CERF ALLOCATION REPORT ON THE
USE OF FUNDS AND ACHIEVED RESULTS

ZIMBABWE
RAPID RESPONSE
MEASLES
2022

22-RR-ZWE-55485

Edward Kallon

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.	12 July 2023	
A mini-AAR was conducted at the operational level. An expanded ICCG was called for and the meeting had members of the ICCG and 5 NGOs who are not traditional members of the ICCG.		
Please confirm that the report on the use of CERF funds was discussed with the Humanitarian and/or UN Country Team (HCT/UNCT). Report was shared with the HCT, findings from the AAR will also be presented and discussed at the HCT meeting	Yes ☒	No ☐
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 ☐

1. STRATEGIC PRIORITIZATION

Statement by the Resident/Humanitarian Coordinator:

The April 2022 Measles rapidly spread to all the ten provinces in the country resulting in 4,087 cases and 405 deaths by August. Covid induced disruptions to routine vaccinations, funding constraints, and the occurrence of the outbreak among vaccine hesitant communities in hard-to-reach areas were identified among the key factors contributing to the rapid spread of the disease during CERF application strategic analysis and prioritization. The CERF focus was thus containment and lifesaving especially of children an age group recording the highest attack rate. While the government provided vaccination, CERF funds enabled purchase of additional vaccines, operational support, supplies for measles vaccination, and strengthened RCCE to increase uptake of vaccination and reduce measles transmissions.

The outbreak started slowing down by the third month of CERF implementation. While this could not be solely attributed to the CERF interventions, increased engagement among partners as a result of the CERF activities and increased material, technical and operational support, allowed for reach of higher numbers of individuals delivering a fast response to communities in the ten most affected districts. Investments made during CERF not only averted deaths but contributed to long term health outcomes. RCCE efforts among vaccine hesitant communities led to some behavioural change and softening of attitudes towards life-saving vaccinations. The operational support to hard-to-reach communities also ensured increased attention of the national health response to such areas.

CERF's Added Value:

With high staff attrition and reduced funding support, the increased burden from the outbreak and weakened health system potentially impacted every aspect of the Measles response. CERF funding enabled quick investigation of suspected cases for relevant follow up. A total of 273 samples were collected from October 2022 to March 2023. This in return informed preparedness and response activities including refresher sessions on case management and prepositioning of necessary drugs. Focal persons were re-oriented on measles case-based surveillance and how to conduct active case search. By March 2023, provinces had managed to conduct 540 active case searches and vaccinated a total of 611,587 children aged 5-14 years representing a measles vaccination coverage of 99.9 per cent of the targeted children. Rapid case search contributed to early containment of the outbreak. Additionally, 13,171 children aged 9-59 months missed during the under-5-years vaccination campaign were also vaccinated. The CERF - funded active case searches also led to identification of gaps mainly unimmunized children who eventually got immunized through government follow up programmes.

RCCE interventions were key in influencing community members from the vaccine hesitant religious groups to bring children below 15 years for lifesaving vaccination in 8 districts (Chikomba, Chipinge, Chiredzi, Mwenezi, Gutu, Bikita, Goromonzi and Mazowe). Lifesaving message dissemination on hygiene promotion and vaccination, and establishment of community based peer educators was specifically vital. Capacitated teams of 1,452 school health masters and 4,262 Village Health Workers, conducted targeted social mobilisation to raise awareness on vaccination campaign and build vaccine acceptance.

Did CERF funds lead to a fast delivery of assistance to people in need?

Yes ☒ Partially ☐ No ☐

Lack of operational costs, and insufficient supplies of vaccines were part of the major gaps in the response. CERF funding ensuring that teams were mobile and able to deliver assistance in hard-to-reach areas. Areas that would have waited longer before being serviced were covered with the availability of CERF funds.

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

The support came when the country was still in the middle of the measles outbreak and therefore helped to close critical gaps and needs such as procurement of laboratory reagents, transportation of specimens, training of health workers on surveillance and case

management and vaccination of the targeted age group leading to containment of the outbreak. The country had applied to the Measles-Rubella Initiative, and as the vaccines took long to be delivered, CERF procured vaccines were made available, hence enabling the Measles vaccination campaign to commence in the eight most affected districts.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

UNICEF and WHO worked together in development of the proposal (submitted as two separate projects) and supervision of the implementation of the vaccination campaign. Meetings were held with Red Cross and the organization supported at district level in Masvingo with mobilisers and supervision. At implementation, other community-based organisations as Youth Empowerment and Apostolic Women Trust worked with MoHCC to address issues of service demand and access.

