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Revised country programme document

Zimbabwe

Summary

The revised country programme document (CPD) for Zimbabwe is presented to the Executive Board for final approval. At the second regular session of 2006, the Board commented on the draft CPD and approved the aggregate indicative budget for the country programme. A summary results matrix is presented separately.

Decision 2002/4 also states that the present document will be approved by the Executive Board at the first regular session of 2007 on a no objection basis, unless at least five members have informed the secretariat in writing by 6 December 2006, of their wish to bring the country programme before the Board.

<i>Basic data</i> [†] (2004 unless otherwise stated)	
Child population (millions, under 18 years)	6.3
U5MR (per 1,000 live births)	129
Underweight (% , moderate and severe, 2003)	17
Maternal mortality ratio (per 100,000 live births, 2002)	695
Primary school enrolment (% net, male/female, 2003/2004)	79/80
Primary schoolchildren reaching grade 5 (% , 2002/2003)	70
Use of improved drinking water sources (% , 2002)	83
Adult HIV prevalence rate (% , end 2003)	20.1
Child work (% , children 5-14 years old)	26
GNI per capita (US\$)	^a
One-year-olds immunized against DPT3 (%)	85
One-year-olds immunized against measles (%)	80

[†] More comprehensive country data on children and women are available at www.unicef.org.

^a Range \$825 or less.

The situation of children and women

1. Since the late 1990s, the Zimbabwean economy has been underperforming. Negative economic growth rates resulted in a decline of 30 per cent in the gross domestic product between 2000 and 2005. Contributing factors include recurrent droughts, inflation, foreign currency shortages, low investor confidence, policy constraints, limited donor funding and HIV and AIDS. With inflation at 782 per cent as of February 2006 and declining real value of public social investments, the coping capacities of the 63 per cent of the population under the poverty line are severely strained (Poverty Assessment Study Survey, 2003). Thus, Zimbabwe is unlikely to meet most of the Millennium Development Goals. For example, life expectancy at birth for females decreased from 62 to 46 years between 1992 and 2002 (Central Statistical Office, Census 2002). Between 1994 and 1999, infant and under-five mortality rates rose from 52.8 to 65 per 1,000 live births, and from 77.1 to 102.1 per 1,000 live births, respectively. The maternal mortality ratio increased from 283 in 1984 to 695 per 100,000 live births in the period 1995-1999 (Demographic and Health Survey [DHS], 1999). Though recently published information is not available, these indicators have likely worsened.

2. In the last six years the nutritional status of children has stagnated, with stunting remaining at about 27 per cent. Levels of underweight increased from 14 per cent of children in 1999 (DHS, 1999) to 17 per cent in 2003 (National Nutrition Survey, 2003). Malnutrition levels improved slightly in 2004 but deteriorated in 2005. In December 2005 the Zimbabwe Food and Nutrition Site Surveillance System found 3.4 per cent wasting among its 25 sites, with the highest site reaching 7.3 per cent. Underweight averaged 17 per cent, with the highest site reaching 26 per cent. Low birthweight and vitamin A and iron deficiency anaemia remain significant public health concerns, and the elimination of iodine deficiency through universal salt iodization needs continuous monitoring.

3. The immediate causes of increased morbidity and mortality are preventable diseases and malnutrition; underlying causes are HIV/AIDS, food insecurity and deteriorating social services, which adversely impact child-caring capacity and economic productivity. Formerly a net exporter of food, Zimbabwe has received food aid since 2002 because of a combination of consecutive years of drought, the HIV and AIDS epidemic, economic decline, policy constraints and an underperforming agriculture sector. The number of food-insecure people averaged 2.9 million for the 2005-2006 season including mobile populations during Operations Murambatsvina, of whom 60 to 70 per cent were children and women (Vulnerability Assessment Committee, 2005).

