# ANNUAL REPORT
# ON THE USE OF CERF GRANTS
# ZIMBABWE

| | |
|---|---|
| **Country** | **Zimbabwe** |
| **Resident/Humanitarian Coordinator** | **Alain Noudehou** |
| **Reporting Period** | **1 January 2010 – 31 December 2010** |

## I. Summary of Funding and Beneficiaries

| | | | | |
|---|---|---|---|---|
| **Funding** | Total amount required for the humanitarian response: | Original Requirements<br>revised upwards | US$<br>US$ | 378,457,331<br>478,399,290 |
| | Total amount received for the humanitarian response: | | US$ | 224,529,923 |
| | Breakdown of total country funding received by source: | CERF:<br>CHF/HRF COUNTRY LEVEL FUNDS:<br>OTHER: (Bilateral/Multilateral) | US$ | 19,366,147[1]<br>US$<br>US$ |
| | Total amount of CERF funding received from the Rapid Response window: | | US$ | 10,439,418 |
| | Total amount of CERF funding received from the Underfunded window: | | US$ | 8,926,729<br>(From 2009 Second Underfunded Window |
| | Please provide the breakdown of CERF funds by type of partner: | a. Direct UN agencies/IOM implementation: | US$ | 14,124,284 |
| | | b. Funds forwarded to NGOs for implementation (in Annex, please provide a list of each NGO and amount of CERF funding forwarded): | US$ | 5,242,863 |
| | | c. Funds for government implementation: | | US$ |
| | | **d. TOTAL:** | **US$** | **19,367,147[2]** |
| **Beneficiaries** | Total number of individuals affected by the crisis: | *An estimated 6 million vulnerable people will continue to feel the impact of the erosion of basic services and livelihoods over the past 10 years<br>* 1.9 million food insecure people January to March 2010)<br>Some 1.2 million people living with HIV/AIDS with 343,600 adults and 35,200 children under age 15 requiring anti-retroviral treatment<br>*33 per cent of children under age 5 are chronically malnourished and 7 per cent suffer from acute malnutrition.<br>*1.6 million orphaned and vulnerable children, including more than 100,000 child-headed households requiring assistance. | | |
| | Total number of individuals reached with CERF funding: | Women: 9,880,530<br>Men: 8,123,503<br>Children under 5: 4,597,819<br>Female Children over 5:338,105<br>Male Children over 5: 304,564<br>Unspecified:283,207<br>Total: 27,005,648[3] | | |

[1] To be checked against Financial Report for the time period.
[2] To be checked against Financial Report for the time period.
[3] Most of the projects were designed to reach massive number of beneficiaries such as measles vaccination. In addition, we are reporting on the last quarter of 2009 and entire 2010.

| | |
|---|---|
| Geographical areas of implementation: | Seven out of ten provinces in Zimbabwe namely- Midlands, Mashonaland Central, Masvingo, Matebeleland South, Harare, Mashonaland West, and Manicaland |

## II. Analysis

Under the CERF Rapid Response Window, Zimbabwe received a total of US$19.4 million supporting response activities aimed at stemming the spread of measles as well as meeting food needs during a World Food Programme (WFP) food pipeline break. The CERF allocation, mainly due to its flexibility and timely allocation, enabled the rapid planning and implementation of preliminary activities necessary for the immunisation campaign including training, micro-planning, procurement of vaccines, apostolic faith summit (advocacy with religious objector groups who had suffered the most death and illness due to measles), strengthening of surveillance and country wide social mobilization activities. These activities were essential to the vaccination campaign and prevention of additional deaths. They enabled the campaign to be better organised, with necessary human and material resources mobilised in time, which was critical in cutting the measles transmission chain. CERF was both the first and largest donor for the campaign (at least 61 per cent of the total required funds).

Between September 2009 and May 2010**,** the country had recorded 7,754 of suspected measles cases as well as 517 deaths, including 497 children between the age of nine months and four years. Ninety-nine per cent of fatalities occurred at community level in 50 of 62 districts (80 per cent of the country). Only one per cent was reported from health care facilities, also due to late reporting of health services. Only ten per cent of cases were already vaccinated children indicating that the likely reason for the outbreak was the failure of earlier vaccination.

The 6.7 per cent measles Case Fatality Rate (CFR) indicated severity of the disease in a country that had achieved and sustained zero measles deaths for more than a decade and demonstrated how much health care facilities had been affected by a decline in health services. By 2006, Zimbabwe had achieved a 91 per cent reduction in the number of measles deaths, surpassing the United Nations target of 90 per cent as per MDG goals. WHO and UNICEF carried out the measles campaign from 24 May to 2 June 2010 with other partners.

At the pre-campaign planning stage, the only funding that could be accessed in a timely manner was from CERF. Resources enabled immediate response activities to start stemming the rapidly spreading outbreak. Further funding became available after the campaign had started and supported other areas of the intervention. The CERF enabled micro (52 districts and 11 provincial) and macro (national level) planning for the campaign targeting at least five million children. Planning (covering such areas as vaccine, vitamin A and supplies procurement, delivery, health workers, transport) enabled the contextual analysis and development of appropriate strategies to reach the entire country, focusing on the worst affected or previously missed groups. Planning at district and national levels avoided logistical challenges, strengthened the prioritized use of available funds and prevented unnecessary illness and death.

Approximately 85 per cent of the affected population were religious objectors to vaccination and modern medicine. Therefore, there was a need for targeted advocacy and persuasion, particularly among leaders of the different religious groups to support the vaccination or treatment as required[4]. The CERF funded social mobilization efforts among apostolics targeted group leaders at the Johanne Marange headquarters (Mutare) and at a national summit (attended by at least 600 group leaders) as well as community level "kraal" leaders and health workers. The high success rate registered in vaccination of apostolic members verified by the post campaign survey (97 per cent) was attributed to the early and comprehensive engagement with religious objectors. In addition, the post campaign survey verified that advocacy through health workers, including village health workers (53 per cent), schools (29 per cent) and the media (26 per cent) enabled the public to know where and when to access immunization.

To guarantee a safe and effective immunization campaign, it was necessary to provide training refreshers

[4] A Knowledge Actions and Practice assessment indicated that the biggest hindrance to accessing vaccination and/or treatment was fear of expulsion from the sect by leaders who had banned medical treatment.

to health workers, volunteers and mobilisers on standard practices. The CERF funds ensured training of 188 supervisors; 4,181 vaccinators; 3,504 volunteers; 6,200 mobilisers, as well as the production of training materials and procurement of training stationery and tallying of survey results. The high number of children (5,164,307) that were vaccinated during the 9 days of the campaign - resulting in administrative vaccination coverage of 97 per cent - may be attributed in part to the high quality of health worker training. Vitamin A supplementation was provided to 1,612,564 children aged between 6 months and 5 years, representing 92 per cent (administrative coverage).

As measles cases continued to be reported during the campaign period, it was necessary to put in place measures in all 62 districts ensuring that all cases would be recorded, tested and treated to prevent a further spread of diseases. The CERF funds made it possible to procure fuel to support active case finding, transportation of samples to the national virology laboratory, and printing of education materials for both the health care facilities and communities to assist in identification and reporting of measles.

Critical CERF support covered 50 per cent of payment allowances, motivating health workers to reach the target for the campaign. The partial payment of allowances covered extended to 16,190 urban and rural health workers comprising of vaccinators, vitamin A administrators, tally recorders, supervisors, crowd controllers, mobilisers, and drivers both within static and outreach units. Allowances covered the full training period and part of the campaign period.

A survey partially covered by CERF resources was implemented two weeks after the conclusion of the campaign to validate its impact. The results found that the programme, which exceeded the 95 per cent benchmark set for measles, and 93 per cent benchmark for vitamin A supplementation, reached 97 per cent of the target population. While a detailed breakdown of the survey results is not available, the programme reached a large number of children belonging to the apostolic group (i.e. vaccination objectors).

*Table 1: Summary of Measles and Vitamin A coverage results, 2010 Measles vaccination campaign*

| **Measles**<br>**Vaccination for Children** | | **Vitamin A supplementation**<br>**Children** | |
|---|---|---|---|
| Initial Target (6 months to 14 years) | 4,912,375 | Initial target:<br>6 to 59 months | 1,630,678 |
| Coverage | 5,164,307 | Revised target | 1,733,169 |
| Revised target | 5,310,480<br>or 97 per cent | Coverage | 1,625,783<br>or 93 per cent |

*Source: Measles mass immunisation campaign report and Post campaign survey summary report (2010)*

In addition to the survey, the CERF supported national post measles National Immunization Day (NID) and quarterly surveillance meetings after the campaign. These review meetings supported further strengthening of district surveillance of measles and contributed to the containment of the outbreak, which formally ended in November 2010.

CERF funds strengthened partnerships for the coordination of the vaccination campaign at the cluster level. The Health Cluster put together a team to carry out rapid nationwide measles assessments ahead of the request for CERF funding. This team then joined with the EPI taskforce to support campaign preparation. It coordinated the implementation of the campaign and reported to the cluster and the Humanitarian Country Team.

