Investing in Zimbabwe's Children

BUILDING RESILIENCE AND ACCOUNTABILITY FOR A BRIGHTER FUTURE

unicef | for every child
ZIMBABWE

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Contents

Foreword

I am proud of the story that is outlined in this document – it is a record of Zimbabwe's achievements in the last few years, a testament of how UNICEF and its partners have, through strong programmes and efficient implementation, been able to deliver improvements to the lives of women and children. These achievements would not have been possible without the leadership of the Government, the funding support of the development partners, the tireless efforts of our implementing partners, and the indefatigable spirit of the Zimbabwean people.

The well known story is that Zimbabwe's economy in the last two decades has undergone severe contraction, that the AIDS pandemic and adverse weather conditions have compounded the negative effects of economic decline. As a result of the subsequent underfunding and loss of skilled human resources, the country's once-strong social service systems were seriously hit, and the population they serve suffered deepening poverty. Maternal and child mortality rose, disease outbreaks occurred, along with an increase in protection risks among vulnerable children.

The less well-known story is that of the response and recovery. The effects of the decline have, as various data show, begun to turn around. For the first time in 20 years, mortality in both under-five children and mothers is dropping. HIV prevalence has declined, mother-to-child transmission of HIV is also in decline and more adults and children with HIV are on life-prolonging anti-retroviral treatment. Secondary school attendance rates have improved and pass rates are equally on the rise. More vulnerable families are receiving social cash transfers and systems are in place to protect vulnerable children from violence and abuse. In summary, the context for children in Zimbabwe is much better than it has been in decades.

The progress made has been due to the hard work of Government, development partners, UN agencies, the civil society, and others to get the systems back up and running again. Government has adopted progressive policies which have expanded access to services and saved lives. Stronger coordination lies at the heart of everything we do. Sector Ministries have been robust in leading the coordination mechanisms under the development funds which UNICEF manages, thus ensuring that service delivery is aligned with national priorities, operates at scale, and partners' support is harmonized under a common programme. Coordinated efforts also helped rapid and effective response to several emergencies.

Stronger service delivery has been achieved by training human resources, installing and repairing social infrastructure and procuring essential equipment and supplies.

Support for vulnerable children and families has been increased, through various direct social assistance programmes, including harmonized social cash transfers, public works programmes, and assistance towards medical costs and school fees.

There is much work still to be done, both to sustain the gains and achievements made so far, and to build on that progress towards more accountable and resilient social service systems for the children of Zimbabwe. The Sustainable Development Goals have set a new agenda and targets that we all must endeavor to meet. Now more than ever, we are challenged to do more with less, and that means we must strengthen our resource base and create new and renewed partnerships.

We will continue to work for the children of Zimbabwe until no one of them is left behind. We invite you to join us in investing in a resilient, accountable and sustainable future for them.

Dr. Mohamed Ag Ayoya – Representative

The Development Context in Zimbabwe

ZIMBABWE HAS A GOOD STORY TO TELL

Zimbabwe's positive story is often untold. The significant challenges since the near-collapse of 2008 have been met with remarkable achievements. Government, donors and UNICEF resources were pooled together and distributed across sectors to drive a recovery process that has yielded positive results. Indicators of this success include reductions in maternal mortality, child mortality, mother-to-child transmission of HIV, child malnutrition, and improvements in the number of children completing primary school. UNICEF has managed this in a harmonized, results-driven, data-rich approach. The recovery, however, is not complete, and recent progress made must be maintained with further funding and investment and a focus on building resilience in communities and accountability in service delivery systems.

Zimbabwe's story is especially remarkable when understood in terms of what the conditions were in the first decade of the new millennium. It is a story set against a backdrop of gradual decline with roots in a complex milieu of causes. Despite being a model of social development in the 1980s and early 1990s – with progressive policies that led to education and health being among the best on the continent – by the turn of the millennium, the country had begun to spiral into an economic and social crisis which culminated in hyperinflation, human capital flight, and a cholera outbreak that claimed over 4,000 lives in 2008.

By 2008, the social sectors were on the verge of collapse. The education system, once arguably the best on the continent, had begun to falter badly. Although enrolment rates remained high, examination pass rates and other indicators of quality were plummeting. In the absence of significant central government financing, a complex system of fees, levies and 'incentives' evolved that further disadvantaged the poorest. A full 50 per cent of students did not continue their schooling beyond grade seven. Students from the poorest quintiles made the transition from primary to secondary education even less frequently.

The once strong primary health care system had also weakened badly. By 2010, the maternal mortality ratio had more than doubled from the 1990 base year for the Millennium Development Goals and under-five mortality had increased by more than 20 per cent. User fees meant limited access, particularly for women in rural areas or in the poorest communities, to basic health services and critical interventions such as emergency obstetric care.

The government's social protection mechanisms that functioned well previously, such as the Social Development Fund and supplementary feeding programmes, had withered away. The social welfare and justice for children sectors were also limited by a loss of human and administrative capacity. As the coping strategies of families and communities became increasingly taxed, children became more vulnerable to violence, exploitation and abuse in schools, communities, across borders and within their own homes.

Zimbabwe needed all the international help it could get, but development partners recognized that financing social services directly through individual programmes would at best be a fragmented approach and at worst would undermine government ownership and capacity. There was a need for a harmonized funding mechanism to channel external resources in a coordinated way to revitalize social service delivery in Zimbabwe.

Transition Funds became this mechanism. Between 2010 and 2012, the country had achieved a measure of political and economic stability through the formation of an Inclusive Government. By bringing together external funders, government and NGO implementation partners to renew service delivery in health and nutrition, education, child protection, and water and sanitation, it became possible to obtain national scale impact at sectoral level under line ministry leadership. These pooled funds were entrusted to UNICEF to manage, and this meant that for the first time, funding for the social sectors was coordinated, large-scale and predictable.

Crisis became opportunity as efforts to push back against the decline began in 2010. More than 24 million textbooks in all core subjects were distributed to all 8,000 primary and secondary schools in the country, taking the ratio of pupils to textbooks from 10:1 to 1:1. Around half a million orphans and vulnerable children received assistance and an additional half a million had their school fees paid annually. The first national social cash transfer programme for the extremely poor was initiated and by 2012 was already reaching 20 000 households.

All 1,400 primary health care facilities in the country were receiving a basic package of essential medicines and vaccines, dramatically reducing stock-outs. All 20 major urban centres were supplied with water treatment chemicals and technical support for rehabilitation of water treatment plants, thus bringing the worst cholera outbreak in Zimbabwe's history under control. In a relatively short time, the trajectory had changed and the country was on a path to recovery.

This is the story of a hardy and resourceful population and strong systems that could be bolstered. It is a story of the enormous good that can be achieved when the government, donors, UN agencies, and other development partners unite around a common goal – to help the most vulnerable members of society, and to save lives.

The story, however, hangs in the balance as the ever-increasing list of global disasters draws international attention away from Zimbabwe and the renewal of donor funding diminishes. With the end of the transition funds in 2015, and their transformation into development funds, the need to continue building on the successes remains urgent.

KEY INDICATORS – PROGRESS AND RECOVERY, 2011 - 2015

Maternal mortality: deaths out of every 10 000 live births • 2011: 960 • 2015: 614	**Number of children completing primary school** • 2011: 43 per cent • 2014: 99 per cent	**Child mortality: Children under five** • 2011: 94 • 2015: 75
Stunting: • 2010/2011: 32 per cent • 2015: 27 per cent (ZDHS 2015)		**Exclusive breastfeeding for first six months** • Rose from 26 per cent to 48 per cent (ZDHS 2015)

UNDERSTANDING ZIMBABWE'S SITUATION

Key events leading to the emergency of 2007-8

To understand the recent progress in social sector indicators, it is necessary to understand the nature of the crisis that peaked in 2008. The genesis of the decline can be traced to pre-independence structural imbalances and post-independence events:

- The residual effects of the violent struggle for independence
- Structural inequality inherited from the pre-independence era
- Inequities in land distribution and economic opportunity, major fault-lines in an otherwise promising dream at the time of independence
- The controversial land reform policy which resulted in productivity losses
- Declines in foreign exchange income from a once-lucrative tobacco industry
- Economic crisis and deteriorating infrastructure leading to a breakdown in social service delivery
- The AIDS pandemic which decimated productive sectors of the economy, weighed down the health system, and increased the burden of care for orphans and vulnerable children
- Climate-related crises resulting in widespread food insecurity and hunger

How economic crisis led to a breakdown in social service delivery

The 2005-2010 Situational Analysis for Women and Children in Zimbabwe showed that after the progress and successes of the 1980s, there had been a steady decline in circumstances for the most vulnerable members of society. Recurrent droughts, coupled with shortcomings in implementation of the necessary fiscal adjustments, led to a decline in real GDP growth. Between 1991 and 1995 real GDP growth averaged only 1.5 per cent per annum.

The onset of the land reform programme and decline in agricultural output, together with a growing budget deficit and severe foreign exchange shortages, contributed to further declines in GDP from zero per cent in 1998 to negative 7.4 per cent in 2000 and subsequently negative 10.4 per cent in 2003. The cholera, and a subsequent measles outbreak in 2009, was symptomatic of the decline that had begun in the late 1990s but had turned sharply from 2000 to 2008, severely impacting social well-being.

During this period, the country experienced political crises accompanied by economic decline with profoundly negative consequences for development and the eradication of poverty. GDP fell by more than 40 per cent between 2000 and 2008 and hyperinflation peaked in September 2008 at about 500 billion per cent before the Zimbabwe dollar went out of circulation.

Poverty in Zimbabwe, and its effect on children

As is so often the case with economic decline, it is the poor who suffer the most, and in Zimbabwe, poverty has a child's face.

Poverty is defined both monetarily and non-monetarily and is measured using wellbeing indices such as household characteristics, asset ownership, access to productive resources, goods and social services. 78 per cent of Zimbabwean boys and girls live in consumption poverty, which means they lack the minimum amount to purchase a basket of necessary commodities. 26 per cent of children in the country live in extreme poverty, meaning they are deprived of two out of seven basic dimensions: access to shelter, sanitation facilities, safe drinking water, information, food, education and health. Rural children are harder hit and deeper entrenched than their urban counterparts.

Children born into or hit by poverty are more likely to suffer from ill health and under nutrition. They are more susceptible to HIV and are at an increased risk of violence, abuse and neglect. If a child comes from a poor and energy-deficient household that lacks adequate water and sanitation, the chances of them remaining trapped in poverty and social deprivation are very high - with lifelong implications for them, their children, and society as a whole.

As men and women of bread-winning age leave the country to seek work, family structures break down and children are left neglected and vulnerable to abuse and exploitation. The absence of adults in the home is compounded by HIV-related deaths which have orphaned one in four children. Poor nutrition in an agrarian and subsistence farming economy is exacerbated by climate-related shocks such as droughts and floods.

Responding to child poverty is the thread that links UNICEF programming across its different sectors. Because poverty is multidimensional, it has implications on the wellbeing of children in terms of their health, nutrition, education, and protection. Recognizing that the most effective way to address the poverty challenges in Zimbabwe is to do so systemically, UNICEF constantly works to integrate an equity approach – reaching the most marginalized children first – across its programmes, using reliable data to buttress planning.

While gains may be achieved in specific sectors, it is by creating linkages across sectors that results can really have an impact. With better integration in programming across the UNICEF sectors, it is possible to systematically and holistically address the poverty challenges that children face.

Source: Update of the Situation Analysis of Children and Women in Zimbabwe January 2015

TRANSITION FUNDS

The beginnings of recovery through pooled funds – a coordinated, multi-donor effort

In response to the near-collapse of social services and the humanitarian crisis in 2008, UNICEF helped to establish the harmonized funding instruments – the Transition Funds. These were mechanisms to pool resources together and coordinate service provision, while ensuring that social programmes were aligned with government priorities and avoided duplication.

The Health Transition Fund (HTF) was established to mobilize resources and reverse the decline in Zimbabwe's once-robust primary health care system. The HTF sought to immediately improve maternal, newborn and child health and nutrition, increase availability of essential medicines and vaccines, train and retain key health personnel, and provide technical support to the health ministry in policy, planning, and finance.

By 2014, Zimbabwe had managed to bend the high maternal mortality curve after twenty years of continuous incline: in 2009, an estimated 3,840 mothers were dying annually but by 2014, the figure had declined to 2,456. Within five years, Zimbabwe had averted 1,384 maternal deaths annually. Similarly, in 2009, 37, 600 deaths of children less than five years of age were being recorded annually but by 2014, the figure had come down to 30,000, meaning the country had averted 7,600 deaths of children annually.

In the Water, Sanitation and Hygiene (WASH) sector, significant resources were channeled through UNICEF to support interventions in 33 rural districts. The British government, through the Department for International Development, committed GBP 33 million and a further $6 million was received from the Swiss government. By December 2016, the programme had installed 1, 620 new boreholes, provided 1, 600 schools with gender-sensitive sanitation facilities, assisted 2, 500 villages to be declared free of open defecation, and rehabilitated 32 piped water schemes and over 10, 000 boreholes. These interventions had greatly transformed the lives of up to 3 million Zimbabweans, particularly women, girls and children living in the 33 rural districts.

Under the urban WASH programme, UNICEF's focus was on restoring WASH infrastructure in 14 towns that had been severely impacted by the cholera outbreak of 2008. The Australian government was the only donor, providing $26.7 million to improve access to water supply and sanitation services and hygiene practices for 350,000 people.

The Education Transition Fund (ETF) was the first to be set up in 2009 to mobilize resources for the education sector and ensure equitable access to quality education. Managed by UNICEF, the ETF was created to respond to acute shortages of teaching and learning materials, textbooks and supplies in schools where most were operating on a 1:10 textbook to pupil ratio. One of its earliest achievements was to procure and distribute 23 million textbooks to schools in Zimbabwe, thereby bringing down the textbook-to-pupil ratio in core subjects to 1:1.

The 2014 Multiple-Indicator Cluster Survey (MICS) showed that these and other efforts to improve quality through school improvement grants, training of teachers, and curriculum review had begun to bear fruit. Pass rates were starting to improve in both primary and secondary schools, the primary completion rate had risen from 42.6 per cent in 2009 to 98.9 per cent in 2014, and the secondary school attendance rate rose from 44.8 per cent to 57.5 per cent during the same period.

The Child Protection Fund (CPF) was set up to support implementation of the National Action Plan for Orphans and Vulnerable Children – to address the needs of the large number of orphans and other highly vulnerable children in Zimbabwe affected by increasing levels of poverty.

The CPF focused on reducing poverty in approximately 55,000 extremely poor and labour-constrained households by providing them with bi-monthly, unconditional cash grants (the Harmonized Social Cash Transfer Programme), expanding protection services (legal, welfare, judicial) to child survivors of violence, exploitation and abuse through the national case management system, and providing education assistance (fees, school supplies) to poor orphans and other vulnerable children through the Basic Education Assistance Module (BEAM).

By the end of 2015, 52,000 poor households in 19 districts were receiving regular cash transfers. Of these households, 83 per cent had children living in them. Child protection and welfare services were provided to 35,460 children in 37 districts through a strengthened social welfare workforce. A successor CPF is currently in place and is supporting attainment of the third generation National Action Plan for the period 2016-2020.

The table summarises key MICS results:

INDICATOR	2009	2014
Maternal mortality	960/100,000	614/100,000
Under-five mortality	94/1,000	75/1,000
Full immunization	37	70
Prevalence of stunting	35	28
Exclusive breastfeeding (6 months)	26	41
Use of improved drinking water	73	76
Use of improved sanitation	60	62
Open defecation	33	32
Net intake rate (primary school)	74	73
Net attendance (primary school)	91	94
Net attendance (Secondary school)	45	57
Children under 5 whose births are registered	39	32
Women (20-49 years) married before 18	32	33

The drivers of success

Zimbabwe's achievements are the result of strong evidence-based programming, coordinated partnerships, strong donor support, and a people's resilience. While outcomes have been solid, the recovery is by no means complete. Gains made are tenuous, and while the data reveals gains, averages can mask inequities, geographical disparities and uneven quality.

The gains were built on existing systems. Strong coordination, effective government leadership in each of the sectors, and successful partnerships with NGOs and donors, enabled the programmes to be delivered efficiently. UNICEF as the fund manager instituted robust programme and financial monitoring systems to minimize operational and reputational risks and ensure value-for-money. Evidence-based programming underpinned by good data allowed for targeted and equitable programming. This data-driven approach also enabled results to be accurately tracked and for the strength of the programmes to be assessed. A key outcome of the coordinated approach has been the ability to innovate and improve implementation in response to lessons learned.

Renewed commitment is needed

Agreements underpinning all four transition funds came to a close in 2015 and 2016, and as the country still grappled with a limited fiscal space, the need to renew donor commitments has become imperative to sustain gains made.

Zimbabwe's story is still unfolding. It is a long journey and the gains can easily be lost. UNICEF was able to help Zimbabwe come back from the brink of near-collapse, but the path to full recovery is still lengthy and precarious as the country continues to face challenges. The new rallying call – "sustaining the gains" does not mean that Zimbabwe has reached its destination – no nation can ever make this claim – but rather that important steps have been made, in spite of the continuing economic crisis and a challenging development context. The gains made need to be consolidated and urgent investment is needed to sustain the recovery, and build resilience and accountability.

THE UNICEF ZIMBABWE COUNTRY PROGRAMME STRUCTURE

ZIMBABWE COUNTRY PROGRAMME OF COOPERATION 2016–2020

HEALTH	HIV/AIDS	WASH	NUTRITION	EDUCATION	CHILD PROTECTION
Quality Maternal, Newborn & Child Health	Proven HIV Prevention & Treatment	Improved & Equitable WASH Usage	Quality Child Survival & Growth Services	Equitable Access to Quality Inclusive Educations	Improved Child Protection & Response Systems

SOCIAL INCLUSION
Improved Evidence-based Policy Environment and Systems for Disadvantaged and Excluded Children

CROSS-SECTORAL PROGRAMME
Strengthening the effectiveness and efficiency of UNICEF and partners to deliver results across all programme areas

CHAPTER 1

Health

Sister Mtasa,
Hurungwe District Hospital

Health at a Glance

The focus of the health sector under UNICEF is to prevent maternal, newborn and child mortality, and strengthening the sector according to the framework set out in the Health Development Fund.

