CERF ALLOCATION REPORT ON THE
USE OF FUNDS AND ACHIEVED RESULTS

ZIMBABWE
RAPID RESPONSE
CHOLERA
2023

23-RR-ZWE-59553

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PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:		
An AAR was not conducted mainly because by the time the grant expired, the cholera was still raging. However, at the ICCG level a Mini AAR was conducted for Measles response in July 2023 and findings were shared and discussed at the HCT meeting of August 2023. These were subsequently adopted into the cholera response and hence informed implementation of the response. An in depth Intra Action Review was just concluded in July 2024.	[NA]	
The report was discussed as part of the ongoing cholera response. The Grant expired while cholera was still ongoing. CERF allocated additional money through an Anticipatory Action application and the cholera response was continuing. HCT and ICCG are both forums where partners and clusters implementing the response present progress updates but also get to learn on what other partners are also doing in the cholera fight.	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:

Zimbabwe went through a cholera outbreak since the 12th of February 2023. The first case was recorded in Chegutu district (Mashonaland West province). The outbreak spread to over 55 out of 63 districts by January 2024 in the country in all the provinces. As of 06 September 2023, a cumulative total of 29842 cases and 569 deaths had been reported bringing the CFR to 2.2% which was above the acceptable WHO threshold of 1%. CERF then allocated Zimbabwe a US$1 million grant to respond to the outbreak. The main objectives were to a) reduce morbidity and mortality due to cholera in the 15 districts and b) provide access to safe water, sanitation, and hygiene in cholera-affected communities in selected provinces of Zimbabwe. The grant targeted 500,000 people, including 103,054 men,111,642 women, 285,303 children and 35,000 persons with disabilities. The grant contributed to strengthened capacities of rapid response teams and frontline responders in cholera and diarrhoea case management, and IPC at CTCs/CTUs and oral rehydration points and in refugee camps while ensuring that population at risk of Cholera were enabled to adopt protective and preventive measures. To enhance complementarity, WHO collaborated with UNICEF, UNHCR and complemented government to provide these life-saving interventions to the affected communities. 34,330 were able to access safe water supply, hygiene promotion, operationalized Oral Rehydration Points, and case area targeted interventions (CATI) to reduce transmission between and among the cholera-affected households.

CERF's Added Value:

NA

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

Yes ☒ Partially ☐ No ☐

By September 2023, assistance reached the 15 cholera impacted districts. Oral Rehydration Points and Cholera Treatment Centres were also availed in hot pots areas. As the cholera outbreak raged, it became obvious that affected communities were travelling long distances to access medical attention. This was said to be contributing to the spread of the disease but also high case fatalities. With the CERF funding, partners were able to bring treatment closer to affected communities by setting up Treatment Centres and Oral Rehydration Points within affected communities.

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

In 15 selected districts WHO was able to reach to affected people on time with the RRT who now the capacity had to respond. UNICEF had also operationalized Oral Rehabilitation Centres enabling people to access treatment in time. These two actions ensured affected communities accessed care faster and closer to their communities. At the time, most government services were only available in established health centres.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

The grant enabled the continued functioning of the EOC where partners deliberated and planned for responding to new cases as surveillance increased. Rapid Response Teams were also able to quickly get to where cases were identified. Partners were also able to reach crisis spots. WASH and hygiene promotion were provided at health facilities and in communities which improved the response.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

Other donors funded the response through the INNGOs and local NGOs and ensured that cholera affected people accessed treatment. The response to cholera also encouraged partners to collectively mobilize resources through a Flash Appeal. Response to cholera also encouraged partner to mobilize resources through a Flash Appeal. The government also committed around US$12mil to support the response.

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

[While not direct funding was provided for cross cutting areas such as AAP, PSEA, GBV, partners realised that Cholera obviously had protection issues. Using existing programmes, the HCT agreed to mainstream protection through the response. As such cholera response trainings did incorporate elements of Protection. Communities were sensitized on aspects of Protection and so were health workers.]

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	**17,405,034**
CERF	996,521
Country-Based Pooled Fund (if applicable)	[Fill in]
Other (bilateral/multilateral)	97,478
Total funding received for the humanitarian response (by source above)	**1,093,999**

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

Agency	Project Code	Sector/Cluster	Amount
UNICEF	23-RR-CEF-035	Water, Sanitation and Hygiene	500,000
WHO	23-RR-WHO-028	Health	496,521
Total			**996,521**

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

Total funds implemented directly by UN agencies including procurement of relief goods	**718,206**
Funds sub-granted to government partners*	[Fill in]
Funds sub-granted to international NGO partners*	278,315

[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.

Funds sub-granted to national NGO partners*	[Fill in]
Funds sub-granted to Red Cross/Red Crescent partners*	[Fill in]
Total funds transferred to implementing partners (IP)*	**278,315**
Total	**996,521**

* 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.

