

E/ICEF/2004/P/L.4/Rev.1

1 November 2004

English

**UNITED NATIONS CHILDREN'S FUND**

Executive Board

**First regular session 2005**

17-21 and 24 January 2005

**Revised country programme document**

**Zimbabwe**

*Summary*

The Executive Director presents the revised country programme document (CPD) for Zimbabwe for final approval by the Executive Board. At the annual session of 2004, the Board commented on the draft CPD and approved the aggregate indicative budget for the country programme. In accordance with decision 2002/4 (E/ICEF/2002/8), the draft CPD has been revised, taking into account, as appropriate, comments made by delegations during that session, and a summary results matrix has been added.

Decision 2002/4 also states that the present document will be approved by the Executive Board at the first regular session of 2005 on a no objection basis, unless at least five members have informed the secretariat in writing, by 10 December 2004, of their wish to bring the country programme before the Board.

*Basic data* \*  
(2002 unless otherwise stated)

Child population (millions, under 18 years)	6.6
U5MR (per 1,000 live births)	123
Underweight (% moderate and severe, 2003)	17
Maternal mortality ratio (per 100,000 live births, 1995-1999)	700**
Primary school enrolment (% net, male/female, 2000)	80/80
Primary schoolchildren reaching grade 5 (% , 1999)	94
Use of improved drinking water sources (% , 2000)	83
Adult HIV prevalence rate (% , 2003)	24.6
Child work (% , children 5-14 years old)	...
GNI per capita (US\$)	***
One-year-olds immunized against DPT3 (%)	58
One-year-olds immunized against measles (%)	58

\* The statistics in this table are the latest official UNICEF statistics. The analysis in the text below includes information from other studies and surveys.

\*\* The WHO/UNICEF/UNFPA estimate for MMR is 1,100 per 100,000 live births for the year 2000. This estimate is adjusted for misclassification and underreporting.

\*\*\* Estimated range \$735 or less.

## The situation of children and women

1. Zimbabwe is experiencing a reversal of progress made in assuring the health and well-being of its children and women, according to the draft Common Country Assessment (CCA), the Millennium Development Goals report on Zimbabwe, [the Zimbabwe Human Development Report 2003](#) and other reports. Though gaps exist in recent data, several trends are clear. Life expectancy, for example, dropped from 61 years during the early 1990s to 43 years in 2001, and is projected to decline to 35 years by 2005. Between 1990 and 1999, infant and under-five mortality rates rose from 53 to 76 per 1,000 live births, and from 80 to 126 per 1,000 live births, respectively. The maternal mortality ratio, a measure of the robustness of the health services, deteriorated from 610 per 100,000 live births in 1995 to 1,100 per 100,000 live births in 2003. To put Zimbabwe back on track towards achieving the Millennium Development Goals, it is critical to continue to support effective programmes for improving the situation of children and women.

2. The immediate causes of the high mortality and reversal of progress are a combination of preventable diseases and malnutrition. An increase in the disease burden is exemplified by a resurgence of epidemics of malaria, cholera, dysentery and tuberculosis. Prevention of malaria has been made more difficult by population movements from non-endemic to endemic areas. Two million cases of malaria are reported annually, and there is an increase in mortality from the disease. Immunization, which had reached universal levels by 1990, dropped sharply after 1997. Routine DPT3 coverage dropped from 83 per cent in 1995 to 47 per cent in 1999 and thanks to concerted efforts, improved to 80 percent by 2003. Recurrent cholera epidemics

in some districts imply a decline in hygiene as well as the coverage and quality of water and sanitation. Nearly half of rural boreholes are non-functional because of destruction caused by cyclones Eline and Japhet and the breakdown of maintenance systems.

3. The nutrition situation has deteriorated markedly since the early 1990s. Marked improvements characterized the first post-Independence decade when prevalence of stunting among children under five improved from 38 to 26 per cent, and levels of child underweight remained at between 13 and 16 per cent from 1980 to 1990. However, according to a Demographic Health Survey, from 1999 to 2003, the level of underweight increased from 14 to 17 per cent. Wasting increased from around 1 per cent in 1988 to 6 per cent in 1996, a level that appears to have stagnated throughout the humanitarian crisis, with reported levels of wasting remaining at 5 per cent (Ministry of Health/UNICEF 2003). Along with low birthweight, vitamin A and iron deficiency anaemia also remain significant public health concerns. Poor feeding practices, the HIV/AIDS epidemic, the orphan crisis and a reduction in caring capacity exacerbate the relatively high levels of severe and chronic malnutrition found in Zimbabwe.

4. The underlying causes of high malnutrition, morbidity and mortality are food insecurity, deteriorating social services and a high disease burden, especially of HIV/AIDS. Formerly a net exporter of food, Zimbabwe has received food aid since 2002 because of a combination of consecutive years of drought, the HIV/AIDS epidemic and weakened capacities for response. The number of food-insecure people averaged about 5 million in the 2003/04 season, of whom about 60 to 70 per cent are children and women. In urban areas, an increase in food insecurity is linked to an increase in poverty. A 2004 urban vulnerability assessment showed a doubling of urban poverty since 1995, with about 2.5 million urbanites being food-insecure. The assessment identified the greatest livelihood shocks to food security as inflation, high cost of services, unemployment, high taxes, deaths, illnesses and hospital costs.

