United Nations CERF Central Emergency Response Fund

ZIMBABWE
RAPID RESPONSE
DROUGHT
2020

20-RR-ZWE-40612

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Resident/Humanitarian Coordinator

PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:

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

The AAR did not take place at the end of 2020 as it was difficult to organize and find a suitable time with the 2020 Zimbabwe Humanitarian Needs Overview/Humanitarian (HNO)- Humanitarian Response Plan (HRP) process ongoing. Inputs from recipient agencies have been collected via email. Agency CERF focal points and cluster coordinators were consulted via email and phone. In addition, the CERF allocation and agency project reports were discussed during the Inter-Cluster Coordination Group (ICCG) meeting on 16 December. No AAR is planned.

Please confirm that the report on the use of CERF funds was discussed with the Humanitarian and/or UN Country Team (HCT/UNCT).	Yes ☐	No ☒

Due to time constraints in meeting the CERF reporting deadline and only one regular monthly HCT meeting on 10 December, the RC/HC report on the use of CERF funds was not discussed in the HCT yet. The alternative modality followed was to collect comments and inputs from the recipient agencies as key members of the HCT. Due to the time lapse, an HCT discussion of the report not planned.

Please confirm that the final version of this report was 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 ☐

The draft CERF report was shared with all agency CERF focal points and cluster coordinators, as well as with the heads of the recipient agencies receiving the CERF allocation for the 2020 drought response in Zimbabwe.

1. STRATEGIC PRIORITIZATION

Statement by the Resident/Humanitarian Coordinator:

CERF funds led to a strongly coordinated fast delivery of time-critical assistance to 926,079 million people who were left vulnerable by the combined effects of cyclone Idai, a weak economic environment, drought. A rigorous prioritization and targeting process and innovative delivery of assistance ensured that people at risk of food insecurity are supported during the lean season thereby cushioning them against decrease in quality dietary habits and minimizing exposure to negative coping mechanisms. The UN and humanitarian partners delivered Food, Agriculture and Nutritional support, Health, Protection and WASH services. By so doing CERF funds helped in reducing worsening malnutrition situation. Further WASH support contributed to a reduction in widespread outbreak of waterborne disease during a time of reduced water availability. With the increasing reports of protection incidences CERF funds allowed for enhanced availability and accessibility of a wide range of protection services for prevention and response.

Since the CERF response was delivered alongside other responses including government, CERF funds contributed to increased coordination and collaborations as partners worked to reduce duplication of efforts.

CERF's Added Value

CERF funds did contribute to all four of the ERC's priority areas. CERF funds initially led to a fast delivery of assistance to people in need and helped UN humanitarian agencies and partners to respond to time-critical humanitarian needs. With the support from CERF funds, agencies were able respond to the drought situation during the lean season, beginning in February, when drought-induced condition were at a peak. However, fast delivery and time-critical response were compromised due to the Covid-19 lockdown, especially on the procurement side. The disbursement of funds from the CERF secretariat funds was fast but implementation was affected by delays due to the Covid-19 pandemic. On the other hand, when the Covid-19 outbreak started in March 2020, the CERF secretariat allowed recipient agencies to extend at no cost and reprogram funds. This flexibility ensured a timely and effective response.

In addition, the CERF process strengthened the HCT and improved coordination among the humanitarian community. The Humanitarian Country Team (HCT) meetings provided a platform to discuss the CERF allocation for Zimbabwe. The CERF process strengthened coordination as development and operationalization of the CERF projects required the participation and input from multiple actors including UN agencies, NGOs and government departments. CERF funds supported coordination of the response at district, provincial and national levels, among government line ministries, and among cluster partners. Furthermore, CERF funding served as catalytic funding for additional resources for some clusters in the appeal, but not for others.

Did CERF funds lead to a fast delivery of assistance to beneficiaries?

Yes ☒ Partially ☐ No ☐

Assistance was delivered to people in need fast, as CERF funds cut down on time taken to mobilize resources. The delays experienced however were all due to the COVID-19 pandemic prevention measures and general economic slow-down.

Did CERF funds help respond to time critical needs[1]?

Yes ☒ Partially ☐ No ☐

People in need received assistance which helped through the lean season as well as WASH support in times of reduced water availability.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

With CERF funding clusters were able to attract twinning funding to support the response.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

The response was implemented alongside government response but also COVID-19 response. To avoid duplication partner coordinated with other partners, government to ensure efficient delivery of support. Collaboration was also evident within programmes i.e CERF response aspects were integrated into COVID-9 response to maximize reach e.g Nutrition response

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

Given the difficult operating environment – pandemic- having ready funds enabled easy delivery and innovation among the humanitarian community. The flexibility of the CERF funds allowed partners to innovate to deliver assistance in such a way discovering ways of reaching more people in need as manifested by the reach by Health, Nutrition and Protection.

Considerations of the ERC's Underfunded Priority Areas[2]:

All four chronically underfunded humanitarian priority areas (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection) were addressed through this allocation. Of these areas, support for women and girls required most urgent funding.

Mainstreaming gender is key to ensuring equal access to food among assisted households. WFP and partners carried out gender sensitizations with a view to increasing the participation of women at community and household level. Gender imbalances were addressed by ensuring equal participation and involvement of both men and women in decision-making of food assistance. This was achieved through continued gender awareness trainings and campaigns. Partners used pre-distribution briefings to transmit gender

[1] Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns, locust control, etc.).

[2] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

messages including topics on gender equality and gender-based violence. Before distribution of items partners used the briefing sessions to disseminate gender message dissemination. Strategies put in place to achieve gender equality led to some positive changes in gender equality and women empowerment indicators at household level. For instance, as of October 2020, the proportion of households reporting decision-making by women was 62 per cent, while the prevalence of households reporting joint decision-making was relatively high at 35.1 per cent. The percentage households reporting sole decision-making by men was the lowest at 2.9 per cent.

At the community level, women were included in distribution committees to ensure equal representation to ensure the needs of women are represented. Results from process monitoring showed that on average, women constituted 65.9 per cent of distribution committees. Trainings were also rolled out to equip distribution committees, enabling women to develop skills needed to effectively execute their duties. Women from affected populations were included in the help desk committee as ex-officio members to facilitate the handling and documentation of the concerns of women and girls. The agriculture project activities were specifically designed to benefit both men and women. However, Project results indicated that only 39 per cent of stock feed beneficiaries were female, which may be explained by the fact that livestock is largely owned by men in rural settings. However, women constitute 74 per cent of the beneficiaries of the vegetable input packs. This is in accordance with the rural context in Zimbabwe where women participate in gardening activities more than men.

Under the nutrition project, communities were sensitised to report GBV related incidents through the suggestion boxes, hotlines, community leaders and health centre committees. The nutrition response was designed to target the most vulnerable – who are women and girls. Activities were carried out during the day to ensure safety of the vulnerable. It is a requirement for all service providers to be trained in Protection against sexual exploitation and abuse (PSEA). Outreach services were introduced to bring services closer to the communities and reduce distances travelled which would expose the vulnerable to abuse. The outreach services also provided an additional platform for reporting and giving feedback.

As for health, the drought situation and Covid-19 outbreak tend to exacerbate gender inequality. To address these disparities, the WHO project gathered data and addressed the causes of women's and men's lack of access to health services through provision for Covid-19 testing and other health services. For the UNICEF project, the majority (90 per cent) of community health workers (CHWs) targeted were women. During recruitment of CHWs, efforts were made to ensure that information on the project was was shared widely and women were encouraged to apply. The project included a response to gender-based violence (GBV). This included training Village Health Workers on GBV and PSEA and linking of the referral pathway with the case management system. The UNFPA project's focus was on supporting emergency obstetric and neonatal care (EmONC) and sexual reproductive health (SRH) and therefore the main beneficiaries were pregnant women and young girls.

With regard to the WASH project, 17 staff of implementing partner (IPs)were trained on the prevention of GBV. IPs were further helped to develop and set up internal mechanisms for reporting and handling GBV. A total of Partners supported the Community Health Committees with a 'directory' of hotline numbers and a referral system. Also, the District Water Supply and Sanitation Sub-Committee DWSSC through the Rural district councils were supported with data bundles and hotline mobile numbers to assist the communities. The cases of GBV that were reported by the communities were referred to the department of Social Services at the local level as well as partners that deal with GBV like Msasa project, Regional Psychosocial Support Initiative (REPSSI) and Childline.

As for protection, the UNFPA project was predominantly a GBV risk mitigation and response project, and it ensured risk mitigation and access to essential life-saving GBV services through its three outcomes. UNFPA continuously engaged with all cluster partners and CERF implementing agencies to sensitize them on the roles and responsibilities of all actors on GBV risk mitigation, in line with the IASC guidelines. The project leveraged the co-location other CERF-funded projects to ensure practical and effective location of mobile One Stop Centres and safe spaces in hotspots and entry points identified by food security, WASH and shelter projects funded by the CERF allocation. The UNICEF Child Protection project deliberately targeted women and adolescents in the prevention of protection violations and GBV. Women and girls were empowered through targeted trainings and information dissemination. As part of the programme, UNICEF developed Information, Education and Communication (IEC) materials on PSEA and GBV and translated a globally developed pocket guide for community workers on identifying and referring GBV cases into local vernacular languages. The programme was involved in regional initiatives on safe spaces for women and girls, GBViE risk mitigation management information systems and the roll-out of a training for clusters on GBViE risk mitigation.

A number of projects under this funding delivered tailored activities e.g SRH targeting people with disabilities, where tailored activities did not exist partners instituted measures to enable people with disabilities access services by either delivering services close to the people and also increasing inclusivity by using disability friendly modes of delivery sign language and tools. GBV services specifically targeted caregivers of people with disabilities to increase access. Partners across the projects also involved organizations working with people with disabilities to increase reach.

The projects were implemented during a time when schools were closed but also with lockdown in place. No Education emergency activities were implemented as the Education cluster was not part of the CERF application but was implementing Education support in response to the COVID-19 pandemic.

The project ensured that tailored referral services were provided for people with disabilities (PWD). Children, adolescents and caregivers with disabilities in hardest hit districts received disability sensitive support including rehabilitation, provision of assistive devices and referral to specialist services. The child protection case management system integrated PWD as a priority group of vulnerable children who were identified, assessed and referred for the appropriated social services.

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	**800,770,933**
CERF	14,894,023
Country-Based Pooled Fund (if applicable)	0
Other (bilateral/multilateral)	191,868,939
Total funding received for the humanitarian response (by source above)	**206,762,962**

Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

Agency	Project Code	Sector/Cluster	Amount
FAO	20-RR-FAO-006	Food Security - Agriculture (incl. livestock, fisheries and other agriculture-based livelihoods)	1,000,005
UNFPA	20-RR-FPA-006	Protection - Sexual and/or Gender-Based Violence	803,030
UNFPA	20-RR-FPA-007	Health - Health	649,725
UNICEF	20-RR-CEF-007	Protection - Child Protection	800,004
UNICEF	20-RR-CEF-008	Health - Health	700,381
UNICEF	20-RR-CEF-009	Nutrition - Nutrition	1,751,850
UNICEF	20-RR-CEF-010	Water Sanitation Hygiene - Water, Sanitation and Hygiene	1,799,699
WFP	20-RR-WFP-006	Food Security - Food Assistance	6,790,003
WHO	20-RR-WHO-007	Health - Health	599,326
Total			**14,894,023**

Table 3: Breakdown of CERF Funds by Type of Implementation Modality (US$)

Total funds implemented directly by UN agencies including procurement of relief goods	**10,180,526**
Funds sub-granted to government partners*	1,429,673
Funds sub-granted to international NGO partners*	1,324,289
Funds sub-granted to national NGO partners*	1,959,533
Funds sub-granted to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**4,713,495**
Total	**14,894,023**

* Figures reported in table 3 are based on the project reports (part II, sections 1) and should be consistent with the sub-grants overview in the annex.

2. OPERATIONAL PRIORITIZATION:

Overview of the Humanitarian Situation:

In mid-March 2019, Zimbabwe was hit by Cyclone Idai. By August the situation had deteriorated because of the failure of the 2019 maize crop. From early 2019, the UN and humanitarian partners were supporting the Government to respond to a complex set of humanitarian challenges in Zimbabwe. However, by August 2019 the situation had deteriorated significantly as the impact of drought and crop failure was compounded by macro-economic challenges, including hyper- inflation and austerity measures. As a result, 6.7 million Zimbabweans were in need of humanitarian assistance both in rural districts and urban centres. The food security sector identified 4.1 million people in rural areas as severely food insecure at the peak of the lean season (January-April 2020). Of this population, the Integrated Food Security Phase Classification (IPC) analysis identified to 1.1 million people in emergency (IPC phase 4) and 2.9 million people in crisis (IPC phase 3). Health, education, water, sanitation and hygiene services, and availability of essential drugs were significantly reduced. Doctors frequently went on strike as their monthly salary had been reduced due to the hyper-inflation. Availability of safe water sources was significantly reduced, which increased the risk of outbreaks of waterborne disease. Reports indicated school dropout was becoming a serious concern because families were increasingly unable to afford school fees as well as challenges in providing school-feeding. In January 2020, the humanitarian country team finalized the Humanitarian Response Plan, which covered 2020, recognizing of the severity of humanitarian needs in the country. An estimated 6.7 million people were considered to be in need of humanitarian assistance, while 5.6 million people were being targeted by humanitarian partners in 2020. The humanitarian situation in Zimbabwe was further compounded by the Covid-19 pandemic beginning in March 2020. On 11 March 2020, the WHO elevated Covid-19 outbreak first reported in Wuhan China to a pandemic. Whilst developments were taking place at an international level, the Government of Zimbabwe simultaneously reacted. On 17 March, before cases were reported, the President of Zimbabwe declared Covid-19 a national disaster and on 23 March the borders were closed to all non-essential travel and gatherings were restricted to <50 people. A 21-day national lockdown commenced on 30 March 2020 (at the time of reporting a curfew and restrictions on gatherings remain in place. Furthermore, 10034 cases and 277 deaths have been reported (Source: Ministry of Health and Child Care [MoHCC] SITREP, 30/11/2020).

In light of the outbreak,, the United Nations and humanitarian partners revised the HRP in July to reflect the response to the Covid-19 pandemic by integrating a multisectoral migrant response and reprioritizing the various humanitarian cluster responses in order to reflect the immediate public health crisis and the secondary impacts of the pandemic on vulnerable people.

Operational Use of the CERF Allocation and Results:

In response to the humanitarian impact of the drought and economic crisis, this $15 million CERF Rapid Response allocation supported emergency assistance. The funding will enabled UN agencies and NGOs to support the Government's response in providing immediate life-saving assistance to 926,079 people (including 23,948 people with disabilities). The UN and NGOs have prioritized the most time-critical life-saving activities in the health, water, sanitation and hygiene, nutrition, protection (gender-based violence and child protection) and food security (food and livelihoods assistance) sectors across the affected areas.

This funding enabled UN agencies and partners to respond to life-saving food security and nutrition needs through in-kind food assistance to 328,026 beneficiaries, distribution of commodities of 4,920.40 metric tons ; provision of 10,000 smallholder farming households with vegetable seeds and fertiliser input packs benefitting approximately 50,000 people, reaching also 10,912 smallholder farming households with extension and training on garden production, harvesting and post-harvest management practices, and distribution of 800 metric tonsof survival stock feed to 3,200 households benefitting more than 6,400 head of cattle that were at risk of succumbing to drought related death. Nutrition support was provided through active screening of 461,857 children under the age of five years for early identification and referral for treatment of acute malnutrition, training of 1,038 health workers on infant and young child feeding in emergencies (IYCF-e), integrated management of malnutrition (IMAM), active screening resulting in the treatment of 16,127 children with severe acute malnutrition, provision

to 519,701 children aged 6 to 59 months with vitamin A supplements, and support with IYCF-e messages to 652,623 mothers and caregivers of children less than 2 years. length

Urgent health needs were addressed through the capacity building of 40 laboratories to detect Covid-19 resulting in 100,572 people tested between July and October 2020, training of 92 rapid response team (460 people) across the 10 provinces resulting in 7,320 Covid-19 investigations, and training of 546 health workers on surveillance, infection prevention and control and Covid-19 case management. In addition, 95,267 people were supported through the distribution of essential medicines and commodities for 120 health care facilities, with training of 290 community health workers on integrated community case management, malaria case management, screening for malnutrition, Vitamin A supplementation, basic community maternal, newborn and child health (MNCH) services and home care for women and children, home visit procedures, community-based surveillance. Finally, access to emergency obstetric and neonatal care and sexual reproductive health care was improved through the procurement of 485 reproductive health kits for 124 health facilities, supporting 14,221 deliveries and 768 caesarean sections, with 37,293 benefited directly from deliveries and information sharing.