4. The health and education systems, eroded by deteriorating infrastructure, decreased public expenditures and high attrition of human resources, are now characterized by shortages of essential supplies, reduced accessibility by the poor, low motivation of staff and weakened planning and management capacities. The health system has seen the highest erosion of human resources from “brain drain” and AIDS and has a vacancy rate of 50 per cent and 32 per cent for doctors and nurses, respectively. With AIDS patients occupying about 70 per cent of hospital beds, the strain on health services is enormous, making it difficult for the Government to maintain critical services. Coverage with three doses of combined diphtheria/pertussis/tetanus vaccine (DPT3) dropped from 80 per cent in 1999 to 58 per cent in 2003, but rebounded to 85 per cent in 2005 thanks to efforts by the Ministry of Health and Child Welfare with support from UNICEF, the World Health Organization (WHO) and donors. Recurrent cholera epidemics in some districts imply deterioration in hygiene and in the coverage and quality of water and sanitation. About a third of rural water supply facilities are non-functional due to poor maintenance.

5. The decline in HIV adult sero-prevalence from 24.6 per cent in 2003 to 20.1 per cent in 2005 is attributed to a combination of lower rates of new infections and mortality. Nevertheless, an estimated 1.61 million adults (1 in 5) lived with HIV/AIDS in 2005, with 160,000 new infections occurring per year and 3,200 AIDS-related deaths per week. Females comprise 56 per cent of people 15-49 years old living with HIV/AIDS. Unequal gender relations fuel the disease, especially through intergenerational transmission. Over 40 per cent of young women aged 12-19 years have sex with men 5 to 10 years older, and 12 per cent report that their last encounter was forced (Orphans and vulnerable children [OVC] survey, 2004-2005). To halt the epidemic, factors such as the lower social and economic status of women, negative sociocultural practices and gender norms, lack of open discussion on sex, sexually transmitted infections, and HIV and AIDS need to be addressed boldly. Access to treatment and care is inadequate. Of the 364,000 people requiring antiretroviral therapy (ART), only 23,000 (6 per cent) received it in 2005, with children aged 0-14 years constituting 7 per cent of them. In 2004, only 7 per cent of all HIV positive pregnant women received antiretroviral (ARV) prophylaxis (Ministry of Health and Social Welfare, 2005).

6. Based on recent surveys, UNICEF estimates that 25 per cent of all children, nearly 1.6 million, were orphans in 2005, and 200,000 children lost one or both parents due to HIV/AIDS. The 2002 Census found that 50,000 households were headed by a child under 18. Orphaned children are less likely to access health care, attend school and access basic materials (clothes, blanket, shoes) and are more likely to have psychological problems and to be subjected to forced sex in

adolescence, and these factors result in a higher likelihood of contracting HIV (OVC survey, 2004-2005). In response to this crisis, especially in regard to school attendance, a total of 969,962 children had their school fees paid through the Basic Education Assistance Module (BEAM). The majority of those assisted through BEAM were in primary school, in pursuance of Government policy of universal primary education.

7. Although primary school enrolment rates were above 90 per cent in 2004, and showed gender parity (Ministry of Education, Sports and Culture, 2004), attendance and completion rates have been dropping. The rising costs of education being borne by communities may exacerbate this trend. In 1999, 84 per cent of rural children aged 6-12 years attended school; in 2004 only 77 per cent did (DHS, 1999; OVC survey, 2004-2005). Completion rates have steadily declined since the late 1990s, to 68 per cent in 2004. Due to the rising costs and high inflation, the allocation for procurement of teaching/learning materials remained low in real terms. This impacted negatively on a number of quality indicators. In 2004, for example, grade 7 examination pass rates was a modest 67 per cent and the textbook-pupils ratio was low, ranging between 1:6 and 1:10 in all subjects (Ministry of Education, Sports and Culture, 2004).

Key results and lessons learned from previous cooperation, 2005-2006

Key results achieved

8. The effective responses of UNICEF and its partners, both to acute emergencies including during Operation *Murambatsvina*, and increasing chronic poverty has led to increased donor funds for the expanded programme on immunization (EPI), malaria, nutrition, OVC and water and sanitation. These resources funded important results in health, including revamping the cold chain systems and increasing coverage in immunization. Malaria interventions were scaled up: coverage of insecticide-treated nets (ITNs) increased from below 20 per cent to over 50 per cent in high-endemic districts. Vitamin A supplementation reached 82 per cent coverage, and 1.3 million children under five were immunized during national child health days. Innovative procurement arrangements have helped improve the availability of ARV and tuberculosis drugs. The programme's water and sanitation humanitarian response reached 220,000 people.

