ANNUAL REPORT OF ON THE USE OF CERF GRANTS 2011 IN ZIMBABWE

COUNTRY	**ZIMBABWE**
RESIDENT/HUMANITARIAN COORDINATOR	**Alain Noudehou**

I. SUMMARY OF FUNDING IN 2011 – US$

Funding	1. Total amount required for the humanitarian response		478,000,000[1]
	2. Breakdown of total response funding received by source	2.1 CERF	15,016,297
		2.2 COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	1,384,459
		2.3 OTHER (Bilateral/Multilateral) (ECHO, CIDA, Spain, DFID, Ausaid, Government of Korea)	27,469,803
		2.4 TOTAL	43,870,559
	3. Breakdown of funds received by window	☒ Underfunded	11,016,803
		1. First Round	4,995,491
		2. Second Round	6,021,312
		☒ Rapid Response	3,999,494
	4. Please provide the breakdown of CERF funds by type of partner	4.1 Direct UN agencies/IOM implementation	10,612,716
		4.2 Funds forwarded to NGOs for implementation	4,403,580
		4.3 Funds forwarded to government partners	
		4.4 TOTAL	15,061,297

[1] CAP 2011

II. SUMMARY OF BENEFICIARIES PER EMERGENCY

Total number of individuals affected by the crisis	Individuals	12,294,642
Total number of individuals reached with CERF funding	Female (Headed households)	2,304,645
	Male (headed households)	2,098,934
	Total individuals (Female and male) HH	4,403,579
	Of total, children under 5	605,851

III. GEOGRAPHICAL AREAS OF IMPLEMENTATION

The interventions funded under CERF were implemented in various parts of the country and were in the Agriculture, Education, Food, Health, Nutrition, Multi-sector and Water and Sanitation sectors.

Agriculture

FAO - The 2010/2011 agricultural season was affected by drought in many parts of the country. Matabeleland South province was more adversely affected, with the districts of Mangwe, Umzingwane and Matobos districts experiencing crop failure, which was why they were chosen for implementation of the CERF funded interventions.

IOM undertook targeted smallholder farmers' interventions in the area of Matobo and Gwanda South in Matabeleland South and Hwange in Matabeleland North. These areas are highly dependent on livestock and small grain drought resistant varieties of crop production. The 2010/11 drought severely affected this primary source of livelihood, hence the need for timely interventions to avert a disaster and to restore their livelihoods.

Education

The repair of storm-damaged school intervention under the Rapid Response window was undertaken by IOM. It had a countrywide focus. Schools were prioritized based on existing and more risk of recurrent floods as well as vulnerability assessment. The seven districts covered were Mberengwa, Gokwe North, Gokwe South in Midlands province; Chipinge in Manicaland province, Buhera in Mashonaland East province, Nkayi in Matabeleland North province and Bulilima in Matabeleland South province.

Food

Interventions by WFP were undertaken in: Lupane, Bubi, Nkayi, Hwange, Tsholotsho districts in Matabeleland North province; Umzingwane, Insiza, Gwanda, Bulilima and Mangwe districts in Matabeleland South province, Bulawayo peri-urban; Hurungwe in Mashonaland West province, Rushinga in Mashonaland Central province, Mutoko in Mashonaland East province, Nyanga Makoni, Mutare and Chipinge in Manicaland province, Chiredzi in Masvingo province and Kwekwe in Midlands province.

Health

UNFPA implemented a project in reproductive health in the following areas, using funds from the first underfunded emergency round: Tsholotsho in Matabeleland North province, Hurungwe in Mashonaland West Province, Guruve and Mbire in Mashonaland Central, Mutasa and Chipinge districts in Manicaland. These districts were identified based on high numbers of maternal deaths as well as their remote location from the provincial hospitals (next referral level). In addition, the prevalence of obstetric fistula was found to be high in Chipinge and Tsholotsho, confirming the need for strengthened EmONC in these districts. WHO received funding during the second allocation of the underfunded emergency round and its intervention is ongoing. The project is covering Chipinge and Chimanimani Districts in Manicaland province, and Chiredzi district in Masvingo province. All three districts recorded high cholera cases in 2011. MDM is the implementing partner in Chipinge district while Save the Children is implementing in Chiredzi and in Masvingo province. WHO is supporting MOHCW in carrying out case management training in Chimanimani district.

Nutrition
In the first round of CERF funding, UNICEF, IOM, and WFP submitted a joint project – UNICEF and IOM were responsible for delivering therapeutic care to severely malnourished children, while WFP was responsible for delivering supplementary feeding to moderately malnourished children. Target districts (14) were to be consistent among the agencies.

In the first round of CERF funding, UNICEF was responsible for delivering therapeutic feeding interventions in seven districts: Hurungwe in Mashonaland West province; Makoni and Nyanga in Manicaland province; which were supported by GOAL and Lupane in Matabeleland North province, Insiza and Gwanda in Matabeleland South province and Rushinga in Mashonaland Central province.

IOM was responsible for delivering the same intervention package in seven additional districts: Mutare and Chipinge in Manicaland; Chiredzi in Masvingo province, Mutoko in Mashonaland East province, Kwekwe in Midlands, Bulilima and Mangwe districts in Matabeleland South province.

WFP was resposible for delivering supplementary feeding interventions in a selected group of 14 target project districts. During the first round of CERF funding, WFP delivered supplementary feeding interevetions in the following districts: Hurungwe in Mashonaland West; Rushinga in Mashonaland Central province; Mutoko in Mashonaland East province; Nyanga, Makoni, Mutare, Chipinge in Manicaland Province; Chiredzi in Masvingo province, Kwekwe Midlands province, Lupane, Insiza, Gwanda, Bulilima, and Mangwe.

In the second round of CERF funding, IOM and WFP submitted separate projects. IOM will continue to deliver therapeutic feeding interventions consistent with the first round but in an additional seven districts: Nkayi, Umguza, Bubi, Tsholotsho, Hwange in Matabeleland North; and Beitbridge in Matabeleland South: and Mutoko district in Mashonaland East province. As of 31 December 2011, under the second round of CERF funding, IOM's implementation had not been initiated.

WFP will deliver a different set of interventions in eight districts: Lupane, Tsholotsho, Bubi, Nkayi, Hwange in Matabeleland North Insiza, Umzingwane, and Bulawayo peri-urban.

Protection/Human Rights Rule of Law
Funds set aside for Gender Based Violence (GBV) interventions were utilized to support projects in Buhera and Makoni in Manicaland province, Mutoko and Mudzi in Mashonaland east; and Mberengwa district in Midlands province. These districts were selected because the project addressed urgent gaps at the three previously established one stop centres in Mudzi, Makoni and Mberengwa districts, as well as introduced one-stop centres in the three additional districts that are known for cases of Politically Motivated Violence (PMV) against women, which have the most significant gaps in service provision and access to care for GBV survivors. The intervention is ongoing.

Multi-sector
Regarding mixed migration interventions implemented by IOM, both grants were used at the Nyamapanda border post in Mudzi district, Mashonaland East province. As for refugees, UNHCR implemented the project at the Tongogara refugee camp, the Waterfalls Medical Facility and detention centres in Zimbabwe.

In addition, 20 urban councils as follows were assisted with water treatment chemicals under the rapid response grant: Beitbridge, Bindura, Bulawayo, Chegutu, Chinhoyi, Chipinge, Gwanda, Gweru, Harare, Kadoma, Kariba, Kwekwe, Marondera, Masvingo, Mutare, Plumtree, Rusape, Shurugwi, Victoria Falls, Zvishavane, ZINWA Harare (Manyame, Mazoe, Save).

WASH
The UNICEF CERF project on cholera was implemented in Mudzi district of Mashonaland East provice, in three districts of Manicaland province (Buhera, Chipinge and Mutare districts), which were hardest hit by the last cholera epidemic and were always at risk of cholera; as well as in Tsholotsho district of Matabeleland North province, which was prone to floods and droughts.

IV. PROCESS AND CONSULTATION SUMMARY

I) Was the CERF report discussed in the Humanitarian and/or UN Country Team and by cluster/sector coordinators?
YES ☒ NO ☐

Remarks:

II) Was the final CERF report shared for review with in-country stakeholders (i.e. the CERF recipient agencies, cluster/sector coordinators and members and relevant government counterparts)?

YES ☒ NO ☐

The report was shared with the cluster leads who were also tasked with sharing it with CERF recipient agencies as well as the wider members of the Humanitarian Country Team.

V. ANALYSIS 1 – RESPONSE TO FLOODS/STORMS

1. The humanitarian context

The purpose of this CERF application was to provide emergency rehabilitation support to schools affected by storms in 2011. During school assessments conducted by the Ministry of Education and Emergency Education Response and Preparedness Joint Network (EERPJN) which is part of the Education cluster, personnel indicated that there was an urgent need for school rehabilitation assistance in over 1,600 schools that had been damaged by storms. More than 400,000 children in many cases were attending school in the open, many children were forced to walk long distances to schools that have been less affected by the storms, with parts of schools closed, children were learning in cramped and unhealthy school environments and sanitation facilities were becoming a public health concern. With no separate sanitation facilities available for the female students, it was reported that many girls were dropping out of school due to a lack of privacy. Further to physical infrastructure rehabilitation needs, school heads and school development committees (SDCs) requested support for child protection and essential life-saving skills training for all school staff and their students. This project supported training for 70 school management committees that were selected for emergency rehabilitation support.

This project followed recommendations from a survey to determine the state of schools infrastructure conducted by the EERPJN in 2011. A multi-sectoral approach was adopted in coming up with the infrastructural rehabilitation and Disaster Risk Reduction (DRR) interventions. Further sectoral networking resulted in the provision of technical support that was given by the Ministry of Education, Sport, Arts and Culture MoESAC, the Rural District Councils (RDCS), the Department of Public Works, the police, the Ministry of Health and Child Welfare (MoHCW), SDCs and community leaders, among others. In this project, the SDCs and parents assisted with labour and the provision of locally available resources like bricks, sand, water and stones for school rehabilitation.

While the project was successful in rehabilitating schools and providing child protection and life-saving skills training in the short implementation timeframe, it did highlight such gaps in schools that were not targeted in this project. This project has only dealt with selected 70 schools in seven districts out of long lists of over 1,600 storm-damaged schools in Zimbabwe. Over 1,500 schools still do not provide a proper environment for teaching their pupils, many of whom must take classes outside or under trees.

2. Provide brief overview of CERF's role in the country

At the beginning of 2011, following an assessment by EERPJN, the MoESAC requested the support of NGO partners in their specific provinces to assess schools across the country to assess the impact of damage caused by rain and windstorms in the ongoing rains season (November to March). Given the severely limited resources of the Ministry, travel to schools has in the past been very difficult and as such, detailed information on schools has not been available. In January 2011, joint Ministry and Network teams visited 141 primary and 29 secondary schools, which have been deemed severely affected by storm damage.

Initially, district education officials requested support through the provision of emergency supplies such as tents. However, provincial and central level ministry staff later indicated that with further rains expected and the flooding/storm crises continuing, temporary structures such as tents will not be sufficient to provide the much-needed support that school children needed. Furthermore, water and sanitation facilities had also been destroyed or loosened and emergency upgrading assistance in this area was critical to prevent possible WASH transmittable disease outbreaks or the danger of structures collapsing.

Seven districts were identified and included Gokwe North, Gokwe South, Mberengwa, Bulilima, Nkayi, Buhera and Chipinge. In these areas, school building showed serious storm damage on the roof trusses and asbestos sheets, cracked walls, broken window panes and damaged doors. The situation was compounded by an acute shortage of emergency repair funds affecting all provinces in the country. The schools themselves were faced with serious resource constraints as communities were still recovering from the economic meltdown from the 2008/9, making it difficult for them to address the problems without external assistance. All in all, approximately 140,000 children have been affected by the damages.

Unfortunately the ERF did not have adequate resources that could have had a meaningful impact on the crisis at hand. Therefore, the Education cluster approached all donors in-country who indicated that they had no funds for schools emergency repairs, the Education cluster lead decided to approach the Humanitarian Coordinator to discuss the issue of a possible CERF request with the Humanitarian Country Team (HCT). A proposal was drafted by IOM and UNICEF as cluster lead and after review by the HCT was presented to the CERF for possible funding. Simultaneously, three partners who led the assessment were requested to facilitate a smooth implementation of the project as well as utilizing existing relationships with local authorities. The detailed selection criteria for schools was developed with EERPJN members and the Ministry of Education's personnel and included, *inter alia,* the risk of physical injury posed by the damage and the number of children negatively impacted by such damage. The application of this criteria to the schools assessed in the selected districts was done by the implementing partners in consultation with local authorities to select interventions according to objective criteria. The exact works to be undertaken at each school was determined based on the in-depth needs assessments. There was strong involvement with local authorities such as the provincial and district Ministry of Education, health authorities, environmental health technicians and the district water and sanitation sub-committees. Members of the MoESAC, MoHCW and the District Development Fund (DDF) were involved in assessing the institutions, the supervision of works, and involved in training the committees for operation and maintenance. There were estimates that in 2011, 70 schools could be supported with emergency repair work. This estimate was derived from an average cost per-school of $10,000 based on rapid assessments and prior experience of IOM and implementing partners.

3. ***What was accomplished with CERF funding***

The overall objective of the project was to protect 36,720 children affected by storms in 70 schools and afford them access to quality basic education in a safe and protective environment in seven districts of Mberengwa, Chipinge, Buhera, Gokwe North, Gokwe South, Nkayi and Bulilima. The project improved the physical, protective and social environments in 70 schools most affected by the storms, and provided support and training in key life skills such as dealing with Disaster Risk Reduction (DRR) and dangers of abuse and exploitation. This was done through the refurbishment of schools, support to teachers, school development committees and with children, in order to make schools safer through the provision of emergency upgrading of school facilities, especially classroom block refurbishment and toilet construction. The project focused on schools that were damaged by storms and were in dire need of emergency assistance to make sure that they could provide teachers and students with the basic support necessary for them to realize their educational objectives.