RECOVERING FROM CRISIS TO PROVIDE ACCESSIBLE CARE FOR FAMILIES

COMMITMENTS

- Strengthening the capacity of health systems to deliver quality maternal, new-born, child and adolescent health care at all levels of service delivery
- Strengthening partnerships, commitment and accountability of Government and other partners to plan, budget and sustain innovative financing mechanisms for the scale up of low-cost, evidence-based health interventions
- Increasing demand and utilization of quality maternal new-born, child and adolescent health services at all levels of service delivery, including among disadvantaged and marginalized groups

KEY INTERVENTIONS

- Maternal and newborn health
- Child health
- Health systems strengthening
- Health emergencies and resilience
- Knowledge management and implementation research

TARGET RESULTS BY 2020

- Increased proportion of pregnant women attending at least four ANC visits from 70 per cent to 90 per cent
- Increased skilled birth attendance from 80 per cent to 90 per cent
- Increased proportion of newborns receiving three post-natal visits within 28 days of delivery to at least 60 per cent
- Increased coverage of children fully immunized by the age of one year from 69 per cent to 90 per cent
- Increased proportion of children 0-59 months with diarrhoea treated with oral rehydration salts (ORS) and zinc from 14 per cent to 60 per cent
- Increased proportion of children 0-59 months with suspected pneumonia treated with appropriate antibiotics from 34 per cent to 60 per cent
- Increased proportion of children 0-59 months with malaria treated with ACT (artemisinin combination therapy) or other appropriate antimalarials from 79 per cent to 90 per cent
- Increased proportion of children aged 0-59 months sleeping under an insecticide treated net from 27 per cent to 80 per cent

SUSTAINABLE DEVELOPMENT GOALS FOR HEALTH

- **SDG Goal 1:** End poverty in all its forms everywhere

- **SDG Goal 3:** Ensure healthy lives and promote well-being for all at all ages

- **SDG Goal 5:** Achieve gender equality and empower all women and girls

Sister Mtasa in the delivery ward of the Hurungwe District Hospital

A once-strong health system that faced collapse

In the 1980s and 1990s, Zimbabwe's health system was arguably one of the best in sub-Saharan Africa. It had an efficient structure, organized through national governance, provincial leadership and well managed at district level. More than $40 per person was spent on public health in 1991 – the highest in the region – and information and logistical systems functioned well.

Over the past decade or more, this system was progressively undermined, as funding fell. In 2009 the budgetary allocation for public health had fallen to just over $6 per person. Consequently, the sector underwent a loss of professional staff, a decline in drugs and equipment and a steady decay in infrastructure as facilities could no longer cover their running costs. Outdated policies and procedures meant that by 2008, the health system was in a state of near collapse.

Previously uncommon disease epidemics, became more frequent. A cholera outbreak claimed 4000 lives in 2008 and 1600 young children died of measles in 2009. There was a rapid deterioration in maternal, new born, child and adolescent health indicators, which derailed Zimbabwe's ability to achieve the Millennium Development Goals (MDGs). HIV spread rapidly, and significant challenges with availability of Anti-Retroviral Therapy meant an increase in HIV/AIDS mortality and morbidity amongst mothers and children and reduction in life expectancy of the general adult population.

From critical to stable – The Health Transition Fund helps to bring the sector back from the brink

Between 2012 and 2016, under the pooled funding modality the Health Transition Fund, the sector began to strengthen. With the rallying call to 'build back better' the UNICEF-managed fund mobilized over $50 million annually, enabled streamlined support from partners, and health service delivery began to show improvements.

The focus was to scale up high-impact maternal, newborn and child health interventions, with the goal of ensuring that 80 per cent of pregnant women, new-born babies, children and adolescents would have equitable access to high impact, cost-effective and quality health interventions. Obstetric and newborn health had previously been the most underfunded health programme in the system, but in this period mothers, pregnant women, newborns and children under-five received improved, life-saving services and the system began to strengthen.

The other three emphases in the HTF's strategy for recovery were Human Resources for Health – which included the training of doctors and midwives as well strategies for staff retention; providing and distributing vital medicines, vaccines, blood and commodities, and giving strong support to health policy, planning and financing.

The Zimbabwean health system's capacity to recover has been attributed to a strong institutional memory, clarity of overall Government and Ministry strategies; the availability of motivated staff; development partner support in addressing key health services delivery, bottlenecks and its focus on essential, high impact interventions based on the key health system pillars.

Signs of recovery

By 2014, coverage of key reproductive maternal, newborn, and child health interventions had increased and, for the first time in almost twenty years of continuous deterioration, Zimbabwe had managed to bend downwards the rising curves in maternal and under-five mortality. The 2014 Multiple Indicator Cluster Survey, the 2012 Census findings, the 2013 Inter Agency Group for Maternal Mortality Estimate and the 2015 ZDHS all indicate a recovery.

THE HEALTH CRISIS AND RECOVERY IN INDICATORS

	1990	2010 / 2011	2015
Maternal mortality	390 deaths per 100,000 live births	960 deaths per 100 000 live births	651 deaths per 100,000 live births
Birth attended by skilled provider	69%	66%	78%
Under-five mortality	102 deaths per 100,000 live births	84 deaths per 100,000 live births	69 deaths per 100,000 live births
	2005	2010	2015
HIV prevalence 18-49 years old	18.1 %	15.2%	13.8%
Stunting	35%	32%	27%

(2015 ZDHS)

Liverpool School of Tropical Medicine (LTSM) 2016 Survey found that in the 47 district level hospitals (both government and mission) surveyed, all had at least one medical doctor available, compared to 96% in the 2015 Survey. Some facilities (34%) had four or more doctors, which when compared to the situation in March 2012 where PMD reports indicated there were 21 hospitals without any doctor at all, show these improvements are very significant. The 2016 HFA found that most (87%) of the doctors available were present in the facility on the day of the survey, an improvement on 2014 when 73% were present.

Source: LSTM Centre for Maternal and Newborn Health: Independent Evaluation of the Health Transition Fund in Zimbabwe

From recovery to rehabilitation: A new modality in the Health Development Fund

The Health Development Fund, 2016-2020, which replaced the Health Transition Fund continues to address the slippage that had occurred during the general decline. This sectoral response was implemented through two programmatic areas and five systemic interventions.

The HDF has seven pillars: maternal, newborn and child health (MNCH), sexual reproductive health and rights; procurement and provision of pharmaceuticals; human resources, results-based financing, policy and monitoring and evaluation and innovation and research.

MATERNAL HEALTH AT HURUNGWE DISTRICT HOSPITAL

Taurai Mukasha is 20 years old and is lying in bed nursing her one-day-old baby, Anashe Muvumo with a look of contentment on her face.

Just hours earlier, the look on her face would not have been so peaceful. She lives two kilometres away from Hurungwe District Hospital and when she arrived at 3 am she was already in labour and had to hire a car to get there.

Taurai was aware that it was important for her to deliver at hospital, as she had been warned in her ante-natal check-ups that she had high blood pressure and there might be complications. And so when she began to haemorrhage after delivering her baby, she was terrified, and thought she was going to die but thanks to the prompt care she received to stop the bleeding she is now well and smiling at her healthy newborn baby.

Sister Mtasa, the Acting Sister in Charge, explains that despite the ageing infrastructure of the hospital and the rudimentary equipment, the staff on duty were able to act swiftly to save Taurai's life. In the labour ward, a table has been covered with the paper inserts from pharmaceutical boxes, to provide a clean surface. A post-haemorrhage kit, essential medicines and suction equipment - the supplies needed to deal with maternal or neonatal complications are neatly arranged on it.

Hurungwe hospital services a catchment of 28 000 people and illustrates how limited resources are being used in an efficient way. Fifteen years ago, Taurai and other labouring mothers may not have been so well cared for. Now, the hospital makes do, and follows an organized system for screening, diagnosis, admissions and outpatients. A brief tour of the premises leads from two wards - a male and a female one (there are plans to build a maternal wing) to a three-room outpatient department.

The wards have recently been painted and the ceilings fixed. In the other wing, a paediatric department spills out onto the corridor where a scale is hung up from the rafters outside, and screening is done on the threshold. A makeshift laboratory neighbours the HIV testing and counselling room where young volunteers make their way through piles of filing.

Sister Mtasa is concerned about the limitations of infrastructure, equipment and supplies, in particular, the lack of adequate space for lab testing of TB and other samples. Despite these concerns, the overriding picture is not one of despair but rather an energized positive attempt to make the best of things.

The Community pitches in too, with the Health Committee raising funds from surrounding villages to upgrade the Waiting Mothers Shelter from one room to six.

"I thought I would come next week, I didn't expect to go into labour so early."

Left Taurai Mukasha and her newborn baby

"In the old days we gave birth at home. I prefer it now that we go to hospital."

Maternal Mortality – a major success in the last ten years

In the last few years, Zimbabwe has managed to avert an estimated 1,384 maternal deaths and 7,600 child deaths as a result of the combined interventions. Access to maternal and child health services has increased significantly. The biggest improvement is in post-natal care of newborns, where 85 per cent of newborns were receiving a health check while in facility or at home following delivery in 2014, or a post-natal care visit within two days after delivery, compared to 11.7 per cent in 2009. This is an over six-fold increase.

The second highest improvement was in the post-natal care of mothers with 78 per cent of last live births receiving a health check while in facility or at home following delivery (compared to 21 per cent). This is an increase of 187 per cent. Full immunization coverage improved by 88 per cent (Zimstat 2014b).

THE MATERNITY WAITING HOME – PLUMTREE HOSPITAL

Esther Nyoni arrived at the maternity waiting ward in January and has waited out her last trimester here. Expecting her first baby, she is just 16 and her boyfriend is in Johannesburg, South Africa looking for work. She worked as a shopkeeper for a while to raise the money to come here. Her mother doesn't work, so there was little income to rely on to travel to the Plumtree District Hospital. It's good to be at the facility, she says, because the other girls provide company and support. She developed chest problems, and was able to seek help from the health workers. When her food stuff ran out, she and some of the other women received a weekly ration of rice from the hospital. Her relatives in town are able to help with other small necessities like soap.

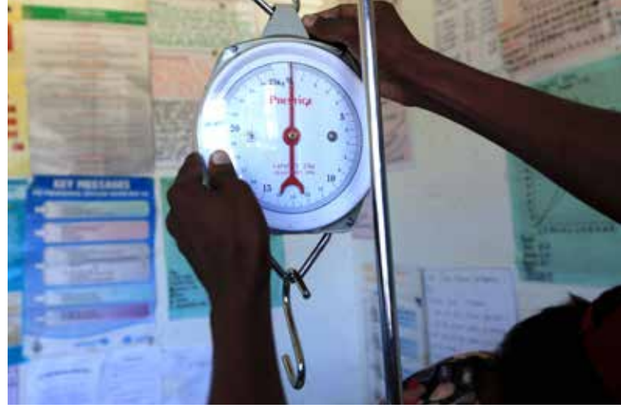
Although she is far from home, Esther is glad to be at the waiting mothers' ward because otherwise she would have no choice but to deliver at home when the time came, and she is worried about what would happen if there were complications. Her family, like many in the rural parts of the district, are subsistence farmers and were badly hit by the drought last year. At least for now, Esther can rely on the relative safety of a hospital delivery.

Providing essential pharmaceuticals and medical supplies

Prior to the crisis in the health sector, the Zimbabwean government used to procure essential medicines. Since this ceased, donor support has become the primary funding source for essential medicines – placing health facilities in a vulnerable position as international support is threatened. Low availability of medicines at health facilities can lead to loss of confidence in the health system by the population. For example, if somebody has already spent money on transport to a clinic, and the drugs are unavailable, they are less likely to return and less likely to stick to their regimen.

A further risk of not maintaining regular supplies of pharmaceuticals is that facilities will start to charge for drugs. This in turn creates inequalities, as it can lead to catastrophic spending in a household. To cover the health care costs of a sick family member, assets might be sold, which has a further impoverishment effect on households.

By 2016, more than 85 per cent of primary health care facilities were stocked with at least 80 per cent of selected essential medicines most of the times – a crucial achievement but also a fragile one as availability of essential medicines is extremely sensitive to fluctuations in funding. The anticipated effects of fund decreases include issues of access, quality, equity – a backward slide that Zimbabwe simply cannot afford to make.



Results-based financing: a finance system that depends on efficient service delivery

Before the introduction of the Health Transition Fund and as a result of reduced government funding, health facilities had to find funding to cover all costs aside from staff salaries. This meant that many clinics introduced user fees. To counter this, and to enable health facilities to run efficiently, the Health Transition Fund provided a fixed quarterly grant to 48 facilities in 42 districts, varying in amount from $750 to $1,500 a month, depending on the type of health facility, to cover their running costs.

Public primary facilities receiving these grants were then able to use the grants as operational budget, thereby abolishing user fees, particularly for pregnant women, lactating mothers and children under five. By 2016, many more rural primary health centres were providing services free of charge to these populations. Under the Health Development Fund, the disbursements are now linked to results – how well the facility uses the funding to deliver improved quality of service. Ongoing financing is dependent on results.

At rural clinics there is now almost full coverage of free services but patients referred to higher levels still have to pay. The full removal of user fees continues to pose a challenge, since available funds are not sufficient to cover running costs. A voucher mechanism is in the process of being introduced for referrals. The current objective is to improve national capacity for health financing across all health service delivery levels with special emphasis on the most peripheral health facilities.

Human Resources for Health

To curb the significant exodus of skilled health professionals, a quarterly retention allowance for midwives, nurses, doctors and managers was introduced and is supported by development partners. Using this strategy, more than 70 per cent of health workers have been retained. There are now at least three doctors at district hospital level in 75 per cent of the district hospitals. By 2016, 77 per cent of health facilities had comprehensive emergency obstetric and newborn care, up from 70 per cent in 2015. More than 2,500 midwives had been trained and by 2016, 89 per cent of health facilities had at least one health worker trained in integrated management of neonatal and childhood illnesses. This success has been largely due to the allocation of post-allowances which stopped the outflow of human resources to other countries.

Support in policy development and system strengthening

UNICEF's support to the health sector has included a drive to strengthen governance, with an appropriate level of decentralization and accountability mechanisms. These include providing technical support to generate evidence-based strategy and work plans; strengthening monitoring and evaluation, reporting and reviews; data generation; revision of policies; coordination of supply chain management and consolidating all aspects of the national health policy and strategy for quality assurance in health, such as infection control.

By 2016, 77 per cent of health facilities had emergency and obstetric care, but quality remains an issue

Current prognosis and funding gaps

The Government of Zimbabwe is committed to recovering the health sector, as evidenced by increased budgetary allocation. In 2016 the per capita expenditure was allocated at $24.35, up from $23 in 2014 and the $5 mark 2008/9. However, by 2017 this amount had dropped again to $20.54. In order to meet the needs of the population by 2020, Zimbabwe should be spending $42 per capita, or a projected $ 681.91 million annually on health. The SADC average is $134.90 per capita. Financing for the sector continues to face challenges, including lack of policy clarity, low investment levels into the economy, significant levels of national debt, and a general slowdown in regional and global economic performance.

Since the onset of the Health Development Fund, funding has dropped by 35 per cent while the needs are expanding. The consequences of not meeting the funding gaps include challenges such as how to maintain motivated health workers, keeping facilities stocked with essential medical supplies, abolishing user fees and maintaining community buy-in to seek and maintain health services.

However, the gains made are fragile, and the needs remain significant. The current Health Development Fund needs to be adequately supported in order to sustain the recovery and prevent more loss of life.

The Health Transition Fund Program duration: 1 January 2012 to 31 December 2015	Initial program budget: $435,336,88 Actual budget: $235.222.354 Actual expenditure: $207.743.840 Donors: Governments of UK, Ireland, Sweden, Norway, and Canada. EU Fund manager UNICEF
Health Development Fund Program duration: 2016 to 2020	Initial program budget: $681.91 Million (total amount for five years) Donors: Governments of UK, Ireland, Sweden, Norway, and Canada. EU

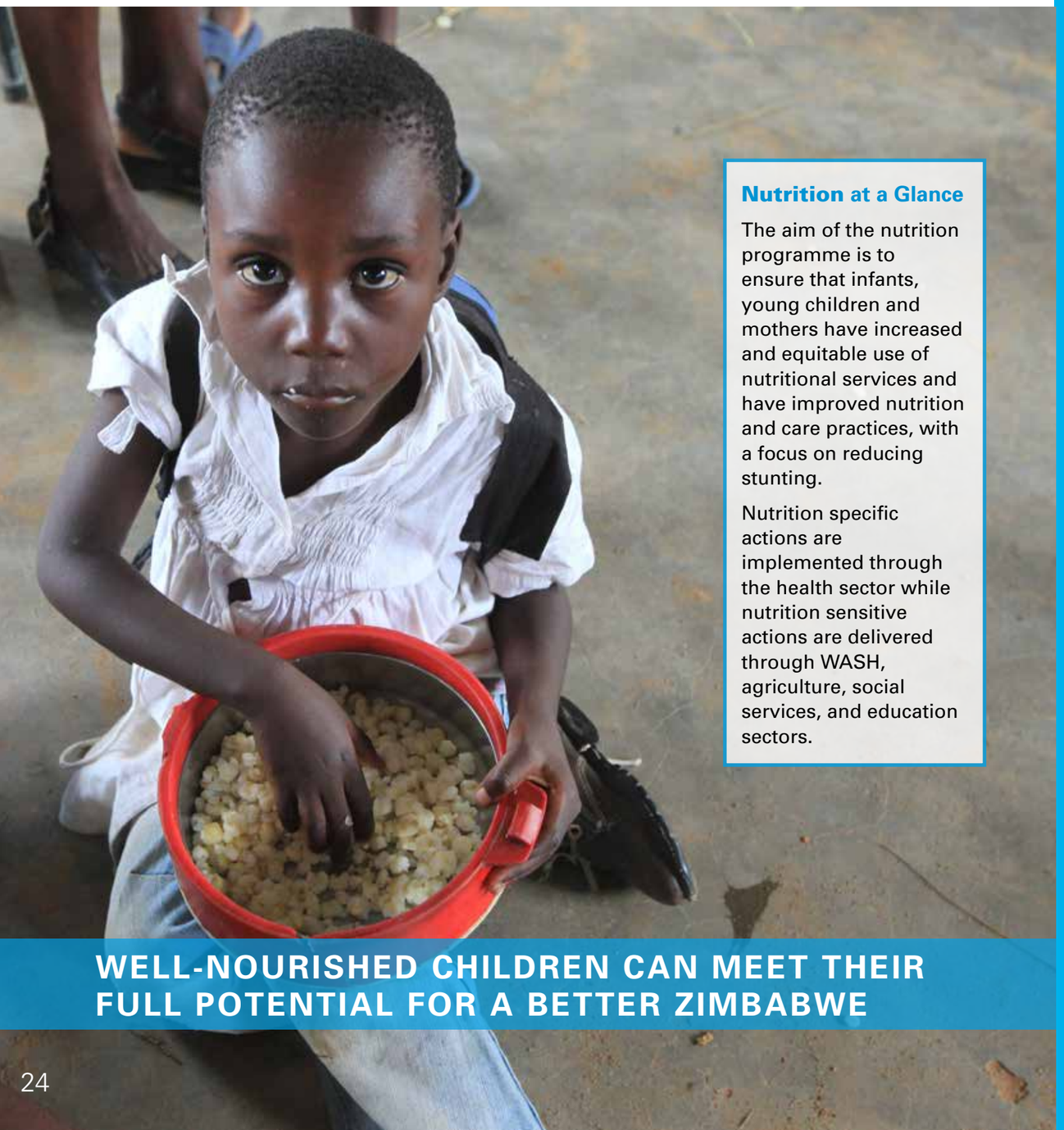
Remaining challenges

The health sector needs to focus on improving the quality and equity of health services for mothers, newborns and adolescents, including family planning. In addition, hard to reach communities, religious and other socio-cultural objectors should be prioritized. Preventing HIV among women and girls of reproductive age is critical to reducing child mortality and improving maternal health. UNICEF's efforts to implement more comprehensive programming, better coordination and maximizing efficiencies among all actors must be maintained.