WFP received a $5 million grant in support of the food assistance interventions. The CERF grant was used to improve food access for 1.8 million highly vulnerable food insecure households during the peak hunger season in February and March 2010. The funds contributed to bridge a break in the provision of food assistance while resources from other donors were being mobilized. According to the December 2010 Community and Household Surveillance (CHS), the grant, together with other donor grants, contributed to improved dietary quality and diversity for food insecure households. The survey showed an increase in acceptable food consumption, which was a result of the food assistance provided by the government. From May 2009 to April 2010, WFP assisted up to 1.4 million beneficiaries with CERF

funding.

Together with partners and donors, grant allocation and programme implementation was prioritised at Food Aid Coordination meetings held on a monthly basis. Monthly monitoring reports from Cooperating Partners (CP) informed WFP on the progress of the programme and on encountered challenges.

**Underfunded Emergency Window - October 2009 to June 2010**

At the time that the Health Cluster applied for and received funding from the CERF underfunded window, the health system in Zimbabwe was in the process of adjusting to heightened health service demands. The unprecedented cholera outbreak of 2009/2010 and years of limited government funding for health had led to the collapse of the health system along with its interlocking six pillars of human resources, financing, information, leadership or governance, products and delivery. As a result, four referral hospitals had closed down.

An evaluation of the health system by the Ministry of Health and Child Welfare (MOHCW), in the Cholera Command and Control Centre (C4), revealed that disease surveillance and outbreak response was affected by non reporting of health care facilities (on average, only 30 per cent of cases were reported on a weekly basis against the 80 per cent benchmark), poor communications and staff attrition. The Village Health Worker programme, which forms the backbone of the disease surveillance early warning system, had collapsed and had been identified as an underfunded priority. Anecdotal information based on field visits indicated that communities lost faith in the health system. This may have caused late treatment seeking behaviour and consequently the high number of community deaths reported during the cholera outbreak of 2008/2009[5].

Beyond the importance of having to respond to the outbreak, it was necessary to revitalise the health care system to prevent a further escalation and future outbreaks of other diseases. The CERF grant was used to revitalise the Village Health Worker programme, kick start the disease surveillance system, as well as support and coordinate the response to the cholera outbreak.

The initial CERF grant received in response to the Flash Appeal under the Rapid Response window in January 2009 was intended to aid the rapid response to the outbreak. Delays in the declaration of the outbreak, however, held up the sourcing of the funding. As the needs remained significant, the second tranche from the underfunded window was needed to reinforce some of the activities/interventions introduced with the Rapid Response window grant at the beginning of 2009.

Both the Village Health Worker (VHW) programme and the national Health Information Programme (HIP) had suffered from the socio-economic crisis due to attrition of VHWs caused by lack of resources for allowances and programme management. The CERF prevented programmes to fail completely while buying time to secure additional funding from the United Nations Development Programme (UNDP) and the African Development Bank (ADB) for VHW and NHIS.

Using the CERF funding, 290 VHWs were trained and equipped in Chipinge and Beitbridge districts through World Vision. The project further reviewed training manuals/syllabus, handbooks and the strategic plan; trained 42 national trainers and 300 VHWs from Mudzi, Mt Darwin and Chiredzi; and equipped them with VHW kits and bicycles. The VHWs were instrumental in the response to outbreaks of cholera and measles in those areas, carrying out health education, supporting active cholera and measles case finding, mobilizing communities including objectors for measles vaccination, as well as supporting referral to hospital of sick children.

CERF supported the procurement of 15 motorcycles, which were handed over to MOHCW to support rapid response to outbreaks and disease surveillance in Mt Darwin, Chiredzi and Mudzi districts. This was a consolidation of the 09-WHO-99-RR project which supported the procurement of 11 vehicles and 124 motorcycles intended to strengthen rapid response to outbreaks of cholera and other diseases. Recently, these vehicles have also supported response to outbreaks of cholera and measles, influenza A H1N1 and typhoid in Midlands, Manicaland, Masvingo, Matabeleland North and South and Harare.

[5] 61 per cent of the 4288 deaths reported occurred outside health care facilities. A total of 98, 592 cases were reported to MOHCW/C4

Through the CERF, WHO supported National Microbiology Reference Laboratory (NMRL) to carry out cholera confirmatory tests by procuring reagents, consumables and equipment including 60 portable sterilisers, 2 class two bio-safety cabinets, viral transport media and swabs, 2 inverted microscopes, a PCR hood, 2 incubators, an autoclave, micro-centrifuge and centrifuge. This equipment supported the laboratory to test for other communicable diseases including influenza A H1N1 and anthrax. NMRL provided provincial and district laboratories and health care facilities with transport media to support testing of cholera in the 2008/2009 cholera outbreak and the subsequent outbreaks. It has decreased the lab turn around time from up to 14 days to few hours, against a benchmark of 24 hours, using rapid test kits and 3 days using culture tests.

Through the CERF, with direction of the Information Communication Technology working group chaired by the MOHCW, radio communication equipment was procured and installed at 32 locations including provincial medical director's offices and all (21) health care facilities in Mt Darwin. The equipment included repeaters, lightening arresters, solar panels, antennae and VHF bases, mobile VHF vehicle and hand held kits *with batteries*, transceivers, lightening arresters, aerials, and software for the equipment. The activities undertaken include assessments and training of radio operators and provincial maintenance focal points. The project has strengthened early detection, reporting and facilitated early response to disease outbreaks linking health care facilities, particularly those in hard-to-reach areas to the district, provincial and national hospitals. When additional funding is secured, the project shall be extended to cover other hard to each location.

The recruitment of staff for the Emergency and Humanitarian Action programme supported health promotion (including the Village Health Programme); strengthening of the national health information system and the national Epidemiology and Disease Control and Environmental health programmes. Staff, together with the Health Cluster Coordinator, provided close support to MOHCW. Prioritisation of the CERF was done through the Health Cluster, using priorities already identified through the CAP, the WHO Country Cooperation Strategy (CCS) and the Health Cluster strategic document. In the implementation of the VHW programme, a national taskforce comprising Health Cluster partners, MOHCW and local NGOs was formed to prevent duplication and promote programme partnership. All of these programmes report to the Health Cluster that coordinates project priority setting through its Strategic Working Group (SAG)[6].

The 2007 Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS) estimated the maternal mortality rate (MMR) at 725 deaths per 100,000 live births, one of the highest in the region. Haemorrhage, hypertension, sepsis and obstructed labour remain the four leading causes of direct obstetric deaths. Effective interventions exist to treat these complications, and deaths are avoidable. The ZMPMS estimates that successful prevention and treatment of these complications represents the potential to reduce maternal deaths by 46 per cent. The CERF was drawn on to fund response activities that were largely underfunded.

CERF funding was used to address maternal and neonatal deaths in Matabeleland North and Mashonaland West provinces with high numbers of notified maternal deaths from the available 2006 national registry. The provinces also rank within the last 3 provinces in the country in terms of caesarean section rates. The project focused on all district hospitals as well as all rural health clinics in two of the districts (Binga and Kariba rural) with a very high proportion of hard-to-reach populations. The districts are two of the least developed and poorest in the country, have the lowest literacy rates, the worst geographical terrain and the poorest rates for malnutrition, water and sanitation, access to health and education. The grant was used to refurbish maternity waiting homes and strengthen the referral system by repairing 11 ambulances (to tackle the delay in reaching care) and to increase awareness on the importance of giving birth in a health facility (to tackle the delay in seeking care). It was also used to establish radio communications; as well as to ensure the stocking of facilities with essential supplies and equipment and training of health staff (to tackle the delay in receiving appropriate care).

In total, 12 district hospitals and 20 rural health centres benefited from the interventions. Sixty-five health workers (nurses and doctors) in the two provinces were trained in integrated emergency obstetric and newborn care (EmONC) and prevention of mother to child transmission (PMTCT) life saving skills, which resulted in at least one trained health staff per comprehensive EmONC facility. Twelve maternity waiting

[6] The Health Cluster Strategic Advisory Group was put in place to steer the Cluster, giving it strategic direction.

homes were refurbished, by conducting minor repairs, and in seven cases, major repairs (e.g. building of toilets). Each of them was equipped with beds, mattresses, blankets, pillows and pillowcases for the pregnant women (whereas many of them used to sleep on the floor before the intervention). To increase enrolment in the maternity waiting homes, CERF funding was also used to provide food rations (sugar beans and maize meal) for six months for the women staying at the maternity waiting homes (MWH). Eight district hospitals with functioning operating theatres in the provinces were provided with anaesthetic machines to enable them to carry out caesarean sections. Furthermore, the funds were used to translate (into local Tonga), print and distribute 13,000 copies of the booklet '*You and your pregnancy'.* All activities were planned and implemented in close coordination with the Ministry MOHCW. Social mobilization was further conducted in Binga and Kariba rural through community activities on safe motherhood.