9. The country programme contributed to improved understanding of the situation of children and women through the generation of new knowledge. This included support to the 2004-2005 OVC survey; the national inventory and atlases on water and sanitation facilities and interventions; the mapping of nutrition and OVC programmes; the incorporation of HIV and OVC issues in the 2005 Rural Vulnerability Assessment; and the strengthening and expansion of the Zimbabwe Food and Nutrition Sentinel Site Surveillance System. The programme also supported statistical analysis of education, nutrition and OVC data from various sources. *DevInfo* was used to develop the Zimbabwe Statistics Database (*ZIMDAT*) for monitoring Millennium Development Goals.

10. UNICEF supported the development of national and sectoral policies, including the new National HIV/AIDS Strategic Framework 2006-2011, the National Plan of Action for Orphans and Vulnerable Children (NPA for OVC), the

Behaviour Change Strategy and National Treatment Strategic Plan. Furthermore, a national Basic Education Policy, and Gender-based Strategy were developed and a review of social protection programmes was conducted in preparation for the National Poverty Reduction Strategy.

11. The programme supported the Government, non-governmental organizations (NGOs) and community-based organizations (CBOs) to scale up community-level assistance to OVC. The Vice-President launched Zimbabwe's NPA for OVC in late 2005. UNICEF provided technical support to the newly established National Secretariat of the NPA for OVC for costing of the NPA and development of a national monitoring and evaluation system coordinated by the National AIDS Council (NAC). A multi-year and multi-donor programme of support was established to enable the efficient and cost-effective channelling of financial resources to children, families and communities in need.

Lessons learned

12. Collaboration with local authorities, Government institutions, donors and other development partners enabled the programme to reach vulnerable people during the humanitarian response. Good programme planning and technical leadership, taking into account the critical role of development partners and focusing on the respect for and promotion, protection and fulfilment of rights, created an enabling environment for sustained policy dialogue and action in response to evolving situations.

13. A well-facilitated process of assessment, analysis and action (Triple A) involving both duty bearers and children was followed in the development of the NPA for OVC, and the subsequent multisectoral and joint programme of support for OVC will be critical for scaling up programmes. New knowledge generated from the Triple A processes was swiftly used to plan interventions and to mobilize human, financial and organizational resources. A transparent monitoring and evaluation system and broadened partnerships widened participation, which facilitated reaching more children.

The country programme, 2007-2011

Summary budget table

<i>Programme</i>	<i>(In thousands of United States dollars)</i>		
	<i>Regular resources</i>	<i>Other resources*</i>	<i>Total</i>
Basic education and gender equality	1 375 000	8 600 000	9 975 000
Young child survival and development	1 280 000	12 400 000	13 680 000
Water, sanitation and hygiene	570 000	6 655 000	7 225 000
HIV/AIDS and young people's development	1 650 000	7 605 000	9 255 000
Child protection	950 000	34 980 000	35 930 000
Strategic planning, social policy and communication	2 291 093	5 990 000	8 281 093
Cross-sectoral costs	2 998 907	3 770 000	6 768 907
Total	11 115 000	80 000 000	91 115 000

* Additional funds may be mobilized for humanitarian responses as required.

Preparation process

14. The 2005 Millennium Development Goals progress report highlighted key national priorities and was the foundation for the Zimbabwe United Nations Development Assistant Framework (ZUNDAF). The ZUNDAF, developed under the guidance of a task force co-chaired by the United Nations Resident Coordinator and the Office of the President and Cabinet, involved six thematic groups composed of the Government, United Nations agencies and civil society. A joint Government/UN strategy meeting was held in June 2006 to approve the ZUNDAF.

15. An internal UNICEF strategy meeting in late 2005 reaffirmed the need to prioritize activities, create synergies and build partnerships. The identification of priority areas for intervention was further informed by discussions and findings of mid-year and annual reviews and Joint Programme Reviews, including the updating of the Situation Analysis on Children and Women and the findings of the 2004-2005 OVC Survey and Vulnerability Analysis, in which young people participated. This country programme document was developed in consultation with the Government, United Nations agencies, civil society and donors, and the process included a desktop environmental assessment screening. A Government inter-ministerial meeting held on 20 June 2006 that discussed the draft CPD affirmed that the document generally reflected Government position and priority needs and comments submitted on 19 July 2006 were all incorporated into this final document.

