005)	Police
Attempted rape* cases(Juvenile under 16 years)*	120	157	124 (2005)	Police
Reported sodomy of children, cases*	200	226	223 (2005)	Police

Goal and Indicator	2001	2002	Latest	Data Source
Reported incest of children, cases*	39	35	38 (2005)	Police
Attempted incest of children, cases*	0	0	0	Police
4. Take immediate and effective measures to eliminate the worst forms of child labour as defined in the International Labour Organization Convention No. 182, and elaborate and implement strategies for the elimination of child labour that is contrary to accepted international standards				
No of working hours of children under 18 years	–	–	–	
Forced or compulsory labour	N/A	N/A	N/A	
Prostitution, pornography, phonographic performances	–	–	–	
Illicit activities, in particular for production and trafficking of drugs	N/A	N/A	N/A	
Work which by its nature or circumstances , is likely to harm the health, safety or morals of children	438	–	471 (2004)	MOHCW-NHIS

***** *Stands for national indicator which is not among the WFFC indicators*

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APPENDICES

- The progress being made against WFFC and MDG targets are monitored through data collected by the Central Statistical Office (CSO) through routine censuses and surveys, civil society, research and academic institutions.
- Data from administrative records and ad hoc surveys conducted by line ministries are also utilized. Table A gives a summary of Zimbabwe's monitoring instruments on the situation of children by coverage and periodicity. Some of the key monitoring instruments include Millennium Development Goals progress reports, Demographic and Health Surveys, Population Censuses, Poverty Assessment Surveys, Zimbabwe Vulnerability Assessments, Education Management Information System, Health Information System and Child Labour Survey and Labour Force Survey.

Table A:
Use of Monitoring Instruments to Track WFFC/MDG Targets Related to Children, Zimbabwe.

Monitoring Instrument/ Responsible Institution	Areas covered	Periodicity	Comments
Zimbabwe MDG Progress Reports (Government of Zimbabwe and UN)	All 8 MDG Goals	Annually (2004, 2005)	More comprehensive reports every five years (2007. 2010,2015)
Monitoring and Evaluation System for Children	The NAP has put in place the mapping of OVC interventions. To this effect, a baseline survey has been taking place since 2004-6. The Secretariat has put in place thorough participatory methodologies for reporting. The local stakeholders have been mandated to develop local work plans and reporting mechanisms. The National AIDS Council has developed a national HIV M & E system and the NAP for OVC will feed into this system.		
Child Health Situation Reports (Ministry of Health and Child Welfare)	Information on current status of child health and the main determinants of illness and death in children.	Adhoc (1999, 2006)	This is a comprehensive report on the health situation of children. Provides some time series data.
Zimbabwe Situation Analysis 0n Reports on Children (UNICEF)	The situation of children various areas	Every five years (1999, 2002, 2005)	This is a comprehensive report on the situation of children
Population Censuses (CSO)	Size of population, age and sex composition; orphanhood; disability; education – school attendance and attainment; literacy levels; employment rates, employment status, unemployment, dependency; mortality – child, adult, maternal; fertility; migration; housing conditions- type of dwelling, tenure status, sanitation, type of water source and distance, type of energy for cooking.	Every 10 years (1982,1992, 2002)	Regular and reliable source of data. Unlike surveys information available at lower levels such as districts, wards etc
Intercensal Demographic Surveys (CSO)	Generally as for population census.	Every five Years (1987, 1997)	Regular and reliable source of data

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Table A:
Use of Monitoring Instruments to Track WFFC/MDG Targets Related to Children, Zimbabwe.