The four health system blocks that were supported through the Health Transition Fund must continue to be funded throughout the current and ongoing phase as they are crucial for making the system fully functional throughout the implementation of the Health Development Fund's strategic programme. Despite the declining maternal and child mortality rates, the number of deaths remains unacceptably high. In order to push the maternal and child mortality curve down further, there is an absolute necessity to find continued support for the health sector.

CHAPTER 2

Nutrition



Nutrition at a Glance

The aim of the nutrition programme is to ensure that infants, young children and mothers have increased and equitable use of nutritional services and have improved nutrition and care practices, with a focus on reducing stunting.

Nutrition specific actions are implemented through the health sector while nutrition sensitive actions are delivered through WASH, agriculture, social services, and education sectors.

WELL-NOURISHED CHILDREN CAN MEET THEIR FULL POTENTIAL FOR A BETTER ZIMBABWE

COMMITMENTS

- Equity-focused national policies, legislation, strategies and plans are adopted for scaling up of high impact critical nutrition interventions
- Strengthened sub-national capacity to implement and coordinate multi-sectoral scale-up of services to protect, promote and support optimal infant and young child nutrition and related maternal nutrition
- Children, caregivers and communities in selected districts apply optimal nutrition and care practices; and seek preventive, promotive and curative nutrition services

KEY INTERVENTIONS

- Protection, promotion and support of optimal breastfeeding
- Complementary feeding;
- Hygiene and early child care and development
- Micronutrient nutrition and anaemia prevention services
- Nutrition for women during adolescence, pregnancy and lactation
- Care for children with severe acute malnutrition

SUSTAINABLE DEVELOPMENT GOALS FOR NUTRITION

- **SDG Goal 2:** End hunger, achieve food security and improved nutrition and promote sustainable agriculture

- **SDG Goal 3:** Ensure healthy lives and promote well-being for all at all ages

TARGET RESULTS BY 2020

- Proportion of children breastfed within one hour of birth (timely initiation of breast feeding) increased from 58.9 per cent to 70 per cent, and exclusively breastfed up to five months from 41 per cent to 60 per cent;
- Proportion of children who are fed complementary foods in a timely manner (introduction of solid/semi-solid/soft food) increased from 87.3 per cent to 92 per cent, and fed a minimum acceptable diet increased from 11 per cent to 50 per cent;
- Proportion of children who receive vitamin A supplements twice yearly (full vitamin A supplementation coverage) increased from 32.3 per cent to 80 per cent;
- Proportion of the population consuming adequately iodized salt at household level increased from 56 per cent to 90 per cent; and
- The number of districts with multi-sectoral costed and sustainable plans that include clear targets on reducing stunting increased from zero to eight districts.

The right to a healthy start: the first 1,000 days

One of the most basic rights a child has is the right to a healthy diet providing the necessary nutrients for growth and development. This diet starts before the child is born – a mother's ability to access good nutrition during her pregnancy, to breastfeed exclusively for at least six months and to provide a varied diet including breast milk for the first two years, will benefit a child for a lifetime. Known as the first 1000 days, this window period enables optimal brain and physical development, a solid foundation for future learning, strength and the ability to recover from childhood illnesses. Failure to meet this basic right causes damage that will last a lifetime and increase the risk of stunting. There is no cure for stunting and its effects are irreversible.

But, through no fault of their own, not all mothers or families are able to provide this kind of head start for their children. In Zimbabwe, data from the ZDHS 2015 details a picture of what is sometimes known as the invisible emergency. Of children under-five surveyed, 8 per cent were underweight, 27 per cent were stunted, and 3 per cent suffered from wasting.

Malnutrition doesn't always look like an emergency. So-called 'invisible malnutrition', which does not have immediate health effects, continues to gnaw at Zimbabwe's potential. Seemingly, the child is well and developing, but a failure to thrive is not always dramatic. If children do not receive enough Vitamin A or iodine for example, brain development is affected and the body cannot support adequate growth. The IQ is affected, and the cascading consequences lead to poor performance in school, early school drop-out, unemployment and continued poverty. This has a negative implication for the economy.

UNICEF has adopted a three-pronged approach to malnutrition in Zimbabwe: prevention, treatment and emergency response. These are formalized into three categories, namely stunting reduction, Community Management of Acute Malnutrition (CMAM), and nutrition in emergencies.

LIFE-SAVING TREATMENT AT THE MPILO STABILIZATION CENTRE

The Stabilization Centre at Mpilo Central Hospital in Bulawayo, Zimbabwe's second city, is a child-friendly environment where mothers and caregivers spend time – usually a week or more – while their infants recover from malnutrition. In this unit they are stabilized, monitored, treated with therapeutic milks (F75, F100) and transitioned to ready-to-use therapeutic food (RUTF).

Matron Sithole is a dedicated health professional in charge of managing acute malnutrition at Mpilo Hospital. He is enthusiastic about the work his hospital does, exchanging greetings and words of encouragement with each nurse he passes, and pausing to note the wellbeing of patients.

More than 80 per cent of hospitals in Zimbabwe have a facility where babies and children are screened for malnutrition at the first point of entry, along with HIV and TB testing. A simple screening armband (mid-upper arm circumference tape) is placed around the upper arm to detect if there is cause for concern. If the circumference measurement is in the green section, all is well, but yellow signals wasting and need for intervention, and red shows that the wasting levels are severe. Combined with the weight and height ratios, health workers are able to pick up a problem and either admit the child for outpatient treatment, or place them into an inpatient treatment programme such as the Stabilization Unit at Mpilo Hospital.

When a child is malnourished, timely treatment is important.

In the unit, there are currently 16 patients – it accommodates 24. The group feeding room is full of women of differing ages, and babies and toddlers receiving food with varying levels of enthusiasm. Normally, a room of this size, with 16 children under 24 months would be filled with high-energy noisy chaos, toddlers on a mission of curious enquiry. Not so in this space. The symptoms of malnutrition include apathy and listlessness – a failure to thrive.

Primrose Ndlovu is 21 years old. It was difficult for her to bring her 18 month-old baby to the hospital because at home, she is the only one caring for the family. When Primrose's mother died, it was left to her to take responsibility for her siblings of four, eight and 13 years old. But when her baby, Lungisani, developed a swollen body and what looked like burns on his feet and ankles, she decided she had to leave her siblings with their stepfather and travel to Bulawayo.

Oedema manifests in malnourished children and signals the need for urgent intervention, but luckily for Lungisani he responded to the treatment within ten days and is beginning to stabilize.

Primrose's circumstances are not unique. Endemic poverty, loss of one or both parents and illness at home mean a labour-constrained household where there is no breadwinner. Primrose and her family have been surviving on food disbursements from the Food for Work programme.

Primrose Ndlovu and Lungisani

Malnutrition is not caused by lack of food alone. It is exacerbated by a lack of variation in the diet – common in a country which relies heavily on maize as the main staple. Frequent diarrhoea-based illnesses caused by unsafe drinking water can also prevent vital nutrients from being absorbed. Malnutrition, like child poverty, is a multi-dimensional problem requiring an integrated response. Primrose's stay at the Mpilo Stabilization Unit will include counselling and advice on the best strategies to feed Lungisani and keep him healthy after discharge.

Treatment: Working to end stunting in Zimbabwe's children

An estimated 1 million children in Zimbabwe suffer from malnutrition. Treatment and prevention of both acute (wasting) and chronic (stunting) malnutrition significantly contributes to child survival. Treatment of acute malnutrition is life-saving. With severe acute malnutrition, the risk of death is nine times higher than in children who are well nourished.

Prevention: Community-based management of malnutrition (CMAM)

Prevention and home-based programmes are critical to reduce stunting in Zimbabwean children. These take the form of screening and monitoring in health centres, social and behavior change communication programmes for appropriate feeding practices, and community-based outpatient care.

Only 1 per cent of cases need to be hospitalized. The rest can recover at home in the Community-Based Management of Acute Malnutrition Programme (CMAM).

Dealing with invisible malnutrition by being vigilant within communities

Malnutrition is not always an obvious or common phenomenon, so it is necessary to actively seek out the patients who need treatment and care. Growth monitoring promotion is necessary on an ongoing basis in clinics across the country, and extends beyond the formal health facilities. Community volunteers are critical, with Village Health Workers fulfilling the role of lay-educators, that provide information to families at risk, and are trained to spot the signs of malnutrition. A strong outpatient system enables parents to go home with a supply of RUTF and allow a home-based recovery process.

Ready-to-use Therapeutic Food (RUTF) for management of acute malnutrition

"Look at how much RUTF we have in stock!" enthuses Matron Sithole, unlocking the storeroom to reveal stacks and stacks of cartons of life-saving nutrient sachets. RUTF, the 'miracle food' in ready-to-use sachets that can be administered straight to the child's mouth, is one of the key means to treat severe malnutrition, and UNICEF prioritizes procuring and delivering it to hospitals and clinics. A nutritious blend of peanut butter, oil, sugar, milk powder and vitamin and mineral supplements, RUTF is malnutrition's most effective treatment. Its texture and taste are suitable for young children as it doesn't require additional processing such as cooking before consumption, it doesn't contain water and is therefore resistant to contamination by micro-organisms, it doesn't require refrigeration, and has a long shelf life of up to two years without sophisticated packaging. Families who have received care in health facilities are therefore able to take a supply of easy-to-administer RUTF home with them until full recovery has taken place.

Right UNICEF provides health facilities with Ready-to-use Therapeutic Food (RUTF)

An integrated response to preventing stunting

RUTF is not the only nutritional response in UNICEF's armoury. Medical care and monitoring of cases go hand in hand with nutritional support and the community-based system. Vitamin A supplements for children under age five, iodized salt and other micro-nutrient fortified staple foods are promoted as part of a systemic and longer term response to the dangers of stunting and nutrient-poor diets. UNICEF works with the government to prioritize prevention, improve nutrition policies, and integrate treatment for acute malnutrition into community and health systems. Each of the UNICEF supported sectors – Health, WASH, HIV and AIDS, Education, Child Protection – provide opportunities for caregivers to receive nutrition information and for children at risk of malnutrition to be referred for support.

> "Look at how much RUTF we have in stock!"

Emergency preparedness and climate resilience

When emergencies and shocks hit a region in the form of droughts or floods, as happened in Zimbabwe in 2016 and then early 2017, the resulting food insecurity can cripple a country and devastate communities, but the worst affected are children. Crops fail, livestock die and water sources dry up. Those who rely on subsistence agriculture to survive need immediate relief. Emergency funds are set aside specifically to respond to malnutrition resulting from climate shocks, with escalated response during times of drought.

Why it works: The UNICEF approach to nutrition is proven, evidence-based and multi-sectoral

Preventing malnutrition requires a systemic approach

Part of the success of UNICEF's approach to nutrition is that interventions include different sectors. Part of Zimbabwe's story is that adverse weather events such as drought have a direct impact on food security – but the effects of climate change go beyond hunger. Children are adversely affected by water supplies too, and health systems need to be resilient to cope with an increased disease burden. Providing for the nutrition needs of children cannot be seen in isolation. Health, water, sanitation, HIV and AIDS, education and child protection services all play their part.

According to the Zimbabwe Vulnerability Assessment Survey of February 2016, on average, 35 per cent of households had inadequate water supply for domestic use. Mothers and children walked long distances to draw water, and many of the sources were contaminated, with risks of diarrhoea, typhoid and cholera rising in vulnerable communities.

Prevention therefore involves a range of programmes, from educating women on the important health benefits of breastfeeding, to working to improve the availability of water, sanitation and food security. Interventions by other sectors, like HIV and AIDS, WASH and social protection, enable children to be identified and treated for malnutrition.

Educated mothers have healthier children

45% of children with uneducated mothers are stunted compared to 9% of children with educated mothers (secondary education).

(ZDHS 2015)

A strong partnership with government and other sectors

The strengths of UNICEF's partnership with the Government of Zimbabwe are that systems are well-thought-out and responsive and programming is evidence-based. This makes it easier to coordinate relief across all sectors and to innovate, with interventions that respond to climate change and create more resilience in the population. Donors too are increasingly recognising the value that comes from working in a multi-sectoral approach and with other UN agencies. Several donor-funded initiatives emphasized the need for this multi-sectoral approach and funds were allocated to be administered jointly between UNICEF and other UN agencies.

Priorities going forward: Working to scale up and increase coverage

Preventing stunting

The prevalence of stunting in Zimbabwe has decreased, but remains too high at 27 per cent. Concerted efforts to reduce this crippling condition now include training nutrition ward coordinators to help multi-sectoral ward food and nutrition security committees to compile and implement the ward-level micro plans for stunting reduction.

The % of stunted children decreased from 32% in 2010/2011 to 27% in 2015.

The % of children with wasting has not changed since 2010/11, at 2%

The proportion of underweight children has decreased from 10 % in 2010/11 to 8% in 2015.

In Zimbabwe, only 8 % of children aged 6 to 23 months consume an acceptable diet.

(ZDHS 2015)

Treatment costs $100 per child for an eight-week period

Scaling up the multi-sectoral programmes to address acute malnutrition

In 2016, the programme to address acute malnutrition was operational in 19 districts, and significant gains were made. However, it still needs to reach a total of 63 districts to benefit all Zimbabwean children. The Global Acute Malnutrition (GAM) rate in Zimbabwe was at 5 per cent in 20 districts while the percentage of children who are severely affected and suffering from wasting sits at 2 per cent.

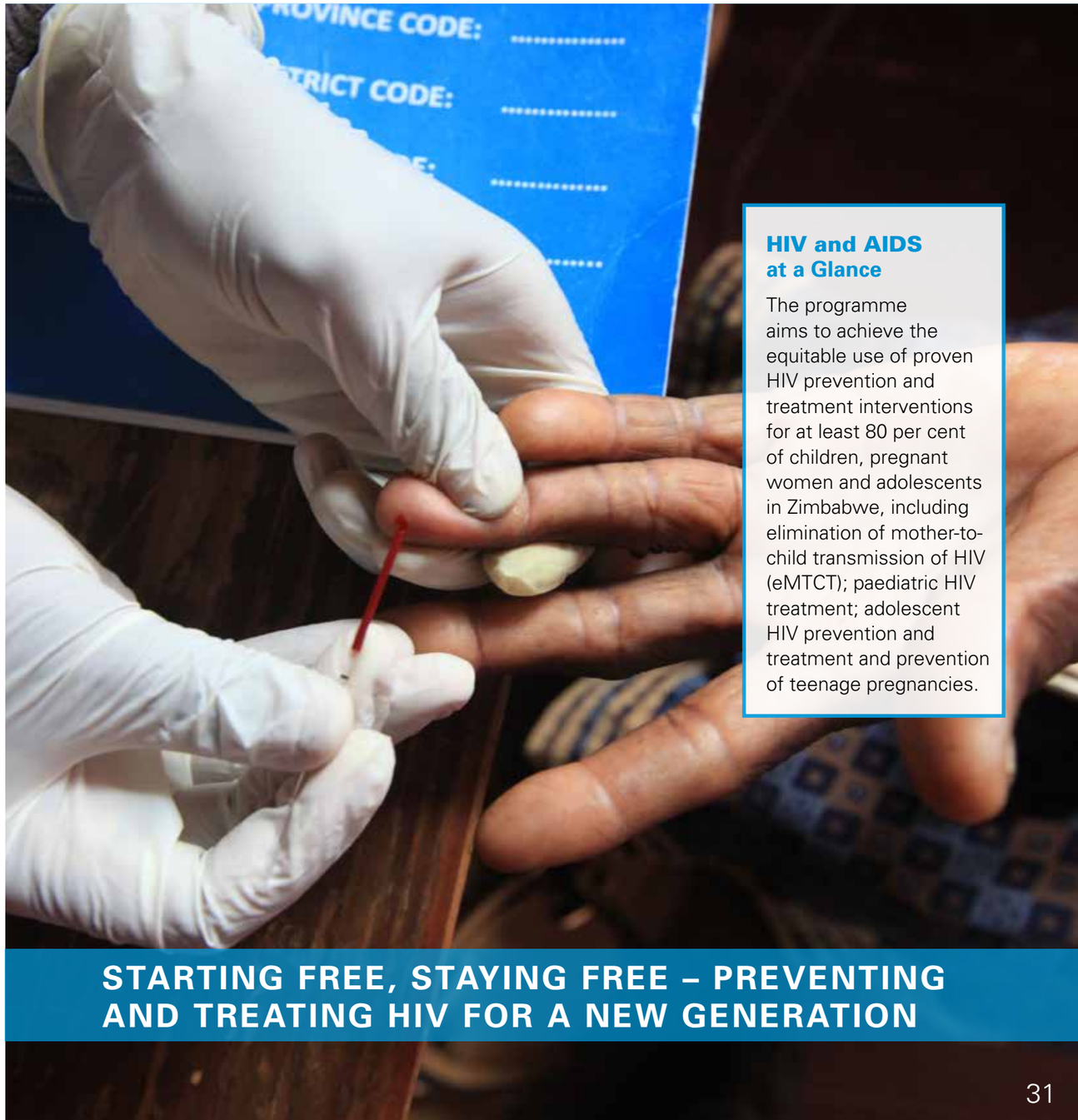
Although the 27 districts hard hit by drought did receive intensive assistance, they still have an unacceptably high level of global acute malnutrition (GAM) and the interventions made in those areas must be sustained and scaled to other districts. Treatment costs $100 per child for an eight-week period which, considering the lifelong effects of stunting and the implications for future generations, is a small price to pay.

Ensuring a healthy start for all children

Another key priority is to sustain the multi-sectoral initiatives for prevention of malnutrition. A comprehensive early childhood development package that incorporates optimal infant and young child feeding practices, water, sanitation and hygiene as well as food security and micronutrient provision is in process. Targets such as increasing the Vitamin A coverage to 80 per cent, can be met if funding is sustained. It is critical for Zimbabwe that its children do not get left behind through one of the most preventable challenges in a child's life.

CHAPTER 3

HIV



HIV and AIDS at a Glance

The programme aims to achieve the equitable use of proven HIV prevention and treatment interventions for at least 80 per cent of children, pregnant women and adolescents in Zimbabwe, including elimination of mother-to-child transmission of HIV (eMTCT); paediatric HIV treatment; adolescent HIV prevention and treatment and prevention of teenage pregnancies.