Goals, key results and strategies

16. The overall goal of the country programme, in line with the ZUNDAF, is to promote every Zimbabwean child's right to equitable access to good quality services, including those in health; water, sanitation and hygiene; basic education; and protection. The country programme places OVC and HIV and AIDS at its centre by focusing on vulnerability reduction, gender equality, prevention of HIV, and the survival, protection, care, treatment and support, for those living with HIV/AIDS.

17. In **education**, the programme will contribute to these results: (a) net primary and secondary attendance ratios increased by 10 per cent; (b) completion rates in primary and secondary completion rates increased by 10 per cent (c) life and survival skills incorporated in primary education and (d) quality and relevance of primary and secondary education improved resulting in a 25% increase in grade 7 pass rate.

18. In **child survival**, the programme will contribute to these results: (a) vaccination coverage with routine antigens increased and sustained at 90 per cent at national level and at least 80 percent in all districts (b) routine vitamin A supplementation coverage increased from 46 percent to 80 per cent; (c) polio eradication maintained; and neonatal and maternal tetanus eliminated; (d) coverage of children under five years and pregnant women sleeping under insecticide treated net (ITN) increased from 50 percent to 80 per cent in the 17 malaria endemic districts; (e) prevalence of underweight in under-five children reduced from 17 percent to 13 per cent; (d) deficiencies of vitamin A and iron controlled and the elimination of iodine deficiency disorders sustained; and (e) at least 50 per cent of newborns born at home receive essential care in convergence rural districts.

19. In **water, sanitation and hygiene (WASH)**, the programme will contribute to these results: access to an improved water source increased by 20 per cent and access to sanitation increased by 10 per cent in rural convergence districts.

20. In **child protection**, the programme will contribute to these results: (a) an increased proportion of children protected from violence, exploitation, and abuse; (b) at least 25 per cent of needy OVC reached with free basic support; and (c) registered births among children 0-4 years old increased by at least 25 per cent.

21. In **HIV and AIDS**, the programme will contribute to these results: (a) reduction in HIV prevalence among young people (15-24 years) to below 10 per cent; and (b) coverage of home-based care and counselling increased to 25 per cent and (c) at least 90 percent of HIV positive pregnant women attending ANC receive comprehensive PMTCT services in seven convergence rural districts.

22. In **strategic planning, social policy and communication**, the programme will contribute to these results: (a) strengthened national information and knowledge on the situation of children and women; (b) quality Millennium Development Goals monitoring; (c) the development and implementation of the Zimbabwe Economic Development Strategy for 2007-2011 that addresses key challenges for children and women and gender equality; (d) Capacity development for mainstreaming of human rights and gender in development and (e) sustained advocacy for the realization of child rights.

23. The programme will rely on several strategies: (a) development of the capacity of duty bearers at all levels to respect, promote, protect and fulfil children's rights and the development of the capacity of rights holders, especially children, young people and women, to increase their participation and claim their rights; (b) the use of vulnerability analysis to identify districts for convergence of resources; (c) evidence-based advocacy for the development and implementation of child-centred national and sectoral policies, strategies and legal and institutional reforms that ensure the realization and monitoring of child rights; (d) support to nationwide service delivery of immunization and education; and (e) the mainstreaming of emergency preparedness and response.

Relationship to national priorities and the ZUNDAF

24. The three national priorities of fighting HIV and AIDS, promoting gender equality and women's empowerment, and reducing poverty are articulated in the Millennium Development Goals Reports (2004 and 2005) and are incorporated into the ZUNDAF outcome areas. The country programme is designed to contribute to five of the six ZUNDAF outcomes: (a) reduced spread of HIV infection, improved quality of life of those infected and the mitigated impact of HIV and AIDS; (b) improved access to quality and equitable basic social services; (c) gender mainstreamed and institutionalized in all sectors of development; (d) enhanced national capacity and ownership of development processes towards the attainment of the Millennium Development Goals by 2015; and (e) strengthened mechanisms for promoting the rule of law, dialogue, participation in the decision-making process and promotion of human rights.

