RESIDENT/HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS

ZIMBABWE

RAPID RESPONSE

CHOLERA

2018

18-RR-ZWE-32288

RESIDENT/HUMANITARIAN COORDINATOR	**Bishow Parajuli**

REPORTING PROCESS AND CONSULTATION SUMMARY

a. Please indicate when the After-Action Review (AAR) was conducted and who participated.

While an AAR was not conducted, cholera response review meetings were held continuously led by the Inter-Agency Coordinating Committee on Health (IACCH) with the participation of all stakeholders. All agencies that received funding from this CERF allocation received and provided inputs internally as well as from implementing partners and national counterparts. All relevant inputs were compiled and integrated in the report including follow-up and feedback. The final version of the report was shared with the Humanitarian Country Team (HCT), for additional inputs. It is also anticipated that once finalised, all agencies will share this report with the relevant stakeholders

b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report on the use of CERF funds was discussed in the Humanitarian and/or UN Country Team.

YES ☒ NO ☐

c. Was the final version of the RC/HC Report shared for review with in-country stakeholders (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?

YES ☒ NO ☐

PART I

Strategic Statement by the Resident/Humanitarian Coordinator

CERF funds played a crucial role in quickly scaling-up activities in the critical phase of cholera case acceleration at the onset of the outbreak. The crisis came at the backdrop of a deteriorating economic situation in Zimbabwe over the past decades and which led to considerable decline in basic Water, Sanitation and Hygiene (WASH) services with a downward trend in low coverage of both drinking water and improved sanitation.

The Ministry of Health and Child Care (MoHCC) declared a Cholera outbreak on 6 September following confirmation of cases in Glenview and Budiriro suburbs of Harare. As of 21 September, a cumulative 5,891 suspected cases (83 confirmed cases) were reported in Harare's high-density areas and other parts of the country, with 38 deaths (36 of which in Harare). Based on the trajectory of the outbreak, the MoHCC expected as many as 50,000 people to be infected by the cholera outbreak before it would be fully contained and given the then approaching rainy season.

Rapid funding made available from the CERF targeted children, women and men of Harare city, directly benefiting 50,000 people at risk of immediate contamination and 600,000 people at risk mainly in 10 districts of Harare. The timely funding to support the immediate response came before the rainy season, which started at the end of October 2018 and continued until March 2019. The response therefore significantly contributed to the immediate containment of the outbreak which if, had not been addressed, would have led to a larger outbreak during the rainy season. With the funds, there was an increase in access to lifesaving treatments and awareness of cholera prevention and early treatment seeking among the affected and at- risk communities.

1. OVERVIEW

18-RR-ZWE-32288 TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)	
a. TOTAL AMOUNT REQUIRED FOR THE HUMANITARIAN RESPONSE	**28,000,000**
FUNDING RECEIVED BY SOURCE	
CERF	3,099,371
COUNTRY-BASED POOLED FUND (*if applicable*)	0
OTHER (bilateral/multilateral)	8,018,732
b. TOTAL FUNDING RECEIVED FOR THE HUMANITARIAN RESPONSE	**11,118,103**

18-RR-ZWE-32288 TABLE 2: CERF EMERGENCY FUNDING BY PROJECT AND SECTOR (US$)			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	18-RR-CEF-104	Water Sanitation Hygiene - Water, Sanitation and Hygiene	1,096,628
UNICEF	18-RR-CEF-105	Health - Health	755,105
WFP	18-RR-WFP-058	Food Security - Food Aid	230,175
WHO	18-RR-WHO-040	Health - Health	1,017,463
TOTAL			**3,099,371**

18-RR-ZWE-32288 TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Total funds implemented directly by UN agencies including procurement of relief goods	**2,390,402**
Funds transferred to Government partners*	17,000
Funds transferred to International NGOs partners*	685,770
Funds transferred to National NGOs partners*	72,654
Funds transferred to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**775,424**
TOTAL	**3,165,826**

** These figures should match with totals in Annex 1.*

2. HUMANITARIAN CONTEXT AND NEEDS

An outbreak of cholera was declared by the Ministry of Health and Child Care (MoHCC) on 6 September 2018 following confirmation of cases in Glenview and Budiriro suburbs of Harare. The outbreak was first noticed on 5 September 2018, when a cluster of 25 case-patients from these suburbs were admitted at Beatrice Road Infectious Disease Hospital (BRIDH) in Harare having presented with signs and symptoms of acute watery diarrhoea, vomiting and dehydration. As at 21 September, a cumulative 5,891 suspected cases (83 confirmed cases) were reported in Harare's high-density areas and other parts of the country, with 38 deaths (36 of which in Harare).

Key drivers of the crisis in Harare City included dilapidated water and sanitation infrastructure, characterized by water pipe and sewer breakages. Experiences in erratic municipal water supplies have been implicated in the unprecedented cholera outbreak that occurred in 2008/9. These same factors were still present coupled with further degradation of health and sanitary infrastructure that occurred over time. The water supply situation in Harare remained a major challenge. Such challenges of chronic piped water shortage and dilapidated sewage system compelled the population to resort to water from boreholes and shallow wells which were contaminated as was revealed from the water quality assessments. The contaminated water sources revealed to be the point source of infection to which populations were continually exposed thereby contributing to a high case attack rate during the crisis. Harare City was facing a dual cholera - typhoid outbreak, with the National Microbiology Reference Laboratory recording mounting multidrug resistance attributed to prolonged, widespread, indiscriminate and self-administered use of antibiotics for typhoid treatment throughout the year.

A total of 9,946 cholera cases were reported in Harare City from September 2018 to December 2018. Amongst these, 313 were confirmed cases and 69 deaths with a case fatality rate of 0.64. Amongst the affected population, 21% were children under the age of five that were line listed. This age group was of concern since they are vulnerable to diarrhoeas and prone to other infectious diseases and malnutrition, due to reduced immunity. They received Zinc as part of cholera treatment, which was contributed to their recovery and ensured that these children do not slide into malnutrition, and if they do, have access to appropriate management. In addition, approximately, 51% of the case load were females, whilst 49 % were males. While cholera is an equal opportunity infection, the most active group aged 15 to 45 years bore a high burden (59 per cent of cases).

Given the high HIV prevalence (13.7%) and susceptibility of PLHIV to infections it was important that they received appropriate care if they contracted cholera with no interruption to HIV treatment. Emergency measure was put in place to ensure continued access to treatment and retention in care for children, adolescents, pregnant and lactating women. Tracking and follow up systems were strengthened to ensure all clients on ART were retained in care.

During the crisis, there was need to improve case management in the cholera treatment centers to ensure that deaths do not increase above what had already been reported, as well as to improve infection control to avoid transmission of cholera. There was also the need for strengthening emergency case detection by providing allowances to the Rapid Response Teams to follow up contacts of cases and bring them to treatment centers for assessment and treatment. In addition,

provision of medicines and other needs for an improved case management and stopping further deaths, procurement of infection control and water treatment chemicals to stop further infection was of need.

Following the declaration of cholera outbreak by the MoHCC on 5 September, the Interagency Coordinating Committee on Health (IACCH) met regularly to ensure coordination of the response. Additionally, a detailed response plan was finalized, which estimated suspected cholera case to reach 50,000 cases with a potential to reach 100,000 cases in the event of limited interventions to contain current outbreak given the multiple risk factors. Population at risk in Harare was 600,000 and the total across the country was 1 million, and population in the epicenter is 200,000.

The geographical coverage of the humanitarian response plan was the 23 cholera hotpots of: Harare, Chitungwiza, Chegetu, Hurungwe, Sanyati, Kariba, Makonde, Chiredzi, Mwenezi, Chipinge, Mutare, Masvingo, Gweru, Rusape, Makoni, Bindura, Shamva, Kwekwe, Gokwe North, Gokwe South, Beitbridge, Mudzi, Hwange, Norton, Epworth, Buhera, Mutasa, Masvingo, Wedza, Murehwa, Seke, Marondera.