The WASH response addressed the lifesaving needs the repair of 468 boreholes reaching a total of 143,118 people with safe water, key health and hygiene messages to 165,713 people on critical handwashing, safe water collection, transportation and storage, household water treatment and Covid-19 awareness and prevention among other issues; distribution of WASH hygiene kits to 10,000 families, and 1,000 hygiene sessions by 481 trained village health workers utilising mobile trucks, establishing 154 community health clubs and 42 handwashing stations.

Urgent protection needs were met through the provision of GBV essential services through mobile One Stop Centres (OSCs) to 15,996 individuals; GBV community-based sensitization and surveillance, including information on GBV Referral pathways to 164,033 individuals; assistance of 12,352 women and girls with psychosocial support through Safe spaces; distribution of 4,000 dignity kits; access to psychosocial support (PSS), post-rape care, and emergency protection support through remote, online and face-to-face case management services and mobile clinics to 57,596 people; Information on CPiE and GBV services, psychosocial support and referral for specialised protection services to 5,771 adolescents at risk of sexual violence including pregnant adolescents and young mothers at risk of child marriage and sexual violence; access to appropriate care and child protection services for 630 unaccompanied and separated children; disability sensitive support including rehabilitation, provision of assistive devices and referral to specialist protection services to 7, 868 children and adolescents with disabilities and their caregivers; legal assistance to 2,678 children in contact/conflict with the law.

People Directly Reached:

Through this CERF RR grant, a total of 926,079 people were reached and assisted in comparison with a total number of 635,197 people planned. This significant increase can be explained by the increased total reached number of people by the Nutrition cluster. Disaggregated by gender and age, this total number of people reached includes 382,970 women, 240,166 girls, 221,691 boys, and 81,252 men. As for displacement status, all people reached under this CERF grant were affected persons, other than internally displaced persons (IDPs), refugees and host communities. The cluster partners used initiative means by decentralizing service delivery to community level thereby increasing access to services

The total number of people planned (256,760) vs reached (844,827) for the Nutrition/Nutrition sector constitutes a very significant increase due to the overachievement of MIYCFe and health worker training following the integration with Covid-19 responses where it was a requirement for all health facility staff to be trained. Change in modalities for capacity building to on the job training due to Covid-19 resulted in improved reach of participants.For the Health/Health sector there was also a significant increase between the planned number of 153,259 and the total number of 239,487 people reached. The difference is due to the planned number of people receiving treatment for diarrhoea, SAM and other nutrition deficiency conditions (9,600) versus 138,910 people receiving treatment for diarrhoea, 8,587 children with malnutrition, 13,268 pregnant women, 3,545 children with marasmus, 5,635 children with kwashiorkor, 1,896 people with pellagra, 32,931 people with nutrition deficiencies reaching a total of 171,841 people. The WASH/WASH sector reached a total of

143,118 people, a significant increase from the 100,000 people planned as the targeted water points (boreholes and piped water schemes) served more people than those estimated using the SPHERE standards.

The Protection/GBV sector also saw an almost doubling from 89,390 people planned to a total number of 164,033 reached. With community cadres' movements facilitated during the Covid-19 lockdown, the enhanced dissemination of information throughout all the wards in each target district had a total reach of 164,033 against the original target of 76,937. Use of mobile services and decentralizaed service delivery increased outreach In addition, given the constraints emanating from the humanitarian situation, GBV service provision through mobile OSCs proved to be the most effective and accessible service delivery modality during the implementation period. The further de-centralization of service delivery through outreach, reinforced with provision of additional PPE and the engagement of additional counselling staff contributed to the overachievement. Due to the evolving Covid-19 context, and the need for enhanced availability of PSS and GBV risk mitigation services in remote and hard to reach areas, de-centralization of safe spaces resulted in the reach of 12,352 vulnerable women and girls against a target of 6,480. For the Protection/Child Protection sector the total number increased as well from 60,000 people planned to 64,630 people reached as innovative remote methods were adopted for provision of psychosocial support such as tele-counselling, but also increased use of community-based cadres such as childcare workers (CWCs).

People Indirectly Reached:

For food security, four WFP Cooperating Partners (CPs) reached a total of 94,121 indirect beneficiaries with complementary activities. CPs conducted Covid-19 awareness trainings and adhered to guidelines during the distributions to LSA beneficiaries including other community members. Protection training that included Prevention of Sexual Exploitation and Abuse plus Gender to CPs has benefitted both LSA and other community members by increasing the CPs abilities to implement protection conscious interventions. The agriculture project reached 10,912 farmers with extension and training on garden production, harvesting and post-harvest management practices surpassing the project target of 10,000 farmers. An additional 640 farmers who did not receive any stock feed from the project were trained on improved livestock management and fodder production surpassing the project target of 3,200 farmers. For nutrition, the 461,857 caregivers of the under five children screened were also reached with nutrition messaging as well as capacitated for mother-led-MUAC activities.

For the health sector, it is estimated that 1 million people were also reached through risk communication and community engagement initiatives using sms exchange and WhatsApp platforms. In addition, a total of 48,123 Zimbabweans benefited from improved health service delivery capacity owing to refresher training of CHWs on community management of diarrheal diseases, an additional 66,687 community members in 9 districts are benefitting from improved access to treatment for drought induced conditions (HCFs in the targeted districts are not reporting stockouts). A total of 111,717 people were indirectly targeted through services provision to pregnant women and through information sharing. Under the WASH sector, the number of people reached with health and hygiene education is expected to continue beyond the lifespan of the project due to continuous dissemination of critical messages by the trained 481 village health works as well as the established 150 community health clubs as well as IEC materials placed in public places, schools and health care facilities.

On the protection side, a total of 524,905 people were indirectly reached with the project interventions, including through information sharing on GBV referral pathways and the mid-term outcomes of the livelihood component integrated into safe spaces for women and girls. Child Protection actors and other sectors also benefited from capacity building via both online PSEA and GBV risk mitigation trainings, through which 120 partner staff and 70 partner staff were reached respectively. Other indirect beneficiaries included service providers in the case management system; disability services providers such as rehabilitation units; community cadres such as Community Childcare Workers (CCWs); and Child Protection Committees (CPCs). Caregivers of children who received services were also reached out with messages using virtual contacts. In total indirect beneficiaries are estimated to be 15,000 people reached indirectly.

Table 4: Number of People Directly Assisted with CERF Funding by Sector/Cluster*[3]

	Planned					Reached				
Sector/Cluster	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Food Security - Agriculture (incl. livestock, fisheries and other agriculture-based livelihoods)	12,939	12,032	13,189	11,840	**50,000**	12,939	12,032	13,189	11,840	**50,000**
Food Security - Food Assistance	90,451	77,852	77,529	77,206	**323,038**	96,899	81,252	73,379	76,496	**328,026**
Health	44,193	36,355	36,356	36,355	**153,259**	59,871	59,871	59,872	59,872	**239,486**
Nutrition	67,599	0	97,829	91,332	**256,760**	382,970	0	240,166	221,691	**844,827**
Protection - Child Protection	10,000	10,000	20,000	20,000	**60,000**	4,922	2,112	33,366	24,230	**64,630**
Protection - Sexual and/or Gender-Based Violence	41,563	16,510	21,010	10,307	**89,390**	75,227	47,180	22,780	18,846	**164,033**
Water Sanitation Hygiene	30,680	28,320	21,320	19,680	**100,000**	43,909	40,531	30,513	28,166	**143,119**

[3] The Country Team has confirmed that these figures represent direct beneficaries.

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

Table 5: Total Number of People Directly Assisted with CERF Funding by Category*

Category	Planned	Reached
Refugees	0	0
Returnees	0	0
Internally displaced people	0	0
Host communities	0	0
Other affected people	635,197	926,079
Total	**635,197**	**926,079**

Table 6: Total Number of People Directly Assisted with CERF Funding*			**Number of people with disabilities (PwD) out of the total**	
Sex & Age	**Planned**	**Reached**	**Planned**	**Reached**
Women	174,360	382,970	3,636	5,987
Men	107,018	81,252	3,636	5,987
Girls	179,256	240,166	3,636	5,987
Boys	174,563	221,691	3,636	5,987
Total	**635,197**	**926,079**	**14,544**	**23,948**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 20-RR-FAO-006

1. Project Information

Agency:	FAO	**Country:**	Zimbabwe
Sector/cluster:	Food Security - Agriculture (incl. livestock, fisheries and other agriculture-based livelihoods)	**CERF project code:**	20-RR-FAO-006
Project title:	Emergency Response to drought-affected farmers in Zimbabwe		
Start date:	19/02/2020	**End date:**	18/08/2020 (2/12/2020)
Project revisions:	No-cost extension ☒	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 50,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 13,200,000**
Amount received from CERF:	**US$ 1,000,005**
Total CERF funds sub-granted to implementing partners:	**US$ 98,865**
Government Partners	US$ 0
International NGOs	US$ 44,905
National NGOs	US$ 53,960
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF Rapid Response grant, from 19 February through 2 December 2020, FAO and its partners provided 10,000 smallholder farming households, comprising 50,000 people, with vegetable seeds and fertiliser input packs composed of tomato, onion, leafy vegetables and biofortified sugar bean seeds and top dressing and basal fertiliser. In addition, the project reached 10,912 smallholder farming households with extension and training on garden production, harvesting and post-harvest management practices, surpassing the project target of 10,000 farmers. The project procured and distributed 800 metric tons of survival stock feed to 3,200 households benefitting more than 6,400 head of cattle that were at risk of succumbing to drought related death. Using a combination of training approaches that included training of trainers for lead farmers and onsite demonstrations, 3,840 farmers were trained on improved livestock management and fodder production surpassing the project target of 3,200 farmers. FAO further procured 10,000 watering cans; however, these had not yet been distributed to farmers at the time of writing as a result of delays in procurement caused by Covid-19. FAO has put in place arrangements with the local district authorities for delivery of the watering cans once they are delivered by the supplier.

3. Changes and Amendments

Zimbabwe declared a national disaster as a result of the Covid-19 pandemic in March 2020 and several containment measures were introduced, including a national lockdown. Ports of entry were closed except for formal imports of essential goods such as food and medical supplies. Stringent internal movement restrictions were put in place and had a wide impact, with exceptions made only for essential services such as the food, health, and security sectors. These restrictions impacted the implementation of CERF project activities, resulting in delays that affected ongoing tenders, as well as the issuance of new tenders for the procurement of project inputs – namely stock feed, watering cans, seeds and fertilisers. Teleworking arrangements resulted in delays in the execution and approval of various due diligence procedures and processes. This subsequently delayed the contracting of implementing partners. FAO submitted a no cost extension for three months which was approved by the CERF secretariat and the project end date was amended to 18 November 2020. The procurement of watering cans was particularly challenging in light of the restrictions put in place due to the CovidCovid-19 pandemic. Evaluating tenders and seeking clarifications from suppliers took longer than usual as most suppliers were not operating at full capacity. FAO requested a further extension of the project by two weeks to finalize the procurement of the watering cans. At the time of writing, watering cans had still not been delivered. FAO has liaised with the district authorities and put in place measures to ensure delivery of the watering cans to the beneficiaries.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Food Security - Agriculture (incl. livestock, fisheries and other agriculture-based livelihoods)									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	12,939	12,032	13,189	11,840	**50,000**	12,939	12,032	13,189	11,840	**50,000**
Total	**12,939**	**12,032**	**13,189**	**11,840**	**50,000**	**12,939**	**12,032**	**13,189**	**11,840**	**50,000**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	0	0	0	0	**0**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

The project reached 10,912 farmers with extension and training on garden production, harvesting and post-harvest management practices surpassing the project target of 10,000 farmers. The additional 912 farmers comprised of 74 per cent women and 26 per centr men. An additional 640 farmers who did not receive any stock feed from the project were trained on improved livestock management and fodder production. As a result, the project surpassed its target of reaching 3,200 farmers.

6. CERF Results Framework

Project objective	Improve food and nutrition security for 10,000 drought-affected, food insecure smallholder farming households (50,000 people)
Output 1	10,000 drought-affected farming households have access to fast growing nutritious vegetables

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Food Security - Agriculture (incl. livestock, fisheries and other agriculture-based livelihoods)			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of households receiving vegetable packs	10,000	10,000	Beneficiary lists; Implementing partner reports
Indicator 1.2	Number of households growing vegetables	10,000	10,000	Implementing partner reports
Explanation of output and indicators variance:		No variance		

Activities	**Description**	**Implemented by**
Activity 1.1	Select and contract implementing partners	FAO
Activity 1.2	Procure vegetable seed packs	FAO
Activity 1.3	Distribute vegetable see packs	Sustainable Agriculture Technology and World Vision Zimbabwe
Activity 1.4	Conduct refresher trainings for extension staff	Sustainable Agriculture Technology and World Vision Zimbabwe
Activity 1.5	Monitor garden interventions and utilization of vegetable seed packs	Sustainable Agriculture Technology and World Vision Zimbabwe
Activity 1.6	Post distribution assessment	Sustainable Agriculture Technology and World Vision Zimbabwe

Output 2	3,200 households receive supplementary stock feed to save cattle from drought related deaths

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Food Security - Agriculture (incl. livestock, fisheries and other agriculture based livelihoods)			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Quantity of stock feed made available to farmers	800 metric tons	800 metric tons	FAO procurement records

Indicator 2.2	Number of households accessing stock feed	3,200	3, 200	Beneficiary lists
Explanation of output and indicators variance:		No variance		

Activities	**Description**	**Implemented by**
Activity 2.1	Procurement of stock feed	FAO
Activity 2.2	Registration of beneficiaries to receive stock feed	Sustainable Agriculture Technology
Activity 2.3	Distribution of stock feed to farmers	Sustainable Agriculture Technology
Activity 2.4	Refresher training on stock feed utilization	Sustainable Agriculture Technology
Activity 2.5	Monitor utilization of stock feed	Sustainable Agriculture Technology
Activity 2.6	Post distribution assessment	Sustainable Agriculture Technology

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[4] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [5]:

Results of national assessments (Second Round Crop assessment, ZimVAC Rural Livelihoods Assessment conducted in the drought-affected areas highlighted the need for stock feed and access to diverse nutritious crops as key requirements to help communities and households mitigate against the impact of drought. These recommendations were taken into account during the design of the project. Project sensitization meetings were conducted by the implementing partners and held in all four project districts. These meetings enabled the field team to engage with local leadership and beneficiaries and to verify the selection of targeted wards and villages. Following the sensitization meetings, inception meetings were held in each district to bring together key stakeholders from the Rural District Development Committee (RDDC) to deliberate implementation strategies and to share lessons learnt, challenges and successes from previous seasons. In these meetings, participants deliberated and finalized timelines and activities to be included in the project.

b. AAP Feedback and Complaint Mechanisms:

FAO implementing partners Sustainable Agriculture Technology and World Vision used a combination of approaches to ensure an effective Grievance Handling Procedure and Beneficiary Feedback Mechanism were in place. The mechanism used a combination of a Help Desk and Suggestion Box. During ward-level awareness meetings, communities were encouraged to make use of the iHelp Desk and suggestion box to air grievances and provide feedback on the project. In most areas, farmers preferred the use of the Help Desk over the suggestion boxes. All grievances and feedback on the project were recorded freely and anonymously, without fear of reprisal The feedback received helped identify areas of concern in the overall assistance and helped improve the response.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

[4] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[5] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

During meetings and training session with beneficiaries, project staff raised awareness on the prevention of sexual exploitation and abuse.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The project activities were specifically designed to benefit both men and women. The project results show that only 39 per cent of stock feed beneficiaries were female, which was due to the fact that livestock is largely owned by men in rural settings. However, women constituted 74 per cent of the beneficiaries of the vegetable input packs, which was in accordance with the rural context in Zimbabwe where women participate in gardening activities more than men.

e. People with disabilities (PwD):

The project did not have a specific output that addressed the specific need of people with disabilities. However, the participation of people with disabilities was ensured through the household targeting approach used in the project. The provision of vegetable seeds and stock feed was targeted at the household level, rather than to individuals, which ensured project benefits accrued to disabledindividuals who were part of beneficiary households.

f. Protection:

The project used a participatory and community-based approach to target project beneficiaries. This minimized the risk of social conflict as a result of inclusion and exclusion errors. Project activities were carried out during appropriate hours, taking into account local norms and the different roles and responsibilities of men and women.

g. Education:

The provision of training, extension and advisory services to smallholder farmers – carried out to ensure to proper utilization and handling of the project inputs – was an important aspect of the project design. Beneficiaries of the vegetable input packs distribution also received training on good agricultural practices, including vegetable production, harvesting and post-harvest management. Recipients of supplementary stock feed also received training on good animal husbandry and supplementary feeding regimes.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	[Fill in]

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Cash and voucher assistance was not considered due to the prevailing challenging environment, whch was characterised by cash shortages, hyperinflation and shortages of basic commodities. Under these conditions, yhe use of cash- and voucher-based assistance was assessed to be inappropriate.