STARTING FREE, STAYING FREE – PREVENTING AND TREATING HIV FOR A NEW GENERATION

COMMITMENTS

- Increase national, provincial, district, facility and community capacity to provide essential HIV information and services for women, children and adolescents in targeted poorly performing districts
- Strengthen leadership, commitment, accountability and capacity for evidence-based planning and budgeting for scale up of HIV prevention and treatment interventions for children and adolescents in targeted districts
- Enhance capacity of children, adolescents and caregivers to adopt behaviours that empower them to prevent HIV and facilitate utilization of relevant HIV and AIDS services in targeted districts
- Integrate HIV and syphilis testing and treatment in the maternal, neonatal and child health
- Increase access to HIV and SRH prevention and treatment services for children, adolescents and young people
- Expand treatment for children, pregnant women and adolescents living with HIV
- Integrate HIV testing and ART follow up in nutrition programme
- Improving capacity, monitoring and accountability for HIV comprehensive services for children, adolescents, pregnant and lactating mothers at all levels from national to provincial

KEY INTERVENTIONS

- Full cascade of the elimination of mother to child transmission (eMTCT) of HIV
- Supporting HIV education and prevention in schools
- Strengthen programming in HIV and sexual and reproductive health rights for adolescents
- Keep HIV negative pregnant and lactating women negative
- Peer support for HIV children and adolescents on prevention and treatment including treatment adherence support
- Use of social media including the U-Report
- Early Infant diagnosis (EID) including use of Innovative approaches (PoC devices), Pediatric anti-retroviral therapy (ART); Tracking and follow up of HIV positive mothers and their babies in the community
- HIV testing (PITC of malnourished children); follow up of children on ART
- Enhancing the capacities of service providers on integrated HIV testing, counselling and treatment of children, adolescents, pregnant and lactating women as well as M&E
- Reducing barriers to utilization of services
- Planning and budgeting to scale up HIV services for children and women
- Building capacity for HIV service delivery from national to provincial, district up to health facility levels.
- Improving data quality, collection and reporting by age and gender

TARGET RESULTS BY 2020

- Coverage of triple drug regimens for all pregnant women living with HIV increased from 43 per cent to 90 per cent
- ART coverage increased from 38 per cent to 81 per cent for eligible under-15 year-old children and from 34 per cent to at least 81 per cent for eligible 10 to 19 year-old adolescents
- Per cent of eligible 10 to 19 year-old adolescent males who have voluntarily undergone medical circumcision increased from 18 per cent (10 to 14 years) and 15 per cent (15 to 19 years) to at least 60 per cent
- The rate of condom use at last sexual encounter among adolescents aged 15 to 19 years reporting multiple encounters in the last year increased from 62 per cent to 80 per cent

STATISTICS SNAPSHOT

- Zimbabwe's HIV prevalence rate sits at 14.7%, with an estimated 1,349,070 people living with HIV in 2015
- Every fourth Zimbabwean child has been orphaned by HIV
- Women have a higher prevalence rate at 16.7 per cent compared to men at 13.8 per cent (ZDHS 2015)
- Young women aged 15-24 years are two to three times more likely to contract HIV than young men of the same age

Progress over a decade

Since 2002, HIV prevalence rates have declined from 22 per cent to around 14.7 per cent in 2015. New infections have also been declining sharply, after having peaked in 1994.

UNICEF's HIV Programme: Quality interventions across age groups

The current UNICEF country programme aims to increase access to quality interventions from before birth, through childhood into adolescence, encouraging healthy behavior and widely available services that range from medical treatment to gender-appropriate information. The programme prioritizes prevention of mother to child transmission; prevention and treatment amongst adolescents as well as mainstreaming in nutrition, child protection, C4D and education programmes. UNICEF aims to strengthen national, sub-national and community service delivery capacity; to enhance the capacity of children, adolescents and care givers to adopt positive behaviors in a bid to prevent HIV infection and facilitate utilization of HIV and AIDS services. This is achieved by bringing HIV testing services closer to the population at community level, increasing the demand for service utilization, making support systems available for HIV positive adolescents and pregnant women and creating a conducive environment for HIV care and support for children and adolescents in school.

UNICEF further aims to strengthen the capacity, leadership and accountability for evidence based equity focused planning and budgeting for a scaled-up HIV response at all levels. This is achieved through providing evidence to inform programme planning and implementation.

Zimbabwe has made significant strides in expanding access to HIV testing and treatment, including prevention of mother-to-child transmission (PMTCT), anti-retroviral treatment (ART) for children, adolescents, pregnant and lactating women. However, despite increased access, more is needed to provide timely and quality HIV services that are equitably distributed across the country in order to meet the 90-90-90 Global targets and elimination of mother to child transmission of HIV.

Above Voluntary counselling and testing in Hurungwe District

Equitable access to quality interventions

One of the HIV programme's aims is to ensure that 80 per cent of pregnant women, newborns, children and adolescents have equitable access to and utilize high-impact, cost-effective and quality health interventions and practice healthy behaviors by 2020.

In a one-year period – 2015 to 2016:

- access to ART by HIV positive pregnant women increased from 84 per cent to 95 per cent
- access to ART for HIV positive children 0-14 years increased from 38 per cent to 83 per cent
- more adolescents accessed ART – the number increased from 62,845 to 66,886
- The proportion of HIV exposed newborns receiving effective ARVs for PMTCT increased to almost 100 per cent, (98 per cent) from 78 per cent in 2015 and far exceeding the target of 85 per cent for 2016

UNICEF HIV section in collaboration with Child Protection section, supports the implementation of HIV sensitive social protection programmes using the Harmonized Social Cash Transfer platform as an entry point in ten districts. This has enhanced linkages and referrals for children in need of HIV services from vulnerable households to health facilities as well as referral of vulnerable HIV infected children, adolescents and pregnant women in need of social support from health workers to the community case care workers.

Start Free – preventing mother to child transmission of HIV – a success story

Zimbabwe has made significant progress in reducing the rate of mother to child transmissions.

In 2009, the transmission rate was 31 per cent. This rate has dropped steadily, in what has been a notable success story. In 2013 the rate was 9.61 per cent and by 2016 was 7.2 per cent. Estimations suggest that 6,400 children were prevented from becoming HIV positive in 2011 and this number had doubled by 2013.

The coverage of PMTCT offered to pregnant mothers was rapidly scaled up in these years and there has been a decline in new paediatric infections, to the extent that it became possible to shift the language from 'prevention' to elimination. Access to PMTCT services continues to increase. By 2016, 95 per cent coverage had been achieved.

However, the World Health Organization (WHO) standard of elimination is 50 per 100,000 live births. This is a difficult target to reach. There is still an overall prevalence of 15 per cent, which means that there are still women being infected, whose babies are at risk.

While coverage has been good, it is not possible to relax the level of vigilance. Availability of services is not the same as utilization, or retention of gains made. In a breastfeeding population, the risk of new infection is ever-present. Future pregnancies remain at risk, mothers must be retained in care and family planning must be a part of the package of care that mothers including those HIV positive are offered. Every year, there is a new cohort of pregnant women who need to be tested, treated and tracked. There is a need to improve the data tracking of mothers and their babies, and to invest across all levels of care, from birth to 24 months.

The first decade – Paediatric ART and the importance of early infant diagnosis

The coverage of paediatric ART has expanded since 2009 when it was below 50 per cent to 70 per cent of the country. The challenge is how to maintain and retain the successes made in the Prevention of Mother to Child Treatment programme. Early infant diagnosis is important in this – at six weeks, babies should be tested. Ideally, clinics need to have point of care machines to test, rather than having to send blood away to be analysed at a reference laboratory.

There is also a need to track the mothers and babies after testing – to be able to use the data to understand subtle storylines behind the figures. For example, data shows that there is a high incidence of HIV detection at six months of age, but whether this is due to mothers being infected after having given birth or whether it was missed in the initial screening is currently unknown.

Data also assists in tracking patterns of adherence – another challenge that faces the HIV landscape. Children on ART need to be continuously monitored to ensure that they are adhering to the drug regime prescribed to them. Many of these children are being supported by their grandparents, and a lack of understanding of the value of ART prevents them from believing in the child's longevity. More work needs to be done to provide testing at community level, using a family-centred approach. Lack of disclosure between partners or in communities remains a challenge – mothers hide their child's status and either discontinue or refuse to initiate treatment because of shame and stigma, or fear of being divorced.

Testing together and receiving treatment for the sake of her baby

When Agnes (not her real name) realised she was pregnant, she and her husband decided to get tested for HIV together. "We knew of the importance of testing and I wanted to be sure, because of the baby".

Initially, her husband's results showed as positive while she was negative. Later, when she was 3 months pregnant, she tested positive and enrolled in the treatment protocol for the baby. Now 9 months old, her daughter is healthy and HIV negative.

The second decade – prevention and adherence in adolescents

A generation of adolescents living with HIV need a particular, targeted level of support in order to keep taking their ARVs. Initiatives to provide this have been scaled up. Community Adolescent Treatment Supporters (CATS), trained to work with this age-group, and HIV positive themselves, are stationed at treatment centres across the country. These young volunteers are equipped to deal with obstacles to adherence, which range from stigma (parents or grandparents not revealing to children their status) – to rebellion. Adolescents born with HIV wrestle with conflicting emotions including blame and resentment, as they approach their teenage years and are particularly vulnerable to falling out of a regular treatment regime.

However, prevention is also critical for adolescents. The generation that started their lives HIV negative regardless of their parents' status, are vulnerable to transmission as they enter the age of sexual activity. HIV testing among adolescents and young people remains low. Young people between the ages of 15 and 24 make up approximately half of all new infections, with girls and young women being particularly vulnerable. Much of this is due to inadequate knowledge and unprotected sex. There is still much work to be done in preventing teenage pregnancies and targeting young people with key educational messages about preventing HIV, as well as undoing attitudes that stigmatize those living with the virus. Services for the adolescents should be sensitive to their needs, hence it is important to develop the capacity of service providers on the relevant knowledge and skills on how to effectively communicate with and support adolescents using friendly tools and educational materials.

Community Adolescent Treatment Supporters

Right A variety of educational materials are used to promote adherence among adolescents

Improved engagement with young people

In 2016, UNICEF reported that the use of social media through U-Report allowed adolescents and young people to express their views on HIV and Adolescents, Sexual and Reproductive Health (ASRH) issues. Child friendly IEC materials that were developed and distributed facilitated counselling and disclosure on HIV. Adolescents and young people are engaged in planning and monitoring interventions that affect them, including development of national strategies and guidelines ensuring that issues of adolescents and young people are well articulated. The improved health workers' knowledge and skills on how to manage children has led to formation of support groups for children and adolescents living with HIV. Adolescents report marked improvement in relationships with health workers and support received from care givers following the latter's training on how to manage and support adolescents living HIV. The use of CATS has encouraged other adolescents to open up and freely discuss their experiences thereby reducing stigma and promoting adherence to HIV treatment.

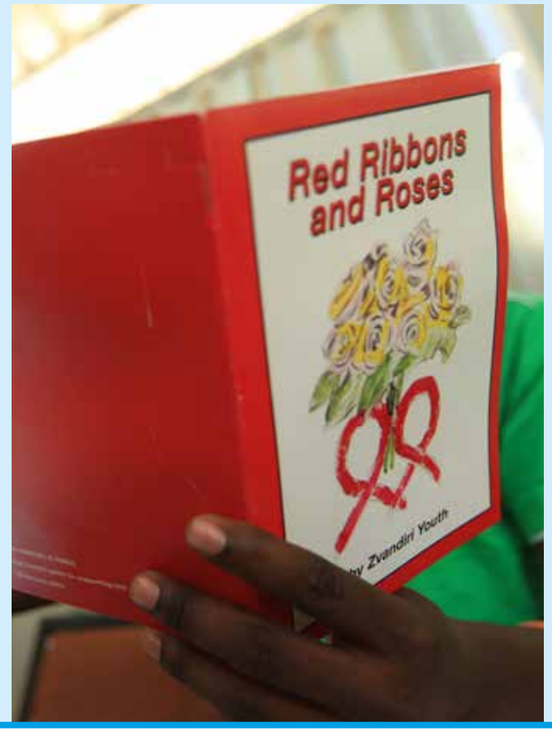
It is critical that quality data by age and sex is collected and reported on, to assess progress and provide evidence to inform implementation.

ENCOURAGING ADOLESCENTS TO STAY ON THEIR TREATMENT

Africaid – Zvandiri

"There are so many reasons young people default on their treatment. Sometimes it is because they don't understand – they need answers. Or they don't want their friends to know their status. Sometimes they are staying with a 16-year old caregiver while their parents are living in South Africa, and they don't have someone to remind them. It's an emotional thing."

Albert (not his real name) is passionate about what he does – helping adolescents to overcome the barriers to adhering to their treatment. An HIV positive recent adolescent himself, Albert comes twice a week to the Opportunistic Infection Clinic (OIC) section of the Hospital in Bulawayo, to weigh, capture data, and counsel people who for a number of reasons might be shying away from the reality that they must stay on ART to stay healthy. Albert is one of the team of CATS – Community Adolescent Treatment Supporter, trained by Africaid as part of the Zvandiri project. He is convinced that the peer-to-peer approach is what makes his volunteer work effective. Using a combination of home visits, games, songs, and sharing his personal story, Albert becomes like a big brother to some of the adolescents he supports.



Zvandiri: How a young girl's words and wishes empowered HIV positive youth

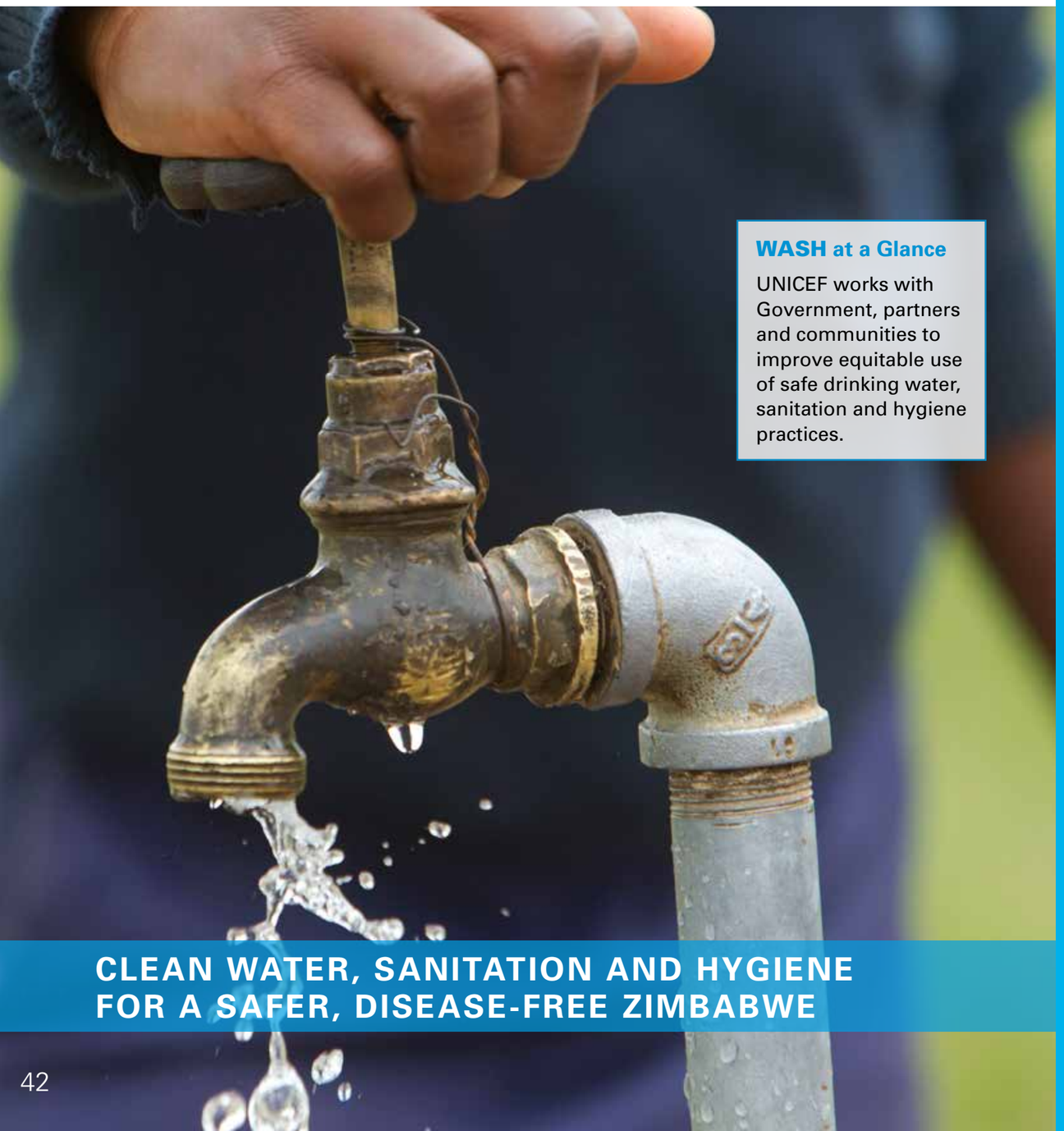
In 2004, Africaid established the Zvandiri ('Just as I am' in the local Shona language) programme after Simbisai, a 15 year-old girl, wrote a letter to Africaid requesting the establishment of a support group for young people living with HIV.
A group of 18 HIV positive adolescents were then assisted to establish their own Zvandiri support group. The programme has since grown into a combination of community-based, adolescent-led services.

They are integrated within the clinical care provided by the Ministry of Health and private clinics. Zvandiri provides community-based treatment, care, support and prevention services for children and adolescents with HIV, and their families, through community support groups, Zvandiri centers and community outreach teams.

Its interventions, led by young people living with HIV, support HIV positive children and other vulnerable children and their families with knowledge, skills and confidence to keep safe and to cope with the stigma and discrimination associated with people living with HIV and survivors of sexual violence and abuse.

Wash

CHAPTER 4



WASH at a Glance

UNICEF works with Government, partners and communities to improve equitable use of safe drinking water, sanitation and hygiene practices.

CLEAN WATER, SANITATION AND HYGIENE FOR A SAFER, DISEASE-FREE ZIMBABWE

COMMITMENTS

- Rehabilitate water and sanitation infrastructure in rural and urban areas
- Promote sanitation and hygiene practices
- Promote school hygiene
- Build capacity-building to improve WASH sector coordination and efficiency; and build more equitable service outcomes and quality
- Improve WASH information management systems to improve data reliability, equity analysis and use technological innovations
- Emergency preparedness and response

KEY INTERVENTIONS

- Rehabilitation of water and sanitation infrastructure in urban and rural areas
- Capacity-building to improve sector coordination and efficiency and building more equitable service outcomes and quality
- **WASH** sector management information system to improve data reliability, equity analysis and use of technological innovations, including emergency preparedness and response
- Engagement with the private sector

URBAN WASH

- Emergency Rehabilitation and Risk Reduction program
- Bulawayo Water and Sanitation Response (BOWSER
- Small Towns Water, Sanitation and Hygiene Programme

RURAL WASH

- Community water supply
- Community Sanitation and hygiene promotion (Elimination of open defecation in communities)
- School Sanitation and hygiene promotion
- Sector governance

SUSTAINABLE DEVELOPMENT GOALS FOR WASH

- **SDG Goal 6:** Ensure access to water and sanitation for all

- **SDG Goal 13:** Take urgent action to combat climate change and its impacts

TARGET RESULTS BY 2020

- Proportion of the population using an improved drinking water supply increased from 98.4 per cent to 99 per cent urban and 67.5 per cent to 75 per cent rural
- Proportion of the population practising open defecation decreased from 1.1 per cent in urban areas and 43.5 per cent in rural areas to 0.5 per cent and 10 per cent respectively
- Proportion of households with basic handwashing facilities increased from 50.5 per cent to 70 per cent

Strong systems eroded, leading to waterborne diseases

Prior to the 2008 crisis, Zimbabwe had been a model in water resource management. Over the last decade however, access to safe water and basic sanitation was affected by the general economic decline in Zimbabwe. A weak institutional capacity, power shortages and cyclical droughts have taken their toll, particularly on the most vulnerable communities. In small towns, revenue collection evaporated, maintenance on infrastructure lagged and a failure to provide basic amenities led to outbreaks of water-borne diseases such as cholera and typhoid.

