Zimbabwe 2006

IRIN/Zimbabwe/2003

Consolidated Appeals Process (CAP)

UNITED NATIONS

Consolidated Appeals Process (CAP)

The CAP is much more than an appeal for money. It is an inclusive and coordinated programme cycle of:

- strategic planning leading to a Common Humanitarian Action Plan (CHAP);
- resource mobilisation (leading to a Consolidated Appeal or a Flash Appeal);
- coordinated programme implementation;
- joint monitoring and evaluation;
- revision, if necessary; and
- reporting on results.

The CHAP is a strategic plan for humanitarian response in a given country or region and includes the following elements:

- a common analysis of the context in which humanitarian action takes place;
- an assessment of needs;
- best, worst, and most likely scenarios;
- stakeholder analysis, i.e. who does what and where;
- a clear statement of longer-term objectives and goals;
- prioritised response plans; and
- a framework for monitoring the strategy and revising it if necessary.

The CHAP is the foundation for developing a Consolidated Appeal or, when crises break or natural disasters strike, a Flash Appeal. Under the leadership of the Humanitarian Coordinator, the CHAP is developed at the field level by the Inter-Agency Standing Committee (IASC) Country Team. This team mirrors the IASC structure at headquarters and includes UN agencies and standing invitees, i.e. the International Organization for Migration, the Red Cross Movement, and NGOs that belong to ICVA, Interaction, or SCHR. Non-IASC members, such as national NGOs, can be included, and other key stakeholders in humanitarian action, in particular host governments and donors, should be consulted.

The Humanitarian Coordinator is responsible for the annual preparation of the consolidated appeal *document*. The document is launched globally each November to enhance advocacy and resource mobilisation. An update, known as the *Mid-Year Review*, is to be presented to donors in July 2006.

Donors provide resources to appealing agencies directly in response to project proposals. The **Financial Tracking Service (FTS)**, managed by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), is a database of donor contributions and can be found on www.reliefweb.int/fts

In sum, the **CAP works to provide people in need the best available protection and assistance, on time.**

ORGANISATIONS PARTICIPATING IN CONSOLIDATED APPEALS DURING 2006:

AARREC	CESVI	GSLG	OCHA	UNAIDS
AASAA	CHFI	HDO	OCPH	UNDP
ABS	CINS	HI	ODAG	UNDSS
Abt Associates	CIRID	HISAN - WEPA	OHCHR	UNESCO
ACF/ACH/AAH	CISV	Horn Relief	PARACOM	UNFPA
ACTED	CL	INTERSOS	PARC	UN-HABITAT
ADRA	CONCERN	IOM	PHG	UNHCR
Africare	COOPI	IRC	PMRS	UNICEF
AGROSPHERE	CORD	IRD	PRCS	UNIFEM
AHA	CPAR	IRIN	PSI	UNMAS
ANERA	CRS	JVSF	PU	UNODC
ARCI	CUAMM	MALAO	RFEP	UNRWA
ARM	CW	MCI	SADO	UPHB
AVSI	DCA	MDA	SC-UK	VETAID
CADI	DRC	MDM	SECADEV	VIA
CAM	EMSF	MENTOR	SFCG	VT
CARE	ERM	MERLIN	SNNC	WFP
CARITAS	EQUIP	NA	SOCADIDO	WHO
CCF	FAO	NNA	Solidarités	WVI
CCIJD	GAA (DWH)	NRC	SP	WR
CEMIR Int'l	GH	OA	STF	ZOARC
CENAP				

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MAP OF ZIMBABWE

Map No. 4070 Rev. 1 UNITED NATIONS
June 2002

Department of Public Information
Cartographic Section

1. EXECUTIVE SUMMARY

Many of the humanitarian challenges facing Zimbabwe are common to countries in Southern Africa, particularly the "triple threat" of Human Immuno-Deficiency Virus/Acquired Immuno-Deficiency Syndrome (HIV/AIDS), food insecurity and declining capacity for basic social service provision, in addition to a large number of orphans and vulnerable children. The humanitarian situation in Zimbabwe is further impacted by economic decline, and formal and informal migration of skilled and unskilled labour, which could be countered by appropriate Government policies. In the 2005-2006 season, at least three million people will require food assistance, as the country has harvested an estimated 600,000 Metric Tonnes (MTs) of maize, compared to its requirement of 1.8 million MTs. While the HIV/AIDS prevalence rate among adults is reported to have dropped to 21.3% in 2005, the disease continues to cause the death of 3,000 Zimbabweans per week. HIV/AIDS has also fuelled a rapid growth in the number of orphans and vulnerable children, which has now reached over 1.3 million. The economic situation, with high inflation rates, shortages in foreign exchange, high unemployment and negative growth, adds to the vulnerability and suffering of the population.

In 2005, the humanitarian situation was further compounded by the Government's Operation Murambatsvina/Restore Order, which targeted what the Government considered to be illegal housing structures and informal businesses. The operation led to rapid growth in the number of displaced and homeless people, combined with loss of livelihoods for those that previously worked in the informal sector. Based on Government estimates that 133,000 households were evicted during the Operation, the Secretary-General's Special Envoy for Human Settlement Issues in Zimbabwe estimate that some 650,000-700,000 people were directly affected through the loss of shelter and/or livelihoods.

The Inter-Agency Standing Committee (IASC) members participating in the Consolidated Appeals Process (CAP) for Zimbabwe project that the humanitarian situation is likely to continue to deteriorate in 2006, particularly due to the steady decline of the economy, which will have an adverse effect for already vulnerable populations. Among the expected developments in 2006 are decreases in the quality and access to basic services; deepening of urban poverty; continued difficulty of people previously employed in the informal sector in re-establishing their livelihoods; continued emigration, both legally and illegally; new farm evictions; and deepening overall vulnerability to natural disasters. In this scenario, participants in the CAP expect that, unless appropriate humanitarian action is taken, the use of negative coping mechanisms will increase, placing vulnerable persons at further risk, deepening poverty and minimising opportunities for long term recovery.

The priority humanitarian actions for 2006 will be to save lives, enhance positive coping mechanisms, mitigate the impact on vulnerable populations, and ensure a comprehensive and co-ordinated humanitarian response. The objectives of this Appeal are to: (i) reduce morbidity and mortality rates; (ii) increase access and quality of basic social services; (iii) prevent the further deterioration of livelihoods and enhance community coping mechanisms; (iv) provide protection for the most vulnerable; and (v) contribute to the prevention, mitigation and provision of care and treatment for HIV/AIDS.

The 2006 Consolidated Appeal aims to: provide food assistance to an estimated 3 million people; provide agricultural and livelihoods support to 1.4 million households; improve access and quality of education services for 93,000 children; provide temporary shelter to 23,000 displaced and homeless households; immunise 5.2 million children against preventable communicable diseases and ensure nutrition and disease surveillance; provide home-based care for 55,000 persons living with HIV/AIDS; provide basic health care, including essential drugs and anti-retroviral drugs to 3.6 million people; assist 600,000 women and children in mother and child health care programmes; target 1.6 million community members in health monitoring and surveillance; reach 4.5 million people with messages to promote behavioural change and prevent HIV; sensitise 1.5 million people on the prevention of Sexual and Gender-Based Violence (SGBV); provide multi-sectoral assistance to 300,000 mobile and vulnerable populations; provide assistance to 96,000 returning deportees; ensure assistance and psychosocial support to over 500,000 orphans and vulnerable children; and to deliver improved water and sanitation services for 2.4 million people. To this end, a total of 46 appealing agencies, including UN organisations, national and international Non-Governmental Organisations, community and faith based organisations, are requesting a total of **US$ 276,503,174** to implement programmes and projects as part of the 2006 CAP.

TABLE I. SUMMARY OF REQUIREMENTS BY SECTOR AND BY APPEALING ORGANISATION

Consolidated Appeal for Zimbabwe 2006
Summary of Requirements - by Sector
as of 16 November 2005
http://www.reliefweb.int/fts

Compiled by OCHA on the basis of information provided by the respective appealing organisation.

Sector Name	Original Requirements (US$)
AGRICULTURE	43,762,933
COORDINATION AND SUPPORT SERVICES	2,597,975
ECONOMIC RECOVERY AND INFRASTRUCTURE	5,317,188
EDUCATION	4,540,716
FOOD	111,000,000
HEALTH	39,550,749
MULTI-SECTOR	26,130,849
PROTECTION/HUMAN RIGHTS/RULE OF LAW	8,029,990
SECURITY	100,520
SHELTER AND NON-FOOD ITEMS	20,282,400
WATER AND SANITATION	15,189,854
Grand Total	**276,503,174**

Consolidated Appeal for Zimbabwe 2006
Summary of Requirements - By Appealing Organisation
as of 16 November 2005
http://www.reliefweb.int/fts

Compiled by OCHA on the basis of information provided by the respective appealing organisation.

Appealing Organisation	Original Requirements (US$)
ACF	1,500,000
Africare	5,578,384
ANPPCAN	124,600
Arise Zimbabwe	308,000
ASAP	168,228
ATP	352,800
CARE INT	650,000
CDES	23,519
Christian Care	2,557,190
CRS	4,177,188
DACHICARE	350,500
DSHZT	1,065,000
FAO	30,955,000

Consolidated Appeal for Zimbabwe 2006

Summary of Requirements - By Appealing Organisation

as of 16 November 2005

http://www.reliefweb.int/fts

Compiled by OCHA on the basis of information provided by the respective appealing organisation.

Appealing Organisation	Original Requirements (US$)
FCT	500,000
HOSPAZ	870,602
ILO	3,450,000
IOM	30,878,300
JJB	33,000
MCI	13,750,000
MDA	2,050,000
Mvuramanzi Trust	813,300
NHZ	53,500
OCHA	2,597,975
ORAP	172,800
OXFAM UK	4,726,647
PCC	52,000
PLAN Zimbabwe	263,800
Practical Action Southern Africa	1,640,000
PUMP AID	565,000
SAFIRE	564,000
SAHRIT	36,000
SC - UK	2,847,830
SCN	305,000
SOS	370,500
UNDP	150,000
UNDSS (previously UNSECOORD)	100,520
UNFPA	1,580,000
UN-HABITAT	1,000,000
UNHCR	2,303,349
UNICEF	23,763,815
UNIFEM	841,600
WFP	111,000,000
WHO	16,937,600
WVZ	4,000,000
ZACH	218,500
ZNCWC	257,127
Grand Total	**276,503,174**

The list of projects and the figures for their funding requirements in this document are a snapshot as of 16 November 2005. For continuously updated information on projects, funding requirements, and contributions to date, visit the Financial Tracking S ervice (www.reliefweb.int/fts).

2. 2005 IN REVIEW

2.1. HUMANITARIAN RESPONSE IN 2005

The United Nations Inter-Agency Humanitarian and Developmental-Relief Programme for Zimbabwe provided the strategic framework and the action plan for humanitarian and recovery activities during 2005, since an Inter-agency Consolidated Appeal was not produced. This Programme estimated that a total of US$ 74,327,000 would be required for actions in agriculture, coordination, education, health and nutrition, protection and water and sanitation. The Programme's overall goal was to: "Mitigate the impact of social and economic conditions by supporting social protection mechanisms and strengthening livelihoods in highly affected communities". This entailed implementing community safety net programmes for facilitating transition from humanitarian actions to rehabilitation of household livelihood capacity and increased access to basic services.

The specific sector goals, objectives and achievement for 2005 include:

Agriculture: *To address household food security, and assist vulnerable populations to become less dependent on food assistance.*

- Agricultural inputs, including seeds, fertilisers and tillage provided to 310,000[1] vulnerable households, complementing Government efforts in food security.

Coordination and humanitarian guidance: *To implement timely and co-ordinated provision of humanitarian assistance and protection to communities in need.*

- Improved coordination based on reliable quantitative and qualitative information;
- Consultative meetings with key stakeholders to build concurrence on major priorities;
- Continued objective joint assessments of humanitarian needs between the humanitarian community and the Government;
- Training in Sphere Minimum Standards, Humanitarian Principles, Disaster and Emergency Preparedness and Response, including production of District Disaster Manuals. Key Government officials participated in these training sessions.

Education: *To ensure that 50,000 vulnerable children, especially girls, have access to minimum standards of education by the end of 2005, working in collaboration with the Government.*

- Procurement and distribution of core textbooks and stationery for up to 20,000 children most affected by urban displacements;
- Educational support for the 12% of households that care for orphans and other vulnerable children.

Food: *To address the food needs of the most vulnerable through targeted food distribution, focusing on nutrition rehabilitation and safety-net community based programmes such as school feeding and HBC.*

- Targeted feeding programmes, which reached 1.3 million vulnerable persons, including orphans, pregnant women with HIV, and AIDS patients;
- WFP support of 300,000 MTs to compliment 1.2 million MTs of planned imports.

Health and Nutrition: *To avert the decline in service delivery and quality and respond to immediate needs.*

- Extended Programme on Immunisation (EPI) and adequate response to cholera outbreaks (5 outbreaks in the Manicaland province);
- Ongoing training in Emergency Obstetrics Care provided to over 500 health professionals to help reduce maternal mortality;
- Training of 563 health staff in key posts at the district and health centre levels;
- Completion of two rounds of the National Nutritional Surveillance System while supporting hospital and community based Therapeutic Feeding programmes.

[1] Food and Agriculture Organization of the United Nations (FAO) Emergencies Unit

Protection of the Most Vulnerable: *To provide a meaningful protection environment, identify all Orphans and Vulnerable Children (OVCs) and ensure access to basic services for at least 25% of them, as part of the Government-led OVC National Plan of Action. In addition, focus was to provide meaningful protection and multi-sectoral assistance to mobile and vulnerable population. Many different actions supporting OVC at community level were undertaken through civil society organisations.*

- Psycho-social support provided for approximately 150,000 orphans;
- Training on the prevention of sexual exploitation and abuse for 208 humanitarian workers and staff from United Nations (UN) agencies and implementing partners;
- Counselling for 93 street children who were placed in institutions, and the reunification of 35 of these with their families;
- Support to a significant number of mobile and vulnerable populations in different parts of the country;
- Community support and relief for 334 children with disabilities affected by the emergency will soon be provided.

Water and Sanitation: *To reduce morbidity and mortality due to disease outbreaks, alleviate the burden of care of Persons Living With HIV/AIDS (PLWHA) and mitigate the adverse effects of HIV/AIDS by improving access to safe domestic water supply and adequate sanitation systems, in rural, peri-urban and urban areas for approximately 7.5 million people, by working with city authorities and rural communities.*

- Rehabilitation of 2,507 boreholes;
- Construction of 6,982 community latrines;
- Construction of 2,534 school latrines;
- Daily transport of 230,000 litres of water to populations affected by urban displacements;
- Provision of 150 temporary toilets to urban resettlement areas;
- Hygiene education to populations affected by urban displacement.

2.2. CHANGES IN THE CONTEXT AND HUMANITARIAN SITUATION

The overall political context in Zimbabwe remained generally stable in 2005. However, the economic and social situation continued to deteriorate, thus increasing the level and degree of vulnerability of many Zimbabweans. In September 2005, Parliament ratified the constitutional amendment to Chapter 17, which nationalised all commercial farms and ousted the powers of the courts to entertain any claims by owners of nationalised commercial farms. This has further marred the interest of foreign investors in the Zimbabwean economy.

Between May and July 2005, the Government of Zimbabwe carried out Operation Murambatsvina/Restore Order, which was described as an urban cleanup campaign, and which led to the destruction of thousands of housing structures and informal markets deemed illegal, leaving people without alternative shelter or any means of support. The Operation further exposed the underlying challenges involved with rapid, unplanned urbanisation and the subsequent acute housing problems. The Secretary General's Special Envoy for Human Settlements Issues in Zimbabwe undertook a fact-finding mission in June-July 2005, and concluded, based on Government estimates, that 133,000 housing structures had been destroyed, that the same number of households had been directly affected.

Of those who have lost their homes, the situation is fluid and varied. Many continue living in the open, while others stay in the ruins of their former houses or drift from location to location. Some have been taken in by relatives and friends, often in overcrowded conditions, especially in urban areas. Additionally, some have found alternative rental housing in urban areas, while others have returned to rural areas. In response to Operation Murambatsvina/Restore Order, the Government constructed 5,000 housing units under the Garikai/Hlalani Kuhle programme. However, there will be need for a stronger targeting mechanism, so that those most in need are given first priority.

In recognition of the magnitude of the humanitarian situation created by Operation Murambatsvina/Restore Order, the UN Emergency Relief Coordinator issued a letter to Donor Governments in September 2005 requesting support for the UN Common Response Plan to address

the needs of the vulnerable affected populations. The Plan requested a total of US$ 29,870,404 to address the various priority needs of an estimated 300,000 vulnerable individuals, between September and December 2005.

Access to affected families remained inadequate and at times inconsistent, especially in the locations where people were evicted. There was sometimes delayed access in the areas with high concentrations of evicted people, such as Caledonia Farm and Hopley Farm. In October 2005, the UN was still negotiating details for the provision of temporary shelter to the most vulnerable people affected, while the services listed below have continued:

- Provision of blankets and other non-food items to 157,000 individuals;
- Distribution of 300 MTs of food aid from Consortium for Southern Africa Food Security Emergency (C-SAFE) and 1,450 MTs from World Food Programme (WFP);
- Provision of 230,000 litres of clean water per day and 42,000 purification tablets;
- Provision of 150 temporary toilets in 3 camp sites and 500 kilos of lime and 2.5 MTs of soap;
- Psycho-social support, toys and sleeping material for children in camps and institutions;
- Delivery of 4,000 plastic sheets;
- Reproductive health assistance and distribution of 1,070 oral contraceptive cycles, 18,000 male condoms and 150 female condoms;
- Provision of Home-Based Care to 7,000 chronically ill people;
- Assistance to 2,500 affected refugees in Tongogara camp.

2.3. LESSONS LEARNED

Overall, good progress was made in the provision of humanitarian assistance during 2005. However, few of the set goals and targets were achieved fully. Humanitarian response, particularly to those affected by Operation Restore Order, remained relatively ad hoc and slow, mainly because of politicisation, lack of resources and challenges related to establishing a coherent and coordinated strategy.

Donor Response
In 2005, significant funding was provided for humanitarian operations and during Operation Murambatsvina/Restore Order, some donors immediately authorised the reallocation of funding from existing programmes. This flexibility facilitated a more rapid response. Financial tracking in 2005, in the absence of an appeal, has recorded only funding without reference to requirements. With the issuance of a Consolidated Appeal for 2006, both will be tracked on www.reliefweb.int/fts.

The Policy Environment
Zimbabwe has adopted many global policy commitments such as the Millennium Development Goals (MDGs), and has a number of national policies that are progressive. These include the National Plan of Action for OVCs, the HIV/AIDS levy and the National Antiretrovirus (ARV) roll out policy. However, there is a need to strengthen the conversion of these adopted policies into effective programmes. The present situation has shown the need for dialogue with the Government and other key stakeholders in order to create a common understanding on strategies and policies to assist the most vulnerable.

Assessments and data collection
Within the areas of assessments and data collection, significant progress was made in 2005 through the formulation of strategies, targeting and prioritisation. These include the Government-led Zimbabwe Vulnerability Assessment Committee (ZIMVAC), nutritional surveillance and several health assessments jointly conducted with the Government of Zimbabwe. However, there is still room for improvement in the speed with which the information between all the implementers of programmes is disseminated. In order to maximise the use of available data and improve its use by decision makers, it has been recommended to involve all stakeholders at all stages of the assessments; share information with authorities and decision makers; improve technical coordination to facilitate better vulnerability analysis using different data sources; and to improve resource mobilisation to implement programmes based on findings.

Coordination
Coordination among UN Agencies, NGOs, the Red Cross Movement, Donor and Government partners needs significant improvement, particularly in establishing effective information flow and sharing, in

order to minimise delays and reduce ad hoc and inadequate responses. To this end, measures should be taken to strengthen geographical coordination at the field level, improve communication between the field and headquarters, and institutionalise weekly and monthly meetings between humanitarian agencies, Government counterparts and the donor community. The current efforts by the UN Humanitarian Coordinator to establish an Office for the Coordination of Humanitarian Affairs (OCHA) field office will serve to address the above-identified priorities.

Information Management

Information management needs to be improved through more efficient information sharing between agencies and sectors, especially at the technical level. Agencies also need to make better use of the information available at the community and local levels and ensure that it is consolidated and centralised nationally. Furthermore, disaggregating data by age and gender would improve programme planning and targeting.

Dialogue with the Government

The Government of Zimbabwe recognises the current humanitarian situation to be the result of droughts, and as part of long-term development challenges that the country is effectively working on. The Government has acknowledged that more than 2.9 million people will be in need of food relief in 2005/2006. In this regard, there is a need for the Government, the UN and the humanitarian community as a whole to engage in building a common understanding of the humanitarian situation, the appropriate policies and the modes of collaboration. This will greatly facilitate the response to the needs of vulnerable populations.

3. THE 2006 COMMON HUMANITARIAN ACTION PLAN

The main priorities identified in the 2006 Common Humanitarian Action Plan for Zimbabwe are (i) reduced morbidity and mortality rates, (ii) increased access to basic services, (iii) prevention of further deterioration of livelihoods and enhanced community coping mechanisms, (iv) protection of the most vulnerable, and (v) reduction in the impact of HIV/AIDS.

3.1. THE CONTEXT

As highlighted by the UN Special Envoy for Humanitarian Needs in Southern Africa, the sub-region currently faces the "triple threat" of HIV/AIDS, food insecurity and weakening capacity for the delivery of basic services. The humanitarian situation in Zimbabwe is further compounded by economic decline, and formal and informal migration of skilled and unskilled labour, which could be countered by appropriate Government policies. The situation is characterised by high HIV/AIDS prevalence (21.3%[2]); reduced agricultural production, impacted by recurring droughts; and steadily declining economic performance, with an inflationary rate of over 360% and a formal unemployment rate of over 80%. Furthermore, Zimbabwe is experiencing decline in access and in quality of basic social services; gender inequalities, increasing homelessness; migration from rural areas to urban areas; and other vulnerabilities worsened by Operation Murambatsvina/Restore Order. These factors have resulted in a larger and more diverse number of vulnerable people requiring humanitarian assistance and livelihood support to meet their basic food and non-food needs over the next five years.

Natural hazards
Zimbabwe is one of many countries prone to natural disasters such as drought and floods caused by cyclones as well as epidemiological outbreaks, particularly cholera and malaria. Mashonaland Central and Masvingo provinces remain particularly prone to natural hazards. These natural disasters have rendered hundreds of households and communities even more vulnerable. National and local capacity to rapidly respond to sudden onsets of disasters needs to be further developed in order to save lives, protect assets, and deliver emergency assistance.

HIV/AIDS pandemic
Zimbabwe is one of the countries that is most affected by HIV/AIDS in the world, with an Ante-Natal Clinic (ANC) prevalence rate of 21.3%.[3] In 2004, an estimated 1.8 million Zimbabweans were believed to live with the virus and an estimated 3,000[4] people died from AIDS every week. The pandemic has contributed to a reduction in the overall life expectancy of the average Zimbabwean from 61 years in the 1990s to 34 years in 2004. This has had an adverse effect on society, with over 1.3 million children orphaned as a result of the pandemic. The percentage of orphans within the population ranges from 20% to 30% throughout Zimbabwe. HIV/AIDS increase the prevalence of illness, reduce household productive capacity, and absorbs scarce resources. Coupled with the general economic decline, the effect of HIV/AIDS on individual, household, community and national lives and livelihoods is devastating. This situation requires concerted efforts from the international community now rather than later, when the costs of actions will be prohibitive, including support to the efforts of the Government through the AIDS Levy and the ARV roll out policies.