Assessments on safety of borehole water indicated that as of November 2017, 74 percent of the boreholes in Harare city do not have inline chlorinator fitted. Contaminated water from boreholes and wells are suspected to be the source of the outbreak. Sewage was seen flowing on the ground all over the affected areas from blocked sewer pipes. The high daily caseloads are indicative of a point source of infection to which people are continually exposed - this is suspected to be contaminated water from boreholes and wells that are used due to shortages of piped water. The City of Harare supported with fixing sewer bursts and increasing water supply in the key hot spots. In addition, the Government intensified food safety and hygiene audits in food premises and institutions, Weekly WASH sector emergency meeting are held to address challenges and gaps.

Health sector risk assessment conducted in May 2018 on historical cholera data found Harare to be a gateway to the rest of Zimbabwe, with the huge potential to spread the disease to other non-affected areas that have similar risk factors. There was a risk of cross border spread from Harare to Lusaka (Zambia), where a major outbreak ended earlier this year, and to Mozambique from Mutare (Manicaland province). The outbreak occurred before the rainy season i.e. end of October 2018 and continue until March 2019. It was noted that if the outbreak was not contained immediately, a second and larger peak may occur during the rainy season. In view of the rapidly escalating number of cases, the large population at risk at the epicenter, the evidence of spread to four previously unaffected provinces, the relatively high case fatality rate (estimated at 0.64%) and the upcoming rainy season, the internal risk assessment undertaken by WHO concluded that the cholera outbreak was high for further spread within Zimbabwe with a potential for high impact on the population. The concurrent typhoid outbreak added to the complexity of the situation.

3. PRIORITIZATION PROCESS

The overall strategic objective of CERF request was to provide immediate life-saving assistance to 50,000 people 10 areas of Harare if immediate interventions in health, water and sanitation and hygiene and food aid interventions was not undertaken and sustained until current outbreak was contained. Children under five years of age were among the most vulnerable groups constituting 21 per cent of the total affected population. These age group were particularly vulnerable to diarrhea compounded by other infectious diseases.

- Specifically, the CERF request was necessitated to provide immediate and life-saving assistance by supporting the following activities:
- Facilitate rapid scale up of cholera outbreak response activities, increasing access to lifesaving treatment, awareness of cholera prevention among the affected and at-risk communities, procurement and distribution of essential medicines, medical commodities and supplies such as tents, for establishment of cholera treatment units/centres for management of cases and procurement and provision of cholera kits and other sundries

- Provide safe water, proper sanitation and health education for improved hygiene and safe food handling practices by the community thereby reduction of case fatality rate to below 1% and reduce the spread of the outbreak by supporting 200,000 people in cholera affected areas supported to improve their WASH conditions through provision of hygiene kits and dissemination of related WASH information to prevent cholera.
- Provide safe food to approximately 50,000 people being treated for cholera symptoms during the incubation and treatment period thereby facilitating minimal interface between infected and non-infected people in the provision and preparation of food.

WHO, WFP and UNICEF will work through the existing coordination arrangements to ensure effective coordination and response in the above interventions in WASH, Health, Protection and Food Security sectors.

Since the outbreak was declared by the Government of Zimbabwe on 5 September 2018, the UN Resident Coordinator and the Humanitarian Country Team decided to call for a CERF application to augment the initial cholera response in support of the Government, coordinated by the MoHCC. OCHA team from the regional office was requested to provide coordination support and was deployed to Harare. As immediate action, an inter-sector working group (representing all sectors) with key operational NGOs was activated and the first meeting took place on the 19 September. The leading sectors are WASH and Health, however it was decided that additional sectors (Food Security and Protection) would complement the response to provide a comprehensive assistance package. The Government through support from WHO convenes regular Interagency Coordinating Committee on Health (IACCH) to ensure coordination of response and communicate response gaps to all stakeholders. Technical thematic committees are also activated and include Case Management, WASH, Health and Hygiene Promotion, Surveillance and Laboratory and Logistics. These forums will be utilized to ensure effective coordination of response.

At the time of drafting the CERF application, the UN and partners in Zimbabwe had not issued any humanitarian response plan, however given the combination of the food insecurity crisis (approximately 1.1 million people currently in IPC phase 4) and the cholera outbreak, discussions were ongoing on the possibility of issuing a flash appeal to address the humanitarian crisis. Since then, a decision was made to draft a flash appeal to address the larger humanitarian crisis in the country.

Implementation of CERF projects utilized existing Government structures and local communities during design and planning phase. Women and men were consulted on needs through community dialogue on cholera and priorities for interventions set based on information from the affected communities as well as based on evidence. For WASH, CERF funds allowed UNICEF to improve coordination of cholera response activities among partners by strengthening the Emergency Strategic Advisory Group (ESAG) for WASH in Emergencies, which was led by the Government of Zimbabwe and UNICEF as co-chairs. ESAG is a key on-going platform to discuss and reach a consensus of WASH sector/cluster on various implementing issues and contributed to well-coordinated response as a sector. In this cholera response, ESAG prepared within a week a sector response plan to the outbreak as well as costed workplan for the sector to take forward. The ESAG also worked, with technical support from UNICEF, on a detailed technical needs assessment which was a joint initiative of Government, civil society and UNICEF

4. CERF RESULTS

CERF allocated $3,099,371 to Zimbabwe from its Rapid Response Window to respond to the cholera outbreak. The aim of the funding was to address immediate, life-saving needs of identified populations affected by cholera, in terms of WASH, health and food:

Health: UNICEF, WHO and partners provided support to 9,946 people and have access to life saving treatment for cholera at the Treatment Centres, 18,112 people have access to life saving treatment through Oral Rehydration Therapy Points (ORPs) in the most affected communities and 601,130 people in the community to be mobilized for cholera prevention and treatment seeking. Essential medicines and commodities and infection control materials were procured and distributed to all Cholera Treatment Centres (CTCs). Additionally, 8 tents were pitched for Oral Rehydration Points (ORPs) within the communities for

ease access for medical assistance. This allocation also managed to print and distribute a total of 20,000 cholera SBCC IEC materials to the communities and reached 629,188 people within the affected 10 suburbs.

WASH: UNICEF and implementing partners reached a total of 351,117 people through water, sanitation and hygiene (WASH) interventions, including hygiene kit distribution, infection, prevention and control (IPC) improvement at cholera treatment centers, and health and hygiene education. Specifically, 77,008 people gained access to safe drinking water, 64,877 people were protected from contaminated water through sewerage rehabilitation, and 351,117 people received key health and hygiene messages on cholera prevention. More people were reached with hygiene education as the program and partners took advantage of the Oral Cholera Vaccination campaigns to disseminate key hygiene education. Mobile toilets were also placed in three cholera treatment centres to reduce the risk of spreading cholera and protect all patients. A total of 545 out of the targeted 600 schools received a WASH hygiene kit comprising of soap, buckets, jerrycans, IEC material, disinfectants and protective clothing. These were all the schools within the cholera hotspot area.

Food: WFP and partners covered institutional feeding and a take home ration upon discharge (first phase, and food distributions to at-risk communities who also received health and hygiene kits; health and nutrition messaging and sensitization for oral cholera 2 vaccine campaigns (second phase). A total of 8,860 beneficiaries were reached, moving a total tonnage of 255.231 MT (137.967MT maize grain, 5.644MT vegetable oil, 24.63MT cowpeas and 86.99MT super cereal). Through the provision offered to inpatients in all cholera treatment centres in Harare, WFP contributed to reducing cross contamination.

5. PEOPLE REACHED

CERF funds facilitated the implementation of cholera outbreak response activities through procurement and distribution of essential medicines, infection control materials, increasing access to lifesaving treatment and awareness of cholera prevention and early treatment seeking among the affected and at-risk communities. The targeted population were children, women and men of Harare, estimated at 600,000 in 10 districts of Harare (Glenview, Budiriro, Mbare, Epworth, Glen Norah, Granary, Mabvuku, Mufakose, Stoneridge, Kambuzuma). However, a total of 629,188 people (336,018 Females and 293,170 Males) were reached against the target of 600 000 people.