The CERF funding thus resulted in increased coverage of, demand for and access to EmONC for the most vulnerable populations. The work approach proved being a good practice and has later been replicated (e.g. the approach to address MWHs) by other partners such as UNICEF. Through further fundraising activities, UNFPA received additional grants in 2010 to complement EmONC activities, including the provision of blood coupons to avail free blood products for obstetric emergencies (through ERF) as well as to expand the MWH refurbishment to other district hospitals.

CERF funds made it possible for UNICEF to ensure that all villages in the two districts have a community-based staff member working with pregnant women and families to encourage them to book early and plan for a health facility delivery. Mothers and the community were also trained on healthy ways of taking care of newborn babies. The VHW have become a strong link between the community and health facility, assisting mothers to access emergency care for themselves and their newborns. The availability of CERF funds enabled timely implementation of the programme and helped to initiate evidence-informed interventions to save lives of mothers and newborns.

In nutrition, CERF funding primarily scaled up the Community-based Management of Acute Malnutrition (CMAM) programme through training of health workers, establishment of new health care facilities and procurement of additional supplies to cater for expansion of the programme. This resulted in an increased number of children accessing treatment for acute malnutrition and strengthened the management and treatment of acute malnutrition. Under this UNICEF project, 109 new health care facilities are now providing standard services to manage/treat children with acute malnutrition. With 3,356 cartons of Ready to Use Therapeutic Food (RUTF) spread procured under the CERF funded programme, 4,726 children with acute malnutrition were treated. To ensure programme continuity, the project supported the expansion of services for treatment of severe acute malnutrition, through training of 216 health workers (nurses and doctors) and 2,538 VHWs.

In the area of WASH, 3,887 metric tons of water treatment chemicals were procured and distributed to 12 cities, towns and growth points benefiting more than 4 million people. Additionally, communities and schoolchildren benefited from the intervention through the rehabilitation of 322 water points, to be used by 80,500 persons (23,023 women and 21,252 men and 36,225 children). Furthermore, some 10,253 school children, teachers and surrounding communities benefited from the restoration of water supply through the drilling and rehabilitation of 34 water points in Marondera. The project, ensured continuity and sustainability through hygiene promotion and education, and building the capacity of 332 water point committees through water facility management training. Thanks to the construction of 268 latrines in 46 primary schools, it is now possible for more than 6,700 schoolchildren (3,700 girls and 3,000 boys) to have access to safe toilet facilities.

At least 47 per cent of women in Zimbabwe have experienced either physical or sexual violence (or both) at some point in their lives; while 25 per cent have been sexually abused 1(ZDHS, 2005/2006). CERF funding strengthened the overall Gender-based Violence (GBV) response implemented by UNFPA by providing lifesaving and victim friendly multi-sectoral services to survivors of GBV, with an emphasis on health (PEP, medical affidavit etc), psychosocial support, police (victim-friendly unit) and legal aid. The establishment of one stop centres and the development of referral pathways enabled victims to access these services easily. Part of the intervention by UNFPA provided services in the districts of Mberengwa, Mudzi and Makoni. In Makoni, the project included the establishment of one-stop centres in these districts (to enable survivors to access services under one roof) and improvement of the referral system (to enable survivors to get the services as and when they needed them).

In Mberengwa and Mudzi, a different approach included planning meetings with key stakeholders including government representatives, implementing and funding partners and community leaders. Sensitization meetings of the communities followed the meetings on the services that are offered by the one-stop centres. One hospital in each district, has received support to refurbish the buildings. The rooms have been adequately furnished to provide positive environment for counselling and providing services to survivors. Police victim friendly units have also been given support in the form of furniture and computers. Standard operating procedures were developed and distributed to all hospitals. In addition, community GBV sensitization took place for men, women, boys and girls, including community leaders. In Makoni, 71 people accessed medical services at the one-stop centre and 64 accessed legal aid. In addition, 1,127 people were reached with awareness raising activities, among which 272 are community leaders.

In Mberengwa and Mudzi, services are not concentrated in one site but referral pathways have been established to ensure that clients are referred to the right services quickly through improved coordination. In Mberengwa, about 313 clients were seen through the referral pathway, while 1,504 people were reached with outreach activities. In Mudzi, 1,245 people were reached with outreach activities to raise awareness on the available services.

The one-stop centres and referral pathways that were established with CERF funding are new developments within the multi-sectoral approach and the success has led to the consensus that these concepts should be adopted nation-wide.

UNICEF implemented part of the GBV response to strengthen sensitisation and capacity building of leaders and communities. The impact can be demonstrated through sensitised and trained participants attesting to changing practices on GBV brought about by increased knowledge on GBV and skills empowerment, including traditional harmful practices. One example is shifting to the use of cattle to avenge spirits instead of a girl child, as was the practice in some areas. CERF funding enabled the project to implement mechanisms that not only covered existing gaps in the humanitarian situation, but allowed programme continuity. Planning meetings conducted with community leaders and other stakeholders encouraged community participation in project implementation and provided communities with the opportunity to define their own contribution, including selection criteria for lay counsellors to be trained on providing psychosocial support to GBV survivors. Child protection committees were formed, and existing structures strengthened in project wards by providing them with information on gender-based violence, child rights and referral pathways. Technical support (including the development of standard operating procedures), was provided through partners to establish District Coordinating Committees in project districts to continue GBV coordination following the conclusion of the project. The production of two thousand booklets outlining project lessons learned in Mudzi district by the implementing partner, Women's Action Group, allowed for programme continuity through the documentation of experiences and best practice in implementation that may be used to guide future interventions and even help mobilise other resources for similar and continued response Implementing partners realised that the fight against GBV would require a multi-sectoral approach to address all facets of the problem and prompted the creation of partnerships with other organisations and stakeholders within project districts. Synergies were created with the government and civil society partners offering services to GBV survivors such as health, legal aid, among others.

A response to the IDP needs was formulated based on the outcome of joint rapid assessments conducted by district authorities, IOM and its partners in January, February, and in June 2009 in 157 communities from 20 districts in Harare, Manicaland, Mashonaland Central, Mashonaland East and Mashonaland West provinces. The assessment found 14,305 IDP households were in need of immediate assistance that included shelter, food, NFIs, livelihoods, legal assistance and protection of their civic rights especially physical integrity and safety. Data from UNHCR and its partners from the first half of 2009 showed at least 12,000 displaced persons in Harare, 10,000 in Mashonaland Central and 10,500 in Mashonaland West. An unknown number had since returned home, but was still in need of lifesaving assistance and protection. Additionally, some 3,513 evictees following farm acquisitions and other 341 households affected by legal demolitions required assistance.