Did CERF funds help improve resource mobilization from other sources?

Yes ☐ Partially ☒ No ☒

UNICEF unlocked internal funds to respond to the outbreak.

Considerations of the ERC's Underfunded Priority Areas[1]:

The most pressing priority need was access to women, girls and children belonging to the Apostolic faith religious groups that prohibit use of modern health interventions. Mortality at community level among children from such groups is usually very high. While resources from this grant enabled access to these groups through the Apostolic Women Empowerment Trust (AWET) with risk communication and community engagement, much still needs to be done to expand this reach in all provinces.

The CERF response targeted actions that ensured the inclusion of women and girls, migrants, internally displaced persons, and mobile population, including linking the affected populations with on-going child protection, gender-based violence, reproductive health, and empowerment services, which were offered through integrated vaccination campaigns. Additionally, the response design ensured that People Living with Disability are included by removing barriers to access. The response directly assisted 61,606 people living with disability (PwDs), and this was achieved through adopting an inclusive RCCE approach, where the perceptions of learners with disability were gathered during the rapid assessments and key barriers noted were on access to information on vaccination and hygiene promotion messaging.

However funding challenges hindered participation of other sectors like protection to provide sustained input into the entire process. Priority had to be given to purchase of vaccine which was the greatest need.

[1] 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.

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	**11,842,048**
CERF	1,508,647
Country-Based Pooled Fund (if applicable) N/A	N/A
Other (bilateral/multilateral)	3,912,650
Total funding received for the humanitarian response (by source above)	**5,421,297**

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

Agency	Project Code	Sector/Cluster	Amount
UNICEF	22-RR-CEF-068	Health	889,759
WHO	22-RR-WHO-040	Health	618,888
Total			**1,508,647**

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

Total funds implemented directly by UN agencies including procurement of relief goods	**1,303,031**
Funds sub-granted to government partners*	N/A
Funds sub-granted to international NGO partners*	N/A
Funds sub-granted to national NGO partners*	205,616
Funds sub-granted to Red Cross/Red Crescent partners*	N/A
Total funds transferred to implementing partners (IP)*	**205,616**
Total	**1,508,647**

* 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:

Zimbabwe responded to a measles outbreak from April 2022 to March 2023, which was reported in parts of the country. The disease was first recorded in Manicaland province, Mutasa district, on the 10th of April 2022 and spread to 46 out of the country's 63 districts (73 per cent) in all provinces. As of 9 September 2022, a cumulative total of 6,551 cases, 4,633 recoveries, and 704 deaths had been reported. The situation was further compounded by relatively high attack rates in children over 5, in the age groups 5-9 and 10-14 years respectively. Concurrently, the country was facing the threat of importation on wild poliovirus where cases had been reported from Malawi and Mozambique that necessitated response through two nationwide rounds of supplementary polio immunization. COVID-19 cases continued to be reported in all districts of the country and vaccination to COVID-19 was being integrated into other vaccination activities. These challenges were compounded by weaknesses in the health system that included chronic underfunding, high staff attrition rates including at health facility level, weaknesses in supply chain management and declining routine vaccination coverage rates. The government responded to the measles outbreak by initiating the vaccination of children under 5 regardless of vaccination status, but there was a huge gap in vaccines supply, capacities for surveillance, diagnosis and case management, and risk communication and community engagement to key communities particularly vaccine hesitant communities.