More than 36,720 children were directly assisted by the project as they are now learning in safe, secure rooms in the targeted schools after some refurbishments were done easily, and thus reducing the number of pupils learning from outside or under the trees as was previously the case. This intervention helped alleviate the suffering of more than 36,720 children who were receiving lessons in the open and in most cases at the risk of harsh weather conditions. The DRR training conducted at all 70 schools was meant to enable the school community to mitigate further damage to school buildings as well as reducing threats to the lives of students, teachers and the entire community. The main activities in this project included the selection process of the beneficiary schools, together with the Provincial Education cluster chaired by the Ministry of Education and Culture (MOESAC). Inception meetings for the project were conducted in the seven districts, followed by meetings with all the school heads and School Development Committees (SDCs) of the respective schools. The Rural District Council (RDC) and the Department of Public Works were also involved in implementation of the project. This facilitated technical support and social mobilization, which led to the participation by communities in contributing labour and locally available building materials. Through IOM, Plan International, World Vision and Save the Children provided the rest of the building materials and ensured regular and joint monitoring and supervision with the MOESAC, RDC and the Department of Public Works until the successful completion of the project. The major challenge to the CERF project was that the implementing partners started actual operations in mid-June 2011, citing funding problems for complimenting the CERF project. In addition, the April-May holiday was also highlighted as a major challenge, since school heads were on holiday and this caused further delays. This has resulted in requesting a no cost extension for three months, which extended the project's duration until October 2011. Cement scarcity in Zimbabwe due to the breakdown of machines at the main cement producer in August not only delayed the project further but left the whole country with very little supply of cement for about two months. No refurbishments could take place since all buildings required cement for construction from either the ground level or window level. Cement became expensive and adjustments on charges had to be made to suit the prevailing economic situation in the country in order to finish the project within a designated period of time.

All stakeholders in the project did the monitoring and evaluation of this project, with IOM taking the overall role. The IPs conducted day-to-day monitoring activities for the project. This involved the progress of the community on the project, the movement of locally acquired building materials, monitoring the deliveries of purchased building materials and addressing emerging school needs. IOM also initiated joint supervision visits. Weekly reports were produced internally and monthly reports were submitted on the progress of the work. Finally the local authorities, that is the local councils and Public Works Department would inspect various stages of rehabilitation and finally certify the buildings.

4. An analysis of the added value of CERF to the humanitarian response

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries? If so how?
YES ☒ NO ☐

Although the CERF funds addressed the urgent needs of 70 schools in seven districts, and supported the Ministry of Education Arts ,Sports and Culture' infrastructural development as it has limited capacity to refurbish 1600 storm-damaged schools due to a lack of resources. The needs identified by the schools were vast and the project only addressed the identified needs in the targeted 70 schools. In most of the schools, there was a great need for infrastructural development and rehabilitation. Although the Ministry of Education is aware of the dire conditions in most rural schools, especially satellite schools, it is facing constraints in light of a lack of funding for capital projects. Therefore, CERF funding came at the right time.

b) Did CERF funds help respond to time critical needs?
YES ☒ NO ☐

CERF funds were helpful and came at a time when most schools that had been damaged by storms proved difficult to repair and the School Development Committees had no financial resources of their own to start reconstruction and repair works.

c) Did CERF funds result in other funds being mobilized?
YES ☐ NO ☒

However, CERF funded activities stimulated community-based responses for example in Mt. Darwin, the local business community provided resources to carry out repairs in some schools not covered by the CERF funds.[2]

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ NO ☐

Improved coordination with implementing partners and other humanitarian organizations was experienced during training on Disaster Risk Reduction (DRR). Partnerships with local government structures like the Rural District Councils and Public Works Department ascertained handover of responsibility for the refurbishment of school infrastructures and created responsibility for ongoing support and the maintenance of school buildings.

[2] UNICEF: CERF funding enabled UNICEF to mobilize additional complementary funds towards the provision of clean water in urban areas. About $3 million was accessed from non-humanitarian sources for the period 1 July 2011 to 30 March 2012.

VI. LESSONS LEARNED

LESSONS LEARNED	SUGGESTION FOR FOLLOW-	RESPONSIBLE
In considering Disaster Risk Reduction (DRR) training, teachers, parents and children had an appreciation of the trainings and this will bring change as a gradual process, the project timeframe tended to be rather inadequate. Local partners involved have indicated that they will find ways of following up by building on this through other fora, albeit on a very limited scale.	Education cluster should continue to advocate and fundraise to meet some of the DRR training needs in schools.	Ministry of Education sports, Art and Culture.
The short implementation period of the Rapid Response Funds (six months in total with the no-cost extension) was not enough time for a project, which involves significant construction or refurbishment. It also puts all stakeholders in a difficult position where they encountered challenges caused by external factors such as the countrywide shortage of cement at some point in 2011.	The Education cluster should continuously engage other donors in order to ensure multi- donor support for a medium-long term countrywide response.	Education cluster
Close partnerships with local government structures like the Rural District councils throughout the project period ensured local ownership of the project.	Rural district councils should take full responsibility of schools and make sure that they are refurbished. The responsible Ministry (MoESAC) should be engaged at all levels and periodic reports should be submitted.	Government and Ministry of Education sports, Art and Culture.

ANNEX I. RESPONSE TO FLOODS/STORMS

IOM - EDUCATION

CERF PROJECT NUMBER	11-IOM-014	Total Project Budget	$ 9,100,000
PROJECT TITLE	Emergency rehabilitation assistance to storm-affected schools	Total Funding Received for Project	$ 977,054
STATUS OF CERF GRANT	Completed[3]	Amount disbursed from CERF	$ 977,054

Beneficiaries	Targeted	Reached
Individuals	36000	36720
Female	16000	18500
Male	20000	18220
Total individuals (Female and male)	36000	36720
Of total, children under 5		
TOTAL	36000	36720

Gender Equity

Both girl and boy students equally benefited from the project. 14 schools received 1 x 10 latrines block for girl students, which enabled girls to have girl-only latrines.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
The overall objective of the project was to restore and provide safe educational facilities for children in communities affected by storms. The specific objective was to support the emergency rehabilitation of education facilities at 70 schools damaged by floods and storms.	▪ Enhanced protective and learning environment for 36,720 beneficiaries ▪ Strengthening the participation and knowledge of teachers, children and community members on child protection and essential life-saving skills; 70 schools received improved knowledge on child protection and essential life-saving skills through Disaster Risk Reduction (DRR) training. At the end of the project all 70 schools were fully rehabilitated through community participation and pupils were learning in classroom blocks and IOM, partners and local authorities were continuing monitoring to ensure a full completion of the project..	All stakeholders in the project did the monitoring and evaluation of this project. Implementing partners conducted the day-to-day monitoring activities for the project. This involved the progress of the community on the project, the movement of locally acquired building materials, monitoring the delivery of purchased building materials and addressing emerging school needs. IOM constantly initiated joint supervision visits. Local authorities, the Council and Public Works Department inspected various stages of rehabilitation and certified the buildings.

[3] CERF. There was a three-month extension for the rapid response project 11-IOM-014 to carry out emergency repair of flood-affected schools. From 2011, two out of eight IOM projects, totalling 34 per cent of funding provided by the CERF to IOM, have required extensions. Both projects required additional time to allow for proper consultation with local stakeholders, including authorities and beneficiaries. These delays have put into question IOM's implementation and risk management capacity in Zimbabwe. Consequently, please note that future requests for CERF funding to IOM projects in Zimbabwe will require detailed implementation plans and risk assessments to demonstrate that contingencies are identified in advance and to ensure the completion of activities within the CERF implementation period.

V. ANALYSIS 2 – RESPONSE TO CHOLERA OUTBREAK

1. *The humanitarian context*

Since the epidemic in 2008, cholera has claimed over 4,200 lives, a cumulative caseload of over 97,000 and a case fatality rate of 4.5 per cent, well above the normal emergency threshold of 1 per cent international standard. The disease spread rapidly in Zimbabwe's 2008/9 season covering 55 of the 62 districts and into neighbouring countries. The underlying causes of the unprecedented cholera and current outbreaks were the inability of the population to access and use safe water and sanitation services. Cholera spread was only stemmed by humanitarian interventions such as the supply of water treatment chemicals and the provision of NFIs. Consequently, less than 1,000 cholera cases and around 20 deaths were reported during the 2009/10 rainy season - a 99 per cent reduction in disease burden on the previous year.

At the time of requesting for this CERF grant, Zimbabwe was experiencing an outbreak of cholera. During 2011, 746 cumulative cases and 25 deaths had been reported by mid April 2011 in ten districts with outbreaks in two districts despite the fact that rainy season was over. This was mainly because the underlying causes had not been addressed. Outbreaks of cholera continued to be reported in Chipinge district, Manicaland province. Chipinge was also the district's worst-affected with 399 cases between January and April 2011. Districts affected by cholera during 2011 were Chiredzi with 126 cases, Mutare with 80, Buhera with 64, Bikita at 42, Chimanimani at 26, Murehwa with five, Kadoma with two and Mutasa and Chegutu, which had both reported one case each. Cumulative cases and deaths reported had surpassed those of best-case scenario for the country as contained in the contingency plan for that year, in which it was anticipated that 553 cases and 12 deaths would be reported in 16 districts. In the most likely scenario, cholera occurrence should have ranged from 553 but actual cases were 20,471 and deaths from 12 to 430 which had been predicted to occur in 16 but ended up being reported in 57 districts. Males account for 48.4 per cent of all line listed cases (n=312), females for 51.6 per cent (n=344), within an age range of 0.75 to 85 years, with a median age of 27 years. Such cholera-affected areas were seeing increased transmission rates escalating in vulnerable mobile populations (such as workers and religious groups).

Simultaneously, over four million people faced the risk of consuming contaminated water due to an acute shortage of water treatment chemicals putting the population at critical risk of further public health risks (including re-current severe cholera outbreak, typhoid and other outbreaks of water-borne disease).

Urban councils and the Zimbabwe National Water Authority (ZINWA) were not able to procure essential water treatment chemicals due to low cost recovery, significant tariff reductions by the Government and increased operational costs (electricity and salaries). As such, humanitarian action was required to mitigate public health threats to the population. The emergency response effort required additional non-food items (NFIs - water treatment tablets, soap and jerry cans) for emergency response in the cholera affected regions as well as treatment chemicals to safeguard the urban water supply. Both the provision of water treatment chemicals and NFIs was time-critical to prevent the loss of life - given the need to contain contamination immediately and the limited faculty of under-serviced infrastructure and governance deterioration across the water, sanitation and hygiene (WASH) sector.

Rural areas were also struggling, except where NGOs initiated operations to maintain water, sanitation and hygiene promotion services. The breakdown of maintenance (at all three tiers of the maintenance support system) and dissolution of many community water-point committees has meant that many rural boreholes and wells – the mainstay of the rural water infrastructure – are not functioning. Particularly affected are health institutions – clinics and hospitals as well as schools in rural areas. Zimbabwe's extensive rural sanitation program has also experienced a sharp decline in coverage. With crumbling infrastructure, full pits, unavailable (and unaffordable) cement supplies, many rural families reverted to open defecation. Open defecation is as high as 48 per cent in some areas, which translates to

increased risk to water borne disease outbreaks given the limited availability of hygiene promotion and its enablers such as soap and buckets.

As a result, the country required support to respond to the outbreak of cholera and to reduce loss of life in urban centres where the shortage of water chemicals has placed the population at risk of rapidly spreading waterborne diseases as well as supply NFIs in rural areas where they were required. As such, UNICEF requested CERF funding to act early and to respond to time-critical needs for water treatment chemicals (procuring on behalf of urban councils) and to provide NFIs (water treatment tablets, soap and jerry cans) to affected districts.

Assessment findings

Cholera and disease assessment

- Epidemiological reports (Ministry of Health and Child Welfare - MoHCW, 2011) indicated that cholera cases reported came from 10 districts in the country and a total of 1,140 cases and 45 deaths were reported in 2011. MoHCW and WHO reported that the crude case fatality rate of the 2011 outbreak was 3.4 per cent.

Emergency response monitoring assessment

- Approximately 90 per cent of WASH Emergency Response Unit (WERU) responses to emergency alerts such as cholera, typhoid, storm damage, flooding and displacement were within 24 hours with an average aim of providing safe water of 72 hours demonstrating that with the necessary resources this unit can be effective.

ZINWA and Urban councils chemical needs assessment

- See below under current response – outcome of recent discussions/assessments regarding very limited capacity to procure treatment chemicals from June 2011.

Funding situation

UNICEF managed to secure funding for water treatment chemicals until June 2011. Over $10.6 million had been provided by the following donors for water treatment chemicals between February 2009 and June 2011: a) Ausaid b) Belgium c) CERF d) DFID e) ECHO f) Global Thematic g) the Government of Belgium h) Japan i) French Committee j) the Netherlands and k) UNICEF. Sufficient funding, however, was not available within UNICEF or institutional donors to fully-support the procurement of water treatment chemicals neither beyond June 2011 nor for NFIs for emergency response to the cholera outbreak in Zimbabwe.

UNICEF held discussions with major WASH sector donors in Zimbabwe for possible support in this regard. These donors had insufficient funds available under the humanitarian window. As such, UNICEF requested funds from CERF for the provision of water treatment chemicals to 20 urban councils and ZINWA catchments and for NFIs for emergency response to the cholera outbreak in Zimbabwe. Therefore, the strategy for prioritizing the CERF envelope was adequate.

2. *Provide brief overview of CERF's role in the country*

Decision making for this CERF grant request was directly informed through consultative processes and humanitarian coordination linked to the Humanitarian Cluster (WASH cluster in particular) and the Consolidated Appeals Process (CAP).

The provision of water treatment chemicals and NFIs were included as priority interventions in the WASH Cluster's response plan for Zimbabwe (CAP-2011), which had been developed by the WASH cluster and had the following key objectives:

- to prevent, respond to and control in a timely animated manner WASH related emergencies;

- arrest decline of and restore water, sanitation and hygiene promotion services for vulnerable men, women and children in both urban and rural settings; and
- improve sector information and knowledge management and coordination for an effective humanitarian response.