OPERATIONAL PRIORITIZATION:

Overview of the Humanitarian Situation:

The current cholera outbreak in Zimbabwe was first reported on 12 February 2023 but daily cases started to increase in mid-May 2023. As of 30 May 2023, a total of 1,799 new cholera cases and 44 deaths had been reported from 31 districts. The number of cases has been averaging 60-80 a day and could increase further. This could overburden the health care system if activities to stop transmission are not quickly scaled up. In 2022, six cholera cases had been reported after three years without any reported cases. The risk factors for the outbreak have remained the same resulting in the continued spread of the outbreak in areas that have not reported any cases. The incessant rains have compounded the situation as evidenced by the second wave that started on the 18th of September. Massive population movement associated with the festive season has worsened the situation. In response, the government has released funds from the treasury to respond to the outbreak, but this is not adequate. An appeal has been made to partners to augment government efforts.

Operational Use of the CERF Allocation and Results:

Emergency Relief Coordinator (ERC) Martin Griffiths has allocated $1 million from the Central Emergency Response Fund for an urgent response to the cholera outbreak in Zimbabwe. This funding enabled UN agencies and partners to reach 596,066 people including 154,329 men,167,381 women, 274,356 children and 35,000 persons with disabilities in the Health and WASH sectors.

In targeted hot spot areas people were provided with safe water through rehabilitation of water points. Communities also had increased access to hygiene supplies and messaging which was provided through door-to-door campaigns. For Cholera patients and the Health System in general, the allocation accelerated case management and prevention through establishment of oral rehydration points (ORPs), Risk Communication and Community Engagement (RCCE), surveillance, infection prevention and control (IPC), in targeted high-risk districts and populations. To enhance complementarity, WHO, UNHCR, UNICEF and partners collaborated and coordinated with government departments to ensure the response is multi sectoral but also to maximize on resources available through different channels.

People Directly Reached:

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Data was collected using standardized collection tools designed and adopted for use in collaboration with MoHCC. Trainings on cholera data management were conducted and among the outputs was a clear line list register which has a variable for reinfection to avoid double counting of cases. In addition to this, a unique identifier was given to each patient. Data is collated at district and provincial level and is available in DHIS2 which is the country's Health Management Information System. Periodic data harmonization exercises were conducted to ensure data quality and integrity.

To directly respond to people in hotspot areas, door-to-door campaigns were used reaching out people while rehabilitating water systems, distributing critical hygiene supplies, and enabling cholera case management through oral rehydration points (ORPs). To enable reporting and avoid double counting, registers from community health volunteers for door—to—door campaigns were used. These registers record the number of people who were within the households at the time of the first visit. For any second/repeat visits, the numbers were not recorded as direct reach but as indirect reach. The assumption was that the same people participated in the first visit. Furthermore, through trained Water Point User Committees, which were set up at the 50 rehabilitated, water point user registers were opened. These committees map and record the users of the water system, and these figures were used to establish reach. For the distribution of critical hygiene kits, distribution registers were used for reporting. The registers capture details at the household level, including the number of recipients in the house beyond the household head. In total 11,698 people were reached with hygiene supplies, information and education materials where cholera cases had been reported while 17,904 people received hygiene kits. Meanwhile, ORP registers were used to count the number of people who received services at the ORPs, about 360 ORPs were established.

People Indirectly Reached:

Following sensitization of interfaith leaders on cholera prevention and control, cascading of the cholera messages has filtered through to communities at village level and reached more people than targeted. The trainings also covered participants from different sectors and government line ministries who then cascaded the messaging through their community-based structures. A total of 1,829,455 people were reached indirectly through information, education, and communication (IEC) materials on handwashing, cholera transmission, and household prevention measures. In collaboration with partners, UNICEF, WHO and UNHCR also conducted mobile campaigns in targeted hotspot areas of Harare and Manicaland. These campaigns delivered messages on cholera prevention and provided demonstrations on handwashing and household water treatment. Radio talk shows, drama sessions in schools and at marketplaces and sports events were also utilized to promote cholera prevention messages.]

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	111,642	103,054	156,105	129,198	499,999	**134,579**	**121,859**	**156,207**	**152,927**	**565,572**
Water, Sanitation and Hygiene	110,000	105,000	155,000	130,000	500,000	167,381	154,329	143,529	130,827	**596,066**
TOTAL	221,642	208,054	311,105	259,198	999,999	301,960	276,188	299,736	283,754	**1,161,638**

* 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	4,054	0
Returnees	0	[Fill in]
Internally displaced people	0	[Fill in]
Host communities	0	[Fill in]
Other affected people	495,946	596,066
Total	**500,000**	**596,066**