Economic difficulties[5]
The steadily declining economic performance of the country is one of the key factors compounding the humanitarian situation. Zimbabwe's Gross Domestic Product (GDP) contracted by an estimated 7% in 2005 due to reduced agricultural production, high inflation rates, lack of foreign direct investment, lack of foreign exchange and regular fuel shortages. This follows the economic contractions of 4% and 10.5% in 2004 and 2003 respectively. The inflation rate peaked in January 2004 at 623% and stabilised in early 2005 at 130%, but soared to 360% in October 2005 and was projected to increase further to at least 400% by the end of 2005. The introduction of the foreign currency auctioning system in 2004 resulted in an acute shortage of foreign exchange and a widening discrepancy between the official and parallel market rates. On 20 October, during the monetary policy statement, the Reserve Bank proposed floating the local currency, the implications of which are yet to be fully assessed.

[2] Ministry of Health and Child Welfare (MoHCW) ANC Survey 2004.
[3] United Nations Programme on HIV/AIDS (UNAIDS) Global press release of 10 October 2005.
[4] Ministry of Health and Child Welfare September 2004.
[5] Figures where cited are from the IMF September 2005 report.

Despite these economic challenges, Zimbabwe managed to make a first instalment of US$ 120 million for debt repayment to the International Monetary Fund (IMF) in August 2005 and has stated its commitment to provide a further US$ 175 million within the next six months. The debt repayment, however, will likely result in reduced budget allocations for basic social services such as health, education, water and other public sector priorities. International financial institutions have warned that unless bold and drastic measures are taken by the Government to change the current macro economic policies, the economic outlook for Zimbabwe will remain bleak.

The price of fuel in the global market has also affected Zimbabwe. Fuel prices in the formal market increased by 733% from January to October 2005, from Zimbabwean Dollar (ZW$) 3,000 (almost US$ 0.05) per litre to ZW$ 22,000 (almost US$ 0.34) respectively. However, while fuel shortages were rampant in the country, it was reported that fuel was sold in the parallel market at the cost of up to ZW$ 130,000 (US$ 2) per litre. The shortages and the high cost of fuel have impacted all aspects of life, especially the availability and cost of basic food and non-food items, as well as the delivery of basic social services. The resulting increased cost of living has not been matched by a corresponding increase in income.

Formal unemployment is estimated at over 80% and increasing, as many businesses in the formal sector have had to lay off staff, due to declining business opportunities, increased operational costs and declining consumer purchasing power. Consequently, it is presumed that much of the skilled and unskilled labour may move to the informal sector, engage in illegal cross border trade, or immigrate to neighbouring countries. The informal sector, which served as a significant coping mechanism in the past, was significantly affected during Operation Murambatsvina/Restore Order.

Regional dynamics

Many of the humanitarian challenges that Zimbabwe is facing are common to countries in Southern Africa, in particular the “triple threat” of HIV/AIDS, food insecurity and declining capacity for basic social service provision, in addition to a large number of orphans and vulnerable children. Community-level interrelations throughout the sub-region, migration, and formal and informal cross border trade render the Southern African countries interdependent and susceptible to each other’s difficulties. On one hand, as a landlocked country, Zimbabwe’s relations with neighbouring countries who have access to the sea are important for the transport of its imports and exports. On the other hand, as Zimbabwe previously played a pivotal economic role, and was often referred to as the “breadbasket” because of its large production of cereal and dairy supplies for export, the economic challenges that Zimbabwe faces impact the entire sub-region. Zimbabwe is no longer a major exporter, but a major consumer. Having lost much of its purchasing power, it is unable to maintain its commitments and is leaving a void in the sub-regional economy. In this context, many Zimbabweans legally and illegally migrate to neighbouring countries, further impacting in their home country.

Urbanisation

Most developing countries in the world are grappling with management of increased rural migration. In Zimbabwe, factors such as the increasingly difficult living conditions in the rural areas, the general economic decline and the immediate effects of the fast-track land reform programme have resulted in accelerated migration to the urban areas, especially to Harare and Bulawayo. While the general population growth is reported to be 1-2% annually in the last decade, the urban growth rate is 5-6%. Consequently, the current urban population is estimated at 4.5 million out of the overall population of 12 million, and is projected to increase to 8 million by 2015. However, the existing policies and resources for land allocation and the provision of infrastructure and housing have not been able to keep up with the urban influx. For example, the Government of Zimbabwe estimates the urban housing backlog to be 1 million housing units. As a result, more and more people have come to live in substandard and insecure conditions in the low-income urban areas. Operation Murambatsvina/Restore Order exacerbated the situation, through the destruction of livelihoods and housing for 133,000 households, many of which require immediate shelter support.

Brain drain

Zimbabwe used to enjoy one of Africa’s highest literacy rates at 97%, with a highly qualified civil service and work force. However, due to the current economic difficulties and, sometimes, political differences with the Government, many are immigrating to other countries within and beyond the continent. For example, at the Plum Tree border between Zimbabwe and Botswana alone, over

18,000 Zimbabweans cross the border weekly.[6] This has resulted in significant brain drain and loss of labour from key public and private sector positions, leading to a rapidly declining social service delivery. Brain drain and loss of labour is also compounded by qualified personnel either being chronically ill or deceased due to HIV/AIDS. For example, in the health sector 56%, 32% and 92% of doctor, nurse and pharmacist positions are vacant. In addition, unskilled labour is emigrating, further impacting the availability of labour in productive sectors such as agriculture.

Changing social fabric
The social fabric in Zimbabwe is being transformed as HIV/AIDS and economic/livelihood difficulties negatively reinforce each other. With 21.3% of adults infected by HIV/AIDS, the number of orphans and other vulnerable children is increasing. OVCs are more likely to drop out of school to take care of chronically ill parents or elders. In many cases, grandparents with limited livelihood opportunities are left to raise orphaned children. Widowed women and men often become the sole breadwinners and caregivers of families. Furthermore, economic hardships are leading many families to migrate or separate, often with women and children left in rural areas and men moving to urban areas in search of employment opportunities. Economic hardships also result in increased use of negative coping mechanisms such as commercial sex trade, corruption, crime and unsustainable utilisation of fauna and flora.

Contentious human rights issues
The Government of Zimbabwe has domesticated and ratified most of the international conventions and treaties to correspond with national legislation, including the Convention on the Rights of the Child, but has yet to incorporate them into the domestic legal systems. In this context, the Government has reiterated one of its priorities as “the promotion of key rights”, particularly the rights of women and children, as part of the MDGs. The key rights that are at stake in Zimbabwe range from political to social and economic rights. However, adherence to humanitarian principles is often not fully implemented, and remains of concern to the humanitarian community. Examples include difficulties in providing services to the population evicted from newly reallocated farms and to those affected by Operation Murambatsvina/Restore Order.

The environment for humanitarian response assistance
There is a need for concurrence and shared understanding with the Government on the extent of the humanitarian situation in the country and on the policies that would facilitate effective response. It is also necessary to establish forums for dialogue, where all stakeholders can discuss issues of concern and jointly agree on strategies for response. Furthermore, the developments of standard operating procedures need to be accelerated, in particular with regard to accreditation of humanitarian staff, registration and unfettered access to vulnerable groups.

3.2. THE HUMANITARIAN CONSEQUENCES

A wide variety of needs assessments and vulnerability analyses were carried out in 2004 and 2005, informing the humanitarian response. The humanitarian context has been outlined above, and the consequences for vulnerable groups are described below.

Insufficient cereal production
Given the annual cereal requirement for human and livestock consumption of 1.8 million MTs of maize and the estimated harvest of around 600,000 MTs in 2004/2005, the Government of Zimbabwe has committed to importing 1.2 million MTs to meet the shortfall. It is reported that, between April and September 2005, the Government imported an average of 82,000 MTs of maize per month from the sub-region, the total of which was estimated to have reached about 500,000 MTs by the end of September 2005. However, fuel shortages have limited the distribution of maize from Grain Marketing Board (GMB) depots to different parts of the country. Therefore, the distribution of food to vulnerable groups in rural and urban areas is a major challenge. In order to complement Government efforts, humanitarian actors are planning to import and distribute 300,000 MTs of maize. While drought was a major contributing factor to the low agricultural production in the 2004/2005 cropping season, the inadequate and late supply of inputs such as fertilisers, seeds and tillage also compounded the low crop yields. With the shortages of foreign exchange and the fuel to transport these inputs, it is feared that the 2005/6 cropping season will also experience similar constraints, even if rainfall levels are adequate.

[6] Source: Embassy of the Republic of Botswana, Zimbabwe

Rising food insecurity
The ZIMVAC 2005 estimated that 2.9 million people or 36% of the rural population would not be able to meet their food requirements of 2100 kilocalories a day during the 2005/6 marketing year. This estimate was based on a market price of ZW$1,300(US$ 0.02)/Kg of maize, which has since risen almost fourfold. Households that are classified as food insecure include those headed by orphans, single parents, widows, and elderly persons, as well as households that have experienced a recent death. Some food insecure households are engaging in negative coping mechanisms, such as reductions in meals per day (62%), expenditure on education (41%), expenditure on health (36%), and expenditure on agricultural inputs (35%).

Deepening urban poverty
Urban poverty is increasingly deepening. Reports indicate that poverty prevalence in urban Zimbabwe increased by 66%[7] between 1995 and 2003, with an estimated 66% (Urban ZIMVAC 2004) of the urban population being food insecure. Some 57% of the urban population consume less than 2 meals per day, citing inflation, cost of services such as school and hospital fees, unemployment, taxes, death and illness as the main hazards and threats to their livelihoods.

Increased health hazards and risks
Child mortality has doubled from 59 to 123 per 1,000 live births between 1989 and 2004. The maternal mortality ratio, a measure of the robustness of the health services, deteriorated from 695 per 100,000 live births in 1999 to more than a 1,000 deaths per 100,000 live births in 2002. Results from a World Health Organization/ Ministry of Health and Child Welfare (WHO/MoHCW) Health Impact Assessment carried out in 17 districts in November 2003 indicate that crude mortality was high, and an examination of cause-specific mortality illustrates clearly the impact of HIV/AIDS. Chronic morbidity levels were also high, with 8.7% of the sample considered to be chronically ill, and 18.4% of households having a chronically ill member.

Unaffordable education
Primary school enrolment rates remain above 90%, which means that the majority of school age children are in school, with no significant difference between the enrolment rates for boys and girls. However, 25% of primary school children do not complete school *inter alia* because of the unaffordable costs. The textbook-pupil ratio is high, ranging between 1:6 and 1:10 due to the high cost of production. As a result, the quality of education is rapidly deteriorating: less than 40%[8] of pupils pass their grade 7 exams. The unaffordable cost of education, the increasing numbers of boys and girls heading households (about 50,000 due to HIV/AIDS), and the abuse of girls seeking money to survive are barriers to school completion. At the household level, declining completion rates and low enrolment levels are occurring due to increased childhood mortality rates and the need, especially for girls, to care for sick parents, among other factors.

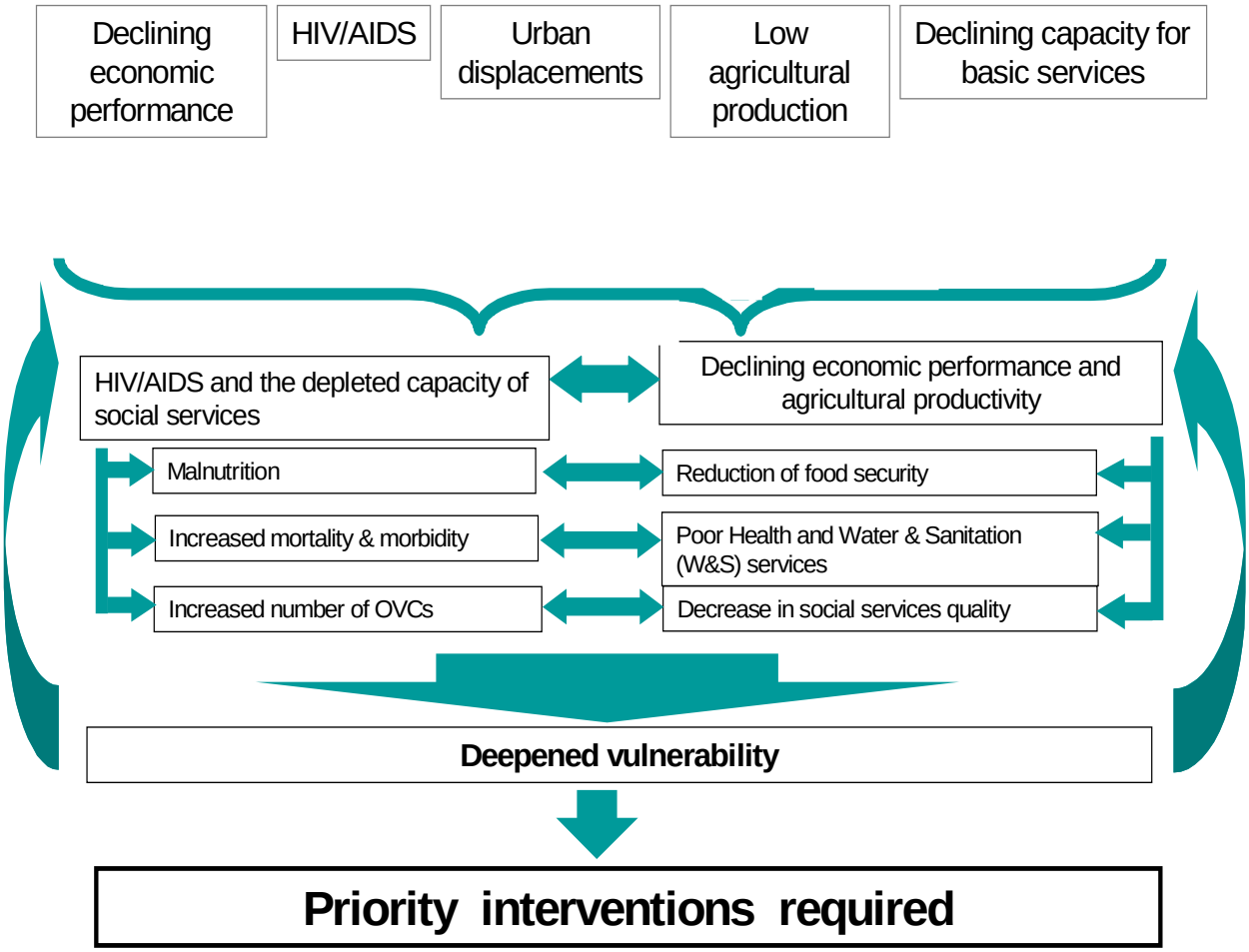
Inadequate access to safe water and sanitation
In rural areas, the operation and maintenance systems of water and sanitation facilities have almost collapsed, resulting in 30% (12,636)[9] of water facilities not functioning. This has led to an acute shortage of safe water supply for drinking and other domestic purposes among approximately 2.5 million people. In most urban areas, water and sewage systems have broken down due to excessive load and poor maintenance, resulting in large volumes of raw sewage being discharged into natural watercourses (for example Harare/Chitungwiza city.) This has put the entire urban population, particularly children, at very high public health risks of water and sanitation related diseases such as diarrhoea, cholera and dysentery.

Increased malnutrition
Recently, the Food and Nutrition Sentinel Site Surveillance System registered an increase in malnutrition in ten vulnerable districts from November 2004 to March 2005. Underweight, a useful measure for nutritional trends, increased from 14.2 to 16.9%. Wasting, a measure of acute malnutrition increased in all ten districts, with the highest district at 9%, approaching cut-off levels for emergency nutrition actions. The average wasting for the ten districts increased from 2.9 to 4.4% from December to March, with severe malnutrition accounting for approximately 25% of all wasting cases in

[7] Pass-II final draft report.
[8] Education Management Information System (EMIS) 2004.
[9] National Water and Sanitation Inventory 2004.

March. In two hospitals where HIV screening was conducted, 70% of the children who were admitted for severe malnutrition were HIV positive.

The model below elaborates on the interrelationship between the above factors, and demonstrates the causes and effects. The negative dynamic needs to be interrupted if further deepening of the vulnerability in Zimbabwe is to be minimised.



VULNERABLE GROUP CATEGORIES[10]	
Orphans and Vulnerable Children	**1,300,000**
• In 2006 more than 225,000 children will either lose one or both of their parents to AIDS, or care for a chronically ill parent; • In rural areas, 2 in 5 households care for orphans and other children made vulnerable by HIV/AIDS; • Two thirds of female-headed households care for OVCs; • Double orphans are 70% less likely to have basic materials (blanket, pair of shoes, change of clothes); • OVCs are 30% less likely to go to an appropriate health facility when they are sick; • Maternal orphans are 50% more likely to have stunted growth; • Orphans, particularly those who have lost both parents, are less likely to go to school; • Maternal orphans are significantly more likely to be infected with HIV.	
People Living with HIV/AIDS (PLWHA)	**1,820,000**
• An estimated 21.4% of Zimbabweans between the ages of 15-49 years are HIV/AIDS positive; • 165,000 children between the ages of 0-14 years are estimated to be infected with HIV and/or living with AIDS; • The annual number of HIV positive births is 39,720; • The weekly number of deaths due to AIDS is 3,000.	
Chronically Ill	
• Households caring for one or more chronically ill persons in rural areas; • Women; • Girls.	
People with severe disabilities	
• An estimated 150,000 children are disabled.	
Mobile Vulnerable Populations/Homeless	
• Operation Restore Order victims: 300,000 most vulnerable individuals.	
A Government of Zimbabwe nationwide clean-up operation, carried out between 19 May and 28 July 2005, resulted in the loss of homes and livelihoods for thousands of households.	
• Ex-farm workers: 150,000 individuals.	
As a result of the Government of Zimbabwe's fast-track land reform programme, an estimated 150,000 farm workers lost their livelihoods. While these actions were most intense between 2000 and 2002, it is expected that the introduction of the 17th Amendment in 2005, which aims to nationalise land, will result in increased numbers of affected farm workers and their families.	
Populations with disputed citizenship	**50,000**
Refugees	**10,000 individuals**
Food insecure population	**2.9 Million**

[10] Figures not available for all categories

3.2.1. The Overall Context

Participants in the CAP workshop recognised that 2006 would be characterised by the continued steady decline of the economy with adverse effects for the population at large and increased needs for response capacity. It is expected that there will be continued price increases for fuel and basic items such as food, household goods and transport. It is further expected that the international community's lack of influence on national policies will continue. In addition, the country, and region as a whole, has experienced significant weather fluctuations including droughts in the past, which may reoccur. Therefore, in this scenario vulnerability is expected to increase.

3.2.2. The Nature Of Vulnerability

The analysis of the current trends and consequences all suggest an increase in the numbers of vulnerable people, including the possibility of new vulnerabilities arising. It is expected that in 2006:

- The quality and access to basic social services will continue to decrease;
- Negative coping mechanisms currently adopted by vulnerable populations will be exacerbated, thus deepening poverty in the medium and long term;
- Urban poverty will not only deepen due to the overall economic situation, but also as a result of increased unemployment from the closure of businesses;
- Homeless populations currently returning to previous informal settlements could be re-evicted;
- The majority of people who lost their livelihoods during the Operation Restore Order will not have completely resumed their livelihoods;
- Skilled and unskilled labour will continue to emigrate, both legally and illegally;
- Continuing farm evictions will result in increased numbers of Mobile and Vulnerable Populations;
- Vulnerable populations will be more susceptible to both natural and man-made disasters.

3.2.3. The Capacity for Response

Greater gains are anticipated only if all actors within the humanitarian community work together in a coordinated manner and remain flexible in their programming. It is expected that in 2006:

- Further progress will be made in obtaining and maintaining access to vulnerable populations;
- With high inflation and economic decline, the operational costs for humanitarian programmes will continue to increase drastically; however, this may not be matched by a corresponding increase in donor resources. As a result, fewer beneficiaries will be assisted for the same amount of resources;
- The political environment will continue to be unpredictable;
- The issue of the NGO Bill may still not be resolved, which may hamper the planning and response of the humanitarian community and the needs of the impacted population;
- Continued brain drain and the movement of qualified national personnel to the private sector or international jobs will hamper the institutional capacity of humanitarian actors to deliver assistance.

3.3. STRATEGIC PRIORITIES FOR HUMANITARIAN RESPONSE

Priorities

I. Life Saving Actions;
II. Enhancing national coping mechanisms including livelihoods and safety nets;
III. Comprehensive approach to response.

Goal

"Improved quality of life for the most vulnerable through the provision of life saving support and enhancement of coping mechanisms."

Objectives

I. Reduced morbidity and mortality rates:

- Emergency health care;
- Provision of water & sanitation;
- Link to food insecurity;
- HIV/AIDS prevention and treatment;
- Management of child malnutrition;
- Temporary shelter.

II. Increased access to basic social services:

- Health;
- Water and sanitation;
- Shelter;
- Education.

III. Prevent further deterioration of livelihoods and enhance community coping mechanisms:

- Agricultural support focused on livelihoods;
- Education;
- Training;
- Income generation through urban small trading;
- HIV prevention;
- Food;
- Protection.

IV. Provide protection for the most vulnerable:

- Orphans and vulnerable children;
- Mobile and vulnerable populations;
- The homeless;
- Disputed citizenship persons;
- Survivors of exploitation and abuse;
- Women;
- Children, particularly those heading their families.

V. Reduce the impact of HIV/AIDS:

- Prevention;
- Care;
- Treatment;
- Mitigation.

4. SUMMARY ON STRATEGIC FRAMEWORK FOR HUMANITARIAN RESPONSE

STRATEGIC OBJECTIVES	CORRESPONDING RESPONSE PLAN OBJECTIVES		ASSOCIATED PROJECTS
I. Reduce Morbidity and Mortality rates	**Health**	To improve access to treatment of Opportunistic Infections (OI), ART, HIV prevention and care services to vulnerable populations including children	• Reducing morbidity and mortality of U5s (WHO); • Prevention and control of micronutrient deficiencies in the context of HIV/AIDS and declining food security (United Nations Children's Fund (UNICEF)); • Procurement of vital drugs and medical supplies (WHO); • Procurement of ARVs and lab reagents (WHO); • Strengthening Immunisation Systems (PLAN Zim); • Prevention of mother to child transmission of HIV (UNICEF); • Reaching vulnerable children and women with immunisation to prevent EPI outbreaks (UNICEF); • Measles: National Immunisation Days (UNICEF); • Malaria Control through Insecticide Treated Net (ITN) (UNICEF); • HIV/AIDS assistance to MVPs (International Organization for Migration (IOM)); • Reproductive Health – Safe parenthood (United Nations Population Fund (UNFPA)); • Community based Home-Based Care (HBC) and counselling for PLWHA and children (UNICEF); • Strengthening the capacity of home based care providers to provide quality services to HIV/AIDS patients and their families (Hospice Association of Zimbabwe (HOSPAZ)).
	Food	To save lives and safeguard nutrition well being	• Targeted Food Support for Vulnerable Groups (WFP); • Child Supplementary Feeding (Save the Children Norway-Zimbabwe (SCN-Z)).
	Nutrition	To reduce mortality from severe acute malnutrition	• Hospital and community based management of malnutrition (UNICEF).
		To strengthen nutrition aspects of HIV programming in the context of food security (Anti-Retroviral Therapy (ART),HBC,OVC, infant feeding)	• Addressing the link between HIV/AIDS and malnutrition (*Action Contre la Faim* (ACF)); • Nutrition Care and Support to PLWHA (UNICEF); • Prevention and control of micronutrient deficiencies in the context of HIV/AIDS and declining food security (UNICEF).
		To monitor the nutrition situation and identify areas of need and appropriate timing of actions	• Zimbabwe Food and Nutrition Surveillance System (UNICEF).
		To strengthen preparedness in emergency selective feeding	• Zimbabwe Food and Nutrition Surveillance System (UNICEF); • Hospital and community based management of malnutrition (UNICEF); • Prevention and control of micronutrient deficiencies in the context of HIV/AIDS and declining food security (UNICEF).
		To strengthen communities' ability to identify and care for malnourished children	• Hospital and community based management of malnutrition (UNICEF).
		To ensure a well coordinated nutrition response that reaches the most vulnerable	• Zimbabwe Food and Nutrition Surveillance System (UNICEF); • Hospital and community based management of malnutrition (UNICEF).