The WASH cluster response plan included interventions, which were considered to be time-critical and life-saving. The response plan consisted of four broad programmes as follows (of which two were the focus of this CERF grant request):

- Emergency WASH services (including NFIs) to affected communities with an assessment within 24 hours and a response within 72 hours;
- Rural WASH service provision for households and institutions incorporating needs of vulnerable groups at risk of WASH related disease;
- Urban WASH service recovery through the provision of chemicals, repair of existing and the development of alternative water sources; and
- Support to sector coordination.

Under the Zimbabwe WASH cluster, a Strategic Advisory group (SAG) was formed in January 2009 to provide, inter-alia, strategic and technical guidance to the sector for WASH emergency, recovery and transition, and where appropriate making policy recommendations. The SAG consists of key selected members of the WASH cluster, including national and international NGOs, donors, UN agencies and WASH cluster lead. This proposal was presented to and endorsed for submission to the HCT by SAG at a meeting held on 27 May 2011.

3. *What was accomplished with CERF funding*

The CERF funding supported the provision of safe water in 20 urban councils and ZINWA's catchments benefiting four million people (approx. 2,080,000 female, 1,920,000 male including 560,000 children under 5), who in the absence of water treatment chemicals would have been forced to drink unsafe water. In addition, the funding supported 40,000 (approximately 21,000 females) vulnerable people affected by and at threat of cholera through the provision of essential WASH NFIs.

The project contributed to reduced morbidity and mortality in Zimbabwe due to cholera and other WASH-related diseases. The immediate provision of safe water through water treatment chemicals reduced disease impact on four million vulnerable people living in 20 urban centres and ZINWA's catchments. The NFI component of the project contributed to preventing the spread of cholera through timely and effective response, benefiting 40,000 people.

During the project, no cholera outbreaks were reported in the target 20 urban councils and ZINWA catchment areas. This could be attributed to the timely procurement and delivery of water treatment chemicals to urban council and ZINWA water treatment utilities and the distribution of NFIs to the communities at risk of cholera and other WASH-related diseases.

4. *An analysis of the added value of CERF to the humanitarian response*

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries? If so how?

YES ☒ NO ☐

CERF funding enabled UNICEF to procure critical supplies immediately, since a shortage was reported and, to distribute the same among beneficiaries.

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

YES ☒ NO ☐

Urban councils in Zimbabwe as well as the Zimbabwe National Water Authority (ZINWA) were not able to procure essential water treatment chemicals due to low cost recovery, recent significant reductions of tariffs by the Government and increased operational costs (power and salaries). Consequently, over four million people faced the risk of consuming contaminated water due to an acute shortage of water treatment chemicals, putting the population at critical risk of severe cholera outbreak. In this context, CERF funding helped respond to the critical needs and to mitigate immediate public health threats to the vulnerable population through the provision of water treatment chemicals as well as essential NFIs.

c) Did CERF funds result in other funds being mobilized?

YES ☒ NO ☐

CERF funding enabled UNICEF to mobilize additional complementary funds towards the provision of clean water in urban areas. About $3 million was accessed from non-humanitarian sources for the period 1 July 2011 to 30 March 2012.

.

d) Did CERF improve coordination amongst the humanitarian community?

YES ☒ NO ☐

CERF support ensured timely and coordinated response to WASH emergencies. NFI's procured through CERF were distributed through Environmental Health Alliance members. In this regard, regular meetings of the EHA members were held to plan and coordinate implementing the response. The National WASH cluster also had a standing agenda item that included reports on progress with the implementation of CERF-funded projects.

VI. LESSONS LEARNED

LESSONS LEARNED	SUGGESTION FOR FOLLOW-UP/IMPROVEMENT	RESPONSIBLE ENTITY
CERF provided UNICEF, local authorities and ZINWA resources to fill in a critical funding gap that gave all stakeholders time to develop a strategy to ensure future supplies of water treatment chemicals.	Regularly update the stock for pre-positioned WASH supplies.	UNICEF, ZINWA, local authorities and WASH Cluster partners.
Cost recovery is a necessary arrangement to ensure a sustained supply and delivery of water treatment chemicals by the urban councils and to ensure the continued supply of safe water.	Ensure a strong focus on cost recovery in future urban rehabilitation programmes.	UNICEF and other partners.

ANNEX I. RESPONSE TO CHOLERA OUTBREAK

<table>
<tr><th colspan="6">UNICEF – MULTI-SECTOR</th></tr>
<tr><td>CERF PROJECT NUMBER</td><td>11-CEF-028</td><td>Total Project Budget</td><td>$ 4,500,000</td><td rowspan="4"><table><tr><th>Beneficiaries</th><th>Targeted</th><th>Reached</th></tr><tr><td>Individuals</td><td>4,000,000</td><td>4,000,000</td></tr><tr><td>Female</td><td>2,080,000</td><td>2,080,000</td></tr><tr><td>Male</td><td>1,920,000</td><td>1,920,000</td></tr><tr><td>Total individuals (Female and male)</td><td>4,000,000</td><td>4,000,000</td></tr><tr><td>Of total, children under 5</td><td>560,000</td><td>560,000</td></tr><tr><td>TOTAL</td><td>4,000,000</td><td>4,000,000</td></tr></table></td><td rowspan="4">Gender Equity

The project benefited 4 million people of which about 52 per cent were women and girls.</td></tr>
<tr><td>PROJECT TITLE</td><td>Provision of emergency water treatment chemicals and Non Food Items (NFIs) to save lives at risk of cholera</td><td>Total Funding Received for Project</td><td>$ 3,022,440[4]</td></tr>
<tr><td>STATUS OF CERF GRANT</td><td>Completed (31 December 2011)</td><td>Amount disbursed from CERF</td><td>$ 3,022,440</td></tr>
<tr><td colspan="4"></td></tr>
<tr><th colspan="2">OBJECTIVES
AS STATED IN FINAL CERF PROPOSAL</th><th colspan="3">ACTUAL OUTCOMES</th><th>MONITORING AND EVALUATION MECHANISMS</th></tr>
<tr><td colspan="2">To allow 20 target urban councils and ZINWA were able to provide safe water to all residents benefiting about four million people.

To provide 40,000 vulnerable people affected by and at-risk of cholera with essential WASH NFIs.</td><td colspan="3">20 targeted urban councils and ZINWA were able to provide safe water to all residents, benefitting about four million people.
▪ Essential water treatment chemicals including aluminium sulphate, chlorine and HTH were procured for 20 urban councils and seven catchments of Zimbabwe National Water Authority (ZINWA). The timely provision of water treatment chemicals ensured that urban councils and ZINWA were able to provide safe water to about four million people and that there were no water cuts because of stock out of chemicals.

40,000 vulnerable people affected by and at-risk of cholera were provided with essential WASH NFIs.
▪ 40,000 vulnerable people affected by and at risk of cholera were provided with essential NFIs including soap, jerry cans and water purification tablets.</td><td>Owing to public health risks associated with the water treatment chemicals, UNICEF has systemized their monitoring both on the supply side as well as on their utilization. In order to track chemical deliveries, utilization and stocks and to ensure the efficient use and no water cuts due to treatment chemicals being unavailable, regular field visits were conducted within local authorities and close contacts were maintained with the supplies, target utilities and partners.</td></tr>
</table>

[4] UNICEF - Comments on 11-CEF-028 are invalidated by edits in the narrative.

V. ANALYSIS 3 - UNDERFUNDED EMERGENCIES FIRST AND SECOND ROUNDS

1. The humanitarian context

The humanitarian situation in Zimbabwe is showing considerable improvements in most sectors but significant elements of fragility remained a cause for concern in key sectors such as food security, health and nutrition, and water, sanitation and hygiene. Although a crop and livestock assessment conducted in March 2011 had estimated that food production would increase compared to the 2009/2010 season, due to increased planted acreage and timely agricultural inputs and extension support provided by all humanitarian stakeholders. However, the expected good harvest was affected by low erratic rainfall and a prolonged mid season dry spell that occurred between February and March 2011, resulting in drought in Gwanda, Bulilima districts (Matabeleland South) and Manobo and Hwange (Matabeleland North) districts.

Agriculture, Food and Nutrition interventions

The Ministry of Agriculture Second Round Crop and Livestock assessment noted that the 2010/2011 season was ideal for cropping. Although the season started on a promising note with good rains in December 2010 and January 2011, the dry spell critically affected crop production in some parts of the country and the effects were more pronounced in the southern districts (Matabeleland North and South) where crops were a write-off. The drought destroyed agro-ecological livelihoods, resulting in humanitarian needs for populations unable to recover from the negative effects of the continuing socio-economic challenges. These areas were severely impacted by the drought and time-critical interventions were required for the largely pastoralist communities where livestock and drought resistant small grain crops are the primary source of livelihood.

There is consensus within government departments and other stakeholders that timely interventions to support the food insecure vulnerable households in the drought-affected areas was critical to ensure the survival of productive animals which are essential for nutrition, transportation and ploughing. A participatory rural appraisal and sample surveys carried out by Caritas in cooperation with the Ministry of Agriculture, other stakeholders and community leaders, revealed that food shortage in the target areas was drastic. The needs assessment found that an average 75 per cent of the target population had to sell livestock due to food insecurity. Furthermore, due to grain shortages, many families stated their concerns of not being able to feed their livestock. This, in turn, forced these households to increase bartering or selling their livestock without proper livestock production plan. The three selected wards in Bulilima are located in the old communal areas, which are characterised by poor and over used soil. Communities in these wards have very limited livelihood options such as crop and animal production as they are largely pastoralist communities. Poor agricultural practises combined with the severe drought left vulnerable households exposed to acute food insecurity. Therefore, it was important to respond to their food security levels by restoring their livelihood mechanisms. The second round of underfunded emergency targeted southern Zimbabwe, particularly Matabeleland south province that was severely affected by the impact of the long dry spells on agricultural production during the 2010/11 season. The Zimbabwe national nutrition survey conducted in 2010 shows poor scores on indicators related to stunting (up to 47,8 per cent of children in Mangwe), underweight (up to 14,9 per cent of children in Mangwe and Matobo districts) and food deficit (up to 60 per cent of children in Mangwe and Umzingwane). In addition, the prevalence of HIV in the area is high. According to the ZimVac 2011 rural assessment report Matabeleland South is one of the provinces estimated to have the highest proportion of food insecure people in the 2011/2012 consumption year (16 per cent of the people in Matabeleland South were estimated to be food insecure during the lean season from January to March 2012). In the project proposal FAO had suggested four districts in Matabeleland South to be covered by the project. Given that no implementing partners were able to do all four districts, FAO decided, in consultation with the CERF Secretariat, to downscale to three districts while maintaining the number of beneficiaries. This combined with increasing levels of vulnerability and impoverishment generally in the country has jeopardized the food security situation of many families. The ongoing project seeks to improve nutrition and to strengthen the dietary diversity and communal resilience capacity through the cultivation of a variety of crops and small stock production.

National rates of chronic and acute childhood malnutrition stand at 35 per cent and 2.4 per cent respectively, which means that one in every three Zimbabwean children suffers from chronic malnutrition. Globally, maternal and child under-nutrition contributes to 35 per cent of all child deaths and 11 per cent of the global disease burden. Applying these statistics to Zimbabwe, under-nutrition is likely to contribute to more than 12,000 child deaths each year (Situation Analysis of Children and Women, 2005-2010).

Despite improvements in food security over the past three years, Zimbabwe has continued to face a substantial national cereal deficit. Based on estimates of acute malnutrition in 2010 (2.4 per cent Global Acute Malnutrition), with 0.6 per cent severe acute malnutrition (SAM), it is estimated that over 65,000 children under the age of 5 years are acutely malnourished of which about 16,000 suffer from severe acute malnutrition (SAM). Consistent with the 2007 joint UN statement on the "Community Based Management of Acute Malnutrition (CMAM)," the Government of Zimbabwe has adopted CMAM as its primary strategy for treating acute malnutrition. CMAM aims to treat uncomplicated SAM on an outpatient basis using ready to use therapeutic foods (RUTF), to treat complicated SAM in inpatient facilities applying standard WHO therapeutic care guidelines and, to treat moderate acute malnutrition through the provision of fortified supplementary foods, nutritional counselling, and the creation of linkages with food security programmes.

Despite concerted efforts over the past three years, just 40 per cent of eligible health facilities in Zimbabwe provided CMAM services at the beginning of 2011, default rates in existing CMAM sites exceed SPHERE targets (>75 per cent, <10 per cent and <15 per cent for recovery, death and default, respectively), and death rates are borderline. No supplementary feeding programmes were established countrywide for the treatment of children with MAM and those graduating from therapeutic care.

The delivery of life saving care for acute malnutrition was prioritized during the first and second round of the underfunded emergency grants to Zimbabwe. While the rate of global acute malnutrition (GAM) represents a limited public health threat, affecting only 2.4 per cent of children 6 to 59 months (NSS 2010), nearly 10,000 young children (0.6 per cent) at any given time suffer from severe acute malnutrition, a strong predictor of mortality. A sudden deterioration in the food security or health situation in Zimbabwe could trigger a rapid deterioration in rates of acute malnutrition, as seen in 2008; when rates of GAM were estimated at 5.6 per cent, just shy of the national emergency threshold of 7 per cent.

Based on results reported by partners, CERF funding prioritized CMAM as the most appropriate area for nutrition as a life-saving package. Health workers were supported in delivering life-saving therapeutic care for severely malnourished children, and supplementary feeding for moderately malnourished children. CERF monies complemented existing UNICEF inputs, including the provision of therapeutic feeding supplies and some equipment. Through CERF supported work in the first round of funding, CMAM services were expanded to an additional 318 rural health centres and 36 referral centres in the 14 prioritized districts. These facilities serve an estimated 3,045,404 people, of which 653,213 are children under the age of five. Over the life of the project, CERF implementing partners in collaboration with the MoCHW provided treatment to more than 7,000 severely malnourished children. Although official statistics are unavailable, the quality of treatment services appears to have improved as well, as documented by lower than national average default and death rates (about 30 per cent and 9 per cent, respectively). Data from GOAL suggested a 25.3 per cent default rate and a 3.7 per cent death and WVI data suggest 22.3 per cent default and 6.5 per cent death rates. It is worth noting that high default rates might be masking higher than reported death rates, especially in remote areas servicing the most vulnerable communities.