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	110,000	167,381	8,076	8,076
Men	105,000	154,329	7,455	7,456
Girls	155,000	143,529	10,120	10,128
Boys	130,000	130,827	9,347	9,347
Total	**500,000**	596,066	**34,998**	**35,000**

PART II – PROJECT OVERVIEW

2. PROJECT REPORTS

3.1 Project Report 23-RR-CEF-035

1. Project Information

Agency:	UNICEF	**Country:**	Zimbabwe
Sector/cluster:	Water, Sanitation and Hygiene	**CERF project code:**	23-RR-CEF-035
Project title:	Providing access to safe water, sanitation and hygiene in cholera affected communities in selected provinces of Zimbabwe		
Start date:	01/07/2023	**End date:**	31/12/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 9,128,000**
Total funding received for agency's sector response to current emergency:	**US$ 559,000**
Amount received from CERF:	**US$ 500,000**
Total CERF funds sub-granted to implementing partners:	**US$ 220,640.00**
Government Partners	US$ [Fill in]
International NGOs	US$ 220,640.00
National NGOs	US$ [Fill in]
Red Cross/Crescent Organisation	US$ [Fill in]

2. Project Results Summary/Overall Performance

UNICEF and its partners worked with and through the Government to deliver the cholera prevention programme in the capital city, Harare (Glen View, Budiriro, and Kuwadzana suburbs), Chitungwiza, and Manicaland Province (Buhera and Mutare Rural Districts) from July 2023 to December 2023. The programme achieved the following results:

- Through the rehabilitation of 50 water points i.e., solarization of piped water systems, equipping of boreholes with handpumps and installation of inline chlorinators in Harare to reduce the risk of cholera transmission, 34,330 people now use safe and basic water services.
- A total of 596,066 people directly received hygiene messages on safe water chain, household water treatment, handwashing at critical times, and other cholera prevention strategies. This was achieved through door-to-door campaigns conducted by 200 trained community health volunteers. Additionally, 1,829,455 people were indirectly reached through 15 radio sessions, 29 mobile campaigns where handwashing and household water treatment were demonstrated, and three drama sessions organized in cholera hotspot areas to enhance hygiene practices.
- Through Case Area Targeted Interventions (CATIS), to minimize risk of transmission between and among households 11,698 people were reached with hygiene supplies, information and education materials where cholera cases had been reported.

- A total of 2,984 households (17,904 people) were provided with critical hygiene kits (*water collection and storage containers, household water treatment chemicals, IEC materials, and soap*) to promote and encourage safe water handling and good hygiene practices.
- UNICEF unblocked sewer chokes in Harare. Additionally, UNICEF took measures to decontaminate the environment after sewer overflows. These measures further reduced the risk of cholera transmission, the contamination of water sources and the general environment. The activity benefitted 4,000 people through improved sanitation.
- A total of 360 Oral Rehydration Points (ORPs) were established in Harare and Manicaland, with 4,352 people seeking treatment for dehydration – a key symptom of cholera. Of these, 322 were referred for further management at CTCs/ CTU's due to severe dehydration. The rest were managed at the ORPs and discharged home.

3. Changes and Amendments

No changes or modifications were made to planned activities as the context largely remained the same, thus UNICEF did not engage CERF to make any changes.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Water, Sanitation and Hygiene									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Other affected people	110,000	105,000	155,000	130,000	**500,000**	167,381	154,329	143,529	130,827	**596,066**
Total	**110,000**	**105,000**	**155,000**	**130,000**	**500,000**	**167,381**	**154,329**	**143,529**	**130,827**	**596,066**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	**33**	**19**	**8**	**4**	**64**

* 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 1,829,455 people were reached indirectly by UNICEF and its partners through information, education, and communication (IEC) materials on handwashing, cholera spread, and prevention mechanisms at household levels. In collaboration with partners, UNICEF also conducted mobile campaigns in targeted hotspot areas of Harare and Manicaland. These campaigns delivered messages on cholera prevention and provided demonstrations on handwashing and household water treatment. Radio talk shows on Capitalk FM and Diamond FM, along with drama sessions in schools, marketplaces, and at sports events were also utilized to promote cholera prevention messages. To reduce environmental and water contamination, sewer chokes - which were polluting urban areas with faecal matter - were also repaired.

6. CERF Results Framework

Project objective	To provide access to safe water, and hygiene to 500,000 people in cholera-affected districts in Harare and Manicaland Province, Zimbabwe
Output 1	An estimated 24,250 women, men, and children in cholera-affected areas in Harare and Manicaland province have safe access to and use a sufficient quantity and quality of water to meet their drinking and domestic needs.