STRATEGIC OBJECTIVES	CORRESPONDING RESPONSE PLAN OBJECTIVES		ASSOCIATED PROJECTS
	Water and Sanitation	To prevent and control the occurrence of epidemics and the spread of water, sanitation and hygiene related disease, and to mitigate the resulting adverse effects amongst vulnerable populations	• Emergency safe water supply, sanitation and hygiene (UNICEF); • W&S to reduce public health risks (Oxfam); • Emergency W&S (World Vision Zimbabwe (WVZ)); • Emergency W&S for rural mission hospitals (Zimbabwe Association of Church related Hospitals (ZACH)); • Water for Life with Elephant pump (Pump Aid) .
	Shelter	To provide temporary shelters for those affected by Operation Murambatsvina	• Emergency Provision of temporary shelter to Operation Restore Order (ORO) affected (IOM); • Technical Support to provision of temporary shelter (United Nations Human Settlements Program (UNHABITAT)).

STRATEGIC OBJECTIVES	CORRESPONDING RESPONSE PLAN OBJECTIVES		ASSOCIATED PROJECTS
II. Increased access and quality of basic services	**Health**	To ensure access to a minimum package of basic health services to the most vulnerable population	• Improved health for most vulnerable children and mothers (Save the Children-UK (SC-UK)).
		To maintain the capacity of the health system to respond to humanitarian crisis in the vulnerable populations	• Health Information and Surveillance System (WHO); • Strengthening Epidemiological environmental health field surveillance (WHO); • Strengthening Epidemic and Pandemic Alert and Response (EPR) in the health sector (WHO).
		To build the capacity of civil society and communities in the vulnerable areas to respond to health needs in emergencies	• Empowering vulnerable communities to identify and timely respond to health emergencies (WHO); • Community centred capacity development for HIV prevention (UNICEF); • Community based HBC and counselling for PLWHA and children (UNICEF); • Promotion of child health care practices for children U5 in the communities (UNICEF).
	Shelter	To provide appropriate longer-term shelters and livelihoods for ex-farm workers	• Emergency assistance to mobile and vulnerable populations (IOM).
		To develop appropriate solutions to housing and infrastructure for the urban poor	• Policy engagement with Government and strengthening of CBOs (UNHABITAT); • Shared Learning: influencing policy and changed practice in provision of housing for the urban poor - Dialogue On Shelter for the Homeless in Zimbabwe Trust (DOSHZT); • Alternative to forced evictions-practice (DOSHZT).
		To make human settlement policies more pro-poor	• Policy engagement with Government and strengthening of CBOs (UNHABITAT); • Shared Learning: influencing policy and changed practice in provision of housing for the urban poor (DOSHZT); • Alternative to forced evictions-practice (DOSHZT).
		To strengthen sectoral Community-Based Organisations (CBOs) advocacy and service delivery capacity	• Policy engagement with Government and strengthening of CBOs (UNHABITAT).
	Education	To ensure that opportunities and spaces exist for children, including pre-school children (4-6) in deprived areas to play while having access to early cognitive simulation and psychosocial care	• Early Childhood Development Project (African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN)).

STRATEGIC OBJECTIVES	CORRESPONDING RESPONSE PLAN OBJECTIVES		ASSOCIATED PROJECTS
		To prevent HIV/AIDS through life skills education and peer education and counselling approaches	• Child Learning and Life Skills (UNICEF); • Primary education and Life Skills Project (Alliance for Southern African Progress (ASAP)).
		To ensure access by children to textbooks and other teaching and learning materials for children	• Education Support for OVCs (SOS); • Primary education and Life Skills Project (ASAP); • Primary education for OVCs in Nyanga - Career Development Education Support (CDES); • STRIVE Programme[11] (Catholic Relief Services (CRS)); • OVC educational Sponsorship Programme - New Hope Zimbabwe (NHZ).
		To reduce the impact of HIV/AIDS on children through expansion of educational opportunities relevant to the lives of orphans and other vulnerable children	• Reducing HIV/infection among young women (UNFPA); • Primary education and Life Skills Project (ASAP).
		To make schools physically safer, more protective against sexual and other forms of abuse, more environment-friendly, and provide guidance and counselling services	• Child Learning and Life Skills (UNICEF).
		To maintain gender equity in primary completion and eliminate sexual abuse and the 5% gender gap at the secondary level	• All projects in the education sector.
		To promote gender equity and equality in education	• All projects in the education sector.
		To strengthen data and improve monitoring and coordination systems at the national and district levels	• All projects in the education sector.
II. Increased access and quality of basic services (continued)	**Food**	To increase child attendance and learning and provide an incentive for parents and care givers to keep children and OVCs in school	• Targeted Food Support for Vulnerable Groups (WFP).
	Water and Sanitation	To prevent and control the occurrence of epidemics and the spread of water, sanitation and hygiene related disease and mitigate the resulting adverse effects amongst vulnerable populations	• Emergency safe water supply, sanitation and hygiene (UNICEF); • W&S to reduce public health risks (Oxfam); • Emergency W&S (WVZ); • Emergency W&S for rural mission hospitals (ZACH); • Water for Life with Elephant pump (Pump Aid).
		To improve access to safe and reliable water supply, sanitation and hygiene amongst 6,500,000 vulnerable people in urban, peri-urban and rural communities including mobile and vulnerable populations	• Emergency safe water supply, sanitation and hygiene (UNICEF); • W&S to reduce public health risks (Oxfam); • Emergency W&S (WVZ); • Emergency W&S for rural mission hospitals (ZACH); • Water for Life with Elephant pump (Pump Aid).
		To enhance institutional and community capacity in monitoring and response, with regard to disease outbreaks, maintenance of water points, sanitation facilities, access to safe water and hygiene during crises, with special reference to vulnerable populations	• Improved access to safe water and sanitation through community based management of rural water sources and participatory health and hygiene education trainings (Practical Action and Christian Care).

[11] Improving Care and Support for Vulnerable Children in Zimbabwe

STRATEGIC OBJECTIVES	CORRESPONDING RESPONSE PLAN OBJECTIVES		ASSOCIATED PROJECTS
III. Prevent further deterioration of livelihoods and enhance community coping mechanisms	**Agriculture**	To promote and disseminate improved land use systems, integrated crop and pest management approaches, soil and water conservation, including reduced tillage, aiming at agricultural intensification	• Provision of agricultural input and extension support to smallholder farmers in the communal areas (FAO); • Development of alternative labour technology (Dananai Child Care (DACHICARE)); • Development of Tivertone Irrigation Scheme (Manicaland Development Association (MDA)); • Borehole rehabilitation (Organization of Rural Associations for Progress (ORAP)); • Community Gardens (ORAP).
		To enhance the productivity of communal areas through linking the local farming expertise with private sector partners and through efficient marketing opportunities	• Market linkages for small holder farmers (Southern Alliance for Indigenous Resources (SAFIRE)); • Integrated Agricultural recovery – processing and marketing Soybean (AFRICARE).
		To support programmes related to improved browse and the production of fodder for livestock feed, particularly in areas where livestock forms the main livelihood. To protect assets through small stock provision where livestock forms the main means of livelihoods	• Newcastle disease control in rural areas (FAO); • Emergency control of epidemic foot-and-mouth (FAO); • Small Livestock restocking for vulnerable households in rural areas (FAO).
	Food	To protect livelihoods and enhance resilience to shocks	• Targeted Food Support for Vulnerable Groups (WFP).
		To increase nationwide food access and resilience to shocks	• Targeted Food Support for Vulnerable Groups (WFP).
	Livelihoods	To ensure access to a livelihood package to the most vulnerable	• Rural micro finance for vulnerable groups (CARE); • Livelihood income and food security (Farm Community Trust of Zimbabwe (FCTZ)).
		To build the capacity of civil society and communities in targeting the vulnerable and providing livelihood opportunities	• Protecting vulnerable livelihoods (CRS).
	Water and Sanitation	To enhance institutional and community capacity in monitoring and response with regard to disease outbreaks, maintenance of water points, sanitation facilities, access to safe water and hygiene	• Improved access to safe water and sanitation through community based management of rural water sources and participatory health and hygiene education trainings (Practical Action).

STRATEGIC OBJECTIVES	CORRESPONDING RESPONSE PLAN OBJECTIVES		ASSOCIATED PROJECTS
IV. Provide protection for the most vulnerable	**Multi sector: MVPs**	To address the urgent humanitarian needs of urban displaced and mobile vulnerable populations in Zimbabwe through the delivery of minimum emergency assistance	• Emergency Assistance to Mobile and Vulnerable Populations in Zimbabwe (IOM).
		To address the growing humanitarian needs of deported Zimbabwean migrants To provide adequate assistance as the basis for protecting the dignity of refugees and meeting their basic needs while strengthening self-reliance projects.	• Humanitarian assistance for MVP and deported migrants at Beitbridge border town (IOM); • Local Settlement Programme for Refugees in Zimbabwe (United Nations High Commissioner for Refugees (UNHCR)).
	Protection	To prevent sexual and gender-based violence (SGBV)	• Prevention of sexual and gender based violence (UNICEF); • Protection of women and girls from the impact of gender based violence in Zimbabwe (United Nations Development Fund For Women (UNIFEM)).
		To enhance the protection and welfare of the most vulnerable populations	• All projects in Child Protection, Multi Sector (MVPs) Sectors; • Community centred capacity development for HIV prevention (UNICEF).
		To improve the humanitarian protection of vulnerable people and other marginalised groups through principled assessments, response, and advocacy	• Humanitarian Guidance in protection priorities (Office of the High Commission (OHC)).
		To enhance the mainstreaming of humanitarian protection through coordination of sector planning and response to the humanitarian situation	• Humanitarian Guidance in protection priorities (OHC).
	Child Protection	To provide relief, care and livelihoods support for the most vulnerable groups of children, including HIV-infected children and child-headed households	• HIV/AIDS and HBC and Psycho-Social Support (PSS) training for residential care institutions (Zimbabwe National Council for the Welfare and Children (ZNCWC)); • Protection of children affected by internal displacement (SC-UK); • Community based protection of rights of OVCs- mitigating impact of HIV/AIDS.
		To provide psychosocial support and life-skills training	• Child Rights Project (ANPCCAN); • Children psychosocial Support Programme (Arise Zim); • Psychosocial Support for street children (Partner Country Coordinator (PCC)).
		To prevent and respond to child abuse (physical, sexual, emotional abuse, and neglect)	• Child Rights Project (ANPCCAN); • Children psychosocial Support Programme (Arise Zim); • Psychosocial Support for street children (PCC).
		To prevent and respond to child cross-border movement and economic exploitation	• Beitbridge cross border initiative: protecting and care for children deported from SA (SCN-Z).
		To reunite and integrate unaccompanied and separated children into the community.	• Prevention of family separation and reunification of children deprived of their family environment (UNICEF).
		To facilitate child participation and institutional capacity building	• Strengthening Community level information collection and usage (UNICEF); • Child participation Forum (ZNCWC); • Child Rights Project (ANPCCAN); • Strengthening Child Protection Response structures (SOS).
	Education	To make schools physically safer, more protective against sexual and other forms of abuse, more environment-friendly and provide guidance and counselling services	• Child Learning and Life Skills (UNICEF).

STRATEGIC OBJECTIVES	CORRESPONDING RESPONSE PLAN OBJECTIVES		ASSOCIATED PROJECTS
V. HIV/AIDS care, prevention and mitigation	**Multi-sector: (MVPs)**	To contribute to a reduction of HIV prevalence rates among cross-border and mobile populations	• Humanitarian assistance for MVP and deported migrants at Beitbridge border town (IOM).
	Health	To improve access to treatment of Opportunistic Infections (OI), ART, HIV prevention and care services to vulnerable populations, including children	• Responding to HIV/AIDS in the informal cross border cross border trade sector (IOM); • Nutrition Care and Support for PLWHA (AFRICARE); • Increasing men's involvement in HIV/AIDS care and support (AFRICARE); • Response to HIV risk and Gender-Based Violence (GBV)- use of the IASC Manual (IOM) .
	Nutrition	To strengthen nutrition aspects of HIV programming in the context of food security (ART,HBC, OVC, infant feeding)	• Addressing the link between HIV/AIDS and malnutrition (ACF); • Nutrition Care and Support to PLWHA (UNICEF); • Prevention and control of micronutrient deficiencies in the context of HIV/AIDS and declining food security (UNICEF).
	Child Protection	To provide relief, care and livelihood supports for the most vulnerable groups of children, including HIV-infected children and child-headed households	• Protection of children affected by internal displacement (SC-UK).
	Agriculture	To reduce the negative impact of HIV/AIDS on the infected and affected farming population	• Improving food and nutrition security through home gardening (FAO); • Integrated nutrition gardens and livestock projects (PUMPAID); • Feed them First (ATP); • Integrated Agricultural Recovery Action (AFRICARE); • Livelihood Income and food security - Farm Community Trust of Zimbabwe (FCTZ); • Marketing Links for Smallholder Farmers (SAFIRE); • Sustainable Livelihoods and Food Capacity (Christian Care).
	Education	To prevent HIV/AIDS through life skills education and peer education and counselling approaches	• Child Learning and Life Skills (UNICEF); • Primary education and Life Skills Project (ASAP); • Reducing HIV amongst Young Women (UNFPA).
		To reduce the impact of HIV/AIDS on children through expansion of educational opportunities relevant to the lives of orphans and other vulnerable children	• Child Learning and Life Skills (UNICEF); • Primary education and Life Skills Project (ASAP); • Reducing HIV amongst Young Women (UNFPA).
	Food	To increase the mobility of PLWHA and enable them to engage in productive activities while also aiding their consumption and absorption of medication	• Targeted Food Support for Vulnerable Groups (WFP).

STRATEGIC OBJECTIVES	CORRESPONDING RESPONSE PLAN OBJECTIVES		ASSOCIATED PROJECTS
Ensuring a coherent and comprehensive approach to response	**Coordination**	To provide effective and coordinated delivery of humanitarian assistance to vulnerable populations	• Facilitation and coordination of humanitarian assistance, advocacy, protection and information management (OCHA).
		To ensure effective and coordinated protection of vulnerable populations	• Facilitation and coordination of humanitarian assistance, advocacy, protection and information management (OCHA).
		To ensure information on humanitarian response is comprehensive, up-to-date and widely disseminated	• Facilitation and coordination of humanitarian assistance, advocacy, protection and information management (OCHA).
	Child Protection	To coordinate the response, advocacy and resource mobilisation for child protection activities	• Coordination of child Protection Actions for vulnerable children affected by the Emergency (UNICEF).
	Agriculture	To increase the collaboration with Government technical services, agricultural research centres and FAO-in-house technical expertise	• Mudiwa, Morris (FAO Sub-Regional Office for Southern and East Africa (FAOSAFR)) <morris.Mudiwa@fao.org>; • Coordination and Humanitarian principles: Vincent. Lelei Vincent.Lelei@undp.org; • Livelihood recovery at Household and community levels: Mfaro Moyo Mfaro.moyo@undp.org; • Education, Nutrition, Child Protection, Water and Sanitation: Roeland Monasch: rmonasch@unicef.org; • Basic Health Services Shadreck Khupe Khupes@whoafr.org; • Mobile and Vulnerable Population, Cross Boarder Mobility and irregular migration: Mohammed Abdiker: iomhre_headofoffice@iom.co.zw; • Protection/Human Rights/Rule of Law: Nana Busia: Nana.Busia@undp.org; • Safety and Security of Staff and Operations: Bjarne Lauritzen: Bjarne.lauritzen@undp.org.
	Health	To coordinate stakeholders in order to improve and integrate the response to health crises	
	Nutrition	To ensure a well coordinated nutrition response that reaches the most vulnerable persons nationwide	
	Education	To strengthen data, monitoring and coordination systems at the national and district levels	
	Food	To support the ZIMVAC process	
	Protection	To enhance mainstreaming of humanitarian protection through coordination of sector planning and response to the humanitarian situation	
	Water and Sanitation	To coordinate the water and sanitation humanitarian response.	

5. RESPONSE PLANS

5.A AGRICULTURE

Introduction

The combined effects of natural disasters, the reduced production capacity and its impacts on the economy led to critical food shortages during 2002, 2003 and 2004. The policies adopted in food production and marketing have not created an entirely favourable environment for farmers to engage in viable farming. During the 2004/05 season, erratic rains further compromised the level of cereal outputs. According to the ZIMVAC Report of 2005, 2.9 million people, representing 36% of the rural population, will not be able to meet their food requirements in the current marketing season. The Government has been addressing these production shortfalls with substantial external food-support actions, and indicated its intention to import 1.2 MTs of maize. Zimbabwe received over 700,000 MTs of food aid during 2002-2004. Formal employment and export earnings have significantly dropped, with the unemployment rate around 80%. According to the ZIMVAC Report of 2005, food-insecure households are already engaging in negative coping mechanisms, such as: reducing the number of meals per day (62%), reducing education expenditures (41%), reducing health expenditure (36%), and reducing expenditures on agricultural inputs (35%). The shortage of agricultural inputs (seeds, fertilisers and tillage) and their lack of affordability by many, given a monthly inflation rate of over 350%, has further aggravated the situation and impaired production recovery efforts.

Sectoral Analysis

Livestock production is one of the major sources of livelihoods in Zimbabwe's communal areas. Besides offering multiple uses to rural households, livestock – especially in the northern part of the country – forms the bulk of the drought fallback assets used to alleviate the food security status of livestock owners. In the southern part, livestock (cows and goats) are a major source of food security. In 2003, the cattle population stood at 5.3 million, with over 4 million of the herd held by smallholder farmers. Another fact worth noting is that Zimbabwe is traditionally a beef-exporting country, although exports to the European Community remain suspended because of the outbreak of Foot-and-Mouth Disease (FMD). Countrywide livestock trade has helped to ensure food security, particularly amongst rural communities. However, reports by the Department of Veterinary Field Services (DVS) and Tsetse Control noted that since 2001 there have been 5 primary FMD disease outbreaks. These were followed by numerous secondary outbreaks over the 2001–2005 period. The disease has proved difficult to control, especially due to the numerous cattle movements throughout the country following the fast-track land reform.

Poultry production, on the other hand, is very important to communal households, particularly those of vulnerable rural families. A baseline livestock study commissioned by FAO in Zimbabwe in 2005 indicated that poultry was the most widely bred livestock in rural areas, with up to 97% of households owning poultry. The smallholder poultry population in Zimbabwe is estimated at over 11 million birds. Since 2001, the country has had New Castle Disease (NCD) outbreaks, which were contained through mass vaccinations by DVS. Although no outbreaks were experienced during 2003, there was a resurgence of the disease in 2004. However, due to DVS's inadequate resources, it failed to contain the disease and it the spread to all the provinces in 2005. The outbreak has already claimed thousands of chickens nationwide and negatively impacted on the livelihoods of many people. In view of the growing concern about the avian influenza, FAO plans to assist the Government in establishing a preparedness plan, improve public awareness, and increase surveillance of migratory wild birds and waterfowls.

Preliminary information collected from NGOs indicates that approximately 310,000 households (50% of the households identified by ZIMVAC as food insecure during the 2005–06 marketing year) will receive support in the form of seed and/or fertiliser for the 2005/06 agricultural season. According to weather experts, the majority of the country is forecast to receive normal to above-normal rainfall during the first half (October–December) of the 2005/06 cropping season. However the southern provinces are forecast to receive below-normal rainfall during the second half of the season (January–March). Although the season looks promising from a meteorological point of view, the level of preparedness is a cause for concern. The country is experiencing acute fertiliser shortages (i.e. Compound D and Ammonium Nitrate) and a lack of fuel. The later will affect land preparation (draft power), with tractor owners lacking the fuel necessary for normal operation. This fuel shortage will also affect input deliveries to rural markets for smallholder farmers requiring ready access. While seeds, particularly maize, are generally available, they are priced beyond the reach of most communal farmers. Price per kilogram of maize seed has increased by more than 270% from last season's levels. In the light of the above context, the country may not be able to make good use of the

forecasted favourable season. It is therefore predicted that the level of support in terms of number of households covered for this category during the 2006/07 season will be the same as for the current season.

Sector Strategy and Priorities

The agricultural programmes will be focused on preventing further deterioration in livelihoods, primarily as a consequence of the macro-policy environment. A multi-pronged strategy will be adopted, focusing on: i) strengthening community and household livelihoods (both crop and livestock) through inter-agency and multi-disciplinary collaboration as well as through establishment of marketing linkages with the private sector; ii) improving food security and increasing agricultural productivity by bridging short-term relief activities and medium-term community-based projects; and iii) developing standardised assessment, monitoring, and evaluation tools. Given the high threat posed by the HIV/AIDS pandemic, mainstreaming HIV/AIDS-related actions within the overall agricultural assistance programmes will be a priority. With an HIV/AIDS prevalence rate of 21.3% (National Aids Council (NAC) figures), one of the strategies in this regard will be to examine and promote traditional practices and methods, like minimum tillage, in order to cater to the reduced labour availability and varying nutritional requirements of infected people.

Objectives

The objectives below were designed based on the fact that input preparations for the 2005/06 summer season were already underway by October 2005, and the season was about to start. The objectives for the sector in articulating the strategies are as follows:

- To promote and disseminate improved land use systems, integrated crop and pests management approaches, soil and water conservation including reduced tillage aiming at agricultural intensification;
- To reduce the negative impact of HIV/AIDS on the infected and affected farming population;
- To link emergency programmes with recovery programmes and medium term strategies;
- To maximise the efficiency and effectiveness of the agricultural relief programmes, with increased coordination among all stakeholders and expanded monitoring/evaluation;
- To enhance the productivity of communal areas through linking the local farming expertise with private sector marketing opportunities;
- To support programmes related to improved browsing and the production of fodder for livestock feed, particularly in areas where livestock forms the main livelihood. Asset protection in the form of small stock (goats, chickens, etc) provision will also be carried out;
- To increase collaboration with Government technical services, such as Agricultural Research and Extension (AREX), agricultural research centres and FAO in-house technical expertise on suitability of approaches through monitoring and evaluation exercises.

Activities

The following activities will be carried out by a wide range of stakeholders involved in the provision of assistance to vulnerable households in order to improve their food and livelihood security.