Another issue that is closely tied to poor national agricultural season is the availability of food at the household level. In this regard, World Food Programme (WFP) requested support to cover a pipeline break under WFP's food assistance interventions under PRRO 200162, a programme that was in its second year of implementation and was meeting the life-saving, critical food needs of an estimated 369,000 vulnerable people who are extremely poor and hosting chronically ill patients. Specifically, the CERF grant met the urgent food needs for malnourished adults and children, 13,600 in the first round and 9,025 in the second round of funding.

WFP through its safety net programme has been supporting 369,000 people in 21 districts who are extremely food insecure and hosting malnourished chronically ill patients and orphaned and vulnerable children. In spite of the CERF grants and as a result of the limited donor funding, WFP had to reduce the rations of these households by more than half, affecting an estimated 369,000 beneficiaries in the short-term. The WFP country office had to cut the cereals and pulses from 10 kg to 5 kg and from 1.8 kg to 1 kg per person per month, respectively in April 2011. As a result, a reduction in rations resulted in delivering 783 Kcal providing one third of the daily requirements of adults. Starting in July 2011, rations for vegetable oil were reduced from 0.6 to 0.3 kg per person per month. This has had an impact on the recovery rate of malnourished patients as they take longer to recover and as a consequence have to be kept longer on food assistance. CERF funds

were therefore used to complement existing resources in supporting these households to provide for their basic needs.[5]

The 2011 second round crop and livestock assessment indicated that districts in the southeast and south of the country had suffered a prolonged mid-season dry spell and as such, there were cereal deficits of up to eight months in most districts. The districts that were most-affected were the districts in which WFP was working. CERF funds directly benefited beneficiaries of the safety net programmes, which included households hosting acutely malnourished patients and orphaned and vulnerable children.

Health interventions

During the first round, an intervention targeting basic emergency obstetric and newborn care (EmONC) was prioritized under health interventions. Although this service should be available at all levels, and comprehensive EmONC services should be offered at the district level and onwards, the great socio-economic challenges in recent years have contributed to a severe decline in the availability of basic services for the population, including health services. A sharp decrease in funding for health, the loss of experienced health professionals and shortages in essential supplies and commodities continue to contribute to the deterioration of health infrastructure. The maternal mortality ratio (MMR), an important indicator of a country's development status and quality and access to healthcare services, was estimated at 725/100,000 live births in 2007(Zimbabwe Maternal and Perinatal Mortality Study, 2007). This is twice as high as the global MMR, which stands at 358/100,000, and 50 per cent higher than the MMR in the eastern and southern African region, which is 550/100,000 (WHO, Trends in Maternal Mortality 2010). The ZMPMS 2007 also estimated a perinatal mortality of 29/1000 births, with 49 per cent of deaths occurring within the first 24 hours after delivery. During the second round of grants, funds for the Health cluster were provided for cholera response.

Multi-sector (Protection, IDPs, Asylum Seekers, and Refugees)

Despite the signing of the Global Political Agreement and the formation of an inclusive government (GNU), major political issues have not been resolved and the Government of Zimbabwe remains polarized. This persisting political issue and the forecasted elections have led to the increased mobility and vulnerability of women and girls to gender based violence (GBV). With recent announcements on the possibility of elections[6], tensions have risen within communities and reports of politically motivated violence (PMV) have begun to resurge. PMV is a well-known phenomenon during election times in Zimbabwe and used as a strategy to intimidate opposition supporters. Besides being victims of several forms of assault, women and girls are especially vulnerable to politically motivated sexual violence. The use of sexual violence is exacerbated by the fact that it is a widespread phenomenon in the country in general, with national estimates showing that about 25 per cent of females over age 15 have experienced sexual violence at least once, and between 36 per cent and 38 per cent of women have been victims of intimate partner violence. Another closely related issue is that of asylum seekers, refugees and migrants. Zimbabwe is considered a transit and destination country for refugees as well as trafficked persons, primarily fleeing conflict, human rights abuses and serious economic challenges from places such as Burundi, the Democratic Republic of Congo, Somalia and Ethiopia. A joint IOM-UNHCR needs assessment on the humanitarian situation at Nyamapanda border post conducted on 9 February 2011 in coordination with Mudzi district's local authorities as well as Zimbabwean and Mozambican border officials showed urgent needs for humanitarian intervention. The statistics provided by the Department of Immigration showed that 4,921 (156 female, 4,765 male and 26 minors) asylum seekers/refugees were received at the border post between January 2010 and January 2011. The number continues to increase with 966 asylum seekers/refugees arriving in the month of January 2011, mainly from Somalia. The needs assessment confirmed the request made by local authorities for the urgent provision of shelter, food, health, water and sanitation, protection counselling and transportation to Tongogara refugee camp for asylum seekers/refugees.

The border post did not have adequate facilities and services to address the humanitarian needs arising from the increased influx of asylum seekers/refugees via Nyamapanda. Some of the asylum seekers/refugees

[5] CERF. This is associated with the second round of CERF funding. It remains unclear how much of it was achieved in 2011. There is no mention of the first round of CERF funding for WFP, which was focused on supplementary feeding for moderately malnourished children.

[6] Elections were supposed to take place at the end of 2010 (18 months after the establishment of the GNU), however they have been pushed back because of delays in the constitutional reform process which is highly-political and supposed to be finalized and endorsed through a referendum before the elections can take place.

arrive in poor health conditions, especially complicated malaria diarrhoea, dehydration and sometimes with infectious diseases such as chicken pox.

After screening, and owing to limited humanitarian access and presence, as well as poor communication and lack of capacity and/or awareness concerning migrant and refugee protection and rights on the part of authorities and persons of concern, the asylum seekers/refugee groups proceeded to walk towards Harare en route to Tongogara Refugee Camp (TRC) over 600 kms away. In an effort to address mixed-flows in a more comprehensive manner, IOM and UNHCR, in collaboration with the Government and local authorities in Mudzi district designed a programme to address immediate humanitarian needs at the border as well as Tongogara refugee camp, which was partially funded by the CERF. IOM responded to the immediate needs of asylum seekers and refugees at the border, focusing on protection, food, immediate medical assistance and transportation to Tongogara Refugee camp, while UNHCR reinforced the existing refugee camp to accommodate shelter and food for newly arriving asylum seekers and migrants at Tongogara refugee camp.

IOM established the Temporary Reception Centre at Nyamapanda border post, about 2.5 km from the border after the local authority in Mudzi made 100m x 50m land available for the operation to provide immediate life-saving assistance to asylum seekers and migrants. This core emergency humanitarian response averted physical and/or psychological harm, provided assistance to and protection of the dignity and rights of migrants/refugee/asylum-seekers, women, minors and other vulnerable migrants.

WASH Interventions

Another humanitarian issue that has persisted in Zimbabwe is related to inadequate clean water and sanitation facilities. Despite concerted efforts to bring cholera under control, in 2010/2011, sporadic cholera outbreaks were still evident in Zimbabwe indicating the compromised state of water, sanitation and hygiene services. The Ministry of Health and Child Welfare (MoHCW) and the World Health Organisation (WHO) reported a high case fatality rate (2.3 per cent) for cholera cases much above the WHO threshold of 1 per cent. Following evidence from the mortality study (CDC, 2009), which showed that having sought medical intervention at a Cholera Treatment Centre (CTC) lowered odds of dying, the WASH cluster included the provision of WASH services in clinics as a priority within the Consolidated Appeals Process (CAP) 2011. For health centres to have a meaningful role, they should be well equipped with supplies and have functional WASH services in order to effectively manage cholera outbreaks.

The proposed intervention submitted to the CERF was to complement support from ECHO, for the rehabilitation of clinics nationally. ECHO had been providing funding for such interventions from 2006. In Zimbabwe, 19.6 per cent (252) of rural clinics serving approximately 1,764,000 men, women and children had no water on-site at clinics on the survey date (Vital Medicines and Health Services Survey (VMHSS), Round 6, 2010). Additionally, 37 per cent (n=307), clinics have had non-functional or erratic safe water supplies (Action Contre la Faim, 2009). According to the VMHSS report (VMHSS, Round 6, 2010), the unavailability of water was among the reasons for discontinuing maternity services at some rural health centres and as such limited the provision of life-saving services to women in need of emergency obstetric care. Clinics are often observed to have dilapidated water, sanitation and medical waste disposal systems at facilities. At least 20 per cent of health centres do not have safe water on site as well as hygiene supplies and hand washing facilities. In addition, there is limited human resource and financial capacity to respond to WASH emergencies at clinics and to maintain WASH systems. This often causes a reduction in health service provision for child delivery, diarrhoea and cholera.

The initiative was therefore launched with the aim of providing WASH services at clinics appreciating the role of clinics in cholera control and the provision of maternal services. In schools, it was envisaged that there would be a reduction in risk of cholera and water-borne disease transmission to young boys and girls. MoHCW and WHO shows that 23 per cent of cholera cases listed as at week 51 in 2010 were aged between 0 and 14 years old, proving that children are prone to cholera as well. A high HIV prevalence of 13.7 per cent[7] makes children as well as men and women more vulnerable to opportunistic infections including water and sanitation-related diseases. Poor WASH has contributed to high malnutrition rates among children, which lead to lower school and work productivity from impaired cognitive function and learning capacity.

The Ministry of Education, Sport, Arts and Culture (MoESAC) stated in their *Strategic Investment Plan for 2011* that a quarter of all primary schools were in need of major repair and that almost all schools have

[7] Ministry of Health and Child Welfare (2009). National HIV estimates.

inadequate sanitation facilities. At the end of 2010, at the national review of the Education Trust Fund (ETF), the Minister of Education stated that the provision of water and sanitation facilities in schools was a priority. A UNICEF-led rapid assessment conducted in February 2009 by education partners indicated significant problems in school-based WASH facilities and a lack of essential training to ensure safe hygiene behaviour of children and teachers in schools. Of the 187 schools assessed, only one school had basic cleaning supplies, less than 25 per cent had access to functional hand-washing facilities on school grounds and none of the teachers had received emergency hygiene training to transfer to children in their care. UNICEF (2010) reported that more than 40 per cent of diarrhoea cases in school children resulted from transmission at school rather than homes and, that girls suffered more when the school environment did not provide the privacy they require for their sanitary needs and ended up absconding or dropping out of school. *School Sanitation and Hygiene Study* conducted in 2010 by UNICEF in Zimbabwe indicated that good hygiene practices were severely affected by a lack of essential resources like safe water, detergents, and sanitation facilities. The repair and rehabilitation of WASH services in schools was additionally a priority within CAP 2011 and would be implemented in collaboration with the Education cluster with lobbying and advocacy for sector wide standards on technology options and updating hygiene promotion curriculum in schools.

2. ***Provide brief overview of CERF's role in the country***

OCHA, through the Inter-Cluster Forum (ICF), co-ordinated the process of application for CERF grants in 2011. After invitation by the Emergency Relief Coordinator to provide funding proposals for both the first and second round of the underfunded emergency, OCHA circulated the information and requested cluster leads to consult with their cluster members in order to prioritize interventions to be funded with the available funds since the needs far outweighed the resources available through the CERF grant. An ICF meeting was convened where OCHA made a presentation on the life-saving criteria and the funding status of CAP 2010 and in the second round CAP 2011 via pressing humanitarian needs. Cluster leads were encouraged to develop projects that focused on the priorities and challenges, and funds be used in a concentrated manner (projects should be financially significant, the funds should not be divided into a big number of small projects with a very limited impact) and keep sight of the fact that projects must meet the CERF's life-saving criteria.

Following consultations at the meeting, the clusters agreed on priority areas. Regarding gender, the cluster leads worked with the GenCap adviser to ensure equitable gender representation in the formulation of the projects. The GenCAP adviser later monitored some of the projects during implementation and provided feedback to relevant clusters.

For the agriculture projects, LICI cluster identified the areas and prioritized the needs based on needs assessments and information from government stakeholders and partners operating on the ground. The project was developed and implemented, underscoring gender equality. The proposed livelihood activities in the above areas came out of the community and stakeholder sensitization meetings. Stakeholders in areas affected by the drought sought interventions that would consider the needs of women, men, boys and girls. This enabled the community to recognize the different needs of women (especially female-headed households), children and others in terms of required livelihoods restoration or/and the protection of food security. Furthermore, during the selection of beneficiary households, priorities were given to households headed by women or unemployed youth (girls and boys), families with orphans as well as those households with chronically ill people and the elderly.

In order to agree on food for the safety net programme under WFP, the Humanitarian Country Team had discussed through the monthly UNCT meetings the pipeline break. The coordination team sent required information well ahead of the time the CAP was used to prioritizing resources allocation. As part of the consultation process, the Nutrition cluster and the technical working group on CMAM were both consulted and provided input before formulating the project. [8]WFP has a gender policy that is used in all its activities. WFP will promote the participation of women in food assistance activities and assistance will be given to any individual who is malnourished irrespective of their gender. In addition, WFP has established mechanisms to report instances of sexual abuse and harassment by aid workers at the community level if and when they occurred, however, experience has shown that these cases are minimal.

[8] Ibid.

In the Nutrition cluster, the 2011 CAP was used to determine areas of priority. According to the 2011 CAP, the Nutrition cluster in collaboration with the Ministry of Health and Child Welfare's National Nutrition Department aimed to increase coverage of CMAM services from 40 per cent to between 60 and 80 per cent, and to introduce supplementary feeding for exits from therapeutic care and for moderately malnourished children.

The CMAM Working Group convened under the chair of the MOHCW to discuss priorities for the delivery of life-saving nutrition interventions and agreed to focus on increasing coverage of CMAM services in 14 high priority districts. This coverage would include, in eight of the 14 districts where WFP had a current presence supplementary feeding support for those transitioning out of the treatment programme. IOM and UNICEF were identified as the lead agencies for the delivery of therapeutic services, while WFP was identified as the lead in delivering supplementary feeding services. The CMAM programme targeted malnourished children regardless of gender. Recognizing the important relationship between the nutritional status of mothers and nutritional outcomes in children, the programme placed particular emphasis on care for malnourished pregnant and lactating women.

A different process of prioritization was followed for the second round of CERF funding. This process will be discussed in the final report on the second round of CERF funding.