## III. Results

| Sector/ Cluster | CERF project number and title (If applicable, please provide CAP/Flash Project Code) | Amount disbursed from CERF (US$) | Total Project Budget (US$) | Number of Beneficiaries targeted with CERF funding | Expected Results/ Outcomes | Results and improvements for the target beneficiaries | CERF's added value to the project | Monitoring and Evaluation Mechanisms | Gender Equity |
|---|---|---|---|---|---|---|---|---|---|
| Health | 10–WHO-030<br><br>Reaching the vulnerable children and women of child bearing age with immunisation to prevent loss of life from communicable disease outbreaks | 1,977,233 | 3.2 million | 1.5 million below 5 years<br>5 million 5- under 15 years | ▪ Over 14,000 health workers, mobilisers and volunteers trained to plan and conduct measles campaign over a period of ten days in May 2010<br><br>▪ Appropriate micro plans developed to reach all the target populations.<br><br>▪ Five million children immunized against measles and one million provided with Vitamin A supplementation<br><br>▪ Allowances for health workers participating in the campaign paid | ▪ Over 14,000 health workers, mobilisers and volunteers trained to plan and conduct measles campaign over a period of ten days from 24 May to 2 June 2010<br><br>▪ The target was 4, 912, 375 children from six months to under 15 years, but due to population discrepancies, the figure was adjusted to 5,310,480, out of which 5,164,307(97 per cent) were reached. 93 per cent of children 6-59 months received Vitamin A supplementation. The target was similarly adjusted from 1,630,678 to 1,733,169, reaching 1,625,783.<br><br>▪ Appropriate micro plans developed to reach all the target populations. | Rapid allocation of CERF funds allowed the campaign to begin immediately after the needs were identified, allowing for implementation of activities critical for the success of the campaign. | ▪ In and end process monitoring was carried out during the campaign<br><br>▪ Post campaign survey was carried out three weeks after the campaign<br><br>▪ Evaluation meetings and quarterly surveillance meetings held with immunization programme managers to review the campaign and plan improvements to the routine immunisation programme. | ▪ Beneficiaries of this project were 97 per cent of children between six months and 15 years in Zimbabwe.<br><br>▪ There was no significant difference between the number of vaccinated boys and girls.<br><br>▪ Special attention was paid to members of the Apostolic faith sect, geographically hard to reach and other hard to reach groups including school children and children in urban areas.<br><br>▪ Results of a Knowledge Actions practices assessment among apostolic groups identified religious leaders as influential in the decision to vaccinate or receive medical treatment. It led to planning of meetings with high-level leaders |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | ▪ Children with measles continued to be picked up through surveillance activities in all 62 districts and treated as appropriate.<br><br>▪ Post campaign and coverage survey conducted within a month after the actual measles campaign. | ▪ Children with measles continued to be picked up through surveillance activities in all 62 districts and treated as appropriate<br><br>▪ Post campaign and coverage survey conducted within a month after the actual measles campaign.<br><br>▪ Transmission cut, as indicated by the drop in the laboratory positivity rate from over 20 per cent to less than two per cent.<br><br>▪ Surveillance activities strengthened following the campaign through various strategies including: evaluation meetings Reach Every District Approach and increased cased based investigation, some of which were contributed to by CERF. | | | of the main objector sect at Johanne Marange (Manicaland) and at national level for all leaders of all Apostolic sects.<br><br>▪ Meetings at provincial level with cultural, religious and political leaders enabled the rallying of communities for the campaign. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Health | 09-WHO-044 UFE<br><br>Health cluster coordination, disease surveillance and health information management in the health sector | 819, 464 | 4,148,000 | 12,595,418 country wide; 907,441 children below 5 and 3,933,548 women<br><br>620,000 in three districts; 349,356 females | ▪ A cluster coordinator in place to help MoHCW in facilitating health partners' interventions, sharing information and capacity building<br><br>▪ Technical staff recruited<br><br>▪ Radio communication equipment and computers purchased<br><br>▪ Improved surveillance at community level<br><br>▪ Project monitored | ▪ Three technical staff recruited to support MOHCW key activities in health promotion, data management and environmental health<br><br>▪ Procurement of 15 motorcycles for Environmental Health Technicians (EHTS) in the Mudzi, Mt Darwin and Chiredzi districts to intensify water quality monitoring and disease surveillance activities<br><br>▪ Training in integrated diseases surveillance and response for 65 provincial level health workers<br><br>▪ Procurement and installation of radio communication equipment including repeaters, lightening arresters, solar panels to power the radios, aerials, 72 VHF hand held radios and batteries, vehicle mobile units and software for the equipment<br><br>▪ Production and dissemination of 2,000 cholera control guidelines<br><br>▪ Procurement of laboratory equipment and supplies for the National Microbiology Reference Laboratory<br><br>▪ Training and equipping of 130 VHWs in Beitbridge and 160 in Chipinge, an expansion of the 09-WHO-010 project to revitalise the VHW programme | Non-functional communication systems continued to cause challenges for hard to reach health care facilities to make surveillance reports. The CERF through several projects worked towards the revitalisation of the surveillance system by improving communication.<br><br>Continued training in disease surveillance and response is needed for new cadres of staff following the migration of skilled ones; the CERF is contributing to this pool of skilled staff.<br><br>The water quality surveillance programme is being revitalised, motorcycles will enable EHTs to carry out field, activities in the programme<br><br>Items procured for the VHW programme are both incentives for work as well as work aids. They have enabled better coverage of VHW areas (30 households each VHW). | ▪ Joint monitoring visits to the field by WHO and MOHCW<br><br>▪ Monitoring of communication project by the MOHCW ICT coordination forum | ▪ Men, women and children equally benefited |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | ▪ Reference materials, uniforms, kits and bicycles for 400 VHWs procured and distributed to Beitbridge, Chipinge, Chiredzi, Mudzi and Mt Darwin. | MOHCW national level programmes strengthened through the recruitment of staff resulting in revitalisation of VHW programme, strengthened surveillance as evidenced by increased dissemination of information to partners and strengthened environmental health programmes. | | |
| Health | 10-CEF-028<br><br>Reaching vulnerable children and women of child-bearing age with immunisation to prevent EPI target disease outbreaks | 3,462,185 | 3,834,042 | 5,164,307 children 6 months to 14 years;<br><br>1,686,187 children under 5 | ▪ Objective: Provide logistical support to nationwide measles campaign in order to immunise at least 95 per cent of children aged 6 months to 14 years against measles and to provide Vitamin A supplementation to at least 95 per cent of children aged six months to five years | ▪ 97 per cent coverage (reported and 98 per cent by survey results) achieved for measles<br><br>▪ 92 per cent coverage (reported and 97 per cent by survey results) achieved for vitamin A supplementation<br><br>▪ Vaccines, injection safety material and indelible markers procured and distributed to all districts | Rapid allocation of CERF funds allowed project intervention immediately after needs were identified.[7]<br><br>The CERF funding enabled the reduction in the risk of death from measles for the lives of over five million children | ▪ National support supervisory visits to all provinces and selected districts were conducted prior to the campaign.<br><br>▪ Monitoring and supervision during the campaign using a standardised checklist for vaccination practices, waste disposal, and logistics management | ▪ The project targeted as beneficiaries, children between 6 months and 14 years (both boys and girls). The country achieved high coverage in both measles vaccination and Vitamin A supplementation in 2010 |