Crop production

- Promote a variety of methodologies for input provision (fairs and vouchers, micro-credit, seed subsidies), aimed at reducing disruption of local markets and increasing entrepreneurial capacity, while increasing access of rural households to essential agricultural inputs for the 2006/07 main cropping season;
- Extend the agricultural actions to vulnerable urban and peri-urban households;
- Rehabilitate smallholder irrigation schemes and provide inputs and training to support small-scale irrigation;
- Promote local seed multiplication by small holder farmers;
- Strengthen technical back up for programme implementation, including extension and training services (including production, processing, consuming and marketing), as well as local capacities;
- Establish market linkages between communal farmers and suitable private companies;
- Strengthen internal savings of rural communities to improve rural micro-economies;
- Promote crop diversification through the distribution of legumes such as sugar beans, sweet potatoes and small grains (sorghum, millet);

- Enhance productivity and livelihood security, through the promotion of improved land use and farming practices, including promotion of appropriate cropping programmes and efficient field and crop management practices (i.e. crop rotations, organic and mineral fertiliser application, integrated pest management);
- Focus on conservation agriculture and environmental impact reduction;
- Expand the scope of agricultural assistance to include short-season and winter crops (vegetable gardens), thereby creating an enabling environment for multiple cropping;
- Promote and use appropriate crop diversification in cooperation with farmers;
- Organise field days and extension seminars to demonstrate improved land use and management systems;
- Mainstream HIV/AIDS issues into agricultural actions;
- Conduct a study on the impacts of HIV/AIDS on rural livelihoods and food security;
- Training in HIV/AIDS awareness and positive living and mainstreaming for NGOs, AREX and FAO staff;
- Encourage labour-saving farming methodologies, tools and crops;
- Develop curriculum and provide direct assistance for school nutrition gardens to be established for nutrition, agriculture and life skills improvement;
- Start herbal and medicinal plants/gardens on HIV/AIDS initiatives;
- Strengthen existing Home Based Care Givers groups through the provision of skills in horticulture, agro forestry, water harvesting and micro irrigation techniques;
- Further improve coordination activities and information flow between stakeholders;
- Establish demonstration plots in districts to encourage the uptake of new technologies.

Livestock

- Provide technical support to veterinary services on disease control;
- Rehabilitate water points;
- Re-stock small species (particularly those suited for high HIV/AIDS-prevalent communities) and cattle (where appropriate conditions exist);
- Provide support to veterinary services for the prevention and control of FMD, other Trans Boundary Animals Diseases (TADS) and common parasitic diseases;
- Support livestock systems, particularly where they constitute a significant component of local livelihoods;
- Rehabilitate dip tanks.

Other priorities

- Strengthen coordination effectiveness for stakeholders participating in food security recovery;
- Monitor the humanitarian response in the agricultural sector;
- Monitor data for all programmes through monthly reports, which will be shared with key Stakeholders and used to inform programming;
- Monitor the food situation in the country and produce periodic reports.

All the above activities shall be implemented through collaboration between the Ministry of Agriculture and its departments (AREX, Agricultural Engineering, and Veterinary Services), NGOs and FAO to ensure capacity building for sustainability.

Indicators

- Quantity of inputs distributed in time for seasonal use;
- Number of vulnerable households targeted, with emphasis on the different methods adopted;
- Area planted, yields and total crop production obtained from distributed inputs;
- Local production of seeds (number of farmers involved, type and quantity of seeds produced, including winter support programmes);
- Number of nutrition garden drip kits and treadle pumps distributed;
- Number of small-scale irrigation schemes rehabilitated;
- Number of families involved in the adoption of labour-saving farming techniques;
- Number and types of materials for HIV/AIDS awareness produced;
- Reflection of HIV/AIDS programme mainstreaming in AREX strategy documents;
- Number of families involved in conservation agriculture techniques;
- Number of families experiencing surplus marketable crop yields;
- Number and types of livestock and livestock-owning households supported through feeding schemes (e.g. fodder crops);
- Number of water points rehabilitated;

- Number of dip tanks rehabilitated;
- Number and type of livestock distributed;
- Number and type of livestock vaccinated against FMD, New Castle and other TADS;
- Level of coordination, minimisation of gaps or overlaps in the assistance;
- Quality and timeliness of information flow;
- Quality of monitoring and assessment data and analysis;
- Recommendations on the suitability and appropriateness of the different methods.

5.B COORDINATION AND SUPPORT SERVICES

Situation analysis

The humanitarian situation in Zimbabwe deteriorated significantly during 2005, resulting in an increased need for humanitarian response and coordination. Faced with the "triple threat" of HIV/AIDS, food insecurity and limited capacity for social services delivery, communities are fighting for their very survival. Additional suffering is caused by reduced access to basic infrastructure such as water and sanitation, and by livelihood deterioration. Furthermore, frequent unavailability of essential commodities (e.g. maize, cooking oil and fuel) and major increases in costs combined with hyperinflation, without a corresponding increase in income and salaries, worsens the ability of many to meet their basic needs.

Internal displacements due to the recent evictions under Operation Murambatsvina/Restore Order and cross-border migration have significantly impacted on vulnerable groups such as AIDS-affected families, orphans, elderly and widows. Those displaced from resettled farms and urban areas have generally poor access to priority actions such as shelter, food, water and sanitation, and HIV/AIDS care and treatment.

Objectives

Consequently, in this increasingly complex situation of deepening vulnerability, the humanitarian community needs to continue strengthening and consolidating its coordinated and collaborative approach by addressing the following:

- Effective and coordinated delivery of humanitarian assistance to vulnerable populations;
- Effective and coordinated protection of vulnerable populations;
- Comprehensive and up-to-date information on humanitarian situation and response that is widely disseminated to all stakeholders.

From June 2004 to December 2005, the humanitarian coordination function in Zimbabwe was supported by the Humanitarian Support Team (HST), managed and funded through UNDP. Following the closure at the end of 2005 of the HST as a United Nations Development Programme (UNDP) project, OCHA in consultation with all partners will transform the HST into an OCHA unit to ensure continued and strengthened coordination capacity in support of humanitarian activities. OCHA will continue providing support to the UN Humanitarian/Resident Coordinator, the UN system, IASC members, donors and NGOs and working with the relevant Government ministries and with beneficiaries.

OCHA will strengthen its coordination capacity for facilitating analysis, humanitarian assessment and response, and for ensuring transparency among all key stakeholders through the setting up of an efficient financial tracking system of contributions, for the purpose of accountability to beneficiaries and donors. More efforts will need to be put into building a common understanding with the Government on key policy areas, impact on livelihoods, food security, and access to basic services.

Objectives

- Effectively coordinate the delivery of humanitarian assistance to vulnerable populations by: developing a coordinated analysis among humanitarian stakeholders, including the Government, on humanitarian priorities; assisting and supporting the Humanitarian Coordinator, the field IASC and the UN Country Team, and NGOs to ensure a coordinated humanitarian approach, programming, common services and response; carrying out regular multi-sectoral field assessments and ensuring a coordinated and timely response to the needs of the affected populations; establishing effective co-ordination mechanisms within and among sectors; monitoring the implementation of the 2006 Consolidated Appeal with the full participation of all key stakeholders, contributing to raising funds for the humanitarian response; assuring quarterly

update of the humanitarian contingency planning; and, establishing a disaster preparedness strategy with all the stakeholders;
- Effectively coordinate the protection of vulnerable populations, by promoting the humanitarian principles through training of the various actors, regular field visits, consultations with various actors and advocacy; and, enhancing the humanitarian protection to vulnerable people and to other marginalised groups through principled assessments, response and advocacy;
- Ensure that information on humanitarian response is comprehensive, up-to-date and widely disseminated to all stakeholders, by producing timely, relevant and multi-sectoral information on the ongoing humanitarian situation and response disseminated to relevant stakeholders; and ensuring that the "Who does What Where" matrix, including financial tracking information, is regularly updated on humanitarian response and capacities of the different partners, including information on type of assistance, intended target group and implementing partnerships.

Indicators
- Regular consultations, meetings and workshops between the Government, UN, donors and NGOs, including monthly meetings by sectoral humanitarian working groups, including minutes;
- Joint assessments and information sharing resulting in common analysis of the protection needs of the most vulnerable;
- Production of regular documents, reports and briefings including humanitarian situation analysis & response analysis for main sectors, including up-to-date statistics to the Humanitarian Coordinator (HC), the United Nations Country Team (UNCT), Headquarters (HQs), the IASC, NGOs and other humanitarian partners;
- Coordinated implementation and monitoring of recommendations from humanitarian working groups;
- Sufficiently funded humanitarian response and effective resource mobilisation strategies.

5.C LIVELIHOODS RECOVERY AT HOUSEHOLD AND COMMUNITY LEVELS

Introduction

The deterioration of the social and economic situation since 1999 and withdrawal of donor developmental support due to policy differences, all contributed to the depletion of services in the rural areas. As a result, the humanitarian community saw a need to give immediate support to some livelihood initiatives at the community and household level, while a separate process at the national level is being undertaken to deal with the broader policy and macroeconomic issues.

The recurrence of disasters and subsequent cumulative negative impacts on communities and households has led to a drain of resources and the undermining of cultural norms. Illustrating this change in daily reality, reports indicate that an increasing number of families are refusing to take in orphans or vulnerable children due to their inability to feed their own children, thus breaking 'extended family' bonds, and contributing to the erosion of traditional safety nets.

Combinations of ongoing drought, HIV/AIDS, and weakened capacity for governance have resulted in a new reality for people, households, and communities. Whereas they first adopt traditional coping mechanisms, such as caring for a relative's child, these measures must be either adapted or abandoned once they have been exhausted.

The combination of major changes in the agricultural sector, four seasons of drought, disastrous macroeconomic decline, the negative effects of Operation Murambatsvina/Restore Order, and reduced household assets has created a humanitarian emergency that is severely impacting women, children, the elderly, the orphaned, the disabled, and the chronically ill.

The UN has responded by drafting a UN wide multi-sectoral humanitarian response plan with ILO and UNDP, which is responsible for the recovery actions.

Objectives

The **main goal** of the livelihoods programme is to respond to the livelihood needs of the vulnerable groups affected both by Operation Murambatsvina and the wider humanitarian situation in the country.

- To ensure access to a livelihood package among the most vulnerable populations;
- To build the capacity of civil society and communities in targeting the vulnerable and providing livelihood opportunities.

Strategies

- Strengthening of community structures that will target vulnerable individuals with appropriate livelihood opportunities;
- Direct actions with livelihood services such as agriculture, petty trade, and small scale manufacturing using simple technologies, among others;
- Support for skills upgrading for specific livelihood activities;
- Awareness-raising among communities on the significance of their role in the diversification of livelihoods;
- Coordination of stakeholders to improve integrated response to livelihoods and safety nets promotion;
- Regular situation analysis, as well as monitoring and reporting on the impact of the actions by implementers and supporting partners.

Indicators

- Proportion of vulnerable populations accessing livelihood opportunities in urban and rural areas;
- Proportion of targeted community based institutions able to provide capacity support;
- Proportion of civil society and communities trained in livelihood diversification;
- Proportion of trained civil society and communities directly responding appropriately to livelihood priorities.

5.D EDUCATION

Introduction

In 2006, nearly 200,000 children of school-going age will either lose one or both of their parents to AIDS, or care for a chronically ill parent. These children need a safe and protective environment to safeguard their future. Schools remain the safest places for children, in terms of HIV prevention and care. School enrolment rates remain high (over 90%), with no significant difference between the enrolment rates for boys and girls. An urgent emergency education response is needed to retain children in school and encourage students remaining out of school to enrol. For this, children's immediate learning needs and conditions must be met. These include providing protective learning environments; ensuring children's access to instructional materials; ensuring access to school feeding, safe water and sanitation; providing access to psychosocial care and support (including materials and spaces for play and early stimulation of pre-school children); providing grants to meet the costs of schooling; improving physical environments; and improving skills for primary environmental care, HIV prevention and gender-sensitivity in schools. Children do not attend school regularly, due largely to the lack of access to these basic services in schools. The Basic Education Assistance Module (BEAM), a Government programme targeting the most vulnerable children, reaches less than half of the total number of children in need of support, while Government expenditure on education has been stagnant at about 19% of the annual budget in the past five years.

School feeding has been found to help improve attendance. The WFP-supported school-feeding programme, which provided a daily wet meal to 1.1 million children, was temporarily suspended in May 2005 pending approval of an alternative food basket. School Feeding was expected to resume in October 2005 in eight of the country's fifty-seven districts. Plans are underway to familiarise schools and parents responsible for cooking with the new school feeding food basket of cereal, pulses and oil. WFP requires up to US$ 160 million for school feeding and vulnerable group feeding by October 2005, but it had only received US$ 80 million in pledges (equivalent to over 150,000 MTs).

Economic decline and HIV/AIDS both have negative impacts on school completion. 25% of primary school children do not complete school, mainly due to the unaffordable costs. The textbook-pupil ratio is high, between 1:6 and 1:10, due to the high cost of production. The unaffordable cost of education, the increasing numbers of boys and girls heading households (about 50,000 due to HIV/AIDS), and susceptibility of the vulnerable girls to abuse, all together are barriers to school completion. At the household level, there are declining completion rates and low enrolments, due to increased childhood mortality rates, the need (especially for girls) to care for sick parents, and others. HIV/AIDS education remains largely didactic, focusing on the acquisition of facts rather than the social aspects of the pandemic.

A 2004 review of gender issues in education highlights the following as contributing to the decline in completion rates, especially for girls:

- High direct and indirect cost of education;
- Long distance to school, especially secondary schools;
- Unsafe school environments;
- Lack of adult guidance for children of migrant parents;
- Prioritisation of survival needs that relegate education needs;
- Negative religious and cultural influences;
- Need for girls to stay home to care for sick family members or to work to support their families.

The land reform programme reorganised settlement patterns in rural areas and led to the establishment of 628 new schools for newly re-settled areas, with an estimated enrolment of 150,000 children. However, hunger, lack of learning materials and furniture, unsafe physical makeshift infrastructures, some under hazardous conditions in tobacco barns, and the frequent movement of teachers due to the lack of decent accommodation remain major challenges. The EMIS 2004 data show that children in resettlement areas (where the satellite schools are located) had the lowest pass rates in 2003, at 28%. Many schools are also health hazards, as most do not have proper toilets. Most of the toilets are temporary structures. Some schools have no access to safe water. Their source of water is the river or dam or open wells. This exposes both the teachers and pupils to health hazards.

In drought-stricken areas, practical environmental skills are taught theoretically and have limited application. Children do not acquire skills relevant to improvements in the nutrition status of their families. They do not learn enough about food processing and preservation techniques that they can in turn teach their family members.. Although the vulnerable grades, 1-4, are the same for boys and girls, the drop out rate is higher for girls. Orphans have shown a greater vulnerability to dropping out.

At the institutional level, the HIV/AIDS pandemic, dry arid conditions, limited economic activities, and transport problems in remote areas have led to a decline in qualified staff numbers in all cadres including teachers, managers and support staff. As a result, there is a reduction in educational resources, and reduced capacities at all work levels. With declining human and institutional capacity, support for coordination becomes critical in the bid to maximise the utilisation of scarce resources. UNICEF has therefore been facilitating partner coordination in the education sector. The Education Working Group (EWG) meets on a monthly basis chaired by the Ministry of Education, Sports and Culture. The Working Group operates through sub-groups (girls' education, Early Childhood Development (ECD) and life skills). These groups have initiated and actively participated in the recently completed OVC baseline survey and have supported the development of a girls' education strategic plan. The ECD sub-group is currently reviewing ECD provision, while the HIVAIDS sub-group has recently initiated the development of the HIV/AIDS in Education Sub-sector policy, both being done to ensure better sector-wide responses for vulnerable children. The partners (UN agencies and European Union (EU)) supporting education activities have defined a collaborative framework which would guide their joint programming efforts in the districts in which they have a presence. In order to continue strengthening coordination and collaboration, catalytic resources are needed to facilitate joint planning, review and monitoring mechanisms.

The emergency education projects proposed will address the most urgent and immediate needs to keep children in schools, namely:

- Lack of access to instructional materials in most schools;
- Lack of access to school feeding;
- Lack of access to safe water and sanitation;
- Inadequate psychosocial care, support and early stimulation;
- Inability of parents to meet the indirect costs of basic education, especially of OVC;
- Unsafe school environments;
- Strengthening of coordination and joint programming among partners.

Objectives

The education sector has the following broad priority action areas for emergency education response in 2006:

- Ensure that the 200,000 children who will lose one or both of their parents to AIDS or live and care for a chronically ill parent stay in school;
- Ensure opportunities and spaces exist for children; including pre-school children aged 4-6, in deprived areas to play while having access to early cognitive stimulation and psychosocial care;
- Prevent HIV/AIDS through life skills education and peer education and counselling approaches;

- Ensure access of children to textbooks and other teaching and learning materials;
- Reduce the impact of HIV/AIDS on children through expansion of educational opportunities relevant to the lives of orphans and other vulnerable children;
- Make schools physically safer, more protective against sexual and other forms of abuse, more environment-friendly and providing guidance and counselling services;
- Maintain gender equity in primary completion and eliminate sexual abuse and the 5% gender gap at secondary level;
- Promote gender equity and equality in education;
- Strengthen data, monitoring and coordination systems so that they will be improved at national and district levels.

Indicators
The following sector wide indicators will be used for measuring progress towards the above outlined objectives:

- School attendance rate (primary & secondary school);
- Orphan/Non-orphan school attendance ratio (10-14 years of age);
- Drop-out rate (primary & secondary school);
- Pupil/Teacher Ratio and Textbook/Pupil Ratio;
- Percentage of schools with meaningful life-skills education.

5.E FAMILY SHELTER AND NON-FOOD ITEMS

Introduction
Between May and July in 2005, the Government of Zimbabwe embarked on Operation Murambatsvina(OM)/Restore Order, an urban cleanup campaign involving the destruction of thousands of housing structures deemed illegal. This operation resulted in a massive increase in homelessness and thousands of people staying in the open. As such it led to an urgent need for the immediate provision of temporary shelters. OM further exposed the underlying problem of rapid, unplanned urbanisation and the subsequent acute shelter problems.

A first large urban influx of population occurred at independence when the urban areas were opened up to the majority black population. Increasingly difficult living conditions in the rural areas due to drought, general economic decline and structural changes caused by the land reform programme accelerated migration to the urban areas, especially to the larger urban centres of Harare and Bulawayo. While the general population growth has been between 1-2% in the last decade, the growth in urban population has been 5-6%. The urban population is today about 4.5 million of the total population of approximately 12 million. At the present growth rate, the urban population will be close to 8 million by 2015[12].

Existing procedures and resources for land allocation, urban planning, provision of infrastructure and housing have not been able to keep up with the urban influx and increasing numbers of people have come to live in substandard and insecure conditions in low-income urban areas. The urban migrants have been renters, living in backyard shacks, overcrowded hostels or developed squatter settlements outside of formal planning and building control. The Government of Zimbabwe estimates an urban housing backlog of 1 million housing units.

While the Government claims OM sought to address some of the symptoms of this rapid and uncontrolled urban growth, the immediate short-term effect has been to increase the problem of substandard housing for the poor by making a large number of people homeless.

Needs of the persons affected by Operation Murambatsvina/Restore Order
The people affected by OM were among the most vulnerable of society, and most earned their living in the informal sector. The loss of homes affected life in more ways than increasing the number of people without a roof over their head; it also interrupted income activities, schooling and ARV treatment for people living with AIDS[13]. The Special Envoy on Human Settlement Issues in Zimbabwe reported

[12] Zimbabwe Millennium Report 2005
[13] In July 2005, UNICEF, IOM and other UN partners together with the Government of Zimbabwe conducted a rapid assessment to identify needs of those affected by "Operation Murambatsvina/Restore Order". The assessment, which sampled households in five urban areas around the country, showed that shelter, followed by food, blankets and clothing were the highest needs among the affected population. It also indicated that access to treatment for the chronically ill had fallen by about 40%, and that people required shelter, followed by financial assistance, land and legal vending stalls in order to restore their lost livelihoods.

approximately 130,000 households to be affected by OM, but there are no certain figures on the number of people needing immediate assistance, and uncertainty remains as to how many have already found a solution to their housing situation on their own.

Ex-farm workers
Another group of people in need of shelter is ex-farm workers who have lost their homes and livelihoods as a result of the fast-track land reform. Currently, this group is estimated at approximately 150,000 families, but while this process was most intense between 2000 and 2002, it is expected that the number will increase following the 17th Amendment in 2005[14].

General housing needs among the urban poor
In addition to addressing the immediate housing needs of those affected by the above-mentioned evictions, there is an urgent need to address the underlying problems related to the provision of housing for the urban poor. As noted, the lack of secure tenure and housing hinders the establishment of livelihoods, education, and access to other basic services. Health and social problems have followed the densification of low-income urban areas.

Several issues of human settlement must be addressed in order to solve the general problem of homelessness and to avoid a repetition of evictions such as those during OM. To this end, a dialogue should be established between the Government and communities on how to provide homes with secure tenure, as well as houses and services that are affordable to the urban poor.

Response strategy
The immediate needs of the most vulnerable among those affected by OM will be addressed through the provision of temporary shelters. Similarly, assistance to evicted ex-farm workers will include shelters. In parallel, the general problem of homelessness will be addressed through supporting communities and organisations of the homeless poor and entering into a policy dialogue with the Government.

The most vulnerable populations targeted under this sector include the chronically ill, elderly, orphans, the handicapped, female or child-headed households, families who lost their only source of livelihood, and HIV/AIDS affected households

Immediate temporary shelter
The strategy aims to secure stands on planned and legal land for families affected by OM, who will also receive a basic shelter structure, which permits them to claim occupancy for the purpose of securing tenure. This temporary shelter will be simple enough to allow for targeting a large number of people. Similarly, the shelter needs of ex-farm workers will be addressed through securing land, on which assistance will support them to establish their permanent homes and livelihoods.[15]

Policy engagement and strengthening of CBOs
The strategy involves engaging with Government directly on human settlement policy issues, such as land allocation procedures and in this context, the roles of central and local Government, savings and financing arrangements, appropriate technical standards and their linkage with town-planning and building legislation. This will be done by exposing Government officials to best practice pro-poor housing policies from other countries. In addition, local best practices will be promoted through piloting concrete solutions to policy and technical questions, thus influencing policy through practice. This will be done by strengthening community-based organisations, both in their advocacy on human settlement policy and as service providers. The strategy thus seeks to enhance the access to public land for development of human settlement areas for community groups and housing cooperatives. These groups will be supported in developing solutions for affordable housing and infrastructure to the poor.

Objectives
- Provide temporary shelters for those affected by Operation Murambatsvina;
- Provide appropriate longer-term shelters and livelihoods for ex-farm workers;
- Develop appropriate solutions to housing and infrastructure for the urban poor;
- Make human settlement policies more pro-poor;
- Strengthen sectoral CBOs advocacy and service delivery capacity.

[14] Project proposal submitted under Mobile and Vulnerable Population Sector
[15] The support packages to those affected by Operation Murambatsvina and the ex-farm workers will include water and sanitation, as well as non-food items and HIV/AIDS interventions as explained in the sector for Mobile and Vulnerable Populations.