Reproductive Health

CERF funding has helped rehabilitate the quality of care as well as the referral chains between communities and the first two crucial levels of care (primary and secondary/district level), which are the main access points for the rural population. In addition communities have been educated about danger signs during pregnancy, the importance of delivering at a health facility and the services that are available and have been improved with the funding (EmONC supplies, maternity waiting homes, ambulances). This significantly increased safe motherhood in the districts. Implementing partners noted an increase in referrals, an increase in institutional deliveries and an increase in uptake of stays at the maternity waiting homes.

Multi-sector - IDPs

The selection of the intervention was guided by IOM verifications and responses to a steadily growing number of internal displacement cases resulting from political violence and land reform, among other factors. The data collected and information products disseminated among humanitarian partners contributed greatly in terms of improving preparedness and coordinated rapid humanitarian responses on the ground. According to the IOM's IDP database, between October 2010 and May 2011, the number of households that were forced to vacate their places of habitual residence (either through displacement or evictions) increased by 375 per cent when compared to the same period in 2009-2010. From October 2010, IOM and partners had assisted more than 1,000 households affected by displacement in five provinces. There is a strong sense among the humanitarian community that these incidents follow the pattern of the 2008 pre-electoral violence and that there is a high risk of violence and displacement in the run-up to the next elections. Indeed, all of the cases where IOM has responded in 2011 coincide with those that experienced political violence in 2008.

IOM and the IDP sub-cluster prioritized the provision of light support packages to newly displaced populations. Over the previous months, IOM had been supporting members of the IDP sub-cluster to respond to new cases of internal displacement, mostly as a result of political violence. Consequently, stocks of emergency light support package had been scarce and had limited the capacity to support partners in responding quickly to emergency cases of new displacement. IOM continued monitoring the situation of more than 15,000 individuals countrywide that remain at risk of displacement, particularly in Manicaland, Mashonaland West and Masvingo provinces. As the IDP sub-cluster lead, IOM aimed to retain the capacity to respond to up to 1,000 cases of new displacement after the sub-cluster has received reports. The second component of this project is addressing time-critical life-saving needs of 300 households of two displaced communities in Bulawayo district, namely Trenance and Killarney (441 households were displaced, with 68 per cent being targeted). The 300-targeted households have volunteered for the resettlement while the other 141 have chosen to relocate to rural or other areas. The two communities have been affected by multiple-displacements resulting from various causes including land reform and clean up campaigns, with the last evictions being in July 2010. Currently these vulnerable households continue to be in the acute phase of displacement as they have no adequate shelter, sanitary facilities and clean drinking water and are facing the risk of further displacement triggered by local authorities' decision. In fact, the Bulawayo City Council has indicated that the land where these communities have settled on is prime land for council and they still need to be relocated.

With regard to the Multi-Sector needs, IOM and UNHCR submitted a joint proposal in the first round (and coordinated separate proposals in the second round) to address resource gaps in meeting the underfunded urgent humanitarian needs of the increasing number of migrants, asylum seekers and refugees entering Zimbabwe through legal and illegal means. To prepare the projects, IOM convened a meeting of all multi-sector Cap partners/members to review needs/priorities based upon the 2011 Zimbabwe CAP multi-sector (Migration and Refugees) Programmes and to solicit proposals for CERF-supported activities related to each of the 2011 Zimbabwe CAP multi-sector programmes. Initially, IOM and UNHCR made separate proposals concerning Nyamapanda and Tongogara, respectively. After discussion, it was agreed that a joint approach would be best-suited to addressing this chronic gap. No other proposals were received, although NGO participants advised on ways in which they could support the implementation of the proposed project. It was noted that addressing the mixed-migration challenge at Nyamapanda and Tongogara has long-been seen as a priority which has lacked government response capacity and has been chronically underfunded or not funded at all, given limited budgets and other competing priorities. The meeting included other UN agencies as well as NGOs. While there was no direct government participation in this meeting, it should be noted that both IOM and UNHCR "partnered" up with the Government on issues falling with the multi-sector programmes and the Government has, on several occasions, expressed an interest in additional support related to mixed-migratory flows.

Both the joint proposals (first round) and separate proposals (second round) were within the humanitarian context and projection of needs and possible scenario in the CAP 2011, as well as based on assessments conducted by IOM at the border, statistics provided by local and central authorities. This also included the ongoing monitoring and assessment of UNHCR and its implementing partners with regard to increasing needs in Tongogara refugee camp. In the second round, multi-sector was prioritized for CERF grant, through various discussions at the ICF, as one of the under-funded sectors with critical resource gaps in providing life-saving humanitarian assistance and protection to migrants, asylum seekers and refugees entering Zimbabwe. Proposals submitted took into account the needs and concerns of different age and gender groups, based on the baseline information gathered by IOM and UNHCR in their respective areas of responsibilities.

After the ICF meeting that determined sectors to be prioritized, detailed selection criteria were developed jointly between the WASH and Education cluster members for the selection of beneficiary districts. Based on this, the MoESAC, MoHCW together with WASH and Education cluster members assisted in selecting priority districts and institutions focusing on cholera attack rates experienced in the geographical areas to be considered. UNICEF requested for Expressions of Interest (EOI) from NGO members of the WASH cluster. Incorporating the EOI from the NGOs, a proposal was developed by UNICEF and sent to OCHA for funding.

An invitation to bid for implementing partnerships was sent, through UNICEF, to all NGOs in the field and partners were selected on the basis of expertise, proven field experience and those who would be capable of conducting all the elements of the programme. The selection process was facilitated by the WASH cluster's Strategic Advisory Group (SAG). The exact works to be undertaken at each institution was determined based on the in-depth needs assessments that the IP conducted.

There was strong involvement of local authorities such as the Provincial and District Ministry of Health Authorities, Environmental Health Technicians and the District Water and Sanitation Sub-Committees. Members of the MoESAC, MoHCW and the District Development Fund (DDF) were involved in the assessment of the institutions, the supervision of works, and in training the committees for operation and maintenance. Complementary works at institutions was from the WASH cluster's clinic technical working group as well as the Education Cluster's technical working group on school WASH.

3. *What was accomplished with CERF funding*

For both Agriculture interventions under IOM and FAO, the projects are ongoing. The beneficiaries and government stakeholders welcomed the project in these drought-affected areas. With current forecasts in the 2012 rainfall season, pointing to below than normal rainfall in the same areas, these timely interventions will go a long way in increasing food security as well and availing water for both domestic and productive use. Under the FAO project, some 3,000 beneficiaries are in the process of receiving trainings on small livestock production and gardening. Input distribution for the gardening component will start in March 2012. Distribution

of small livestock is expected to start in April 2012. Therefore, a more accurate forecast of impact will only be available in the HC's report covering 2012 interventions. The protection of livelihoods for 45,125 beneficiaries was assisted. The funding helped save the lives of malnourished and chronically-ill clients as well improved food access for beneficiaries.

CERF funded activities in the first round improved access to the life-saving care of malnourished children in 14 high-risk districts: Seven through UNICEF supported work in collaboration with Goal and World Vision, and seven through IOM supported work in collaboration with Plan. All health facilities in each of these districts are now capable of delivering both inpatient and outpatient care in a quality, timely fashion. Community-based volunteers have been trained to support active case finding by screening, using mid-upper arm circumference and assessment of oedema to ensure malnourished children are identified and referred for treatment, and are actively supporting home visits to follow up with children who graduate or default from treatment programmes. CERF funding, complemented the supplies and other inputs by UNICEF and IOM for the management of SAM.

In addition to supporting the delivery of life-saving services for children suffering from severe acute malnutrition, CERF funding was used to assist 7465 moderately malnourished children with supplementary feeding through WFP. The supplementary feeding programme recorded a 64 per cent recovery from MAM. In addition to caring for moderately malnourished children, 9,025 chronically ill adults received fortified blended food (CSB+), and their households received a ration to assist in the productive recovery of the ill patients.

In the first round, CERF funding supported district where all the project-related trainings were completed and admissions have commenced, with over 7,000 admissions having been reported in the CMAM programme at the health facility level up until December 2011 and monthly trends rising steadily in several districts as community awareness on this programme have also increased.

The situation regarding politically motivated violence (PMV) remains the same and is likely to get worse as the constitutional referendum and elections get nearer. However, response services have been strengthened. CERF funding will contribute to better-coordinated services for survivors of PMV and GBV at the district level, reaching out to the most vulnerable (including displaced populations). Also, communities are being made increasingly aware of the dangers as well as available services they can access.

Risks of conflict-induced displacement will continue to prevail countrywide, predominantly as a result of political violence but also as the Fast Track Land Reform Process reaches completion in the estimated 200 remaining commercial farms. While displacements resulting from the Fast Track Land Reform Programme dominate new displacements, a continuation of displacements as a result of political violence and intimidation indicate a strong potential for further increases in the context of a deterioration of the socio-political situation.

Under the first component of the project, IOM has procured 340 standard non-food item packs consisting of men, women, boys and girls clothing, four blankets, kitchen utensils, sanitary wear, soap, 20 litre bucket with lid, one jerry can and two mosquito nets. This was necessitated by the fact that the current new displacements have lost property and household assets during the displacement and are therefore in need of blankets, clothing, kitchen utensils, soap and sanitary wear. The NFI packs have been delivered to the IOM warehouse and are in the process of being delivered in the coming months to communities that have been recently displaced as a result of political violence, heavy rains as well as the ongoing farm takeovers in a bid to acquire the remaining farms from the remaining 300 white farmers.

Under the second component of the CERF project, the communities have been allocated land in the Hyde Park location for the resettlement of beneficiaries through Bulawayo city council. Each household will be allocated a plot measuring 2000 square metres. All the resettled households will be able to do small and quick impact livelihoods within the allocated land. The benefiting households will be able to realize income from the livelihoods that they will do as well as feeding their families. The project has faced challenges for it to start as the stakeholders and host communities had varied views of the project. The plots earmarked for the project were claimed by the host community for their children. The local leadership had the same view as the host community, which meant community sensitization could not be done on time. However, numerous efforts and meetings with all the necessary stakeholders were done and all stakeholders finally agreed on the resettlement project implementation. Currently, pegging of the allocated plots is being done, and the registration of beneficiaries will be carried out in mid February 2012. Thereafter, health check-ups among

beneficiaries will be conducted prior to the actual relocation process and proceed with the construction of emergency shelters and emergency latrines.

As the IDP sub-cluster lead, IOM aims to retain the capacity to respond to up to 1,000 cases of new displacement within one week after the sub-cluster receives reports for the duration of the project (i.e. nine months). It was therefore agreed in the IDP sub-cluster that funds would be requested for rapid restocking of emergency items distributed throughout this period and in light of the above, will only remain at a centralized storage facility for no more than two months.

In order to address urgent protection needs and within the framework of facilitating durable solutions, IOM together with other humanitarian agencies has embarked on an active advocacy initiative with local authorities to provide land for the voluntary relocation of two IDP communities that were being assisted with resources from the CERF grant. In these meetings, the municipality of Bulawayo has acceded to the voluntary movement of beneficiaries from Killarney and Trenance to a more permanent location. Following a meeting with IOM on 17 August 2011, the council has identified land in two locations for possible relocation. Based on the progress, IOM and IDP sub-cluster members agreed to support the initial stage of the relocation process with CERF funding

Since the establishment of the Temporary Reception Centre at Nyamapanda border post, the disorganized movement of migrants and asylum seekers has been contained with less groups passing through various porous points at the border and walking along the road to Harare (about 250 km). Information collected through registration, including of nationality, gender, age, health condition, days travelling and place of origin, has provided better understanding and accurate information on the causes, scale and magnitude of the mixed movement, and the needs of humanitarian assistance to prepare appropriate intervention.

Asylum seekers and migrants arriving at the border post were ill informed and had wrong expectations from their point of origin. Through CERF funding, asylum seekers and migrants were given information on safe migration and the dangers of irregular movement in neighbouring countries, as well as security and protection and their rights and obligations. Joint information sessions were also held in collaboration with immigration authorities to reduce the number of persons vulnerable to human trafficking and smuggling.

The humanitarian situation for asylum seekers and migrants at Nyamapanda border post has improved through CERF funding as all beneficiaries received humanitarian assistance at the border post and were directed to the Temporary Reception Centre. Here they were provided with food (cooked meals), medical attention, shelter, clean water and sanitation facilities, NFIs (soap, blankets, toothbrush, cloths) and transportation to Tongogara refugee camp to seek and process their asylum request in Zimbabwe. The project has also significantly alleviated pressure in the border community which already had limited resources and was faced with asylum seekers/refugees and migrants begging for food, water and money for transportation.

CERF funding also improved the health situation of asylum seekers and refugees as they received immediate medical care and treatment to reducing the risk of transmittable diseases. The asylum seekers and migrants received medical assistance from medical nurses at a reception centre with some of them being referred to the rural district clinic for further treatment.

The project also improved the coordination and awareness of the humanitarian situation for mixed migrants among stakeholders and donors and generated additional funds. The Ministry of Regional Integration and International Relationship in collaboration with IOM organized consultation meetings with all stakeholders. Several donors and partners such as the UNHCR regional coordinator and DG ECHO visited the temporary reception and border post to assess the current situation for migrants and asylum seekers at the border post. Due to delays in coordination with local authorities for the provision of a suitable site for the establishment of the transit centre, the centre was opened in August to receive beneficiaries.

As for the assistance provided to refugees and asylum seekers at the Tongogara Refugee Camp (TRC) the assistance under the CERF contributed to improved nutritional and sanitary situations in the camp. No malnutrition was reported among refugees, asylum seekers and new arrivals. An average of 5,343 individuals was assisted until December 2011. The contribution from CERF enabled UNHCR to address the unmet and unplanned needs for food, health and shelter, improving the humanitarian situation. The shelter materials procured under the second round of CERF funding will be utilized during the first quarter of 2012 to improve

the dwellings. UNHCR procured food items (maize meal, rice, sugar beans, salt, sugar and CSB) for three months, drugs and medicines, fuel along with construction materials for 500 dwellings and paid salaries for three UNHCR and two IP national staff for an average five months. More than 90 per cent of new arrivals have abandoned the camp after staying for short periods of time (a few days to a couple of weeks) without notifying the Government, UNHCR or other partners. Considering the persisting needs and resource gaps, and following a multi-donors camp visit organized by UNHCR and the Government of Zimbabwe, UNOCHA initiated, in late December 2011, the coordination of a joint technical assessment mission by UN agencies, IOM and the Government of Zimbabwe to more precisely assess the situation at the main crossing (Nyamapanda) as well as in the Tongogara Refugee Camp. The aim was to make a set of recommendations to better-address the mixed migration flow into Zimbabwe and the humanitarian needs and concerns therein.