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

Sector/cluster	Water, Sanitation and Hygiene

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	WS.6 Number of people accessing sufficient and safe water for drinking, cooking and/or personal hygiene use asper agreed sector standard	24,250	34,330	Water point user committee registers, Handover certificates; Partner reports.
Indicator 1.2	Number of households with access to water treatment materials	2,850	2,984	Distribution registers; Partner reports
Indicator 1.3	WS.15 Number of communal water points (e.g. wells, boreholes, water taps stands, systems) constructed and/orrehabilitated	25	50	Handover certificates; Partner reports

Explanation of output and indicators variance:	More people were reached than planned. UNICEF was able to repair or rehabilitate more water systems because UNICEF used existing borehole contingency stocks in complement to CERF funds for the other costs required to repair a borehole. Further, the cost of the proposed activity is based on a full kit of borehole parts whereas some repairs did not require all parts – enabling one kit to repair more than one borehole. In addition, as the exact sites were not defined at the time of the proposal, the average number of people per water system was based on a conservative estimate for the targeted province. However, some parts are more and less densely populated. The rehabilitations took place where the population using each water point was higher than the planned number. For WASH kits, UNICEF switched to using Waterguard, a locally produced household water treatment chemical, which has a lower unit cost than the imported Aquatabs, which is

	what was budgeted. This conversion lowered the cost of hygiene supplies, allowing UNICEF to procure more materials.	
Activities	**Description**	**Implemented by**
Activity 1.1	Emergency rehabilitation of 25 boreholes.	Government; Local Authorities; IPs/NGO's
Activity 1.2	Procurement of household water treatment chemicals	UNICEF

Output 2	250,000 at-risk and affected people in Harare and Manicaland provinces have timely access to culturally appropriate, gender- and age-sensitive information, services and interventions related to hygiene promotion, and adopt safe hygiene practices
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Water, Sanitation and Hygiene

Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	WS.16b Number of WASH/hygiene kits distributed	2,850	2,984	Distribution registers; Partner reports
Indicator 2.2	WS.17 Number of people receiving WASH/hygiene messaging	500,000	596,066	Volunteer registers; Partner reports
Indicator 2.3	WS.16a Number of people receiving critical WASH supplies (e.g. WASH/hygiene kits)	14,250	17,904	Distribution registers; Partner reports

Explanation of output and indicators variance:	UNICEF strategically used its existing contingency stock to enable distribution of critical hygiene supplies to a larger number of households in the targeted areas under the CERF project. This resulted in more hygiene kits being distributed to the affected population and reaching more people. For hygiene messaging, UNICEF leveraged a larger volunteer force to reach more people through interpersonal communication in alignment with the Ministry of Health and Child Care's strategy. The strategy was highly effective as they included all Village Health Workers (urban)/Community Health Volunteers (rural) in targeted districts, providing them with training to promote cholera prevention messages. This approach ensured more people were reached, ultimately contributing to a reduction in cholera cases.

Activities	**Description**	**Implemented by**
Activity 2.1	Procurement and distribution of hygiene kits to 2,850 households	Government; Local Authorities; IPs/NGO's
Activity 2.2	Dissemination of cholera prevention and hygiene messages in communities and institutions	Government; Local Authorities; IPs/NGO's
Activity 2.3	Case and or Cluster Area Targeted Interventions	Government; Local Authorities; IPs/NGO's

Output 3	[An estimated 500 vulnerable, cholera affected communities (250 children under 18 years-,132 girls and 118 boys, 180 women and 70 men) in Harare City and Manicaland Provinces have access to an integrated package of WASH and Health live-saving cholera interventions linked to Oral Rehydration Points]
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Water, Sanitation and Hygiene

Indicators	Description	Target	Achieved	Source of verification
Indicator 3.1	Number of Oral Rehydration Points operationalized	360	360	MoHCC and Partner reports
Indicator 3.2	Number of new suspected cholera cases referred to Oral Rehydration Points]	500	4,352	MoHCC and Partner reports
Indicator 3.3	Number of people receiving treatment for acute watery diarrhea (incl. cholera)	111	322	MoHCC and Partner reports
Explanation of output and indicators variance:		A total of 360 ORP kits were procured, for establishment of the same ORP sites to control epidemiological spread of the cases in communities. The number of cases seen at ORPs and those referred for further management were higher than the set targets as more cases were reported in localized areas.		

Activities	Description	Implemented by
Activity 3.1	Procurement of commodities for the set-up of Oral Rehydration Points (Taped Buckets with stands 8 pieces, Water Resourvoirs-20 litres, Cups-500 mls, Big size basin for storing utensils, ORS SACHETS-1 box, Long spoons for mixing ORS, PPEs-GUM BOOTS 1 pair, HEAVY DUTY GLOVES- 1 pair, LATEX GLOVES-1 par, HARD BROOMS- 1 pieces, HAND WASHING SOAP-10 litres, SODIUM HYPOCHLORIDE 10 litres and Tippy bags for handwashing soap	Government; Local Authorities; IPs/NGO's
Activity 3.2	Provide Health volunteers/Village Health Workers with funds for communication for cholera case reporting and referral to Oral Rehydration Points and the contribute to the management at ORPs	Government; Local Authorities; IPs/NGO's