Relationship to international priorities

25. Both the ZUNDAF and the country programme aim to progress the Millennium Development Goals and *A World Fit for Children* Plan of Action, emphasizing the care and support of OVC and fighting HIV/AIDS. The programme is also guided by the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and the African Charter on the Rights and Welfare of the Child. The programme addresses all five focus areas of the UNICEF medium-term strategic plan 2006-2009 and the UNICEF Regional Leadership Agenda.

Programme components

26. **The basic education and gender equality** programme's key results will be achieved through a focus on the education of OVC, especially girls within the framework of a new basic education policy. Improving the quality and relevance of primary and secondary education, strengthening national systems for Educational Management Information, and the Monitoring of Learning Outcomes will contribute to increased enrolment and completion. The review and updating of core curricula will be complemented by improving access to learning materials and improving teacher effectiveness, including through gender-sensitive life skills, teaching and psychosocial counselling. The programme will support school, community and institution-based initiatives that develop capacities for early childhood education and care.

27. The incorporation of life and survival skills into primary and secondary education will be achieved through the implementation of the new strategy for HIV and AIDS in Education and Life Skills. To preserve human resources in education, teachers will be mobilized to access appropriate HIV/AIDS prevention and care services, including ARVs.

28. Linkages will be forged between girls' education; child protection; water, sanitation and hygiene; HIV prevention; and young people's participation and school feeding. The main focal partners will be the Ministry of Education, Sports and Culture, the Ministry of Technical and Higher Education, and the NAC, supported by a network of NGOs.

29. Using the broad-based partnership framework, gender will be mainstreamed through the implementation of the girls' education strategy. This will include provision of gender-disaggregated data, the promotion of early, positive gender-socialization, the assurance of the safety and security of girls attending school, the prevention of and response to gender-based violence and sexual and economic exploitation. Advocacy for free OVC education and support from the private sector and international community will complement parental, community and Governmental efforts to address the direct and opportunity costs of schooling. The participation of young people in HIV prevention and girls' education will be mainstreamed through school clubs.

30. **The young child survival and development** programme's key results will be achieved through scaling up high-impact interventions against preventable childhood illnesses, malnutrition and maternal health problems. Within the framework of the Integrated Management of Neonatal and Childhood Illness (IMNCI), Roll Back Malaria and Child Survival Partnership initiatives, the

programme will support immunization coverage of routine antigens, Vitamin A supplementation, neonatal interventions and the prevention and control of malaria and other childhood diseases. Inputs will include the procurement and distribution of vaccines, supplies, fuel, bottled gas, transport for outreach and essential drugs to support home-based treatment of childhood illnesses and the training of facility and community health workers.

31. To contribute to the reduction of maternal deaths and improve maternal health, the programme will complement United Nations Population Fund (UNFPA) and WHO in providing emergency obstetric care, focusing on community-based schemes for case referral, and the prevention and treatment of malaria and malnutrition during pregnancy. Neonatal care initiatives at facility and community levels will be supported.

32. The programme will contribute to the Universal Access Initiative by mobilizing efforts for increased uptake and coverage of voluntary and confidential counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) of HIV and paediatric AIDS treatment and care. The programme will work with key stakeholders, including civil society organizations (CSOs) in several areas: advocacy for more equitable access to AIDS treatment, especially ART for children and women; procurement of supplies and essential drugs, including ARVs; the training of health workers; and technical backstopping for effective monitoring and accessing of global funds.

33. Support to improved nutrition will emphasize OVC, community capacity development and the integration of nutrition within the overall strategy for HIV and AIDS prevention, care and support, and Community-Based Nutrition. Integration of community IMNCI, PMTCT, VCT and ARV treatment will include infant and young child feeding. The programme will support the development of a national nutrition policy; a national nutrition surveillance system; elimination of deficiencies of iodine, vitamin A and iron; the therapeutic feeding of severely malnourished children; and in partnership with the World Food Programme (WFP), the continuation of technical support to feeding programmes.