Operational Use of the CERF Allocation and Results:

In response to the crisis, the RC/HC for Zimbabwe requested $1.5 million on 23 September 2022 from CERF's Rapid Response window for life-saving activities concerning the ongoing Measles outbreak since 10 April 2022. This funding enabled UN agencies (UNICEF and WHO) and partners to provide life-saving assistance to 616,052 of the most vulnerable affected people, including 305,153 boys, 310,899 girls, and 137,075 people with disabilities to access critical health, WASH, risk communication and community engagement services as part of this response. The Initial target was based on an assumed pooling of resources from CERF (purchase of 673,199 vaccines doses and campaign operational funds) and procurement of an additional 697,667 vaccines that were to be sourced through the Measles-Rubella (MR) Initiative. Due to price variations, 640,000 vaccine doses were procured through CERF. However, with COVID-19 pandemic induced disruptions still prevailing, 402,865 children were reached during the campaign, while vaccine supplies continued to support routine immunizations post-campaign. In total, the pooled resources targeted 8 rural districts and 2 metropolitan cities (total 10 districts) with a combined target of 1,370,756 children. However, given MR Initiative vaccine application eventually did not materialize, the number of districts reduced to 8, with the two metropolitan cities of Harare and Bulawayo (target 697,667) excluded.

People Directly Reached:

The CERF response had initially been planned to target 1,370,756 children under 15 years old. However, due to inadequate vaccines, the target population through CERF funding was revised to 8 districts to target 612,206 children, excluding Harare and Bulawayo, which had a combined target population of 758,550. With the CERF funding, 640,000 vaccines were procured, and directly reached out to a total of 616,052 people including 611,587 children below the age of 15 years across 8 districts who were vaccinated using the CERF procured MR vaccine.

The data collection for this information was conducted using specially designed tally sheets and summaries, structured to capture sex and age-disaggregated data, and through counting the doses administered to establish the number of children reached, the possibility of double counting was eliminated. Additionally, vaccination teams were capacitated on this methodology, including the capture of data in the national health information management system for access at all levels of the health delivery system. Data quality and performance monitoring were managed by the national command centre. The MR1 coverage increased in the 8 targeted districts, thereby contributing to containment of the measles outbreak. RCCE interventions contributed to vaccination of children below 15 years in 8 districts through dissemination of lifesaving messaging on hygiene promotion and vaccination, capacity building of 1,452 school health masters and 4,262

Village Health Workers, who conducted targeted social mobilisation to raise awareness on vaccination campaign and build vaccine acceptance.

People Indirectly Reached:

The CERF funded Measles campaign, through risk communication and community engagement activities, reached an estimated total of 1,000,000 people through multi-media platforms, where a total of 114 announcements were broadcast on 3 radio stations (2 national and 1 provincial). Additionally, other community engagement activities reached 650,000 parents and caregivers in the 8-priority districts, including through field campaigns and other community platforms. These populations were reached with life-saving targeted messages on prevention of transmission, measles vaccination, hygiene promotion, and behavioural change to reduce infant and child mortality, with an emphasis on providing clarity to community perceptions and beliefs and encouraging vaccine acceptability amongst vaccine-hesitant communities (religious apostolic sects). On training, a total of 1,340 health care workers were capacitated on measles case management and surveillance, thereby conducting some 540 active case searches, which additionally integrated surveillance for other vaccine-preventable diseases and polio. Supportive supervision was also integrated and offered an opportunity for managers to address other health issues at facilities. A total of 13,171 children under the age of 5 benefited from the measles vaccination campaign. In Harare city, 3,892 children were reached with Vitamin A supplementation and others with critical life-saving and routine vaccination supplies.

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

	Planned					Reached				
Sector/Cluster	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Health	0	0	712,793	657,963	**1,370,756**	0	0	310,899	305,153	**616,052**

* 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	68,538	30,803
Returnees	0	0
Internally displaced people	68,538	30,803
Host communities	1,233,680	554,446
Other affected people	0	0
Total	**1,370,756**	**616,052**

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	0	0	0	0
Men	0	0	0	0
Girls	712,793	310,899	71,279	32,035
Boys	657,963	305,153	65,796	29,571
Total	**1,370,756**	**616,052**	**137,075**	**61,606**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 22-RR-CEF-068