Monitoring Instrument/ Responsible Institution	Areas covered	Periodicity	Comments
Income Consumption and Expenditure Surveys (CSO)	Food Poverty and Total Consumption poverty lines, incomes by source , household consumption and expenditure patterns, demographic characteristics, education, labour force and employment, unemployment, occupation, industry, hours worked, employment status, informal /formal sector, housing conditions – type of dwelling, electrification of house, water and sanitation facilities, energy for cooking, Onwership and access to household goods.	Every five years (1985, 1990/91, 1995/96, 2001)	Results for 2001 are not published. The 2006 survey was not conducted. This is a useful source of data for poverty analysis.
Indicator Monitoring Labour Force Survey (CSO)	Economic activity, unemployment, underemployment, informal economy inactivity. Work safety and health Population size, composition and structure, household housing characteristics. **Child Labour module** Children's demographic characteristics, education level, marital status, activity status, living conditions, health status. Child labour-economic activity and inactivity. Characteristics of child labourers in education, employment status and living conditions. Causes of child labour. Consequences of child labour.	Every five Years (1987, 1994, 1999, 2004)	Regular and reliable data set. The 2004 survey had a specific module on child labour. Will be more useful with Child Labour components.
Zimbabwe Demographic and Health Survey (CSO and USAID)	Household characteristics, demographic characteristics, housing characteristics, education- attainment and enrolment, labour force and employment, occupations, access to mass media, child health, malaria prevention and treatment, fertility-trends, birth intervals, age at first birth, adolescent fertility, fertility regulation, proximate determinants of fertility, child and maternal mortality, maternal and child nutrition- stunting, wasting, breastfeeding, HIV prevalence, awareness of AIDS and other sexually transmitted diseases, domestic violence etc	Every five years (1984,1989,1999 and 2005/06)	Provides very good data which is analyzed usly and which is comparable over time.
National Nutritional Survey (MOHCW)	Age ,weight and height, vaccination, immunization, child feeding practices - breastfeeding, complementary feeding, Vitamin A deficiency, water and sanitation etc	In 2003 and every six months since 2005	Conducted in 10 selected districts.
Poverty Assessment Study Surveys (MPSLSW and UNDP)	Demographic characteristics, OVC, Nutrition, Immunization, Education, Health, HIV and AIDS knowledge, disability, economic activity and inactivity, reproductive health, fertility, mortality including maternal, food security, household and housing characteristics including water and sanitation etc. Also thematic reports on OVC vis-à-vis education, health, nutrition , food security etc. Thematic report on Child Health and nutrition	Every 5-10 years (1995, 2003)	Very good source of data on children and poverty, OVC, disability etc. Should improve on regularity.
Health Information Surveillance System (MOHCW)	The report provides data on nutritional status of under fives, morbidity, notifiable diseases, EPI target diseases, HIV and related diseases, incidences of Acute Respiratory Infection diseases, malaria, diarrhoea and dysentry, leprosy, schistosomiasis, injuries including road traffic accidents, common reported disabilities, common reported mental disorders, mortality status, health resources - facilities, personnel and financial, health services, curative activities, paramedical activities	Weekly, monthly, quartely and annually	Problem of timeliness and coverage. Latest annual report published for 2002. Weekly publications are for notifiable/ epidemic prone diseases.
National Survey of HIV and Syphilis Prevalence Among Women Attending Antenatal Clinics in Zimbabwe (MOHCW)	HIV and syphillis prevalence among women attending antenatal clinics by age, residence, occupation etc	Annually (from 1991)	Trends possible from 2000 when methodology was standardized. The latest available data is for 2005.
Zimbabwe Maternal and Child Health and Family Planning Coverage Survey (MOHCW)	Aimed at assesing the extent of coverage of MCH services and the trends. It covers nutrition, immunisation, maternity services and tetanus toxoid, family planning, accessibility and quality of health services	Adhoc (1988, 1991,)	Not being produced regularly. Last report was in 1991