In rural areas where there is a lack of infrastructure, sources where villagers collect water either became contaminated or dried up, and practices like open defecation led to contamination of the water table, rivers and other sources. Schools that didn't have a water source became a breeding ground for diarrhea-based illnesses. The cholera outbreak of 2008 flagged the need for a concerted intervention.

WASH indicators in Zimbabwe – 2015

- The majority of households in Zimbabwe (78 per cent) have access to an improved source of water: 69 per cent in rural areas compared to 97 per cent in urban areas
- 29 per cent of households travel 30 minutes or longer to obtain drinking water – in rural areas, this figure is 39 per cent
- In 72 per cent of urban households and 20 per cent of rural households, water is available on premises
- Just over one-third of households have an improved toilet facility
- 23 per cent of households do not have any sanitation facility at all
- The most commonly used improved toilet facility among households in Zimbabwe is a pit latrine with a slab (13 per cent)
- Rural households are more likely to have an unimproved toilet facility or have no toilet at all when compared with urban households (48 per cent and 5 per cent, respectively)
- Source: Zimbabwe Demographic Health Survey (ZDHS) 2015

The link between WASH and childhood diarrhoea

- 2008/9 Cholera outbreak affected 52 out of 62 districts – with 98,531 cases and 4,282 deaths
- Cholera has been reduced by 98 per cent since the 2008/9 rainy season
- Diarrhoeal diseases remain a leading cause of mortality for children under-five
- Diarrhoea is more prevalent among children whose households do not have an improved source of drinking water (16 per cent) compared with children from households that do (12 per cent) and among children whose households do not have an improved toilet facility or who share a facility with other households (14 per cent) compared with households that have an improved, unshared toilet facility (11 per cent)

Strong systems enabled an effective response

Fortunately, the strong systems that had characterized the Water and Sanitation and Hygiene (WASH) sector in the past, were still in existence and provided a strong enough base to kick off a recovery. These systems, especially within Government, rely on clear lines of communication, a tradition of consultation and community participation as well as strong reporting structures.

By 2011 an effective National Water Policy had been created, and by 2013 the National Sanitation and Hygiene Strategy was in place to guide the response. This strategy was divided into two streams: the Urban WASH and the Rural WASH programmes.

Urban WASH

Emergency response and quick-fixes

Immediately following the cholera outbreak in 2008, the government, together with UNICEF, the World Bank, the African Development Bank, GIZ, as well as other donors and NGOs, embarked on several initiatives to address the underlying causes. The Emergency Rehabilitation & Risk Reduction programme, the Bulawayo Water and Sanitation Response (BOWSER) and the Zim-fund, all born out of Zimbabwe's coordinated response, enabled the sector to address the emergency needs but also formed the basis for the recovery that was to follow.

Water was trucked to problem areas, chemicals supplied to treat unclean water, sewerage pipes were unblocked, boreholes drilled and emergency pumps supplied. There had been an outflow of skilled personnel in the period prior to this, so there was also a need for intensive training. 440 local operators were equipped with the professional knowledge to operate and maintain the infrastructure.

Early Recovery, Rehabilitation and Development

In 2013, the Government of Australia contributed $30 million to Zimbabwe to help reduce the burden of diarrhoeal diseases, including cholera, amongst 500,000 inhabitants, including women, children and the vulnerable in 14 small towns. This phase saw the repair and replacement of pumps, water treatment plants, sewage networks and wastewater treatment plants along with the building of institutional capacity for water utilities, and strengthening policy and institutional frameworks to provide water, sanitation and hygiene services. The programme mobilized communities to learn better hygiene practices, trained municipalities in customer care, and supported improvements in Information, Communication and Technology (ICT), billing systems and business plans.

The Small Towns' Water and Sanitation Programme

Building on the recovery phase, UNICEF and partners have been able to further improve the operational capacity of water reticulation systems and treatment plants, rehabilitate sewage systems, and enhance cost recovery in the target towns. Human resources have been equipped with better management, financial and technical skills, and target communities have participated in education and knowledge-building programmes, in a coordinated drive to improve responsibility, accountability and efficiency and manage water and sanitation resources sustainably.

UNICEF and infrastructure

It is unusual for UNICEF to embark on country-wide urban infrastructure provision and rehabilitation programmes. However in the case of Zimbabwe there was a need for a widespread institutional response to swiftly contain the cholera epidemic and address its underlying causes – decayed infrastructure and lack of professional capacity.

Key Achievements

Water Supply	374,000 people regained access to water and sanitation services through rehabilitation of supply systems and boreholes. 4 million people improved their level of water supply through treatment chemicals supplied to urban councils
Sanitation	31,000 people regained access to sanitation services through the rehabilitation of sewage and wastewater collection. 227,000 people experienced improved levels of wastewater collection.
Hygiene	869,000 people were reached with hygiene messages through participatory education, health clubs and community mobilization. 5 million people were reached through mass media, interpersonal communication, health clubs and participatory hygiene education.

Further investment is needed

In 2016, multiple occurrences of typhoid indicate that the infrastructure is still fragile and efforts to improve access must be further strengthened so that all Zimbabweans can have safe, equitable access to water and improved sanitation facilities. The work of the WASH sector impacts on more than disease control; it has a fundamental role in tackling hunger, achieving universal primary education, reducing gender inequality and child mortality and helping lift communities out of poverty.

PROFILE OF KAROI TOWN

In Karoi town, at a meeting of the Water and Sanitation Steering Committee, the levels of enthusiasm emanating from this broad cross section of the Karoi community are palpable. Although the meeting has been called at short notice, there are representatives from the local hospital, the Education Department, the Town Council, the health center, local business and the 18 vibrant Health Clubs that have turned into flourished Community Based Organizations (CBOs).

The state of the town council offices tells a dual story – of dilapidation and recovery. Husks of once-functioning vehicles rust in the open yard. A door is askew, off its hinges and propped open with a brick. But resilient flowerbeds yield bright blooms – reminders that renewal is always possible. A man in overalls balances his ladder on unsteady barrels as he applies a fresh slick of paint to the outside of the building. Inside the boardroom, a huge solid wood oval table speaks of times when budgets were bigger. But the people sitting around the table are speaking of innovation, recovery and possibility.

Never Saririmo is the Technical Director of Chenai, a Health Club that turned into a ommunity Based Organization that deals with waste management in Karoi and the surrounding areas. Still wearing the blue overalls from tending to the bio-digester he is in the process of building, his positive energy is contagious.

Community Health Clubs received training over a period of 20 weeks, their task being to disseminate information pertaining to healthy hygiene practices, as a response to cholera outbreaks in small towns. In this case, however, the Health Club has had a much bigger role to play. He describes several innovations – creating paving stones from melted plastic mixed with sand, using a bio-digester to create manure and develop a nutrition garden, and turning scrap metals into bells as an income generation project.

“We will not need a landfill in Karoi Town,” he promises. “We will turn our bio-degradable waste into food gardens and our recyclable waste into income generation.”

Floor tiles made from sand mixed with melted plastic: a waste management innovation from the Karoi town council

Small towns regenerate though strengthened systems

In Karoi, revenue collection is on its way to being vastly improved as a result of an upgraded digital collection system. They have ring-fenced funds from the refuse account to deal with solid waste management and from the health account to plough back into maternal health. Other improvements include renovating the water system, setting up health clubs in government schools, purchase of a new refuse compactor, renovation of public toilets and sewer systems as well as training of staff in customer care.

Karoi is one of many small town success stories. In some cases, capacity-building also means hand-holding after the recovery process is underway, but here, the council is running its own WASH programme. Ownership and participation are clearly evident. Waterborne diseases have been eradicated and innovative entrepreneurship has arisen out of the renewal process. Hygiene promotion is not just an emergency response but has been built into the system as a whole.

Rural WASH

The WASH sector faces the challenge of an imbalance between rural and urban services. Rural poverty is exacerbated by a lack of water and sanitation infrastructure, with 98 per cent of those without access to an improved source of drinking water living in rural areas. Before the concerted efforts of the rural WASH programme, 48 per cent of the rural population practised open defecation, without access to household latrines or hygiene services. As a result, diseases continued to negatively affect rural households, with diarrhea-related illnesses causing around 4,000 deaths among children under five every year.

In 2011, the National Action Committee for Water and Sanitation called for a rural WASH programme to address these inequities. In 2012, the British and Swiss governments responded with GBP 33 million and $6 million grants respectively to provide water and sanitation in 33 of the most disadvantaged rural districts in the country. The goals of the programme were to reduce mortality through water-related diseases, reduce the burden on women and children who are mainly responsible for water collection, and improve dignity through better WASH services. This in turn was to improve basic education and gender equality outcomes.

MICS 2014 reports that open defecation is at 31.7%, affecting mostly rural areas, where 44% of the population practises open defecation.

Demand-led sanitation in Hurungwe

Driving towards the Hurungwe district offices, a large billboard catches the eye – "This area is declared almost 100 per cent Open Defecation-Free." Gains made in sanitation and hygiene in rural areas have largely been due to a demand-led strategy known as Community-led Total Sanitation (CLTS) – an approach which has seen a rapid uptake in improved latrine-building in the areas where it was implemented.

For 30 years, the government provided the resources for communities to build toilets, but this supply-led approach was not working, as people receiving cement used it to build other structures which they thought were more important. The change from a top-down to a bottom-up approach has borne much better results, with 90,000 improved latrines being built by communities involved in the demand-led approach, as compared with 20, 000 in the previous supply-led period.

Demand-led sanitation in Makota Village

Several kilometres off the main road, with pathways overgrown with the ubiquitous wild orange flowers that fill the countryside here, Makota Village residents and Health Club Committee members have gathered to tell the story of how they became an open-defecation free zone. There is a clear "before and after" in their narrative – before "triggering" and after "triggering". What is triggering?

The CLTS approach uses a provocative methodology, which requires that the community publicly map out – by drawing on the ground – the places in the open bush where they defecate. Demonstrations follow, which clearly illustrate how flies land on food and carry disease-causing bacteria. These are meant to shock and shame – and they do. The community leaders, who have been trained to understand the fecal-oral contamination route, enlist others in the village to create dramas, songs and poems that spread the message to the rest of the village.

The philosophy behind CLTS is that merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene. But the community-led "triggering" process propels collective action, decision-making and responsibility.

"After the triggering, we all understood the importance of the 'Blair Toilet.' We encouraged each other to construct latrines," explains Hilda Chilasasa, a focal person for the Sanitation Action Group (SAG), involving 30 households in the surrounding area. Before the triggering, she explains, there were 20 households in the village and surrounds that did have toilets but they were not of the standard required. Ten had none at all. The Upgraded Blair Ventilated Toilet has specific requirements and is suitable because it is easy to build in stages. One bag of cement is all that it takes. It must have a slab, a ventilation pipe, a fly screen, walls and a roof.

"We had a focal group of five or six people. We would meet every Monday and contribute $2 per person. We bought a bag of cement every week, and people in the community helped with construction."

Additionally, households had to build a hand-washing system, a pot rack and a rubbish pit.

"Previously, we used to put our utensils on the ground. Dogs and chickens would eat the leftover scraps from the pots. Children would come and play with them. This structure helps – the water drips off and the sun kills any remaining bacteria."

Building latrines is one thing, but are they actually used?

"If you walk around the bush here, you will see only cow dung," reports the headman, Mr Makota.

Since the triggering, mothers and caregivers have noticed that there have been no instances of cholera or diarrhoea.

Health clubs are a key part of this story. There are two in Makota Village, each 20 members strong. They meet twice monthly to discuss hygiene issues, make products to generate income and plant vegetable gardens. They also encourage neighbouring villages to follow suit.

Improved latrines and washing facilities are constructed by Community Health Clubs

Figures collected by UNICEF show that for every $5 that the WASH sector put into the latrine construction programme, the community was putting in $50. In two years, 700,000 people constructed toilets and 3,000 villages were declared Open-Defecation Free. With this trend, the Sustainable Development Goals would have been reached by 2030. But unfortunately funding has dipped and the programme has slowed.

A further setback has been that in some areas, flooding damaged work that has been done – but on the plus side, the new climate-resilient design has proved to be more hardy. Even though the superstructures may have been damaged, the substructures are intact even in areas hit by floods.

Beyond hand pumps to more sustainable piped-water options

Zimbabwe's Water and Sanitation Sector has begun to prioritize piped water schemes, in the understanding that hand pumps alone cannot reduce poverty. Historically, Zimbabwe relied a great deal on the borehole and hand pump system, after a substantial investment in water accessibility in the 1980s and 1990s. The unique hand pump, known as the 'bush pump', designed in the 1970s and patented by Peter Morgan in the 1980s has a tough design and could last as long as three years without maintenance, but after decades of wear and tear, there is now a need to replace them. In 2010, 75 per cent of hand pumps required repair to be functional. Rather than continuing with outdated hand-pump technology, the option of piped water is far more efficient and sustainable.

Climate change resilience and community involvement

Similarly, the boreholes drilled across the countryside in that period are seasonal, not constructed according to any standard or regulation and prone to drying out. Of the approximately 60,000 boreholes that have been sunk over the years in Zimbabwe, 40 per cent have water levels too low to function – part of the reality of climate change. There is a need for better, more consistent monitoring of ground water. Communities possess untapped knowledge as to which boreholes last throughout dry periods. WASH UNICEF has been using a model that combines local knowledge with the expertise of a hydrologist: the borehole site is chosen by the community, and water quality is scientifically tested.

IN BIRIMAHWE, A PIPED WATER SCHEME GIVES BACK HOURS IN THE DAY

A single tap stands in the middle of a smooth concrete slab, fenced by neat bamboo lattice-work. This tap has changed the lives of the 650 people who are now able to bring their buckets, fill them up and walk a few hundred metres back to their homes. The smile on Sithembile Marufu's face says it all.

"We used to set out at 3 am, about 20 of us, men and women. We would walk to those hills there – we'd be back at 7 or 8 am." Sithembile is a widow, unemployed and looking after five dependents.

"My seven-year-old grandchild, she kept having diarrhoea. The water we were getting before was not safe. But now, when there was that typhoid outbreak (in Hurungwe district in 2017), it never reached here."

Sithembile's situation is typical of 28 per cent of the rural population – women and children who walk anything between three to five kilometres daily, wasting a workforce that could be used more productively. The response? Get piped water into households so that families have access to clean, safe water for domestic use. Since the current systems are fossil-fuel driven, an additional prerogative is to use solar power to run pumps, which keeps maintenance low. Piped water schemes make a much more profound impact in terms of labour saving, safety and cost.

Sithembile, also a member of the district Water, Sanitation and Hygiene Committee (DWSHC), explains that each household contributes US 50 cents per month for the maintenance and upkeep of the equipment, as well as contributing labour and paying the salary of someone to safeguard the infrastructure at night. Altogether, they are banking an income of $50 per month in case they need a technician to repair the panels or pump, although they are confident that with the training they received, they can manage the general maintenance themselves. "We own this now," a district official notes.

A simple switch, and the pump powers up, taking two and a half hours to fill the two 5, 000 litre tanks. Three more taps are planned for the surrounding households, and the community have already started digging the trenches for the pipes.

Sithembile demonstrates how easy it now is to turn on the tap, fill up her bucket, and walk 50 metres to her kitchen, grinning broadly the whole time. She has more time and energy to help her children with their homework or work in her food garden. The furthest household from this particular tap is 700 metres – a stone's throw compared to the distance they previously travelled.

WASH in schools: Piped water means clean hands and healthier children

The Rural WASH project targeted 1,600 primary schools through improvement of student toilet ratio.

'Blair type' latrines were constructed, hand washing facilities installed and healthy hygiene practices promoted in target schools. There is still more work to be done in assisting schools to have access to permanent water sources that will assist in and complement school feeding.

In the case of Birimahwe Primary School, only a few kilometres away from where the piped water is being pumped, a water point has enabled the school to cook a meal for the children each morning, start a nutrition garden and ensure that children learn safe hygiene habits. Before the tap was installed, the school paid $5 for an oxcart to bring the water for their daily needs – water which came from unprotected sources like shallow wells and rivers.

Above Solar panels power the Birimahwe piped water scheme

Innovations in the WASH Sector

Drought relief funds stretch further for better climate resilience

Using emergency drought relief funds, UNICEF, together with the government, has been able to introduce 20 piped water schemes in water-scarce areas like Birimahwe in Hurungwe District. Sixteen have so far been built. The impact on communities is immediately positive. The aim is to scale up these model piped water schemes to reach more districts across Zimbabwe so that inequities can be reduced. Investing further in climate-friendly technology such as solar power will enable better resilience and to future-proof access to safe, sustainable water supplies.

Real-time reporting – a digital inventory

A recent WASH innovation is a near real-time reporting and monitoring platform called the Rural Water Information Management System (RWIMS) which has the potential to revolutionize development, particularly in Zimbabwe, where mobile network coverage is widespread. RWIMS has replaced the paper system and has allowed local authorities to have near real-time data which is accurate and reliable for informed decision-making. Previously, Rural District Councils had to use paper systems to update their WASH data and this was cumbersome and time-consuming. But now at the click of a button, they have updated and accurate data.

Every ward has a tablet, and information that they upload goes to a main server, so in near real time, WASH technical experts are able to access data about villages – where the water points are, how many households are in the village, which pumps are working, which need fixing, and the water levels in boreholes. UNICEF has also integrated RWIMS with U-Report, an SMS-based platform that enables pump minders to report on faults to the water points, thus activating a response mechanism. A system like this has enormous potential to reduce costs and increase efficiency in data collection and use.

Left Sithembile Marufu, member of the Waterpoint User Committee operating the solar powered pump

The way forward

Weathering the future with more resilient systems

Urban WASH is working to actively protect the gains already made in the sector by continuing to support the capacity of small towns in their revenue collection, management and maintenance of WASH services. Innovations, such as health clubs' initiatives to generate income through waste management, bio-digesters and other climate friendly technologies need increased support.

Combating disease and poverty by providing access to water and sanitation

Supporting WASH through UNICEF programming enables a basic human right to be met: the availability and sustainable management of water and sanitation for all. This plays a critical role in the prevention and management of disease as well as reducing poverty. WASH in schools goes beyond teaching children to wash their hands before meals, it also enables the food to be grown and the meals to be cooked. Piped water schemes free up valuable time for women and children to spend on productive activities, while a new focus on energy efficiency and climate resilience provides the key to future sustainability.

CHAPTER 5

Education

Education at a Glance

Increase equitable access to, and completion of, quality, inclusive education, with improved learning outcomes.

ENSURING QUALITY ACCESSIBLE EDUCATION FOR ALL THE CHILDREN OF ZIMBABWE

KEY INTERVENTIONS

Equity

- School Improvement Grants (SIGs)
- Early Learning
- Second Chance Education Programme
- Children with Disability

Quality

- The Performance Lag Address Programme (PLAP)
- The Early Reading Initiative (ERI)
- Teacher Professional Standards (TPS)
- The Zimbabwe Early Learning Assessment (ZELA)
- School monitoring
- Curriculum Development
- HIV/AIDS and Lifeskills
- Humanitarian Response to disasters

System Strengthening

- Information Management
- The Education Management Information System (EMIS)
- The Zimbabwe Early Learning Assessment (ZELA)
- Policy Development
- The Education Sector Strategic Plan (ESSP, 2016 to 2020)

STATISTICS SNAPSHOT

The percentage of the national budget allocated to the basic education subsector is high ($ 803.8 million or 23 per cent of total budget in 2016). 98 per cent of this funding goes towards employment costs.