5. Declining infrastructure and public expenditures, combined with a high attrition of human resources, have severely eroded public health and education systems. These two sectors are characterized by shortages of essential supplies, reduced accessibility by the poor, low motivation of staff and weakened planning and management capacities. Health has seen the highest erosion of human resources, attributable to 'brain drain' and AIDS mortality. For example, the vacancy rate in the 1,530 posts for doctors is 55 per cent, and in the 11,640 posts for nurses is 40 per cent. With AIDS patients occupying up to 70 per cent of hospital beds, the strain on the health services is enormous, making it difficult for the Ministry of Health and Child Welfare to maintain critical services, including outreach and response to epidemics.

6. AIDS remains one of the major killer diseases among both adults and children, with an estimated 3,290 people (2,600 adults and 690 children) dying of AIDS per week in 2003. Over 90 per cent of children with HIV became infected through parent-to-child transmission, whereas most adults became infected through

heterosexual sex. Girls and women make up nearly 80 per cent of young people aged 15-24 who are infected with HIV. Adult HIV prevalence has soared in the last several decades, increasing from less than 1 per cent in 1983 to around 25 per cent in 2003, according to 2003 statistics of the Ministry of Health, Centers for Disease Control and Prevention (CDC) in the United States, and UNAIDS. The trend is levelling off, thanks largely to the political commitment of the Government, which declared HIV/AIDS a national disaster and arranged for a tax levy of 3 per cent to be collected from salaries of **all employed Zimbabweans** and set aside for HIV/AIDS activities through the National AIDS Council. Nevertheless, the scale of the epidemic remains worrisome. Of the more than 1.82 million people infected in 2003, about 1.54 million were adults 15-49 years of age and 165,000 were children under 14 years of age. Women made up 56.5 per cent of the adults, and children under 14 years made up 9 per cent of the total number. Unequal power relations between men and women fuel the disease, especially through intergenerational transmission. Estimates indicate that about 67 per cent of young women aged 15-24 years have sex with men 5 to 10 years older, and more than one in five women aged 15-29 reported having had forced sex.

7. The most devastating effect of the disease has been the orphaning of generations of children. **UNICEF estimates that of the 1.3 orphans in Zimbabwe in 2003, about 980,000, or 78 per cent, were orphaned by AIDS, a number projected to surpass 1.4 million by 2010. Orphans will account for over 21 per cent of children by 2010, compared with a current figure of about 19 per cent, according to a 2003 projection by UNICEF.** On average, about 2 per cent of orphans are below 1 year old, 15 per cent below 4 years old, 35 per cent 5 to 9 years old and 50 per cent 10 to 14 years old. Most orphans live in the rural areas because parents tend to migrate back to their home villages when they are sick. Though communities absorb most orphans through an extended family system that is already overstretched, many orphans are under the care of poor grandparents, abusive relatives and foster parents, or older siblings. Because of the size of the problem, households that take in orphans are more likely to become poorer because of the increase in the number of dependants relative to caregivers, a ratio estimated to average 2.2, compared with 1.4 in non-orphan households with children **according to UNICEF estimates.**

8. Children orphaned by AIDS are more likely to suffer from damaged psychosocial development because of the stress of watching parents die slowly from the disease, separation from relatives and the powerful stigma and discrimination associated with the disease. These children are also less likely to have a birth certificate, go to school and access health or water and sanitation services. At the same time, such children **may be** malnourished, food-insecure and sick, and to live or work on the streets and be subjected to the worst forms of abuse. Orphans are also more likely to be excluded from inheritance of property because of a lack of official wills. Analysts estimate that 25 per cent of all children live with at least one HIV-positive parent who is unable to access antiretroviral (ARV) treatment.

9. Several important gains made in education in the 1990s are being eroded. By 2000, the **primary school** net enrolment ratio in Zimbabwe had climbed to 92 per cent, and the literacy rate for those aged 15-24 had reached 98 per cent. Enrolment was marked by gender parity. These results were largely due to policies promoting free and compulsory primary education, including the 1987 Education Act on free education. However, the introduction of fees and levies in the 1990s **as a result of the Economic Structural Adjustment Programme**, combined with the current complex emergency of **drought and HIV/AIDS**, counteracted the positive effects of the free **primary** education policy. Since 2000, **net attendance** has dropped by 24 per cent, from 85 to 67 per cent for boys, and from 86 to 63 per cent for girls. By 2000, completion rates that had peaked at 83 per cent in 1990 had declined to 75 per cent **by 2000 and further down to 63 percent in 2002**, with 10 per cent of girls not completing school, compared with around 5 per cent of boys. The rising costs of school fees, textbooks and uniforms, plus the impact of hunger and HIV/AIDS, has negatively affected enrolment, attendance and learning ability. The decline in education calls for new ways to address these issues. Policies such as recent plans to educate about 800,000 orphans and vulnerable children through the basic education assistance module need support.