As the cholera outbreak did not spread to the extent initially feared (i.e. 50,000 people), the number of people targeted was significantly reduced. Despite the fast procurement of food through its regional forward purchasing facility, WFP was not able to meet all those infected, as the rate of infection during the initial phase was very fast, and WFP had to rely on its available food in-country.

The response covered institutional feeding and a take home ration upon discharge (first phase), and food distributions to at-risk communities who also received health and hygiene kits; health and nutrition messaging and sensitization for oral cholera 2 vaccine campaigns (second phase). A total of 8,860 beneficiaries were reached, including 4,147 males and 4,713 females. The program was implemented from October 2018 to April 2019 and managed to move a total tonnage of 255.231 MT (137.967MT maize grain, 5.644MT vegetable oil, 24.63MT cowpeas and 86.99MT super cereal). Through CERF funding, WFP was able to provide food to inpatients in all cholera treatment centres in Harare, thereby contributing to reducing cross contamination.

18-RR-ZWE-32288 TABLE 4: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SECTOR[1]									
Cluster/Sector	**Female**			**Male**			**Total**		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Food Security - Food Aid	2,28	2,425	**4,713**	2,469	1,678	**4,147**	4,757	4,103	**8,860**
Health - Health	172,820	163,198	**336,018**	144,064	149,106	**293,170**	316,884	312,304	**629,188**
WASH - Water, Sanitation and Hygiene	83,366	108,527	**191,893**	66,349	92,875	**159,224**	149,715	201,402	**351,117**

[1] *Best estimate of the number of individuals (girls, women, boys, and men) directly supported through CERF funding by cluster/sector.*

18-RR-ZWE-32288 TABLE 5: TOTAL NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING[2]									
	Female			**Male**			**Total**		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Planned	183,600	122,400	**306,000**	176,400	117,600	**294,000**	360,000	240,000	**600,000**
Reached	172,820	163,198	**336,018**	144,064	149,106	**293,170**	316,884	312,304	**629,188**

[2] *Best estimate of the total number of individuals (girls, women, boys, and men) directly supported through CERF funding This should, as best possible, exclude significant overlaps and double counting between the sectors.*

18-RR-ZWE-32288 TABLE 6: PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY CATEGORY		
Category	**Number of people (Planned)**	**Number of people (Reached)**
Refugees	0	0
IDPs	0	0
Host population	0	0
Affected people (none of the above)	600,000	629,188
Total (same as in table 5)	**600,000**	**629,188**

6. CERF's ADDED VALUE

a) Did CERF funds lead to a <u>fast delivery of assistance</u> to people in need?

YES ☒ PARTIALLY ☐ NO ☐

For WASH, CERF funds were vital to implement initial life-saving interventions, such as blanket distribution of hygiene kits and bucket chlorination of drinking water. The rapid fund release helped quickly scale-up activities in the critical phase of cholera case acceleration at the onset of the outbreak. For the health interventions, UNICEF immediately procured and distributed cholera kits to the affected districts and in addition procured and distributed essential medicines and commodities to the cholera treatment centres for case management and to avoid stock outs. Tents were pitched for Oral Rehydration Points (ORPs) in the affected communities for ease

access for medical assistance within the affected communities. Furthermore, the funds were used to purchase infection control and water treatment chemicals to stop further infection among the affected communities. The funds were also used for fuel and allowances to the National Rapid Response Team follow up contacts and to avoid community deaths.

b) Did CERF funds help respond to time-critical needs?

YES ☒ PARTIALLY ☐ NO ☐

For WASH, CERF funds contributed to the time-critical needs of providing safe drinking water and hygiene messages. Moreover, the funds allowed UNCEF to place mobile sanitation facilities in three cholera treatment centers to ensure that cholera patients and other patients do not use the same sanitation facilities and reduce the risk of cholera infection. Other time-critical needs that the funds supported
included procurement and distribution of essential medicines and commodities to the established cholera treatment centres. These medicines were distributed for immediate case management with no stock outs recorded at all the 3 treatment centres. These in turn improved case management and avoided any further deaths within the treatment centres. A reduction in the case fatality rate was immediately noticed as the treatment centres were fully stocked up and medical assistance was provided. In addition, Oral rehydration points were immediately established for quick medical assistance within the communities to further avoid deaths within the communities

c) Did CERF improve coordination amongst the humanitarian community?

YES ☒ PARTIALLY ☐ NO ☐

For WASH, CERF funds allowed UNICEF to improve coordination of cholera response activities among partners by strengthening the Emergency Strategic Advisory Group (ESAG) for WASH in Emergencies, which was led by the Government of Zimbabwe and UNICEF as co-chairs. ESAG is a key on-going platform to discuss and reach a consensus of WASH sector/cluster on various implementing issues and contributed to well-coordinated response as a sector. In this cholera response, ESAG prepared within a week a sector response plan to the outbreak as well as costed workplan for the sector to take forward. The ESAG also worked, with technical support from UNICEF, on a detailed technical needs assessment which was a joint initiative of Government, civil society and UNICEF. In the case of the health response, UNICEF mainly worked with MOHCC, which heads the public health system, through interactions with various departments including Pharmacy, Epidemiology & Disease Control, EPI, Health promotion and Environmental health. Using the CERF Funds, UNICEF provided support to MoHCC through these departments and strengthened response to the cholera outbreak. The technical support provided included procurement and distribution of essential medicines and supplies, vaccines and immunization response, and support for community mobilisation and engagement. Since UNICEF traditionally procures the essential medicines and commodities on behalf of the Government of Zimbabwe, it used the same system and arrangements with National Pharmacy of Zimbabwe and Medicines Control Authority of Zimbabwe (MCAZ) to respond to the cholera outbreak.

d) Did CERF funds help improve resource mobilization from other sources?

YES ☒ PARTIALLY ☐ NO ☐

For WASH, CERF funds allowed UNICEF to mobilize resources from other donors by demonstrating how UNICEF effectively implemented immediate response activities and highlighting needs for additional interventions. UNICEF received additional funds from other bilateral donors and was able to establish rapid response teams for cholera and future outbreaks.

e) If applicable, please highlight other ways in which CERF has added value to the humanitarian response

The UNICEF emergency response was, guided by the Core Commitments for Children in Humanitarian Action and its policy on humanitarian action. There were monitoring activities were conducted on a regular basis by UNICEF staff and at field level, together with MoHCC (and as needed, district) staff. UNICEF then put in place a robust system to monitor the performance of the partners that the agency had engaged through regular programme and financial spot-checks as defined in its Harmonized Approach to Cash Transfers (HACT) Guidelines. Results monitoring were primarily through the analysis of line lists, situation reports, field assessments and reports on social mobilization and community engagement, while implementation progress monitoring used to implement partner's monitoring system, the National Health Information System (NHIS) and the district health information system (DHIS II). UNICEF was responsible for monitoring and reporting of outcome (specific objectives) and the overall objective and lower level results (outputs and inputs) In addition to the core health interventions. UNICEF supported two Civil Society Organisations that is - Childline and Child Protection Society to provide cholera sensitive critical child protection services and continue to provide technical support to partners and the Department of Social Welfare in managing cases of children affected by cholera. Capacity building of partners in cholera response, technical guidance and liaison with ESARO Child Protection advisors. Childline facilitated and delivered training of child protection

workforce in Child Protection in Emergency, training of health workers in conducting child protection risks assessments and referrals. Childline also delivered direct services to affected children through established Child Friendly Spaces (CFS) for contacts and referrals for affected children in liaison with health workers in Cholera Treatment Centres (CTCs). Through CFS Childline provided psychosocial support, sensitization on safe reporting of cases at risk of child protection violations, conducting home visits to follow up identified cases of children in need of protection services. UNICEF also provided supplies such as recreational kits and Information, Education and Communication materials to Childline for provision of play therapy, learning and access to child friendly information on cholera and protection.

7. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT	
Lessons learned	**Suggestion for follow-up/improvement**
Cholera outbreak response coordination mechanism was in place but can be further strengthened.	Overall cross-cluster and government-cluster coordination can be strengthened by ensuring more efficient cross-partner sharing, better understanding the local authority's activities, and cutting down the number of overlapping meetings.
Planning figures for worst case scenario were overestimated in 2018 cholera response to ensure all populations in need can receive life-saving interventions.	National cholera hotspot mapping which was supported by UNICEF will help prepare for targeted scenarios moving forward.
Rapid response teams were effective to implement timely response to cholera cases.	Rapid response teams can be maintained and activated in future outbreaks.
The CERF funds were timely and are integral as a catalyst for the critical and lifesaving period of the response. Through the CERF funding and other activities, the Country avoided a second peak of cholera and ensured that the first scenario of 10,000 cases was not surpassed.	There is a need for the continued provision of CERF rapid response funds which conforms to the Lifesaving Criteria.

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
At the time the CERF funds are disbursed to different agencies / sectors the RC/HC offices should organize inception meetings to ensure multi-sectoral collaboration	Partners implementing CERF project should coordinate from project design stage, early implementation and evaluation stage	UNRCO

PART II

8. PROJECT REPORTS

8.1. Project Report 18-RR-CEF-104 - UNICEF

1. Project Information			
1. Agency:	UNICEF	**2. Country:**	Zimbabwe
3. Cluster/Sector:	Water Sanitation Hygiene - Water, Sanitation and Hygiene	**4. Project Code (CERF):**	18-RR-CEF-104
5. Project Title:	WASH Cholera Response		
6.a Original Start Date:	10/09/2018	**6.b Original End Date:**	09/03/2019
6.c. No-cost Extension:	☒ No ☐ Yes	if yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☒ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 3,000,000
	b. Total funding received for agency's sector response to current emergency:	US$ 4,711,5936
	c. Amount received from CERF:	US$ 1,096,628
	d. Total CERF funds forwarded to implementing partners	**US$ 633,264**
	of which to:	
	▪ Government Partners	US$ 0
	▪ International NGOs	US$ 633,264
	▪ National NGOs	US$ 0
	▪ Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance

UNICEF and implementing partners reached a total of 351,117 people through water, sanitation and hygiene (WASH) interventions, including hygiene kit distribution, infection, prevention and control (IPC) improvement at cholera treatment centers, and health and hygiene education. Specifically, 77,008 people gained access to safe drinking water, 64,877 people were protected from contaminated water through sewerage rehabilitation, and 351,117 people received key health and hygiene messages on cholera prevention. More people were reached with hygiene education as the program and partners took advantage of the Oral Cholera Vaccination campaigns to disseminate key hygiene education message. Mobile toilets were also placed in three cholera treatment centres to reduce the risk of spreading cholera and protect all patients. Furthermore, our post distribution monitoring demonstrated that approximately 85% of people were able to recall at least two prevention messages, which confirmed the effectiveness of hygiene promotion activities. The CERF funding was utilized from the initial stage of cholera outbreak response and made a substantial contribution to containing the outbreak. A total of 545 out of the targeted 600 schools received a WASH hygiene kit comprising of soap, buckets, jerrycans, IEC material, disinfectants and protective clothing. These were all the schools within the cholera hotspot area.

3. Changes and Amendments

There was not a major change and amendments to the original proposal. The operation of response activities was interrupted for one week in January 2019 due to civil unrest. A total of 351,117 people received key health and hygiene messages on cholera prevention, representing 176% of the targeted 200,000 people. This is because more people were reached with hygiene education as the program

and partners took advantage of the Oral Cholera Vaccination (OCV) campaigns to disseminate key hygiene education. Furthermore, various hygiene promotion channels were used to raise awareness. These include door to door campaigns, roadshows, mass media campaigns (radio, SMS, TV), school and community health clubs. The WASH activities were also closely integrated with the Communication for Development social mobilization activities to have a wider reach. The WASH team also worked closely with the education sector. A total of 545 schools were identified by the education sector to be within the cholera hotspot. These are the schools that benefitted from the WASH hygiene kit distribution.

4. People Reached

4a. Number of people directly assisted with CERF funding by age group and sex

	Female			Male			Total		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Planned	41,360	62,040	**103,400**	38,640	57,960	**96,600**	80,000	120,000	**200,000**
Reached	83,366	108,527	**191,893**	66,349	92,875	**159,224**	149,715	201,402	**351,117**

4b. Number of people directly assisted with CERF funding by category

Category	**Number of people (Planned)**	**Number of people (Reached)**
Refugees	0	0
IDPs	0	0
Host population	0	0
Affected people (none of the above)	200,000	351,117
Total (same as in 4a)	**200,000**	**351,117**
In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	A total of 351,117 people received key health and hygiene messages on cholera prevention, representing 176% of the targeted 200,000 people. This is because more people were reached with hygiene education as the program and partners took advantage of the Oral Cholera Vaccination campaigns to disseminate key hygiene education. Furthermore, various hygiene promotion channels were used to raise awareness. These include door to door campaigns, roadshows, mass media campaigns (radio, SMS, TV), school and community health clubs. The WASH activities were also closely integrated with the Communication for Development (C4D) social mobilization activities to have a wider reach.	

5. CERF Result Framework

Project objective	The project will contribute to the scale up of cholera interventions and ensure a rapid response to cholera, thereby contributing to a reduction of the transmission of the disease to less than 10 suspected cases per day"

Output 1	200,000 people improve their WASH conditions in the cholera affected areas			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of households with access to a hygiene kit (soap, household water treatment products, IEC materials)	20,000	16,433	UNICEF/Partners indicator reporting tracker

Indicator 1.2	Number of schools with access to a hygiene kit (soap, household water treatment products, IEC materials and buckets)	600	545	UNICEF/Partners indicator reporting tracker
Indicator 1.3	Number of people protected from contamination through water quality monitoring and repairs of sewer bursts	200,000	351,117	UNICEF/ Partners indicator reporting tracker
Explanation of output and indicators variance:		A total of 16,433 out of 20,000 households were reached with CERF funding. However, the total response reached 27,975 households. The balance of funds meant for WASH hygiene kits was used to cover other emerging gaps. These include procurement of disinfectants and protective clothing that were used in the CTCs, mobile latrines and sewer bursts. A total of 351,117 people received key health and hygiene messages on cholera prevention, representing 176% of the targeted 200,000 people. This is because more people were reached with hygiene education as the program and partners took advantage of the Oral Cholera Vaccination campaigns to disseminate key hygiene education. Furthermore, various hygiene promotion channels were used to raise awareness. These include door to door campaigns, roadshows, mass media campaigns (radio, SMS, TV), school and community health clubs. The WASH activities were also closely integrated with the Communication for Development social mobilization activities to have a wider reach		

Activities	**Description**	**Implemented by**
Activity 1.1	Purchase of hygiene kits	UNICEF
Activity 1.2	Distribution of hygiene kits	Oxfam, WHH
Activity 1.3	Water quality monitoring	Oxfam, WHH

Output 2	3 CTCs improve their WASH/IPC conditions			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of CTCs supported with Infection, Prevention and Control (IPC) products	3	3	Implementing partner's monthly report
Indicator 2.2	Number of CTCs supported with management/desludging of mobile toilets	3	3	Implementing partner's monthly report
Explanation of output and indicators variance:		No variance		

Activities	**Description**	**Implemented by**
Activity 2.1	Purchase of Infection Prevention and Control (IPC) products to CTCs/CTUs	UNICEF
Activity 2.2	Distribution of Infection Prevention and Control (IPC) products to CTCs/CTUs	UNICEF, Oxfam, WHH
Activity 2.3	Management and desludging of mobile toilets in CTCs/CTUs	UNICEF, Oxfam, WHH Implementing partners (Oxfam and WHH) subcontracted private sector for this activity. As such, UNICEF, Oxfam and WHH contributed to overseeing this activity.