9. Visibility of CERF-funded Activities

Title	Weblink
N/A	N/A

3.2 Project Report 20-RR-FPA-006

1. Project Information

Agency:	UNFPA	**Country:**	Zimbabwe
Sector/cluster:	Protection - Sexual and/or Gender-Based Violence	**CERF project code:**	20-RR-FPA-006
Project title:	Ensuring access to life-saving, survivor-centred GBV services for most vulnerable women and girls in remote and hard to reach drought-affected areas.		
Start date:	18/02/2020	**End date:**	17/08/2020 (17/11/2020)
Project revisions:	No-cost extension ☒	Redeployment of funds ☒	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 4,260,265**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 803,030**
Total CERF funds sub-granted to implementing partners:	**US$ 581,081**
Government Partners	US$ 0
International NGOs	US$ 106,053
National NGOs	US$ 475,028
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF RR grant, from 18 February 2020 to 17 November 2020, UNFPA and its partners provided GBV Essential services through mobile One Stop Centres (OSCs) to 15,996 individuals (13,506 females, 2,490 male). UNFPA and partners furtherreached 164,033 individuals (66,026 Male, 98,007 female) through GBV community-based sensitization and surveillance, including information on GBV referral pathways, assisted 12,352 women and girls with psychosocial support through Safe spaces and procured and distributed 4,000 dignity kits.

Between February and November 2020, the project assisted a total of 164,033 people in the nine targeted drought-affected districts (Binga, Gokwe North, Chivi, Mwenedzi, Mbire, Buhera, Kariba, Mudzi, UMP), and contributed to GBV risk mitigation andprevention and response in line with the GBV minimum standards and the IASC GBViE integration guidelines.

3. Changes and Amendments

The programme overall reached a total of 164,033 people across the planned activities, representing 183% achievement against the 89,390 targeted beneficiaries.

On March 30th, one month and a half into the implementation of the CERF project, Zimbabwe went into a National Covid19 lockdown. Despite the recognition of GBV services among essential services, which allowed mobility of GBV service providers within the project, implementation capacity was reduced due to the limited availability of PPE and infection prevention and control supplies to cater for both GBV essential service staff and survivors. International and regional Supply chains were also affected by overwhelming demand of both

Project related supplies i.e. dignity kits, and Covid19 infection prevention and control supplies, generating further delays of implementation.

In view of the Covid19 related national lockdown and the consequent reduction of implementation capacity, UNFPA applied for a no-cost extension and reprogramming of funds, in order to cater for the evolving needs, including the procurement of the protective equipment necessary for continuation of essential services at mobile OSCs and safe spaces. The no-cost extension was approved for a three months'' period, with revised project end on 17 November.

The extended duration of the project, summed up with a revised implementation modality, in view of the reduced mobility of survivors during the lockdown, contributed to further expand accessibility of services, through a de-centralization mechanism, which included setting up an increased number of safe spaces and mobile OSCs outreach sessions, in the attempt to reach those in remote and hard to reach areas, as they were further constrained by the unavailability of public transport during Covid19 lockdown.

These factors contributed to over-achievements across the three outcomes of the project.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Protection - Sexual and/or Gender-Based Violence									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	41,563	16,510	21,010	10,307	**89,390**	75,227	47,180	22,780	18,846	**164,033**
Total	**41,563**	**16,510**	**21,010**	**10,307**	**89,390**	**75,227**	**47,180**	**22,780**	**18,846**	**164,033**
People with disabilities (PwD) out of the total										
	145	60	65	30	**300**	1,034	442	405	327	**2,208**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

A total 524,905[6] were indirectly reached with the project interventions, including through information sharing on GBV referral pathways and the mid-term outcomes of the livelihood component integrated into safe spaces for women and girls.

6. CERF Results Framework

Project objective	To ensure GBV survivors' access to life-saving services in hard to reach areas of nine drought-affected districts in Zimbabwe
Output 1	Increased access to life-saving multi-sectoral GBV services

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Protection - Sexual and/or Gender-Based Violence			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of mobile OSCs outreach sessions conducted	9	341	IP OSC Program Reports
Indicator 1.2	Number of GBV survivors accessing services at mobile OSCs	1,800	15,996	IP OSC Program Reports

Explanation of output and indicators variance:

All nine target districts were reached with mobile OSCs outreach sessions.

Due to the evolving Covid-19 context, and the need for enhanced availability of mobile services, the Mobile OSCs teams further de-centralized the response through an increased number of outreach sessions in each of the target districts (Buhera 44, Mbire 32, Mudzi 38, UMP 56, Kariba 56, Chivi 40, Mwenezi 34, Binga 24, Gokwe 17), resulting in a total of 341 outreach sessions.

Due to the Covid-19 lockdown, mobility restrictions, and related unavailability of public transport, static GBV services were highly de-prioritized in Zimbabwe during the project implementation. As a result, an increased demand for mobile services was recorded. Furthermore, exposure to GBV, including Intimate partner violence, was recorded to an increase of over 60 per cent during the lockdown[7].

Given the constraints emanating from the humanitarian situation, GBV service provision through Mobile OSCs proved to be the most effective and accessible service delivery modality during the implementation period.

The further de-centralization of service delivery through outreach, reinforced with provision of additional PPE and the engagement of additional counselling staff contributed to the overachievement.

Activities	**Description**	**Implemented by**
Activity 1.1	Conduct mobile roving One Stop Centres outreach for GBV survivors	Musasa

[6] Applied 3.2 multiplier, average household size in Zimbabwe
[7] Data from National GBV hotline, Zimbabwe

Activity 1.2	Provide Clinical management of rape and counselling to GBV survivors at mobile OSCs	Musasa

Output 2	Improved availability of GBV risk mitigation measures

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Protection - Sexual and/or Gender-Based Violence

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of safe spaces established	9	75	IP Programme Reports
Indicator 2.2	Number of women and girls accessing PSS and other GBV risk mitigation services at safe spaces	6,480	12,352	IP Programme Reports
Indicator 2.3	Number of dignity kits procured	4,000	4,000	Programme Reports
Indicator 2.4	Number of dignity kits distributed	4,000	4,000	Programme Reports

Explanation of output and indicators variance:	Safe Spaces for Women and girls were established in all 9 target districts. Due to the evolving Covid-19 context, and the need for enhanced availability of PSS services in remote and hard to reach areas, the implementing partners managing Safe spaces de-centralized the response through the establishment of an increased number of spaces, with an average 8 spaces set up in each of the target districts, establishing of 75 safe spaces against a target of nine. Due to the de-centralization, the project reached 12,352 vulnerable women and girls against a target of 6,480, with PSS and GBV risk mitigation services through safe spaces. As noted elsewhere in the report, the higher reach is due to de-centralization – the set up of a higher number of safe spaces allowed reaching more beneficiaries than the original target. This was also possible within the COVID19 context, where, despite mobility constraints, availability of safe spaces closer to the people allowed continuity of service uptake. Community cadres in the nine target districts carried out mobilization and demand creation activities that further contributed to the increased number of vulnerable women and girls who were made aware of the Safe spaces and seeking services. 4,000 dignity kits were procured and distributed to identified vulnerable women and girls in the nine districts through community-based outreach and safe spaces, as per project target.

Activities	**Description**	**Implemented by**
Activity 2.1	Establish safe spaces for women and girls	FACT, ZAPSO, World Vision, Zichire
Activity 2.2	Provide Psychosocial Support (PSS) and GBV risk mitigation support at safe spaces	FACT, ZAPSO, World Vision, Zichire
Activity 2.3	Procure dignity kits	UNFPA
Activity 2.4	Distribute Dignity kits	UNFPA, Musasa, FACT, ZAPSO, World Vision, Zichire

Output 3	Increased GBV surveillance and referrals to life-saving services

Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☐
Sector/cluster	Protection - Sexual and/or Gender-Based Violence			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of community cadres sensitized on GBV surveillance and referrals to life-saving services	225	227	IP Programme Reports
Indicator 3.2	Number of women, girls, men and boys reached with information on GBV referral pathways	76,937	164,033	IP Programme Reports
Explanation of output and indicators variance:		The programme trained a total of 227 community cadres – against a target of 225 – to manage potential attrition. Community surveillance and sensitization on the referral pathways continued during the Covid-19 lockdown, thanks to the classification of community-based IPs as essential services. The integration of GBV information within the Covid-19 broader infection prevention and control sensitization was streamlined, and the IPs worked closely with other cluster partners to target beneficiaries at gatherings, including food distribution and community water points, where most Covid-19 sensitizations also took place. With complementarity from other programmes, community cadres' movements were facilitated during the Covid-19 lockdown. They were also provided with additional data and airtime packages to facilitate communication. This enhanced dissemination of information throughout all the wards in each target district, with a total reach of 164,033 against the original target of 76,937.[8]		

Activities	**Description**	**Implemented by**
Activity 3.1	Sensitize Community cadres on GBV surveillance and referral pathway life-saving services	FACT, ZAPSO, World Vision, Zichire
Activity 3.2	Conduct community-based outreach, GBV surveillance and referrals to GBV life-saving services	FACT, ZAPSO, World Vision, Zichire

[8] The Country Team has confirmed that all reached beneficiaries are direct.

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[9] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP)[10]:

The project was designed based on close consultations with affected populations, and in particular most vulnerable women and girls in the nine target districts. Consultations were conducted during needs assessment, through key informants' interviews, e.g. affected women and girls at hotspots, and targeted focus group discussions. Multi-sectoral service providers, such as health personnel, school staff, local and religious chiefs, community volunteers, were engaged to ensure utilization of locally accepted mechanisms for the dissemination of life-saving information and service provision.

The implementation of the programme was guided by ongoingexchanges with the recipient community. In order to understand and respond to the evolving needs of the beneficiaries, targeted focus group discussions were conducted on an ongoing basis at safe spaces and during community outreach sessions. This feedback of these discussions was utilized to adjust delivery modalities. Examples of programme adaptation include customization of NFIs kits (e.g. dignity kits) to better fit the needs of both women and men andto respond to increased GBV risks in the changing Covid19 context,and de-centralization of mobile OSCs and safe spaces locations in order to reach those in remote and hard to reach areas during the lockdown. Engagement of affected communities was critical to ensure that the survivor-centred approach and the do no harm principles were respected throughout the implementation period.

UNFPA provided all implementing partners with a weekly monitoring tool, which included a narrative section to record implementation challenges, evolving needs and concerns of the recipient community. While the Covid19 lockdown and movement restrictions prevented UNFPA to directly monitor interventions on the ground, IPs were engaged in cross-monitoring of all interventions, with the aim to verify the status of inter-sectoral response and possible impact on GBV risks.

b. AAP Feedback and Complaint Mechanisms:

In addition to presenting a GBV complaints' mechanisms for the targeted population, the community-based GBV surveillance system led by the behaviour change facilitators also worked as a consistent monitoring tool to identify critical concerns and address them timely. The BCFs integrate GBV surveillance through safety audits, participant observation and engagement with local communities and chiefs, and report incidences related to the project interventions' delivery and service uptake on a regular basis. The information is collated through a database at district level. Behaviour change facilitators are trained in all the aspects of the survivor –centred approach, including confidentiality, privacy and safety, and the informed consent principles.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

UNFPA has a formal internal mechanism for SEA reporting. As per UNFPA's procedures, all implementing partners are required to sign a code of conduct which includes the adherence to PSEA principles. All service providers and humanitarian aid actors engaged in this project were sensitized on the utilization of the reporting mechanisms to ensure service provision as well as enactment of disciplinary

[9] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[10] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

measures for UN staff according to internal procedures. All IPs were also sensitized on the PSEA core principles and obligations and have undergone a mandatory training on PSEA through the UNFPA learning portal.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

This project is predominantly a GBV risk mitigation and response project, and it ensured risk mitigation and access to essential life-saving GBV services through its three outcomes. Through its IPs, UNFPA continuously engaged with all cluster partners and CERF implementing agencies to sensitize them on the roles and responsibilities of all actors on GBV risk mitigation, in line with the IASC guidelines. The project leveraged on the co-location of the CERF interventions under various agencies to ensure practical and effective location of mobile OSCs and safe spaces in hotspots and entry points identified within food security, WASH and shelter projects within the same CERF response.

e. People with disabilities (PwD):

Women and girls with disabilities and disability organizations were critical actors for the definition of specific project components and location sites, in the spirit of leaving no one behind. Close interaction with disable people's organizations was a critical way to ensure enhancement of referrals to GBV services for PwDs, including in remote and hard to reach areas. Service providers and community cadres were also equipped with basic sign language skills and tools to ensure inclusiveness, while particular attention paid to providing support for caretakers, such as transport to and from GBV services and psychosocial support.

f. Protection:

Project interventions were designed with a great emphasis on ensuring protection from harm and reducing the risks of unintended consequences of all planned interventions. Lessons learned from previous programming were applied to ensure set up of risk mitigation and response mechanisms was conducted in close consultation with the most vulnerable and at risk groups – including women and girls, adolescents, people with disabilities and those in remote and hard to reach areas – in order to ensure their full participation in the definition of specific interventions, ensure safe access to services and adequate availability of non-discriminatory community-based complaints mechanisms. Linkages with other actors was strengthened during the design and implementation phase to ensure inclusion of protection risk mitigation and integration of protection measures, such as distribution of NFIs and protection service delivery within other sectors projects sites, such as food distribution points, water points, shelter sites.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	[Fill in]

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

CVA was not part of this project as this was not considered the most effective form of assistance in the highly volatile local currency environment and foreign currency crisis. In addition,the use of cash was perceived as potential trigger for unintended consequences including exacerbated risks of GBV and SEA exposure for the project's beneficiaries.

9. Visibility of CERF-funded Activities

Title	Weblink
Dignity kids can change lives: responding to women and girls needs during COVD-19	https://zimbabwe.unfpa.org/en/news/dignity-kits-can-change-lives-responding-needs-women-and-girls-during-Covid-19-pandemic
UNFPA Zimbabwe Annual Report	https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/unfpa_zimbabwe_2019_annual_report_final.pdf
Responding To GBV during Covid-19	https://twitter.com/UNFPA_Zimbabwe/status/1300135047073234945

3.3 Project Report 20-RR-FPA-007

1. Project Information

Agency:	UNFPA	**Country:**	Zimbabwe
Sector/cluster:	Health	**CERF project code:**	20-RR-FPA-007
Project title:	Strengthening Emergency Health Response in Nine Priority Drought-affected Districts		
Start date:	19/02/2020	**End date:**	18/08/2020 (18/11/2020)
Project revisions:	No-cost extension ☒ Redeployment of funds ☒ Reprogramming ☐		

Funding

Total requirement for agency's sector response to current emergency:	**US$ 8,444,050**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 649.725**
Total CERF funds sub-granted to implementing partners:	**US$ 61,460**
Government Partners	US$ 61,460
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

The main objective of this UNFPA project was to support provision of comprehensive obstetric and neonatal care and sexual reproductive health services. With this CERF grant, implemented between 19 February 2020 and 18 November 2020, UNFPA supported the Ministry of Health and Child Care to improve access to emergency obstetric and neonatal care and sexual reproductive health. In the context of the CERF-funded project, UNFPA procured 485 reproductive health kits including male and female condoms and medicines for the treatment of sexually transmitted diseases. 124 health facilities in the nine districts (Mwenezi, Chivi, Mudzi, UMP, Mbire, Binga, Gokwe North and Kariba) benefitted from the reproductive health (RH) kits. A total of 37,293 people benefited directly from the project including deliveries and information sharing. The Project supported 14,221 deliveries and 768 Caesarean sections. The project supported the printing of a total of 46,000 SRH booklets and brochures.