Overall enrolment has been increasing but more than 1.2 million children of school-going age between 3 and 6 years are out of school.

- 93 per cent primary school enrolment, with gender parity
- 52 per cent secondary school enrolment
- Enrollment of children with disabilities increased from 34,734 in 2015 to 49,692 in 2016

SUSTAINABLE DEVELOPMENT GOALS FOR EDUCATION

- **SDG Goal 2:** End hunger, achieve food security and improved nutrition and promote sustainable agriculture

- **SDG Goal 4:** Ensure inclusive and quality education for all and promote lifelong learning

- **SDG Goal 8:** Promote inclusive and sustainable economic growth, employment and decent work for all

TARGET RESULTS BY 2020

- Number of primary and secondary schools with functional school management committees increased from 6,041 to 7,000
- Number of children and young people with access to life skills-based technical education (by age, gender and geographic location) increased from 23,623 to 100,000
- Number of children with disabilities enrolled in primary and secondary education increased from 34,734 to 50,000
- Percentage of trained ECD teachers increased from 32.7 to 40 per cent
- Average number of visits per school by District Education Inspectors per year increased from 1.3 to 3
- Primary and secondary schools using teaching and learning materials which have been developed to deliver the curriculum
- Children in humanitarian situations in UNICEF-targeted districts access formal or non-formal basic education
- Percentage of in-school children aged 15 to 19 with comprehensive knowledge on HIV prevention by sex increased by 15 per cent
- Education Sector Performance Review (ESPR) with specific focus on equity and inclusive education conducted every year
- EMIS data for the year is available for use in the same year, including data on children with disabilities
- The 2016-2020 Education Sector Plan includes risk assessment, risk management and disaster risk reduction
- Data on access and learning (disaggregated by sex, location and wealth-quintile) available within prescribed timelines
- At least two research studies are published and used to inform sector development

A Threat to Quality and Equity – How the economic crisis affected education in Zimbabwe

The Zimbabwean education system had been a flagship of quality in the southern African region but began to experience a serious downturn as the challenges of the economic crisis peaked in 2008. The sector suffered a serious skills flight. Although there are 14 teacher education colleges in Zimbabwe, and no shortage of qualified staff, hyper-inflation and deteriorating working conditions caused teachers to migrate, or to leave public schools and set up private institutions known as home schools that offered extra lessons. The additional cost involved could only be afforded by a minority of rich clients. As a result, equitable and quality learning and teaching were compromised.

Other threats to the system included loss of learning time, with the average annual attendance rate dropping to an estimated 29 days out of 180 in 2008. An acute shortage of textbooks, stationery, equipment and furniture followed, along with poor maintenance of school infrastructure resulting in rapid deterioration of classrooms and water and sanitation facilities.

By 2008 the Zimbabwe education system was in disarray

- 8,000 schools had closed, an estimated 20,000 teachers had left their posts and learning materials were in drastically short supply or, in some schools, non-existent
- Retention of learners in the system was low: only 49 per cent of learners of primary school age were in primary or secondary schools, while at secondary level only 45 per cent of learners of secondary school age attended secondary school or higher (Zimstat 2009)
- With the Education Transition Fund's response, the system began to recover
- Data from the multiple indicator cluster surveys undertaken by the Zimbabwe National Statistical Agency (Zimstat) in 2009 and 2014 show significant improvements in the key education outcomes, for example in the primary completion rate (from 42.6% to 98.9%), the secondary school attendance ratio (from 44.8% to 57.5%) and school readiness (from 75.0% to 86.2%)

(Source: Assessment of the Transition Funding modality, a pooled funding mechanism for the social sectors in Zimbabwe – Final Report)

The sector's response: Recovery through pooled funding, managed by UNICEF

The Education Transition Fund (ETF) was the first of the transition fund mechanisms (TFMs) to be launched. In September 2009, donors working in the sector responded to the absence of significant national government financing for non-wage expenditure, by pooling resources and establishing a joint funding mechanism. The initial response was to revive the sector by providing essential learning and teaching materials to schools.

The second Education Transition Fund (ETF II) then expanded its scope, as the broader impacts of the decline in government financing became clear. These impacts included school and learning supervision, information availability and school governance. The second ETF also sought to address the system of fees, levies and incentive payments that had significantly affected access to schooling for the poorest.

In 2014, the Education Transition Fund became the Education Development Fund (EDF) with the overall objective of improving the quality of education for children in Zimbabwe. This was to be done through improving the quality of the school environment and systems, improve quality of teaching and learning, and providing a second chance education to children who have dropped out of school to continue with their education up to 16 years.

Achievements and successes – results of the ETF's work

The education sector has seen consistent improvements in access and learning outcomes over the last three years. Enrolment rates continue to swing upwards, particularly in primary schools, and the new curriculum is in place, helping to modernize quality of learning, laying a foundation for the early years and emphasizing Science, Technology, Engineering, Mathematics (STEM) skills. UNICEF's priorities are to increase equitable access, improve quality, and strengthen systems – three focus areas designed as a roadmap out of systemic poverty.

Above Children at the Birimahwe Primary School benefit from the School Improvement Grant, piped water, and a daily meal.

Improving Equitable Access

School Improvement Grants

School Improvement Grants are funds given to financially constrained schools to be spent on the needs that they themselves have determined and prioritized. Schools develop a five-year plan from which they would identify the priorities on which they would spend the money. To ensure proper use and accounting for the funds, school heads and key Ministry of Primary and Secondary Education personnel are trained in financial management. In addition, independent accounting firms verify the spending. Successfully piloted in 2013, the programme was scaled up to all 72 districts and $49 million was disbursed between 2013 and 2015, benefitting 2.5 million children and empowering schools to be responsive to their own needs.

Early Childhood Development

Early Child Development (ECD) lays the first foundation for children to develop intelligence and social behaviour and to prosper throughout their school careers. In 2005, the Ministry introduced a policy that required every primary school to attach at least one ECD B class to the school. This made it available to all Zimbabwean children beyond the privileged few who had previously had access. From 2014 onwards, ECD became part of the formal school system with the introduction of the Infant School Module comprising ECD A, ECD B, Grade 1 and Grade 2. Junior School covered Grade 3 to 7.

"We bought desks and school furniture. Before that, the learners had nowhere to sit. We could provide textbooks for every child for four key subjects. This new classroom block was painted. We now have a 1 to 1 ratio of textbooks to pupils."

Madam Pukhaya, deputy head of Birimahwe Primary School, on how the School Improvement Grant was spent

While most primary schools have set up these classes, more needs to be done on training ECD paraprofessionals and professionals and developing appropriate materials for the early years. Various organizations, including NGOs, have trained ECD para-professionals, with UNICEF training over 9,950 between 2011 and 2014 alone.

However, the government now seeks to prioritize the training of qualified ECD teachers through three-year training in teacher education colleges. This will help teachers to bring out the best in young children and manage the age-group effectively. The government will also ensure that age-appropriate infrastructure and furniture are procured for schools.

Early Childhood Development (ECD) is the foundation of human development. These early years are critical for the formation of intelligence, personality and social behaviour. Investing in early learning has lifelong rewards both for the child and the nation.

98 per cent of primary schools in Zimbabwe have established ECD B classes, and 84 per cent have ECD A classes

School feeding is part of the ECD package

Child hunger is still experienced in rural and semi urban areas, limiting children's capacity to thrive. Providing a solid meal for school-going children is an important aspect of this intervention. In pursuit of this, in 2016, the government introduced the "Home Grown School Feeding Programme" that covered all children in Infant School (i.e. ECD A to Grade 2), as the first step. The programme is supported through a government grain scheme, complemented by parental contributions towards relish and labour.

Including children of all abilities

UNICEF works to expand education opportunities for children with disabilities by procuring materials and by supporting the formulation of an inclusive education policy as well as development of systems that ensure inclusivity and sustainability.

According to a situation analysis[1] conducted in 2015, only 23 per cent of children with disabilities were enrolled in school in 2014 (27,299 at primary and 4,955 at secondary level). Zimbabwe has one teachers' college that offers specialized training in children with special needs. Children with disabilities are among the most marginalized in society, facing daily discrimination and abuse and refusal of access to schools. Of the few schools that cater for children with special needs, most are in the urban areas and are affordable only to the elite. The phenomenon of abandoning children with disabilities is commonplace, mostly because caregivers lack the knowledge, skills and means to look after them.

To help the government meet its commitments to children with disabilities, UNICEF procures equipment, materials and assistive devices for special schools to cater for all types of disabilities. These include wheelchairs, walking frames, canes, styluses and slates, digital talking calculators, hearing aids, mirrors, mattresses and braille and sign language textbooks. Working to improve access, quality and equity for children with hearing, visual, physical or intellectual impairment, UNICEF also provides special schools with grants, in line with its equity focus.

Beyond this, UNICEF supports development of policies and systems to sustain these improvements, change entrenched attitudes and help professionals to identify children at risk. The vision is to have people who work with children at all levels – community, school, district, and national level – possessing the capacity to include and nurture the most vulnerable children in the systems in which they operate.

1 Sue Kageler (2015). Education Sector Analysis, Zimbabwe. MoPSE

Second Chance Education Programme

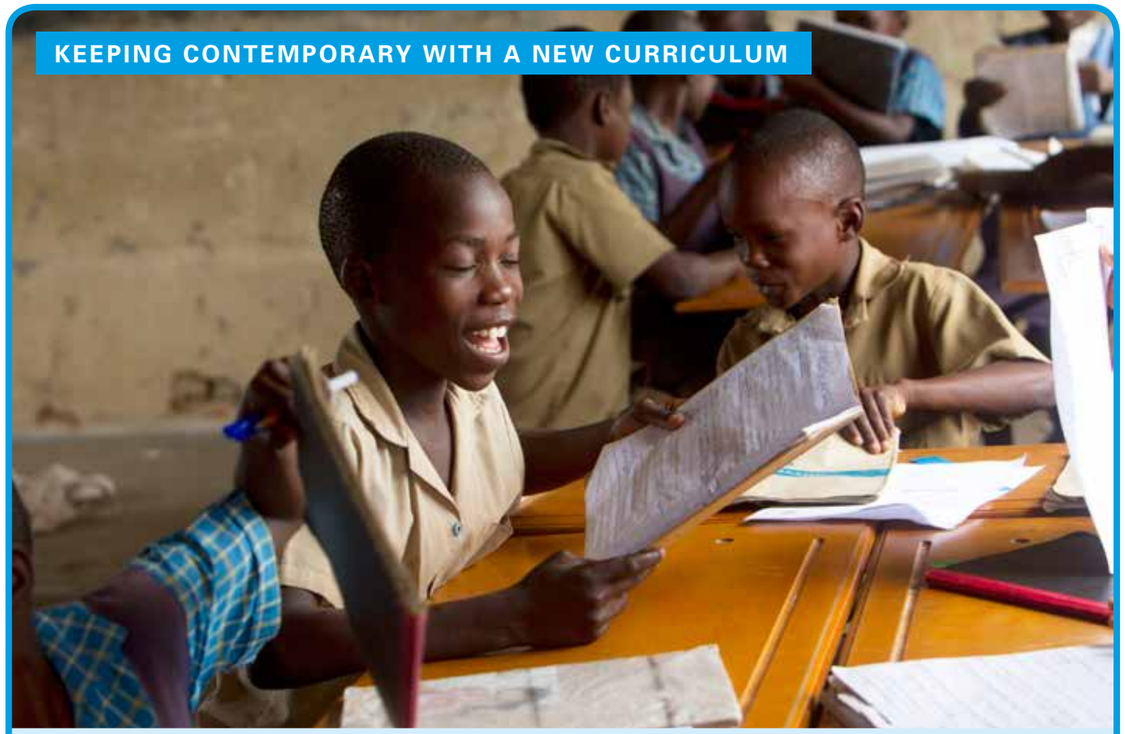
UNICEF works with the Ministry of Primary and Secondary Education to strengthen its capacity to respond to the needs of out-of-school children and young people. In 2012, according to the National Census, 1.2 million children aged between three and six years were 'out-of-school'. Sixty-nine per cent were of ECD age, 12 per cent were of primary school age, and 17 of lower secondary school aged. At secondary school level, more than half a million students were two years or more over-age for their grade. The strategy is to provide education opportunities for out-of-school disadvantaged children and youth, to equip them with lifeskills, literacy and technical and vocational training.

Improving Quality

Teaching and learning

UNICEF invests in the education delivery skills of teachers through a number of strategies. The Performance Lag Address Programme (PLAP) capacitates teachers to close the performance gap among affected learners. The Early Reading Initiative (ERI) strengthens the teaching skills of infant class teachers and supervisors from Early Child Development Year 1 to Grade 2. Teacher Professional Standards (TPS) are an agreed set of performance standards to guide and support all teachers in the execution of their teaching responsibilities and in their professional development. The Zimbabwe Early Learning Assessment (ZELA) is an annual curriculum-based assessment that provides information on the extent to which learners in the early grades are acquiring the competences expected at their grade level. District and provincial offices across the country also support effective teaching by conducting school monitoring visits in order to evaluate standards in teaching and to provide support to those teachers who require it.

KEEPING CONTEMPORARY WITH A NEW CURRICULUM



At the time of political independence in 1980, Zimbabwe reformed the curriculum to redress imbalances inherited from the colonial administration. Initially the emphasis was on access but in the second decade after independence, the focus moved to quality. In 1998, the Presidential Commission of Enquiry into Education and Training (Nziramasanga Commission) found that the curriculum was too academic and recommended revision. These revisions began to be implemented in 2015, following further review and input from stakeholders.

The new curriculum had to align with the development needs of the country, reflect the Zimbabwean context and remain consistent with international trends and standards.

Citizens in Zimbabwe need new skills to live and work competitively in the global marketplace. The new curriculum is designed to equip students with information and technological skills relevant to a digital world, while still valuing their heritage, history and cultural traditions. The curriculum prepares young Zimbabweans to be active, participatory citizens, able to contribute to an indigenized economy, equipped with literacy, numeracy and practical competencies. The syllabus fosters life-long learning for success in a knowledge economy.

The values of the new learning programme are embedded in principles of inclusivity, accessibility, equity, continuity, respect, (Unhu/Ubuntu/Vumunhu), gender-sensitivity, diversity, transparency and accountability.

The reform process rests on five pillars:

1. The legal and regulatory framework programme
2. Teacher professional standards
3. The Centre for Educational Research, Innovation and Development (CERID)
2. Teacher capacity development
4. Infrastructure development

School Health

UNICEF seeks to improve the provision of water, sanitation, and hygiene (WASH) in the most vulnerable schools which have been lagging behind in terms of access to sanitation and potable water. Water-borne diseases hold back children's potential. Bringing potable water and hand washing facilities to schools, introducing hygiene clubs, and building toilets to a specified standard all contribute to the general wellbeing of children and, by extension, to their academic and future potential. Helping de-worm school children and treat them for bilharzia is another aspect of the school health intervention.

"In the past we had to pay somebody $5 to fetch our water in an ox-cart."

WATER IS LIFE! WASH AT BIRIMAHWE PRIMARY SCHOOL

The children line up to wash their hands, waiting patiently for their turn to come. A volunteer para-professional dips the red cup in the bucket, pouring water over pair after pair of small hands. Inside the classroom, an enormous pot contains the morning meal – a maize staple (samp) and vegetables, prepared at the school and picked from their flourishing food garden.

"In the past we had to pay somebody $5 to fetch our water in an ox-cart. It came from about 4 km away and it wasn't safe water," explains the Deputy Head. "There were lots of cases of diarrhoea amongst the children. But now that we have a tap at the school, children can wash, we can grow healthy food for them, and we save money."

The recently installed tap is part of the WASH in Schools programme, and school management reports that there is less absenteeism amongst both pupils and teachers as a result of improved health. It has also had a positive impact on staff turnover.

Boreholes were drilled in 20 satellite schools in the most disadvantaged areas of Binga, Hurungwe and Mwenezi. School toilets and hand-washing facilities were also built in 27 schools in the same districts.

HIV/AIDS and Lifeskills

Zimbabwe was the first country in sub-Saharan Africa to introduce HIV and AIDS education in schools, through teacher training colleges, in 1992. UNICEF supports the Ministry of Primary and Secondary Education to implement a Life Skills, Sexuality, HIV and AIDS Education programme targeted at both students and teachers.

Humanitarian response

With natural disasters such as droughts, floods and severe storms occurring regularly and with climate change experts predicting more climate-related disasters in the region, UNICEF, in close collaboration with other partners, supports the education sector with emergency relief and recovery assistance. The assistance comes in the form of 'school-in-a-box' kits, learning materials, temporary shelters, training teachers in disaster risk reduction, and promoting safe schools.

System strengthening and managing data effectively: EMIS

UNICEF is committed to strengthening political commitment, accountability and national capacity for evidence-based legislation. Planning and budgeting for scaling up quality and inclusive education requires long-term support. Some of the major successes include development of sector plans and the education management information system.

UNICEF has supported strengthening of the Education Management Information System (EMIS) that, since 2014, has been able to collect, process, analyse and deliver timely, comprehensive, quality education data. The data has been used for evidence-based policy development, decision-making, planning, programme design, review of sector performance, and research.

Working with the Government of Zimbabwe: The Education Sector Strategic Plan

The 2016-2020 Education Sector Strategic Plan (ESSP) articulates the priorities, policies and programmes that the Ministry of Primary and Secondary Education will pursue over the five-year period. Together with donors and development partners, the process of developing the sector plan involved central, provincial and district level education stakeholders and civil society, and adopted a highly consultative approach. Through such consultations, stakeholders were able to identify major challenges faced by the sector, particularly in the context of economic recession and limited resources. Issues that the ESSP prioritizes include improving teacher welfare, the learning environment, quality of learning, school governance, and resource mobilization for marginalized students.

The situation now, and future priorities

While significant gains have been made, challenges persist. The cost of education remains an obstacle for families trapped in poverty. Parents seek work in neighbouring countries, leaving children at home with grand-parents increasing pressure to bring in food – particularly in rural areas. Academic achievement is also compromised by factors such as no electricity for reading at night, fatigue as children are expected to compensate at home in labour-constrained households, and hunger. Adolescents out of school become vulnerable to exploitation. In the education sector, these challenges are best addressed systemically. Policy development, resource provision and providing solar energy for schools make a stronger impact when implemented together, but more resources are needed to do justice to the scale of the need.

Child Protection

CHAPTER 6

KEEPING CHILDREN SAFE FOR A BETTER TOMORROW

UNICEF's Child Protection Programme at a Glance

UNICEF helps children, families and communities access improved child protection (prevention and response) services reinforced by household and community economic resilience in targeted areas.