10. The rapidly declining economy has also reversed Zimbabwe's social and economic gains. **Erratic fiscal and monetary policies are among the many causes of the economic decline**. Despite several home-grown economic revival plans, per capita real GDP growth declined from a positive 5.5 per cent in 1990 to a negative 14.1 per cent in 2003, with inflation **peaking at 622.8 percent in January 2004**. **The economic** decline reduced **national** capacity for investing in children and key sectors, **especially in health and education**. By 2003, poverty had increased from 40 per cent of people in the late 1980s to about 70 per cent, showing significantly higher levels in rural than urban areas and in households with chronically sick parents or headed by children, women and grandparents. To revitalize the economy, fundamental policy changes beyond the recent monetary policy and anti-corruption drive are needed.

11. Domestic political struggles, coupled with **the controversial** land reform, have compounded Zimbabwe's economic woes, led to political polarization, and strained relations with donor countries. **Targeted** international sanctions, combined with a withdrawal from development cooperation by the International Monetary Fund, the World Bank and most donors, have worsened prospects for **economic** recovery. Build-up to the March 2005 parliamentary elections is likely to heighten the current political tension. Although the issues of governance and human rights are contentious, the Government has reiterated as priorities the "promotion of key rights", particularly the rights of women and children, and support for the creation of an environment in which rights are promoted, protected and fulfilled.

12. Only 54 per cent (\$24.8 million) of the total budget of \$45.8 million approved by the Executive Board for the country programme was funded because of donor withdrawal. An additional \$13.9 million

came through the consolidated appeal process (CAP), bringing total other resources to about 85 per cent of budget.

## **Key results and lessons learned from previous cooperation, 2000-2004**

### **Key results achieved**

13. Despite constraints caused by underfunding, good progress was made in several areas with the cooperation of the following donors: Australia, Belgium, Canada/Canadian International Development Agency (CIDA)/the International Development Research Council, CDC, Denmark, the European Commission Humanitarian Office (ECHO), Italy, Ireland, Japan, Netherlands, New Zealand, Norway, Micronutrient Initiative, Rotary International, South Africa, the Swedish International Development Cooperation Agency (SIDA), United Nations Foundation, United Kingdom/Department for International Development (DFID), the United States Agency for International Development (USAID) and several UNICEF National Committees.

14. Three results in particular deserve attention. First, the declining rates of immunization were reversed through efforts of the Ministry of Health and Child Welfare, the World Health Organization (WHO), UNICEF and other partners, with funds or assistance provided by various UNICEF national committees, CIDA, and the Global Alliance for Vaccines and Immunization and WHO. UNICEF contributed financial and technical assistance and provided the vaccines and related supplies. As a result of the combined efforts, routine coverage of DPT3 rose from 47 per cent in 1999 to **80 per cent in 2003**. Moreover, support to special immunization days helped to achieve national measles coverage of 95 per cent and vitamin A supplementation of 90 per cent in 2002. In 2003, mop-ups in 16 underperforming districts achieved similar coverage rates.

15. Second, the nutrition situation was stabilized through supplementary and therapeutic feeding, with a rate of wasting of 5 per cent achieved. This effort of the Government was supported by the World Food Programme (WFP), NGOs and UNICEF, with funding provided by ECHO, DFID and Norway. UNICEF assistance reached over 770,000 children under five years old with supplementary feeding and nearly 4,500 children with therapeutic feeding.

16. Third, Zimbabwe's first National Plan of Action on Orphans and Vulnerable Children (OVC) was developed and adopted **by the Cabinet in 2004** through the convening of a national conference. Technical support and funding from ECHO, Italy, the Netherlands, SIDA and various UNICEF National Committees helped to mobilize partners and stakeholders, including children, to create the plan and initiate its implementation.

### **Lessons learned**

17. The major lesson learned is that the human rights-based approach to programming applied in Zimbabwe developed the capacities of communities to better mobilize their resources and make use of external assistance in responding to the humanitarian situation. Pre-emergency development of community action plans that had identified the needs of high-risk groups, as well as the introduction of village registers and vulnerability maps, had created awareness of the rights, obligations and roles of village leaders and families, and had made it easier to organize local mobilization for response.

18. Another important lesson learned is the usefulness of using community-level lessons and best practices to influence national-level policies and strategies. The empowering nature of the community centred capacity development approach and its success in mobilizing for community social action convinced the Government to initiate a review of its decentralization strategy to include greater community participation through the Rural Development Councils and in the formulation of the National Plan of Action for OVC.

## The country programme, 2005-2006

### Summary budget table

(In thousands of United States dollars) \*

<i>Programme</i>	<i>Regular resources</i>	<i>Other resources</i>	<i>Total</i>
Health, nutrition and environment	800	4 000	4 800
Child learning and life skills	590	3 200	3 790
Child protection	460	4 000	4 460
HIV/AIDS and young people development	700	2 400	3 100
Cross-sectoral costs	1 300	400	1 700
<b>Total</b>	<b>3 850</b>	<b>14 000</b>	<b>17 850</b>

•Additional funding expected from Consolidated Appeals for 2005/2006.

### **Preparation process**

19. The process involved Government counterparts, other United Nations agencies, civil society, donors and young people **coordinated by the Ministry of Finance and Economic Development**. Midterm, annual and end-of-programme cycle reviews, including a joint United Nations Development Assistance Framework (UNDAF) midterm review and updated analyses on the situation of children, were followed by the development of the draft CCA and UNDAF through high-level United Nations consultations with the Government. Other critical processes were the development of the Millennium Development Goals report and the Consolidated Appeal Process (CAP). A desktop environmental assessment screening of the programme was also done.