3. Changes and Amendments

The Covid-19 outbreak disrupted socio-economic activities in Zimbabwe thereby increasing the complexity of the existing humanitarian situation that had resulted from drought. At global level, Covid-19 associated logistical issues resulted in delays in shipment of procured sexual and reproductive health (SRH) Kits. The Covid-19 lockdown initiated on 30 March 2020 restricted movement, gatherings and other face –to-face interactions. The general implementation of activities was delayed as human resources and activities were reprogrammed to respond to emerging Covid-19 needs. The planned technical support by UNFPA which required meetings and visits to project implementation sites, was therefore hampered. A three months no cost extension was requested and approved leading to the project ending on 17 November 2020 instead of the original project end date of 17 August.

There was a reduction in prices of some of the RH kits procured through the UNFPA Procurement Services Branch, leading to savings of $140,000. A request was made to the CERF secretariat, and approval granted to utilise these savings to procure Personal Protective Equipment (PPE) for health workers as well as drapes for the RH kits in the nine target districts. PPE remains a challenge in the country and this is affecting the morale of the health workers, including those working in humanitarian response.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	44,193	0	0	0	**44,193**	37,239	0	0	0	**37,239**
Total	**44,193**	**0**	**0**	**0**	**44,193**	**37,239**	**0**	**0**	**0**	**37,239**
People with disabilities (PwD) out of the total										
	1,345	0	0	0	**1,345**	1,133	0	0	0	**1,133**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

A total of 111,717 people were indirectly targeted through services provision to pregnant women and through information sharing.

6. CERF Results Framework

Project objective	Increase access to Emergency Obstetric Care and other Maternal Health Services to Pregnant Women in 9 Most Drought-Affected Districts of Zimbabwe
Output 1	Minimum Initial Service Package (MISP) and maternal nutrition services provided to pregnant and lactating women in nine (9) drought-affected districts

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of supported districts implementing MISP	9 districts	9	Programme Reports
Indicator 1.2	Number of normal deliveries supported by the project in the 9 districts	13,450	14,221	HIMS
Indicator 1.3	Number of Caesarean sections supported by the project	743	768	HIMS
Indicator 1.4	Number of facilities that receive Emergency Reproductive Health Kits	100	124	Programme Reports
Indicator 1.5	Number of health workers trained on MISP	252	207	Programme Reports
Indicator 1.6	Number of kits distributed	(433) 483[11]	483	Programme Reports

Explanation of output and indicators variance:	The number of facilities increased from 100 originally planned to 124 after guidance from UNFPA Humanitarian office to include all the delivery facilities in the districts. Lower prices of RH kits by the suppliers led to savings which were used to procure drapes for the delivery packs and PPE for the health workers. As a result, more health facilities received RH kits (124 versus a target of 100), more deliveries were supported (14,221 against a target of 13,450) and more caesarean section were also supported (768 against a target of 743) The number of health workers trained in MISP was 207 against a target of 252) as some of the health workers were redeployed for Covid-19 response during the project implementation.

Activities	**Description**	**Implemented by**
Activity 1.1	Identify the coordination body on MISP and hold district level workshop on MISP implementation	MOHCC
Activity 1.2	Training of Health workers on MISP implementation	MOHCC
Activity 1.3	Procure and distribute Emergency Reproductive Health Kits	UNFPA, MOHCC

[11] 433 was a typo in the original UNFPA SRH project proposal target, target was supposed to read 483

Output 2	Lifesaving SRHR information and services provided			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☐
Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of women reached with information on SRH and maternal health services	30,000	37,239	Programme Reports
Explanation of output and indicators variance:		The number of women reached with information increased as the number of facilities supported increased from 100 to 124. The increase in the number of supported facilities was due to savings in the procurement of RH kits which enabled more facilities to be supported and therefore more women were reached with SRH information. A total of 37,239 women were reached against a target of 30,000.		

Activities	**Description**	**Implemented by**
Activity 2.1	Develop IEC material for integrated SRH and GBV	MOHCC, UNFPA
Activity 2.2	Print and distribute IEC material	UNFPA, MOHCC
Activity 2.3	Sensitisation meeting of health workers on RH kits	MOHCC, UNFPA
Activity 2.4	Provide emergency obstetric and neonatal care	MOHCC

Output 3	Maternity waiting homes supported with nutritional and antenatal services for high risk pregnant women			
Was the planned output changed through a reprogramming after the application stage?			Yes ☐	No ☒
Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of pregnant women in MWH supported with nutritional services including SRH and GBV information	12,600	11,264	Programme Reports
Explanation of output and indicators variance:		Health facilities had reduced number of clients accessing services including admissions into maternity waiting homes due to restricted movements and transport challenges during the Covid-19 and lockdown period. As a result, the target of 12,600 women was not met as only 11,264 women in maternity waiting homes were supported.		

Activities	**Description**	**Implemented by**
Activity 3.1	Distribute food for women admitted in maternity waiting homes (not part of this CERF project)	WFP
Activity 3.2	Provide information on SRH and GBV for women admitted in Maternity Waiting homes	MOHCC/UNFPA

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[12] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [13]:

In the supported rural districts, the health centre committees, which comprise community representatives and health facility staff, were in charge of the project overall and regularly reviewed project implementation. There was a strong sense fo ownership of health care facilities and services by the local communities including women in the rural communities where the project was implemented. Some health facilities in the focus districts have maternity waiting homes where a significant proportion of high-risk pregnancy mothers were admitted. This setting provided a platform to engage women, offer health promotion andeducation as part of their antenatal care and address any concerns that they may have related to service provision including delivery care at the health facility.

b. AAP Feedback and Complaint Mechanisms:

Feedback mechanisms included focus group discussions with the women admitted in maternity waiting homes. Client feedback suggestion boxes were also mounted at maternity waiting homes and hospital wards. Clients with any complaints or feedback but needing to be anonymous submitted their feedback via the suggestion boxes. The suggestion boxes were emptied and reviewed by the hospital executive weekly. A few women routed their feedback directly via the hospital executive, either through the hospital matron or medical superintendent.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

UNFPA has a formal internal mechanism for SEA reporting. As per UNFPA's procedures, all implementing partners are required to sign a code of conduct which includes the adherence to PSEA principles. All service providers and humanitarian aid actors engaged in this project were sensitized on the utilization of the reporting mechanisms to ensure service provision as well as enactment of disciplinary measures for UN staff according to internal procedures. MoHCC personnel were sensitized on the PSEA core principles and obligations during the MISP orientation. Health care workers are also guided by the professional conduct rules that ensure respect for all, doing no harm and respecting privacy and confidentiality.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The project's focus was on supporting emergency obstetric and neonatal care (EmONC) and sexual reproductive health (SRH) and therefore the main beneficiaries were pregnant women and young girls. Men were reached through the pregnant women as well as for the provision of STI treatment, condoms and SRH information.

e. People with disabilities (PwD):

The health facilities provided SRH services to beneficiaries including people with disabilities who needed services. In areas where communication and reach were a challenge, the health workers worked closely with families and organisations within the community that support people with disabilities.

[12] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[13] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

f. Protection:

The vulnerable women who lived long distances from the health facilities were accommodated in the maternity waiting homes in the last two to three weeks of their pregnancies to ensure that they were safe and able to access care in time. The health teams worked closely with the protection sector where necessary.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

CVA was not utilised as maternity/SRH services are offered for free. There are some mechanisms in place at district level to support maternal services such as the Results Based Financing (RBF) supported by other donors.

9. Visibility of CERF-funded Activities

Title	Weblink
Distribution of RH kits in Gokwe North	https://twitter.com/UNFPA_Zimbabwe/status/1328348079825833985
Training of health workers Minimal service package	https://twitter.com/UNFPA_Zimbabwe/status/1328355086909706242
UNFPA promotes menstrual health management	https://zimbabwe.unfpa.org/en/news/unfpa-promotes-menstrual-health-management-girls-during-Covid-19-lockdown

3.4 Project Report 20-RR-CEF-007

1. Project Information

Agency:	UNICEF	**Country:**	Zimbabwe
Sector/cluster:	Protection - Child Protection	**CERF project code:**	20-RR-CEF-007
Project title:	Addressing sexual and other forms of violence and separation of children as a result of the socio-economic situation and drought in Zimbabwe		
Start date:	19/02/2020	**End date:**	18/08/2020 (18/11/2020)
Project revisions:	No-cost extension ☒	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 5,766,030**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 800,004**
Total CERF funds sub-granted to implementing partners:	**US$ 747,669**
Government Partners	US$ 0
International NGOs	US$ 239,829
National NGOs	US$ 507,839
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

The main objective of the UNICEF Child Protection project was to increase availability and accessibility of Child Protection Services are to all children and adolescents at risk of child protection violations in 10 targeted districts facing drought-induced food insecurity, and the deepening economic crisis. Through this CERF RR grant, from February 2020 to November 2020, UNICEF, in collaboration with the Ministry of Public Service and Social Welfare, worked through five NGO partners to reach a total of 64,630 beneficiaries against a planned target of 60,000 beneficiaries with critical child protection services. Of this number, 57, 596 were reached with psychosocial support (PSS), post-rape care, and emergency protection through child friendly spaces and the case management system; 7,868 children and caregivers received disability sensitive support including rehabilitation, provision of assistive devices and referral to specialist services; 47,533 children, including adolescents were reached with awareness messages on CPiE including Violence against children, GBV and PSEA; and 630 separated and unaccompanied children were identified, documented and reunified with (extended) family or placed in appropriate alternative care.

3. Changes and Amendments

UNICEF Child Protection project implementation was severely disrupted by the COVID-19 outbreak which saw the imposition of the lockdown from March 2020 as part of the containment measures. Project activities were delayed especially during the initial period of the outbreak as partners' access to project sites were restricted. The no-cost extension granted by CERF provided the much-needed additional time for the successful implementation of the delayed project activities. The budget realignment enabled UNICEF to adjust and adapt project activities that were no longer feasible in the context of COVID-19 impacts; and to engage more NGO partners in order to expedite project implementation.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Protection - Child Protection									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	10,000	10,000	20,000	20,000	**60,000**	4,922	2,112	33,366	24,230	**64,630**
Total	**10,000**	**10,000**	**20,000**	**20,000**	**60,000**	**4,922**	**2,112**	**33,366**	**24,230**	**64,630**
People with disabilities (PwD) out of the total										
	0	0	500	500	**1,000**	0	0	3,777	4,091	**7,868**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Child Protection actors and other sectors also benefited from capacity building via both online PSEA and GBV risk mitigation trainings, through which 120 partner staff (53 females and 67 male) and 70 partner staff (35 female and 35 male) were reached respectively. Other indirect beneficiaries included service providers in the case management system; disability services providers such as rehabilitation units; community cadres such as Community Childcare Workers (CCWs); and Child Protection Committees (CPCs). Caregivers of children who received services were also reached out with messages using virtual contacts. In total, indirect beneficiaries are estimated to be 15,000 people reached indirectly.

6. CERF Results Framework

Project objective	Critical Child Protection Services are available and accessible for all children and adolescents at risk of child protection violations in 10 targeted districts facing drought-induced food insecurity, and the deepening economic crisis.
Output 1	The most vulnerable children report child protection violations and access critical child protection services, specialist services as well as PSS in safe protective environments

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Protection - Child Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	# of unaccompanied and separated children affected by humanitarian situations accessing appropriate care and child protection services	1,000	630	Partner reports
Indicator 1.2	# of boys and girls in affected areas children accessing psychosocial support (PSS), post-rape care, and emergency protection support through child friendly spaces and the case management system	20,000	57,596	Partner report
Indicator 1.3	# of adolescent girls at risk of sexual violence, pregnant adolescents and young mothers at risk of child marriage and sexual violence receive information, psychosocial support and referral for protection services.	20,000	5,771	Partner reports
Indicator 1.4	# of children, adolescents and caregivers with disabilities in hardest hit districts receiving disability sensitive support including rehabilitation, provision of assistive devices and referral to specialist services (disaggregated by gender and age)	1,000	7,868	Partner reports
Indicator 1.5	# of children in contact/conflict with the law reached with legal assistance	1,000	2,678	Partner reports

Explanation of output and indicators variance:	Indicator 1.1 was under achieved because less cases of family separation and unaccompanied minors were reported during the lockdown as movement was restricted. To a certain extent, the Covid-19 outbreak reduced migration and family separation whereby caregivers leave children unattended to look for livelihood opportunities in urban settings, mining areas and across the borders. Indicator 1.2 The target was surpassed as the project adopted innovative remote methods for provision of psychosocial support such as tele-counselling, but also increased use of community-based cadres such as childcare workers (CWCs) Indicator 1.3 was not fully achieved due to the closure of schools and banning of assembly in communities during the lockdown which led to abandoning the approach of Child Friendly Spaces and schools as contact centres for children in need of child protection services. Indicator 1.4 was surpassed as use of outreach services resulted in more children with disabilities being accessed. Indicator 1.5 was overachieved because some new partners such as Legal Resource Foundation were contracted to step in and provide free legal assistance.

Activities	**Description**	**Implemented by**
Activity 1.1	Support Child Friendly spaces and Provision of quality socialization, play and learning activities	Childline Zimbabwe
Activity 1.2	Provision of trauma counselling, PSS, and safe socialization skills for affected children, adolescents, young mothers and caregivers.	Regional Psychosocial Support Initiative
Activity 1.3	Provide sensitization on PSEA, including menstrual hygiene management (MHM) dialogues, and referral for child protection services	Regional Psychosocial Support Initiative
Activity 1.4	Facilitate safe case reporting, case management follow ups and resolution including cases of sexual abuse in line with multi-Sectorial Management of Sexual Abuse Protocol.	Childline Zimbabwe and Musasa Project
Activity 1.5	Strengthening Case management and support for children, adolescents and caregivers with disabilities	JF Kapnek Charitable Trust

Output 2	Negative coping strategies and harmful practices are prevented through risk mitigation and social mobilisation
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Protection - Child Protection

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	# of children, including adolescents, reached with awareness messages on CPiE including Violence against children, GBV and PSEA	34,000	47,533	Partner Report

Indicator 2.2	# of adults reached with awareness messages on CPiE including Violence against children, GBV and PSEA	5,000	7,034	Partner Reports
Explanation of output and indicators variance:		More children were reached than targeted due to a change in operational modality from transmission of messages through face to face dialogues to remote mass media communication channels and methods. Closure of schools and banning of assembly also led to IPs resorting to the use of social media, television, radio and other modes of transmission to communicate child protection-related messages on positive parenting, prevention of violence against children and the importance of mental health and psychosocial support during the Covid-19 pandemic and the lockdown messages. [14]		
Activities	**Description**	**Implemented by**		
Activity 2.1	Disseminate awareness messages through community level awareness campaigns and community dialogues on CPiE including Violence against children, GBV and PSEA	Regional Psychosocial Support Initiative Adult Rape Clinic Plan International		

Output 3	Separated and unaccompanied children are identified, documented and reunified with (extended) family or placed in appropriate alternative care			
Was the planned output changed through a reprogramming after the application stage?		Yes ☒	No ☐	
Sector/cluster	Protection - Child Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	# of Separated and unaccompanied Children receiving support for family tracing reunification forester care and placements in alternative care (disaggregated by type of placement)	1,000	630	Partner Reports
Indicator 3.2	# of Foster care parents identified, screened, trained and monitored. Emergency foster care training include categories of children affected by emergency in need of foster care placements, possible duration, protection and safeguards, monitoring schedules submission of returns, access to CP humanitarian services (eg child friendly spaces) by children under foster car, reporting any changes noted, access to humanitarian aid by foster parents	400	357	Partner reports
Explanation of output and indicators variance:		This output's reach is below the target as a result of restrictions due to the Covid-19 pandemic, which included prohibition of assembly.. The IP usually uses gatherings within communities to sensitize community members on the value of voluntary foster care for vulnerable children including survivors of		

[14] Please note that the Country Team has confimed that figures reflected here are all direct beneficiaries.

	violence. These accessible community gatherings had been used as the first step of screening before the formal police clearance for identified prospective parents. The fact that such gatherings could not take place led to a reduction of the pool of potential foster parents. Training and screening of foster parents were affected in the same way. Lastly, reduced economic livelihood options and border closure resulted in reduced family separation in some districts and reduced demand. The targeted had been adjusted during the project duration to 700 unaccompanied and separated minors to be reached.