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Monitoring Instrument/ Responsible Institution	Areas covered	Periodicity	Comments
Education Management information system (MoESC)	Enrolment, early childhood education care and disability. Internal education efficiency-dropouts, reasons for dropping out, transition, repetitions. Human and financial resources, school infrastructure (buildings, furniture etc) including water and sanitation. Pupil to book ratios etc	Annually	This is data for children in primary and secondary schools. Problem of timeliness. The latest published data is for 2004.
Agriculture and livestock Survey (ALS)	Household members working on farms by sex, casual and permanent employees by age	Annually	Regular information especially on child labour in agriculture for all land use areas.
Zimbabwe Vulnerability Assessment Study (Nutrition Commission)	Food security situation, health, nutrition, HIV and AIDS, disability, education etc	Annually	Usually for rural areas. Since 2003 some annual urban surveys have been carried out.
Victim Friendly Units, Police	Gender based violence and abuse in general for children and other age groups.	Routine information	Response to enable victims of sexual abuse to testify without fear of the perpetrators.
Sexual abuse statistics, Police	Sexual abuse by type	Annually	
Orphans and Vulnerable Children Survey (MPSLSW and UNICEF)	Orphanhood and OVC prevalence, living arrangements, household characteristics, assistance to household, child health, basic material needs for personal care, schooling status, succession planning, psychosocial well-being, knowledge of HIV and AIDS nutrition, education, food security, coping mechanisms, street children, infected and affected children, abuse, child labour, disabled children,	Adhoc 2004/2005	Comprehensive report on orphans and children. The next one will be in 2007.
Village Registers (Ministry of Local Government)	Basic information on communities on access to basic social services, issues of orphanhood	Routine	Rolled out to 20 districts. Records kept by village clerks. Needs strengthening.

Table B:
Summary on 2015 MDGs Indicators and Situation of Children in Zimbabwe

MDG, Indicator and Millennium Declaration	Comment
Goal 1: Eradicate Poverty and hunger	Only possible with improved economic conditions, increased agricultural productivity and combated HIV and AIDS.
Percentage of people below the Total Consumption Poverty Line (TCPL)	
Human Poverty Index	
Percentage of population below the Food Poverty Line (FPL)	
Percentage of under-five children who are malnourished	
Percentage of under-fives having at least three meals a day	

MDG, Indicator and Millennium Declaration	Comment
Goal 2: Achieve Universal primary education	
Primary school completion rate	Quality issues such as pass rates, pupil-teacher and pupil-book ratios, staff working conditions, appropriate infrastructure in terms of specialist classrooms, furniture, safe water, sanitation and HIV and AIDS need to be addressed.
Net enrolment ratio in primary education	
Literacy rate of 15-24 year olds	
Primary school level pupil-teacher ratio	
Primary school level pupil-book ratio	
Goal 3:Promote gender equality and empower women	
Net enrolment ratios by gender, primary education level	Gender equality in education is almost achieved in primary education. Secondary education needs to improve in terms of trained teachers, pupil-book ratios, science laboratories, transition rates to Form 5 for girls, 'O' level pass rates, furniture, safe water, sanitation, and HIV and AIDS needs to be addressed
Net enrolment ratios by gender , secondary education level	
Literacy rates of 15-24 year olds by gender	
Net completion rates by gender, for primary and secondary	
Secondary school level pupil-book ratio	
Form 4 to 5 transition rate for boys and girls	
Science laboratories (biology, chemistry, core-science, physics) average percent shortfall	
Goal 4: Reduce child mortality	
Under five mortality rate (death per 1 000 live births)	If the observed decline in the prevalence of HIV and AIDS is sustained the target is achievable. More emphasis to be put on PMCTC, nutrition programme and other preventative measures.
Infant mortality rate (death per 1 000 live births)	
Percentage of under-fives who are undernourished	
Percentage of children vaccinated against measles	
Goal 5: Improve maternal health	
Maternal mortality ratio	If the observed decline in the HIV and AIDS prevalence is sustained the situation may improve. There is need to address issues of poverty, an inefficient referral health system, health personnel brain drain and shortage of essential equipment, drugs and other sup plies. Can improve with the general improvement in the economy and incomes.
Proportion of births attended by skilled health personnel	