### **Goals, key results and strategies**

20. The country programme places OVC and HIV/AIDS at its centre. **UNICEF will continue to play a critical role in advocating for children's rights to overall health, education, equity, protection and participation**. All programme components integrate into their strategies and activities the prevention of HIV and orphanhood, and the survival, protection, and development of OVC as well as care and mitigation for those suffering from HIV/AIDS. Orphans are defined as children below 18 years who have lost one parent (single orphans) or both parents (double orphans). Other vulnerable children include those who are HIV positive **or have parents who are HIV positive or living with HIV/AIDS, and more generally those children who are especially vulnerable because of poverty, malnutrition, disabilities, abuse, living on the street, discrimination or exclusion, whether as a consequence of HIV/AIDS or not**.

21. The country programme goal is to promote every Zimbabwean child's right to access quality health services and basic education while benefiting from equity and protection. A special focus is placed on **care and support for OVC and preventing HIV infection**.

22. The overarching country programme strategy is to develop the capacities of those responsible for the care and well-being of children, from the community to the national level, to respect, promote, protect and fulfil children's rights, giving special attention to **care and support for OVC and preventing HIV/AIDS**, in a protracted and deepening humanitarian situation. The programme will run over a two-year period and be reviewed annually **within the framework of the 2005-2009 Zimbabwe United Nations Development Assistance Framework (UNDAF)** to ensure that it responds to the changing macroenvironment and adapts appropriately. Based on the programme strategy's success in previous country programme implementation, it will be adapted to the new programme at two levels.

23. First, at the community level, UNICEF will support development of the capacity of vulnerable households and communities to reduce the vulnerability of OVC and promote their access to basic social services and sustainable livelihoods. Efforts will focus on a holistic approach, encompassing all facets and stages of a child's life. This assistance will focus on 18 districts that will act as innovative models, with at least one district from each of the 10 provinces covered. Criteria for district selection are based on high

levels of the number of orphans, prevalence of sexually transmitted diseases as a proxy for HIV/AIDS, child population and poverty. Second, at the national level, UNICEF will advocate for national policies, strategies and legal and institutional reforms that ensure realization and monitoring of child rights in general, with emphasis placed on OVC and HIV/AIDS. Delivery of critical national-level services, including immunization and education, will continue.

24. Key expected results of the country programme contribute to the outcomes identified in the UNDAF results matrix. In the area of girls' education, the country programme will contribute to: a) development of a National Education Policy, b) an increase of 10 per cent in the net primary school enrolment rate, c) an increase of 5 per cent in the primary completion rate, and d) elimination of the 5-per-cent gender disparity in net primary school attendance. In the area of integrated early childhood development, UNICEF will contribute to: a) an increase from 15 to 60 per cent in households in 17 malaria-endemic areas that own insecticide-treated nets, b) a reduction from 17 per cent to 14 per cent in children under five who are underweight, c) an increase of 10 per cent in access to safe water and sanitation, d) an increase from 80 to 90 per cent in fully immunized children aged 12-23 months, and e) an increase from 46 to 70 per cent in children aged 6-59 months who have received two doses of vitamin A. In the area of HIV/AIDS, UNICEF will contribute to these results: a) at least 70 per cent of people aged 10-24 who can both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission; b) all hospitals in the country offer the Government-approved minimum package of services for prevention of mother-to-child transmission of HIV. In the area of child protection, UNICEF will contribute to: a) an increase by 25 per cent in the percentage of children aged 0-17 whose births are registered, and b) a 30-per-cent increase in the number of abuse victims receiving quality care and support.

#### **Relationship to national priorities and the UNDAF**

25. The country programme links together national priorities for United Nations assistance articulated in the Zimbabwe Millennium Development Goals progress report, draft CCA and UNDAF, National Economic Revival programme and various policy and legal documents. The documents include the **National Orphan Care Policy, the National Strategy on Children in Difficult Circumstances, the 2004 National Plan of Action for OVC, the 2004 Health Revival Action Plan, the National HIV/AIDS Policy and Strategic Framework and the 2004 Gender Policy.** Within the context of the national priorities, the Government of Zimbabwe will allocate complementary financial, human and organizational resources, and where needed strengthen the policy and legal frameworks for the smooth implementation of the country programme.

#### **Relationship to international priorities**

26. The programme's foundation is 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 the five UNICEF

organizational medium-term strategic plan (MTSP) priorities, the five priorities of the Eastern and Southern African Regional Leadership Agenda, *A World Fit for Children* Plan of Action and the child-related Millennium Development Goals, emphasizing OVC and fighting HIV/AIDS.

## **Programme components**

### **Child learning and life skills programme**

27. With special focus on education of OVC, the programme seeks to (a) increase the primary school enrolment of girls and boys; (b) reduce drop-out rates related to the school environment; (c) improve the quality and relevance of education; (d) reduce the gender gap in basic education; (e) incorporate life and survival skills in primary education; and (f) contribute to the national policy-review process on education. Linkages will be forged between the work done regarding violence in and around schools, school water and sanitation and birth registration in the 18 districts and the WFP school feeding. The main focal partners will be the Ministry of Education, Sports and Culture and the Ministry of Technical and Higher Education.