[7] Between September 2009 to mid May 2010, Zimbabwe recorded 7,754 suspected cases and 517 deaths, of which 512 were community deaths. A total of 50 districts out of the 63 (80 per cent) had confirmed outbreaks by mid May 2010 indicating that most of the country had been affected by the outbreak; 57 districts had reported suspected measles cases.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | ▪ Outcomes: All measles vaccines, injection safety materials and cold chain equipment delivered in a timely manner to all 62 districts<br>▪ IEC Materials developed and distributed nationwide in a timely manner prior to the campaign in Mid-May 2010 | ▪ Posters and banners printed<br>▪ Radio and television advertisements flighted in local languages | | | |
| Health | 09-FPA-023<br><br>Reaching women and new born babies with life-saving reproductive and child health services including emergency obstetric and neonatal care in institutions and communities | 935,360 | 4,012,500 | The number of admitted women per MWH is on average 100 per month. During the project period, 10,800 women in MWHs were reached. However, they represent about 15 per cent of the total number of pregnant women at the facilities. Therefore in can be concluded that an estimated total of 72,000 pregnant women and their 68,400 newborns were reached | ▪ No stock out of three core EMONC drugs / equipments in all targeted institutions<br>▪ At least one waiting mother centre fully functional in each of the targeted hospitals<br>▪ C-sections are offered in at least 90 per cent of district hospitals | ▪ No stock out through the supply of clean delivery kits and other essential EmONC supplies<br>▪ Through refurbishment, all targeted hospitals now have a fully functional MWH. This resulted in an increases admission rate and thus increased number of institutional deliveries.<br>▪ The hospitals were supported with equipment and supplies to conduct c-sections, however, some were still not able to carry them out because of factors beyond our control, such as the absence of a doctor. Currently our out of the targeted hospitals 50 per cent were conducting c-sections. | With CERF funding the full coverage of EmONC strengthening in the two provinces and its two most vulnerable districts has been achieved. With the limited funding available such wide coverage otherwise this would not have been possible. | ▪ An M and E framework (including indicators, baselines, targets and data collection methods) was used to monitor progress. A capacity assessment was conducted to guide procurement needs. Regular progress review meetings were held and field visits were conducted for monitoring and to detect and address bottlenecks to implementation. | ▪ The project focused on pregnant women and women of childbearing age. The safe motherhood sensitizations also involved men and acknowledges them in playing a vital role in safe motherhood issues. During the sessions, the role of women in decision-making was discussed too. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Protection/Human Rights/Rule of Law | 09-HCR-029<br><br>Comprehensive Protection and emergency assistance to IDPs and Returnees in Harare and Mashonaland Central Provinces | 205,996 | 4,927,138 | Network of community-based workers established and trained to monitor displacement patterns, humanitarian conditions and the process of return and reintegration<br><br>Minimum conditions for return of the displaced and returnee families are created, including support for reintegration and reconciliation through life-saving and emergency livelihoods interventions [small income generating activities supported] and the distribution of NFIs. | ▪ A network of three legal counsellors was set up to cover the three provinces. Two psychosocial support counsellors, two legal assistants, a reconciliation officer and three livelihoods officer were also on board to mainstream sustainable reintegration and reconciliation initiatives<br><br>▪ 70 community sessions were conducted to assist the population of concern to deal with SGBV issues in places of return, host communities and places of displacement in the Harare, Mash Central and Mash West Provinces | ▪ CERF funds allowed the project to begin immediately after recovery and reintegration plans were formulated and mechanisms for delivery whereby community livelihoods interventions formed an entry point for protection interventions in return/host communities that were heavily polarized as the material assistance formed a platform for more sensitive protection interventions. This intervention helped to kick-start the restoration of individual household livelihoods. | A monitoring system was put in place through the field presence of UNHCR protection assistant, programme assistant and data base assistant.<br><br>Monitoring tools were developed to track progress and impact.<br><br>A training workshop was held by UNHCR to better equip partners with skills on using data collection and reporting tools. | ▪ All deserving vulnerable IDP/Returnee women received sanitary ware.<br><br>▪ A 70 per cent: 30 per cent rule was applied in delivering assistance where vulnerable host/return community constituted the 30 per cent targeted beneficiaries<br><br>▪ In Harare, 107 Households[HH] [ 191 Male and 264 Females] received NFI support including sanitary ware for women | ▪ CERF funds allowed the project to begin immediately after recovery and reintegration plans were formulated and mechanisms for delivery whereby community livelihoods interventions formed an entry point for protection interventions in return/host communities that were heavily polarized as the material assistance formed a platform for more sensitive protection Interventions. This intervention helped to kick-start the restoration of individual household livelihoods. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Assistance provided to some 400 most vulnerable IDPs/returnees families and host families for emergency income generation activities in two provinces.<br><br>Training workshops on IDPs rights conducted for the relevant government officials, civil society and community leaders in the targeted districts will contribute to improved protection and advocacy/awareness on basic human rights and rights of the displaced persons. | ▪ Child protection sessions were conducted at community level with children, adults and community leaders as part of child protection mainstreaming across all interventions in Harare, Mash west and Central Provinces.<br><br>▪ A total of 265 beneficiaries were assisted by UHNCR and its partners to access and receive Civil status documentation [birth certificates, i.d cards and death certificates], which are life-saving/essential as they enable access social services such as health care and education.<br><br>▪ 6000 people, including IDPs/Returnees, host/return communities and traditional leaders benefited from community reconciliation sessions conducted to assist the population of concern to deal with sustainable reintegration and reconciliation in places of return, host communities and places of displacement in | ▪ In addition, the CERF funding allowed for a strong partnership and collaboration between UNHCR and IOM in a very sensitive humanitarian context, allowing both agencies to provide leadership and leverage, not only in areas of specialization but also geographically.<br><br>▪ CERF funds have made it possible for UNHCR's partner staff to receive specialized training from Save the Children UK on mainstreaming Child safe guarding and child participation which was then used at community level during the children's feedback meetings in the projects interventions.<br><br>▪ CERF funds have also made it possible for Save the Children to support UNHCR's life-saving child protection mainstreaming through specialized services and support visits in the field including children's feedback meetings. Where children indicated that they appreciated the renovation of a borehole in an IDP settlement as it meant that their families had an alternative option when fetching water. The next nearest borehole was located an estimated ten km away. | Monitoring visits were conducted by the UNHCR programme officer and reports were submitted. IPs also engaged field staff and community-based workers to monitor and report progress.<br><br>UNHCR and its partners through the establishment of protection monitoring mechanisms by field presence, assessed the number of vulnerable returnees in need of reintegration and reconciliation support. These households were assisted under CERF funding. | | ▪ In addition, the CERF funding allowed for a strong partnership and collaboration between UNHCR and IOM in a very sensitive humanitarian context, allowing both agencies to provide leadership and leverage, not only in areas of specialization but also geographicall.<br><br>▪ CERF funds have made it possible for UNHCR's partner staff to receive specialized training from Save the Children UK on mainstreaming child safe guarding and child participation which was then used at community level during the children's feedback meetings in the projects interventions. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Individuals and families affected by displacement are offered adequate physical, legal and social protection<br><br>Ten awareness sessions conducted and information disseminated on SGBV and child protection by the psycho-social community workers in their respective wards.<br><br>Ten awareness sessions on IDPs rights and conflict resolution/reconciliation conducted by the legal counsellors in each district for better co-existence | Mash Central and Mash west provinces.<br><br>▪ Psychosocial counselling support was extended directly to 369 HH [289 Female and 339 male individuals] in the three provinces of Harare, Mash West and Mash Central to deal with post-traumatic stress and broken-down psycho-social support systems<br><br>▪ Two UNGP on IDPs sensitization Workshops were conducted in Harare and Mash West provinces. The same UNGP sensitisation sessions, however could not be conducted in Mash Central Province due to restricted operational space and political sensitivities. | ▪ Children indicated that the renovated borehole was mostly being used by their parents.<br><br>▪ The first ever United Nations Guiding Principles sensitization workshops were conducted by UNHCR under CERF funding in Mashonaland West's politically sensitivities Hurungwe District and a follow-up UNGP Workshop in Harare Province, where UNHCR Was part of an inter-agency collaborative workshop for technical and central level government officials | | | ▪ CERF funds have also made it possible for Save the Children to support UNHCR's life-saving child protection mainstreaming through specialized services and support visits in the field including children's feedback meetings. Where children indicated that they appreciated the renovation of a borehole in an IDP settlement as it meant that their families had an alternative option when fetching water. The next nearest borehole was located an estimated 10 km away. Children indicated that their parents were mostly using the renovated borehole.<br><br>▪ The first ever United Nations Guiding Principles sensitization workshops were conducted by UNHCR |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | ▪ Improved Nutrition: In Harare, 117 HH received nutrition garden inputs/support. Totalling 500 direct and indirect beneficiaries.<br><br>▪ In Mash Central, 479 HH[ 272 Male and 207 Female] totalling 2,373 direct and indirect beneficiaries received agricultural Inputs as part of reintegration livelihoods support<br><br>▪ In Mash Central ,a total of 555 beneficiaries form 107 HH HH[52Male and 55] Female received small livestock [goats, rabbits free range chickens and guinea fowl] as part of reintegration livelihoods support<br><br>▪ In Mash Central, 179 HH have benefited from cash for work projects which were implemented | | | | ▪ CERF funding in Mashonaland West's politically sensitivities Hurungwe District and a follow-up UNGP workshop in Harare province, where UNHCR was part of an inter-agency collaborative workshop for technical and central level government officials |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | ▪ In Mash Central, 69 HH i.e. 195 beneficiaries benefited from nutrition garden inputs/support.<br><br>▪ In Mashonaland, West, 415HH i.e. 2075 direct and indirect beneficiaries benefited from livelihoods support | | | | |