Activities	Description	Implemented by
Activity 3.1	Identification of separated and unaccompanied minors and placement in community foster care arrangements children and other alternative care arrangements and follow up according to IDTR process guidelines	Child Protection Society
Activity 3.2	Facilitate identification, screening and training of foster parents.	Child Protection Society

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[15] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [16]:

Existing community-based child protection mechanisms were used such as the Child Protection Committees (CPCs) and the Community Childcare Workers (CCWs). CPCs were used for community level coordination of child protection interventions. They assisted in ensuring community level multi-sectoral linkages (such as between education, health, nutrition, police and food security) for ensuring comprehensive child protection services. The CCWs were used as frontline cadres for case identification and case follow up. They worked closely with qualified social workers for referring child protection cases and providing updates on the situation of resolved cases.

b. AAP Feedback and Complaint Mechanisms:

The project made use of toll-free lines and helpdesk as mechanisms to facilitate community feedback. Helpdesks were placed in strategic places at the community level in consultation with community members. Most of the feedback provided by the community was positive, while some wanted more clarification on the services being provided. Community awareness on the services was provided through community-based child protection structures.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

UNICEF strengthened, through Childline and Musasa project, toll free lines and sensitized communities on their availability as safe and accessible mechanisms for reporting any cases of sexual exploitation and abuse (SEA). UNICEF also empowered and supported individuals, communities, and partners to report cases of SEA. UNICEF provided a survivor-centred assistance and support that was

[15] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[16] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

timely, predictable, sustainable and adequately resourced. UNICEF also ensured all its partners in this project complied with requirements for Prevention of Sexual Exploitation and Abuse (PSEA) as stipulated in the UN Partner Portal for registration of partners, that all partners undergo self-assessment, adhere to agreed plans to strengthen PSEA and their staff undergo training. Each partner has PSEA focal points who are there to respond handle and investigate SEA issues whenever they arise. UNICEF has a PSEA focal points who are responsible for steering PSEA work within the organization and has investigation protocol in place.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The project targeted women and adolescents in the prevention of protection violations and GBV. Women and girls were empowered through targeted trainings and information dissemination. The programme developed IEC materials on PSEA and GBV and translated a globally developed pocket guide for community workers on identifying and referring GBV cases into in local vernacular languages. Currently the programme is involved in regional initiatives on safe spaces for women and girls, GBViE risk mitigation management information systems and the roll-out of a training for clusters on GBViE risk mitigation.

e. People with disabilities (PwD):

The project ensured that tailored referral services were provided for people with disabilities (PWD). Children, adolescents and caregivers with disabilities in hardest hit districts received disability sensitive support including rehabilitation, provision of assistive devices and referral to specialist services. The child protection case management system integrated PWD as a priority group of vulnerable children who were identified, assessed and referred for the appropriated social services.

f. Protection:

The project ensured that protection services were accessible to all and built the capacity of key child protection actors, community structures as well as the general public to monitor child protection violations, sexual and gender-based violence incidences in the process of service delivery ensuring that services are accessible to all. UNICEF also lobbied for critical CP services for survivors of violence especially sexual violence, such as access to reporting, medical care, PSS, mental health and access to justice to be considered as critical services to be offered during times when regulations restrict free movement to prevent the spread of the disease.

g. Education:

The project was not necessarily focused on education but sought to target adolescent girls at risk of sexual violence, pregnant adolescents and young mothers at risk of child marriage and sexual violence with information, psychosocial support and referral for protection services. As the schools were closed these children were reached through remote channels such as the radio and social media.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Child protection services by their nature are provided in-kind through trained social workers and community-based structures.

9. Visibility of CERF-funded Activities

Title	Weblink
Indoor play ideas to stimulate young children at home	https://www.unicef.org/zimbabwe/stories/indoor-play-ideas-stimulate-young-children-home

3.5 Project Report 20-RR-CEF-008

1. Project Information

Agency:	UNICEF	**Country:**	Zimbabwe
Sector/cluster:	Health	**CERF project code:**	20-RR-CEF-008
Project title:	Strengthening Emergency Health Response in 9 Priority Drought-affected Districts		
Start date:	18/02/2020	**End date:**	17/08/2020 (17/10/2020)
Project revisions:	No-cost extension ☒	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 2,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 700,381**
Total CERF funds sub-granted to implementing partners:	**US$ 654,561**[17]
Government Partners	US$ 654,561
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF grant, from 18 February 2020 through 17 October 2020, UNICEF and its partners procured 26 various essential commodities and supplies including Oral Rehydration Solution (ORS), sodium hypochlorite, gentamicin, chloramphenicol, ceftriaxone, amoxicillin, metronidazole, chlorhexidine, cannulas and syringes for 120 HCFs in the 9 targeted districts across seven provinces.[18] Furthermore, 290 Community Health Workers (CHWs) were trained on integrated community case management, malaria case management, screening for malnutrition, Vitamin A supplementation, basic community maternal, newborn and child health (MNCH) services and home care for women and children, home visit procedures, community-based surveillance and given the developments since the design of the proposal it also integrated information on Covid-19 preventive measures and messaging.

With CERf support, UNICEF carried out procurement and distribution of essential medicines and commodities and refresher trainings for CHWs, contributing to the prevention of morbidity and mortality among women and children at risk of diarrheal disease outbreaks and other drought induced diseases in nine dought-affected districts. As of the end of week 46 (week ending 15 November 2020) 294,123 cases of common diarrhoea and 123 deaths (case fatality rate: 0.042 per cent) were recorded in Zimbabwe. During the same period, 40,358 common diarrheal cases and 40 deaths were reported in the 9 supported districts (DHIS2 Zimbabwe). The advent of Covid-19 and the continued economic deterioration in Zimbabwe, which has resulted in recurrent strikes by health care workers, underlined the importance of CHWs as a key cadre for community-based-healthcare, surveillance and information dissemination.

The project assisted a total of 95,267 people in nine drought-affected districts.

[17] SM200032

[18] Manicaland: Buhera, Mashonaland Central: Mbire, Mashonaland East: Mudzi and UMP, Mashonaland West: Kariba, Masvingo: Chivi and Mwenezi, Matabeleland North: Binga and Midlands: Gokwe North. Full list of essential medicines and supplies procured in annex.

3. Changes and Amendments

The humanitarian context and project implementation were greatly impacted by the Covid-19 pandemic, in which context the Government of Zumbabwe declared a national disaster on 23 March. The borders were closed to all non-essential travel and gatherings were restricted to <50 people. A 21-day national lockdown commenced on 30 March 2020 (at the time of reporting a curfew and restrictions on gatherings remain in place. These unforeseen developments resulted in a myriad of challenges associated with the timely implementation of activities. The main activity under this grant that was impacted was concerned with procurement of essential life-saving medicines and supplies. The Covid-19 pandemic resulted in a global shortage of critical medical supplies and personal protective clothing and general supply chain disruptions resulting to procurement and delivery delays. Despite engaging local and offshore suppliers, UNICEF was unable to procure latex gloves and stocks of azithromycin 250mg. Other procured supplies such asmetronidazole 100mls, cannulas 22g and chlorhexidine solution 5 per cent are not expected to arrive in country until December 2020.

Covid-19 also resulted in the inclusion of additional components within the CHW refresher training. The training package was expanded to include information on Covid-19 and basic Infection Prevention and Control. Furthermore, social distancing and infection prevention and control measures had to be implemented at the training venues to mitigate against risks associated with group-based trainings.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached[19]				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	29,152	28,008	19,435	18,672	**95,267**	29,152	28,008	19,435	18,672	**95,267**
Total	**29,152**	**28,008**	**19,435**	**18,672**	**95,267**	**29,152**	**28,008**	**19,435**	**18,672**	**95,267**
People with disabilities (PwD) out of the total[20]										
	0	0	0	0	**0**	0	0	0	0	**0**

[19] The number of people directly assisted was calculated based on the number of people served by the targeted HCFs + the average household size x number of households that the newly trained VHWs will provide community based health care for.

[20] Data is not disaggregated by disability

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

A total of 48,123 Zimbabweans benefited from improved service delivery capacity owing to refresher training of CHWs on community management of diarrheal diseases. Additionally, 66,687 community members in nine districts benefittied from improved access to treatment for drought induced conditions (HCFs in the targeted districts are not reporting stockouts (Source: Vital Medicines Availability and Health Services).

6. CERF Results Framework

Project objective	Contribute to the reduction of mortalities and morbidities related to drought and disease outbreaks in drought-affected areas of Zimbabwe through the provision of life-saving and emergency basic health services and interventions
Output 1	95,267 people have access to life saving treatment for drought induced health conditions including diarrhoeal disease outbreaks

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**[21]	**Source of verification**
Indicator 1.1	Number of people accessing treatment for drought induced health conditions including diarrhoeal disease	95,267	95,267	DHIS2
Indicator 1.2	Number of health facilities with no stock out of health commodities to manage drought induced diseases	120	120	Vital Medicines Availability and Health Services (VMAHS)
Indicator 1.3	Number of community health workers (CHWs) Trained	270	290	Training Registers
Explanation of output and indicators variance:		The number of CHWs who were trained surpassed the target owing to a strategy that combined trainings under the DFID grant to ensure value for money.		

Activities	**Description**	**Implemented by**
Activity 1.1	Procurement of essential health medicines, supplies, commodities and equipment for management of maternal newborn health diseases increased by drought	UNICEF and NatPharm
Activity 1.2	Distribution of the essential health medicines commodities in the nine districts	UNICEF and NatPharm
Activity 1.3	Provision of treatment services in all the health facilities within the affected districts	UNICEF and Ministry of Health and Child Care
Activity 1.4	CHWs refresher training on maternal and new born health diseases and diarrheal diseases referral and community case management	UNICEF and Ministry of Health and Child Care

[21] See above comment, as project was mainly concered with procurement the number remained the same

Activity 1.5	Monitoring of Project Activities by UNICEF and Government Ministry Staff	UNICEF and Ministry of Health and Child Care

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[22] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [23]:

The prevailing needs of the targeted districts were determined through consultations with Provincial directors and monitoring of weekly disease surveillance reports which were factored into projections. As members of the communities the affected populations make their voices heard through the Health centre committee that service as a platform for community engagement and participation. The quantities and type of essential medicines and supplies procured under this grant were determined based on projections developed by the Ministry of Health and Child Care and other stakeholders including NatPharm.

b. AAP Feedback and Complaint Mechanisms:

Health care facilities where the procured essential medicines and supplies are administered are managed through Health Centre Committees. These committees, whose remit is defined at the national level, are composed of community leaders, members and health care workers. Crisis-affected people (including vulnerable and marginalized groups) as members of the community channel their complaints and suggestions through the Health Centre Committees using suggestion/complaints boxes and directly reporting to the HCC members, who deliberate over them and take appropriate action. Boxes are in discreet locations to ensure confidentiality. Furthermore, Health Center Committees encourage community members to complain (through the mechanisms in place) if they are not satisfied with service delivery, encounter discrimination or sexual exploitation or are asked to pay for services that should be free.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

Suggestion boxes were placed at health care facilities to facilitate easy, safe and confidential reporting of incidents of sexual exploitation and abuse in suggestion boxes at HCFs. Furthermore, complaints against CHWs were submitted through this mechanism.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The majority (90 per cent) of community health workers (CHWs) targeted were women. These women promote health-seeking behaviour among other women. During recruitment of CHWs, effort was made to ensure that information iwas shared widely and women were encouraged to apply. The project integrated gender-based violence (GBV) through training VHWs on GBV and PSEA and linking the referral pathway with the case management system.

e. People with disabilities (PwD):

The needs of People with Disabilities, andpeople with other barriers to health services such as financial, and geographical limitations, were taken into account in the evolving context of Covid-19. To ensure access to continuity of essential services support was provided to

[22] These areas include support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[23] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

the MOHCC to develop modalities for implementation of integrated outreach services that brought health services to communities and enhanced PWDs access to the services.

f. Protection:

As part of their comprehensive 3-week pre-service training, CHWs complete modules on Child Protection and the Prevention of Sexual Exploitation and Abuse. Thus, before being deployed CHWs are sensitised on key protection issues. Furthermore, protection issues are elaborated on during their first refresher training and mainstreamed in all additional capacity building trainings attended by CHWs.

g. Education:

Education remained an essential component of the project, targeting particularly VHWs, and CHCs with critical knowledge about the on provision of high-quality health services.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

This intervention was concerned with the pre-positioning of supplies and the training of VHWs. Thus, cash interventions were not within the scope of the planned activities.

9. Visibility of CERF-funded Activities

Title	Weblink
Boosting community awareness on health and nutrition issues during the Covid-19 emergency	https://www.unicef.org/zimbabwe/stories/boosting-community-awareness-health-and-nutrition-issues-during-Covid-19-emergency

3.6 Project Report 20-RR-CEF-009

1. Project Information

Agency:	UNICEF	**Country:**	Zimbabwe
Sector/cluster:	Nutrition	**CERF project code:**	20-RR-CEF-009
Project title:	Providing lifesaving and protective nutrition intervention to most vulnerable children and women in 25 drought-affected districts in Zimbabwe.		
Start date:	18/02/2020	**End date:**	17/08/2020 (31/10/2020)
Project revisions:	No-cost extension ☒	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 5,819,158**
Total funding received for agency's sector response to current emergency:	**US$ 100,000**
Amount received from CERF:	**US$ 1,751,850**
Total CERF funds sub-granted to implementing partners:	**US$ 1,226,846**
Government Partners	US$ 713,651
International NGOs	US$ 342,664
National NGOs	US$ 170,531
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

With the support of CERF funding, from 18 February 2020 throuh 31 October 2020, UNICEF and its partners supported active screening of 461,857 (240,166 girls and 221,691 boys) children under the age of five years for early identification and referral for treatment of acute malnutrition in the 25 emergency districts[24]. A total of 1,038 health workers were trained on infant and young child feeding in emergencies (IYCF-e). Integrated management of malnutrition (IMAM), and active screening resulted in the treatment of 16,127 (8,385 girls and 7,741 boys) children with severe acute malnutrition and 69 per cent of them discharged from the nutrition program as cured. To continue service provision during the Covid-19 lockdown period, the Mother-led mid upper arm circumference (MUAC) innovation of screening at household level was initiated and scaled up to all 25 districts to ensure active screening even when mothers and babies were not able to leave their homes due to the movement restrictions. A total of 519,701 children aged 6 to 59 months received vitamin A supplements. UNICEF procured and prepositioned essential commodities and equipment at provincial warehouses and health facilities throughout the country to ensure ease of access even during the Covid-19 related movement restrictions. The number of mothers and caregivers of children less than 2 years who were supported with IYCF-e messages was 652,623. Coordination structures in all 10 provinces and 25 districts were activated, while national level bi-weekly coordination meetings were regularly conducted to share information and ensure smooth implementation of the emergency response. A near real time data management system RapidPro was developed and implemented in the 25 districts to support evidence-based programming. Accountability to affected populations (AAP) plans were developed and implemented to ensure involvement and participation of beneficiaries.

[24] Bulawayo, Harare Urban, Buhera, Chimanimani, Chipinge, Makoni, Mutare, Mbire, Mount Darwin, Mudzi, Seke, Hurungwe, Kariba, Mhondoro-Ngezi, Sanyati, Chiredzi, Chivi, Masvingo, Mwenezi, Binga, Lupane, Tsholotsho, Umguza, Gwanda, Gokwe North

3. Changes and Amendments

There were delays in implementation due to the onset of Covid-19. In this context, a no cost extension was requested and granted. The family led MUAC (FLM) was initiated as a screening innovation for infection prevention and control in the advent of Covid-19.[25]

[25] These were all direct benefifiaries in the 25 targeted districts. High numbers were acheaved by combining resource from CERF with additional funding for COVID prevention activities. We reached all our intended beneficiaries and more because of the intgration and maximising on available resouces. If needed the numbers can be reduced to report on 100% of our planned beneficiaries but we reached much more than we had planned and had a very robust data collection and reporting system, the RapidPro which enabled us to get weekly data of mother and children reached.