Indicators

- Number of affected families provided with temporary shelters;
- Number of ex-farm workers provided with longer-term shelters and livelihoods;
- Number of successfully piloted housing solutions for the urban poor;
- Number of pro-poor changes in existing human settlement policies and legislations;
- Number of affordable housing solutions provided to the urban poor by CBOs accepted by Government.

5.F FOOD

Introduction

Zimbabwe faced serious food shortages in 2005, following a poor harvest, which is expected to carry over into 2006. While the Government has been importing significant amounts of food in order to address the shortfalls, to date these efforts do not meet the total requirements. Moreover, distribution networks for bringing the grain to those who need it the most are not guaranteed. Given the difficulties farmers face in accessing inputs, and taking into account the limited amount of tillage available, prospects for the April 2006 cereal harvest are not promising. A policy environment conducive to surplus grain production and marketing is required to minimise the recurrence of food shortages. As in other countries in Southern Africa, the triple threat of food insecurity, high prevalence of HIV/AIDS and weakened capacity for governance continues to take its toll.

Within this context, carefully targeted food aid plays a critical role in sustaining vulnerable, food insecure households and preventing famine, destitution and the breakdown of normal societal functions. The food sector strategy contributes towards the CAP goal of "improved quality of life for the most vulnerable through the provision of life saving support and enhancement of coping mechanisms", in particular by improving access to food among vulnerable groups. Without food aid, communities risk increased suffering and growing destitution among vulnerable groups, including further reduction in meals, disposal of assets, malnutrition and migration. Earlier and increased mortality, particularly among people with AIDS, is also likely.

The targeted programmes include:

Vulnerable group feeding: In 2006, vulnerable households in food insecure districts will receive monthly food packs of cereal and pulses. Beneficiaries include people with no other means of self support (very low food production, income, assets), with a special priority placed on child-headed households, people with chronically-ill family members, the disabled, the elderly and households with large dependency ratios. Vulnerable Group Feeding (VGF) programme will stop in April 2005 following the harvest, and will resume, if necessary and authorised by Government, in October. Implementing partners include CARE, CRS, Christian Care, CONCERN, GOAL, HELPAGE, ORAP, OXFAM, Plan International, Save the Children Fund (SCF), and World Vision.

School feeding: Pre and primary school children in an estimated 16 districts will receive a daily school meal in 2006, with plans to supplement this meal with a take home ration for orphans and vulnerable children, in order to provide a further incentive toward continued education. A joint effort by WFP, UNICEF, FAO, United Nations Educational, Scientific and Cultural Organization (UNESCO) and several NGOs is planned to combine school feeding with complementary water, sanitation, health, agriculture (school gardens) and education-support initiatives. Implementing partners include CARE, Christian Care, GOAL, ORAP, SCF Norway and World Vision.

Home-based care and orphan support: Food support to Home Based Care programmes will expand in 2006, in light of continuing food insecurity. In food insecure and HIV-prevalent areas, HBC will combine a monthly food ration with basic first aid and medical care, health education, psychosocial support, counselling and material/hygiene support for largely or occasionally bed ridden AIDS patients unable to access/afford proper institutional care. Food is also extended to orphans of former HBC clients and other vulnerable children; it is also linked to support for household gardens, training, income generation and other food security initiatives. Efforts to expand food support to OVCs in 2006, through school feeding, take home rations, and in partnership with UNICEF, are also planned, as an estimated 1.3 million orphans are at particular risk for malnutrition. Implementing partners include Africare, CARE, Mashanbanzou Care Trust, Zimbabwe Red Cross Society and several community-based organisations.

Prevention of mother to child transmission of HIV/AIDS: In late 2005, a pilot programme was launched to provide support to malnourished mothers and children through MCH clinics that offer Prevention of Mother To Child Transmission (PMTCT) This follows elaboration of a national strategy on food support to PMTCT developed under the Ministry of Health and Child Welfare, involving UN agencies, NGOs and donors. Beneficiaries of this activity include HIV-infected and/or malnourished mothers and children. [Implementing partners include *Comitato di Coordinamento delle Organizzazioni per il Servizio Volontario* (COSV).]

Other programmes: In 2006, agencies also hope to pilot new programmes to address food insecurity, including expanding food support through urban vouchers and developing food for work programmes that support communities in building assets that improve their food security. These programmes, which would include *inter alia* people affected by Operation Murambatsvina, are still in the nascent stage.

Objectives

The specific objectives of the food sector are to:

- Preserve lives and safeguard nutritional well-being;
- To protect livelihoods and enhance shock resilience;
- Increase nationwide food access and availability;
- Increase child attendance and learning through school feeding, and provide incentives for parents and caregivers to keep vulnerable children, such as orphans, in school;
- Provide food aid for people living with HIV/AIDS, thereby increasing their mobility and allowing them to engage in productive activity while also aiding in medicine consumption and absorption;
- Support the ZIMVAC process;
- Provide food support as an incentive for mothers to participate in Prevention of Mother to Child Transmission programmes, thereby contributing to the reduction of infant HIV infection as well as food aid to malnourished, pregnant women, thereby giving their unborn children the opportunity to achieve full potential.

Indicators

Progress in achieving the desired food supported outcomes will be tracked using the following indicators:

- trends in prevalence in malnutrition;
- change in dietary intake;
- change in household assets;
- Percentage of households using high impact coping strategies;
- school attendance.

Programme monitoring

Progress in achieving the desired food supported outcomes will be tracked using the following indicators: (a) trends in malnutrition prevalence; (b) change in dietary intake; (c) change in household assets; (d) percentage of households using high impact coping strategies; and (e) school attendance.

Food supported activities will be monitored at all action stages, through registration monitoring, food distribution monitoring and post-distribution monitoring. Additionally, output reporting will be compiled from Cooperating Partner NGO data and a specialised protocol, management and reporting system will be in place to address any adverse incidents or attempts of political interference on programme implementation. Guidelines, standard checklists/questionnaires, reporting formats and databases will provide the framework for monitoring and evaluation of programme implementation. Qualitative and quantitative findings will be reported on a monthly/quarterly basis and shared with internal and external stakeholders for follow-up and decision-making through the measurement of achievements in specified programmes objectives and performance indicators. This monthly process will be enhanced by the biannual Community and Household Surveillance, which monitors the outcomes (impact) of food assistance actions upon beneficiaries and their livelihoods, feeding its information into a regional picture of trends.

The food security situation will be tracked by collecting and compiling information on a monthly basis across 47 sentinel sites countrywide through community focus group discussions, gathering of information on maize/cereal availability and sources, reviewing of price trends for food and livestock and monitoring of changes in coping strategies. In addition, prices in urban areas will be collected on a bi-weekly basis. Continued participation and support for the annual ZIMVAC, which provides a national picture of vulnerability and food accessibility constraints, is also envisioned, as is work with

UNICEF in support of the expansion and improvement of the National Food and Nutrition Sentinel Site Surveillance System.

5.G NUTRITION

Sector response plan analysis

There has been a steady deterioration in the nutritional situation of children over the past six years. However, high levels of food distribution and supplementary feeding arrested part of this decline until 2003. Despite this, recent information suggests that nutritional status is again on the decline, and may be further exacerbated by increasing food insecurity due to drought, low availability and declining purchasing power. Furthermore, the operating environment in Zimbabwe is highly complex, unstable and challenging due to the erosion of human resource capacity, the deterioration of health services, the potential shrinkage of humanitarian space, a rapidly changing economic situation and a shortage of basic supplies in all sectors.

In order to facilitate best practices around nutrition programming in this context, the situation requires monitoring that provides relevant and current information on nutritional status. Recently, the Food and Nutrition Sentinel Site Surveillance System picked up an increase in malnutrition in ten vulnerable districts from November 2004 to March 2005. Underweight, a good measure of nutritional trends, increased from 14.2 to 16.9%. Wasting, a measure of acute malnutrition, increased in all ten districts, with the highest district at 9%, approaching cut-off levels for emergency nutrition actions. The average wasting for the ten districts increased from 2.9 to 4.4% from December to March, with severe malnutrition accounting for approximately 25% of all wasting cases in March. In two hospitals where HIV screening was conducted, 70% of the children admitted for severe malnutrition were also HIV-positive. Given the high child mortality rate from severe malnutrition (24.4%), it is likely that some of the mortality from severe malnutrition can be attributed to paediatric HIV. Combined with ZIMVAC 2005 estimates that by March of 2006 there will be 2.9 million people in need of food assistance, it seems imperative that not only should the situation be monitored, but also that preparedness around emergency feeding be strengthened. This should not be limited to a national response, but should include capacity-building within communities to identify, address and handle these issues themselves, especially with regards to child malnutrition and nutrition in the context of HIV (including OVC's and home-based care). If these factors are seriously considered and facilitated, child malnutrition, child mortality, and the nutritional status of those affected by HIV may be mitigated.

Goal

The main goal of the nutrition sector for 2006 is to prevent the deterioration of the nutritional situation, particularly in those populations who are most vulnerable to malnutrition, and to prevent mortality and morbidity associated with malnutrition.

Objectives

The objectives of the nutrition sector actions are:

- To monitor the nutrition situation to identify areas of need and appropriate timing of actions;
- To reduce mortality from severe acute malnutrition;
- To strengthen preparedness in emergency selective feeding;
- To strengthen communities' ability to identify and care for malnourished children to reduce mortality from severe and acute malnutrition;
- To strengthen nutrition aspects of HIV programming in the context of food insecurity (ART, HBC, OVC, infant feeding);
- To ensure a well-coordinated nutrition response that reaches the most vulnerable nationwide.

Activities

- Support the Pilot National Food and Nutrition Sentinel Site Surveillance System in 23 districts, including both those most vulnerable according to ZIMVAC 2005 findings and those affected by urban displacements;
- Based on the lessons learned and review of the pilot surveillance system, support the development of a comprehensive National Food and Nutrition Surveillance System based on the lessons learned during the pilot surveillance system period;
- Provide contingency planning and coordination for large scale under-five emergency supplementary feeding, should acute moderate malnutrition reach recognised emergency thresholds;
- Support community-based nutrition care programmes, including the MoHCW pilot of community therapeutic care;

- Support continued implementation of the national therapeutic feeding programme for severely malnourished children, in view of access difficulties involved with locally produced therapeutic milk components;
- Establish linkages between facility-based therapeutic feeding programmes, community therapeutic care, community nutrition care programmes, and HIV prevention, care and support services;
- Build and restore safety nets with support and increased access to existing nutrition services;
- Nationally reduce micronutrient deficiencies by supporting the development and implementation of a national food fortification programme and a national micronutrient baseline study, with a particular focus on micronutrients and HIV;
- Support the training of health workers and communities on infant and child feeding practices in light of HIV/AIDS (see health sector projects on PMTCT);
- Support the local production of nutrient-dense complementary foods, which could also be used for PLWHA (see health sector projects on PMTCT);
- Support home-based nutrition care programmes and the provision of dietary guidelines in both rural and urban areas benefiting PLWHA and their families;
- Provide nutrition support to home-based care programmes and provide dietary guidelines in both rural and urban areas benefiting PLWHA and their families;
- Strengthen nutritional aspects of nutrition garden programmes in the context of widespread food insecurity.

Indicators
- Malnutrition levels (weight/height, weight/age);
- Number of deaths in Therapeutic Feeding Units;
- Number of children benefiting from community-based nutrition care programmes;
- Establishment of linkages between nutrition and HIV programmes for the comprehensive care and treatment of children;
- Number of IEC materials on nutrition and HIV available at the community level.

Coordination and monitoring
The Nutrition Technical Consultative Group (NTCG), with the UN, NGO and donor representation, and chaired by UNICEF, will be responsible for coordination, ensuring a coherent and comprehensive national nutrition response that reaches the most vulnerable. A mapping exercise of nutrition activities carried out at the beginning of the year and updated regularly will facilitate areas of gaps and duplication, which will be addressed through the group. The NTCG will develop and use a monitoring framework based on an agreed set of indicators to monitor the nutrition response. Gathering of monitoring data will be facilitated through the mapping exercise.

5.H BASIC HEALTH SERVICES

Introduction
Over the recent years, the quality of health services in Zimbabwe has been deteriorating as a result of under-funding, emigration of health staff, and the impact of HIV/AIDS. These three factors have increased the pressure on available resources, with impacts on access and quality of services.

Among the key indicators on deterioration are increases in maternal and under-five child mortality. According to a recent global UNICEF report, Zimbabwe had one of the largest increases in under-five mortality in the Southern African region. Child mortality has doubled from 59 to 123 per 1,000 live births between 1989 and 2004. The maternal mortality ratio, a measure of the robustness of the health services, deteriorated from 695 per 100,000 live births in 1999 to more than a 1,000 deaths per 100,000 live births in 2002. Recent ante-natal care data show a reduction in attendance, and increases in abortion complications and home deliveries attended by un-skilled birth attendants. A critical shortage of Emergency Obstetric Care (EOC) equipment and drugs at all service levels, but most critically at the rural health centre level, has exacerbated the situation.[16]

Although 2004 immunisation coverage figures were higher than in 2003 (86% and 81% for Diphtheria/Pertussis/Tetanus (DPT3) and measles, respectively), these gains will be lost if the current constraints of staff shortage, inadequate transport and fuel are not addressed. Doubled efforts and

[16] UNFPA Zimbabwe will not submit a funding proposal on Reproductive Health (RH)/Emergency Obstetric Care for the 2006 CAP due to an existing multi-year funding arrangement with DFID to address these specific humanitarian needs

continuously increased coverage are needed: any decrease in coverage, in conjunction with high rates of chronic under-nutrition and HIV infection, can increase children's vulnerability to diseases that are prevented by vaccination. Reducing coverage presents the risk of allowing major outbreaks of preventable disease.

Results from a WHO/MOHCW Health Impact Assessment carried out in 17 districts in November 2003 demonstrated that crude mortality was high, and an examination of cause-specific mortality clearly illustrates the impact of HIV. Chronic morbidity levels were also high, with 8.7% of the sample considered to be chronically ill and 18.4% of households having a chronically ill member. As a way of relieving the strain on health institutions, patients with HIV/AIDS-related chronic illnesses are usually discharged to be cared for by relatives and community volunteers; hence the need for home based care programmes.

It has been noted that there is increased morbidity at border towns due to an increased number of returnees, most of whom are chronically ill (approximately 2,000 persons pass through Beitbridge per week according to IOM). Some of these returnees could be on anti-Tuberculosis (TB) and ART programmes, and it is critical that they are maintained.

The latest research, based on figures from an ANC screening, has identified a decline in HIV prevalence rates, from 24.6% in 2002 to 21.3% in 2004, with the general prevalence at 20.1%.[17]. An estimated 1.8 million Zimbabweans are infected with the virus, more than 160,000 of whom are children under 15. More than 3,000 people die per week from HIV/AIDS-related conditions. The 2004 Human Development Report showed life expectancy to be 33.9 years, compared to 61 years during the early 1990s, an alarming 27-year decrease from when there was no AIDS to contend with. Of the estimated 1.3 million orphans in Zimbabwe in 2003, AIDS contributed about 75%, and by the end of 2005, an expected 20% of the nation's children will be orphaned as a result of the disease.

Socio-cultural norms, beliefs and practices that apply to and affect women and men differently have a direct effect on vulnerability to HIV infection. In Zimbabwe, food insecurity and lack of income and shelter are major factors that lead to transactional sex, which increases the risk of HIV infection. Addressing gender roles and power dynamics between girls and boys, women and men, and their impact on sexual relations and decision-making, is critical for effective HIV prevention.

HIV/AIDS increases the prevalence of illness, undercutting household productivity and absorbing scarce resources. The need to access health infrastructure and the amount and quality of food needed to maintain adequate nutrition increase among people with HIV/AIDS. In Zimbabwe, this is occurring at the same time as when there are deteriorated capacities of social services, food shortages, and general economic decline; the effect on individual, household and community lives and livelihoods is devastating. Increased capacity for testing HIV and improved access to ART are urgently required.
The Ministry of Health and Child Welfare has a decreased capacity to sustain programmes aimed at prevention and control of epidemic prone diseases, compared to the past. As a result, there is a resurgence of epidemics, including malaria, cholera, dysentery and tuberculosis. The high prevalence of HIV/AIDS is a major factor in the resurgence of tuberculosis and has placed a further strain on the health delivery system, as AIDS patients occupy between 50% and 70% of all hospital beds.

In terms of infrastructure, equipment and services considered essential for effective functioning of the health services, the deterioration in the situation was clearly reported by the facilities assessed, with less than 50% of equipment available. This includes the radio communication system, which is vital in health service delivery, especially in emergency situations. According to the MOHCW, as of September 2004, 56%, 32% and 92% of the posts of doctors, nurses and pharmacists were vacant, respectively. The lack of qualified health personnel is worse in rural areas, and represents increasing challenges to the provision on ART within these areas. Annual mortality amongst staff was a startling 2.5%, of whom 60% were chronically ill prior to death. Drug and transport availability were also reported as problematic.

Actions by the various stakeholders will focus on the gaps identified within the following thematic areas, associated with, caused or exacerbated by the humanitarian crisis. These include: prevention and control of disease epidemics, EPI, emergency reproductive health, and HIV/AIDS. The other major action will be building capacity for surveillance and emergency response and will target the general population.

[17] 2004 MoHCW estimates.

Objectives
The **main goal** of the Health Sector is to maintain minimum basic health services for the most vulnerable populations affected by the humanitarian crisis.

- To ensure access to a minimum package of basic health services to the most vulnerable populations;
- To maintain the capacity of the health system to respond to the humanitarian crisis in the vulnerable populations;
- To build the capacity of civil society and communities in the vulnerable areas to respond to health needs in emergencies;
- To improve access to treatment of OI, ART, to provide HIV prevention and care services to vulnerable populations, including children;
- To coordinate stakeholders in order to improve and integrate the response to health crises.

Strategies
- Establishment of satellite clinics and outreach services in the hard-to-reach areas, to offer basic health care services to affected populations;
- Strengthening of the communication and referral system;
    - Strengthen radio communication in the health facilities serving vulnerable populations to improve health referral mechanisms and disease surveillance;
    - Strengthening and supporting the ambulance services to improve referrals;
    - Strengthening the continuum of care between the health institutions and the community.
- Procurement of drugs, supplies and other commodities;
    - Support procurement and distribution of essential drugs (including anti-malarias, anti-TB, Sexually Transmitted Infections (STIs) and ARVs), National Immunisation Day (NID) vaccines, and medical supplies to enable vulnerable populations access to minimum basic health care.
- Capacity development;
    - Support skills upgrading of health personnel and community-based workers (including volunteers) in emergency preparedness and response, including Integrated Disease Surveillance and Response (IDSR);
    - Improve the capacity of health service-delivery through the management of trained human resource, to stem the movement of skilled health workers;
    - Establish a district-based clinical mentoring system.
- Community mobilisation;
    - Raise awareness among communities on the significance of their role in responding to health emergencies and develop their capacity to appropriately respond.
- Coordination of stakeholders to improve integrated response to the health crisis.
    - Conduct regular situation analyses, monitor and report on the impact of the response by implementers and supporting partners.

Indicators
- Proportion of vulnerable populations accessing the minimum package of basic health services;
- Proportion of targeted health facilities with basic drugs, equipment and supplies;
- Proportion of civil society and communities trained in emergency preparedness and response;
- Proportion of trained civil society and communities responding appropriately to emergencies;
- Proportion of vulnerable population, including children, with access to HIV prevention, treatment and care services.

5.I MULTI-SECTOR

Mobile and Vulnerable Population

Refugees
The official Government refugee population in Zimbabwe at the beginning of 2005 was 10,668. The majority of refugees come from Democratic Republic of Congo (DRC), Rwanda and Burundi. Other nationalities include Liberians, Somalis, Ethiopians and Sudanese. Of this number, about 1,568 reside in Tongogara Camp, while the rest stay in urban centres. UNHCR had planned a revalidation exercise in May 2005 to determine the actual number of refugees living in the country. However, this exercise did not occur following the insecurity caused by Operation Murambatsvina/Restore order which saw

displacement of refugees from urban areas to the camp, and increased its capacity to 2,500 persons. Given also the refugee influx in 2005, especially from DRC following the clashes and unrest, a safe planning figure of 7,000 refugees for 2006, including the camp population, can be used.

Despite efforts by both the Government of Zimbabwe and UNHCR, Rwandan refugees have not expressed willingness to repatriate. The refugees maintain that conditions back home are not yet conducive to allow for a safe and dignified repatriation. It is anticipated that this position will not change in the immediate future. Notwithstanding, in view of the improved situations in Rwanda, UNHCR will continue to encourage voluntary repatriation of Rwandan refugees. Zimbabwe will continue to host refugees and asylum-seekers and exercise flexibility in its encampment policy to allow refugees to stay in urban centres. In principle, refugees will be allowed to use arable land within the 1,780 hectare total area designated by the Government in Tongogara camp.

Following the election and formation of a unity Government, a small number of refugees from Burundi may opt for voluntary repatriation. Meanwhile, UN agencies' emphasis on identifying and highlighting the needs of especially vulnerable groups will continue. UNHCR and its partners will actively endeavour to promote and encourage gender awareness, as well as participation by women in refugee committees and their involvement in decision-making. Activities, such as providing education to refugees, local authorities, and implementing partners on the seriousness of SGBV and sexual abuse of children will continue.

UNHCR will play its catalytic role in encouraging donors, agencies such as UNDP, UNICEF, WHO, and other International NGOs, to include refugees in their country programmes.

Objectives

- To ensure the integrity of the institution of asylum in Zimbabwe, the right of refugees to access physical and legal protection and continued material assistance while pursuing durable solutions, including return and resettlement;
- To provide adequate assistance as the basis for protecting the dignity of refugees and meeting their basic needs while strengthening self-reliance projects.

Strategic response

- Through close collaboration with the host Government, ensure protection of refugees, their basic human rights, the right to seek asylum, principle of non-refoulement and assist in securing work permits for qualified professionals;
- Ensure basic facilities including shelter, sanitation and continuous water supply is available at the Transit Centre;
- Promote social integration in all fronts, family unity with special emphasis to extremely vulnerable refugees, women and children;
- Promote equal representation of refugee women in leadership, access to registration and ID cards, prevention and response to sexual and gender based violence, active involvement of refugee women in management of food and provision of sanitary materials.

Cross-border mobility and irregular migration

The political and economic decline over the past years serves as impetus to the acute exodus of many Zimbabweans leaving the country. Many such migrants travel with little or no knowledge of cross-border migration and acquisition of proper travel document is seldom undertaken. This puts them at risk as they are often labelled illegal migrants in the receiving country when apprehended with no legal documents.

This has resulted in the deportation of thousands of Zimbabweans who cross into for example South Africa and Botswana irregularly. Official information indicates that on average approximately 8,000 Zimbabwean irregular migrants are deported monthly from South Africa to Zimbabwe through the Beitbridge border crossing point. There have been reports of extreme exhaustion leading to fainting and in some cases, fatalities during these deportations. The lack of sufficient money to return to their homes of origin coupled with their wish to return to South Africa often lead deportees to walk across the border back into South Africa. In the meantime, their continued stay in Beitbridge, with limited coping mechanisms, makes them prone to illnesses such as TB and the spread of HIV/AIDS, as their search for means of survival breeds commercial sexual activities. Consequently, Beitbridge has exceptionally experienced an increase in the prevalence of TB, reflecting an increase in HIV within the border region, which now has the highest prevalence rate in Zimbabwe.