| Protection/Human Rights/Rule of Law | 09-IOM-023<br><br>Comprehensive Protection and emergency assistance to IDPs and Returnees in Harare and Mashonaland Central Provinces | 409,030 | 5,232,307 | IOM: 5,345 IDPs individuals 1,069 households | ▪ Up to 569 most vulnerable displaced/returnee families and host families are assisted with the adequate level of emergency life-saving NFIs, including provision of sanitary material for women.<br><br>▪ 500 IDPs have basic emergency shelter.<br><br>▪ All ten targeted communities have strengthened protection reporting mechanisms, healing and reconciliation mechanisms that promote psychosocial well-being and healing.<br><br>▪ The capacity of partners to mainstream child protection is enhanced. | ▪ 569 displaced and host families assisted with emergency life-saving NFIs including provision of sanitary material for women.<br><br>▪ 375 households assisted with emergency shelter assistance in Caledonia. IOM faced challenges in getting local authorities to accept emergency tarpaulin shelters.<br><br>▪ Five targeted communities were mobilised and trained in order to strengthen protection reporting mechanisms. IOM faced challenges in getting access to some of the targeted communities.<br><br>▪ Save the Children managed to train the two partners in child protection as well as supporting them in the field on child protection issues. | CERF funds enabled speedy response to displaced households.<br><br>CERF funds enabled the partners to incorporate the rights of children in the programme. | ▪ Post Assistance Monitoring (PAM) surveys were conducted to determine the outcome of assistance rendered. Other data collection tools used were monitoring and assessment reports to collect programme related information. | ▪ Women were prioritised as the recipients in NFI distributions.<br><br>▪ Special attention being paid to the needs of women especially in the composition of the NFI pack. The NFI pack was gender sensitive.<br><br>▪ HIV/AIDS and GBV mainstreaming was done in all activities. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Protection/Human Rights/Rule of Law | 09-IOM-024<br><br>Addressing protection needs of the most vulnerable groups in MVP communities through community based protection systems | 138,700 | 538,062 | 150,00 individuals, children: 50,000, women: 90,000, men: 10,000 | ▪ Increase in access to referral mechanisms for communities and survivors of GBV<br><br>▪ Increase in access to basic health and legal support services for child and adult survivors of GBV<br><br>▪ Increase in skills among adult and child survivors to minimize risk and exposure to secondary trauma and violence<br><br>▪ Increase in access to psycho-social support for child and adult survivors of GBV<br><br>▪ All project activities and utilization of funds are expected to be completed by 30 June 2010 | ▪ The project was implemented in six wards in three districts of Makoni, Mudzi and Mberengwa. These districts are in Manicaland, Midlands and Mashonaland East Provinces<br><br>▪ Community activities were jointly facilitated with other service providers from Police - Victim Friendly unit, legal advisors, health and community leaders<br><br>▪ 16 community outreach meetings were held to raise awareness on gender-based violence, HIV and AIDS and the referral pathway.<br><br>▪ 2,221 (1152 females and 1,069 males) community members were reached, these included traditional, leaders, ward councillors and ordinary community members.<br><br>▪ 25 community-based protection committees were established in the three districts under the project.<br><br>▪ 181 (176 women and girls, two men and three boys) who were survivors of GBV benefited through the livelihoods project. | Rapid allocation of CERF funds allowed the project to begin by conducting multi-sector stakeholder meetings and buy in of the project at district and community leadership level which had experienced high post political election GBV.<br><br>After GBV awareness session, it was noted that there was an increase in the number of people reporting GBV through the Police or health centres e.g. in one month, 51 cases of rape and 18 cases of domestic violence were reported in one district.<br><br>The CERF funds enabled joint programming in increasing access to multi-sectoral service provision to survivors of GBV as there is a fine link between communities based activities and the One Stop Centre which offers services to survivors of GBV. | ▪ IOM and its partners jointly planned activities per district.<br><br>▪ Bi-monthly staff meetings were carried out to assess the project's progress.<br><br>▪ Field monitoring of quality of delivery of awareness sessions on GBV and livelihoods activities were conducted throughout the project cycle.<br><br>▪ Three joint monitoring visits were conducted by IOM, UNICEF and UNFPA and reports compiled. | ▪ Both men and women benefited from the project in both the information sharing sessions and the empowering through livelihood and life-skills activities.<br><br>▪ Special attention was paid to the special needs of survivors of GBV among women, girls men and boys to ensure full inclusion and participation in livelihoods and life-skills activities at planning and implementation.<br><br>▪ More women and girls were survivors of GBV as compared to men and boys, hence the hence more female beneficiaries of the livelihoods/life-skills intervention. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | ▪ A total of 1,680 chickens, 425 goats and 12 sewing machines and sewing accessories were procured for the livelihoods component<br><br>▪ Community leaders were sensibitised separately from other community members to enable them to have tools and skills to take the lead as role models in preventing and mitigating GBV as well as refer survivors to appropriate service providers. | | | ▪ Using community-based empowering approaches, both males and females equally participated in identifying and supporting survivors of GBV for the livelihoods project.<br><br>▪ Special attention paid to the active inclusion of men and boys in community awareness sessions on GBV at planning and implementing stages in an effort to harness men to play a protective role and not be perpetrators of GBV. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Health | 09-CEF-040-C<br><br>Reaching mothers and newborn babies with life saving skills in communities | 439,342 | 7,029,000 | 50,000 pregnant women<br><br>50,000 newborn babies | ▪ Communities sensitised about healthful maternal and newborn care practices at community and family level<br><br>▪ Capacity for community based care for mothers and newborns developed through training of community based workers (VHW).<br><br>▪ Care of sick mothers and neonates at home improved<br><br>▪ Linkages between community maternal and neonatal care services and clinical management strengthened | ▪ 600 Village Health Workers trained in community and home based care for mothers and newborns and equipped with VHW kits.<br><br>▪ 58 Village Health Worker supervisors oriented to the community and home based care programme for mothers and newborns.<br><br>▪ Community and home based care programme for mothers and newborns launched in two districts<br><br>▪ There has been an Increase in early antenatal care bookings, health facility deliveries and improved post natal care for newborn babies and their mothers in the two districts.<br><br>▪ Demand for health facility delivery created, and more pregnant women are accessing maternity waiting homes to be near health care facilities for delivery | Allocation of CERF funds allowed the project to be implemented in a timely manner and enabled all planned activities to be done after the needs were identified | ▪ Village health workers keep registers of all pregnant women, including ANC attendance and health facility deliveries in their village.<br><br>▪ Village health workers keep registers on post natal care provided for mothers and newborns at home and at the clinic.<br><br>▪ Village health workers keep records of all community maternal and newborns deaths<br><br>▪ Monthly clinic staff and VHW meetings carried out to assess progress of project. VHWs followed up by health centre staff and community nurses to monitor work progress | ▪ Women of reproductive age were specifically targeted by the project which benefited pregnant women, post natal mothers and newborn babies.<br><br>▪ The families and communities including men, women and young people benefited as the project through health information received and improved health of mothers and newborns leading to reduced maternal and newborn mortality |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Nutrition | 09-CEF-040-D<br><br>Community-based Management of Acute Malnutrition (CMAM) in Zimbabwe<br>UNICEF PBA: SM/2009/0397 | 1,419,326 | 6,040,000 | 4,726 children under five years | ▪ CMAM program coverage in targeted wards would exceed 70 per cent (based upon proportion of eligible facilities<br><br>▪ Proportion of first level health care facilities in targeted wards providing state of the art OTP would exceed 70 per cent (again using eligible facilities).<br><br>▪ Proportion of target districts providing state of the art inpatient care in at least one referral facility would exceed 90 per cent.<br><br>▪ Proportion of exits from OTP/SC who have died will be less than ten per cent<br><br>▪ The proportion of exits from OTP/SC who have defaulted will be less than 15 per cent<br><br>▪ The proportion of exits from OTP/SC who have recovered would be greater than 75 per cent. | ▪ 109 new health care facilities are now providing standard services to manage/treat children with acute malnutrition. ( Six stabilization centres managing children with severe acute malnutrition and medical complications) and 103 outpatient treatment programmes providing treatment on outpatient basis).<br><br>▪ 4,726 children with acute malnutrition were treated under the CERF support.<br><br>▪ To support the expansion of services for treatment of severe acute malnutrition, UNICEF and the implementing partners supported training of 216 health workers (Nurses and doctors) and 2,538 village health workers under CERF funding.<br><br>▪ A total of 3,356 cartons of Ready to Use Therapeutic Food (RUTF) spread was procured for use in treatment of acute malnutrition. | CERF funding has contributed in expanding the coverage of the CMAM programme resulting in more children accessing treatment | ▪ A technical CMAM working group under the nutrition cluster provided a forum to review, monitor and evaluate implementation of the CMAM programme. The group met on a monthly basis to share lessons learned, present and discuss service statistics and sharing updates. In collaboration with the MoHCW implementing partners developed a data collection tool for use in capturing service statistics. Implementing partners shared with UNICEF their monthly and quarterly progress reports. | ▪ The project benefited all children with acute malnutrition regardless of sex. The monitoring tools collected data disaggregated by sex at facility level where services are provided. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Child Protection | 09-CER-040-B<br><br>Peace building and reconciliation: Provision of psychosocial and other essential supports to women and children affected by violence<br>UN CAP 2009: ZIM-09/P-HR-RL/21024/R<br>UNICEF PBA #: SM/2009/0395 | 164,010 | 1,065,000 | 9,162 beneficiaries (including 3,778 children) | ▪ Increase in access to referral mechanisms for communities and survivors of GBV<br><br>▪ Increase in access to basic health and legal support services for child and adult survivors of GBV<br><br>▪ Increase in access to PSS support for child and adult survivors of GBV<br><br>▪ Increase in skills among child and adult survivors to minimise risk of exposure to secondary trauma and violence<br><br>▪ Implementation of life skills and risk mitigation techniques (specifically targeted for women and or children) to minimise survivors' exposure to secondary or tertiary trauma | ▪ Structures to provide psychosocial support for GBV survivors strengthened in three districts<br><br>▪ Trained lay/peer counsellors raising awareness and providing counselling to their peers. (54 group sessions conducted for adults reaching 2,017 people), nine awareness sessions held with schoolchildren (2,779 children reached).<br><br>▪ 9,162 women, men, girls and boys gained knowledge on gender-based violence, child abuse and referral pathways<br><br>▪ 500 women and 500 children empowered with knowledge and skills about their right to protection against GBV as well as where and how to report such violations;<br><br>▪ 22 couples and 106 individuals received counselling and legal assistance<br><br>▪ Increased number of children and women receiving specialised counselling, upon request; more people are seeking either legal or psychosocial support services as they are now aware of the availability of these services | Joint funding arrangement enabled UNICEF, UNFPA and IOM to develop a coherent and integrated programme, reduced transaction costs on government partners | ▪ Partners submitted quarterly narrative reports to UNICEF<br><br>▪ UNICEF and partners met twice a month to discuss progress and any challenges; provide technical capacity building support on results based management.<br><br>▪ UNICEF staff conducted field monitoring visits<br><br>▪ UNICEF, UNFPA and IOM are going to conduct a joint evaluation of the program in February 2011 | ▪ Separate retreats were designed to enable knowledge and skills transfer to be gender sensitive<br><br>▪ Affirmative action taken to ensure that female trained counsellors were the majority |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | ▪ Counsellors are trained on counselling skills in Makoni and Mberengwa; with GBV survivors now having increased access to counsellors<br>▪ Peer counsellors trained on counselling skills in 3 project sites; 248 males and 204 females including 13 boys and 11 girls trained as community based peer counsellors | | | |