28. **The Government of Zimbabwe and** UNICEF will promote broad partnerships for OVC-friendly education policy reform that promotes inclusion and non-discrimination and ensures equitable and gender-sensitive access, completion and learning achievement in education. Emphasis will be placed on home- and community-based initiatives that develop institutional, district and centre-based capacities in quality early childhood education and care and that enable orphans to enrol in and complete their education. **The Government and** UNICEF will encourage the participation of parent-teacher committees, caregivers and OVC in school governance and HIV/AIDS-prevention, and will seek alternative education opportunities for children as a way to prevent sexual abuse.

29. Curricula review and consolidation of quality formal and complementary educational opportunities for OVC that are based on life skills and livelihood skills will be advocated. To preserve human resources in education, teachers will be mobilized to access appropriate HIV/AIDS-prevention and care services, especially to access ARVs through their workplaces. Gender will be mainstreamed, especially through the 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 sexual and economic exploitation, efforts to address the direct and opportunity costs of schooling, and working with teachers to reduce their inhibitions in discussions of sex and sexuality in the context of HIV/AIDS education. UNICEF will also provide support to analyse trends in orphan education and to monitor learning outcomes.

### **The health, nutrition and environment programme**

30. The programme will contribute to the objectives of the National Health Sector Revival Action Plan to reduce infant, child and maternal mortality caused by preventable childhood illnesses, malnutrition and reproductive health problems. The programme's focal points are the Ministry of Health and Child Welfare, the

National Aids Council, the Food and Nutrition Council, the Ministry of National Housing and Local Government and Rural Development Councils.

31. Within the framework of IMCI and Roll Back Malaria, UNICEF will support immunization coverage of all antigens, as well as vitamin A supplementation, and the prevention and control of malaria and other childhood diseases. The objectives are to: (a) increase immunization coverage for all antigens to **90 per cent**, and routine vitamin A supplementation from 46 to 70 per cent; (b) maintain the eradication of polio and elimination of neonatal and maternal tetanus; and (c) increase **from about 15 per cent to 60 per cent** the coverage rate of insecticide-treated nets and prompt treatment of malaria in endemic districts for OVC and pregnant women.

32. UNICEF inputs will include procurement and distribution of vaccines, supplies, and essential drugs to support home-based treatment of childhood illnesses and training of facility and community health workers. UNICEF will provide technical assistance for reviews, studies, monitoring, and evaluations.

33. To help to prevent women from dying and leaving orphans behind, UNICEF will complement the work of the United Nations Population Fund (UNFPA) and WHO in providing emergency obstetric care, including referral of cases and prevention and treatment for malaria, and good nutrition. In support of the WHO "3 x 5" antiretroviral treatment, UNICEF will mobilize efforts for increased uptake and coverage of voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) of HIV. UNICEF will also advocate with the Government, WHO, UNAIDS, communities and other stakeholders to prioritize certain population groups in treatment, especially the mothers, spouses and children enrolled in the PMTCT programmes. Additional UNICEF inputs will include supplies, essential drugs, **procurement of ARVs**, the training of health workers and technical support to monitor and access global funds.

34. Support to improved nutrition will emphasize OVC **and the integration of nutrition within the overall strategy for HIV and AIDS prevention, management and care at the levels of households and communities. The recommendations of the 2003 UNICEF/WFP nutrition review in Zimbabwe will also be taken into account.** Infant and young child feeding will link with community IMCI, PMTCT, VCT, outreach community-based nutrition care and ARV treatment. The control and elimination of deficiencies of vitamin A, iodine and iron, including iron-deficiency anaemia, will be revamped. UNICEF will support the development of nutrition surveillance systems. Community-based growth monitoring will emphasize development of community capacity for improving the nutrition status of OVC and drive the 'triple A' processes in the 18 convergent districts **for longer-term improvement of chronic malnutrition.** The development of a nutrition and childcare policy and strategy with defined outcomes for OVC will be supported. Through partnership work-plans with WFP, UNICEF will support therapeutic and supplementary feeding, assist in training and monitoring in school feeding and advocate for fortification of food aid.

35. UNICEF will contribute to the promotion of universal access to and utilization of safe water and basic sanitation, and the development of coherent national policies, strategies and guidelines responsive to the challenges posed by poverty and the HIV/AIDS and orphan crises. Emphasis will be on developing capacity 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 affected by HIV/AIDS, including those with OVC. To improve the school environment for girls, UNICEF will support water and sanitation facilities and develop teacher capacity to inform students about water, hygiene and sanitation. Possibilities will be explored to use such support as block grants for the education of OVC. UNICEF will also broaden partnerships with the public sector, donors and NGOs to develop community and district capacities for preparedness and response to outbreaks of disease, such as cholera and malaria, that are caused by unsafe water and poor sanitation.