1. Project Information

Agency:	UNICEF	**Country:**	Zimbabwe
Sector/cluster:	Health	**CERF project code:**	22-RR-CEF-068
Project title:	Strengthening Measles outbreak response in 10 most affected districts in Zimbabwe		
Start date:	21/10/2022	**End date:**	20/04/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 7,200,000**
Total funding received for agency's sector response to current emergency:	**US$ 3,100,000**
Amount received from CERF:	**US$ 889,759**
Total CERF funds sub-granted to implementing partners:	**US$ 205,615.88**
Government Partners	US$ 0
International NGOs	US$ 0
National NGOs	US$ 205,615.88
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF RR grant, the Ministry of Health and Child Care, WHO, and UNICEF managed to: vaccinate 611,587 children under 15 years, a 99.9 per cent coverage of the target population; train 1,340 health care workers on measles case management and surveillance, enabling them to conduct 504 active case searches; educate 1,452 school-based health focal points and 4,262 village health workers on social mobilisation to raise awareness on the vaccination campaign and build vaccine acceptance; reach 1,000,000 people through multi-media platforms and 650,000 parents and caregivers with life-saving measles preventative messaging and education on hygiene promotion. Through the supplementary immunisation activity (SIA), children aged 5–10 years (56 per cent) formed most of the population that was reached, while the 11–under-15-year-old age group accounted for 41 percent. Only 3 per cent were children under 5 years of age.

The project assisted a total of 652,400 people, including children and caregivers, with education on the measles outbreak and through administering the measles vaccination in the 8 priority districts i.e., Chikomba, Chipinge, Chiredzi, Mwenezi, Gutu, Bikita, Goromonzi and Mazowe between October 2022 and March 2023.

3. Changes and Amendments

In the application the target population was 1,370,756 but the 2 cities with a combined target population of 758,550 did not participate in the vaccination campaign due to inadequate vaccines. Therefore, a new target was set for only 8 Districts which is 612,206. The 2 cities ended up conducting an intensification of routine immunisation for 5 days using the operational funds. Harare and Bulawayo Metropolitan Provinces initially planned a target of 1,370,756, which were then excluded from the CERF response due to inadequate vaccines. The two provinces had a combined target of 697,667, and these were planned to receive support (vaccines) from other funding streams, which eventually did not materialise.

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	17	14	**31**	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	339,231	313,138	**652,369**	0	0	310,899	305,153	**616,052**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**0**	**0**	**339,248**	**313,152**	**652,400**	**0**	**0**	**310,899**	**305,153**	**616,052**
People with disabilities (PwD) out of the total										
	0	0	35,006	32,314	**67,320**	0	0	32,035	29,571	**61,606**

* 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 CERF funded Measles campaign, through risk communication and community engagement activities, reached an estimated total of 1,000,000 people through multi-media platforms, where a total of 114 announcements were broadcast on 3 radio stations (2 national and 1 provincial). Additionally, other community engagement activities reached 650,000 parents and caregivers in the 8-priority districts, including through field campaigns and other community platforms. These populations were reached with life-saving targeted messages on prevention of transmission, measles vaccination, hygiene promotion, and behavioural change to reduce infant and child mortality, with an emphasis on providing clarity to community perceptions and beliefs and encouraging vaccine acceptability amongst vaccine-hesitant communities (religious apostolic sects). On training, a total of 1,340 health care workers were capacitated on measles case management and surveillance, thereby conducting some 540 active case searches, which additionally integrated surveillance for other vaccine-preventable diseases and polio. Supportive supervision was also integrated and offered an opportunity for managers to address other health issues at facilities. A total of 13,171 children under the age of 5 benefited from the measles vaccination campaign. In Harare city, 3,892 children were reached with Vitamin A supplementation and others with critical life-saving and routine vaccination supplies.

6. CERF Results Framework

Project objective	Improve availability of vaccines to at risk populations in 8 high risk districts
Output 1	Children below 15 years in the 8 high risk districts receive MR vaccination

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	H.4 Number of people vaccinated (children to be reached with UNICEF CERF procured MR vaccine)	652,400	[611587]	[DHIS2]
Explanation of output and indicators variance:		Please see above		

Activities	**Description**	**Implemented by**
Activity 1.1	Procurement and delivery of MR vaccine to the targeted population	[UNICEF, MOHCC]
Activity 1.2	Monitoring of vaccination activities in targeted districts	[UNICEF, MOHCC]

Output 2	Children and caregivers in 10 high risk districts reached with lifesaving messaging on measles vaccination, hygiene promotion and health seeking behaviours