Output 3	200,000 people receive critical WASH-related information to prevent cholera			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of people reached through community engagement sessions	200,000	351,117	UNICEF/Partners indicator reporting tracker
Indicator 3.2	Proportion of people that can recall at least 2 prevention messages	70%	85%	Post Distribution Monitoring Reports
Explanation of output and indicators variance:		A total of 351,117 people received key health and hygiene messages on cholera prevention, representing 176% of the targeted 200,000 people. This is because more people were reached with hygiene education as the program and partners took advantage of the Oral Cholera Vaccination campaigns to disseminate key hygiene education. Furthermore, various hygiene promotion channels were used to raise awareness. These include door to door campaigns, roadshows, mass media campaigns (radio, SMS, TV), school and community health clubs. The WASH activities were also closely integrated with the Communication for Development social mobilisation activities to have a wider reach.		

Activities	**Description**	**Implemented by**
Activity 3.1	Setup and support to three rapid Communication and Social Mobilization teams	Oxfam, WHH
Activity 3.2	Training of 150 CHC and health promoters	Oxfam, WHH
Activity 3.3	Equipment of 150 CHC and health promoters	UNICEF, Oxfam, WHH
Activity 3.4	Door to door house visits, hygiene promotion sessions at vendor markets, shopping centers, public gatherings, church meetings, school meetings, apostolic/ religious groups / communities outreaches	Oxfam, WHH, MoHCC

6. Accountability to Affected People

A) Project design and planning phase:

This project used existing Government structures and local communities during design and planning phase. Women and men were consulted on needs through ongoing community dialogue on cholera and priorities for interventions set based on information from the affected communities as well as based on epidemiological evidence. Information, Education and Communication (IEC) materials used were designed and agreed with Ministry of Health and Child Care (MoHCC) prior to the response

B) Project implementation phase:

The community was engaged throughout the project to: increase awareness where to access cholera treatment, prevention and early treatment seeking. Different channels were used to share and disseminate cholera prevention and general hygiene related information to the different audiences. Community feedback mechanisms were incorporated within the project activities such as community dialogues, live radio call-in programs, live radio broadcast outreaches in the communities and post drama feedback sessions. A rumor tracking tool was developed and was used to capture rumors and community complaints and suggestions were gathered during the door to door visits by the community mobilisers. Information, Education and Communication (IEC) materials were prepared in local languages to ensure that affected populations can understand their contents. While the CERF funded project did not specifically focus on vulnerable and marginalized populations, UNICEF and implementing partners ensured that they can receive hygiene kits and health and hygiene education without encountering any barriers.

C) Project monitoring and evaluation:

Monitoring visits were conducted jointly with UNICEF, MoHCC and City of Harare/Chitungwiza City Health Department at the project sites. Visits to community structures including local leaders and village health workers were conducted. Post distribution monitoring (PDM) was conducted to assess how affected populations used hygiene kits and improved their knowledge about hygiene practices

and cholera prevention. PDM was also a platform to ensure that community members can provide their feedback on hygiene kits. Affected populations were using hygiene kit materials and demonstrated improvements in knowledge on key hygiene practices. This suggested that beneficiaries did not have major issues with WASH interventions provided in cholera-affected areas.

7. Cash-Based Interventions

7.a Did the project include one or more Cash Based Intervention(s) (CBI)?

Planned	Actual
No	No

7.b Please specify below the parameters of the CBI modality/ies used. If more than one modality was used in the project, please complete separate rows for each modality. Please indicate the estimated **value of cash** that was transferred to people assisted through each modality (best estimate of the value of cash and/or vouchers, not including associated delivery costs).

CBI modality	Value of cash (US$)	a. Objective	b. Conditionality	c. Restriction
None	US$ [insert amount]	Choose an item.	Choose an item.	Choose an item.

Supplementary information (optional):
N/A

8. Evaluation: Has this project been evaluated or is an evaluation pending?

This project did not have an outcome evaluation due to constraints with time and human resources. A new emergency (Cyclone Idai) created an extra challenge to focus on evaluating this project.

EVALUATION CARRIED OUT ☐
EVALUATION PENDING ☐
NO EVALUATION PLANNED ☒

8.2. Project Report 18-RR-CEF-105,18-RR-WHO-040 - UNICEF, WHO

1. Project Information			
1. Agency:	UNICEF, WHO	**2. Country:**	Zimbabwe
3. Cluster/Sector:	Health - Health	**4. Project Code (CERF):**	18-RR-CEF-105 18-RR-WHO-040
5. Project Title:	Strengthening response to and management of cholera and other epidemic prone diseases in Harare		
6.a Original Start Date:	01/10/2018 (UNICEF) 01/10/2018 (WHO)	**6.b Original End Date:**	31/03/2019 (UNICEF) 31/03/2019 (WHO)
6.c. No-cost Extension:	☒ No ☐ Yes	f yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☒ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 8,796,218
	b. Total funding received for agency's sector response to current emergency:	US$ 1,532,591
	c. Amount received from CERF:	US$ 1,772,568
	d. Total CERF funds forwarded to implementing partners	**US$ 17,000**
	of which to:	
	▪ Government Partners	US$ 17,000
	▪ International NGOs	US$ 0
	▪ National NGOs	US$ 0
	▪ Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF grant, UNICEF and its partners provided support to 9,946 people and have access to life saving treatment for cholera at the Treatment Centres, 18,112 people have access to life saving treatment through Oral Rehydration Therapy Points (ORPs) in the most affected communities and 601,130 people in the community to be mobilized for cholera prevention and treatment seeking. Essential medicines and commodities and infection control materials worth $462,790 were procured and distributed to all treatment centres to ensure no stock outs. Also, 8 tents worth $11,792 were pitched for Oral Rehydration Points within the communities for ease access for medical assistance. The funds also managed to print and distribute a total of 20,000 cholera SBCC IEC materials to the communities and reached 629,188 people within the affected 10 suburbs.

3. Changes and Amendments

There were no changes, deviations or amendments in the project from the original proposal or project plan. This did not affect the needs of the beneficiaries. All activities were executed according to plan as soon as the funds were disbursed.

4. People Reached

4a. Number of people directly assisted with CERF funding by age group and sex

	Female			Male			Total		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Planned	183,600	122,400	**306,000**	176,400	117,600	**294,000**	360,000	240,000	**600,000**
Reached	172,820	163,198	**336,018**	144,064	149,106	**293,170**	316,884	312,304	**629,188**

4b. Number of people directly assisted with CERF funding by category

Category	**Number of people (Planned)**	**Number of people (Reached)**
Refugees	0	0
IDPs	0	0
Host population	0	0
Affected people (none of the above)	600,000	629,188
Total (same as in 4a)	**600,000**	**629,188**

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	The targeted population were children, women and men of Harare, estimated at 600,000 in 10 districts of Harare (Glenview, Budiriro, Mbare, Epworth, Glen Norah, Granary, Mabvuku, Mufakose, Stoneridge, Kambuzuma). An additional number of 29,188 were people who would have travelled from other areas and be part of affected households within these affected suburbs.