In WASH, the CERF intervention provided resources for 27 boreholes to be drilled and six rehabilitated; as well as 12 piped water schemes rehabilitated at 42 schools and 12 clinics in five cholera-affected districts in three provinces. In addition, 693 toilets and 124 hand-washing facilities were constructed/rehabilitated at 70 schools and 66 toilets built at 23 clinics in these districts.

In total, 93 institutions (70 schools and 23 clinics) were reached with WASH facilities and hygiene promotion messages, benefiting some 243,779 people (50 per cent of whom were women and girls, including 49,275 school children - 47 per cent of whom were girls). Among the beneficiaries were 25,000 general patients and 720 pregnant women who used the clinics that were provided with WASH facilities and services.

The table below suggests that the CERF intervention contributed to a reduction in cholera morbidity and mortality in the beneficiary districts.

Reported cholera cases and deaths by district and year: February 2010 to January 2012

District	February 2010		February 2011		January 2012	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Buhera	130	0	17	0	0	0
Chipinge	39	2	0	0	0	0
Mutare	206	2	50	0	0	0
Total	**375**	**4**	**67**	**0**	**0**	**0**

Source: Epidemiological Bulletin Number 94 of 2011 and 144 of 2012, Ministry of Health and Child Welfare/WHO

4. *An analysis of the added value of CERF to the humanitarian response*

AGRICULTURE, FOOD AND NUTRITION

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries? If so how?
YES ☒ NO ☐

The Humanitarian Country Team, OCHA and the Inter-cluster Forum prioritized the intervention and agreed on areas of intervention in an expeditious manner. This allowed all relevant stakeholders to respond to the needs of these households in a timely manner. Funding from CERF improved the delivery of food assistance to the said beneficiaries through a timely disbursement of resources to allow enough time for the procurement of food items and the distribution thereof to the intended beneficiaries. Regarding nutrition interventions, a national CMAM programme is currently underfunded, limiting expansion of life-saving services to those who need it most. CERF funds resulted in 100 per cent of the eligible facilities in 14 districts being able to provide CMAM services. Work in the second round will reach an additional seven districts. CERF funds made it possible to bring these services closer to the beneficiaries, in a timely manner. Furthermore, community-based health volunteers in the community were capacitated to screen and refer children with SAM to the health facilities, thereby ensuring timely and appropriate care.

b) Did CERF funds help respond to time critical needs?
YES ☒ NO ☐

Both projects by IOM and FAO are ongoing. In response to the ZimVac 2011 and National Nutrition Survey 2010, which indicated Matabeleland South as one of the areas with the highest proportion of food insecure people and high numbers of malnutrition/under nutrition children, FAO saw the need for the provision of assistance in the affected areas. CERF funding was readily available. CERF-funding made it possible for FAO to start up this project in a critical moment related to food security in the affected areas. The short lead time in the disbursement of funds responded adequately to the emergency situations where timely food response was critical. Acute malnutrition is an exceptionally good predictor of mortality - children with severe acute malnutrition (SAM) are 10 times more likely to die than their well-nourished counterparts, and children with moderate acute malnutrition (MAM) are more than twice as likely to die as their well-nourished counterparts[9]. While Zimbabwe has continued to emerge from a critical economic crisis, shortages in qualified health service providers persist and food security is still an immediate concern in many areas around the country. The results of these factors create a very real need for accessible life-saving services for acute malnutrition and for qualified health professionals needed for their delivery countrywide. CERF funds have allowed for the timely expansion of the national CMAM programme into underserved, drought-affected and other highly vulnerable areas throughout the country.

c) Did CERF funds result in other funds being mobilized?
YES ☐ NO ☒

Both Agriculture projects are ongoing but no new funds have been mobilized as a result of the CERF grant. However, under Nutrition, the CERF planning process and submission served as a platform for dialogue with Spain, which ultimately led to emergency funding of about $1.2 million for the nutrition sector.

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ NO ☐

There was improved coordination as the selection of areas and the identification of partners for the project brought a number of stakeholders together. The partners implementing the project are reporting on progress in the monthly LICI cluster coordination meetings as well some updates in the region in Matabeleland NGO forum. According to FAO, the intervention was discussed and coordinated with other agencies in Zimbabwe through the inter-cluster forum (ICF). Food distribution required active stakeholder participation among implementing agencies and cooperating NGOs and the Government. Existing collaboration was extended and strengthened so as to respond in a coordinated effort during the duration of the funding period. Food aid coordination meetings with partners and donors were held on a monthly basis to discuss among other things, the food security situation and programme implementation. Monthly monitoring reports from Cooperating Partners were prepared so as to inform management on the progress of the programme and to improve programme monitoring. In the nutrition sector, the grant served as the impetus behind efforts to standardize the national MOHCW CMAM delivery package, develop a standardized training process and tools, develop standardized forms and patient registers, and finalize a quick reference guide for use by health workers. The grant served to catalyze the cluster's CMAM Working Group, which continues to meet regularly to address common implementation concerns and challenges.

HEALTH

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries? If so how?
YES ☒ NO ☐

Under a project by WHO, health workers were provided with transportation and fuel to carry out field activities like social mobilization, and the provision of relevant supplies to the local health facilities. In the case of intervention by UNFPA, fast delivery took place because of the limited duration of the project,

[9] UNICEF - 2009. Core commitments for children in Humanitarian action; www.ennonline.net/pool/file/lessons/unicef/ccc.pdf.

which forced partners to make an extra effort to finish everything in a shorter time than they would usually take.

b) Did CERF funds help respond to time critical needs?
YES ☒ NO ☐

All cholera alerts have been investigated on time, and samples collected and sent to the laboratory for the confirmation of cases.

c) Did CERF funds result in other funds being mobilized?
YES ☒ NO ☐

No for Health intervention by WHO but yes, some of the implementing partners received $ 3.5 million from CIDA to complement CERF funds for improving the health of women and their children (focusing on gender and maternal and child health) in Mutasa, Mutare and Chipinge (Areas covered with the CERF grant Thsolotsho. Mutasa and Chipinge).

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ NO ☐

Joint coordination meetings have been held among health partners in Chipinge and Chiredzi districts. These meetings have not been held previously due to a lack of funding.

Yes, for reproductive health and reproductive health task force in the Health cluster was set up with all humanitarian partners working on reproductive health and as such activities were coordinated. Also, it ensured that similar approaches and set ups were used by different partners in different districts.

MULTI-SECTOR (PROTECTION, IDPs, ASYLUM SEEKERS, REFUGEES)

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries? If so how?
YES ☒ NO ☐

The implementation pace was fast because of the limited duration of the project, which forced partners to make extra efforts to finish everything a lot faster. Through CERF funding, 2749 asylum seekers and migrants were offered adequate food, water and medical assistance as soon as they arrived at the centre. Within 48 hours, 2436 refugees and asylum seekers were transported to Tongogara refugee camp after they were assessed fit to travel.

b) Did CERF funds help respond to time critical needs?
YES ☒ NO ☐

Yes, especially for GBV, where cases of PMV/GBV are on the increase**.** The humanitarian situation for asylum seekers and migrants coming through Nyamapanda border post was critical. The capacities of the local community and humanitarian organizations was limited to responding to the immediate needs, therefore the CERF was essential in responding timely to reduce suffering and the loss of human life.

c) Did CERF funds result in other funds being mobilized?
YES ☒ NO ☐

Yes, some of the implementing partners have received funding from other resources to complement the activities that were done with the CERF (GBV).

The Swedish International Development Agency (SIDA) and European Commission Humanitarian Office (ECHO) have also contributed emergency funding for the establishment of the reception centre, while CIDA and ECHO showed interest for funding the Nyamapanda operation in 2012.

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ NO ☐

Establishing Nyamapanda reception centre has improved awareness and coordination among local government, UN agencies and local authorities. The Ministry of Regional Integration and International Cooperation organised a one day workshop among stakeholders at Nyamapanda to improve coordination for humanitarian assistance. In addition UN-OCHA also took the lead in discussions on the humanitarian needs for mixed migrants and coordinated with UN agencies and the Government's departments involved a multi-stakeholder assessment to identify the gaps and needs.

WASH

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries? If so how?
YES ☒ NO ☐

The WASH services provided under CERF were critical as illustrated in this report. Had it not been for this funding, there would have been no immediate alternative source of funding to support these services. The outcomes mentioned in this report (the supply of safe and adequate water to schools and clinics, the facilitation of excreta disposal, contribution for the effective management of WASH-related disease outbreaks, droughts, floods and displacement, the facilitation of the delivery of emergency and other life-saving clinical health services and the reduction of risks to diseases in schools and the facilitation of learning space) would not have been realized by December 2011 if CERF funding had not been available.

b) Did CERF funds help respond to time critical needs?
YES ☒ NO ☐

CERF contribution to cholera prevention/mitigation cited in the table above suggests that the intervention addressed in a timely manner critical WASH needs for beneficiary institutions and communities. For example in Tsholotsho, safe sanitation after the project intervention increased access to 5,758 school pupils including 919 ECD children. Some schools such as Nkwizhu with an enrolment of 862 had relocated to a new site above the flood zone. The school had only 20 toilets against the recommended minimum of 43 for its size (based on pupil enrolment). The project added an additional 15 units, thereby substantially increasing coverage to 300 more pupils and staff. Some of the beneficiary schools did not have any latrines for staff, who were either sharing with pupils or resorting to open defecation.

Some institutions had their facilities destroyed by flush floods while others had very few toilets e.g. Mahlaba that only had two latrines against a population of 211 pupils. Some of the beneficiary clinics had shared facilities for both staff and patients.

The two institutions that benefited from the borehole sinking and equipping had no safe water source. Lushabe School, for example, was getting its water for drinking from Gwayi River some 15 kilometres away from the school. Chefunye clinic, the other borehole beneficiary, could not open its doors to save the catchment rural population, as it had no safe water source, thanks to the project. The catchment population was getting its water from nearby rivers for both drinking and watering livestock.

c) Did CERF funds result in other funds being mobilized?
YES ☒ NO ☐

ECHO funding of some 5 million EUR was obtained for emergency response and disaster risk reduction (LRRD) through the Environmental Health Alliance partners.

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ NO ☐

As indicated earlier in this report, the selection of beneficiary districts and Implementing Partners (IPs) was done through a process of consultations and collaboration among WASH stakeholders, e.g. WASH and Education clusters, the Ministry of Education Arts, Sports and Culture. By the same vein, IPs went through a rigorous selection process of the beneficiary institutions and communities, involving District Water and Sanitation Sub-Committees; community leaders/structures.

VI. LESSONS LEARNED

LESSONS LEARNED	SUGGESTION FOR FOLLOW-UP/IMPROVEMENT	RESPONSIBLE ENTITY
Use of mobile phones for beneficiary registration seems to be effective.	Extend the use of mobile phones/Nokia Data Gathering in future projects provided enumerators are familiar with mobile phones.	FAO/WV
Proper coordination is critical.	Coordination should be effective from the consultative process of developing the proposal to implementation so that all those involved are aware of their roles and responsibilities.	The Ministry of Health and Child welfare in collaboration with FNC and other agencies e.g WHO, FAO, WFP and UNICEF
The importance of CERF for this country as sources of humanitarian funding (and funding in general), however, since we are not in a typical acute emergency the criteria are sometimes too rigid to apply in an integrated emergency/transition/protracted crises.	Continue CERF funding in Zimbabwe, however, also be flexible in criteria so that work can happen that is applicable to both acute emergency response as well as protracted crises. This might mean opening up the scope of work that is allowed under CERF slightly (e.g. regarding GBV)	OCHA
Joint field visits with OCHA did not take place.	Get commitment from OCHA to do field visits to the projects, so that they get a better understanding of the work and impact in the area of e.g. RH and GBV and can advocate this within the CERF Secretariat.	OCHA.
Cost recovery is a necessary arrangement to ensure a sustained supply and delivery of water treatment chemicals by the urban councils and to ensure the continued supply of safe water.	Ensure a strong focus on cost recovery in future urban rehabilitation programmes.	UNICEF and other partners.
The process of applying for CERF funding was very consultative as it was done through the Health cluster and partners. Priorities for humanitarian support are discussed and joint decisions are made.	The strategy of joint prioritization and decision making should be maintained.	MOHCW , UN Agencies. Partners, OCHA
CERF funding is processed in a short period of time, and this ensures that life-saving humanitarian assistance is received on time.	Rapid processing of CERF funds allocation should be maintained.	MOHCW , Partners UN Agencies, OCHA, health cluster.
Provision for sub-letting CERF funds to other implementing partners like health NGOs improves the implementation of humanitarian interventions.	The Health cluster has to work closely with partners to identify and strengthen areas of cooperation in project implementation in humanitarian work.	MOHCW, Partners, OCHA, UN Agencies.
CERF-funded projects offer UN agencies opportunities to understand more about operations of partners through MoUs signed between them, and promotes synergies and the quality of collaboration on the ground.	Coordination though is very instrumental in improving collaboration with health and other partners.	MOHCW, Partners, OCHA, UN Agencies.

ANNEX I. UNDERFUNDED EMERGENCIES FIRST ROUND

IOM - AGRICULTURE

CERF PROJECT NUMBER	11-IOM-007	Total Project Budget	$ 2 000 000
PROJECT TITLE	Essential emergency and basic livelihoods restoration for Vulnerable populations in the flood and drought prone areas of Chipinge and Muzarabani	Total Funding Received for Project	$ 599 937[10]
STATUS OF CERF GRANT	Completed	Amount disbursed from CERF	$ 299 937

Beneficiaries	Targeted	Reached
Individuals	3,000	3,000
Female	1,500	1,500
Male	1,500	1,500
Total individuals (Female and male)	3,000	3,000
Of total, children under 5	300	300
TOTAL	3,000	3,000

Gender Equity

Both men and women equally benefited from this project. The girls and women benefited from reduced travelling distances to fetch water. This has also helped women to water their community gardens thus improving the availability of relish for household food security purposes.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

Prevent the loss of life and ensure food security by equipping 600 households in Chipinge and Muzarabani Districts with flood/drought resistant livelihoods options.