| WATER, SANITATION AND HYGIENE | 09-CEF-040-A<br>Emergency safe water supply, sanitation and hygiene promotion to affected vulnerable (High risk of cholera) populations in urban and rural areas of Zimbabwe<br>UN CAP 2009: ZIM-09/WS/20548/124<br>UNICEF PBA #: SM/2009/0394 | 2,541,800 | 28,5 million | 42,700 families 213,500 people - (approximately 57,645 women, and 123,830 children), 100,000 people in two urban centres (approximately 27,000 women and 47,000 children) and 85,000 people in rural areas (22,950 women and 49,300 children) | ▪ Improved access to adequate safe water to 85,000 beneficiaries<br>▪ Reduced incidence of cholera cases in urban towns and cities<br>▪ Access to safe water and sanitation at a reduced distance of less than 1km from rural households<br>▪ Access to safe water and sanitation in 61 schools and clinics<br>▪ Schools are able to store clean water for washing of hands | ▪ 107,368 people (30,707 women, 28,345 men and 48,316 children) benefited from improved access to safe water of which 10,253 are schoolchildren.<br>▪ 3,887 metric tons of water treatment chemicals were procured and distributed to 12 cities, towns and growth points benefiting more than four million people (approximately 850,000 women and 1,350,000 children)<br>▪ 322 water points were rehabilitated benefiting 80,500 people (23,023 women and 21,252 men and 36,225 children) who have access to safe water | High predictability of project funding allowed planning and project preparation done early once the needs were identified | ▪ NGOs supporting the project as implementing partners (IPs) carried out assessments in project districts before project inception and UNICEF regularly conducted project monitoring visits to project sites. The IPs provided monthly progress reports to UNICEF | ▪ Project benefit was well distributed among women and men and girls and boys; participation of both men and women in water point committees, hygiene promotion; and separate latrines were constructed for boys, girls, male and female teachers at targeted schools |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | ▪ Increased knowledge and good hygiene practices among targeted populations | ▪ 332 water point committees were trained on the management of water facilities i.e. 2,002 members comprising 1,330 women and 672 men<br>▪ Water supplies restored to 46 primary schools through the drilling and rehabilitation of 34 water points in Marondera district benefiting 10,253 school children, teachers and surrounding communities<br>▪ More than 6,700 school children (3,700 girls and 3,000 boys) have access to safe disposal of human excreta through the construction of 268 latrines in 46 primary schools.<br>▪ 12,164 school children (5965 boys and 6199 girls) have benefited from hygiene promotion and education on key hygiene messages and practices. A total of 92 school health masters were trained and 48 school health clubs have been established and are conducting hygiene promotion activities within the schools 504,880 people (144,396 women,<br>▪ 133,288 men and 277,196 children) and 8,532 school children benefited from hygiene promotion messages disseminated through distribution of IEC materials<br>▪ 100 community and 216 school health clubs trained during project implementation | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Food | 10-WFP-002<br><br>Protracted Relief and Recovery Operation Zimbabwe 10595.0: Protracted Relief for Vulnerable Groups | 5,000,000 | 545,576,036 (May 2008-April 2010) | Total : 1,600,000 beneficiaries<br>140,330 females under the age of five;<br>323,211 females between 5-18 years<br>397,655 adult females<br><br>131,527 males under the age of five;<br>290,143 males between five and 18 years;<br>325,299 adult males | ▪ 1.6 million people supplied with food<br><br>▪ Increased accessibility of food to the most vulnerable institutions<br><br>▪ Protect livelihood and reduce asset depletion | ▪ 1,826,133 beneficiaries were provided with 5,848 Mt (cereals➔4,075, Vegetable oil➔273, and Corn-soya Blend➔1,500)<br><br>▪ Improved dietary diversity for food insecure households.<br><br>▪ Improved acceptable food consumption for food insecure households.<br><br>▪ Reduced stress in highly vulnerable households after an analysis of the frequency and severity of coping strategies employed by households | Uninterrupted and improved access to food | ▪ The main tools used to monitor the VGF and Safety Net programme are: Registration Monitoring, Verification, Output Monitoring, Food Distribution Monitoring and Post Distribution Monitoring and Institution Feeding Contact checklist (ICC). The tools report on<br><br>▪ monitoring the fairness and transparency of the targeting and registration processes and detect related shortcomings/ anomalies<br><br>▪ Output monitoring tracks the achievement of targets in the delivery of food to beneficiaries. (Quantity of food, gender and age group; and Proportion of female recipients and proportion of women in FDP committees.)<br><br>▪ Monitor the timeliness, adequacy and efficiency of the food distribution process and detect related constraints; and to ensure that the food actually reaches the intended beneficiaries in the required quantities and in good condition.<br><br>▪ Communities and households' have access to, use of and satisfaction with food aid. | ▪ The programme benefited both males and females. WFP ascribed to enhanced commitments to women with cooperating partner agreements explicitly committing to collect gender disaggregated data. Staff was trained on aspects of gender, male involvement and HIV and AIDS. For the VGF it was pleasing to see more women appear in leadership positions than men |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Logistics Cluster | 09-WFP-050<br><br>Augmented Logistics Services to the Humanitarian Community in Zimbabwe ZIM-09/F/23942 | 408,526 | This grant was assigned to the same project with revised scope on providing better coordination on logistical issues. | 60,000 | ▪ Priority relief items will be delivered on time in the right locations to those in most urgent need, through the prompt establishment of a basic logistics network.<br><br>▪ The delivery of the cargo will be scheduled in close coordination with other cluster leads and its partners who will provide the requirements.<br><br>▪ Defining and executing the supply chain for various clusters will lead into capacity building within the agencies and local/international NGOs to respond to similar crises in the future.<br><br>▪ The technical support that WFP will provide to government bodies with whom WHO is working on the cholera response will certainly help on the logistics capacity building of the local authorities.<br><br>▪ All cargo moving through the common transport system will be tracked and the information disseminated. | ▪ The focus of the project was the improved coordination with humanitarian partners. Coordination meetings were held on a weekly and later bi-weekly basis. Rather than executing services for the partners the focus was on assisting them with contacts, guidance and better informationsharing that resulted in mainstreaming the logistics cluster into the day to day humanitarian activities in Zimbabwe. The coordination, especially wash and health clusters enabled that inputs are distributed on time and as prevention which resulted in better preparedness for the expected cholera outbreak and much lower caseload. | The CERF funding allowed for setting up of a coordination and information management structure within the logistics cluster. It also allowed for assisting with services to the Civil Protection Department of Zimbabwe during several small scale operations to which the CPD was able to respond. | ▪ The monitoring and evaluation mechanism used for the project were the ones developed by the cluster – the time between the requested service and the distribution of the items. | ▪ Items have been distributed to cholera patients as well as prevention to other beneficiaries equally to men, women, girls and boys. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Protection /Human Rights /Rule of Law | 09-FPA-022<br><br>Protecting and promoting reproductive health rights in ten MVP communities | 289, 975 | 960,000 | 3876 persons were reached with outreach activities to sensitize them of GBV and the available services. About 60 per cent of them were female.<br><br>384 survivors had been able to access medical services through the one-stop centres and referral pathway. | ▪ Increase access to health, legal and psychosocial services by survivors of gender-based violence. | ▪ A one stop-centre was established in Makoni. This one-stop centre is providing comprehensive services to GBV victims. In Mudzi and Mberengwa, referral pathways were developed that enabled victims to be referred from one service provider to another. Smooth implementation of one-stop centres was hampered by lack of financial and human resources. Statistics from Mberengwa and Mudzi showed that 1,500 victims of GBV were given support through the one-stop centres. The one-stop centres and police victim friendly units have been refurbished and furnished. | The added value of CERF funding to this project was that it filled a gap in service provision for victims of GBV. No donor was providing funds for the provision of comprehensive services to victims of GBV. | ▪ Monitoring and evaluation activities involved quarterly monitoring and support visits to project sites using a standard tool. An end of project evaluation was also undertaken. | ▪ The project is aimed at providing services for GBV survivors, which are predominantly women. During the sensitization meetings both men and women were involved and educated about GBV issues, including gender equality. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Protection /Human Rights /Rule of Law | 09-IOM-022<br><br>Supporting children's right to education in mobile and vulnerable communities<br>ZIM-09/E/20636/109 | 739,850 | 5,232,307 | 14,894 girls, 14,421 boys 678 teachers, 756 community members | ▪ Enhanced protective and learning environment for students<br><br>▪ Strengthened teacher, children's and community participation and knowledge in emergency preparedness | ▪ Training of 1,284 children and 756 community members helped to increase awareness on child protection issues in the 40 schools and surrounding communities. In rural schools children reported on issues of exploitation by teachers and the issues were addressed by the SDCs.<br><br>▪ Capacity building of project partners and MoEASC officials in child protection and health and hygiene enabled them to roll out training at district and school level.<br><br>▪ Through training by the ZRP, children and community members were aware of reporting mechanisms for issues of child abuse.<br><br>▪ The trainings on child protection issues enabled the community leaders and SDCs to come up with ways of addressing child protection issues in their communities.<br><br>▪ The awareness brought about by the project resulted in some decrease in incidences of bullying in six of the project schools.<br><br>▪ Reported that teachers were still resorting to corporal punishment. | CERF funds enabled speedy response to protection issues in schools thereby establishing reporting structures in the targeted schools.<br><br>CERF funds enabled the partners to incorporate the rights of children in schools and communities<br><br>CERF funds improved water and sanitation situations in schools.<br><br>CERF funds increased health awareness in schools and communities.<br><br>Learning environment improved as some schools received furniture and were refurbished. | ▪ IOM had overall monitoring responsibility however joint monitoring was done by all partners. IOM and its partners collected data on the different aspects of the project. Each agency maintained records of its area of responsibility including records of training workshops held, database of stationery and recreational materials procured and distributed. | ▪ 14,894 girls, 14,421 boys<br><br>▪ There were more girls in the programme by 473; this was a three per cent difference in the country's population; but the project was designed to meet children's needs equally. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | ▪ Through the project, support was given the government's Child Friendly Schools Initiative through encouraging alternative forms of discipline.<br><br>▪ Advocacy through national coordination involving the MoESAC was initiated especially in bringing awareness to some of the schools on the need to enforce the MoESAC circular on corporal punishment.<br><br>▪ In some schools in Manicaland, the junior SDC was revived to enable more representation of pupils' concerns in schools. | | | |