By establishing a reception centre, immediate food support, basic health care and medical referrals for further treatment will be provided, as well as transportation assistance for the most vulnerable. This should be coupled with awareness-raising activities on HIV/AIDS to prevent its spread and on the dangers of irregular migration, with the hope that people will be more cautious when resorting to irregularly crossing the border. Training should also be provided to border officials, police, and social service providers on trafficking, smuggling, vulnerabilities of irregular migrants and their rights. As such, a reception centre could assist in building the capacity of Beitbridge to handle migration more humanely and effectively.

Any prevention strategy aiming at reducing irregular migration among people in economic distress necessarily needs to involve an option for improving the economic well-being of the potential migrants. It is therefore encouraging to see that the Governments of Zimbabwe and South Africa have taken steps to facilitate regular channels for labour migration. The management of this movement could be facilitated by providing a foreign placement centre.

Objectives
- To address the growing humanitarian needs of deported Zimbabwean migrants;
- To contribute to a reduction of HIV prevalence rates among cross border and mobile populations.

Strategic response
- To establish a reception centre at Beitbridge border crossing point to receive and process the deportees;
- To provide food assistance to the deportees;
- To provide voluntary transportation assistance to areas of origin;
- To design and implement an information campaign for HIV/AIDS prevention and awareness, the implications of irregular migration, and legal options for migration;
- To design and provide training for relevant Government officials in the border areas (border officials, police, local authorities, social service providers);
- To facilitate labour migration by ensuring proper documentation, process, transport and ensuring placement of qualified labour migrants;
- Conduct HIV/AIDS prevention programmes targeting cross border mobile populations.

Indicators
- Proportion of vulnerable deportees accessing food assistance;
- Proportion of vulnerable deportees accessing basic health services;
- Proportion of vulnerable deportees provided with voluntary transportation assistance;
- Increased awareness of dangers of irregular migration and HIV/AIDS;
- Proportion of trained border officials on trafficking, smuggling, vulnerabilities of irregular migrants and their rights;
- Number of migrants benefiting from legal migration assistance.

5.J PROTECTION/HUMAN RIGHTS/RULE OF LAW

Child protection analysis

The most devastating effect of the HIV/AIDS pandemic has been the orphaning of a generation of children. In 2006, more than 225,000 children will either lose one or both of their parents to AIDS or live and care for a chronically ill parent. Of the estimated 1.8 million orphans (0-17) in Zimbabwe in 2005, about 75% were orphaned by AIDS. Most orphans live in the rural areas because parents tend to migrate back to their home villages when they are sick. The OVC (Orphans and Other Vulnerable Children) Baseline Survey in 21 districts conducted in late 2004 identified that more than 40% of children are now orphaned or made vulnerable by HIV/AIDS in rural districts. The ongoing humanitarian situation increased not only the prevalence of orphans and vulnerable children in the country, but has also severely affected all aspects of child welfare and development: physical, material, psychological, and social.

The OVC Baseline Survey found that orphans, particularly maternal orphans, are more likely to be stunted than non-orphans, which affects their overall development, due to inadequate food intake. In the past year, five different scientific studies found that maternal orphans were significantly more likely to be infected with the HIV-virus. Orphans and vulnerable children are also found to be less likely to be in possession of the minimum basic material needs (a blanket, a pair of shoes, and two sets of

clothes) compared to non-OVCs, with double orphans being particularly disadvantaged in accessing these items.

Psychologically, children affected by HIV/AIDS tend to suffer anxiety and fear during the years of parental illness, then grief and trauma with the death of a parent. Even when parents are alive, economically and socially distressed parents or other guardians often lack sufficient time and emotional space to provide adequate parental guidance. Children of all ages are strongly affected by the stress levels and situation of their adult caregivers.

While the majority of OVC are still being cared for through extended family networks, an increasing number of vulnerable children have been experiencing family breakdowns and falling away from the traditional safety nets. Some have ended up on the streets, while others go to residential care institutions. In addition, some children have been engaging in illegal cross-border movement or risky coping mechanisms for their economic survival. Child abuse and sexual exploitation are serious challenges in this context. As children's protective environment dwindles, their vulnerability increases, and the least powerful members of the society often become victims of increased anxiety and tension. The recent Operation Restore Order also increased the number of children that have become mobile and extremely vulnerable.

While there has been important progress made toward achieving the objectives in the National Plan of Action for Orphans and other Vulnerable Children (National Programme of Action For Children (NPA) for OVC) in 2005, there has still not been an adequate response to address the magnitude of the challenge. In Zimbabwe, there is a strong legal framework, mostly in line with the Convention of the Rights of the Child; however, there are problems in acquiring the resources necessary for its implementation. In addition, the economic decline of the country continues to negatively affect the allocation of national budget towards the protection of vulnerable children, and human resources continue to decline as the unstable socio-economic situation drives professionals in social and other relevant sectors out of the country to search for better opportunities.

Sector priorities
The Child Protection Sector strategies and sector priorities were developed to respond to the need for a holistic approach in addressing the above-mentioned aspects of vulnerability that orphans and other vulnerable children are experiencing under the current humanitarian situation.

The most vulnerable groups of children need assistance to access basic social services and materials, and psychosocial support to overcome trauma and increase their resilience. Assistance and protection should be two integral parts of response to affected children, as they need to be protected from all forms of abuse and exploitation. Assistance should be rendered in such a way that enhances the childcare capacities and protection response structure at the community level. While these preventive efforts at the community level should be a priority, responsive efforts for those without safety nets should enable these particularly vulnerable children to reintegrate into their respective communities. Child participation should be mainstreamed in all relevant sectors in order to ensure that the perspectives of affected children are taken into account when identifying actions. In order for this to happen, relevant institutions need to be trained to enhance their capacities in addressing child protection issues.

Objectives
- Provision of relief, care, psychosocial support, life skill training and livelihood support for the most vulnerable children, including HIV infected/affected children and child-headed households;
- Provision of psychosocial support and life skill training;
- Prevention of and response to child abuse: physical, sexual, and emotional abuse, as well as neglect;
- Prevention of and response to child cross-border movement and economic exploitation;
- Reunification and community integration of unaccompanied and separated children;
- Child participation and institutional capacity development;
- To coordinate the response, advocacy and resource mobilisation for child protection activities.

Indicators
The following sector-wide indicators will be used to measure progress towards the above-outlined objectives:
- Availability of services in type and quality;
- Number of direct and indirect beneficiaries;

- Effective response, reporting, and referral mechanisms put in place to manage cases of abuse and exploitation;
- Number of children being re-united and reintegrated back to their communities;
- Meaningful child participation at all levels.

The sector working group, which has the overall duty to coordinate the work of the various stakeholders, will continue to:

- Revisit, monitor, and direct strategy and resource mobilisation;
- Update the resource databank set-up mechanism and share strategic resources;
- Advocate and operationalise policies that support protection work as well as advocate review of those that constrain protection work.

Humanitarian principles

The year 2006 will likely be a challenging year for humanitarian actors and will require a strengthened coordination capacity for facilitating data gathering, analysis and humanitarian assessment in the area of protection. More effort is needed to build a common understanding of protection issues by all stakeholders, including UN agencies, NGOs and the Government.

The issues of protection of the most vulnerable require a holistic approach. Protection should not only be examined in terms of service delivery, but through the whole spectrum of basic human rights as enshrined in national, regional and international legal instruments. An analysis of the causal factors, linkages and cross-cutting issues is essential in order to address the intricate issues affecting refugees, Internally Displaced Persons (IDPs), the elderly, women and children.

While the Government-initiated Operation Murambatsvina/Restore Order created a massive and sudden displacement of population, it deliberately turned a blind eye on the needs of the most vulnerable in need of protection. The humanitarian community has not had sufficient access to determine these protection needs and develop appropriate action plans. Information is therefore required on who currently needs protection, what kind of protection, and how best can it be delivered. The humanitarian community will continue finding innovative ways of reaching these vulnerable groups.

An analysis of the situation of IDPs in the prevailing environment of economic decline and growing poverty is needed: Zimbabwean IDPs not only face increasing survival problems but also protection matters. While several documents and strategies have been developed, there continues to be a need for systematic information on the needs of IDPs, their situation and their survival strategies. It is therefore necessary to develop a coordinated strategy to respond to their needs, as well as an operational and coordination mechanism to guide a comprehensive response, constructive advocacy, and protection.

Strategies that can be used to promote protection include: developing a common understanding of protection for all agencies dealing with protection; developing networks with national and local authorities; strengthening strategic partnerships, including with IOM and other implementing partners; conducting joint assessments to locate the most vulnerable people in need of protection and map what kind of protection is required; and increasing information sharing, monitoring, and reporting.

Through a strategy of engagement that aims at developing and seizing opportunities for constructive dialogue and partnership while maintaining focus on humanitarian principles and international human rights standards, the humanitarian community needs to help strengthen dialogue between international partners and the Government

Objectives

- Enhance the protection and welfare of the most vulnerable populations;
- Promote humanitarian principles through training various actors, conducting regular field visits, holding consultations with various actors, and ensuring sustained advocacy;
- Enhance the mainstreaming of humanitarian protection through coordination of sector planning and response to the humanitarian situation;
- Improve humanitarian protection to vulnerable people and to other marginalised groups through principled assessments, response and advocacy;
- Maintain international human rights standards in humanitarian programming.

Activities

- Training of UN agencies, NGOs, and Government on humanitarian principles;
- Data collection, compilation and analysis on the nature and magnitude of protection issues: who is affected, how and where are they found;
- Advocacy through the media, seminars, political and civic leaders, to promote mainstreaming of protection in humanitarian programming and response work;
- Awareness-raising activities on issues of human rights and the SPHERE project (which provides minimum standards in disaster response);
- Assessments and information-sharing on protection challenges;
- Development of a strengthened coordination mechanism on all protection activities for various sectors, such as food, water and sanitation, health, and child welfare.

5.K WATER AND SANITATION

Sector Analysis

Zimbabwe has experienced a decline in access to safe water supply and basic sanitation due to a plethora of reasons, including: i) persistent droughts between 2002 and 2004 resulting in severe stress in both surface and underground water; ii) general economic decline; iii) eroded institutional and community capacity; and iv) the effects of the HIV/AIDS pandemic. Close analysis of the major causes of poor health in the country indicate that most ailments (over 80%) that people suffer from and get hospitalised for are directly related to contaminated water supplies and poor sanitation. Given the prevailing scenario, human health cannot be complete without an adequate and safe water supply coupled with basic sanitation services. The unfortunate situation has been compounded by the current drought, which has left many boreholes, family wells and other sources dry. This in turn has left villagers with no option but to get water from whatever source available.

The problems of inadequate water and sanitation are most severe in families with PLWHA, as the quantity of safe water and excreta disposal facilities required are more than triple for this group. As primary caregivers, women bear the brunt of this burden, especially for HBC. OVCs and Child-Headed Households (CHH) are also affected, due to the lack of household coping mechanisms. Girls and young women are among the most vulnerable, as they carry the burden of fetching water from long distances, in addition to their other household chores; this leads many of them to drop out of school.

The Water and Sanitation Working Group, which was established by the United Nations Country Team and coordinated by UNICEF, is responsible for the coordinated planning and implementation of water and sanitation-related humanitarian actions in the country. As a result of this coordination, best practices and experiences are shared among sector agencies.

Rural areas

Despite efforts to restore water supplies through the mechanical rehabilitation of water supply systems during the last 3 years, the operation and maintenance systems of water and sanitation facilities have collapsed, resulting in 30% (12,636) of water supply facilities not functioning.[18] As result, there is an acute shortage of safe water supply for drinking and other domestic purposes amongst approximately 2,500,000 people in rural areas. In the low rainfall areas of the southern and western parts of the country, where surface water has run dry, the frequency of the breakdown of borehole pumps has drastically increased, due to the high pressure on the few water points, which are shared by humans and livestock. The situation is compounded by the decline in access to sanitation, from over 30% in 2001 to 25% in 2004.[19] The combination of these factors further compromises the health of a population already affected by high levels of food insecurity and an HIV/AIDS pandemic.

Zimbabwe continues to experience cholera epidemics, which now affect areas that have not had outbreaks before, such as the northern parts of the country along the Zambezi valley, in Kariba and Binga districts. A total of 207 cases and 14 deaths (Case Fatality Rate (CFR) 7%) were reported in Manicaland Province between January and July 2005[20]. The epidemics have been associated with shortage of safe drinking water supply, and poor hygiene and sanitation in the affected districts. The situation in the whole country is expected to get worse with the start of the rainy season. Therefore, accelerated efforts in prevention and control actions will be required.

[18] National Water and Sanitation Inventory, 2004
[19] National Water and Sanitation Inventory, 2004
[20] Weekly Epidemiological Report: Ministry of Health and Child Welfare- 2005

Urban areas
Water and sewage systems in most urban areas have broken down due to ageing, excessive load, pump breakdowns, and poor operation and maintenance. The breakdown of sewage systems has resulted in large volumes of raw sewage being discharged into natural water courses, which ultimately feed into major urban water supply sources. For example, all the sewage pumps in Chitungwiza Town are broken down, resulting in raw sewage being discharged directly into the environment and residential areas, thereby causing heavy environmental pollution. The town is forced to discharge 50 million litres of raw sewage daily into Manyame River and eventually into Lake Chivero, which supplies water to the 4 million combined populations of Harare, Chitungwiza, Norton, Ruwa and Epworth. This has put the entire population of these towns, particularly the children, at very high public health risks for water and sanitation-related diseases, such as cholera and dysentery. This scenario has created a high demand for water treatment chemicals, which places a large strain on the merger recourses of the local authorities.

Bulawayo City has virtually run dry, as all its water supply dams have dried up. Out of a backup of 208 boreholes drilled within the city in 1992, only 14 are functional. In contrast, 44 are not functional, and 150 have not even been equipped. The city therefore currently relies on small quantities of water carted from the 14 boreholes, and less than 5,000 cubic meters of water per day supplied by the Zimbabwe National Water Authority from a few boreholes in the Nyamandlovu Aquifer. This state of affairs poses a serious threat to the health and well being of approximately 1,000,000 city residents. The situation could substantially improve if all the 208 boreholes were functional.

The Government's Operation Murambatsvina/Restore Order of May 2005 has rendered hundreds of thousands in the urban areas highly vulnerable due to an acute lack of safe water supply and basic sanitation services. Harare alone has over 10,000 poor families in urgent need of these basic services, with remote chances of improvement in the next 12 months unless appropriate action is taken.

Strategies
The main goal in the water and sanitation emergency response is to reduce morbidity and mortality due to related disease outbreaks, and to alleviate the burden of care of PLWHA and on women and children, by improving access to safe domestic water supply and adequate sanitation systems, in the rural, peri-urban, and urban areas. Besides the immediate benefits to the vulnerable people within the humanitarian context, the emergency response will contribute to several national and international MDG priorities.

Operational objectives
- To prevent and control the adverse effects of epidemics and the spread of water, sanitation and hygiene-related diseases amongst vulnerable populations (poor, women, orphans, child headed households and People Living with AIDS);
- To improve access to a safe and reliable water supply, sanitation and hygiene amongst 7,500,000 vulnerable people in urban, peri-urban and rural communities, including mobile vulnerable populations;
- To enhance institutional and community capacity in monitoring and response with regard to disease outbreaks, maintenance of water points, sanitation facilities, and access to safe water and hygiene during crises, with special reference to the vulnerable populations;
- To coordinate the humanitarian response to water and sanitation.

To achieve these objectives, the following strategies need to be employed:
- Service delivery: Supporting the provision of water and sanitation services targeted at the most vulnerable populations, through trucking of water, drilling of new boreholes and wells (specifically targeted), rehabilitation and/or renewal of broken-down water points, and the construction of hygiene enabling facilities, including procurement of chemicals and materials for urban water treatment and restoration of sewage treatment systems;
- Community capacity development: Developing skills amongst vulnerable populations for the construction of facilities, management and monitoring of response activities at community level. Participatory health and hygiene education methodologies will be the approach used for community skills development;
- Monitoring, Evaluation and Research: Carrying out rapid assessments, joint field monitoring visits and research on the effectiveness and impact of the actions;, generating and sharing information.
- Coordination: Instituting coordinated actions that ensure effectiveness and equity and avoid duplication and overlap; generating and sharing information on humanitarian situation and response;

- Advocacy: Advocating with policy makers for timely, equitable, non-partisan, coordinated and integrated responses to the emergency, and instituting supportive policies.

Activities
To meet the objectives in this sector for the targeted caseload, agencies will focus on the following:

First Phase (3 months):
- Carry out rapid water and sanitation needs assessment;
- Promote a coordinated water and sanitation humanitarian response;
- Support rehabilitation and repair of urban water supply and sewage systems in Bulawayo and Chitungwiza;
- Treat water supplies in targeted vulnerable communities and provide water trucking to vulnerable mobile communities in urban and peri-urban areas that are without access to water;
- Construction of 1,500 ecological sanitation and other temporary latrines for 20,000 mobile vulnerable populations in urban and peri-urban areas;
- Promote health and hygiene education, including HIV/AIDS education, amongst the most vulnerable communities and schools;
- Hold regular working group meetings, and monitor impact of programmes;
- Support advocacy activities for emergency water and sanitation response;
- Support the prevention and control of water and sanitation related disease epidemics such as cholera and dysentery.

Second Phase (9 months)
- Drill, flash, renew and rehabilitate up to 8,150 new, collapsed and broken down drinking water supply sources (wells, boreholes and other sources of water supplies (piped water schemes, rain water harvesters, sand abstraction) to serve a vulnerable population of 3,000,000, including health institutions and schools in targeted areas;
- Establish 700 new safe water points (all including Elephant Pumps) to serve 175,000 vulnerable people;
- Construct up to 5,000 latrines to serve a population of 25,000, particularly women, orphans and other vulnerable children in targeted vulnerable communities, at health institutions, nutrition centres, schools and formal and informal peri-urban settlements, in cholera and drought stricken districts;
- Promote health and hygiene education including HIV/AIDS education, amongst the most vulnerable communities and schools;
- Promote sustainable community management of water and sanitation facilities;
- Hold regular working group meetings, and monitor impact of programmes;
- Document lessons learned and best practices for further usage;
- Support advocacy activities for emergency water and sanitation response;
- Support the prevention and control of water and sanitation related disease epidemics such as cholera and dysentery;
- Collect and share information on actors and the status of water and sanitation in the country and develop a database.

Performance indicators
Programme monitoring will be based on the following indicators:
- Number of drilled/flushed/renewed and rehabilitated boreholes, community wells and other alternative sources of water supplies;
- Number of sewage pumps repaired;
- Percentage of vulnerable population in targeted areas with improved access to safe disposal of excreta within 50 metres improved access to new or rehabilitated water points within 500 meters;
- Number of water, sanitation and hygiene related outbreaks responded within 24 hours of notification;
- Proportion of water, sanitation and hygiene related outbreaks detected and managed.

5.L SAFETY AND SECURITY OF STAFF AND OPERATIONS

Strategy

The primary responsibility for the security and protection of staff members, their spouses, dependants, and property, as well as of the organisations' property against disturbances in a host country rests with the host Government. However, although the law-enforcement authorities are generally willing to assist, they sometimes lack the necessary resources to do so effectively. To maintain and enhance safety and security capabilities, the project will have a major impact on timely response and assistance to agencies and support to the existing emergency services provided by the authorities in the country.

Objectives

- To interface between law enforcement and organisations;
- To maintain a high level of security services for staff, dependents and operations;
- To enhance response capabilities in emergency situations;
- To ensure communication of security-related matters to areas where programme implementation is planned for or ongoing.

Indicators

- Increase versus decrease in incidents involving staff or impact operations;
- Distress calls for assistance;
- Activation of the rapid response unit;
- Timely arrival of emergency services to address incidents.

Monitoring of objectives

- Monthly statistics on the types of incidents involving UN personnel;
- Staff/agency reporting, using the UN Division for Security and Safety (UNDSS) Zimbabwe Incident Report form;
- Quarterly Incident Report to UNDSS;
- End of Year Report, which also includes figures on distress calls from staff and up-country missions, as well as on deployment of the rapid response unit.

6. STRATEGIC MONITORING PLAN

The Inter Agency Standing Committee in Zimbabwe is chaired by the Humanitarian Coordinator and comprises of the Heads of UN Humanitarian Agencies, International NGO Consortia, the Red Cross Movement (with the status of standing invitee), and UNHABITAT. The IASC will be the principal body that will monitor the overall implementation of the Consolidated Appeal through a variety of mechanisms. The IASC meets on a weekly or bi-weekly basis as necessary to coordinate strategic and operational policy related to the humanitarian agenda.

This coordination mechanism will be complemented by weekly Dialogue Meetings with the Government to ensure that key strategic issues related to the provision of humanitarian assistance and protection of the most vulnerable are addressed.

Monthly meetings will also be held with donor Governments to provide updates of operational progress and highlight key gaps in the funding of humanitarian assistance.

Monthly coordination meetings in key field hubs in Bulawayo, Mutare, Masvingo, Victoria Falls and Gweru will also provide information on key trends and issues faced at the implementation level. Monthly meetings will also be held with the UN Humanitarian Coordinator and NGOs in Harare.

The vast array of Sector Working Groups as well as thematic working groups will provide the mechanisms for technical monitoring and guidance for all relevant thematic operations and humanitarian response issues. This will be reinforced by an Inter-sectoral Technical Working, which will ensure inter-linkages between sectors and ensure a coherent and comprehensive response.

The ZIMVAC will continue to serve as the main mechanism for assessing and monitoring indicators related to food security, health, water, nutrition and livelihoods for rural areas. The Urban Vulnerability Assessment Committee will be reinstated to assist with data collection and analysis related to food and livelihood vulnerability in urban areas.

Protection issues will be monitored by the Humanitarian Guidance Working Group that will address protection issues related to Mobile and vulnerable populations, abuse and exploitation and child protection.

As the need arises, ad-hoc working groups and committees will be established to deal with new developments requiring special attention not foreseen in the Consolidated Appeal for 2006.

7. CRITERIA FOR PRIORITISATON OF PROJECTS

The inclusion of projects in the Zimbabwe 2006 Consolidated Appeal is based on the following criteria;

- The project contributes towards the attainment of at least one of the strategic objectives outlined in the Common Humanitarian Action Plan;
- The project addresses sector priorities identified by the sectoral working group;
- The appealing agency has the expertise and capacity to implement the project;
- The project will have an impact on the beneficiaries within 2006;
- The project targets at least one of the vulnerable groups identified;
- The project supports the improvement of the quality of humanitarian assistance;
- The appealing agency is accredited and registered with the Government of Zimbabwe.

The schedule below indicates the correlation between the overall context, the specific sectoral analysis, and the corresponding prioritised activities, presented by the participating organisations.

TABLE II. LIST OF PROJECTS BY SECTOR

Table II: Consolidated Appeal for Zimbabwe 2006

List of Projects - By Sector

as of 16 November 2005

http://www.reliefweb.int/fts

Compiled by OCHA on the basis of information provided by the respective appealing organisation.