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MDG, Indicator and Millennium Declaration	Comment
Goal 6:Combat HIV and AIDS, malaria and other diseases	
HIV AIDS prevalence among 15-24 year old pregnant women	With the decline in the prevalence of HIV and AIDS this goal is achievable if efforts are strengthened and sustained. Despite the fall in the HIV prevalence the orphanhood burden continues to increase from the momentum.
Number of children orphaned by HIV and AIDS	
Incidence of Malaria	
Incidence of TB	
Incidence of diarrhea disease	
Goal 7: Ensure environmental sustainability	
Proportion of people with sustainable access to an improved water source	More capital resources and maintenance required for improvement to be realized.
Proportion of people with access to improved sanitation	
Goal 8: Develop a global partnership for development	Zimbabwe needs to improve relations with the international community in order to attract more foreign capital inflows.
Millennium Summit Declaration: Child protection against abuse, exploitation and violence and other commitments relating to the rights of the children.	There is need for improved legal literacy on laws pertaining to child rights as well as enforcement of such laws. Need to reformulate the few laws which do not conform to the Convention on the rights of the children

Table C: List of Thematic Group Participants	
Organizations Represented in Thematic Groups	
Mid-Decade Report on Children, Coordinating Group	Ministry of Health and Child Welfare, Save the Children Norway-Zimbabwe, Save the Children UK, National AIDS Council, Provincial Coordinator NAP for OVC, Ministry of Public Service, Labour and Social Welfare, Plan International, UNICEF
Promoting Healthy Lives	Ministry of Health and Child Welfare - IMCI, EPI, Nutrition, Rehabilitation and Reproductive Health, Nursing
Promoting Quality Education	Central Statistics Office, Save the Children Norway, Catholic Relief Service - Zimbabwe, Plan International –Zimbabwe, Ministry of Education, Sports and Culture
Combating HIV and AIDS	Save the Children Norway, Zimbabwe Association of Church related Hospitals, National AIDS Council, Southern African AIDS Trust, Ministry of Health and Child Welfare, Elizabeth Glaser Pediatric AIDS Foundation, Zimbabwe Network of People Living Positively with HIV and AIDS, UNAIDS, UNICEF
Protecting Children against Abuse, Exploitation and Violence	Central Statistics Office, Ministry of Justice Legal Parliamentary Affaires, Zimbabwe Republic Police, IOM, Plan Zimbabwe, Zimbabwe National Council for the Welfare of Children, Ministry of Public Service, Labour and Social Welfare, Ministry of Health and Child Welfare, CHILDLINE, National Associations of NGO, UNICEF

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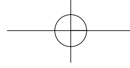