4. Number of People Directly Assisted with CERF Funding*[26]

Sector/cluster	Nutrition									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	67,599	0	97,829	91,332	**256,760**	382,970	0	240,166	221,691	**844,827**
Total	**67,599**	**0**	**97,829**	**91,332**	**256,760**	**382,970**	**0**	**240,166**	**221,691**	**844,827**
People with disabilities (PwD) out of the total										
	7,571	0	3,913	6,393	**17,877**	N/A	N/A	N/A	N/A	**N/A[27]**

[26] As explained above, all these are direct benefiiaries in the targeted districts acheaved by combining resource from CERF with additional funding for COVID prevention activities. We reached all our intended beneficiaries and more because of the intgration and maximising on resouces. If needed the numbers can be reduced to report on 100% of our planned beneficiaries but we reached much more women and children than we had planned. The CERF targets had prioritised the most needy and with more funding availed through integration we were able to cover more children.

[27] Nutrition data are not yet disaggregated by disability. We are working on doing that in the next response.

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

A total of 461,857 caregivers of the under five children screened were reached with nutrition messaging as well as capacitated for mother-led-MUAC activities.

6. CERF Results Framework

Project objective	To protect the nutrition status of vulnerable children under the age of five years, pregnant and lactating women, including those people living with disabilities and HIV; from deterioration due to the impact of the drought in 25 most affected rural and urban districts
Output 1	All children under five in 25 districts are screened for malnutrition, referred and treated for acute malnutrition

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Nutrition			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of children under-5 screened for acute malnutrition	453,969	461,857	RapidPro
Indicator 1.2	Number of children 6-59 months old with SAM and MAM admitted to nutrition rehabilitation programmes	19,481	16,127	DHIS2
Indicator 1.3	Number and proportion of children admitted for SAM who are successfully treated (Recovery Rate)	>7,754 (>75%)	7,125 (69%)	DHIS2
Indicator 1.4	Number of frontline health workers trained on the Integrated management of acute malnutrition	500	1383	RapidPro

Explanation of output and indicators variance:	More was achieved on child screening and training of health care workers due to integration with Covid-19 response activities which required staff in all public health facilities to be trained. This was possible because the Country Team integrated all training activities for health workers with COVID prevention activities which had higher targets, we reached all our targeted beneficiaries and more. For child screening, more caregiver were mobilised to receive COVID prevention messages and and we asked them to bring their children along for screening, and ended up with higher numbers than targeted. Less was achieved on inpatient treatment due to access to health facilities affected by the Covid-19 movement restrictions. Cure rates were lower than expected due to high defaulting rates resulting from disrupted access to health services during Covid-19 lockdown movement restrictions.

Activities	**Description**	**Implemented by**
Activity 1.1	Active screening and referral of children under five in selected cities and districts	Village Health workers and mothers and health facility workers
Activity 1.2	Procurement RUTF and nutrition equipment to all targeted health facilities	UNICEF
Activity 1.3	Distribution of RUTF and Nutrition equipment to all targeted health facilities	Ministry of Health and Child Care with support from UNICEF

Activity 1.4	Training and monitoring of facilities with Integrated management of acute malnutrition including doctors working in in-patient program	Ministry of Health and Child Care trainers and Partners
Activity 1.5	Admission and treatment of children with acute malnutrition through both the outpatient and inpatient facility	Health facilities run by the Ministry of Health and Child Care

Output 2	Community level Infant and Young Child Feeding in Emergencies (IYCF-e) support provided to parents and caregivers of children below the age of two years in collaborationin 25 priority districts
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Nutrition

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of mothers and caregivers of children under 2yrs reached with Maternal, Infant, Young Child Feeding -e (MIYCF-e) counselling and support	256,769	652,623	RapidPro/ VHW reports and health facility, Training reports
Indicator 2.2	Number of Community meetings/dialogues conducted (including through AAP process)	175	87	Implementing Partners' reports
Indicator 2.3	Number of health workers and volunteers trained on MIYCF-e	950	1038	Implementing Partners' reports, RapidPro
Explanation of output and indicators variance:		Underachievement of community dialogues due to the Covid-19 restrictions where it was not possible to mobilise communities and talk to them face to face. Overachievement of MIYCFe[28] and health worker training was due to the integration with Covid-19 responses where it was a requirement for all health facility staff to be trained. Change in modalities for capacity building to on the job training due to Covid-19 resulted in improved reach of participants.		

Activities	**Description**	**Implemented by**
Activity 2.1	Provide Maternal, Infant and Young Child Feeding (IYCF-e) counselling support to mothers and caregivers of children below 2 years including communication material and support to Food security sector on food demonstration and use of specialized supplementary food for young children	Ministry of Health and Child Care and Partners
Activity 2.2	Training of VHWs on community MIYCF and volunteers from care group conducted	Ministry of Health and Child Care trainers and Partners

[28] MIYCF-e, from pregnancy to two years lactation.

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[29] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [30]:

Communities were engaged and sensitized on what to expect from the project right from the beginning of project implementation. However due to the Covid-19 lockdown and movement restrictions more extensive community dialogues were not possible at the beginning. (Community engagements at the start of the project were affected by COVID-19 lockdown.) During implementation however, more AAP activities were implemented. Community dialogues were conducted to get inputs on the community preferred mechanisms, which came out to be feedback though community leaders, village health workers and suggestion boxes. The nutrition sector was more involved through the community engagement working group, in monitoring cluster activities related to accountability to affected people (challenges, beneficiary reach and use of available feedback mechanisms).

b. AAP Feedback and Complaint Mechanisms:

AAP feedback was done through focus group discussions, suggestion boxes and toll-free hotlines. Through AAP activities UNICEF received positive feedback from caregivers on family led MUAC-(FLM). Suggestion boxes were frequently opened (every week) and communities were quick to point out if they were not able to access any commodity usually due to delayed distribution or if there were stockouts, of any commodity. Community member were very quick to point out through the suggestion boxes whenever they were not able to access nutrition commodities. Other concerns raised through these mechanisms were the need for food distribution, and these were referred to the food security cluster.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

Communities were sensitised to report SEA related incidents through the suggestion boxes, hotlines, community leaders and health centre committees. Suggestion boxes, which were the most-widely used mechanism, were opened once a week by selected community leaders for transparency and accountability. The Nutrition cluster did not receive any SEA related complaints.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Communities were sensitised to report GBV related incidents through the suggestion boxes, hotlines, community leaders and health centre committees. The nutrition response is designed to target the most vulnerable, who are women and girls. Activities are done during the day to ensure safety of the vulnerable and travel when there is light. It is a requirement for all service providers to be trained in PSEA. Outreach services were introduced to bring services closer to the communities and reduce distances travelled which would expose the vulnerable to abuse. Outreach services also provided an additional platform for reporting and giving feedback.

e. People with disabilities (PwD):

[29] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[30] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

Outreach brought services closer to the community, which ensured that even those with disabilities and those who find it difficult to travel long distances had access to nutrition services. The programme ensures that no one was left out, including those with disabilities. As of the time of writing. plans were underway to disaggregate assessment data by disability.

f. Protection:

The programme was designed to ensure that all activities were carried out during the day so that the vulnerable could safely travel during the day. In addition, outreach, broughtnutrition services closer to the people and were conducted in designated safe spaces.

g. Education:

To ensure that the affected people fully understand the services provided to them, how they can be involved and participate as well as give feedback where needed, education, sensitisation and training of affected people was a significant part of the nutrition response. Affected people were also educated on how to use the different feedback mechanism.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Most nutrition services provided were in-kind, in the form of screening for SAM, provision of nutritional supplements and treatment.

9. Visibility of CERF-funded Activities

Title	Weblink
Mothers relieved by life-saving interventions for children in Zimbabwe	https://www.unicef.org/zimbabwe/stories/mothers-relieved-life-saving-interventions-children-zimbabwe
First came the drought, then the cyclone	https://www.unicef.org/zimbabwe/stories/first-came-drought-then-cyclone

3.7 Project Report 20-RR-CEF-010

1. Project Information

Agency:	UNICEF	**Country:**	Zimbabwe
Sector/cluster:	Water Sanitation Hygiene	**CERF project code:**	20-RR-CEF-010
Project title:	Restoring access to safe water and improving hygiene practices in 8 of the most food insecure and drought-affected districts in Zimbabwe		
Start date:	18/02/2020	**End date:**	17/08/2020 (17/11/2020)
Project revisions:	No-cost extension ☒	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 23,688,000**
Total funding received for agency's sector response to current emergency:	**US$ 2,800,00**
Amount received from CERF:	**US$ 1,799,699**
Total CERF funds sub-granted to implementing partners:	**US$ 699,664**
Government Partners	US$ 0
International NGOs	US$ 249,326
National NGOs	US$ 450,338
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

With the support of CERF funding, from 18 February 2020 through17 November2020, UNICEF and its partners reached a total of 143,118 people with safe water. This was achieved through the repair of 468 boreholes out of a target of 462 boreholes and rehabilitation of two (2) targeted solar power piped water schemes. Furthermore, 165,713 people were reached with key health and hygiene messages on critical handwashing, safe water collection, transportation and storage of water, household water treatment and Covid-19 awareness and prevention. Awareness and prevention activies included training of 481 village health workers who spearheaded door to door campaigns and the conduct of 1,000 hygiene sessions utilising mobile trucks. In addition, UNICEF and partners resuscitated or established 154 community health clubs and 42 handwashing stations. A total of 10,000 families also received WASH hygiene kits, which included20 liter buckets with tap and lid, 20L jerry cans, 1kg bars of all-purpose soap, household water treatment chemicals and information, education and communication materials (IEC) on various topics that include handwashing, diarrheal disease prevention, Covid-19 awareness and prevention. This project significantly exceeded the target number of beneficiaries to be reached with safe drinking water and key hygiene messages. The targeted water points (boreholes and piped water schemes) served more people than those estimated using the SPHERE standards, which contributed to this over-achievement. Health and hygiene education activities were also intensified; taking into account the Covid-19 pandemic, more community health volunteers were trained, and more hygiene sessions conducted.

3. Changes and Amendments

Due to Covid-19, the CERF allocation could not be implemented within the initially approved time period as field access for implementing partners was hindered and slowed due to the lockdown which commenced on 30 March 2020 in Zimbabwe. In addition, duty of Care

consideration for stakeholders and beneficiaries meant UNICEF and its implementing partners needed to procure PPE before commencing field activities. However, PPE was in short supply worldwide and delivery of these items were delayed. Furthermore, some of the project supplies (hygiene kits and borehole spares) ordered outside the country experienced delays related to the lockdowns in other countries, especially South Africa. In this context, a no-cost extension from 17 August to 17 November 2020 was requested and approved. The no cost extension ensured that all planned project deliverables, objectives and targets were implemented in the targeted districts. This also gave ample time for monitoring and ensuring sustainability of project activities.

The actual number of beneficiaries reached with safe drinking water and key hygiene messages greatly exceeded those included as project targets. The targeted water points (boreholes and piped water schemes) served more people than those estimated using the SPHERE standards, resulting in the over-achievement. Health and hygiene education were also intensified, considering the Covid-19 pandemic, more community health volunteers were trained, and more hygiene sessions conducted. However, establishment of school health clubs could not take place due to closure of schools as part of the Covid-19 restriction and lockdown. In response, UNICEF and partners established additional community health clubs instead of the school health clubs. A total of 165,713 people (50,841 females, 46,930 males, 35,330 girls and 32,612 boys) were reached with key health and hygiene messages through the CHCs and other hygiene promotion activities.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Water Sanitation Hygiene									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	30,680	28,320	21,320	19,680	**100,000**	43,909	40,531	30,513	28,166	**143,119**
Total	**30,680**	**28,320**	**21,320**	**19,680**	**100,000**	**43,909**	**40,531**	**30,513**	**28,166**	**143,119**
People with disabilities (PwD) out of the total										
	2,148	1,982	1,492	1,378	**7,000**	1,641	1,515	1,141	1,053	**5,350**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

A total of 165,713 people was reached with key health and hygiene messages on critical handwashing, safe water collection, transportation and storage, household water treatment and Covid-19 awareness and prevention among other issues. The number of people reached with health and hygiene education is expected to continue beyond the lifespan of the project due to ongoing dissemination of critical messages by the trained 481 village health works ad the established 150 community health clubs as well as IEC materials placed in public places, schools and health care facilities.

6. CERF Results Framework

Project objective	To improve access to safe water and awareness of key hygiene and sanitation practices among 100,000 people in 8 of the most food insecure districts (Mudzi, UMP, Buhera, Chivi, Mbire, Tsholotsho and Lupane) in Zimbabwe
Output 1	Restore access to sufficient water of appropriate quality and quantity to fulfil basic needs for an estimated 100,000 women, men and children in 8 drought-affected districts.

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Water Sanitation Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of people improving their access to water through rehabilitation of protected water sources which are now functional	100,000	143,118	Partner reports
Indicator 1.2	Number of families with access to household water treatment and storage	10,000	10,000	Partner reports
Explanation of output and indicators variance:		The targeted water points (boreholes and piped water schemes) served more people than those estimated using the SPHERE standards, resulting in the over-achievement.		

Activities	**Description**	**Implemented by**
Activity 1.1	Rehabilitation/ repair of 462 boreholes	Government/ IPs/NGOs, Contractors
Activity 1.2	Rehabilitation/ repair of 2 piped water schemes	Government/ IPs/NGOs, Contractors
Activity 1.3	Resuscitation of water point management committees	Government/ IPs/NGOs, Contractors
Activity 1.4	Procurement of borehole spares	UNICEF

Output 2	Improve awareness of safe hygiene and sanitation practices to 100,000 men, women and children in targeted districts

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☒

Sector/cluster	Water Sanitation Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Number of people receiving critical WASH related information for improved hygiene and sanitation practices	100,000	165,713	Partner reports

Indicator 2.2	Number of school children (boys/girls) receiving critical WASH related information for improved hygiene and sanitation practices	20,000	0	
Indicator 2.3	Number of households reached with WASH Hygiene kits	10,000	10,000	Partner reports
Indicator 2.4	Number of people reached through refresher trainings on PHHE.	4,000	5,317	Partner reports
Explanation of output and indicators variance:		Health and hygiene education were also intensified, considering the Covid-19 pandemic, more community health volunteers were trained, and more hygiene sessions conducted. However, establishment of school health clubs could not take place due to closure of schools as part of the Covid-19 restriction and lockdown. Additional community health clubs were established instead of the school health clubs.		

Activities	**Description**	**Implemented by**
Activity 2.1	Refresher training of Village Health Workers (VHWs) and Community Health Workers (CHWs) supporting dissemination of critical lifesaving WASH messages and hygiene practices.	Government/ IPs/NGOs,
Activity 2.2	Resuscitation/ establishment of 80 community health clubs	Government/ IPs/NGOs,
Activity 2.3	Resuscitation/ establishment of 36 school health clubs	N/A
Activity 2.4	Dissemination of critical health and hygiene messages	Government/ IPs/NGOs,
Activity 2.5	Procurement of WASH Hygiene kits	UNICEF
Activity 2.6	Distribution of WASH Hygiene kits	Government/ IPs/NGOs,
Activity 2.7	Post Distribution of WASH hygiene kits	Government/ IPs/NGOs,

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[31] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [32]:

The Districts Water and Sanitation Sub Committees (DWSSC) and Ward and Village Water and Sanitation Sub-Committees (WWSSCs/VWSSC's), with support from UNICEF partners facilitated the assessments and prioritization of vulnerable communities and community members. The selection of beneficiaries was facilitated at village level with support of community leaders. Beneficiary selection criteria was factoring in vulnerability levels such as people living with HIV/AIDS (PLWHA), PLWD, Child-headed families, the elderly,

[31] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[32] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

pregnant and lactating mothers, children, and the chronically ill, who were more vulnerable to the effects of the drought. Beneficiary selection was also strengthened with data sourced from the Rural WASH information Management System (RWIMS) on sanitation and water coverage and access to these facilities was further t used to determine locations for borehole and piped water scheme rehabilitation efforts. Village Health works (VHWs) and or health promoters were also utilised to share concerns raised by the communities during their hygiene promotion sessions and to give feedback where certain issues had been addressed. Common concerns expressed by most districts included the inadequacy of personal protective wear, inability to purchase soap for hand washing beyond the project and the inability to afford sanitary wear for women. These concerns were discussed with the relevant district and ministry departments, which resulted in inclusion of a minimum WASH budget within the rural district councils to support vulnerable households.