Project Code	Appealing Agency	Sector/Activity	Original Requirements (US$)
AGRICULTURE			
ZIM-06/A01	FAO	Provision of Agricultural Input and Extension Support to Smallholder farmers in the Communal Sector	29,375,000
ZIM-06/A02	FAO	Emergency Control of Epidemic Foot-and-Mouth Disease (FMD) in Zimbabwe	810,000
ZIM-06/A03	FAO	Improving food and nutrition security through home gardens	200,000
ZIM-06/A04	FAO	Small Livestock (Goats) Restocking for vulnerable in Rural Areas of Zimbabwe	300,000
ZIM-06/A05	FAO	New Castle Disease Control in Rural Areas of Zimbabwe	270,000
ZIM-06/A06	PUMP AID	Integrated nutrition gardens and livestock projects with Elephant Pumps for 100 poor rural schools	250,000
ZIM-06/A07	ATP	Feed them First! - Disease-free sweet potato for increased yield and improved nutrition for resource poor rural households	352,800
ZIM-06/A08	Africare	Integrated Agricultural Recovery Action (IARA) - Food security enhancement	2,499,550
ZIM-06/A09	Africare	Integrated Agricultural Recovery Action (IARA) - Soybean production	1,087,500
ZIM-06/A10	CARE INT	Drought Recovery With Conservation Agriculture (Dreca)	400,000
ZIM-06/A11	FCT	Livelihood Income and Food Security	500,000
ZIM-06/A12	ORAP	Strengthening of community gardens through the provision of short season and winter crops in Umzingwane and Tsholotsho Districts.	40,800
ZIM-06/A13	ORAP	Borehole (water points) rehabilitation in Tsholotsho, Nkayi and Lupane districts in Matebeleland North Province.	132,000
ZIM-06/A14	MDA	Development of Tivertone irrigation scheme for Food Security enhancement and skills for life	2,050,000
ZIM-06/A15	DACHICARE	Development of alternative labour technology.	350,500
ZIM-06/A16	SAFIRE	Market Linkages Project for Smallholder Farmers	564,000
ZIM-06/A17	Christian Care	Christian Care Sustainable Livelihoods and Food Capacity Production Rehabilitation Programme	1,946,000
ZIM-06/A18	OXFAM UK	Livelihoods Support through Agriculture	2,634,783
Subtotal for AGRICULTURE			**43,762,933**
COORDINATION AND SUPPORT SERVICES			
ZIM-06/CSS01	OCHA	Facilitation and coordination of humanitarian assistance to populations affected by disasters and emergencies, advocacy protection of affected populations and information management	2,597,975
Subtotal for COORDINATION AND SUPPORT SERVICES			**2,597,975**

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Project Code	Appealing Agency	Sector/Activity	Original Requirements (US$)
ECONOMIC RECOVERY AND INFRASTRUCTURE			
ZIM-06/ER/I01	CARE INT	Rural Micro-finance for Vulnerable Groups	250,000
ZIM-06/ER/I02	CRS	Protecting Vulnerable Livelihoods	2,617,188
ZIM-06/ER/I03	ILO	Improving livelihood of the poor through Employment Intensive Infrastructure Projects in 10 out 59 Rural Districts	1,500,000
ZIM-06/ERI04	ILO	HIV/AIDS and the World of Work	450,000
ZIM-06/ERI05	ILO	Business Development Services for SMEs and youth employment	500,000
Subtotal for ECONOMIC RECOVERY AND INFRASTRUCTURE			**5,317,188**
EDUCATION			
ZIM-06/E01	ANPPCAN	Early Childhood Development Project.	90,750
ZIM-06/E02	ASAP	Primary Education And Life Skills Project (PEALS)	168,228
ZIM-06/E03	CDES	Primary Education for OVC in Nyanga District	16,403
ZIM-06/E04	CRS	Support to Replicable Innovative Village/Community Level Efforts (STRIVE)	1,000,000
ZIM-06/E05	NHZ	Orphans and Vulnerable Children Educational Sponsorship Programme	53,500
ZIM-06/E06	SOS	Educational Support for OVCS	200,000
ZIM-06/E07	UNICEF	Child Learning and Life skills	3,011,835
Subtotal for EDUCATION			**4,540,716**
FOOD			
ZIM-06/F01	WFP	Targeted food support for vulnerable groups	111,000,000
Subtotal for FOOD			**111,000,000**

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Project Code	Appealing Agency	Sector/Activity	Original Requirements (US$)
HEALTH			
ZIM-06/H01	ACF	Addressing the link between HIV/AIDS & malnutrition while improving detection, coverage & treatment of acute malnutrition.	1,500,000
ZIM-06/H02	UNICEF	Hospital and Community Based Management of Malnutrition	1,040,000
ZIM-06/H03	UNICEF	Prevention and control of micronutrient deficiencies in the context of HIV and declining food insecurity	650,000
ZIM-06/H04	UNICEF	Zimbabwe Food and Nutrition Surveillance System	657,000
ZIM-06/H05	UNICEF	Nutrition care and support to People Living with HIV/AIDS	660,000
ZIM-06/H06	PLAN Zimbabwe	Strengthening Immunization Systems	263,800
ZIM-06/H07	Africare	Increasing Men's Involvement in HIV and AIDS Care and Support	915,188
ZIM-06/H08	SOS	Home-based care for OVCs	40,000
ZIM-06/H09	SC - UK	Improved health for most vulnerable children and mothers in Binga and Nyaminyami districts	2,000,000
ZIM-06/H10	HOSPAZ	Strengthening the capacity of home based care providers to provide quality services to HIV/AIDS patients and their families (standards implementation)	870,602
ZIM-06/H11	WHO	Health Information and Surveillance System	676,000
ZIM-06/H12	WHO	Procurement of ARVs and laboratory reagents.	12,476,000
ZIM-06/H13	WHO	Strengthening Epidemiological environmental health field surveillance	700,000
ZIM-06/H14	WHO	Strengthen EPR in the health sector	403,600
ZIM-06/H15	WHO	Empowering vulnerable communities to identify and promptly respond to health emergencies	324,000
ZIM-06/H16	WHO	Reducing morbidity and mortality of under fives during the Humanitarian crisis	263,000
ZIM-06/H17	WHO	Procurement of vital drugs and medical supplies	595,000
ZIM-06/H18	UNICEF	Prevention of Mother to Child Transmission of HIV	3,200,000
ZIM-06/H19	UNICEF	Reaching the vulnerable children and women of child bearing age with immunisation to prevent EPI target disease outbreaks.	2,396,550
ZIM-06/H20	UNICEF	Measles National Immunisation Days: Reaching the vulnerable children under five with Measles supplementary vaccination to prevent Measles outbreaks and mortality.	1,900,930
ZIM-06/H21	UNICEF	Malaria Control in Vulnerable Groups through ITN Promotion Reaching the vulnerable groups with ITN in 17 districts	1,337,500
ZIM-06/H22	UNICEF	Community home based care and counselling for people living with HIV and AIDS including children	900,000
ZIM-06/H23	UNICEF	Community centred capacity development for HIV prevention	415,000

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HEALTH			
ZIM-06/H24	ZNCWC	HIV and AIDS Home Based Care& PSS Training for Residential Care Institutions	83,179
ZIM-06/H25	UNICEF	Promotion of child health and care practices for children under five in the communities	370,000
ZIM-06/H26	UNFPA	Reducing HIV infection among young women: Emergency response addressing the main entry point of the HIV epidemic into the young generation	1,580,000
ZIM-06/H27	IOM	Zimbabwe MIDA Health Programme	589,000
ZIM-06/H28	IOM	Response to HIV risks and Gender Based Violence within emergencies – the use of the IASC manual	444,400
ZIM-06/H29	WVZ	Reproductive Health (Safe Parenthood)	1,500,000
ZIM-06/H30	IOM	Responding to HIV and AIDS in the Informal Cross-border Trade Sector in Zimbabwe	500,000
ZIM-06/H31	IOM	HIV and AIDS in Emergency Humanitarian Assistance to Mobile and Vulnerable Populations (Long Term HIV and AIDS Pilot project for ex-farm worker communities in Mashonaland West and Manicaland Provinces)	300,000
Subtotal for HEALTH			**39,550,749**
MULTI-SECTOR			
ZIM-06/MS01	UNHCR	Local Settlement Programme for Refugees in Zimbabwe	2,303,349
ZIM-06/MS02	IOM	Emergency Assistance to Mobile and Vulnerable Populations in Zimbabwe	8,627,500
ZIM-06/MS03	IOM	Humanitarian Assistance for mobile population and deported migrants at Beitbridge border town	2,200,000
ZIM-06/MS04	MCI	Joint NGO initiative for uprooted and other vulnerable communities	13,000,000
Subtotal for MULTI-SECTOR			**26,130,849**

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Project Code	Appealing Agency	Sector/Activity	Original Requirements (US$)
PROTECTION/HUMAN RIGHTS/RULE OF LAW			
ZIM-06/P/HR/RL01	UNDP	Humanitarian guidance in protection priorities	150,000
ZIM-06/P/HR/RL02	ANPPCAN	Child Rights Project	33,850
ZIM-06/P/HR/RL03	CDES	Agriculture Outreach and Extension to OVC	7,116
ZIM-06/P/HR/RL04	CRS	Support to Replicable Innovative Village/Community Level Efforts	560,000
ZIM-06/P/HR/RL05	SAHRIT	Community-Based Protection of the Rights of OVC-Mitigating the Impact of HIV and AIDS	36,000
ZIM-06/P/HR/RL06	JJB	Promotion of Child Rights in Harare City during Emergencies	33,000
ZIM-06/P/HR/RL07	MCI	HIV Mitigation and Youth Development through Sport and Community Support in 5 Districts of Mashonaland East Province, Zimbabwe	750,000
ZIM-06/P/HR/RL08	SC - UK	Protection of Children Affected by Internal Displacement in Zimbabwe	847,830
ZIM-06/P/HR/RL09	SCN	Beitbridge Crossborder Initiative	135,000
ZIM-06/P/HR/RL10	SCN	Provision of Psychosocial Support to Children	170,000
ZIM-06/P/HR/RL11	SOS	Prevention of and response to child abuse: physical, emotional, sexual and neglect	60,000
ZIM-06/P/HR/RL12	SOS	Psychosocial support for OVC	60,000
ZIM-06/P/HR/RL13	SOS	Strengthening child protection and response structures	10,500
ZIM-06/P/HR/RL14	ZNCWC	Talent Nurturing and Development for Children under Residential Care	108,918
ZIM-06/P/HR/RL15	ZNCWC	Child Participation Forums	65,030
ZIM-06/P/HR/RL16	PCC	Psychosocial support for children living and working on the streets in Harare Central Business District (CBD).	52,000
ZIM-06/P/HR/RL17	Africare	Community Based Care Protection and Empowerment for Orphans and Vulnerable Children (COPE for OVC) project	1,076,146
ZIM-06/P/HR/RL18	UNICEF	Coordination of program activities, strengthening of service delivery at District and community level, Capacity building of District Officers and beneficiaries including those affected in Emergency affected areas	675,000
ZIM-06/P/HR/RL19	UNICEF	Strengthening Community Level Information Collection and Usage	350,000
ZIM-06/P/HR/RL20	UNICEF	Prevention of family separation and reunification of children deprived of their family environment	600,000
ZIM-06/P/HR/RL21	UNICEF	Prevention of Sexual and Gender Based Violence (SGBV)	1,100,000
ZIM-06/P/HR/RL22	Arise Zimbabwe	Children psycho-social support programme	308,000
ZIM-06/P/HR/RL23	UNIFEM	Protection of women and Girls from the impact of Gender Based Violence in Zimbabwe	841,600
Subtotal for PROTECTION/HUMAN RIGHTS/RULE OF LAW			**8,029,990**

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SECURITY			
ZIM-06/S01	UNDSS (previously UNSECOORD)	Agency Common Shared Security Services	100,520
Subtotal for SECURITY			**100,520**
SHELTER AND NON-FOOD ITEMS			
ZIM-06/S/NF01	IOM	Emergency Provision of Temporary Shelter and Related Humanitarian Assistance to Destitute Households Affected by Operation Murambatsvina/Restore Order	18,217,400
ZIM-06/S/NF02	UN-HABITAT	Policy engagement with government and strengthening of community-based organizations (CBOs).	500,000
ZIM-06/S/NF03	DSHZT	Shared Learning	65,000
ZIM-06/S/NF04	DSHZT	Alternative to Forced Evictions-Practice informing Policy Mutare Pilot Project	1,000,000
ZIM-06/S/NF05	UN-HABITAT	Technical support to provision of Temporary Shelter	500,000
Subtotal for SHELTER AND NON-FOOD ITEMS			**20,282,400**
WATER AND SANITATION			
ZIM-06/WS01	Christian Care	Response on water and sanitation, hygiene education and nutrition needs for the marginalized vulnerable populations	611,190
ZIM-06/WS02	ILO	Improving livelihood of the poor through Support to Municipal Service Delivery and Community Employment Initiatives in Urban Areas	1,000,000
ZIM-06/WS03	Mvuramanzi Trust	Water and Sanitation Emergency Response	813,300
ZIM-06/WS04	OXFAM UK	Water and Sanitation to Reduce Public Health Risks	2,091,864
ZIM-06/WS05	Practical Action Southern Africa	Improved Access to Safe Water and Sanitation Services through the promotion of Community Based Management (CBM) of Rural Water Sources and Participatory Health and Hygiene Education (PHHE) Trainings	1,640,000
ZIM-06/WS06	PUMP AID	Water for Life with the Elephant Pump	315,000
ZIM-06/WS07	UNICEF	Provision of emergency safe water supply, sanitation and hygiene education to targeted vulnerable populations in urban and rural areas of Zimbabwe.	4,500,000
ZIM-06/WS08	WHO	Community Safe Water Supplies and Sanitation	1,500,000
ZIM-06/WS09	WVZ	Emergency Water and Sanitation Program	2,500,000
ZIM-06/WS10	ZACH	ZACH Emergency Water and Sanitation Projects for Rural Mission Hospitals.	218,500
Subtotal for WATER AND SANITATION			**15,189,854**
Grand Total			**276,503,174**

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ANNEX I.

ZIMBABWE RED CROSS SOCIETY PLAN OF ACTION 2005:

Summary of Humanitarian Situation:
Zimbabwe is suffering a drawn-out, complex humanitarian crisis with a number of interconnected causes. The prime challenge is the long-term impact of HIV/AIDS, which has reduced the productive population and increased the numbers of dependents, old and young; increased household expenditures on medicines and caring, while reducing households' capacities to earn money; and reduced life expectancy. The first case of AIDS was reported in 1985 and since then the social effects of the epidemic have been felt at a national and household level in varying degrees.

The impact of the socio-economic problems alone is devastating to the vulnerable, marginalised families. There are high levels of unemployment in the country, with a considerable number of the productive population also affected by HIV/AIDS. The combined impact is, however, greater than the sum of its parts, as each aspect of the problem interacts with other problems. Lack of money and limited options drive young women to transactional sex, increasing their exposure to HIV. Shortages of food mean that tuberculosis patients fail to maintain their courses of treatment. Malnutrition has decreased the resistance of PLWHA to opportunistic infections. Like in other countries in the region, the most vulnerable are households affected and infected by the HIV/AIDS epidemic, the chronically ill, female-headed households, the elderly, and the extremely resource-poor households

The food insecurity situation in Zimbabwe is widespread, due to low crop production as a result of erratic rain patterns and prolonged dry spells. The food insecure households remain in a precarious situation due to high unemployment, economic crises in the country, hyperinflation, uncontrolled increases in food commodities prices and unavailability of food commodities in some areas of the country due to high transport costs.

The Government estimates that 2.9 million rural populations are vulnerable for the agricultural season 2005/06. The total cereal deficit is 1.2 million MTs over the period from September 2005 to March 2006. The level of deficit necessitates substantial imports. The Government has stated their intention to import 1.2 million MTs of maize and although the maize is available in regional markets, this level of importation will be challenging given the limited foreign currency reserves in Zimbabwe. OCHA reported at the end of August 2005 that South African Grain Information Services estimates that the Government of Zimbabwe imports on average 80,000 MTs of monthly. This leaves room to a shortfall that has the potential to create a serious humanitarian crisis in the country.

On 19 May 2005, the Government of Zimbabwe embarked on an operation to "clean-up" its cities. It started in the capital, Harare, and rapidly evolved into a nationwide demolition and eviction campaign carried out by the police and the army. The operation, formally called Operation Murambatsvina/Restore order, but popularly referred to as "Operation Tsunami" because of its speed and ferocity, resulted in the destruction of homes, business premises and vending sites. It is estimated that some 700,000 people in cities across the country have lost their homes, source of livelihood or both. Indirectly, a further 2.4 million people have been affected in varying degrees. Hundreds of thousands of women, men and children were made homeless, without access to food, water and sanitation, or health care. Education for thousands of school age children has been disrupted. Many of the sick, including those with HIV/AIDS, no longer have access to care. The vast majority of those directly and indirectly affected are the poor and disadvantaged segments of the population. They are, today, deeper in poverty, deprivation and destitution, and have been rendered more vulnerable.

The International Federation of Red Cross and Red Crescent (IFRC) launched an Appeal for Swiss Francs (CHF) 2.48 million (US$ 1,952,756) to assist the Zimbabwe Red Cross Society as it gives humanitarian assistance to 3,000 households (15,000 people) made homeless by the Government's clean-up operation for five month. Zimbabwe Red Cross Society emergency operation focused on immediate delivery of humanitarian assistance in the form of specifically targeted relief items, health and hygiene promotion, and provided immediate sanitation facilities in transit camps, as well as follow up assistance in areas where people will be officially relocated. The Zimbabwe Red Cross Society assumed the overall coordination and implementation of the operation with its volunteers and in close cooperation with public authorities and other agencies.

Combinations of these social, economic and political factors working against each other have created a complex humanitarian situation. This has reversed the gains of the past years, when the economy

was growing steadily and livelihoods were improving. We are now confronted with the emergence and growth of a highly vulnerable population due to common impoverishing forces such as:

- Ageing without reliable support;
- Inadequate social capital;
- Widowhood;
- Economic and social insecurity;
- Poor infrastructure;
- Declining social safety nets for the elderly, disabled and children.

The crisis is so huge that there is a strong need for the humanitarian sector to intervene with assistance to complement the Government's efforts in poverty reduction, livelihood restoration, and economic growth

Profile of Zimbabwe Red Cross

The Zimbabwe Red Cross Society has been delivering humanitarian programmes since its inception in 1980. The experience and capacity that the organisation has built over the years places it in a pole position to contribute to the response to the humanitarian challenges facing Zimbabwe. Its Strategic Plan 2010, which is an institutional development strategy, identifies the mission as the following:

In the fulfilment of our mandate, as pronounced in the Zimbabwe Red Cross Society Act (1981), we will endeavour "To provide timely, appropriate and acceptable humanitarian services to the most vulnerable groups through well-managed programmes in:

- Health education and services;
- Disaster preparedness and response;
- Youth development.

While encouraging self-reliance and the promotion of human dignity."

Zimbabwe Red Cross was recognised by the**:**

- International Committee of the Red Cross (ICRC) 1983 and admitted to the Federation in 1986;
- Good integrity issues;
- Board meetings once a month;
- Human resources 108 staff at HQ;
- Paid staff 388;
- Number of Volunteers 8,000;
- Number of branches 280;
- Number of members 32,000.

Federation Support to the Zimbabwe Red Cross

The regional delegation support to Zimbabwe Red Cross Society focuses on building capacities in the various areas of health and care, disaster management, promotion of Humanitarian Values and organisational development. The health and care programmes will benefit from the Federation's coordinated consortium funding earmarked for HIV/AIDS actions. Water supply and sanitation activities in the targeted districts will be supported through EU funding, also coordinated by the regional delegation. The regional delegation will also continue providing technical support to all programmes upon the national society requests. The challenges are growing by the day and the Federation input is required to build the capacity of the national society. The Federation will accompany the process with some technical support from partners' national societies such as British, Danish and Japanese Cross Societies, among others.

Zimbabwe Red Cross Priorities for 2006

Key areas of action

There are several issues arising from this context, which need to be addressed in order to lessen the humanitarian problems faced by most Zimbabweans, and these include:

Health and Care

Integrated HIV/AIDS Programme

The HIV/AIDS Integrated programme in Zimbabwe is one of the strongest in Africa, reaching more than 18,000 HBC clients and 50,000 OVC. The programme incorporates the following aspects:

- Home-based care action, providing care and support to people living with HIV/AIDS and the chronically ill;
- Provision of start-up funding for income-generating projects or self-help groups;
- HIV/AIDS prevention activities targets at youth and support groups;
- Antiretroviral therapy roll out in collaboration with the Government;
- Support orphans and other children made vulnerable by the effects of HIV/AIDS (OVC);
- Food and livelihood security (provision of emergency food aid in times of drought, support to agricultural recovery, nutrition gardens);
- Provision of safe water and sanitation; health and hygiene education.

Zimbabwe Red Cross Society is a strong partner behind the formulation of health policies in Zimbabwe and the National Global Fund initiatives for malaria, tuberculosis, HIV/AIDS. The most vulnerable people continue to benefit from food aid distribution, most of which are those affected and infected by HIV/AIDS. In an effort to ensure household food security, agricultural inputs have been provided to targeted households and the results on the ground show that the HBC clients and OVC have improved livelihoods. Zimbabwe is one of the three pilot countries in the ART programme, which has already received significant contributions from the Danish Red Cross Society.

Water and Sanitation

Zimbabwe is one of the four countries in the region to benefit from support in water and sanitation activities from the European Commission- African, Caribbean and Pacific countries (ACP)-EU Water Facility Actions. In Zimbabwe, several communities surveyed during the assessment pointed out that boreholes have dried up, forcing vulnerable households to resort to drinking water from unprotected sources or to walk up to 15km to collect water. The drilling of boreholes and the rehabilitation of dried water points will improve access to safe drinking water for beneficiaries and their livestock. Hygiene education and promotion will also form a key part of the sanitation actions.

For a successful and sustainable water and sanitation project, community participation and ownership is crucial. Recruiting volunteers amongst the beneficiaries will ensure community involvement. The HBC project has a livelihood support component, which is complemented by clean water supply and adequate sanitation. Volunteers are trained in hygiene promotion using the Participatory Hygiene and Sanitation Transformation (PHAST) methodology. The PHAST employ a gender sensitive approach developed by World Bank/WHO.

Objective

The objective is to establish sustainable environmental services, comprising safe water supply, functional latrines, and sanitation and hygiene promotion, developed for the vulnerable population of 100,000 in Mount Darwin district.

Expected Results

- A total of 100,000 people with access to safe drinking water, including access for PLWHA and OVC;
- A total of 1,200 Blair Ventilated Improved Pit Latrines (BVIL) constructed at households, schools and health centres in the targeted project area;
- Community members trained in community-based management around the 200 water points in the district;
- People trained in pump maintenance around the 200 water points;
- Health and hygiene promoters trained in the 22 wards targeted by the project;
- Increased hygiene awareness and change in behaviour according to the PHAST practices amongst the 100,000 beneficiaries;
- Increased capacities of Zimbabwe Red Cross Society to mobilise resources and implement water and sanitation projects and respond to disasters.