#### **The child protection programme**

36. The programme will collect and disseminate to stakeholders lessons learned and best practices that enhance the effectiveness of child protection interventions and will advocate, and mobilize and convene partners for, large-scale response to the challenges facing OVC. The Ministry of Public Service, Labour and Social Welfare will be the main focal point within the framework of the National Plan of Action for OVC and the Global Partners Forum for Children Orphaned and made Vulnerable by HIV/AIDS. Other ministries will include Justice, Legal and Parliamentary Affairs; **Education, Sports and Culture**; and Youth, Gender and Employment Creation.

37. Focusing on the 18 districts, UNICEF will support Rural District Councils, local leaders and community-based organizations to develop the capacities of families and households to improve the conditions of OVC. Developed capacities should help to improve economic conditions; provide psychosocial support and counselling of caregivers and abused children; prolong the lives of parents; support succession planning; facilitate integrated care; and develop young people's life and survival skills. To strengthen community-based responses to the problems faced by OVC, UNICEF will support social mobilization that encourages open discussion on HIV/AIDS and promotes cooperative activities and care of children having no family support. Moreover, for OVC, UNICEF will advocate for and promote free and compulsory education, birth registration, access to health and nutrition services; safe water and basic sanitation services; administration of justice; placement services for children without family care; and incorporation of OVC in local and district plans and actions.

38. At the national level, UNICEF will advocate for continued Government protection and resource-allocation for OVC, and also advocate for enforcing the supportive legislative framework. UNICEF will support the **implementation and review of the National Strategy on Children in Difficult Circumstances**, particularly supporting the National Task Force on Children who live or work on the street. To contribute to the national coordination mechanism for the National Plan of Action for OVC **approved by the Cabinet in 2004**, UNICEF

will continue to provide technical and financial support to the national secretariat and advocate for the accelerated establishment of similar mechanisms at the district level. For continued awareness-raising and creation of a supportive environment for OVC, UNICEF will assist ongoing efforts in participatory assessment and analysis of the situation of OVC. Partnerships formed during the rapid OVC assessment in 2004 will be maintained. These include partnerships with USAID, WFP, UNAIDS, the Support to Replicable Innovative Community/Village Level Efforts for Children Affected by HIV/AIDS (STRIVE) programme of the Catholic Relief Services, and the Futures Group International, formed during the rapid OVC assessment in 2004. Support will be provided to the Inter-Ministerial Committee on Human Rights to address the rights of children and women. Support will also be provided to achieving timely reporting on the Convention on the Rights of the Child, on the Convention on the Elimination of All Forms of Discrimination against Women and on the African Charter on the Rights and Welfare of the Child.

### **The HIV/AIDS and young people development programme**

39. This programme will collect and disseminate to stakeholders lessons learned and best practices that enhance the effectiveness of interventions preventing the spread of HIV and strengthening the care of those affected by AIDS while mitigating their suffering and challenges. Within the UNAIDS and UNDAF joint programming, UNICEF will advocate, and mobilize partners for, large-scale response to the HIV/AIDS challenge. UNICEF will emphasize integration of HIV/AIDS in the other sectors and programmes, and the development of partnerships. The objectives will be to (a) identify new knowledge and document best practices and lessons, facilitating their use for programmatic and policy response; (b) provide technical inputs into national tracking and critical analysis of the epidemic in order to have a better understanding of its epidemiological nature. This assessment will cover cultural practices and cross-border migration and will involve possible collaboration with other UNICEF offices in neighbouring countries; (c) support leveraging of global resources, such as those of the Global Fund on HIV/AIDS, Tuberculosis and Malaria, for large-scale response; and (d) develop strategies for participatory youth programming. The main counterparts will be the Ministry of Health and Child Welfare and the National AIDS Council.

40. **The Government and UNICEF** will advocate for institutionalization of the successful community-based counselling and for modifying intergenerational cultural and religious norms and practices that fuel the spread of HIV. Since youth are particularly vulnerable to HIV infection, UNICEF will support the development of policies and strategies that facilitate greater participation of young people in prevention activities. This will include support to peer counselling; promotion of multi-purpose community-based youth centres; increasing the number of primary and secondary schools with youth clubs for strengthening life skills; and the encouragement of youth-to-youth programmes through sports.

### **Cross-sectoral costs**

41. The programme support component will cover recurrent costs, including salaries, utility costs, relevant salaries and security to ensure compliance with the United Nations Minimum Operating Security Standards.

42. The social policy analysis and rights monitoring, evaluation and research unit will seek to: (a) provide an ongoing analysis of the macroenvironment for children and women and its implications for various policies, including laws on OVC; and (b) facilitate linkages with UNDAF and national sector policies, strategies and plans. The unit will also facilitate the implementation of the monitoring, evaluation and programme management described below.

43. The communication unit will coordinate UNICEF advocacy for OVC and HIV/AIDS. Advocacy will reinforce the success of the country programme objective by creating a better understanding of the situation of OVC, highlighting what can be done and helping to ensure that all stakeholders, both national and international, are fully committed to confronting HIV/AIDS and the orphan crisis. Communications initiatives will be developed and carried out in collaboration with a number of different partners, especially other United Nations agencies, Government line Ministries and UNICEF National Committees. The approach will seek to create stronger political leadership on the issue of OVC and HIV/AIDS, educate donor and other partners on worthwhile initiatives and translate this into more funding for these programmes. Emphasis will be placed on public engagement to propel and maintain the commitment of policy makers, politicians, donors, the private sector, civil society groups and other partners to fulfilling their obligations to OVC.