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 implementing partner staff receiving training to support programme implementation	2	2	Programme Documents

Indicator 2.2	# of children, caregivers and individuals engaged through interpersonal channels on lifesaving practices and available services (by location, age, gender, disability)	652,400	650,000 Bikita 65,000 Chikomba 40,000 Chipinge 135,000 Chiredzi 125,000 Goromonzi 20,000 Gutu 75,000 Mazowe 75,000 Mwenezi 120,000	DHIS2
Indicator 2.3	# of people (disaggregated by age & sex) who shared their concerns and asked questions/clarifications to address their needs through the established feedback mechanisms	60,000	62,382 (2,382 children 10-15years 40,000 females +18years 20,000 males +18years	[Post Campaign Rapid Assessment Report CSO Community Feedback Platforms (AWET Hotline, Community Dialogues report Youth Advocates Helpline 393 and Community Dialogues Reports
Explanation of output and indicators variance:		Two targeted areas (Harare and Bulawayo Metropolitan Provinces) were not vaccinated due to inadequate vaccines. These two provinces were planned to be vaccinated using vaccines from other funding streams which did not materialise.		

Activities	**Description**	**Implemented by**
Activity 2.1	Disseminate lifesaving vaccination, health and hygiene promotion messaging through mass media, roadshows, schools, and community platforms	CSO Partners including Youth Advocates, Apostolic Women Empowerment Trust in collaboration with Ministry of Health and Child Care (MoHCC).
Activity 2.2	Refresher training for local actors (community-based cadres, school health masters, environmental health officers) on interpersonal communication, integrated hygiene promotion, vaccine demand creation, community surveillance and triggering in high-risk communities	CSO Partners including Youth Advocates, Apostolic Women Empowerment Trust in collaboration with Ministry of Health and Child Care (MoHCC).
Activity 2.3	Community engagement through social mobilizers and key influencers to build trust in vaccine, manage misinformation and rumours, targeting children and caregivers (mobile populations, caregivers, vaccine hesitant, zero dose and boarder communities)	UNICEF and CSO partner Youth Advocates which supported the establishment of 136 school health clubs and capacitated 1,452 School Health Focal Points on integrated hygiene promotion and vaccine demand promotion. AWET capacitated 241 religious' leaders in 4 districts (Bikita, Chipinge, Gutu and Mwenezi). The leadership conducted community dialogues to address rumours and misinformation influenced by religious beliefs and gender norms related to access to vaccination services.
Activity 2.4	Social listening and utilization of community feedback for enhanced accountability to affected populations	CSO partners conducted offline social listening through network of Youth Volunteers and Behaviour Change Facilitators. Community dialogues and counselling sessions through Youth helpline were utilized as platforms to address feedback and emerging concerns.

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[2] 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 addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP)[3]:

RCCE efforts adopted a people-centred approach integrating Accountability to Affected Populations (AAP) in the design, implementation, and monitoring of the vaccination campaign. Key activities conducted include:

- Production and dissemination of 3,000 posters in 3 of the main official languages including English, Shona, and Ndebele to raise awareness and promote utilization of available feedback platforms, referral services and linkages to address protection issues (sexual exploitation and abuse, violence against children, gender-based violence)
- Capacity strengthening of 12 call-centre/helpline counsellors on documentation, reporting and referral mechanisms. These provided information and counselling to address fears and concerns raised by learners and caregivers through the Youth Helpline platform.
- Orientation of 4,462 community volunteers (4,262 Village Health Workers, 200 Behaviour Change Facilitators) on detecting high-risk transmission mobility corridors, hot spots, and coordination with District Rapid Response Teams.
- Post campaign rapid survey with learners and caregivers' feedback on the vaccination campaign to inform future campaigns highlighting the role of caregivers.

b. AAP Feedback and Complaint Mechanisms:

The RCCE partners promoted utilization of Youth Helpline 393, tollfree hotlines, AWET toll free hotline 8677008840, trusted community volunteers and leaders were the preferred community feedback channels. A community and school-based rapid assessment was conducted in 6 priority districts with low coverage of measles vaccination (Chipinge, Chiredzi, Gutu, Mwenezi, Bikita and Mazowe). 76 per cent of learners were aware of the symptoms of measles. Majority of participants were hesitant, rather than opposed to vaccination. Vaccine hesitancy was triggered by misinformation and conspiracy theories, fear of side effects, rumours of death, vaccine safety concerns, and lack of trust in politicians. Running parallel vaccine programs was also highlighted as one of the factors contributing to mistrust in vaccination campaigns. Based on the insights, CSOs developed messaging stressing the benefits of vaccination and capacitated key influencers (religious leaders, teachers) to demystified myths, address misinformation and build trust in vaccination through community engagement interventions.