ACTUAL OUTCOMES

Restocking of small livestock and guinea fowls
The restocking included

- Procured and distributed 270 goats for vulnerable households in Gumira and Masimbe.
- Procured and distributed 536 guinea fowls.
- Purchased and distributed 220 goats for households in Chadereka in Muzarabani.
- Purchased 100 brooding chickens and distributed 4000 guinea fowl eggs in Chadereka.
- A cumulative 1,017 beneficiaries trained on “Small livestock production” in Chipinge.
- 100 contact farmers trained in guinea fowl and goat production.

Establishment of Community Nutritional Gardens

- A cumulative 358 beneficiaries trained in “low Input Gardening” in Chipinge.
- Established one community garden in Masimbe village in Chipinge.
- Six nutritional gardens established in Chadereka in Muzarabani.
- 10 knap sack sprayers Carbaryl distributed.
- 12 contact farmers trained as trainer of trainers on market gardening.

Improved access to water
The deep wells and boreholes were drilled to support community gardens, drinking purposes as well as for their livestock

- 20 deep wells developed and fitted with windlasses and aprons in Muzarabani.
- Two boreholes drilled in Muzarabani.
- One borehole and one deep well drilled in Chipinge.
- Four water point committees were set up and 28-committee member were trained.
- Conducted PHHE.

MONITORING AND EVALUATION MECHANISMS

Joint monthly monitoring and evaluation between IOM and implementing partners, these joint visits also included other government stakeholders and local authorities.

Implementing partners submitted monthly progress reports to IOM as well as reporting progress to the monthly cluster meeting.

Implementing partners also submitted midterm reports to update on the project.

[10] IOM intends to report all contributions to FTS.

UNFPA - HEALTH

CERF PROJECT NUMBER	11-FPA-010	Total Project Budget	$12,595,200
PROJECT TITLE	Strengthening emergency obstetric care at primary and secondary levels	Total Funding Received for Project	$ 5,864,612
STATUS OF CERF GRANT	Complete (31 December 2011)	Amount disbursed from CERF	$ 897,231

Beneficiaries	Targeted	Reached
Individuals	73,973	39,158
Female	56,936	Directly: 35,690
Male	17,010	Directly: 3,468
Total individuals (Female and male)	73,973	39,158
Of total, children under 5	35,106	TBD[11]
TOTAL	73,946	82,369

Gender Equity

In general, the project benefited women more than men, as the target was to improve emergency obstetric care which applies to pregnant women, However it will also indirectly benefit their families. And, as the project strengthened the referral chain in general too (e.g. through ambulance rehabilitation) this will also benefit boys and men that need referrals.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

Contributing to the reduction of maternal mortality by improving service delivery of emergency obstetric and new-born care and working towards meeting the standard of four functional basic EmONC facilities and one comprehensive EmONC facility per 500,000 population in the targeted districts.

ACTUAL OUTCOMES

- 30 health facilities have been addressed - 18 at the primary/community level and six at the secondary/district level. This means that the objective of the minimum standards has been achieved in all six districts (see table below), where possible we tried to address all four basic EmONC and one comprehensive EmONC facility per district because of the long distances among the communities and facilities in the district. Furthermore, all districts must have one comprehensive EmONC facility.

District	Total population	Addressed health facilities
Hurungwe	324,445	4 basic EmONC 1 Comprehensive EmONC
Guruve	120,980	2 basic EmONC 1 Comprehensive EmONC
Mbire	77,686	2 basic EmONC 1 Comprehensive EmONC
Tsholotsho	130,893	4 basic EmONC 1 Comprehensive EmONC
Mutasa	209,616	4 basic EmONC 1 Comprehensive EmONC
Chipinge	306,307	2 basic EmONC 1 Comprehensive EmONC
TOTAL	1,169,927	18 basic EmONC 6 Comprehensive EmONC

Provision of key selected supplies and equipment for basic and comprehensive EmONC for the 30 rural and district health facilities, including but not limited to needles, gloves, cannula, oxytocin and betadine antiseptic solution.

- Basic EmONC supplies have been distributed to 30 health facilities in the six districts
- Comprehensive EmONC supplies have been distributed to six secondary care level health facilities in the six district (one in each district).
- Repairs of six ambulances (one at each targeted district hospital).

MONITORING AND EVALUATION MECHANISMS

Field visits by the IPs

Joint field visits by IPs and INFPA (done half way as well as at the end of the project for the handover to the MoHCW and community).

Quarterly reporting on financial expenditures, achievements against agreement in annual and quarterly work plan and data collection forms with monthly data on the number of births, referrals, women staying at MWH etc.

[11] The babies that will be born in 2012, which are expected to be 43,211)

	▪ Seven ambulances have been rehabilitated, including servicing, repairs and procurement of tyres. Refurbishment of 30 maternity waiting homes (one at each of the targeted health facilities), including basic repairs to the structures and provision of beds, mattresses and linen. ▪ Refurbishment 24 maternity waiting homes in six districts, including fencing, repairs, painting and construction work in sleeping and cooking areas as well as toilet/bathrooms buildings. In addition, all MWHs were provided with beds, mattresses, pillows, blankets, linen and mosquito nets (as the selected districts were highly-malaria). All this was to ensure that the MWHs were safe, habitable and compliant with the MoHCW national guidelines for maternity waiting homes. Social mobilization to promote institutional deliveries by raising awareness of the risk factors, danger signs and available care, through IEC materials and community events. Several social mobilization meetings were held in the districts: ▪ sensitization of health staff and the community to get their buy in the project, this resulted in significant contributions of the community in the project, such as molding bricks, offloading trucks for the supplies, etc. ▪ social mobilization meetings for the communities to promote institutional deliveries by raising awareness of the risk factors, danger signs and available care, including PMTCT. These meetings also addressed cultural misconceptions and barriers, as well as the need to involve men in the pregnancy of their wives and making sure they go to the health facility to deliver. These sessions were usually done together with the village health workers in the district. On average, these were attended by 30 per cent men. These meetings were held at the communities for all targeted facilities. A total of 144 social mobilization sessions were held, reaching 38,138 women and men of reproductive age. ▪ Three handover ceremonies to officially open and hand over the MWHs to the community and MoHCW were held. Besides the formal speeches from the partners (IP, UNFPA, MoHCW, district authorities and health facility representatives) the meetings included awareness raising drama and songs on safe motherhood, involving village health workers and the community.	

WFP – HEALTH/NUTRITION

CERF PROJECT NUMBER	11-WFP-009	Total Project Budget	$8,521,415[12]
PROJECT TITLE	Delivery of life-saving care for acute malnutrition	Total Funding Received for Project	$ $897,221[14]
STATUS OF CERF GRANT	Completed	Amount disbursed from CERF	$ 897,221

Beneficiaries	Targeted	Reached
Individuals	3,045,404	13,600
Female	1,614,064	7,208
Male	1,431,340	6,392
Total individuals (Female and male)	3,045,404	13,600
Of total, children under 5	395,092	7,465
TOTAL	3,045,404[13]	13,600

Gender Equity

The project mainly benefited women and girls who were 52 per cent of the target population. The project also equally benefited men and boys who were 48 per cent of the target population, this reflects on the general population figures in Zimbabwe

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
Ensure access to comprehensive CMAM services for more than 3,045,402 people, including 395,092 young children, between March and November 2011. Deliver timely appropriate care to approximately 13,500 acutely malnourished children between March and November 2011 (approximately 1247 children with Severe Acute Malnutrition and 8,934 with Moderate Acute Malnutrition). Ensure access to comprehensive CMAM services for more than 689,719 people, including 89,663 young children, between October 2011 and June 2012. Deliver appropriate timely care to approximately 4,304 acutely malnourished children between October 2011 and June 2012 (approximately 1,076 children with SAM and 3,228 with MAM).	By the end of the project period, the proportion of exits from SFP who have recovered will be greater than 80 per cent (WFP). ▪ 64 per cent of children enrolled with MAM successfully recovered. ▪ 7,465 children reached with supplementary feeding.[15] ▪ Training activities for health workers and community health volunteers were scheduled to take place at the front end of this project, with the admission of patients to follow once all training and material criteria have been meet, including the provision of basic equipment. In terms of the reporting period for the second round, the following has been achieved: CMAM service coverage improved in seven districts, all facilities in seven districts enabled to provide CMAM services ▪ 130 health workers trained by World Vision in three districts (Nkayi ,Bubi, Umguza). ▪ 110 health workers and 243 community health volunteers trained by Save the Children in two districts (Hwang, Tsholotsho). ▪ 98 health workers and 111 community health volunteers trained by IOM in two districts (Mukoko, Beitbrdige). ▪ Essential equipment has been ordered and awaiting delivery. Therapeutic feeds have also been delivered to the provincial hospital for distribution. Once equipment is distributed at the health facility level, all necessary elements need for commencing admissions and service deliver will be in place. ▪ Project on track for achieving 100 per cent health facilities in seven districts enabled CMAM service on routine basis (Hwange, Nkayi, Tsholotsho, Bubi, Umguza, Matobo and Beitbridge districts.). Geographic Coverage: Matabeleland North Province: Hwange, Nkayi, Tsholotsho, Bubi, Umguza districts. Matabeleland South Province: Matobo and Beitbridge districts.	Monthly anthropometric tracker tracking nutrition recovery Monthly Food distribution reports Monthly post distribution and food security monitoring Standard tools were developed for use at health facility level. CMAM statistics were being collected on a monthly basis from health facilities and consolidated at the district, provincial and national levels. NGOs partners were conducting site support visits jointly with MOH on a monthly basis.

[12] WFP - This has been adjusted as reflected in FTS.
[13] WFP - 3,045,404 is the figure for the whole CMAM programme.
[14] It remains unclear if there were other sources of funding.
[15] The information provided is not sufficient. It remains unclear how over three million people have been reached through CMAM services.

UNICEF – HEALTH/NUTRITION

CERF PROJECT NUMBER	11-CEF-008-A Joint Programme with IOM and WFP	Total Project Budget	$ 5,907,463
PROJECT TITLE	Delivery of life-saving care for acute malnutrition	Total Funding Received for Project (11-IOM-005, 11-CEF-008-A, and 11-WFP-009)	$ 2,261,755
STATUS OF CERF GRANT	Completed	Amount disbursed from CERF to UNICEF	$ 571,914

Beneficiaries	Targeted	Reached
Individuals	1,044,465	1,044,465
Female	553,566	553,566
Male	490,899	490,899
Total individuals (Female and male)	1,044,465	1,044,465
Of total, children under 5	395,092	395,092
TOTAL	1,044,465	1,044,465

NOTE: Number of beneficiaries as stated in the proposal is based on ensuring access to comprehensive CMAM services and was calculated using the estimated catchment areas of the targeted health facilities. This figure encompasses both beneficiaries provided with access to services and those directly receiving services. The figures above refer to the estimated number reached in the districts of Gwanda, Insiza, Rushinga, Lupane, Nyanga, Makoni and Hurungwe (the UNICEF contribution to this joint project).

Gender Equity

Both boys and girls benefited in the project as the service was need based.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

Ensure access to comprehensive CMAM services for more than 3,045,402 people including 395,092 young children between March and November 2011.

UNICEF Specific Targets
Ensure delivery of CMAM services in 148 rural health centres and 18 referral facilities, serving approximately 1,044,465 people in the districts of Gwanda, Insiza, Rushinga, Lupane, Nyanga, Makoni and Hurungwe

Deliver timely appropriate care to approximately 13,500 acutely malnourished children between March and November 2011 (approximately 1,247 children with severe acute malnutrition and 8,934 with moderate acute malnutrition).

UNICEF Specific Target
Ensure provision of direct medical assistance to 1,222 children with severe acute malnutrition.

ACTUAL OUTCOMES

Ensured delivery of CMAM services in 148 rural health centres and 18 referral facilities in the districts of Gwanda, Insiza, Rushinga, Lupane, Nyanga, Makoni and Hurungwe. These facilities serve an estimated 1,044,465 people (Achieved Target).

- 157 health workers trained by World Vision in four districts (Gwanda, Insiza, Rushinga and Lupane).
- 163 health workers trained by GOAL in three districts (Nyanga, Makoni and Hurungwe).

TO NOTE: Objective 1 was implemented in collaboration with IOM and WFP. Please see CERF projects 11-IOM-005 (IOM) and 11-WFP-009 (WFP) for further details regarding overall project reach.

Outcome Indicator 1: All facilities in target district competent in the management of severe acute malnutrition (Achieved Target of 100 per cent).

Over 1,650 severely malnourished children in the districts of Gwanda, Insiza, Rushinga, Lupane, Nyanga, Makoni and Hurungwe received direct medical assistance. (Exceeded Target).

- 521 children received care for severe acute malnutrition in Gwanda, Insiza, Rushinga and Lupane (World Vision).
- 1,130 children received care for severe acute malnutrition in Nyanga, Makoni and Hurungwe districts (GOAL).[16]

TO NOTE: Objective 2 was implemented in collaboration with IOM and WFP. Please see CERF projects 11-IOM-005 (IOM) and 11-WFP-009 (WFP) for further details regarding overall project reach. UNICEF and IOM were responsible for delivery of services for severe acute malnutrition (therapeutic feeding), while WFP was responsible for delivery of services for moderately malnourished children (supplementary feeding).

Outcome Indicator 2: The programme provided services to 132 per cent of expected caseload (Exceeded Target of 70 per cent).
Outcome Indicator 3: Data on quality of CMAM services is unavailable due to government reporting constraints.

MONITORING AND EVALUATION MECHANISMS

Standard tools were developed for use at health facility level. CMAM statistics were being collected on a monthly basis from health facilities and consolidated at the district, provincial and national levels.