Output 4	Effective WASH leadership and coordination are strengthened and functional
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒
Sector/cluster	Water, Sanitation and Hygiene

Indicators	Description	Target	Achieved	Source of verification
Indicator 4.1	Number of sector emergency response coordination meetings held	12	15	Meeting minutes; Partner reports
Indicator 4.2	Number of monthly project monitoring reports produced	6	6	Partner reports, Field visit reports
Explanation of output and indicators variance:		In response to the rise in cholera cases in Harare, Chitungwiza, and Manicaland, meetings were held more often to strengthen coordination of activities and prevent the further spread of the disease		

Activities	Description	Implemented by
Activity 4.1	Regular and timely sector emergency response coordination meetings	Government; UNICEF; Local Authorities; IP's/NGO's
Activity 4.2	Monitoring of WASH emergency responses	Government; UNICEF

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]:

In collaboration with partners and the Government, UNICEF used cholera situational reports and information from District Rapid Response Teams (RRTs) to identify areas most affected. District Water and Sanitation Sub Committees (DWSSC), local leadership, VHWs, and environmental health officer practitioners then mapped cholera hotspot areas, helping decide project beneficiaries.

Selection criteria included in the project focused on vulnerability to cholera, including limited water and sanitation access, living in a community with reported cases, or having a household with cholera cases. Through rapid assessments, consultations with different groups of people captured views on their priorities, immediate needs and long term needs to adequately consider and cover needs of different groups and vulnerabilities.

Vulnerable and cholera affected families received WASH hygiene kits comprising of soap for handwashing, household water treatment chemicals, a 20-litre bucket, a 20-litre jerrycan, and Information, Education, and Communication (IEC) materials

b. AAP Feedback and Complaint Mechanisms:

UNICEF partners set up toll-free hotlines to ensure accessibility. These hotlines were widely promoted during distributions of critical hygiene kits, branded on mobile trucks, disseminated by volunteers during door-to-door sessions and through the trained water point user committees. All complaints, including those unrelated to the project, are taken seriously. Partners log and follow up on complaints weekly until closed.

Post-distribution monitoring (PDM), conducted by UNICEF's implementing partners in all districts, served as a key opportunity for affected people to share feedback on the usability and acceptability of hygiene kits and other response activities. Localised complaints and feedback mechanisms which was done using various means including suggestion boxes, post distribution monitoring and hotlines supported two-way communication, troubleshooting, and redressal of complaints in a confidential manner. The PDM also revealed high user acceptance and intended use of WASH hygiene kit items. Overall, the distribution was effective with most beneficiaries expressing satisfaction with the quality of hygiene kits distributed. The demonstrations on household water treatment chemicals use were also considered to be effective. While the distribution was an effective intervention, for example for 70 per cent of the households in Manicaland who drank water from unprotected water sources needed water treatment chemicals enabling households who were drinking from unsafe water sources to treat drinking water and reduce the risk of contamination.

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

[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.

Reporting mechanisms for Sexual Exploitation and Abuse (SEA) were shared through the same channels used for project information. All community trainings, including those for beneficiaries, addressed PSEA. UNICEF partners received PSEA training, and beneficiaries were assured of the anonymity of hotlines and designated personnel.

UNICEF ensures partners have clear PSEA reporting and management mechanisms, and that all project staff are trained. For the duration all partnerships, UNICEF emphasizes on having trained investigators to handle cases, guarantee complainant support, and follow established procedures for investigation and potential disciplinary action.

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

The project promoted gender equality and empowered women and girls by ensuring fair access to critical hygiene supplies. The burden of water collection for women was reduced through the rehabilitation of water systems which also led to the reduced risk of exposure to contaminated water sources. This helped to create a safer environment for all, particularly women and girls who may face heightened vulnerability during outbreaks.

Furthermore, the project's focus on inclusivity through accessible reporting mechanisms for Sexual Exploitation and Abuse (SEA) empowers women, and girls, to report abuse and access support services, fostering a safer environment.

e. People with disabilities (PwD):

UNICEF and its partners design activities to ensure inclusivity. Door-to-door hygiene promotion activities target everyone within the household with cholera prevention messages. Additionally, UNICEF works with partners and the Government to train project staff on disability inclusion and the importance of using inclusive language throughout all project activities. Rehabilitation of water supply infrastructure targets systems like solar powered piped water schemes with easy to operate, standpipes to ensure that people living with disabilities could easily access water. In some cases, after establishing enough water capacity, manually operated boreholes were upgraded to solar powered piped water schemes for inclusivity and easy access of water for people living with disabilities.