## Annex 1: NGOS and CERF Funds Forwarded to Each Implementing NGO Partner

| NGO Partner | Sector | Project Number | Amount Forwarded (USD) | Date Funds Forwarded |
|---|---|---|---|---|
| Action Contre La Faim (ACF) | WASH | 09-CEF-040-A | 127,270 | 31 March 2010 |
| Care International in Zimbabwe | WASH | 09-CEF-040-A | 173,982 | 24June 2010<br>29 June2010 |
| Farm Community Trust of Zimbabwe (FCTZ) | WASH | 09-CEF-040-A | 226,400 | 25 June 2010<br>29 June 2010 |
| Africare Zimbabwe | WASH | 09-CEF-040-A | 130,747 | 26 June 2010 |
| Merlin | WASH | 09-CEF-040-A | 184,620 | 16 February 2010<br>25 June 2010 |
| Christian Care | WASH | 09-CEF-040-A | 34,268 | 24 May 2010 |
| Welthungerhilfe (GAA) | WASH | 09-CEF-040-A | 105,775 | 29 March 2010 |
| Women's Action Group | Child Protection | 09-CEF-040-B | 26,654 | 9 March 2010 |
| Women's Action Group | Child Protection | 09-CEF-040-B | 38,509 | 18 June 2010 |
| National Faith Based Council of Zimbabwe | Child Protection | 09-CEF-040-B | 40,348 | 17 March 2010 |
| National Faith Based Council of Zimbabwe | Child Protection | 09-CEF-040-B | 24,652 | 17 August 2010 |
| Community Working Group on Health | Health | 09-CEF-040-C | 357,100 | 3 March 2010<br>7 June 2010<br>7 September 2010 |
| Action Contre La Faim | Nutrition | 09-CEF-040-C | 95,471<br>107,818<br>143,636 | 23 April 2010<br>23 September 2010<br>21 September 2010 |
| Plan International | Nutrition | 09-CEF-040-C | 100,375<br>93,758 | 23 April 2010<br>22 September 2010 |
| Save UK | Nutrition | 09-CEF-040-C | 180,207<br>103,144 | 16 March 2010<br>31 August 2010 |
| IOM | Nutrition | 09-CEF-040-C | 200,000 | 26 March 2010 |
| World Vision | Health | 09-WHO-044 | 56,384 | 18 May 2010 |
| Zimbabwe Community Development Trust | Protection | 09-IOM-023 | 14,119 | 30 January 2010 |
| Zimbabwe Community Development Trust | Protection | 09-IOM-023 | 14,119 | 30 April 2010 |
| AFRICARE | Food | 09-WFP-049 | 135,003 | 21 April 2010 |
| CHRISTIAN CARE | Food | 09-WFP-049 | 278,339 | 21 April 2010 |
| CATHOLIC RELIEF SERVICES | Food | 09-WFP-049 | 167,620 | 16 April 2010 |
| CARE | Food | 09-WFP-049 | 263,518 | 7 May 2010 |
| CONCERN | Food | 09-WFP-049 | 576,252 | 28 May 2010 |
| GOAL | Food | 09-WFP-049 | 366,308 | 6 May 2010 |
| HELPAGE | Food | 09-WFP-049 | 5,256 | 6 May 2010 |
| IFRC | Food | 09-WFP-049 | 8,318 | 16 April 2010 |
| IOM | Food | 09-WFP-049 | 37,410 | 28 May 2010 |
| OXFAM | Food | 09-WFP-049 | 111,166 | 28 April /2010 |
| PLAN | Food | 09-WFP-049 | 144,849 | 15 April /2010 |

| | | | | |
|---|---|---|---|---|
| SAVE | Food | 09-WFP-049 | 83,17 | 21 April 2010 |
| Save the Children Zimbabwe | Health | 09-FPA-023 | 412,997 | 26 November 2009<br>19 February 2010<br>14 May 2010 |
| Help age | Food | 09-WFP-049 | 13,778 | 20 November 2009 |
| WVI | Food | 09-WFP-049 | 66,025 | 26 December 2009 |
| ORAP | Food | 09-WFP-049 | 101,959 | 21 December 2009 |
| World Vision | Food | 09-WFP-049 | 238,490 | 20 April 2010 |
| Zimbabwe Women Lawyers Association (ZWLA) | Protection/Human Rights/Rule of Law | 09-FPA-022 | 11,601 | 20 May 2010 |
| Musasa Project | Protection/Human Rights/Rule of Law | 09-FPA-022 | 11,601 | 17 May 2010 |
| Women's Action Group (WAG) | Protection/Human Rights/Rule of Law | 09-FPA-022 | 11,601 | 21 May 2010 |
| Save the Children Zimbabwe | Health | 09-FPA-023 | 412,997 | 26 November 2009<br>19 February 2010<br>14 May 2010 |
| Christian Care | Protection | 09-HCR-029 | 192 520.00 | 1November 2009 |
| IRC | Education | 09-IOM-022 | 254,212,00 | February, March and August 2010 |
| SC-UK | Education | 09-IOM-022 | 329,110,00 | January 2010 |
| ZCDT | GBV | 09-IOM-023 | 28,237,50 | January and April 2010 |
| SC-UK | GBV | 09-IOM-023 | 11,500,00 | June 2010 |
| WAG | GBV | 09-IOM-023 | 29,520,00 | February, March and November 2010 |
| Musasa Project | GBV | 09-IOM-023 | 5,760,00 | August 2010 |
| Women Action Group (WAG) | Protection | 09-IOM-024 | 18, 720,00 | November 2010 |
| Musasa Project | Protection | 09-IOM-024 | 18, 720,00 | November 2010 |
| ISL | Protection | 09-IOM-024 | 12,800,00 | January 2010 |
| ZCDT | Protection | 09-IOM-024 | 12,000,00 | January and May 2010 |
| SC-UK | Protection | 09-IOM-024 | 18,501,00 | April, May, August, and December 2010 |

## Annex 2: Acronyms and Abbreviations

| | |
|---|---|
| ACF | Action Contre La Faim |
| AIDS | Acquired Immuno Deficiency Syndrome |
| BCC | Behaviour Change Communication |
| C4 | Cholera command and control centre |
| CCS | Country Cooperation Strategy (CCS) |
| CFR | Case Fatality Rate |
| CHDs | Child Health Days |
| CHWs | Child Health Weeks |
| CMAM | Community Management of Acute Malnutrition |
| EHTs | Environmental Health Technicians |
| EOS | Extended Outreach Strategies |
| GAA | Germany Agro Action |
| GBV | Gender Based Violence |
| HIV | Human Immuno Deficiency Virus |
| IDP | Internally Displaced Persons |
| IEC | Information Education and Communication |
| IOM | International Organization on Migration |
| IP | Implementing Partner |
| IRS | Internal Residual Spraying |
| KAP | Knowledge, Attitudes and Practices |
| MOHCW | Ministry of Health and Child Welfare |
| NFBCZ | National Faith Based Council of Zimbabwe |
| NGO | Non-Government Organisation |
| NHIS | National Health Information System |
| OCHA | Office for the Coordination of Humanitarian Affairs |
| ORS | Oral Rehydration Salts |
| PBA | Programme Budget Allotment |
| PCA | Programme Cooperation Agreement |
| RED | Reaching Every District |
| SAM | Severe acute malnutrition |
| SCA | Save the Children Alliance |
| SGBV | Sexual and Gender Based Violence |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNGP | United Nations Guiding Principles on Internally Displaced Persons |
| UNICEF | United Nations Children's Fund |
| VHW | Village Health Workers |
| WAG | Women's Action Group |

| | |
|---|---|
| WFP | World Food Programme |
| WHO | World Health Organization |
| ZCDT | Zimbabwe Community and Development Trust |