34. The programme's focal points are the Ministry of Health and Child Welfare, NAC, the Food and Nutrition Council and Rural Development Councils.

35. The key results in the **water, sanitation and hygiene (WASH) programme** will be achieved within the framework of the national water and sanitation policy through strengthened Government coordination, capacity development for community and school participatory health, hygiene and sanitation education, as well as management of water and waste systems in rural and peri-urban areas. Efforts will focus on households and communities most affected by HIV/AIDS. To improve the school environment for girls, the programme will support the rehabilitation of school water and sanitation facilities. The capacity of teachers to inform students about WASH, including the critical role of hand washing with soap, will be developed. Partnerships with the public sector, donors and NGOs will be broadened so that community and district capacities can be developed for preparedness and response to outbreaks of water- and hygiene-related diseases such as cholera, diarrhoea and malaria. The programme's focal points are the Ministry of Local Government and Urban Development, the Ministry of Health and Child Welfare, the Ministry of Water and Infrastructural Development and Rural Development Councils.

36. The **child protection** programme's key results will be achieved through addressing issues such as harmful traditional and religious practices (especially those that elevate the HIV risk for girls, including child marriages), the worst forms of child labour, trafficking and deportation, justice for children in contact with the law (children as victims/offenders), violence and abuse, unaccompanied and separated children, and children with disabilities. The programme will support the Ministry of Public Service, Labour and Social Welfare and its National Secretariat and the NAC in advocacy and mobilizing and convening partners for a large-scale response to the challenges facing OVC. The programme will coordinate the implementation of a multi-donor programme of support for the NPA for OVC, ensuring that substantial resources are mobilized and channelled to communities, families and children through intermediary organizations. District-level Child Protection Committees and other district coordination mechanisms will be established or strengthened.

37. To ensure universal early birth registration, measures such as the establishment of sub-offices and mobile teams to reach children in remote areas will be supported. The programme will also work to reunify unaccompanied and separated children (both those on the streets and in institutions); to prevent abuse, exploitation and trafficking of children, with cross-border collaboration; to provide support services for victims and strengthen the victim-friendly court system; and to implement recommendations from the United Nations Study on Violence against Children.

38. The **HIV/AIDS and young people's development** programme will achieve its results by supporting large-scale, effective interventions within the context of United Nations joint programming, including the following; (a) implementation of the National Behaviour Change Strategy to ensure a focus on young people; (b) improved quality and coverage of community-based care and counselling services; (c) the leveraging of resources, such as those of the Global Fund; (d) the dissemination of new knowledge and documentation of best practices and lessons learned; (e) improved national tracking systems and critical epidemiological analysis; and (f) strengthening the capacities of key partners for effective coordination and implementation of HIV/AIDS prevention and care interventions. The main counterparts will be the NAC and the Ministry of Health and Child Welfare.

39. In collaboration with UNFPA, the United Nations Development Fund for Women and the United Nations Development Programme (UNDP), the programme will address sociocultural and gender-related norms and practices that fuel the spread of HIV, particularly among girls and young women, including gender-based violence and intergenerational sex. The programme will promote and support home-based care and community counselling; participation of young people in prevention activities; peer counselling and life skills initiatives; the development and dissemination of appropriate youth-friendly information, education and communication and training materials; and support to interventions focused on improving communication and connectedness between young people and their parents and other community members.

40. **The strategic planning, social policy and communication** programme will work with the Government of Zimbabwe, the World Bank, UNDP, UNFPA, donors and Civil Society Organizations in the development and implementation of the Zimbabwe Economic Development Strategy (ZEDS 2007-2011), focusing on

children and women and with a view to improving macro-economic fundamentals, including the reduction of inflation, capacity development for governance systems and the stimulation of private sector and better pro-poor and child-friendly investments and expenditure. Gender will be mainstreamed through the provision of gender-disaggregated data. The programme will coordinate linkages with the ZUNDAF and support capacity development in monitoring and evaluation to inform evidence-based policy development. In addition, the country programme will promote and enhance a national protection system for child rights that reflects international human rights norms, informed by the UNICEF/Government of Zimbabwe 2004 legal review of children and women's rights. Child rights monitoring, through support to the State Party reporting process and institutional capacity development will be key to ensuring quality and timely reporting on the Convention on the Rights of the Child (the last State Party report was submitted in 1996) and the Convention on the Elimination of All Forms of Discrimination against Women. The programme will also promote the participation of children and young people in national processes such as the Millennium Development Goals campaign and child-friendly budget initiative.