#### **Major partnerships**

44. The main partner is the Government of Zimbabwe, through its 10 Ministries, and other partners represented in the Programme Development and Monitoring Committee (PDMC). At the community level, crucial partners include the Rural Development Councils and increasingly community-based NGOs and faith-based organizations. UNICEF will also forge partnerships with civil society, children's networks, orphans and organizations dealing with children's issues, and with other United Nations agencies through the UNDAF. Of critical importance is the deepening and broadening of partnerships with donors who will fund the programme.

#### **Monitoring, evaluation and programme management**

45. The monitoring framework will be the Integrated Monitoring and Evaluation Plan, **using the UNDAF results matrix and related country programme action plan results matrix as a basis**. In collaboration with the Central Statistics Office and United Nations working group on data for development, UNICEF will use *DevInfo* to contribute to the development of a national database for children and women. To arrive at a common analysis and provide the basis for further development of programme interventions **and advocacy for children**, UNICEF will support a systematic national research agenda on children and women, using local and international expertise. **Emphasis will be placed on monitoring the impact of the deteriorating key social**

sectors, namely health and education, on children and women. A current United Nations joint programming effort within HIV/AIDS/OVC among UNICEF, UNAIDS, UNFPA and WHO and poverty assessment analysis among UNICEF, UNDP and UNFPA will be strengthened. Joint programming between UNICEF and UNFPA in conducting the Demographic Health Survey for 2005 and in reproductive health for obstetric care and PMTCT of HIV will be developed.

46. The PDMC, co-chaired by the Ministry of Finance and Economic Development and the UNICEF Representative, will manage the programme through twice-a year meetings. Biannual meetings held in the UNICEF 18 converge districts will allow for field visits of half a day each to communities. In addition to the 10 counterpart Ministries, PDMC members comprise two national autonomous organizations and two non-governmental organizations (NGOs) are members of PDMC. To ensure linkage with the UNDAF, the PDMC at its 2003 annual meeting approved widening its membership to include other United Nations agencies in addition to UNICEF, as well as key donors, to facilitate dialogue with government actors and improve donors' understanding of and participation in the country programming process in order to maximize benefits for children. Internal management take place will be through monthly meetings of the country management team and the programme management team.

## Summary Results Matrix: Government of Zimbabwe – UNICEF Country Programme, 2005-2006

UNICEF MTSP Priority Area	Key results expected in this priority area	Key progress indicators	Means of verification	Major Partners, Partnership Frameworks and Cooperation Programmes	The expected key results in the Priority Area will contribute to:
<b>1. Girls Education</b>	1.1. National Education Policy developed by 2006.	1.1.1 National Education Policy officially launched	National Education Policy	Ministry of Education, Sport, and Culture; Education Working Group; Ministry of Public Service, Labour, and Social; Working Party of Officials; UNESCO; Rural District Councils	<p><b>UNDAF outcome:</b> Increased access to and completion of quality primary and secondary education particularly in marginalised areas e.g. communal and resettlement areas</p> <p><b>WFFC goal:</b> Reduce the number of primary-school age children out of school by 50% and increase net enrolment rate to at least 90% by 2010</p> <p>Eliminate gender disparities in primary and secondary education by 2005</p> <p><b>MDG:</b> Target 3: Ensure that all children, boys and girls alike, will be able to complete full course of primary schooling – by 2015.</p> <p>Target 4: Eliminate gender disparity in primary and secondary education – by 2005;</p>
	1.2. Increase net primary enrolment rate for all children by 10%, including girls and orphans and other vulnerable children, in the 18 priority districts by 2006.	1.2.1. Net primary enrolment rate by sex, orphan, and vulnerability status <sup>1</sup>	EMIS; OVC survey: facility component		
	1.3. Increase primary completion rate for all children by 5%, including girls and orphans and other vulnerable children, in the 18 priority districts by 2006.	1.3.1 Primary completion rate by sex, orphan, and vulnerability status  1.3.2. Primary drop out rate by sex, orphan, and vulnerability status  1.3.3. Percentage of orphans v.s. non-orphans (13-17) who have completed primary school	EMIS; OVC survey: facility and household components		
	1.4. Eliminate the 5% gender disparity in net primary attendance rate by 2006 in the 18 priority districts.	1.4.1. Primary net attendance rate by sex, orphan and vulnerability status  1.4.2. Orphan v.s. non-orphans (10-14) school attendance ratio	OVC survey: household component; Labour Force Survey; PASS II; DHS 2005		