5. CERF Result Framework

Project objective	Reduce morbidity and mortality due to cholera in the city of Harare

Output 1	15,000 people have access to life saving treatment for cholera at treatment centre/units			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of people accessing treatment at cholera treatment centres/units	100% (15,000)	9,946	Harare City Treatment Centres Registers and line lists
Indicator 1.2	Number of cholera treatment centres/units with no stock out of essential medicines and commodities for management of cholera	100% (3)	3	Harare City Treatment Centres Registers and line lists
Explanation of output and indicators variance:		The early introduction of OCV within the 10 affected suburbs allowed a reduction in the cholera cases and availability of medicines for proper case management resulted in no further spreading of the infection		

Activities	**Description**	**Implemented by**
Activity 1.1	Procurement of personal protective equipment to replenish stocks in high burden facilities in Harare	UNICEF with NATPHARM,
Activity 1.2	Distribution of personal protective equipment to replenish stocks in high burden facilities in Harare	UNICEF with NATPHARM,

Activity 1.3	Procurement of essential medicines, commodities and supplies for 15,000 patients (see annex)	UNICEF with NATPHARM,
Activity 1.4	Distribution of essential medicines, commodities and supplies for 15,000 patients (see annex)	UNICEF with NATPHARM,
Activity 1.5	Incorporate in cholera case management training of Health workers on appropriate management of HIV in PLHIV, SAM and Cholera co-morbidity	UNICEF, WHO, IPs, MOHCC and partners

Output 2	18,000 people have access to life saving treatment for cholera through Oral Rehydration Therapy Points (ORPs) in the most affected communities			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of people accessing treatment at community level – through oral rehydration therapy point in Budiriro and Glenview	100% (18,000)	18,112	Harare City District Community Registers
Explanation of output and indicators variance:		N/A		
Activities	**Description**		**Implemented by**	
Activity 2.1	Five ORPs established in high burden wards of Budiriro and Glenview		UNICEF with City of Harare Health Department	
Activity 2.2	Provision of rehydration therapy through ORPs		UNICEF with City of Harare Health Department	

Output 3	600,000 people in the community are mobilized for cholera prevention and treatment seeking			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of people reached by media channels	3 million	3.2 million	UNICEF Cholera Situational Reports
Explanation of output and indicators variance:		More people were reached since there was the use of televisions and radios. Also, the use of Social media such as UNICEF twitter, Facebook resulted in reaching more people.		
Activities	**Description**		**Implemented by**	
Activity 3.1	Information dissemination through social and mass media- UNICEF website, Twitter, Instagram, Facebook, U-Report; and UNICEF radio, TV PSAs, talk shows, drama		UNICEF and UNICEF IPs, MOHCC and partners	
Activity 3.2	Interpersonal communication, group and mass communication IEC-SBCC		UNICEF and UNICEF IPs, MOHCC and partners	
Activity 3.3	Orientation of local authority staff and existing community HIV structures (caregivers, GATS, PLHIV networks) on basic facts on cholera HIV co-infection, recognize early symptoms, referral hygiene and nutrition screening		UNICEF and UNICEF IPs, MOHCC and partners	

Output 4	10,000 children and 5,000 caregivers affected by cholera are reached with psychosocial support, alternative care placement, family tracing, and reunification services			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 4.1	Number of children and care givers affected by cholera who receive psychosocial support by trained service providers	15,000 (66%)	19,890	UNICEF Cholera Situational Reports

Indicator 4.2	Number of separated children affected by cholera who received support for family linkages, tracing and reunification.	500	160	UNICEF Cholera Situational Reports
Explanation of output and indicators variance:		N/A		

Activities	**Description**	**Implemented by**
Activity 4.1	Orient health workers, social workers, community cadres involved in social care on appropriate referral and alternative care placement, family tracing, and reunification of cholera affected children	UNICEF, MoPLSW, Childline, Child Protection Society
Activity 4.2	Provision of psychosocial support to children and their caregivers in the community and at home	UNICEF, Childline
Activity 4.3	Identification and documentation, Tracing and Reunification of separated and unaccompanied Children	UNICEF, Child Protection Society

Output 5	At least 15,000 patients receiving lifesaving treatment at CTCS.			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 5.1	Number of CTCs receiving medicines for case management.	100% (3)	Achieved	MOHCC reports.
Indicator 5.2	CTCs with clinicians receiving on the job orientation in case management.	100% (3)	Achieved	MOHCC reports.
Indicator 5.3	CFR reduced or maintained below 1%	<1%	CFR reduced to 0.64%	MOHCC reports.
Explanation of output and indicators variance:		All CTCs received medical supplies, and staff had orientation on cholera case management and infection prevention and control		

Activities	**Description**	**Implemented by**
Activity 5.1	Procurement of 6 emergency cholera kits for the treatment of cholera cases at CTCs.	WHO
Activity 5.2	Distribution of 6 emergency cholera kits for the treatment of cholera cases at CTCs.	WHO
Activity 5.3	On the job orientation of clinicians at CTCs and CTUs	WHO
Activity 5.4	Provide protocols and guidelines for case management	WHO

Output 6	Emergency detection of cases in the community in affected areas in Harare			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 6.1	Number of RRT members provided with on the job orientation.	100% (24 RRT members)	All 24 RRTs received on the job orientation from the district, provincial or national levels.	MOHCC Reports
Indicator 6.2	Number of patients detected through active case finding.	2640	Most cases were brought to the CTC when they fell sick, however some cases were detected through case finding due to strengthened surveillance systems	Case registers

			and effective RRTs.	
Indicator 6.3	Proportion of cases followed up after discharge from treatment centers	100% (750)	Through utilisation of line lists for the cholera cases, MOHCC and City of Harare were able to institute follow up on cases that reported at the CTCS.	Case Register
Explanation of output and indicators variance:		WCO Zimbabwe worked collaboratively with the Ministry of Health and Child Care and the City of Harare in the procurement and distribution of cholera kits in Harare. This ensured that case management was effective as the facilities were able to utilise the kits management of cholera cases. Availability of the medical supplies had a positive impact on the case fatality rate which was at 0.64 %, below the accepted limit of 1%. To ensure improved quality of care for the cholera patients, WHO with the Ministry conducted on-the-job training for clinic staff. Active cases finding was also instituted, and this had a huge impact in promoting health seeking behaviour among community members. The Laboratory was also instrumental in the confirmation of cases. On the job training was also done for NMRL and Beatrice Laboratory. The support also saw the laboratories receiving the laboratory reagents for improved confirmation.		

Activities	**Description**	**Implemented by**
Activity 6.1	On the job orientation of RRTs	WHO, MOHCC, partners
Activity 6.2	RRTs provided with logistical support to carry out active case finding in the community.	WHO, MOHCC, partners
Activity 6.3	Follow up of discharged patients from the treatment facilities	MOHCC

Output 7	Support the national reference laboratory for case investigation and confirmation			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 7.1	National laboratory augmented to support management of cholera cases	National Microbiology Reference Laboratory	Achieved	MOHCC Records.
Explanation of output and indicators variance:		The target was met.		

Activities	**Description**	**Implemented by**
Activity 7.1	Procure essential laboratory supplies including reagents and consumables for the national microbiology reference laboratory	WHO, MOHCC

6. Accountability to Affected People

A) Project design and planning phase:

This project used existing Government structures and local communities during design and planning phase. All key messages and other communication materials under this project used for social mobilization and community engagement were developed, designed and pretested with the intended audiences before being finalized. Women and men were consulted on needs through ongoing community dialogue on cholera and priorities for interventions set based on information from the affected communities as well as based on epidemiological evidence.

B) Project implementation phase:

Community feedback mechanisms were incorporated within the project activities such as community dialogues, live radio call-in programs, live radio broadcast outreaches in the communities and post drama feedback sessions. Other channels such as U-report with

inbuilt feedback mechanisms were used. Rumours and suggestions were gathered during the door to door visits by the community mobilisers.

C) Project monitoring and evaluation:
Monitoring visits were conducted jointly with MoHCC and City of Harare City Health Department at the project sites. Visits to community structures including local leaders and village health workers were also conducted. Pre and post surveys were undertaken for each of the community engagement activities and rapid assessments/mini surveys were undertaken to determine the effectiveness of the messages and measure changes in community knowledge, attitudes, practices and behaviours related to cholera prevention and general hygiene.

7. Cash-Based Interventions

7.a Did the project include one or more Cash Based Intervention(s) (CBI)?

Planned	Actual
No	No

7.b Please specify below the parameters of the CBI modality/ies used. If more than one modality was used in the project, please complete separate rows for each modality. Please indicate the estimated **value of cash** that was transferred to people assisted through each modality (best estimate of the value of cash and/or vouchers, not including associated delivery costs).

CBI modality	Value of cash (US$)	a. Objective	b. Conditionality	c. Restriction
No	US$ [insert amount]	Choose an item.	Choose an item.	Choose an item.