41. Strategic, evidence-based advocacy and communication involving media, public mobilization and community dialogue will be implemented for leveraging resources and social and behavioural change. Advocacy for the realization of child rights, focusing on OVC and HIV/AIDS within the larger United Nations global campaign for children and AIDS, will be coordinated with Government line Ministries, other United Nations agencies, donors and National Committees for UNICEF to mobilize the increased commitment of policy makers, politicians, donors, the private sector, civil society groups and other partners to fulfilling obligations to children.

42. The programme integrates preparedness and response to protect children in accordance with UNICEF Core Commitments for Children in Emergencies. Governmental capacity will be developed for improved coordination of humanitarian actors through cluster working groups and the training of stakeholders on the code of conduct to prevent violence and abuse in humanitarian contexts. The programme will also contribute to the provision of emergency relief for the most vulnerable and provide support to the Government, in coordination with WHO and the Food and Agriculture Organization of the United Nations (FAO), to help prepare for the potential threat of avian flu.

Cross-sectoral costs

43. Cross-sectoral costs will cover support to programme logistics, recurrent costs including salaries, office space, information and communication technology (ICT), utility costs and security to ensure compliance with the United Nations Minimum Operating Security Standards.

Major partnerships

44. The country programme will be a key component of the broad United Nations partnership described in the ZUNDAF. Building on lessons learned from the last country programme, UNICEF will continue to be an active member of Government led coordination bodies — including the Working Party of Officials for the NPA for OVC, the EPI and Malaria Inter-Agency Coordination Committees, the National

Reproductive Health Task Force and Steering Committee, the Expanded Theme Group on HIV/AIDS, the United Nations technical working group on HIV/AIDS, the national PMTCT Partnership Forum, the National Care and Treatment Partnership Forum and the national HIV/AIDS Monitoring and Evaluation Task Force.

45. New strategic alliances will include the United Nations Joint Expanded Support Programme on HIV/AIDS (with the Joint United Nations Programme on HIV/AIDS, UNFPA, WHO and UNDP), a joint programme with UNFPA and UNDP aimed at strengthening national statistical and Millennium Development Goals monitoring capacity. In education, joint programming with the United Nations Educational, Scientific and Cultural Organization, WFP, FAO, the SNV Netherlands Development Organisation and the European Union/Education Transition Recovery Programme will address girls' education, HIV/AIDS and livelihoods at district level. Partnerships with children, donors and implementers at the district and community levels (including NGOs and community and faith-based organizations) will be deepened and broadened.

Monitoring, evaluation and programme management

46. The ZUNDAF results matrix and monitoring and evaluation plan will provide the overall framework for monitoring and evaluating the achievement of ZUNDAF outcomes, while a related five-year and annually updated Integrated Monitoring and Evaluation Plan will guide detailed monitoring and evaluation of the country programme. In collaboration with the Central Statistical Office and a United Nations working group on data for development, UNICEF will support the use of *ZIMDAT*, to systematically monitor progress on the Millennium Development Goals. The 2004-2005 OVC survey and the 2006 DHS will provide baseline data for most of the basic indicators.

47. To arrive at a common analysis and provide the basis for further development of programme interventions and advocacy for children, the programme will support a systematic national research agenda on children and women, including through developing the capacity of district authorities to gather gender disaggregated data through the Village Register. Capacity development among UNICEF staff and partners on performance standards and field visits will further improve monitoring, evaluation and documentation of interventions and will generate lessons for reinforcing and widening the cyclic process of assessment, analysis and action.

48. The Programme Development and Monitoring Committee, co-chaired by the Ministry of Finance and the UNICEF Representative, will guide and oversee the programme. Annual reviews will be carried out jointly with the Government and other relevant development partners including other UN agencies, donors and civil society organisations to ensure full support for these. Internal management will continue to take place through monthly review meetings of the country management team and the programme management team.