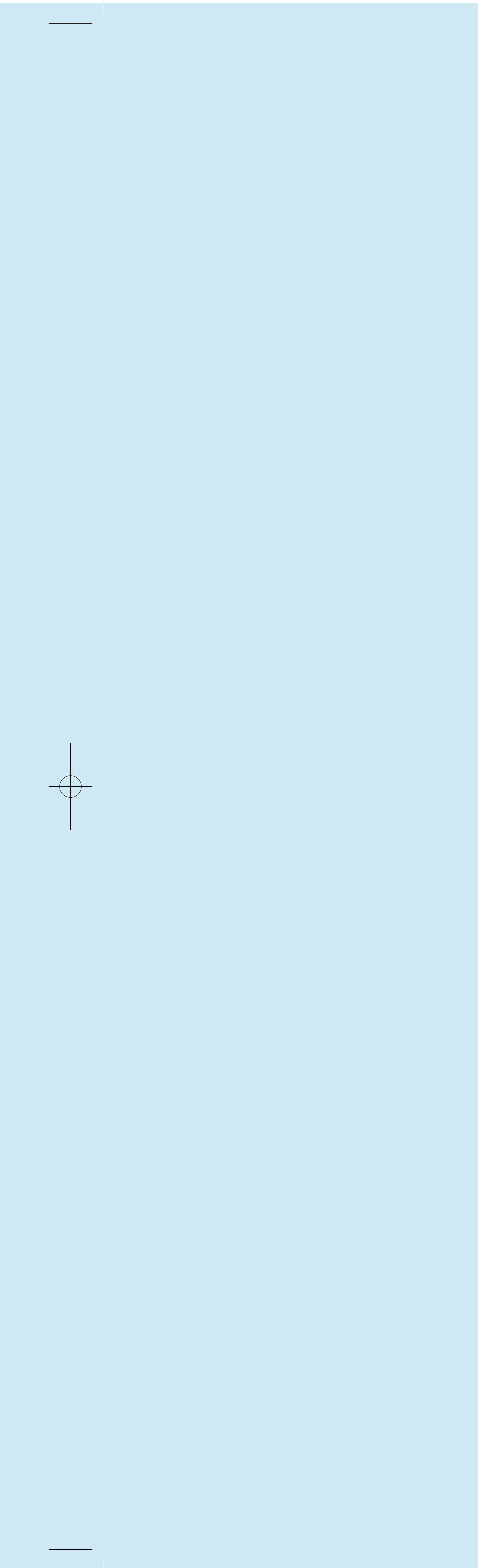

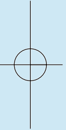
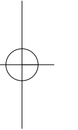

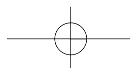

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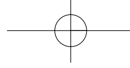

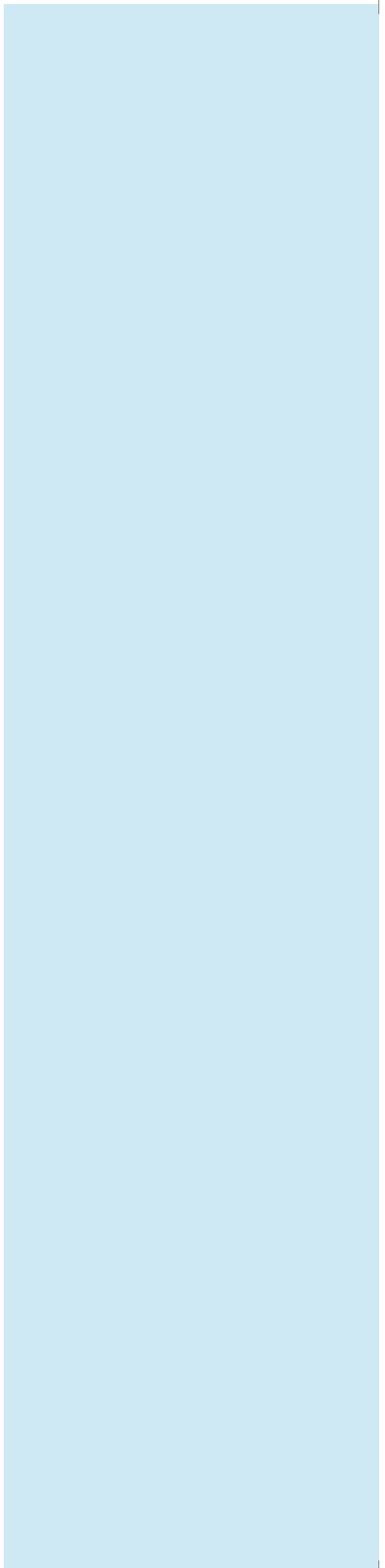

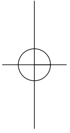

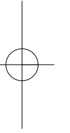

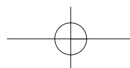

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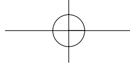

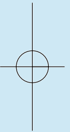
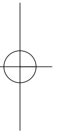
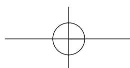

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