Supplementary information (optional):
N/A

8. Evaluation: Has this project been evaluated or is an evaluation pending?

While there was no evaluation for the CERF project, a broader Joint Cholera Response Review led by MOHCC, WHO and other partners was carried out, and this contributed to improved response. Below is the summary of the deliberations.

The Cholera Response Joint Review Meeting was held in Mazowe, Mashonaland Central province, Zimbabwe on 07-08 November 2018. This had been a unique outbreak response in the country's history, with the usual outbreak response mechanisms in place, an early declaration of national disaster and a vaccination campaign added to save lives in view of the unprecedented nature of the outbreak. Furthermore, the cholera outbreak which mostly affected Harare also hit hard most of the suburbs that were battling the typhoid outbreak that started in 2017.

The purpose of the Joint Review was to evaluate the implementation of the National Cholera Response Plan, with the objective of strengthening capacities to prevent, detect and respond to any further outbreaks. The review focused on what worked well during the response, what did not work well, and lessons learned. Critical gaps were identified, and agreement reached on urgent activities to (i) address remaining strategic and operational challenges to reaching zero cases; (ii) ensure highest level of preparedness for the rainy season, particularly in all hotspots and (iii) develop medium-to-long term cholera plan towards a Cholera Elimination road map.

The participants included Government officials from all relevant ministries, from national level, provincial, district and municipal levels. Partners included WHO, UNICEF, US CDC, Africa CDC, MSF, OXFAM, GOAL, Higher Life Foundation, national NGOs, and the private sector. One hundred and fifteen (115) participants including the facilitators were present at the meeting.

EVALUATION CARRIED OUT ☐

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☒

The discussions followed the thematic areas of cholera outbreak response and of the oral cholera vaccination (OCV) campaign. Key discussions on surveillance focused on strengthening surveillance systems as well as strengthening laboratory capacity to detect priority pathogens. The discussions on case management centred on adoption of a locum system as a stop-gap measure for addressing human resources gaps across all staff categories and professions, and on building capacity of health staff on handling co-morbidities as well as reducing the notably high levels of antibiotic resistance, (AMR) to both the vibrio cholera and salmonella typhi. Harare City indicated that the water sanitation and hygiene, (WASH) situation remained unsatisfactory with erratic supplies of portable water in the outbreak areas. The quality of borehole water supplies was alarming, and this may be attributed to inappropriate siting of some boreholes too close to sewer lines, a situation that the local authority was said to be currently addressing. The advocacy and communications team highlighted the need to synchronize and harmonize messages that are disseminated to the community as well as strong and consistent engagement of politicians and local leadership for long term solutions to WASH problems. This helps to build communities' confidence in the interventions and improve uptake of new interventions because such influential persons are considered credible and trustworthy. On logistics, experiences from the current outbreak revealed bottlenecks in the emergency procurement processes due to rigidity of the system. Initial low uptake of the vaccine was observed in the first phase of the OCV campaign that targeted four suburbs, but the use of traditional mass media made information more credible, helped to dismiss myths and misconceptions as well as empowered the community to take up the intervention, achieving 86% coverage. The documentation of the OCV experience will allow information sharing with the provinces and other stakeholders. It was noted that most coordination activities were centered at National level and on Harare City, but little effort was channeled towards strengthening Provincial and District level coordination. As a result, the response and preparedness efforts may not be as agile and effective at sub-national levels. Taskforce meetings on epidemic-prone diseases and other coordination structures need to be strengthened and activated to ensure maximum coordination at these levels. There was a call for the establishment of PHEOCs at all levels together with activation of the incident management system. Incident Management Systems (IMS) need to be in place at the PHEOC to enable maximum coordination. IMS will coordinate and guide the emergency response in terms of plans, processes, procedures, infrastructure, communication, and people that work together in an emergency to react, understand and respond effectively. These are necessary to ensure a smooth, fast, effective and coordinated response. Although IDSR trainings have been conducted in the past as a preparedness and response measure, there has been little coordination in mobilizing resources to ensure the cascading and monitoring of these activities. Resource mobilization is key in ensuring that coordination at all levels is constantly and consistently active, not only as a response measure but also as preparedness measure. As part of the initiative to end cholera, the Global Task Force on Cholera Control (GTFCC) has launched an initiative titled Ending Cholera: A Global Roadmap to 2030 whose objective is to reduce by 90 percent the number of deaths from cholera worldwide by 2030 and Eliminate the disease in at least 20 countries. The above initiatives resonate with Sustainable Development Goals that calls for integrated approaches towards health and social development, and for "leaving no-one behind". Zimbabwe needs to come up with her own Cholera control and Elimination Roadmap in tandem with the president's call for the country to attain upper middle- income status by 2030 and riding on the government's clarion call to modernize water and sanitation infrastructure.	

8.3. Project Report 18-RR-WFP-058 - WFP

1. Project Information			
1. Agency:	WFP	**2. Country:**	Zimbabwe
3. Cluster/Sector:	Food Security - Food Aid	**4. Project Code (CERF):**	18-RR-WFP-058
5. Project Title:	In-clinic feeding to cholera patients to contain the outbreak and support recovery		
6.a Original Start Date:	10/10/2018	**6.b Original End Date:**	09/04/2019
6.c. No-cost Extension:	☒ No ☐ Yes	if yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☐ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 230,175
	b. Total funding received for agency's sector response to current emergency:	US$ 230,175
	c. Amount received from CERF:	US$ 230,175
	d. Total CERF funds forwarded to implementing partners	**US$ 58,705**
	of which to:	
	▪ Government Partners	US$ 0
	▪ International NGOs	US$ 58,705
	▪ National NGOs	US$ 0
	▪ Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance

The World Food Programme received CERF funding to provide food assistance to people infected by cholera to support in the containment efforts in the immediate wake of the outbreak. During the initial phase, the response targeted people who were admitted and received treatment at the treatment centres in Harare through Harare City Health Department, and these people will receive food for the time they would be receiving treatment, i.e. 3-5 days. As the health authorities with the support of UN and NGOs successfully contained the outbreak, and the number of inpatients reduced, the food response strategy was revised to include a month take-home ration for the in-patients upon their discharge and food distributions to at-risk communities in close collaboration with UNICEF WASH. This strategy aimed at reducing further infections and it complemented the on-going national cholera response. The community intervention was implemented through GOAL Zimbabwe. Overall, the response was in two phases: phase one covered institutional feeding and a take home ration upon discharge; and phase 2 covered food distributions to at-risk communities who also received health and hygiene kits; health and nutrition messaging and sensitization for oral cholera 2 vaccine campaigns. A total of 8,860 beneficiaries were reached, including 4,147 males and 4,713 females. The program was implemented from October 2018 to April 2019 and managed to move a total tonnage of 255.231 MT (137.967MT maize grain, 5.644MT vegetable oil, 24.63MT cowpeas and 86.99MT super cereal), and thereby consuming all the resources received Through CERF funding, WFP was able to provide food to inpatients in all cholera treatment centres in Harare, thereby contributing to reducing cross contamination.

3. Changes and Amendments

Initially, WFP's food assistance response targeted infected people who were admitted and received treatment at the cholera treatment centres in Harare, with the objective of minimizing cross-contamination. The food was distributed through Harare City Health Department as institutional feeding to all the inpatients, where the length of stay was anticipated to be between 3-5 days. The patients were also given a take home food ration once discharged. However, through concerted efforts of different partners, including the UN and Government, the outbreak was efficiently contained, and the number of inpatients significantly reduced. As a result, the number of

people reached by the response was much lower than the worst-case scenario anticipated in the proposal of 50,000 people. At the same time, partners intensified preventative efforts once the infection rate declined, through direct engagement with the high-risk communities, disproportionately affected by the infection. Adjusting to the changing circumstances, WFP revised the response strategy to include food distributions to at-risk communities-including those with suspected cholera cases. This was done in collaboration with UNICEF WASH response activities, where a month's food ration was provided to the targeted households, together with UNICEF's hygiene kits and nutrition messaging and sensitization.
The planned ration size was to cover in-patients who would have been admitted into hospital for an estimated length of stay of 3-5 days, however, as the cholera response unfolded, there were not as many hospital admissions as anticipated since the response was robust. Beneficiaries were then allocated a monthly take home ration upon discharge which would cover an additional 30 days so they can find somewhere to start from since they would have been admitted from hospital. Household monthly rations / household monthly food baskets were also being provided together with the WASH kits at community level.