					and at all levels of education – no later than 2015.
<b>2. Integrated Early Childhood Development</b>	2.1. The percentage of households in 17 malaria endemic areas that own ITNs increased from 15% to 60% by 2006.	2.1.1. Percentage of households who own ITNs	MoHCW programme data; OVC survey: household component	Ministry of Health and Child Welfare; Food and Nutrition Council <sup>1</sup> ; PSI; Mvuramanzi Trust; Rural District Councils	<p><b>UNDAF outcome:</b> Rehabilitation of the national health sector resulting in reduced maternal and child mortality and morbidity rates and a reduction in the disease burden</p> <p>Improved access to safe and adequate water supply and sanitation</p> <p><b>WFFC goal:</b> Reduction in the infant and under 5 mortality rate by at least one third</p> <p>Reduction of child malnutrition among children under 5 by at least one third</p> <p>Reduction in the proportion of households without access to hygienic sanitation facilities and affordable and safe water by at least one third</p> <p><b>MDG:</b> Target 5: Reduce by 65% the under-five mortality rate – by 2015.</p>
	2.2. The percentage of children under 5, including orphans and other vulnerable children, who are underweight reduced from 17% to 14% nationwide by 2006.	2.2.1. Percentage of children 6-59 months who are underweight by sex, orphan, and vulnerability status	PASS II; DHS 2005; Food & Nutrition Surveillance; OVC survey: household component		
	2.3. Access to safe water and sanitation increased by 10% respectively from in the 18 priority districts by 2006.	2.3.1. Percentage of households that have access to safe water  2.3.2. Percentage of households that have access to safe sanitation	Census 2002; PASS II, DHS 2005; OVC survey: household component		

<sup>1</sup> The working definition of vulnerable children will be those children that live with a sick adult in a household.

<b>3. Immunization plus</b>	3.1. Percent of children aged 12-23 months who are fully immunized increased from 80% to 90% nationwide by 2006.	3.1.1. Percentage of children 12-23 months who are fully immunized	OVC survey: household component; NNS 2004; PASS II; DHS 2005	Ministry of Health and Child Welfare; GAVI; GAIN; GFTAM; WHO; Rural District Councils	<p><b>UNDAF outcome:</b> Rehabilitation of the national health sector resulting in reduced maternal and child mortality and morbidity rates and a reduction in the disease burden</p> <p><b>WFFC goal:</b> Reduction in the infant and under 5 mortality rate by at least one third</p> <p><b>MDG:</b> Target 5: Reduce by 65% the under-five mortality rate – by 2015.</p>
	3.2. Percentage of children aged 6-59 months who have received 2 doses of Vitamin A increased from 46% to 70% nationwide by 2006.	3.2.1 Percentage of children 6-59 months who received Vitamin A supplementation 2 dose	NNS 2003; DHS 2005; Micronutrient Survey 2005; OVC survey: household component; Food and Nutrition sentinel site surveillance		
<b>4. Fight against HIV/AIDS</b>	4.1. At least 70% of people aged 10-24 can both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.	4.1.1. Percentage of young people aged 10-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	HSTF study; OVC survey: household component; DHS 2005; PASS II	Ministry of Health and Child Welfare; National AIDS Council; Ministry of Health and Child Welfare; Ministry of Youth Development, Gender and Employment Creation; Ministry of Education, Sport and Culture; Ministry of Higher Education and Technology; UN Theme Group on HIV/AIDS; UNAIDS; UNFPA; UNESCO; WHO; Centre for Disease Control; Rural District Councils	<p><b>UNDAF outcome</b> Reduced number of infections</p> <p>Increased access to treatment and care</p> <p><b>WFFC goal:</b> By 2003, establish time-bound national targets to achieve the internationally agreed prevention goal to reduce by 2005 HIV/AIDS prevalence among young men and women aged 15-24 in the most affected countries by 25% and by</p>
	4.2. All hospitals in the country offer the Government approved minimum package of services to prevent mother to child transmission of HIV by 2006.	4.2.1. Number of health facilities offering the minimum package of services to prevent HIV infection in infants and young children against 10,000 inhabitants	PMTCT programme data; OVC survey: desk review component		

	4.3. 30,000 primary school teachers are teaching lifeskills for HIV/AIDS effectively in the 18 priority district by 2006.	4.3.1. Number and percentage of teachers trained in HIV/AIDS and psychosocial counselling by sex	Child Learning and Lifeskills district profiles and further analysis		25% 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/AIDS, encouraging the active involvement of men and boys.  <b>MDG:</b> Target 7: Have halted, by 2015, and begun to reverse the spread of HIV and AIDS
<b>5. Child Protection</b>	5.1. The percentage of children aged 0-17, (including orphans and other vulnerable children, whose births are registered increased by 25%.	5.1.1. Percentage of children under 5 (0-4) and under 18 (0-17) whose births are registered, by orphan status	PASS II, DHS 2005; OVC survey; household component	Ministry of Justice, Legal and Parliamentary Affairs; Ministry of Public Service, Labour, and Social; Working Party of Officials; Rural District Councils	<b>UNDAF outcome:</b> Increased support to orphans, vulnerable children and families affected by HIV/AIDS  <b>WFFC goal:</b> By 2003 and by 2005 implement national strategies and policies to: build and strengthen government, family and community capacity to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psychosocial support; ensuring their enrolment
	5.2. Abuse victims receiving quality care and support in the 18 convergence districts increased by 30% by 2006.	5.2.1. Number and percentage of reported survivors of child sexual abuse who receive medical and legal services	Child Protection programme monitoring		
	5.3. District Child Protection Committees functional in the 18 priority districts by 2006.	5.3.1. # of districts with Child Protection Committees staffed and budgeted	Child Protection programme monitoring		

					in 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 of abuse, violence, exploitation, discrimination, trafficking, and loss of inheritance.
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