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

The response managed to raise awareness on the prevention and reporting of Sexual Exploitation and Abuse (SEA) through broader information dissemination about how to report and receive assistance, while prioritizing 3 key benchmarks: 1. Safe and accessible reporting – ensuring every child and adult has access to a safe, child- and gender-sensitive SEA reporting mechanism; 2. Quality and accessible SEA assistance – Every child and adult who reports SEA has access to immediate, quality SEA survivor centred assistance,

[2] 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.

[3] 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.

including referral pathways. The partners printed and distributed 3,000 posters (English, Shona, and Ndebele) with messaging on SEA and child rights violations reporting channels. Focus Group discussions were held with children on safe reporting channels.

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

The CERF response targeted actions that ensured the inclusion of women and girls, migrants, internally displaced persons, and mobile population, including linking the affected populations with on-going child protection, gender-based violence, reproductive health, and empowerment services, which were offered through integrated vaccination campaigns. Community dialogues, confidential feedback reporting channels were applauded as safe spaces for women to discuss and seek referrals for services.

e. People with disabilities (PwD):

The response directly assisted 61,606 people living with disability (PwDs), and this was achieved through adopting an inclusive RCCE approach, where the perceptions of learners with disability were gathered during the rapid assessments and key barriers noted were on access to information on vaccination and hygiene promotion messaging. A multi-channel approach to RCCE was adopted, no child was left behind. During the vaccination campaign, community-led action included provision of transport to children with disabilities and their caregiver to facilitate access to vaccination centres.

f. Protection:

Partners implementing the CERF response conducted a survey to understand channels to report gender-based violations and child abuse preferred by children in the targeted districts. Use of police stations was the most popular channel that learners (82 per cent) would prefer to report child rights, gender-based violations and sexual exploitation followed by schools (51 per cent) and trusted family members or relatives (38 per cent). However, although highly ranked, community members expressed scepticism on reporting child rights, gender-based violations and sexual exploitation to the police. Based on the insights, partners integrated messaging on measles vaccination, protection and GBV risk mitigation and developed a directory of referral services in the targeted districts, contributing to increased awareness on rights of affected populations and available reporting channels and referral services. The referral network for counselling services included community volunteers, Youth Helpline and a hotline for a women's organisation (Apostolic Women Empowerment Trust).

g. Education:

Through RCCE activities, children in schools, particularly in the under 15 years age-groups were reached with lifesaving information to facilitate their immunization and adoption of hygiene behaviours to prevent measles transmission. Feedback from the children demonstrated high acceptance of vaccination and hygiene promotion practices, which are considered as key to making the learning environment a safe place for children and for facilitating continuity of learning.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No		

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.

N/A

Parameters of the used CVA modality:				
Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
N/A				

9. Visibility of CERF-funded Activities

Title	**Weblink**
Success Story: Apostolic sect women defy religious teaching to save their children	https://www.unicef.org/zimbabwe/stories/apostolic-sect-women-defy-religious-teachings-save-their-children.
Social Media Post: Vaccines and Safe	Mass Measles Vaccination Campaign Social Media Post
Social Media Post: Vaccines save lives, promote continuity of learning	Vaccine benefits social media post