4. People Reached

4a. Number of people directly assisted with CERF funding by age group and sex

	Female			Male			Total		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Planned	12,480	14,280	**26,760**	11,520	12,480	**24,000**	24,000	26,760	**50,760**
Reached	2,288	2,425	**4,713**	2,469	1,678	**4,147**	4,757	4,103	**8,860**

4b. Number of people directly assisted with CERF funding by category

Category	**Number of people (Planned)**	**Number of people (Reached)**
Refugees	0	0
IDPs	0	0
Host population	0	0
Affected people (none of the above)	50,760	8,860
Total (same as in 4a)	**50,760**	**8,860**

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	The discrepancy between the planned and the reached beneficiaries is the direct result of the fact that the cholera outbreak was effectively contained, and the contingency plan adopted by UN (of 50,000 people infected) did not materialize. The original plan was to focus on institutional feeding for up to 50,000 people for a period of 3-5 days per patient. With the shift in response strategy, WFP distributed the same tonnage as a one-month household take home ration to a smaller number of people residing in high risk areas, to prevent the infection of spreading further. Furthermore, with the lead times associated with the food procurement, WFP was not able to reach all people infected during the initial weeks. Realizing that the number of in-patients were reducing significantly, and the increasing community level interventions, WFP opted to revise its strategy yet within the overall objective of the project, to include 'at risk-communities'. This strategy complemented the national efforts at the time, and also achived the objective. The change in strategy was communicated to the CERF Secretariat as a part of the Interim Status Update

5. CERF Result Framework

Project objective	Reduce disease exposure of patients receiving cholera treatment during the outbreak period and support their recovery

Output 1	All people infected by cholera and receiving treatment (50,000) receive twice-daily cooked and nutritious meals to minimize their exposure to contaminated food			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	% of patients and clinic staff receiving cooked meals during clinic treatment period	100% of all people infected by cholera or a projected 50,000 patients, and 760 clinic-based staff	70% (i.e. 819 people)	Health facility-based registers and COMET-WFP reporting platform
Explanation of output and indicators variance:	As the cholera outbreak did not spread to the extent initially feared (i.e. 50,000 people), the number of people targeted was significantly reduced. Despite the fast procurement of food through the regional forward purchasing facility (GCMF), WFP was not able to meet all those infected, as the rate of infection during the initial phase was very fast, and WFP had to rely on its available food in-country. Harare City reported 217 confirmed cases, and 9,755 suspected cases throughout the infection period. The program managed to reach all suspected cases who were admitted to Beatrice Road Infectious Disease Hospital, or 819 people altogether. Most suspected cases were never admitted to the hospital, however, but were treated as outpatients in the surrounding clinics, and hence were not supported by the intervention. Through the community-outreach component, WFP was able to reach a substantial number of these cases during phase 2.			

Activities	**Description**	**Implemented by**
Activity 1.1	Provision of cooked and safe meals to meet the daily kcal of all patients admitted to cholera treating clinics	Harare City Health Department
Activity 1.2	Weekly distribution of sufficient essential food commodities to meet needs, based on past and projected patient treatment capacity	Hospital staff
Activity 1.3	Procurement of the necessary food items through the regional forward purchasing facility to expedite fast arrival in-country	World Food Programme
Activity 1.4	Provision of food to households most at-risk of getting cholera (8,041 beneficiaries)	GOAL Zimbabwe

6. Accountability to Affected People

A) Project design and planning phase:

For the community-outreach phase, WFP selected a trusted partner with a strong track record. The Field Level Agreement (FLA) signed with the partner (GOAL) made provisions for safeguards and beneficiary accountability. WFP also made sure that the existing agreement with Deloitte – the third party handling the community feedback mechanism – was extended to the cholera response. Before inception, clinic staff were sensitized on WFP's commitments to beneficiary accountability and protection.

B) Project implementation phase:

Pre-distribution addresses were conducted before distributions where affected populations were provided with relevant information about the project, entitlements, complaints and feedback mechanisms, project duration and the implementing agency and partners. Posters with entitlements and details of complaint feedback response mechanism were displayed at each distribution point. Feedback on complaints or feedback received were provided to WFP at reporting stage. Verification of the people reached through the community outreach phase were conducted by Cooperating Partner GOAL.

C) Project monitoring and evaluation:

Distribution monitoring was regularly conducted where monitoring of entitlements, complains and eligible beneficiaries was done. Post distribution monitoring was also conducted covering the following areas: household decisions concerning food received, conflicts on food assistance received, beneficiary selection, entitlements, distribution modality, distance travelled by beneficiaries to the food distribution point, meeting urgent household needs, food consumption arising from the food assistance program and the distribution process.

7. Cash-Based Interventions				
7.a Did the project include one or more Cash Based Intervention(s) (CBI)?				
Planned		**Actual**		
No		No		
7.b Please specify below the parameters of the CBI modality/ies used. If more than one modality was used in the project, please complete separate rows for each modality. Please indicate the estimated **value of cash** that was transferred to people assisted through each modality (best estimate of the value of cash and/or vouchers, not including associated delivery costs).				
CBI modality	**Value of cash (US$)**	**a. Objective**	**b. Conditionality**	**c. Restriction**
None	US$ [insert amount]	Choose an item.	Choose an item.	Choose an item.
Supplementary information (optional): N/A				

8. Evaluation: Has this project been evaluated or is an evaluation pending?	
No evaluation was conducted	EVALUATION CARRIED OUT ☐
	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
18-RR-CEF-104	Water, Sanitation and Hygiene	UNICEF	INGO	342,735
18-RR-CEF-104	Water, Sanitation and Hygiene	UNICEF	INGO	290,529
18-RR-CEF-105	Health	UNICEF	GOV	17,000
18-RR-CEF-105	Health	UNICEF	NNGO	22,654
18-RR-CEF-105	Health	UNICEF	NNGO	50,000
18-RR-WFP-058	Food Assistance	WFP	INGO	52,507

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

BRIDH	Beatrice Road Infectious Diseases Hospital
C4D	Communication for Development
CFS	Child Friendly Space
CHC	Community Health Club
CoH	City of Harare
CTC	Cholera Treatment Centre
DHIS	District health information System
ESAG	Emergency Advisory Group
ESARO	East and Southern Africa Regional Office
FLA	Field Level Agreement
GCMF	Global Commodity Management Facility
HACT	Harmonised Approach to Cash Transfers
IACC	Inter-Agencu Coordinating Committee of Health
IEC	Information, Education and Communication
IP	Implementing Partners
IPC	Infection, Prevention and Control
MCAZ	Medicines Control Authority of Zimbabwe
MoHCC	Ministry of Health and Child Care
MT	Metric Tonnes
NGOs	Non-Governemental Organisations
NHIS	National Health Information System
OCHA	Office for the Coordination of Humanitarian Affairs
OCV	Oral Cholera Vaccine
ORP	Oral Rehydration Point
PDM	Post Distribution Monitoring
PLHIV	People Living with HIV/AIDS
RRT	Rapid Response Team
SBCC	Social and behaviour Change Communication
SHC	School Health Club
SMS	Short Message Service
TV	Television
WASH	Water, Sanitation and Hygiene
WHH	Welthungerhilfe
UNICEF	United Nations Childrens' Fund
UNRCO	United Nationa Resident Coordinator's Office
WASH	Water, Sanitation and Hygene Promotion
WHH	Welthungerhilfe
WHO	World Health Organisation
WFP	World Food Programme