Duty of Care consideration for stakeholders and beneficiaries meant UNICEF and it's implementing partners needed to procure PPE before commencing field activities. Additionally, all project activities had to adjust to Covid-19 regulations, including proper wearing of face masks, social distancing, handwashing and body temperature checks. All trainings had to factor in Covid-19 awareness and prevention measures. In this context, some community health clubs established sewing face masks for the local communities and schools

b. AAP Feedback and Complaint Mechanisms:

UNICEF and partners conducted project sensitization and inception meetings at national and sub-national levels. The DWSSCs and implementing partners then conducted ward level sensitization of the project, organising communities and community leaders to prioritize interventions in their wards. In addition, project entitlements were highlighted during the WASH hygiene kit distribution. During distributions of WASH hygiene kits, help desks and suggestion boxes were availed to ensure communities could share their concerns about project implementation, beneficiary selection and on the quality and usefulness of the materials received. Common issues raised included the need to cover more households with the WASH hygiene kits as more households had become vulnerable due to the Covid-19 and associated lockdowns which resulted in reduced livelihoods and coping mechanisms. Post distribution monitoring (PDM) was also conducted, targeting recipients of WASH hygiene kits, and checked for the usefulness and quality of materials and mechanisms used to promote hygiene.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

UNICEF partners were trained on the prevention of SEA and helped the IPs develop and set up internal mechanisms for reporting and handling SEA. Partners supported the community health clubs (CHCs) with a 'directory' of hotline numbers and a referral system. Communities were sensitised to report SEA related incidents through the suggestion boxes, hotlines, community leaders and health centre committees. Suggestion boxes which were the mechanism mostly used were opened once a week by selected community leaders for transparency and accountability. The WASH cluster did not get any SEA related complaints.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

UNICEF's 17 partner staff implementing the CERF program (10 males, seven females) were trained on the prevention of GBV and helped the IPs to develop and set up internal mechanisms for reporting and handling GBV. A total of two Partners supported the CHCs with a 'directory' of hotline numbers and a referral system. The two partners supported the community health clubs (CHCs) on PSEA and GBV mainstreaming by providing CHC members with a directory of hotline numbers to refer cases when encountered in the community. Also, the DWSSC through the rural district councils were supported with data bundles and hotline mobile numbers to assist the communities. The cases of GBV that were reported by the communities, were referred to the department of Social Services as well as partners that deal with GBV, such as the Msasa project, REPPSI and Childline.

e. People with disabilities (PwD):

UNICEF and partners made a deliberate effort to prioritize people with disabilities in the with WASH hygiene kit distributions. Additionally, where applicable, piped water scheme stand posts were located near households with PLWD to enable easy access to the communal water stand post.

f. Protection:

UNICEF and partners ensured adherence to government measures on Covid -19 regulations. Duty of care consideration for stakeholders and beneficiaries meant UNICEF and its implementing partners needed to procure PPE before commencing field activities. Additionally, all project activities had to adjust to Covid-19 regulations, including proper wearing of face masks, social distancing, handwashing and body temperature checks. All trainings had to factor in Covid-19 awareness and prevention measures which resulted in more online meeting with stakeholders and smaller community meetings to adhere to the guidelines. This also saw some community health clubs established sewing face masks for the local communities and schools. Additional considerations were placed on siting and location of WASH infrastructure (piped water scheme communal tap stands) and WASH hygiene kit distribution points to minimize exposure and protect beneficiaries from risks of SEA and GBV. IPs and stakeholders were also trained on protection issues to ensure these were integrated into programming.

g. Education:

Rehabilitation of piped water schemes extended the supply of water to schools. A total of three schools (onw secondary and two primary) benefitted, with a combined enrolment of 949 pupils (488 boys, 461 girls) and staff of 43 teachers. The establishment of school health clubs could not be carried out during the implementation period due to closure of schools during the Covid-19 lockdown and restrictions.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Direct intervention through implementing partners was utilized. The WASH commodities, supplies and services were not readily available in the communities and hence the CVA approach was not appropriate for the delivery of WASH services

9. Visibility of CERF-funded Activities

Title	Weblink
UNICEF Zimbabwe celebrates the joint commemoration on Global Hand Washing Day	https://www.unicef.org/zimbabwe/stories/unicef-zimbabwe-celebrates-joint-commemoration-global-hand-washing-day

3.8 Project Report 20-RR-WFP-006

1. Project Information

Agency:	WFP	**Country:**	Zimbabwe
Sector/cluster:	Food Security - Food Assistance	**CERF project code:**	20-RR-WFP-006
Project title:	Food assistance for acutely food insecure households affected by climate shocks and economic crisis.		
Start date:	15/01/2020	**End date:**	14/07/2020 (14/10/2020)
Project revisions:	No-cost extension ☒	Redeployment of funds ☒	Reprogramming ☒

Funding

Total requirement for agency's sector response to current emergency:	**US$ 365,625,424**
Total funding received for agency's sector response to current emergency:	**US$ 172,990,518**
Amount received from CERF:	**US$ 6,790,003**
Total CERF funds sub-granted to implementing partners:	**US$ 643,351**
Government Partners	US$ 0
International NGOs	US$ 341,512
National NGOs	US$ 301,839
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Under this CERF contribution, from 15 January 2020 through until 14 October 2020, WFP and cooperating partners (CPs) successfully provided in-kind food assistance to 328,026 beneficiaries reaching 170,574 females and 157,453 males. 228,822 unique beneficiaries across Buhera, Mbire, Mwenezi and Tsholotsho districts, of whom 120,702 were female and 108,120 male, were reached in the March and April distribution cycle. Commodities distributed totalled 4,920.40 metric tons of cereals (maize), 531.75 metric tons of pulses (peas) and 294.11 metric tons of vegetable oil.

Due to the very poor performance of the 201920 agricultural season, the negative 2020/21 food security projections, the high inflation coupled with stagnant incomes, and the impact of the Covid-19 on the food security situation, the 2020/21 LSA programme began in July 2020. The grant amendment (further elaborated on in Section 3), allowed for an additional 23,333 unique beneficiaries to be reached during the 2020/21 LSA implementation year for the September distribution cycle in Hwange & Matobo districts.

3. Changes and Amendments

During the period under review, Zimbabwe recorded its first case of Covid-19 in March 2020. As such, WFP suspended operations for a period of eight days to allow time for Personal Protective Equipment (PPEs) to be distributed to all WFP and CP staff, and for necessary health and safety measures to be implemented on the ground at distribution sites. When distributions resumed on 31 March, they adhered to revised Covid-19 Standard Operating Procedures (SOPs), which were developed in line with corporate guidance, as well as that received from the Government of Zimbabwe and WHO.

A project revision for a no cost extension was submitted on 29 June 2020 and approved. Due to a decrease in the price of food basket commodities covered under this grant (cereal, pulses and oil) on the international and regional markets, WFP remained with extra funds at the end of the project. Considering the Covid-19 outbreak, it was agreed WFP could re-programme the funds for the procurement of Personal Protective Equipment (PPE). Following the procurement of PPE at a cost of $472,105.69, it was agreed that the remaining funds would be re-deployed to procure LSA food rations (7.5kg of cereals, 1.5kg of pulses, and 0.75L of fortified vegetable oil) for 23,333 beneficiaries in Hwange and Matobo districts, which were subsequently distributed under the September cycle.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Food Security - Food Assistance									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	90,451	77,852	77,529	77,206	**323,038**	96,899	81,252	73,379	76,496	**328,026**
Total	**90,451**	**77,852**	**77,529**	**77,206**	**323,038**	**96,899**	**81,252**	**73,379**	**76,496**	**328,026**
People with disabilities (PwD) out of the total										
	9,680	8,331	8,262	8,297	**34,570**	1,880	1,277	1,991	1,208	**6,356**[33]

[33]The 2019/2020 implementation year was the first year that CPs were requested to collect disability data for the LSA programme. While people with disabilities were reached with food assistance under this grant, in many cases disability data was not available. At the start of the 2020/21 implementation year, a thorough analysis of all not defined/captured beneficiary data was conducted. Verification exercises are ongoing.

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

Under this grant, the LSA programme worked closely with fourCPs, reaching a total of 94,121 indirect beneficiaries with Complementary activities: World Vision International who implemented in Buhera and Hwange; Lower Guruve Development Association who implemented in Mbire; Mwenezi Development Training Centre who implemented in Mwenezi, and Linkages for the Economic Advancement of the Disadvantaged (LEAD) who implemented in Tsholotsho, CPs conducted Covid-19 awareness trainings and adhered to guidelines during the distributions to LSA beneficiaries including other community members. Protection training that included prevention of SEA plus gender to CPs has benefitted both LSA and other community members by increasing the CPs abilities to implement protection conscious interventions.

6. CERF Results Framework

Project objective	Saving lives through support to food access for acutely food insecure population, aimed at ensuring they are able to meet their basic food and nutrition requirements during severe seasonal shocks such a lean season.
Output 1	Saving lives through support to food access for acutely food insecure population, aimed at ensuring they are able to meet their basic food and nutrition requirements during severe seasonal shocks such a lean season.

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Food Security - Food Assistance			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Number of people receiving food against planned	323,038	328,026	WFP Corporate Systems and Post Distribution Monitoring Data
Indicator 1.2	Quantity of food provided distributed as percentage of planned	6,211,28 metric tons	5,746.260	WFP Corporate Systems and Post Distribution Monitoring Data
Explanation of output and indicators variance:		Prices on the world market were slightly cheaper, hence more food was bought. However, food received by CPs amounted to 5,746 metric tons as milling losses for the maize that was received accounted for 525.92 metric tons of the total food procured as per the milling extraction rate in the contract.		

Activities	**Description**	**Implemented by**
Activity 1.1	Protection Training to WFP implementing partners (Protection & Prevention of Sexual Exploitation and Abuse; Humanitarian principles)	WFP Monitoring and Evaluation Unit in coordination with the Field Offices and Cooperating Partners
Activity 1.2	Food procurement and delivery to WFP and Partner Warehouses	WFP Supply Chain Unit
Activity 1.3	Food distribution to food insecure people	Cooperating Partners in coordination with WFP Field Offices
Activity 1.4	Distribution process monitoring	WFP Field Offices and Cooperating Partners
Activity 1.5	Post distribution monitoring	WFP Field Offices and Cooperating Partners

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[34] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [35]:

Accountability is one of the WFP core principles and values that enables provision of the best possible service. During the reporting period, WFP transmitted diverse information to affected population of programme processes such as the targeting criteria, entitlements and length of assistance. This empowered affected populations to raise queries, concerns as well as make suggestions on possible programme adjustments. During post distribution monitoring 97.8 per cent of households showed high levels of knowledge on programme processes.

Consultation of beneficiaries at all levels is also critical for accountability. The community played a key role during the registration process by defining context specific indicators of food insecurity and vulnerability that would be used during the ranking process. The community was also consulted on issues related to the siting of distribution sites, selection of distribution committees as well as the composition of the helpdesk and in particular, the inclusion of ex-officio members. During post distribution monitoring assisted households were also consulted on various issues related to modality preferences as well as satisfaction towards WFP assistance.

WFP has provided the means through which affected people can provide their feedback which encompasses, queries, complaints and grievances, as well as suggestions on how the programme can be improved. The information that is collected through the mechanisms is analysed and used for evidence-based programme adjustments.

b. AAP Feedback and Complaint Mechanisms:

WFP has put in place complaints and feedback mechanisms to ensure feedback, concerns, suggestions and queries may be raised and are documented. The three official feedback mechanisms include the helpdesk, suggestion box and the toll-free line. The helpdesk and suggestion box are on-site and handled directly by WFP and CPs. All cases are documented and reported to the Country Office. The toll-free line, on the other hand, has been sub-contracted to a private service provider for transparency and credibility. To ensure confidentiality, the toll-free database is encrypted with passwords and is directed only to the focal points. All cases are classified and assigned to focal staff for follow-ups, action and closure. Reports are produced detailing how each concern was handled and its status, in terms of closure.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

WFP rolled out training on Prevention of Sexual Exploitation and Abuse at all levels during programme implementation. Participants included WFP staff from the Country Office and field offices. Staff from Cooperating partners and the government were also trained at national and district level. Staff from private sector organisations, transporters and loaders were also taken on board. To ensure that no one is left behind, the community and beneficiaries were also trained on sexual exploitation and abuse. These trainings were aimed at raising awareness in order to prevent sexual exploitation and abuse and additionally to ensure the community and staff are made aware of SEA reporting channels.

[34] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[35] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

In the context of Covid-19, adequate prevention measures were implemented at all food distribution points to ensure the continued health and safety of staff, beneficiaries and stakeholders. These measures included mandatory handwashing, temperature checks, social distancing and the wearing of face masks.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

Mainstreaming gender is key in ensuring equal access to food among assisted households. WFP and partners rolled out gender sensitizations and awareness campaign with a view to increasing the participation of women both at community and household level. The programme sought to address gender imbalances by ensuring equal participation and involvement of both men and women in decision-making of food assistance. This was achieved through continuous gender awareness trainings and campaigns. The pre-distribution address was used as the forum through which gender messages were transmitted and included topics on gender equality and gender-based violence. Strategies put in place to achieve gender equality yielded positive results. In these sessions, participants reported that, at the household level, gender equality and women's empowerment were largely achieved. The proportion of households reporting decision-making by women was high – at 62 per cent as at October 2020 – while the prevalence of households reporting joint decision-making was relatively high at 35.1 per cent. The percentage households reporting sole decision-making by men was the lowest at 2.9 per cent.

At the community level, women were included in distribution committees to ensure equal representation to ensure the needs of women were represented. Results from process monitoring showed that, on average, women constituted 65.9 per cent of the distribution committees. Women from affected populations were also included in help desk committee as ex-officio members to facilitate handling and documentation of the concerns of women and girls.

e. People with disabilities (PwD):

Through a strict targeting and verification process, WFP ensured that only the most vulnerable households received monthly food assistance under the Lean Season Assistance (LSA) programme. Specific vulnerabilities, including disabled/chronically ill household heads and/or members, were considered during targeting, selection, and registration processes. During implementation, WFP monitored mainstreaming and targeting of disabled persons primarily through Post Distribution Monitoring (PDM). Beneficiaries with disabilities were specifically asked whether they experienced any challenges related to their participation in WFP programming, be it while receiving WFP food assistance or using Complaints and Feedback Mechanisms (CFMs). At the time of writing, the LSA team, in coordination with WFP's ICT unit, was training CP staff to accurately and sensitively capture disability data in WFP's Corporate Data Management system, through data entry trainings and regular data quality assessments.

f. Protection:

WFP designs and implements programmes in ways that take care not to pose protection risks for beneficiaries. Safety, unhindered access and dignity should be maintained to ensure protection of assisted households. The programme mainstreamed protection effectively at all levels during project implementation, through continuous sensitisation and awareness of protection issues during platforms such as the pre-distribution address. Cooperating partners and assisted households also adhered to standard operational procedures such as the early start and completion of distributions. WFP programme sites were situated within at least 5km radius and at central points to facilitate access for all affected and at-risk populations. WFP and partners also ensured the early start and completion of distributions to enable all affected populations to travel before dark. Special queues were available for vulnerable groups and were prioritized during programme implementation. Furthermore, vulnerable people such as the elderly, pregnant and lactating women were prioritised during distributions. There were also specific queues for the elderly, pregnant women, or people with disabilities. In the context of Covid-19 pandemic, WFP put in place Covid-19 standard operational procedures to ensure observance of social distancing guidelines, the use of face coverings, health screening, and availability and use of handwashing facilities to further protect households and reduce the risk of transmission of the Coronavirus.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

During the first half of the 2019/2020 implementation year, the country and WFP faced cash liquidity challenges in obtaining bond notes from the Reserve Bank of Zimbabwe. These challenges delayed assistance to beneficiaries and were further compounded by the effects of Statutory Instrument 142, issued in June 2019, which prohibited the use of foreign currency as legal tender in Zimbabwe.