3.2 Project Report 22-RR-WHO-040

1. Project Information

Agency:	WHO	**Country:**	Zimbabwe
Sector/cluster:	Health	**CERF project code:**	22-RR-WHO-040
Project title:	Strengthening Measles outbreak response in 10 most affected districts in Zimbabwe		
Start date:	01/10/2022	**End date:**	31/03/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 4,642,048**
Total funding received for agency's sector response to current emergency:	**US$ 812,650**
Amount received from CERF:	**US$ 618,888**
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 the CERF grant, MoHCC with assistance from WHO and other partners, trained all health workers (1 340) at facility level in case management, case based surveillance for measles and IDSR, collected 240 samples that were transported to the laboratory for investigation, supported supervisors in conducting supervisory visits to facilities 540 visits documented on ODK, conducted community based microplanning at facility level in preparation for the measles vaccination campaign, managed to review citing of outreach points for routine immunisation during planning, and conducted a vaccination campaign reaching 602,745 children from 5-14 years. A total of 17,080 children under the age of 5 benefited from the measles vaccination campaign. In addition, Harare City reached 1 377 with Penta 1,581 with Penta3 and further with OPV1 (377), OPV3 (596), IPV1 (596), IPV2 (786), MR1 (800), MR2 (975), and Vitamin A (3,802) during the RI intensification exercise which was conducted for 5 days.

3. Changes and Amendments

In the application the target population was 1,370,756 but the 2 cities with a combined target population of 758,550 did not participate in the vaccination campaign due to inadequate vaccines. Therefore, a new target was set for only 8 Districts which is 612,206. The 2 cities ended up conducting an intensification of routine immunisation for 5 days using the operational funds.

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	15,426	15,153	**30,579**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	15,425	15,154	**30,579**
Host communities	0	0	712,793	657,963	**1,370,756**	0	0	277,663	272,766	**550,429**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**0**	**0**	**712,793**	**657,963**	**1,370,756**	**0**	**0**	**308,514**	**303,073**	**611,587**
People with disabilities (PwD) out of the total										
	0	0	71,279	65,796	**137,075**	0	0	29,356	31,802	**611,58**

* 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

During planning for vaccination, review of outreach points and access was also done to ensure continued access of services by the communities. The communities had an opportunity of getting information regarding other health issues being faced in the community. A total of 17,080 children under the age of 5 benefited from the measles vaccination campaign. In addition, Harare City reached 1 377 with Penta 1,581 with Penta3 and further with OPV1 (377), OPV3 (596), IPV1 (596), IPV2 (786), MR1 (800), MR2 (975), and Vitamin A (3,802) during the RI intensification exercise which was conducted for 5 days.

A total of1,340 health care workers were trained on measles case management and surveillance thereby strengthening them for future events. Some 540 active case searches were conducted, and the searches were integrated with other VPDs including AFP surveillance. Supportive supervision was integrated and offered opportunity for managers to address other health issues at facilities

6. CERF Results Framework

Project objective	To support measles response in the 10 priority districts in Zimbabwe
Output 1	Support administration of measles vaccine to all eligible children in the 10 priority 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	Proportion of children that receive the measles vaccine in the 10 priority districts Only 8 Districts participated	95%	100.6%	DHIS tool
Indicator 1.2	H.4 Number of people vaccinated	1,370,756	616,052	DHIS
Explanation of output and indicators variance:		In the application the target population was 1,370,756 but the 2 cities with a combined target population of 758,550 did not participate in the vaccination campaign due to inadequate vaccines. Therefore, a new target was set for only 8 Districts which is 612,206		

Activities	**Description**	**Implemented by**
Activity 1.1	Provision of logistics support for transportation of vaccines and outreach vaccination teams	WHO
Activity 1.2	Mobilization and vaccination of the target children in 10 priority districts	MoHCC
Activity 1.3	Data capturing and reporting	MoHCC

Output 2	Strengthen measles surveillance and monitoring and evaluation of programmatic efforts to ensure progress.

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 measles samples transported to the laboratory for confirmation (3000 samples (50 samples per district per month for six months)	3000	723	[Linelisting from Laboratory, Invoices from courier and case investigation forms]
Indicator 2.2	CC.1 Number of implementing partner staff receiving training to support programme implementation (Number of people trained on IDSR)	100	1340	[training attendance forms]
Indicator 2.3	Number of cases of measles detected through active case search (50% percent of the current cases)	4000	3000	[Active case search form on ODK, Reports, Registers]
Explanation of output and indicators variance:		Project implementation started after the outbreak had been confirmed. So samples were not necessarily collected from every case but periodically to keep track of the evolution of the outbreak and to confirm its end later. The target was therefore an overestimate and the number of samples actually collected are still a good epidemiological rate of testing.		