Partners are also encouraged to track the number of people with disabilities they reach. This data allows UNICEF to monitor the effectiveness of the interventions in reaching this population.

f. Protection:

UNICEF in collaboration with the Government prioritized interventions in areas with high numbers of cholera cases as informed by the epidemiological reports. Thus, interventions were conducted in Harare and Manicaland Provinces which were accounting for 37 per cent and 34 per cent of the national caseload respectively at the time this project was undertaken. Community outreach activities, through interpersonal communication, were designed to reach all community members, including those with mobility limitations as these interventions were done at household level. While the community health volunteers also receive training on identifying protection concerns such as exploitation or abuse with reporting mechanisms also shared with them.

At water point, committees that manage the operation and maintenance of water sources were also trained on preventing violence, exploitation, and abuse at water points. As a result, no cases of violence were reported at the water points

g. Education:

UNICEF and its partners ensured learner inclusion by conducting hygiene sessions that incorporated dramas (theatrical performances) on cholera prevention within schools in the targeted cholera hotspot areas. This saw 49,722 learners being reached with the drama sessions. UNICEF and partners also supported the training of school health masters from 30 schools who are the custodians of all health related and disease prevention strategies in the schools. The school health masters have been working with learners to continue to cascade training and cholera prevention messages in schools. This also resulted in the organizing of inter-school competitions among schools in the cholera hotspot areas. These activities promoted cholera prevention through engaging mediums such as songs, poems, dances and dramas. The aim was to not only educate the learners but to reach out to caregivers within the schools' surrounding communities.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	Not Applicable

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.

Due to the lack of availability of the household water treatment chemicals (Waterguard), particularly in the rural areas, the cash and voucher assistance was not explored as UNICEF urgently needed to make available the chemicals. However, in Harare, UNICEF and partners pushed forward a market-based strategy to try and increase demand for household water treatment chemicals, aiming to have the market respond. This was done through a method of buy-one-get-one free for the water treatment chemical (Waterguard). UNICEF and partners worked with the major retailers in the targeted suburbs where the free bottle valued was provided from the stocks UNICEF bought. This market-based approach reached 604 people.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
Fighting Cholera	In Chiadzwa a community is coming together to fight Cholera | UNICEF Zimbabwe
Launching of cholera vaccination campaign in Zimbabwe	Zimbabwe launches cholera vaccination campaign, boosting existing efforts to combat outbreak | UNICEF Zimbabwe
Integrated approach in fighting cholera in Zimbabwe Community Health Promoters as champions of behaviour change. Delivery of the Oral Cholera Vaccine in Zimbabwe to boost fight against cholera.	UNICEF supports Zimbabwe's Integrated Approach in the Battle Against Cholera | UNICEF Zimbabwe Community Health Promoters in Zimbabwe drive cholera behaviour change campaign | UNICEF Zimbabwe Zimbabwe's fight against cholera receives a major boost through the delivery of Oral Cholera Vaccine | UNICEF Zimbabwe

3.2 Project Report 23-RR-WHO-028

1. Project Information

Agency:	WHO	**Country:**	Zimbabwe
Sector/cluster:	Health	**CERF project code:**	23-RR-WHO-028
Project title:	Strengthening Cholera Response in 15 Most affected districts and populations in the country		
Start date:	26/06/2023	**End date:**	25/12/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 17,405,034**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 496,521**
Total CERF funds sub-granted to implementing partners:	**US$** 57 675
Government Partners	US$ [Fill in]
International NGOs	US$ 57 675
National NGOs	US$ [Fill in]
Red Cross/Crescent Organisation	US$ [Fill in]

2. Project Results Summary/Overall Performance

The project aimed to fortify health systems to effectively counter the cholera outbreak. A cornerstone of the initiative was enhancing surveillance by meticulously documenting and investigating all reported cases, enabling early detection and rapid response. Moreover, by providing on-site support to 408 health facilities, surpassing the target of 400, the project significantly strengthened the frontline response capacity. A substantial increase in healthcare workers trained in cholera Rapid Diagnostic Tests (RDTs), sample management, and case management – reaching 91% of the target – was achieved, empowering health facilities to provide timely and effective care. The establishment of 25 Cholera Treatment Centre's (CTCs), staffed by trained personnel, contributed to improved patient outcomes. To bolster community resilience, over 510,000 individuals were reached through the distribution of 60,000 Information, Education, and Communication (IEC) materials, fostering informed decision-making and preventive behaviours. Collectively, these interventions have significantly augmented the health system's capacity to not only address the current cholera outbreak but also to prepare for future public health emergencies.