TARGET RESULTS BY 2020

- Increased availability and accessibility of age-/gender-appropriate, affordable, and well-coordinated child protection services
- Families and communities have the information, knowledge and skills on violence against children (VAC) and protect children
- Improved evidence-based policies and legislative instruments to address VAC are implemented and reinforced by institutional capacity
- Social cash transfer beneficiary households have improved economic capacity to protect children from practices that expose children to violence, abuse and exploitation

KEY INTERVENTIONS

- Scaling up an integrated national case management system
- Social cash transfers to economically disadvantaged and labour-constrained households
- Promote positive behavior changes and attitudes for the protection of children
- Improving access by child victims and their families to quality, comprehensive and well-coordinated child protection services
- Strengthening the capacities of core child protection government ministries, departments and institutions
- Responding to the protection needs of children in emergencies, including those displaced or unaccompanied minors migrating across borders

SUSTAINABLE DEVELOPMENT GOALS FOR CHILD PROTECTION

- **SDG Goal 1:** End poverty in all its forms everywhere

- **SDG Goal 3:** Ensure healthy lives and promote well-being for all at all ages

- **SDG Goal 5:** Achieve gender equality and empower all women and girls

- **SDG Goal 16:** Promote just, peaceful and inclusive societies

The successes and challenges of social services for children

Through the National Action Plan for Children, UNICEF's child protection programme aims to secure safer futures and a more conducive environment for children in Zimbabwe, with the goal that by 2020, all children should have access to care, protection and support. UNICEF works to achieve this goal through supporting household economic security, expanding access to quality social services, and helping to strengthen the government's child protection systems.

The progress, achieved in the face of extreme challenges in a complex programming environment, is remarkable. Passionate grassroots Child Care Workers (CCWs) are committed to identification of the children at risk and accessing appropriate welfare, protection, legal and psycho-social services. Cases of sexual violence are increasingly followed up with child- and victim-friendly processes. The state workforce is receiving protection and prevention focused capacity enhancement.

The government, with support from UNICEF, is creating a structural system to respond to children's protection needs. The national case management system enables children at risk to be identified, recorded in the database and provided with a broad suite of interventions. Legal frameworks to ensure that implementation measures are compliant with child rights have been instituted.

The challenges however are significant. Key research, (2013)[2] indicates that of children whose rights have been violated, only 30 per cent are aware of where they can seek support, but of that number, only 3 per cent actually receive it. Services are currently not sensitive enough to disability or gender, nor are they age-appropriate.

2 National Baseline Study on the Life Experiences of Adolescents (NBSLEA)

While Zimbabwe continues to restore and strengthen systems for child protection, the range and reach of services remains inadequate due to insufficient funding, low staff capacity, weak referral pathways and tracking, concentration of efforts in urban areas, and limited knowledge of, and confidence in existing systems. In 2014, less than 40 per cent of children who experienced sexual violence knew where to seek professional help and only 2.4 per cent of female victims of sexual abuse accessed available services. Birth registration of children under 5 years has stagnated at 32 per cent.

The first two interventions: Supply services and create demand

Increasing social services for children means making them aware of what is available – and their right to demand it. Supply and demand creation are the first two intervention areas for dealing with child protection cases.

Children play outside the Burombo Hostels. In these high-density urban flats, living conditions are harsh and children are vulnerable to abuse or neglect

Supply addresses issues such as services that are currently inadequate, not age-appropriate, and not sensitive enough to disability or gender; the lack of adequate shelter for vulnerable children; the largely under-funded and under-resourced social workers and services, among others.

Demand creation is the strategy to create awareness and generate interest in and uptake of protection services. Studies on social norms and behaviours reveal multiple factors that influence why children do – or don't – seek help, such as how families and society place certain expectations on children based on gender. Demand creation is therefore essential: to make children aware that support does exist, and that it is safe for them to access it. In other words, to demand what is available.

The National Case Management System – prevention and response in caring for children

Supply and demand-side interventions are partly addressed by the National Case Management System, the government's systematic response to protecting children. The government, with UNICEF support, has created a structural system that responds to the needs of the most vulnerable members of society.

With strategic support from UNICEF at a policy level, and through the Child Protection Fund (CPF), the Department of Social Welfare has developed a National Case Management System which is able to recognize children at risk early and provide a broad suite of interventions depending on the needs of the child. The range of responses include providing alternative care for abandoned and neglected children, seeking justice for child victims, and enabling vulnerable children to access medical care.

Community Child Care Workers (CCWs): dedicated eyes and ears on the ground

Voluntary case workers on the ground, known as the Community Child Care Workers (CCWs), are a critical part of the National Case Management System.

While children may not be able to speak up about rights violations they may suffer, it is critical that there is someone in the community who can provide early intervention and identify a troubled situation, someone who is trained and dedicated and knows who to refer a problem to. This is the role of the CCWs.

Mrs Patience Ndoro, a CCW, is the chairperson of a committee of nine – the Ward Child Protection Committee – which includes two child representatives from a community of 250 children. From within the committee is a team of trained volunteers known as CCWs. These men and women are committed to finding the children who need help, and using the correct channels to escalate the cases where necessary. Together with Sidney Shingaidze and Joyce Makadima, Mrs Ndoro is fiercely passionate about her work. "The community respects and appreciates us," she explains. "They know we are protecting children and that we mean business. We are a very strong team"

As the "dedicated eyes and ears on the ground", she and her fellow committee are invaluable to the children in her community.

RUTH AND KUDZAI'S STORY

Ruth and Kudzai sit at the table in the small section of living space their grandmother left them. It is furnished like a small kitchen but this is also where they sleep. There is an old cupboard against the wall, on its shelf a few battered enamel cups and plates. On the wall, a sign that says 'house prayer' is no longer legible because the words of the prayer have either worn off or are covered in a layer of grime. A bucket stands in one corner of the room - they have to bring water up four flights of stairs. A curtain divides their space from another living space directly behind it.

Burombo flats, the high-density housing block where Ruth and Kudzai live, are rife with social problems. Once a functioning block of flats, these council owned buildings are now occupied by as many as three families per flat; the rooms separated only by curtains. At ten o'clock this Tuesday morning, a group of men sit outside drinking. The apathy of joblessness is evident in their slumped postures. A toddler plays in the dust with an old car tyre and

"This is a child-headed household. We have found them a better place to live."

begins crying as an older child interrupts him. Patience Ndoro, the CCW, marches over to the child and quickly soothes him.

"Ruth and her sister live here alone now since their grandmother died. This is a child headed-household. Ruth is 15, her sister nine. Their brother, 18, brings in a small income from piece jobs." They are clearly comfortable with Mrs Ndoro, whose manner is a combination of pragmatic and caring. "We have managed to find them a new place to live. They will be moving from here as soon as we have raised some funds to buy them a few appliances."

Ruth and Kudzai are double orphans whose grandmother has also passed away. Community Child Care Workers have found them alternative accommodation

A funding gap: support for the Community Child Care Workers

CCWs like Mrs Ndoro and her colleague Sydney Mashingaidze work on a purely voluntary basis. As part of the capacity building programme that UNICEF supports, they are provided with bicycles. "I am too old for that bicycle," laughs Mrs Ndoro. T-shirts, bags and hats give them visible status in the community, but they receive little else. "My reward is in heaven," she tells us firmly. "I wouldn't be able to name a price for the work I do. I am available to the children who need me at all hours of the day and night. Sometimes at two in the morning …"

What would make her work easier? "It's only communication that is a challenge," she remarks. There are however funding gaps – both systemic and operational. Communication and transportation remain challenging, with something as simple as airtime to enable an emergency phone-call, being of critical importance. Additional training in counselling would also help to make the voluntary services of the CCWs even more effective.

"My reward is in heaven. I wouldn't be able to name a price for the work I do."

"Some of the work these CCWs do is of a very sensitive nature and they would need better skills and training in basic counselling, and something to further motivate them," explains one government official.

SIYABONGA'S STORY

Mrs Ndoro and her colleague spotted Siyabonga (13) one day at the end of 2016, on their way to the local clinic. The child was very thin and in pain. They thought that he was suffering from malnutrition and had him admitted to the paediatric ward of the hospital. Children over the age of 5 do not receive free medical treatment but these CCWs were able to assist Siyabonga, who is an orphan living with his deceased mother's young sister, to access a government issued Assisted Medical Treatment Order – an AMTO card that would enable him to get treatment. Siyabonga had a severe urinary tract problem and needed surgery. However, he first had to go through a malnutrition program in order to recover his strength, after which he had successful surgery to treat the urinary tract complications. They had undoubtedly saved the child's life.

Mrs Ndoro is clearly delighted to see Siyabonga looking so strong and healthy now. He smiles uncertainly at the attention he is receiving from her.

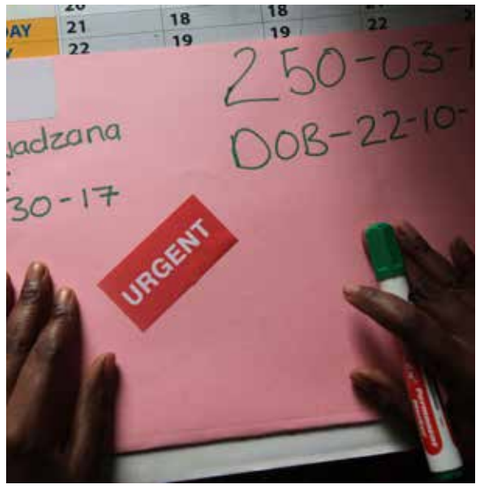
"What do you do for fun, Siyabonga?" His face lights up. "I like football."

"Ah. Who is your favourite team?"

"Orlando Pirates," he says. The adults around him laugh with pleasure, and Siyabonga says solemnly that his favourite subject is Maths and he wants to be a pilot.

"This is our boy," says Mrs Ndoro with pride. "We saved his life."

Regulatory Frameworks – to guide the decisions and actions of social service caseworkers – are being strengthened



The third intervention: Building the capacity of state departments to manage child protection cases

The third aspect of Child Protection's work in Zimbabwe is capacity building within the state system.

A key strategy is planning, designing and supporting the workforce to maintain a protection and prevention focus, which has resulted in the training of 130 social workers and over 9300 CCWs.

Information management is also an important part of the programme at this level. UNICEF has identified the need to bolster the capacity of institutions to generate administrative data. Currently, the systems remain paper-heavy, especially at the service point level. Case analysis is paper-based. In the average week of a social worker's job, four days might be spent filling in forms, rather than talking to children and providing emotional support. Social workers become administrators. There is a need to make the business process more efficient.

Sexual violence and abuse: Children in Zimbabwe need protection

In every stratum of Zimbabwean society, there are children who are exposed to violence - physical, psychological or sexual.

However, the 2012 National Baseline Survey on Adolescent's Life Experiences (NBSLEA) showed that nearly a third of girls are exposed to sexual violence before their 18th birthday, and are three times more likely than boys to experience sexual abuse.

The same study shows that socio-economic factors play a role in children's likelihood to be abused, and that double-orphaned girls are twice as likely to experience sexual abuse as compared to girls that have parents at home. Children living with disability will be at greater risk, while girls in the lower income strata experience emotional abuse and are five times more likely to be pressurized into sex or engage in transactional sex.

The 2014 Multiple Indicator Cluster Survey (MICS) showed that almost 63 per cent of children aged 1 to 14 years experienced psychological aggression or physical punishment in the month before the survey.

Working with NGO partners to respond to the scourge of sexual violence

Victim Friendly Systems: providing sensitive and appropriate help for young survivors

Counsellors at the Family Support Trust use dolls and other means to build a relationship of trust with victims of sexual abuse

HARARE CENTRAL HOSPITAL AND THE FAMILY SUPPORT TRUST

The Family Support Trust (FST) is a local Zimbabwean NGO that offers medical and psycho-social support to sexually abused children.

Every one of the tiny rooms at the FST is used for at least one purpose, sometimes as many as three. The reception, where walk-in or referred cases of sexual abuse are first recorded, doubles up as an office. In a small treatment room containing only a desk piled with medical supplies, a patient will be tested for HIV, receive post-exposure-prophylaxis, and a pregnancy test. Yet another room is equipped with a metal bed for medical examinations. The counselling room, next door to that, has a welcoming atmosphere, complete with gender-appropriate dolls which can be used to give counsel and extract testimony. Despite the cramped conditions, the level of care that survivors of sexual abuse receive at the FST is methodical, respectful and compassionate.

Secluded from the main part of the hospital, here victims receive a critical piece of assistance along with the other aspects of care – filling in of the medical affidavit, which they will need in order to pursue the legal aspect of their case.

They also receive psycho-social support and counselling from trained psychologists and social workers, medical advice and care from doctors and nurses, and the option of long-term follow up in the form of support groups.

FST provides support through the Ministry of Health and Child Welfare as part of the health sector response to child sexual abuse. This 'one stop' child-friendly clinic for abused children is considered a centre of excellence in the management of sexual abuse. Since its establishment in the Harare Central hospital it has opened new clinics in Chitungwiza, Mutare and Beitbridge, bringing the total to four.

The FST unit at Harare Central Hospital sees 100 cases a month. The majority of cases are in the 12 to 16 age group, and the second highest number is within the 0 to 5 age group.

Help is a call away – Childline

Childline Zimbabwe was established in 1997 by a group of Zimbabwean women (known as Soroptimists) as the country's 24-hour toll-free helpline service for children who have been exposed to violence. It was based on models from other Childline initiatives in South Africa and the United Kingdom. From 2014 onwards the Helpline was expanded and the system upgraded with financial support from the embassy of Japan, UNICEF, and Plan Germany. Counsellors on the Helpline increased from six to 12 for the Harare Call centre. The Bulawayo Call centre has four counsellors.

UNICEF support to Childline

UNICEF provides technical and financial support to Childline to improve access to the 24-hour Helpline and to link it to the case management efforts led by the Ministry of Social Welfare. It has also supported a system upgrade of the Helpline to facilitate more accurate data collection.

UNICEF has helped to strengthen Childline's administrative data collection and analysis skills. Several analyses of data provided by Childline have been able to inform programming. Childline provides community-based drop-in centres and localised peer-support mechanisms. An innovative e-platform, specially developed by Childline, is used for peer-support. This new initiative specifically targets adolescents who have survived violence, aimed at preventing re-victimization. In parallel, operational research is being conducted to assess the e-platform's success.

QUICK FIGURES

- 2010: 20 per cent of callers were children
- 2016: 48 per cent of callers were children
- Pre 2014: most cases reported through the drop-in centres
- Post 2014: most cases reported through the Helpline
- 2010 - 2015: Answered 2.5 million calls, responded to over 4,000 letters, counselled thousands of children and their families via the drop-in centres
- Over 45 per cent of cases reported involved child sexual abuse
- 75 per cent of reported cases involved a female child

A counselling room at Childline

The fourth intervention: Cash Transfers – a proven response to lift households out of poverty

The theory behind cash transfer programmes is that a cash distribution at the right time, of the right amount, to the right people can be a life-changing intervention, in part because it prevents the family from making decisions that have a negative effect on children.

More evidence suggests that households mired in chronic systemic poverty, when given the opportunity to manage their own crisis through an unconditional financial disbursement, are able to lift themselves gradually out of the vicious cycle. Far from being a 'handout' that keeps people in a 'begging-bowl', the intervention encourages a sense of agency and dignity.

Research and personal testimonies from beneficiaries indicates that caregivers – in most cases women – are able to make informed decisions about long-term investments in their own survival and well-being.

UNICEF, guided by the most up-to-date research, supports the Harmonized Social Cash Transfer Plus model, which has a suite of services embedded into the disbursement. At the point of disbursement, families are offered support in a number of different forms. These include HIV-related information and referrals, child protection referrals, family counselling as well as referrals for medical attention, food relief, legal- and disability-related information.

HSCT targets the 200,000 households that are food poor. Currently, 55,509 households in 20 of the 65 districts in the country are covered. The majority of these households (61 per cent) are headed by the elderly, and 3 per cent are headed by children. Most heads of household are female (61 per cent), mainly widows; 81 per cent of households include children, many of them orphans (20 per cent). Household members are mostly children (62 per cent), elderly (18 per cent), and the disabled and chronically ill (19 per cent).

Zvimba – Harmonized Social Cash Transfers (HSCT)

In Zvimba, an area where families are excluded from economic opportunity and were hard-hit by drought conditions in 2016, the Harmonized Social Cash Transfer (HSCT) system is helping to lift families out of deep poverty. HSCT complements the National Case Management System and includes the layering of services, such as Child Protection referrals, HIV- and disability-related information and referral support and legal counselling.

The national statistical agency, ZimStats, conducts an enumeration census to assess households that qualify for HSCTs. Once the government (district) officials receive the list of beneficiaries generated by a Management Information System (MIS) in the Social Welfare Ministry, verifications are done, whereby a sampling of the community beneficiaries are re-interviewed. Child Protection Committees (CPC) Focal Persons are selected to support programme implementation at community level. They know the people surrounding them and can determine if people have been recorded incorrectly, and are able to alert officers if a beneficiary household is in fact ineligible. They also assist with beneficiary mobilization once the lists are finalized, informing beneficiaries of pay-dates and information on where they would receive their cash from.

There are 3,981 beneficiaries in Zvimba, with average of five CPC Focal Persons in every ward. Beneficiaries are selected according to a strict list of criteria – focusing on food poverty and household capacity for labour.

A snapshot of qualifying for, and receiving, a Harmonized Social Cash Transfer

- Each household is visited and assessed.
- Questions depend on whether they are in urban or rural contexts
- Questions determine their assets and labour constraints or dependency ration
- For example: do they have building materials, how many blankets are owned, how many times a day do they eat
- Determining the dependency ratio is critically important because research shows that labour constraint is a higher determinacy of poverty than just the assets or income
- The amount varies per household
- $20 for a one-person household
- $30 if there are two people
- $40 for three
- $50 if there are four or more household members
- HSCTs are paid in bi-monthly cash disbursements, totaling 12 per year

Child Protection Committees: checks and balances

The Child Protection Committee members play a critical role in tracking the impact of the disbursements – collecting data on how the families are benefitting, how they are benefitting, and generally monitoring the progress of beneficiary families. Each committee has an average of five HSCT Focal Persons who assist with the actual disbursements. They have been trained in the process, and receive bicycles and cell phones to enable them to carry out their duties.

CASH TRANSFERS: THE ROUTE TO SELF-RELIANCE

Melody Madzima, 42, has five dependents and has been on HSCT for two years. She has used her disbursements to upgrade her own infrastructure: she fenced her small plot and maize field, built a well, started a small vending business, bought a goat, and paid her grandchildren's school fees, which, at $45 per term, were by far her biggest expense and had fallen into arrears. She has managed to save a small amount and does not want to make use of the other layered services, despite the fact that she qualifies. "Maybe there are others who need them," she smiles, testament to the resilient spirit of thousands of Zimbabwean women like her.

Social Policy

CHAPTER 7

Social Policy at a Glance

Social Policy strives for equity and social inclusion, through the generation and dissemination of good evidence, as well as through influencing budgets and policies in favour of children.. The overall aim is to improve equity outcomes and reduce inequality through empowering and building resilience in poor, vulnerable and disadvantaged households.