Activities	**Description**	**Implemented by**
Activity 2.1	Transportation of measles samples for laboratory confirmation	Specimens sent through swift courier)
Activity 2.2	Abridged IDSR training for the affected districts	Participating facilities in campaign trained during preparation for campaign at all facilities
Activity 2.3	Active case searches and contact tracing through village health workers and EHT	Surveillance focal persons at facilities and Village health workers

Output 3	Strengthen and maintain measles outbreak preparedness and response and management of cases.
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	Percentage of children who receive measles treatment	8000	8000	T 6 reporting and registers at facilities)
Indicator 3.2	1 site visit per quarter per district	20	50	ODK
Explanation of output and indicators variance:		[Site visits were integrated/combined with other non-Measles visits hence the number of visits for case identification and supervisions increased.		

Activities	**Description**	**Implemented by**
Activity 3.1	Support measles case management in the priority districts	[Provincial and National supervisors]
Activity 3.2	Site support supervision by the Provincial Health Executive	[540 visits documented in ODK]

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 addressed through project activities and should highlight the achieved impact wherever possible.**

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

The country conducted community-based microplanning involving influential persons as community leaders, village health workers, school teachers, women's groups, politicians and religious groups, During these planning meetings agreed sites for vaccinations and time were established. This formed a basis of partnership and village health workers were a link with health workers in reporting all events in community.

b. AAP Feedback and Complaint Mechanisms:

The Village health worker was tasked to keep a register of all children affected and not affected; Information was shared with Health worker on daily basis at the nearest facility. A feedback of laboratory results was given to each client whose child had a sample collected for investigation. Similar feedback was shared with the Village health workers to inform the community and steps to take.

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

During training, participants were educated on the Prevention of Sexual Exploitation and Abuse (PSEA). All partners in the program were advised to report any form of PSEA including the relevant reporting channels and guidelines. In addition, social communication channels were set up for increased collaboration, participation, response, and action to, PSEA related concerns.

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

The CERF response prioritised the inclusion of minorities, particularly women, and girls. This was achieved through the deployment of largely female led/composed vaccination staff teams, including for the promotion of peer education in the priority districts.

e. People with disabilities (PwD):

The response managed to reach 61,606 PwDs, in complement of other vaccine uptake strategies, the set up of a vaccination site, in Ruwa, increased ease of access to vaccine services for the PwDs target population. Additionally, the house-to-house vaccination strategy was employed in other communities were mobility challenges associated with disability were prevalent in ensuring that the campaign left no-one behind.

f. Protection:

The project considered the demographic profiles of the priority districts, including by collecting sex and age disaggregated data to ensure an all-inclusive response.

[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.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA) Not Applicable

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	Choose an item.	

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 interventions dealt with support to the ministry of Health

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**

9. Visibility of CERF-funded Activities.

Title	Weblink
Success story	https://www.afro.who.int/countries/zimbabwe/news/reaching-communities-risk-measles-vaccination
Twitter Post on AFRO platform	https://twitter.com/WHOAFRO/status/1659846618496024576 https://www.facebook.com/WHOAFRO/posts/563717739268617 (20230520)
French version	https://twitter.com/OMS_Afrique/status/1659846550388891649 (20230520) https://www.facebook.com/OMSRegionAfrique/photos/a.104046971173636/771720691072924/ (20230520)
WHO Zimbabwe twitter	https://twitter.com/who_zimbabwe/status/1620310858273378304?s=46&t=KNg51ZAVo-pXIpk8sx81KQ
	https://twitter.com/who_zimbabwe/status/1622553286774603776?s=46&t=KNg51ZAVo-pXIpk8sx81KQ
	https://twitter.com/who_zimbabwe/status/1631901280468717568?s=46&t=KNg51ZAVo-pXIpk8sx81KQ
	https://twitter.com/who_zimbabwe/status/1620075184626581506?s=46&t=KNg51ZAVo-pXIpk8sx81KQ

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Sector	Agency	Implementing Partner Type	Funds Transferred in USD
22-RR-CEF-068	Health	UNICEF	NNGO	$100,202
22-RR-CEF-068	Health	UNICEF	NNGO	$105,414