3. Changes and Amendments

[Fill in]

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	868	998	1,017	1,171	**4,054**	5708	3130	7264	3984	**20, 086**
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	110,774	102,056	155,088	128,027	**495,945**	128871	118,729	148,943	148944	**545,487**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**111,642**	**103,054**	**156,105**	**129,198**	**499,999**	**134,579**	**121,859**	**156,207**	**152,927**	**565,573**
People with disabilities (PwD) out of the total										
	8,076	7,455	10,120	9,347	**34,998**	**8,157**	**7604**	**10221**	**9627**	**35,609**

* 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 combined effort by the WHO and UNHCR reached an estimated 2.4 million people through cholera prevention and control campaigns. Vulnerable groups, including displaced populations, were targeted by UNHCR. Community outreach involved dialogues and stakeholder engagement, bringing together local leaders, health workers, and community members. Additionally, cholera prevention messages were broadcast on Diamond FM to maximize reach.

6. CERF Results Framework

Project objective	To reduce morbidity and mortality due to cholera in the 15 most affected districts in Zimbabwe by December 2023
Output 1	Strengthened capacities of rapid response teams for surveillance & diagnosis in host communities and refugee camps

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 RRT members trained	90	0	57 Public Health officers oriented however not trained
Indicator 1.2	Proportion of alerts documented and investigated	80%	100%	MoHCC Rumour log books at all Health Facilities
Indicator 1.3	Number of on-site support and supervision visits	400	408	ODK submissions Reports
Indicator 1.4	Number of health care workers trained in RDT and specimen management	910	821	Training reports and attendance registers
Indicator 1.5	Proportion of districts reporting cases with updated line lists	95%	95%	Cholera Response Line list
Indicator 1.6	H.7 Number of functional health facilities supported	25	25	CTCs set up

Explanation of output and indicators variance:	Indicator 1.1 Due to a critical need to focus on securing supplies for the outbreak response, Rapid Response Team (RRT) training was temporarily suspended. The shifting demands of the outbreak response required a reallocation of resources, leading to the postponement of RRT training in favour of supply procurement efforts.

Activities	**Description**	**Implemented by**
Activity 1.1	Training of District RRTs	WHO & MOHCC
Activity 1.2	Provision of logistical support to investigate alerts	MoHCC
Activity 1.3	Conduct on-site support and supervision	WHO & MoHCC
Activity 1.4	Training of Health care workers trained in RDT and specimen management	WHO, UNHCR & MoHCC

Activity 1.5	Training and supporting HCWs to update cholera line lists and produce Situation Reports	WHO, UNHCR & MOHCC
Activity 1.6	Printing and distributing cholera job aids for health workers	WHO, UNHCR& MOHCC

Output 2	Strengthened capacities of front-line responders in cholera and diarrhoea case management, and IPC at CTCs/CTUs and oral rehydration points and in refugee camps

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 Health care workers trained in Cholera and diarrhoea Case Management	910	821	Training reports and attendance registers
Indicator 2.2	Proportion of CTCs/CTUs with health workers trained in cholera management	100%	100%	Training reports and attendance registers.
Indicator 2.3	Case Fatality rate	Less than 1%	2.1%	Cumulative Deaths / Cumulative Cases
Indicator 2.4	H.11 Number of people receiving treatment for acute watery diarrhoea (including cholera)	20 000	75 000	DHIS2
Explanation of output and indicators variance:		CFR target of <1% was difficult to achieve as many factors are at play. The major factor was a combination of delay in health seeking behaviour by the community, untrained staff as well as initial shortages of medicines for treatment. The only indicator not on track is to reduce CFR to <1%		

Activities	**Description**	**Implemented by**
Activity 2.1	Training of health care workers in cholera and diarrhoea case management	MoHCC, WHO and UNHCR
Activity 2.2	Producing and distributing cholera case management algorithms	MOHCC, WHO and UNHCR
Activity 2.3	Capacitating health workers and facility in Tongogara Refugee Camp with essential commodities and training	MOHCC and UNHCR

Output 3	Population at risk of Cholera enabled to adopt protective and preventive measures

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 people reached with prevention and control messages	500,000	510,000	Activities reports and pictures

Indicator 3.2	Number of sensitization meetings held with community influencers/leaders	200	229 influencers and leaders attended sensitisation meetings	Minutes from the meetings.
Indicator 3.3	Number of Cholera IEC materials distributed	50000	60 000	Delivery notes from MOHCC
Explanation of output and indicators variance:				

Activities	**Description**	**Implemented by**
Activity 3.1	Conduct interpersonal communication	MoHCC, WHO, UNHCR
Activity 3.2	Conduct sensitization meetings with community influencers/ leaders	MoHCC, WHO, UNHCR
Activity 3.3	Conduct community awareness and sensitisation among the refugee community within the camp including strengthening coordination of partners	UNHCR
Activity 3.4	Print and distribution of IEC material	MoHCC, WHO, UNHCR

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]:

To assess the outbreak's scope and guide intervention efforts, the Ministry of Health and Child Care (MoHCC) conducted Rapid Risk Assessments in all affected provinces and districts between February and April 2023. This assessment also included traditionally high-risk areas not yet reporting cases. Further ensuring inclusivity, the assessment reached marginalized communities within the Tongogara refugee camp, home to around 18,000 people, through UNHCR support. Throughout the project, feedback mechanisms gathered valuable insights from diverse groups. Community dialogues provided a platform for open discussion, while health facilities incorporated feedback sessions into their morning health education programs. Data collection tools ensured disaggregation by age, sex, and disability, allowing for targeted interventions based on specific needs.

b. AAP Feedback and Complaint Mechanisms:

Communities actively participated in program execution through robust feedback mechanisms. Health Centre Committees, composed of village health workers, traditional leaders, and elected officials, provided a platform for voicing concerns and receiving responses. Additionally, suggestion boxes offered a secure, anonymous option for feedback. Throughout the project, WHO, the Ministry of Health and Child Care, and partners actively strengthened this system, ensuring continuous community input. Regular consultations with diverse

[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.

community leaders, including traditional, religious, and other relevant figures, further deepened engagement and ensured program responsiveness.

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

WHO has Zero Tolerance to Sexual Exploitation, Abuse, and Harassment. Prior to deployment, all field personnel commit to upholding ethical standards through the orientation and signing of the WHO Code of Conduct on PRSEAH. In this response, PRSEAH was embedded in all activities. A total of 2880 health care workers were oriented on PRSEAH during integrated IPC, WASH and case management trainings that were conducted. Communities were sensitised on available confidential reporting mechanisms for lodging sexual misconduct complaints. Community dialogues reached an estimated total of 800 community leaders. Sensitization activities emphasized on awareness to combat sexual exploitation and abuse and empowering affected communities to identify and report misconduct.

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

Data collection disaggregated information by age, sex, and disability, ensuring interventions addressed the specific vulnerabilities of women and girls. Community based interventions were spearheaded by village health care workers and most of them were women. Twenty five percent of the community leadership were women who were active participants in all the activities. A deliberate effort was made to involve young women and girls in the community activities including dialogues and sensitization meetings paying attention to their vulnerabilities.

e. People with disabilities (PwD):

Cholera treatment centers and oral rehydration points were strategically established in close proximity to communities to ensure rapid access for all. These facilities were designed and constructed with meticulous attention to accessibility, particularly for disabled individuals, including women with disabilities. The cholera beds used in the cholera treatment centres were disability friendly

f. Protection:

Protection of all affected persons and at-risk individuals was a cornerstone of the cholera response project. This was achieved through comprehensive measures that ensured the safety and well-being of the community. Cholera treatment centres were fortified with security personnel to deter potential threats and maintain order. Recognizing the importance of privacy and dignity, separate hospitalization wards were established for male and female patients. Adequate lighting was installed throughout the treatment facilities to enhance patient safety and comfort. Beyond physical security, the project prioritized psychosocial support for affected individuals, including survivors and caregivers, to address trauma and promote mental health. Community engagement initiatives were implemented to raise awareness about cholera prevention and control, empowering community members to take ownership of their health and safety. By integrating protection into all aspects of the response, the project aimed to create a safe and supportive environment for those affected by the cholera outbreak.

g. Education:

Education was a critical component of the cholera response project. A total 150 school health coordinators were equipped with knowledge on cholera prevention and control to enable them to effectively educate students. The distribution of 53 000 posters and fliers to schools amplified the message, ensuring that learners were informed about hygiene practices including hand hygiene, early signs of cholera, and the importance of seeking medical attention. This approach aimed to foster a generation of individuals with a strong foundation in preventive health, thereby reducing the vulnerability of communities to future outbreaks.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

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

[Fill in]

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
Cholera containment effort commendable, but more needs to be done-WHO	https://www.afro.who.int/countries/zimbabwe/news/cholera-containment-effort-commendable-more-needs-be-done-who?country=883&name=Zimbabwe
Strengthening Data Analysis for Effective Cholera Mitigation in Zimbabwe	https://www.afro.who.int/countries/zimbabwe/news/strengthening-data-analysis-effective-cholera-mitigation-zimbabwe?country=883&name=Zimbabwe
The World Health Organization Representative's Groundbreaking Visit to Cholera-Affected Provinces in Zimbabwe	https://www.afro.who.int/countries/zimbabwe/news/world-health-organization-representatives-groundbreaking-visit-cholera-affected-provinces-zimbabwe?country=883&name=Zimbabwe
	https://x.com/who_zimbabwe/status/1709453948531191882?s=46&t=KNg51ZAVo-pXIpk8sx81KQ

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
23-RR-CEF-035	Water, Sanitation and Hygiene	UNICEF	INGO	$137,722
23-RR-CEF-035	Water, Sanitation and Hygiene	UNICEF	INGO	$82,918
23-RR-WHO-028	Health	WHO	INGO	$57,675