Food Insecurity
The food situation is expected to be critical between October 2005 and March 2006. In addition to food needs, the assessments by Vulnerability Assessment Committees (VACs) stressed the need for the Government and humanitarian community to design the food insecurity programmes around or with the ongoing HIV/AIDS mitigation activities, and the International Federation of Red Cross has issued an Emergency Appeal for a regional response. The Federation strongly supports the overall analysis of the situation, the assessments undertaken, and the projected needs, and, given the situation, is launching this Emergency Appeal at the request of the seven national societies in the southern Africa region inclusive of Zimbabwe to implement an integrated operation for up to 1.5 million people, with a focus on the following three broad areas of action:

- Food assistance (basic and complementary) to individuals and households dealing with HIV/AIDS (People Living with HIV/AIDS, or PLWHA), orphans and other children made vulnerable by HIV/AIDS (OVCs), and the chronically ill (including tuberculosis patients, elderly, disabled, pregnant and lactating mothers, school going children, and in a larger sense members of vulnerable communities);
- Reinforcing coping mechanisms and livelihoods through the provision of seeds and fertilisers (for main crops and vegetable gardens, food for work, and animal draught power support in Zimbabwe);
- Water and sanitation support, through borehole drilling, the rehabilitation of dried water points, latrine construction, small-scale irrigation schemes, and hygiene education and promotion.

Expected impact of the planned operation will be:

- Stabilised food and nutrition security, by meeting the immediate food needs of vulnerable beneficiaries in Zimbabwe;
- Improved safe drinking access and water outlets for individuals, households, and communities affected by dried up water sources;
- Improved hygiene of vulnerable groups;
- Restored coping mechanisms and livelihoods and productive capacities for vulnerable households, and help to establish sustainability in this area;
- Training provided to national society staff involved in food security and livelihood programming.

Disaster Management
The national society works on strengthening its disaster response capacity and community resilience. In that vein, the programme would like to empower communities through strengthened disaster preparedness and response, through capacity-building in the disaster prone provinces. The Zimbabwe Red Cross Society will continue assisting the food insecure households through an integrated livelihood approach through a risk reduction programme supported by Department For International Development (DFID). The major task of the programme is to empower communities in disaster management through capacity-building, in order to predict, prevent, reduce and respond to impact of disasters

Objective
Strengthened disaster preparedness and response of Red Cross structures and communities through capacity-building in the eight provinces by 2006.

Expected Results

- *Disaster preparedness:* Comprehensive disaster management plan operationalised by the end of 2007;
- *Risk reduction:* Vulnerable communities in ten provinces empowered with sustainable strategies to prepare, respond and recover from the effects of the disaster by the end of 2007;
- *Disaster response:* Capacity of the national society to respond to disasters strengthened in order to reduce community vulnerability by 2006.

Main Activities

- Establish a disaster management policy and an operational plan, which will be circulated to Government and stakeholders;
- Establish and strengthen community-based disaster management programmes, based on the VCA recommendations;
- Establish a national disaster response team;
- Conduct basic disaster management training for national emergency response team members;
- 3 members of staff/volunteers attend the Regional Disaster Response Team (RDRT) training;
- Risk and hazard analysis, and development of early warning systems in 4 communities;

- Respond to all in country disasters within 12 hours of knowledge of the disaster;
- Ensure gender is incorporated into all programme activities.

Humanitarian Values
In order to improve the visibility of the Zimbabwe Red Cross society as the leading humanitarian organisation, a social marketing strategy will be developed and implemented. This will be the instrument for building positive perceptions and endearing the media, the public, and private and public organisations to the Zimbabwe Red Cross Society. It will also help to develop fundraising, international and local partnership and increase resource mobilisation. The information and promotion of humanitarian values and activities will require funding for equipment, publicity materials and administration costs. There is also need for training in fundraising and social marketing. A donor profiling exercise will also be undertaken.

Given Zimbabwe's socio-political environment, dissemination will be one of the priorities to improve understanding of the Seven Fundamental Principles of the Red Cross among local authorities and other key stakeholders. ICRC and Federation fully support Zimbabwe Red Cross Society, and a clear objective is to ensure that the Society is recognised as a neutral and impartial humanitarian organisation with an unequivocal mandate to assist vulnerable groups. The media, both internal and external, will play a pivotal role in building the image of the national society, through highlighting the positive actions of the Zimbabwe Red Cross Society to disasters.

Objectives
Increasing knowledge of Humanitarian Values amongst key stakeholders, while positioning the Zimbabwe Red Cross Society as a highly competent and credible humanitarian organisation within the public and private sector.

Expected Result
- Visibility of the Zimbabwe Red Cross Society as the leading humanitarian organisation is improved;
- Knowledge of the Seven Fundamental Principles of the Red Cross among local authorities and other key stakeholders is increased;
- Awareness of the activities of the Zimbabwe Red Cross Society within the corporate sector and diplomatic community is increased.

Main Activities
- Developing a communication strategy;
- Organising three media tours for ten journalists from the electronic and print media;
- Producing and distributing Red Cross information material to the corporate sector and the diplomatic sector;
- Conducting local dissemination workshops for local authorities;
- Facilitating project site visits by the local and international media;
- Distributing Red Cross information material to relevant Government ministries;
- Issuing press releases and fact sheets on key events;
- Facilitating commemorations of key Red Cross national events such as the Red Cross Day, the AIDS Day, and Day of the African Child;
- Exhibiting at prime events such as the Zimbabwe International Trade Fair, agricultural shows, etc.;
- Organising 12 dissemination meetings for provincial governors, police and Government departments, and the communities;
- Production and distributing information material and publications;
- Facilitating partnership meetings for the senior management with the private sector and the diplomatic community.

Organisational Development
Zimbabwe Red Cross Society is a well-functioning national society, but still requires strengthened organisational development initiatives, especially on capacity-building. However, these initiatives require funding and consultation with local structures in order to be successfully implemented. The national society also requires funding to fully implement the Algiers Plan of Action, which addresses organisational development issues and priority areas of work.

The finance development programme supported by the regional development initiatives will concentrate at headquarters during 2006, and aim to improve financial management in provinces during 2007. The objectives are that, by the end of 2007, all finance and programme staff at headquarters and in the provincial branches have received training in finance management and that the internal financial control system is in place. The national society has implemented a computerised financial system and will be encouraged to meet the criteria to move from working advance to cash transfer system creating donor confidence ad sustainable support.

Objective
Improved capacity for the Zimbabwe Red Cross Society to design and implement its programmes in a strategic direction, to be implemented through volunteer management in all eight provinces by 2007.

Expected Results
- Volunteer Management: An effective volunteer management system will be instituted in all eight provinces by 2006;
- Branch Development: The national society will have functional branches in place in all eight provinces by 2006;
- Capacity-building: The national society will have a human resources policy developed by 2006
- Integration: Volunteer teams will be integrated into all existing programmes by 2006;
- Finance Development: Zimbabwe Red Cross Society's finance management will be improved at all levels.

Main Activities
- Develop a volunteer database by February 2006;
- Craft a volunteer policy by June 2006;
- Implement the volunteer policy and the volunteer code of conduct;
- Conduct an assessment to establish the volunteer base in the first quarter of 2006;
- Conduct volunteer mobilisation and recruitment, as an ongoing activity;
- Train volunteers in social mobilisation, gender mainstreaming, and branch development, with support from the Federation;
- Conduct advocacy meetings with relevant authorities at the provincial and national levels;
- Establish new branches in all wards throughout the eight provinces.

Coordination
Zimbabwe Red Cross Society has effective links with Government and private institutions, which complement other humanitarian services. Zimbabwe Red Cross Society works with technical staff from the Government to provide support to volunteers, food security and health and care services to vulnerable persons. The health and care initiatives take an integrated approach that addresses the effects of HIV/AIDS prevention, care and support; food security; water and sanitation, complemented by organisational development components.

National Society's Partnerships 2005-2007

Movement Partners	**Project area/summary**
ICRC	Humanitarian Values, population movement, national society cooperation, tracing
Federation	Health and care, food security, disaster management, organisational development, governance and management support
British Red Cross Society	Food security/livelihoods
Danish Red Cross Society	Health and care, disaster management, OVC support, food security
Japanese Red Cross Society	Health and care, disaster management, OVC support, prevention
Non-Movement Partners	**Project area/summary**
Government	Health and care
Consortium (Royal Netherlands embassy (RNE), Swedish International Development Agency (SIDA) and Development Cooperation Ireland (DCI)).	HIV/AIDS
DFID	Disaster risk reduction, food security
European Commission Humanitarian Office (ECHO)	Relief, food security
Global Fund	Health and care
WFP	Food relief
EU	Water and sanitation

FINANCIAL SUMMARY		
Budget Items	**CHF**	**US$**
Community capacity Building	73,059	57,527
Water and Sanitation	1,056,728	832,069
Food Security and Integrated Health	2,026,056	1,595,320
Food security Appeal	6,947,555	5,470,516
Zimbabwe clean-up operation	2,480,000	1,952,756
TOTAL REQUEST	**12,583,398**	**9,908,188**

Funding Sources

The Consortium of donors, which includes RNE, SIDA/Swedish Red Cross Society, and DCI, has been supporting Zimbabwe Red Cross Society through the Federation Regional HIV/AIDS project since October 2002. Funding for the 2002 activities, which was originally planned under the Consortium, is now secured for the national society, and a detailed plan and budget are presented separately in the 2006- 2007 Annual Appeal, under the title “HIV/AIDS Consortium”.

The Danish Red Cross Society is major contributor to the HIV/AIDS programme, as well as the Japanese and the Consortium, whose funds contribute to the sustainability of the project.

Currently, negotiations are underway for the next phase of a five-year HIV/AIDS programme starting in 2006, to target all national societies including Zimbabwe. In view of this, the Zimbabwe Red Cross Society is developing new integrated long term HIV/AIDS action plans and budgets for the next period (2006–2010). All bilateral and multilateral partners’’ activities will be reflected in the Action Plan to show a complete picture of HIV/AIDS support in Zimbabwe, and lead to a separate Appeal, which will be issued in early 2006 after full consultations with all stakeholders.

The Consortium funding will be taken into account in the new Appeal to avoid overlapping of support. Strong media and marketing plans will be developed at the same time for this Appeal.

ANNEX II.

ACRONYMS AND ABBREVIATIONS

ACF	Action Contre la Faim
ACP	African, Caribbean and Pacific countries
ADM	Anglican Diocese of Manicaland
AEA	Association of Evangelicals in Africa
ANC	Ante-Natal Clinic
ANPPCAN	African Network for the Prevention and Protection against Child Abuse and Neglect
ANR	Agriculture & Natural Resources
AREX	Agricultural Research and Extension
ART	Anti-Retroviral Therapy
ARV	Anti-retroVirus
ASAP	A Self-Help Assistance Programme
BCC	Behavior Change Communications
BEAM	Basic Education Assistance Module
BRTI	Bio-medical Research and Training Institute
BVIL	Blair Ventilated Improved Pit Latrines
CA	Consolidated Appeal
CADEC	Catholic Development Commission
CAFOD	Catholic Agency for Overseas Development
CAMFED	Campaign For Female Education
CAP	Consolidated Appeals Process
CBD	Central Business District
CBM	Community-Based Management
CBO	Community-Based Organisation
CCA	Common Country Assessment
CCCD	Community Centred Capacity Development
CCZ	Christian Care Zimbabwe
CDES	Career Development Education Support
CFR	Case Fatality Rate
CHAP	Common Humanitarian Action Plan
CHBC	Community Home-Based Care
CHF	Swiss Francs
CHH	Child-Headed Households
CHIPAWO	Children's Performing Arts Workshop
CHW	Community Health Worker
COPE	Community-based Care, Protection and Empowerment
COSV	Comitato di Coordinamento delle Organizzazioni per il Servizio Volontario
CP	Cooperating Partner
CRS	Catholic Relief Services
C-SAFE	Consortium for Southern Africa Food Security Emergency
CTDT	Community Technology Development Trust
CZI	Confederation of Zimbabwe Industries
DA	District Administrators
DAAC	District AIDS Action Committee
DACHICARE	Dananai Child Care
DCI	Development Cooperation Ireland
DDF	District Development Fund
DFID	Department For International Development
DOSHZT	Dialogue On Shelter for the Homeless in Zimbabwe Trust
DPT3	Diphtheria/Pertussis/Tetanus
DRC	Democratic Republic of Congo
DSSAE	Department of Soil Science and Agricultural Engineering
DVS	Department of Veterinary Field Services

EC	Emergency Contraception
ECD	Early Childhood Development
ECHO	European Commission Humanitarian Office
EED	Evangelischer Entwicklungsdienst
EFZ	Evangelical Fellowship of Zimbabwe
EMCOZ	Employers Confederation of Zimbabwe
EMIS	Education Management Information System
EMOP	Emergency Operation
EOC	Emergency Obstetric Care
EPI	Extended Programme on Immunisation
EPR	Epidemic and Pandemic Alert and Response
ERC	Emergency Relief Coordinator
ETRP	Education Transition and Reform Programme
EU	European Union
EWG	Education Working Group
FA	Flash Appeal
FACHIG	Farmers Association of Chiefs/Headmen Investment Groups
FAO	Food and Agriculture Organization of the United Nations
FAOSAFR	FAO Sub-Regional Office for Southern and East Africa
FAWEZI	Forum for African Women Educators in Zimbabwe
FCTZ	Farm Community Trust of Zimbabwe
FFS	Farmer Field Schools
FMD	Foot-and-Mouth Disease
FOST	Farm Orphan Support Trust
FTS	Financial Tracking Service
GAA	German Agro Action
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GIS	Geographical Information System
GMB	Grain Marketing Board
GoZ	Government of Zimbabwe
HAZ	Help Age Zimbabwe
HBC	Home-based Care
HC	Humanitarian Coordinator
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immuno-Deficiency Syndrome
HOCIC	Hope for a Child In Christ
HOSPAZ	Hospice Association of Zimbabwe
HQ	Headquarters
HRAP	Human Rights Approach to Programming
HST	Humanitarian Support Team
HTA	High Transmission Area
IARA	Integrated Agricultural Recovery Action
IASC CT	Inter-Agency Standing Committee Country Team
IASC	Inter-Agency Standing Committee
ICCO	Interchurch Organization for Development Cooperation
ICRC	International Committee of the Red Cross
ICRISAT	International Crops Research Institute for the Semi-Arid Tropics
ICT	Information and Communication Technology
ICVA	International Council of Voluntary Agencies
IDP	Internally Displaced Person
IDP	Internally Displaced Persons
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IFRC	International Federation of the Red Cross and Red Crescent Societies
ILO	International Labour Organization
IMBISA	Interregional Meeting of the Bishops of Southern Africa

IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IOM	International Organization for Migration
IPA	Inter-Country Peoples' Aid
ITN	Insecticide Treated Net
JRS	Jesuit Refugee Service
JSI	John Snow International
LEAD	Linkages for the Economic Advancement of the Disadvantaged
LLIN	Long Lasting Insecticide-treated mosquito Net
LNGO	Local Non-governmental Organisation
LP	Liquid Petroleum
M&E	Monitoring and Evaluation
MC	Mercy Corps
MCH	Maternal and Child Health
MDA	Manicaland Development Association
MDG	Millennium Development Goals
MIDA	Migration for Development in Africa
MMT	Mvuramanzi Trust
MoE	Ministry of Education
MoH	Ministry of Health
MoHCW	Ministry of Health and Child Welfare
MP	Member of Parliament
MSF	Médecins Sans Frontières
MT	Metric Tonne
MVP	Mobile and Vulnerable Populations
NAC	National Aids Council
NAF	Needs Analysis Framework
NatPharm	National Pharmaceutical Company of Zimbabwe
NCD	New Castle Disease
NFI	Non-Food Item
NFN	Natural Farming Network
NGOs	Non-Governmental Organisations
NHZ	New Hope Zimbabwe
NID	National Immunisation Day
NIHR	National Institution for Health Research
NODED	National Organisation for the Development of the Disadvantaged
NPA	National Programme of Action For Children
NSPTF	National Soybean Promotion Task Force
NTCG	Nutrition Technical Consultative Group
OCHA	Office for the Coordination of Humanitarian Affairs
OHC	Office of the High Commission
OI	Opportunistic Infections
OM	Operation Murambatsvina
OPV	Open Pollenated Varieties
ORAP	Organization of Rural Associations for Progress
ORO	Operation Restore Order
ORS	Oral Rehydration Salts
OVC	Orphans and Vulnerable Children
PCC	Presbyterian Children's Club
PEALS	Primary Education and Life Skills Project
PEP	Post Exposure Preventive
PHAST	Participatory Hygiene and Sanitation Transformation
PHHE	Participatory Health and Hygiene Education
PLWHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
PPP	Public-Private Partnership
PRRO	Protracted Relief and Recovery Operation

PSI	Population Services International
PSS	Psycho-Social Support
RDC	Rural District Authorities
RDRT	Regional Disaster Response Team
RH	Reproductive Health
RNE	Royal Netherlands Embassy
RUDO	Rural Unit for Development Organisation
S&L	Savings and Loan
SADC	Southern Africa Development Community
SAFIRE	Southern Alliance for Indigenous Resources
SAHRIT	Southern Africa Human Rights Trust
SCF	Save the Children Fund
SCHR	Steering Committee for Humanitarian Response
SCN-Z	Save the Children Norway-Zimbabwe
SC-UK	Save the Children-UK
SDC	School Development Committees
SGBV	Sexual and Gender-Based Violence
SME	Small Medium Scale
SNV	Stichting Nederlandse Vrijwilligers
SOS	SOS Children's Villages
SRSG	Special Representative for the Secretary-General
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
STRIVE	Support to Replicable Innovative Village/Community Level Efforts
TBAD	Trans Boundary Animals Disease
TB	Tuberculosis
TFU	Therapeutic Feeding Units TFU
ToT	Training of Trainers
TT	Tetanus Toxoid
U5	Children Under five
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNDSS	United Nations Department of Safety and Security
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHABITAT	United Nations Human Settlements Program
UNHC	UN Humanitarian Coordinator
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund For Women
UNMAS	United Nations Mine Action Service
UNRC/HC	United Nations Resident Coordinator/United Nations Humanitarian Coordinator
VAC	Vulnerability Assessment Committee
VAT	Value Added Tax
VCT	Voluntary Counselling and Testing
VGF	Vulnerable Group Feeding
VHF	Viral Hemorrhagic Fevers
VHW	Village Health Worker
VPM	Village Pump Mechanics
W&S	Water and Sanitation
WAAC	Ward AIDS Action Committee
WB	World Bank
WCBA	Women of Child Bearing Age

WFP	World Food Programme
WHO	World Health Organization
WVI	World Vision International
WVZ	World Vision Zimbabwe
ZACH	Zimbabwe Association of Church related Hospitals
ZAPP	Zimbabwe HIV/AIDS Prevention Project
ZBCA	Zimbabwe Business Council on AIDS
ZCDT	Zimbabwe Community Development Trust
ZCTU	Zimbabwe Congress of Trade Unions
ZDHS	Zimbabwe Demographic and Health Survey
ZEPI	Zimbabwe Expanded Program of Immunization
ZFU	Zimbabwe Farmer's Union
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZINWA	Zimbabwe National Water Authority
ZNCC	Zimbabwe National Chamber of Commerce
ZNCWC	Zimbabwe National Council for the Welfare and Children
ZNFPC	Zimbabwe National Family Planning Council
ZPCDA	Zimbabwe Parents of Children with Disabilities Association
ZRP	Zimbabwe Republic Police
ZW$	Zimbabwean dollar
ZWOT	Zimbabwe Widows and Orphans Trust

NOTES:

Consolidated Appeal Feedback Sheet

If you would like to comment on this document please do so below and fax this sheet to + 41–22–917–0368 (Attn: CAP Section) or scan it and email us: CAP@ReliefWeb.int Comments reaching us before 28 February 2006 will help us improve the CAP in time for 2007. Thank you very much for your time.

Consolidated Appeals Process (CAP) Section, OCHA

Please write the name of the Consolidated Appeal on which you are commenting:

1. What did you think of the review of 2005?
How could it be improved?

2. Is the context and prioritised humanitarian need clearly presented?
How could it be improved?

3. To what extent do response plans address humanitarian needs?
How could it be improved?

4. To what extent are roles and coordination mechanisms clearly presented?
How could it be improved?

5. To what extent are budgets realistic and in line with the proposed actions?
How could it be improved?

6. Is the presentation of the document lay-out and format clear and well written?
How could it be improved?

Please make any additional comments on another sheet or by email.

Name:
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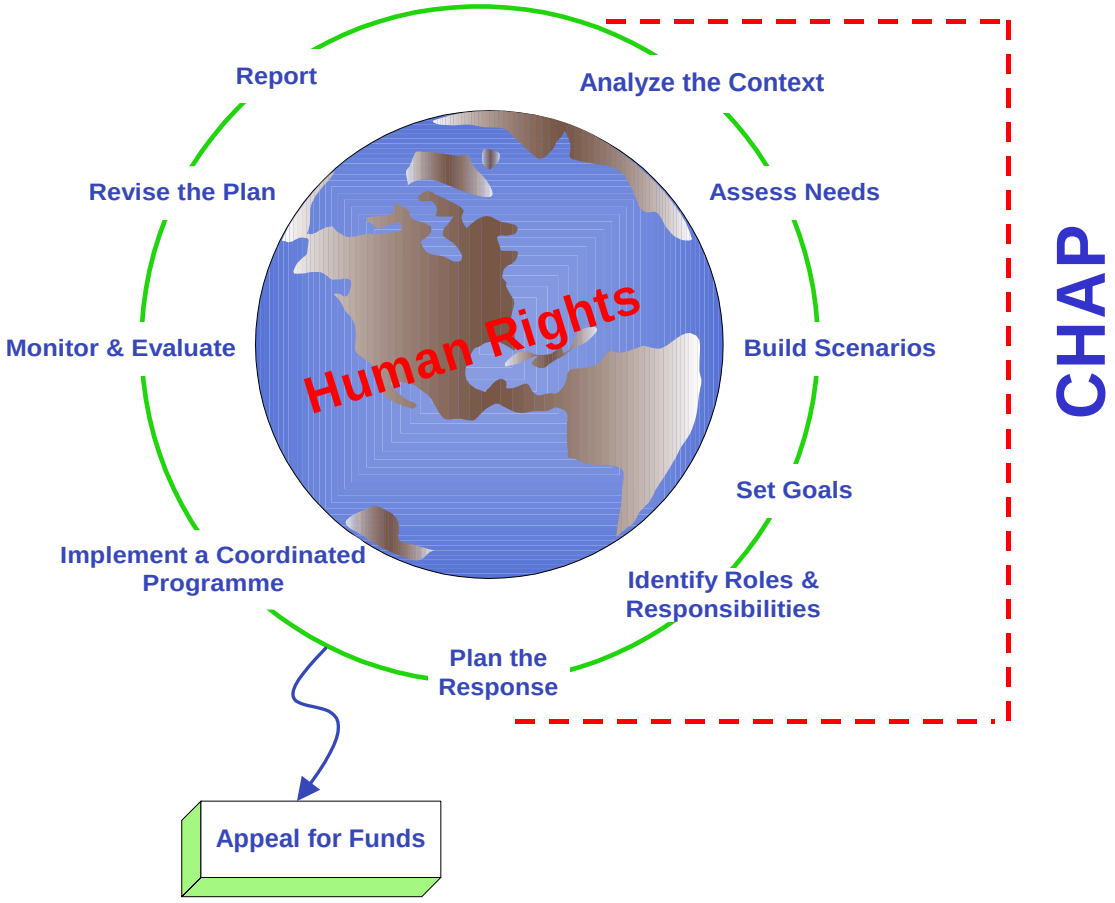

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OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS (OCHA)

UNITED NATIONS
NEW YORK, N.Y. 10017
USA

PALAIS DES NATIONS
1211 GENEVA 10
SWITZERLAND