In December 2020, LSA provided mobile money (RTGS) transfers to beneficiaries in select districts. The LSA programme reaches some of the most remote rural districts in Zimbabwe, thus, mobile money is not feasible in several districts and where feasible many beneficiaries lost part of the transfer value to high tariffs associated with mobile money payments. Moreover, a galloping inflation rate, also due to the substantial difference between the official interbank exchange rate as well as the parallel market rates meant that cash transfers were much less cost-efficient compared to in-kind distributions.

Additionally, given regional commodity shortages and persistent drought, rural markets struggled to maintain stocks of cereals at accessible prices. Therefore, as of January 2020, the LSA programme reverted to providing in-kind assistance to beneficiaries across all 60 rural districts. As of the time of writing, in-kind food assistance continued to be provided during the first half of the 2020/21 implementation year due to the prevailing macroeconomic situation in rural areas, which continued to be characterized by high food inflation and limited availability of physical cash to support cash-in-transit. Additionally, markets monitoring data indicated that commodity shortages were still prevalent in rural markets, a situation exacerbated by the impact of Covid-19.

9. Visibility of CERF-funded Activities

Title	Weblink
Press Release: WFP urgently seeks international support to prevent millions of Zimbabweans plunging deeper into hunger	https://www.wfp.org/news/wfp-urgently-seeks-international-support-prevent-millions-zimbabweans-plunging-deeper-hunger

3.9 Project Report 20-RR-WHO-007

1. Project Information

Agency:	WHO	**Country:**	Zimbabwe
Sector/cluster:	Health	**CERF project code:**	20-RR-WHO-007
Project title:	Strengthening Emergency Health Response in 9 Drought-affected districts in Zimbabwe		
Start date:	19/02/2020	**End date:**	18/08/2020 (18/10/2020)
Project revisions:	No-cost extension ☒	Redeployment of funds ☒	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 2,000,000**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 599,326**
Total CERF funds sub-granted to implementing partners:	**US$ 0**
Government Partners	US$ 0
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF grant, from 19 February 2020 through 18 October 2020, the WHO project assisted in building capacity of 40 laboratories to detect Covid-19, which contributed to 100,572 people being tested for Covid-19 between July and October 2020. The project also assisted in the training of 92 rapid response team (460 people) across the 10 provinces and this contributed to 7,320 Covid-19 investigations in the country. Further to that, 546 health workers were also trained on surveillance, infection prevention and control and Covid-19 case management. Production, printing and distribution of Covid-19 case management, infection prevention and control Risk Communication and Community Engagement (RCCE) and surveillance tools (case definition charts, case investigation forms, surveillance flow charts, surveillance SOPs was also done through this project.

3. Changes and Amendments

Initially the project was planned as drought response in the nine priority districts in Zimbabwe, including Buhera, Mbire Mudzi, Uzumba-Maramba-Pfungwe Kariba District Chivi, Mwenezi, Binga and Gokwe North. The interventions included strengthening of the provincial and district rapid response team in the following areas: (a) Surveillance including timely reporting and investigation of drought related disease conditions; (b) timely data analysis to inform priority setting and work planning; (c) monitoring and evaluation of identified interventions; and (d) advocacy and partnership strengthening. The initiative also sought to strengthen disease surveillance in the affected districts through refresher training and mentoring support to frontline health workers, district level supervisors and district laboratory staff in: (a) timely identification and reporting drought related conditions; (b) data analysis; (c) monitoring and evaluation; and (d) community outreach activities. The capacity of district level laboratories in the nine districts was further enhanced through the provision of laboratory

reagents and equipment to address the common challenges of frequent stock outs of lab supplies and frequent breakdown of old laboratory equipment.

CERF funds were reprogrammed in July to cater for support to Covid-19 response activities on surveillance (active case finding and contact tracing), Case Management, infection prevention and control and Risk Communication and Community Engagement (RCCE). The project also focused on the ten provinces with priority interventions being implemented in high burden districts.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	36,357	36,355	36,356	36,355	**145,423**	59,871	59,871	59,872	59,872	**239,486**
Total	**36,357**	**36,355**	**36,356**	**36,355**	**145,423**	**59,871**	**59,871**	**59,872**	**59,872**	**239,486**
People with disabilities (PwD) out of the total										
	3,636	3,636	3,636	3,636	**14,544**	5,987	5,987	5,987	5,987	**23,948**

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

5. People Indirectly Targeted by the Project

It is estimated that 1 million people were also reached through risk communication and community engagement initiatives using sms exchange and WhatsApp platforms.

6. CERF Results Framework

Project objective	To strengthen Health Response in the Drought-affected districts in Zimbabwe
Output 1	Strengthening drought response at National, Provincial and District Level Health - Health

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Health - Health

Indicators	Description	Target	Achieved	Source of verification
Indicator 1.1	Number of Rapid Response Team (RRT) members trained	45 (5 people per district in all the 9 most affected districts)	92 RRTs (460 people) were trained across the ten provinces	Ministry of Health and Child Care
Indicator 1.2	Number of drought induced disease condition investigations carried out	27 . (A minimum of 3 investigations per district)	8,133 cases of Covid-19 were reported in Zimbabwe between July and September of which 90% (7320) were investigated. The project contributed to these investigations.	Ministry of Health and Child Care Sitrep

Explanation of output and indicators variance:	More RRTs were trained than planned due to reprogramming of funds to focus on Covid-19 response.

Activities	Description	Implemented by
Activity 1.1	Training of the rapid response teams at national, provincial and district levels	Ministry of Health and Child Care, WHO and other Health partners
Activity 1.2	Drought induced disease conditions investigated and reported by frontline MOHCC Health workers supported by WHO and other health partners	Ministry of Health and Child Care, WHO and other Health partners

Output 2	Strengthening disease surveillance and laboratory capacity

Was the planned output changed through a reprogramming after the application stage? Yes ☐ No ☐

Sector/cluster	Health - Health

Indicators	Description	Target	Achieved	Source of verification
Indicator 2.1	Number of people trained on IDSR, surveillance of measles, diarrhoea and malnutrition	(384 health workers) 2 health workers per health facility in 9 priority affected districts. Total	546 health workers were trained across the 10 provinces in Zimbabwe	Ministry of Health and Child Care Intra Action Review reports from the 10 provinces

Indicator 2.2	Number of laboratories supported with laboratory reagents and equipment	9 district laboratories	40 laboratories across the 10 provinces were supported with laboratory reagents and equipment	Ministry of Health and Child Care

Explanation of output and indicators variance:	More health care workers were reached following reprogramming of CERF funds to target the Covid-19 response in the country.

Activities	**Description**	**Implemented by**
Activity 2.1	Training of provincial and district team on case management on drought induced disease conditions	Ministry of Health and Child Care, WHO and other Health partners
Activity 2.2	Procurement and distribution of reagents and equipment	Ministry of Health and Child Care, WHO and other Health partners
Activity 2.3	Supply of laboratories with reagents and equipment for improved detection of priority pathogens	Ministry of Health and Child Care, WHO and other Health partners

Output 3	Strengthening Case Management
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☐
Sector/cluster	Health - Health

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	Number of Health facilities supported with supplies including diarrhoea kits, life savining intravenousrehydration fluids, antibiotics	192 health facilities in the 9 affected districts.	192 health facilities were reached in the 9 priority districts. In addition, the projects reached additional facilities with Covid-19 case management items	MOHCC (NATPHARM) proof of delivery
Indicator 3.2	Number of health workers trained in case management for drought induced conditions	384 health workers (2 health worker per PHC facility trained in case management in the 9 affected di	546 health workers were trained across the 10 provinces in Zimbabwe	Ministry of Health and Child Care Intra Action Review reports from the 10 provinces
Indicator 3.3	Number of people receiving treatment for diarrhoea, SAM and other nutrition deficiency conditions according to country guidelines	9,600 (An average of 50 people per facility.	138,910 people received treatment for diarrhoea across the 10 provinces. In addition to the above 8587 children with malnutrition, 13268 pregnant women, 3545 children with marasmus, 5635 children with kwashiorkor and 1896 people with pellagra were reached. A total of 32931 people with	DHIS2 data

			nutrition deficiencies were reached. In total 171 841 people were reached.	
Explanation of output and indicators variance:		More were reached following reprogramming of CERF funds to target the Covid-19 response in the country.		

Activities	**Description**	**Implemented by**
Activity 3.1	Procurement of medical supplies including the diarrhoea kits	Ministry of Health and Child Care, WHO and other Health partners
Activity 3.2	Training of health workers on management of drought induced conditions	Ministry of Health and Child Care, WHO and other Health partners

Output 4	Monitoring and evaluation			
Was the planned output changed through a reprogramming after the application stage?		Yes ☐	No ☐	
Sector/cluster	Health - Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 4.1	Number of support supervision mission carried out	MOHCC and WHO to conduct supervisory support visits monthly, adding up to 6 during the project period	After reprogramming MOHCC and WHO conducted district support supervisions on Covid-19 and drought response, with 94 districts reached during project life span	Support Supervision reports
Explanation of output and indicators variance:		There was a significant number of support supervision missions that were undertaken to strengthen district capacity for drought and Covid-19 response. These changes were reflected in a reprogramming amendment approved by the CERF secretariat. .		

Activities	**Description**	**Implemented by**
Activity 4.1	Support and supervision (on the job mentoring , provision of updated job aids, updated health promotion materials, health information monitoring tools) for health facilities in drought-affected districts	Ministry of Health and Child Care

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[36] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been integrated and given due consideration.**

a. Accountability to Affected People (AAP) [37]:

The humanitarian response was anchored on the Humanitarian Program Cycle and Ministry of Health and Child Care ensured that communities participated in needs assessment and analysis, implementation and monitoring as well as operational review and planning. During the design phase, the district authorities conducted extensive consultations with health facilities, which culminated in the development of emergency preparedness and response plans. During reprogramming of funds to reflect the Covid-19 crisis, similar consultations were conducted and informed the design of reprogrammed project. At the facility level, the affected communities contributed to programs through the Health Centre Committee who regularly give feedback on the program during the support supervision visits.

b. AAP Feedback and Complaint Mechanisms:

As of the time of writing the complaints mechanisms were at various stages of development in the affected provinces. It was observed that in Manicaland the feedback mechanism was developed around Health Centre Committees where communities are able raise concerns over project implementation. The project team and Ministry of Health and Child Care were also able to respond to issues raised during the supportive supervision.

c. Prevention of Sexual Exploitation and Abuse (PSEA):

To ensure that affected communities are protected from sexual exploitation and abuse, WHO continues to uphold and promote policies on sexual exploitation and abuse in all the areas of operation. They include ensuring that all staff undergo mandatory training on PSEA and ensuring that all staff are aware of reporting mechanisms. At the operational level, WHO also continued to discuss PSEA issues with MOHCC and other health partners. At community level, WHO, MOHCC and health partners also sensitised communities on PSEA as well as reporting mechanisms.

d. Focus on women, girls and sexual and gender minorities, including gender-based violence:

The drought situation and Covid-19 outbreak have tended to exacerbate gender inequality. To address these disparities, WHO and partners gathered data and addressed the causes of women's and men's lack of access to health services through provision for Covid-19 testing services among others.

e. People with disabilities (PwD):

As part of strengthening accountability to people with disabilities (PwD), MOHCC, WHO and health partners promoted people centred approaches which upholds inclusion of people with disabilities.

f. Protection:

The project mainstreamed protection from the design phase and all the interventions that were instituted ensured prioritisation of safety and dignity as the vulnerable communities accessed health services. Further, they also addressed barriers to meaningful access to health

[36] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

[37] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

services through paying particular attention to vulnerable groups, e.g ensuring that old people had access to Covid-19 testing. The project also fostered participation of vulnerable communities starting with grassroots structures such as Health Centre Committees.

g. Education:

The project addressed included an education component in the form of risk communication and community engagement (RCCE) on drought related conditions and Covid-19, which used various media platforms including social media. MOHCC, UNICEF, WHO and health partners developed a communication plan which ensured effective communication with the public, engaging with communities, local partners and other stakeholders to help prepare and protect individuals, families and the public's health during early response to Covid-19.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	0

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Cash and Voucher assistance was not utilised as most of the commodities were purchased and distrubted through NATPHARM. However, WHO and Health partners would consider discussion on the use of this modality for the next funding cycle.

9. Visibility of CERF-funded Activities

Title	Weblink
Infection Prevention and Control	https://www.afro.who.int/news/frontline-health-workers-follow-who-ipc-guidelines-they-provide-care-Covid-19-patients
Rapid Response Team on job trainings	https://www.afro.who.int/news/ministry-health-and-child-care-mohcc-provides-job-support-masvingo-province-Covid-19-rapid
Seke RRT Training	https://www.afro.who.int/news/seke-district-rapid-response-team-drrt-supports-beatrice-isolation-centre-Covid-19-case

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Sector	Agency	Implementing Partner Type	Total Funds Transferred in USD
20-RR-FAO-006	Agriculture	FAO	INGO	$44,905
20-RR-FAO-006	Agriculture	FAO	NNGO	$53,960
20-RR-FPA-006	Gender-Based Violence	UNFPA	NNGO	$267,802
20-RR-FPA-006	Gender-Based Violence	UNFPA	NNGO	$106,050
20-RR-FPA-006	Gender-Based Violence	UNFPA	NNGO	$34,708
20-RR-FPA-006	Gender-Based Violence	UNFPA	NNGO	$66,468
20-RR-FPA-006	Gender-Based Violence	UNFPA	INGO	$106,053
20-RR-FPA-007	Health	UNFPA	GOV	$61,460
20-RR-CEF-007	Child Protection	UNICEF	NNGO	$184,943
20-RR-CEF-007	Child Protection	UNICEF	NNGO	$120,000
20-RR-CEF-007	Child Protection	UNICEF	NNGO	$38,757
20-RR-CEF-007	Child Protection	UNICEF	NNGO	$129,137
20-RR-CEF-007	Child Protection	UNICEF	INGO	$70,000
20-RR-CEF-007	Child Protection	UNICEF	NNGO	$20,000
20-RR-CEF-007	Child Protection	UNICEF	NNGO	$15,000
20-RR-CEF-007	Child Protection	UNICEF	INGO	$169,829
20-RR-CEF-008	Health	UNICEF	GOV	$654,561
20-RR-CEF-009	Nutrition	UNICEF	INGO	$127,954
20-RR-CEF-009	Nutrition	UNICEF	INGO	$89,480
20-RR-CEF-009	Nutrition	UNICEF	NNGO	$80,763
20-RR-CEF-009	Nutrition	UNICEF	INGO	$125,230
20-RR-CEF-009	Nutrition	UNICEF	NNGO	$89,768
20-RR-CEF-009	Nutrition	UNICEF	GOV	$713,651
20-RR-CEF-010	Water, Sanitation and Hygiene	UNICEF	NNGO	$211,331
20-RR-CEF-010	Water, Sanitation and Hygiene	UNICEF	NNGO	$239,007
20-RR-CEF-010	Water, Sanitation and Hygiene	UNICEF	INGO	$249,326
20-RR-WFP-006	Food Assistance	WFP	INGO	$341,512
20-RR-WFP-006	Food Assistance	WFP	NNGO	$72,304
20-RR-WFP-006	Food Assistance	WFP	NNGO	$164,340
20-RR-WFP-006	Food Assistance	WFP	NNGO	$65,195

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

CHW	Community Health Worker
DWSSC	District Water and Sanitation Sub Committee
IDSR	Integrated Disease Surveillance and Response
IPC	Intgrated Food Security Phase Classification
LEAD	Linkage for the Economic Advancement of the Disadvantaged
LSA	Lean Season Assiistance
OSC	One Stop Centres
RCCE	Risk Communication and Community Engagement
RRT	Rapid Response Teams
RUTF	Ready To eat Therapeutic Foods
SRH	Sexual and Reproductive Health
VHW	Village Health Worker