INCLUSIVE, EVIDENCE-BASED POLICY ENSURES THAT CHILDREN'S RIGHTS ARE PROTECTED

COMMITMENTS

- Remove barriers to social inclusivity
- Support the development and operationalization of coherent policy frameworks
- Generate disaggregated data to inform analysis, policies and programming
- Promote investment in children by all actors in the social sector
- Mitigate the weaknesses inherent in the country's social protection system

KEY INTERVENTIONS

- Data and evidence
- Policy and Budgets
- Building national capacities in academic programmes
- Environment and climate

UNICEF'S SOCIAL POLICY PROGRAMME IMPACTS EIGHT MAIN AREAS

Creating an enabling environment	Guiding the drafting of the new constitution	Conducting fiscal space advocacy	Policy reforms (child-friendly sector policies);
Sector action plans	Pooling donor funds	Evidence generation	Systems strengthening

SUSTAINABLE DEVELOPMENT GOALS FOR SOCIAL POLICY

- **SDG Goal 1:** End poverty in all its forms everywhere

- **SDG Goal 16:** Promote just, peaceful and inclusive societies

TARGET RESULTS BY 2020

- At least three national policies on social inclusion developed
- The percentage of poorest households receiving economic support and social cash transfers in the last three months increased from 7 per cent to 40 per cent
- The percentage of annual Government expenditure for social services increased from 29 per cent to 40 per cent
- The number of nationally representative social, economic and health surveys conducted increased from 1 to 3

Social Policy's Successes

The successes of UNICEF's Social Policy team are shaped by solid statistical research and accurate data collection; policy and budget development; building capacity in national academic programmes; and addressing climate change. The significant reach includes influencing decisions made at government level; how money is spent to save lives; ensuring the rights of vulnerable children and families; supporting systems strengthening across social sectors; ensuring academic programmes that are sensitive to child rights; and serious responses to climate change – all with an emphasis on how children's lives are impacted. An underperforming economy and high poverty levels mean that households, facing increased pressure, are unable to withstand financial shocks, which in turn puts children at risk. The social protection system is constrained by low levels of state funding and a reliance on donor support. Programmes to protect children's rights therefore need to carried out with maximum levels of efficiency, prudent management and accountability. UNICEF's commitment to social inclusion is built on four main pillars.

Data and Evidence: The human face of data analysis

Crunching data might not seem as inspiring or immediately rewarding as other aspects of development work. But for the team in UNICEF's Social Policy section, data is a critical foundation of decisions made that affect the lives of marginalized people, and influence how policy is crafted.

It impacts the complicated lives of ordinary people. Like the child whose grandmother is eking a living out of the soil, whose harvest is devastated by late rains and falls asleep listening to his baby sister crying from hunger, or the grandmother who worries about how she will pay school fees for her three dependents. The adolescent boy, orphaned at the age of 10 and living on the streets, falls on the wrong side of the law. The 16-year-old girl, pressured into marrying an older man before she has finished school – these lives are affected by legal frameworks crafted by people they will never meet.

Below Felicitas Chanyedza supports three orphans

Programming and policy to combat child poverty needs to rest on solid statistical research. Decisions made at government level are made based on data – information that tells us where the problems are, how many people are affected, what age those people are, whether they are girls or boys and how their situation is affected by where they live. Due to policy influenced by UNICEF, the child on the wrong side of the law will now have a system in place that protects his rights as he goes through the justice system. New legislation preventing child marriage is as a result of advocacy processes supported by accurate data and research.

Analyzing statistical data looks at the big picture to understand how programming can be improved.

Quality assurance – research that can be trusted

60 per cent of the time of the Social Policy section is spent on data collection, analysis and specialized studies, conducted through the research portfolio. The surveys, conducted with National Statistics systems, are used for policy advocacy and to guide and strengthen programming.

Strong reliable data plays a critical role in shaping the way in which money is spent to save lives in Zimbabwe. It enables cost-effectiveness; interventions to address the root causes of social problems rather than the symptoms only; and thorough coverage. For example, inequities based on age, gender, geographic location or religion can be better understood and remedied through analyzing the statistical information available.

Secondary disaggregated analysis is the necessary counterpart to collection. It provides precise information so that decisions can be made to influence programming in specific areas such as nutrition, child protection, HIV or health. Knowledge management, evaluation and operational research ensure that programmes are relevant, evidence-based, and responsive to the need for innovation.

Other types of research include specialized studies, such as an ongoing longitudinal study on education which tracks out of school youth and specialized research reports on particular areas. Monitoring of results and spending also ensures greater accountability.

Getting to the root of the problem: A case study that illustrates the value of accurate research.

Maternal mortality is a critical indicator for UNICEF, in determining the efficacy of health programmes. If women die in childbirth, the ripple effect for families, children and communities is devastating. Because of accurate data analysis, UNICEF was able to identify that 40 per cent of the maternal mortality statistics were of very young – adolescents who were being forced into child marriages. The problem was not, in these cases, a medical one, but a cultural-behavioural one. By advocating for behavior change and outlawing of child marriages, the Supreme Court did indeed outlaw child marriages with an intended result of leading to fewer very young women dying of childbirth-related complications – and this before any budgetary allocation needed to be made in the health system. Data is not faceless.

Policy and budgets

UNICEF works closely with government on policy development. Three recent policies protect the lives of Zimbabweans: The Social Protection Framework and Action Plan ensures that the rights of vulnerable children and families in Zimbabwe are entrenched into government systems. The National Disability Policy provides a framework for people living with disabilities to be included as actively contributing social and economic citizens. And the National Youth Policy ensures that the needs of the marginalized are protected – critical in a country with a large youth population (41 per cent of Zimbabweans are under 15 years-old).

Monitoring of results is also critical for budget allocations – data can be used to make specific investment cases that benefit children. By tracking and monitoring actual disbursements, incorrect expenditure can be quickly exposed and rectified.

Addressing the fiscal gap is important for ensuring the functionality of programmes such as nutrition or health. This happens at both national and local level. 93 per cent of local authorities are now starting to track budgets to ensure child-friendly spending.

Building national capacities in academic programmes

It is important to ensure that universities are producing graduates that are sensitive to child rights. Responding to a need to produce greater awareness of the needs of children, and the importance of addressing child poverty, UNICEF inputs into academic programmes at Post-graduate, Bachelor and Masters of Arts levels. In 2017 a PHD candidate was also receiving guidance.

Additionally, short courses have been developed for Members of Parliament, police officers and other civil servants, with the intention to capacitate and build awareness so that violence towards children can be reduced, and ultimately eliminated.

Ambassadors for child rights

Over three to four years, 200 graduate teachers, nurses and social workers have been trained in an initiative to strengthen advocacy and create sensitivity and awareness towards children; making ordinary members of the Zimbabwean workforce ambassadors for child rights.

Climate change puts tobacco and other subsistence farmers at risk

Environment and climate

A new priority and focus area in UNICEF responds to the need to take climate change and environmental degradation seriously, particularly when it comes to understanding the impact on children. There are five strands to this component:

Environmental data and statistics	National Climate Change Response Policy	Projects and models	Sustainable energy for children	Green Innovations Hub (GiHub)
How climate change is affecting children in poverty and how climate awareness can be mainstreamed into child-friendly programming	How can policies be responsive to the most vulnerable?	Solar energy in schools; green garden; bio-digesters; solar water pumps. Small projects that yield positive results can impact work done in sectors such as nutrition, water and sanitation, and education.	Understanding how energy poverty can undermine health and access to opportunity.	Support for entrepreneurs

Sustainable energy for children

The situation of children in poverty is exacerbated by lack of access to energy, which can affect school performance, health and nutrition. A recent study on sustainable energy for children, helped provide baseline data to understand these conditions more deeply and then promote models that can make a difference. The study, which will contribute towards the formulation of policies that promote renewable energy, made several recommendations. In schools and health facilities, the viability of mini-solar-grids will have beneficial impact, while teaching renewable energy technologies in school, such as bio-gas and solar, will play a role in changing cultural perceptions and barriers to adoption of new technologies.

Fuel-efficient cook stoves

Only 40 per cent of the rural population has access to electricity. Wood fuel is the most common form of energy used for cooking. The support and roll out of fuel-efficient cook stoves can reduce respiratory diseases, the third highest killer in Zimbabwe.

Culturally, Zimbabweans cook in the middle of the hut, with the family sitting around the fire. This means that children inhale smoke, which can have detrimental effects on their eyes and respiratory health. This has been overcome to an extent by the new cook stoves. They can be mounted in the middle of the room and there are less emissions affecting children.

Left Tobacco farmers are dependent on rainfall for their cash crop.

Energy for night-light is also a problem. With 59 per cent of primary schools and 39 per cent of secondary schools having no access to electricity, children's academic results are affected when they have no light to read at night. Lack of access to pumped water can also affect sanitation, especially at school. When given the opportunity to change from wood-fuel energy to renewable or cleaner sources, 65 per cent of users wanted to change and were prepared to pay for the change to either electricity or paraffin. Torches and cell phones are increasingly being used for lighting in domestic contexts.

Green Innovations Hub (GiHub)

Through supporting young entrepreneurs with smart ideas for social innovation and business, UNICEF is helping to build momentum towards a green movement in Zimbabwe. The Green Innovations Hub was one such platform for encouraging entrepreneurs to make a difference, and give them the boost they needed.

Young people were invited to submit ideas that addressed climate change in their communities. Twelve ideas were shortlisted, and winners awarded grants to develop their projects and products. Green innovations include bio-gel made from sweet sorghum; low-cost fuel pellets; solar powered irrigation and a system to purify and harvest gas from bio-digesters. There is a strong case to be made for the role of innovation, both in creating economic opportunity and contributing to climate change resilience.

Part of the interest and awareness sparked by the GiHub was in the process by which innovations were identified. The climate friendly booklet for schools, developed by UNICEF to raise the profile of environmental issues, was a catalyst for young people to generate ideas and solutions to problems that affected them.

GREEN INNOVATIONS GRANT – TINASHE'S TEMP BAGS

Tinashe Manyonga's big idea solves two problems at once: rampant proliferation of litter and the need for fuel-efficient cooking in his neighbouring communities. In a small garage workshop at his home, Tinashe makes hot/cold bags and boxes out of waste polystyrene and cardboard, which he buys from grassroots sources like school environmental clubs. Along with a variety of other products, his Temp Bags can be branded for specific clients and are targeted to particular niches. One of his ideas is a bag designed for boiled eggs so that vendors can have a hygienic storage facility for this popular street food.

Winning $5000 at the Smart Energy Innovations Challenge in 2012, Tinashe was able to expand his product range and by 2014 he had perfected his 'super cooler', made from a combination of corrugated cardboard, PET plastic bottles, maize bags and polystyrene. With the GiHub grant, Tinashe bought sewing machines and expanded the business. He currently employs 12 people and is looking to establish manufacturing sites in other countries.

Conclusion: Discerning the multiple obstacles to social inclusion

In Zimbabwe there are many ways or reasons to be left behind – geographical, age, gender, income, disability or religion can all play a part in marginalizing people. These multiple factors need to be properly understood for programmes to address equity and social exclusion effectively.

The job of the Social Policy section within UNICEF is to continuously analyze both the ongoing work as well as the shifting landscape of social and environmental pressures. Their findings then need to be communicated to the people and players that are implementing, both within UNICEF and with national government, to influence policy to eradicate child poverty.

Programme Effectiveness

CHAPTER 8

IMPROVING EFFECTIVENESS ACROSS ALL UNICEF PROGRAMMES

Cross-sectoral programmes

Making a difference for the children of Zimbabwe means working across the sectors to improve operational efficiency, innovate, and ensure that the delivery of programming happens in a coordinated way. While each of the sections within UNICEF can boast that progress is being made, and lives are being improved, it is worth reflecting on the factors that make UNICEF's work effective. One of these is that the organization avoids silo-thinking and recognizes that some issues affect everybody. Gender, for example, is mainstreamed across sections.

UNICEF bases its planning and programming on sound evidence and data. Cross-sectoral support is achieved by enhancing the capacities of staff and partners in a human rights approach to programming. Preparing for emergencies so that response is effective and coordinated; publically communicating and advocating for children on social behaviours that may affect them negatively. In addition to these factors, UNICEF keeps abreast of technological change, supporting innovation that can enhance development efforts.

On the operational side, UNICEF places emphasis on strengthening risk management in the Harmonized Approach to Cash Transfers (HACT), supply chain procurement, and end-user monitoring. We also focus on effective and efficient management of our human resource capacities and accountabilities and improving sub-national operational capabilities in service delivery and reporting.

Emergency preparedness and response

Whether fighting a cholera outbreak or responding to droughts and flooding, UNICEF understands the need to plan for emergencies, shocks and disasters. When these occur, response comes in the form of immediate relief efforts, coordinated across sectors and made more efficient because they have been planned for in advance.

Public advocacy and communication for social and behaviour change

In all of UNICEF's work in Zimbabwe, there is a strong element of public engagement. By collecting and analysing reliable data, it is possible to determine what behaviours in society are impacting negatively on children, and then creating awareness in society at all levels – from communities and families to ministries and policy makers.

Technology for development

Innovations such as U-Report are beginning to revolutionize the way that development can be planned and implemented. Using mobile technology platforms, UNICEF has been able to transform community involvement and participation into genuine partnership. In the WASH sector, for example, communities have been able to input into a live database that keeps a real-time inventory of water points that need repair, boreholes that have dried up and progress made in hard-to-reach areas.

Organizational resource mobilization, learning, reporting and risk management

Climate change is increasingly a mainstream and cross-sectoral issue. In the WASH sector, there has been strong evidence that boreholes and wells have been impacted by climate change. The recent drought had a negative impact on food security, and the Nutrition sector has had to increase risk management into all of its programming.

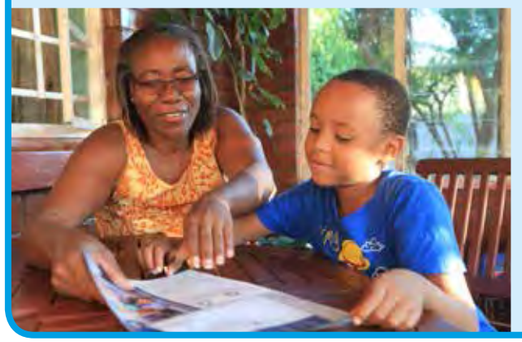
UNICEF AS COORDINATING BODY FOR POOLED FUNDS

FINDINGS OF THE TFM REPORT

Several factors were identified as strengths:

- UNICEF Zimbabwe Country Office has upgraded its human capacity profile; re-engineered internal processes to streamline processes; improved its central procurement capacity and put in place systems to ensure that processes run on time.
- UNICEF's relationship with Government, its perceived neutrality, its status as a UN agency and its technical capacity enable it to engage both strategically and operationally with government, allowing policy influence.
- For Government, UNICEF was seen as being in a position to negotiate with donors on its behalf, arguing for priorities and implementation modalities that are aligned with Government objectives.
- The high trust in UNICEF's systems meant that donors were willing to pool resources and risk, and optimally harmonize fund budgeting, implementation and reporting procedures.
- UNICEF's mandate enables focus and expertise, a key value-add to its role as fund manager.
- Having one fund manager acting across inter-related sectors means that synergies between sectors are better.

"Government and TFM donors alike emphasized that UNICEF adds value as a fund manager because of its technical capacity in-country. It can engage government on behalf of donors, and vice versa, with both recognizing it as a highly legitimate voice in the dialogue. Overall the strong leadership of the UNICEF Health, Education, Child Protection and WASH Sections currently, and UNICEF Zimbabwe overall, was acknowledged by development partners, government and implementing partners."



Left "He has accepted me as his mother." Penny Ndlovu fostered her son Matthew through the Department of Social Welfare

Conclusion

Each of the stories that make up the mosaic of Zimbabwe's bigger story is one of resilience in the face of adversity. These are stories of people who, when dealt circumstances that would challenge any human to the edge of one's capacity, have been able to muster resources, no matter how meagre, whether material or intangible – to try and start again. It is the story of individuals and groups – officials, grassroots workers, NGOs and donors – committed to making a positive difference. Together, these stories do tell a tale of the beginnings of recovery. But they also tell a tale of deep poverty, and the need for far more intervention.

There is no single solution to poverty and its spiral of effects. It is a misconception that if the country's economy improves, the entire population will benefit. Social inclusion does not automatically result from economic growth, as has been seen in examples worldwide. There is no substitute for proper investment in social programmes, alongside rights-based policies that alleviate poverty. Zimbabwe has started to do both of these, and results are showing, but much more is needed, and the country cannot complete its recovery alone. At a time when the problems of the world seem urgent and clamorous in all quarters, it is more important than ever to continue to invest in those stories where the seeds of success have already been planted and are beginning to grow. Zimbabwe is one such story.

Abbreviations

AIDS Acquired Immunodeficiency Syndrome
ANC Antenatal Care
AMTO Assisted Medical Treatment Order
ART Antiretroviral Therapy
ASRH Adolescent Sexual and Reproductive Health
BEAM Basic Education Assistance Module
CATS Community Adolescent Treatment Supporter
CBO Community Based Organization
CCW Community Child Care Worker
CLTS Community-led Total Sanitation
CMAM Community Management of Acute Malnutrition
CPC Child Protection Committee
CPF Child Protection Fund
DCWPS Department of Child Welfare and Probation Services
DHS Demographic and Health Survey
DRM Disaster Risk Management
ECD Early Childhood Development
EID Early Infant Diagnosis
EMIS Education Management Information System
EmONC Emergency Obstetric and Neonatal Care
eMTCT Elimination of Mother-to-Child Transmission (of HIV)
EDF Education Development Fund
ERI Early Reading Initiative
ETF Education Transition Fund
FPL Food Poverty Line
GDP Gross Domestic Product
GNU Government of National Unity
HAKT HIV-AIDS Knowledge Test
HIV Human Immunodeficiency Virus
HMIS Health Management Information Systems
HSCT Harmonized Social Cash Transfers
HDF Health Development Fund
HTF Health Transition Fund
IMR Infant Mortality Rate
JMP Joint Monitoring Programme
LSTM Liverpool School of Tropical Medicine
MDG Millennium Development Goal
M & E Monitoring and Evaluation
MICS Multiple Indicator Cluster Survey
MIMS Multiple Indicator Monitoring Survey
MMR Maternal Mortality Ratio
MNCH Maternal, Newborn and Child Health
NMS National Micronutrient Survey
MoHCC Ministry of Health and Child Care
MoPSE Ministry of Primary and Secondary Education
MSME Micro, Small and Medium Enterprises
MTCT Mother-to-Child Transmission (of HIV)
NBSLEA National Baseline Survey on Life Experiences of Adolescents
ODA Official Development Assistance
ODF Open-defecation Free
OECD Organisation for Economic Co-operation and Development
OVCs Orphans and Vulnerable Children
PHC Primary Health Care
PICES Poverty, Income, Consumption and Expenditure Survey
PMTCT Prevention of Mother-to-Child Transmission (of HIV)
PNC Postnatal Care
PLAP Performance Lag Address Programme
PTR Pupil-Teacher Ratio
RBF Results-Based Financing
RUTF Ready to Use Therapeutic Foods
RWIMS Rural Water Information Management System
SAG Sanitation Action Group
SIG School Improvement Grant
STEM Science Technology Engineering Mathematics
TCPL Total Consumption Poverty Line
TIBF Timely Initiation of Breastfeeding
UNDP United Nations Development Programme
UNICEF United Nations Children's Fund
VFC Victim Friendly Court
VHW Village Health Worker
WASH Water, Sanitation and Hygiene
WFP World Food Programme
WHO World Health Organization
ZDHS Zimbabwe Demographic and Health Survey
ZELA Zimbabwe Early Learning Assessment
ZIMASSET Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMSTAT Zimbabwe National Statistics Agency
ZIMVAC Zimbabwe Vulnerability Assessment Committee
ZINWA Zimbabwe National Water Authority
ZRP Zimbabwe Republic Police

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