NGOs partners were conducting site support visits jointly with the MoH on a monthly basis.

[16] Outcomes have not been fully reported against objectives.

IOM – HEALTH/NUTRITION

CERF PROJECT NUMBER	11-IOM-005 (Joint programme with UNICEF and WFP)	Total Project Budget	$ 5,907,463
PROJECT TITLE	"Delivery of Life Saving Care for Acute Malnutrition"	Total Funding Received (11-IOM-005, 11-CEF-008-A , and 11-WFP-009)	$ 2,261,754.96
STATUS OF CERF GRANT	Completed	Amount disbursed from CERF to IOM	$ 529,187

Beneficiaries	Targeted	Reached
Individuals	2,000,939	2,000,939
Female	1,060,498	1,060,498
Male	940,441	940,441
Total individuals (Female and male)	2,000,939	2,000,939
Of total, children under 5	258,121	258,121
TOTAL	2,000,939	2,000,939

TO NOTE: Number of beneficiaries as stated in the proposal is based on ensuring assess to comprehensive CMAM services and was calculated using the estimated catchment areas of the targeted health facilities. This figure encompasses both beneficiaries provided with access to services and those directly receiving services. The figures above refer to the estimated number reached in the districts of Mutare, Chiredzi, Mutoko, Chipinge, Kwekwe, Bulilima, and Mangwe (the IOM contribution to this joint project).

Gender Equity

Both boys and girls benefited in the project as the service was needs based.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

Ensure access to comprehensive CMAM services for more than 3,045,402 people, including 395,092 young children, between March and November 2011.

IOM Specific Targets
Ensure delivery of CMAM services in 170 rural health centrEs and 18 referral facilities serving approximately 2,000,939 people in the districts of Mutare, Chiredzi, Mutoko, Chipinge, Kwekwe, Bulilima, and Mangwe.

Deliver timely appropriate care to approximately 13,500 acutely malnourished children between March and November 2011 (approximately 1,247 children with Severe Acute Malnutrition and 8,934 with Moderate Acute Malnutrition).

IOM Specific Targets
Provide direct medical assistance to approximately 3,426 children with severe acute malnutrition.

ACTUAL OUTCOMES

Ensured delivery of CMAM services in 170 rural health centres and 18 referral facilities in the districts of Mutare, Chiredzi, Mutoko, Chipinge, Kwekwe, Bulilima, and Mangwe. These facilities serve an estimated 2,000,939 people (Achieved target).

- 335 health workers and 936 community health volunteers trained by IOM in the districts of Mutare, Chiredzi, Mutoko, Chipinge.
- 287 health workers and 480 community health volunteers trained by Plan in the districts of Mutoko, Chipinge, and Kwekwe.

TO NOTE: Objective 1 was implemented in collaboration with UNICEF and WFP. Please see CERF Projects 11-CEF-008-A (UNICEF) and 11-WFP-009 (WFP) for further detail regarding overall project reach.

Outcome Indicator 1: All facilities in target district competent in the management of severe acute malnutrition (Achieved Target of 100 per cent).

5,527 severely malnourished children in the districts of Mutare, Chiredzi, Mutoko, Chipinge, Kwekwe, Bulilima, and Mangwe received direct medical assistance (Exceeded target).

- 2,281 children received care for severe acute malnutrition in Mutare, Chiredzi, Mutoko, Chipinge districts (IOM).
- 3,246 children received care for severe acute malnutrition in Mutoko, Chipinge, and Kwekwe districts (Plan).

TO NOTE: Objective 1 was implemented in collaboration with UNICEF and WFP. Please see CERF Projects 11-CEF-008-A (UNICEF) and 11-WFP-009 (WFP) for further detail regarding overall project reach. IOM and UNICEF were responsible for delivery of services for severe acute malnutrition (therapeutic feeding), while WFP was responsible for delivery of services for moderately malnourished children (supplementary feeding).

Outcome Indicator 2: The programme provided services to 161 per cent of the expected caseload (Exceeded Target of 70 per cent).
Outcome Indicator 3: Data on quality of CMAM services is unavailable due to government reporting constraints.

MONITORING AND EVALUATION MECHANISMS

Standard tools were developed for use at health facility level. CMAM statistics were being collected on a monthly basis from health facilities and consolidated at district, provincial and national levels.

NGO partners were conducting site support visits jointly with the MoH on a monthly basis.

IOM – MULTI-SECTOR

CERF PROJECT NUMBER	11-IOM-006	Total Project Budget	$ 9.200,000
PROJECT TITLE	Life-Saving humanitarian response to refugees and asylum seekers	Total Funding Received for Project 3	$350,000
STATUS OF CERF GRANT	Completed	Amount disbursed from CERF	$ 250,000

Beneficiaries	Targeted	Reached
Individuals	5000	2749
Female	500	127
Male	4500	2622
Total individuals (Female and male)	5000	2749
Of total, children under 5	100	34
TOTAL	5000	2749

TO NOTE: The centre was opened in August to receive beneficiaries thereby limiting the implementation period to August – December 2011 instead of the planned nine months. [17]Although their local government authorities had requested the intervention, there were delays due to the requirement to engage and consult for central government approval.

Gender Equity

Third country nationals from Somalia, Ethiopia, DRC, Burundi and Gabon benefited from the project and 2,622 were male, whilst 127 were female. Women and children were provided with separate shelter from adult males within the centre and provided with need-specific protection including the prevention of sexual or gender based violence (SGBV).

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

To provide immediate humanitarian and protection assistance to refugees and asylum seekers at Nyamapanda Border post.

To provide appropriate support for addressing the legal, physical and material protection and humanitarian assistance to asylum-seekers/refugees transferred from Nyamapanda to TRC.

ACTUAL OUTCOMES

- 2,749 persons (127 female and 2622 male) migrants and asylum seekers received food, health, protection counselling, safe migration information and temporary shelter (with water and sanitation facilities) for resting.
- 2,749 migrants and asylum seekers were provided with three meals per day.
- 2,749 migrants and asylum seekers were health screened, where 635 asylum seekers and migrants were provided with immediate medical assistance mainly against malaria, acute respiratory infection, diarrhea, injuries and skin disease.
- Information leaflets on safe migration, rights and obligation were translated into different languages (Amharic, Somali, Swahili and Arabic) and distributed to beneficiaries.
- 2,436 asylum seekers and refugees were transported to Tongogara refugee camp (2309 were male and 127 female).
- Information sessions were conducted in collaboration with immigration authorities and border security officials.
- Stakeholder coordination meetings to harmonize the assistance provided at the border post were held.
- Presented in multi-sector working group meeting, the situation on asylum seekers and mixed migrants in Zimbabwe and the need of protection and humanitarian needs.

MONITORING AND EVALUATION MECHANISMS

Registration of all beneficiaries receiving assistance at the reception into an IOM database.

Weekly field visits to monitor the operation at the centre.

Weekly reporting of the number of migrants and asylum seekers transported to Tongogara refugee camp.

Monthly monitoring reports shared with the multi-sector cluster.

[17] Since this project was approved on 14 March 2011, it remains unclear why this happened.

UNICEF – WATER AND SANITATION

CERF PROJECT NUMBER	11-CEF-008-B	Total Project Budget	$ 1,953,000
PROJECT TITLE	Emergency WASH assistance to vulnerable populations in institutions in cholera affected areas	Total Funding Received for Project 3	$ 7,075,225
STATUS OF CERF GRANT	Completed (31 December 2011)	Amount disbursed from CERF	$ 1,300,000

Beneficiaries	Targeted	Reached
Individuals	251,702	272,762
Female	114,400	120,515
Male	105,600	123,265
Total individuals (Female and male)	220,000	243,780
Of total, children under 5	31,702	28,982
TOTAL	220,000	272,762

Gender Equity

The project benefited 44 per cent of women and 11 per cent of children under the age of 5 years.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

The risk of WASH-related disease morbidity and mortality among vulnerable boys and girls, men and women in institutions in cholera affected areas reduced

ACTUAL OUTCOMES

Supply of safe and adequate water to schools and clinics

Adequate safe water supply at schools and clinics ensured.

- Drilled/rehabilitated boreholes at 38 schools and 12 clinics.
- Rehabilitated piped water schemes at three schools and eight clinics.

Provide safe excreta disposal facilities

Safe excreta disposal facilities provided at schools and clinics benefiting 25,000 patients (including 720 pregnant mothers).

- Constructed 693 latrines and 124 hand washing tanks at 70 schools.
- Constructed 66 latrines at 23 clinics.

Promote appropriate hygiene practices to communities and institutions affected by WASH-related disease outbreaks, droughts, floods and displacements

Affected communities and institutions reached with appropriate hygiene messages.

- Reached 93 institutions (70 schools and 23 clinics) with WASH facilities and hygiene promotion messages.
- Reached 49,275 pupils with appropriate hygiene messages on the control of WASH related diseases.
- Reached some 243,779 people with hygiene promotion messages on WASH related diseases.

MONITORING AND EVALUATION MECHANISMS

UNICEF has enshrined the project monitoring mechanism which included as part of the Project Cooperation Agreement. This includes the frequency of field visits, quality assurance visits (end of project field monitoring and financial spot checks.

ANNEX I. UNDERFUNDED EMERGENCIES SECOND ROUND

FAO – AGRICULTURE

CERF PROJECT NUMBER	11-FAO-035	Total Project Budget	$ 361,638[18]
PROJECT TITLE	Improved dietary diversity for drought affected households through livestock production and gardening	Total Funding Received for Project	$ 361,638[19]
STATUS OF CERF GRANT	Ongoing (until June 2012)	Amount disbursed from CERF	$ 361,638[20]

Beneficiaries	Targeted	Reached
Individuals (households)	3214	3115
Female	2143	2109
Male	1017	1006
Total individuals (Female and male)	3214	3115
Of total, children under 5	Indirect beneficiaries	Indirect beneficiaries
TOTAL (households)	3214	3115

Gender Equity

The project targets more female-headed households than male-headed households. Children will be secondary beneficiaries of this project.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
Improve food and nutrition security for 3,214 vulnerable small-holder households who depend entirely on rain-fed agriculture, in particular, food insecure farmers that faced harvest losses due to dry spells, in four districts of Matabeleland South by June 2012.	▪ 3115 households have been identified and selected. Beneficiary registration is in progress. ▪ Gardening inputs and tools have been procured by FAO. Distribution of gardening inputs will be done during March/April. Procurement of small livestock is ongoing and distribution is scheduled for April/June.	WV are in the process of beneficiary registration. WV are using mobile phones for registration, this seems to be effective.
Promote diversification of food sources through the integration of small livestock production with other interventions such as gardening in a bid to mitigate the impacts of HIV and AIDS.	▪ Training of trainers in better dietary practices including information on HIV, gender and nutrition issues were done in February 2012. ▪ Initial training of beneficiaries on diversification of food sources including information on HIV, gender and nutrition issues will be done during March 2012. ▪ Further training on nutrition, use of vegetables and small livestock planned for May 2012.	FAO will monitor training of beneficiaries and the distribution of inputs. FAO is present in the districts approximately one week per month.
Improve small stock production and garden outcome through farmer training.	▪ Training of trainers on small livestock production and gardening production was conducted in February 2012. A total of 15 participants attended the training. ▪ Training of beneficiaries on small livestock production and gardening production will be done during March 2012.	

[18] In November 2011, we had been notified of a slight geographical change that did not affect the beneficiary numbers (beneficiary selection in three instead of four districts). Please be sure to reflect this change in this narrative as requested at the time of the communication.
[19] According to the project proposal, this was $ 50,270,000. FAO – the $ 50,2 refers to the total funding request under objective one of CAP MYR 2011.
[20] It remains unclear whether any other funds were received.

IOM - AGRICULTURE

CERF PROJECT NUMBER	11-IOM-035	Total Project Budget	$ 2,000,000
PROJECT TITLE	Emergency livelihoods restoration for vulnerable communities in drought affected areas in Matabeleland (Gwanda, Bulilima, Matobo, Hwange)	Total Funding Received for Project [3]	$1,499,874[22]
STATUS OF CERF GRANT	Ongoing (Ending 30 June 2012)	Amount disbursed from CERF	$ 600,000

Beneficiaries	Targeted	Reached (To date)[21]
Individuals	15,000	1,4046
Female	10,000	9,300
Male	5,000	4,746
Total individuals (Female and male)	15,000	14,046
Of total, children under 5	5,000	4,000
TOTAL	15,000	14,046

Gender Equity

Beneficiary selection ongoing

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

To support emergency livelihoods restoration for the most vulnerable communities and ensuring food security in drought-affected districts.

To prevent the loss of life and ensure food security by providing the most vulnerable households with time sensitive drought resistant livelihoods options.

ACTUAL OUTCOMES

No actual outcomes yet as the project is ongoing.

Activities conducted to date:

Gwanda and Bulilima

- Site Identification and verification
- Beneficiary identification, selection, verification and registration
- Community Mobilisation
- Sourcing of drilling Contractors
- District Management Meetings
- Garden Site Clearing
- Delivery of garden equipment: All the hardware equipment has been delivered to all the sites in the twelve project sites. Each garden site received a five thousand litre tank and its stand, fencing poles, rolls of diamond mesh fencing wire, straining wire, barbed wire, solar panels, pump and control box, cable and enough poly pipes, bends and taps for one hectare.
- Training activities include training in crop production, irrigation management, study circle methodology. Planned trainings also include training for transformation, constitution making, compost making, horticulture i.e. nursery production, transplanting, fertiliser soil improvement, pest and disease control, harvesting, drying, storage, marketing and will also include exchange visits

MONITORING AND EVALUATION MECHANISMS

Joint monthly monitoring and evaluation between IOM and implementing partners, including joint visits with other government stakeholders and the local authorities.

Implementing partners are submitting monthly progress reports to IOM as well as reporting progressing to the monthly LICI cluster meeting.

[21] IOM - It remains unclear whether we should give the updated figures or activities, since this report is for activities, which took place in 2011.
[22] IOM will report this contribution to FTS.

WFP - FOOD

CERF PROJECT NUMBER	11-WFP-053	Total Project Budget	$ 261,299,547
PROJECT TITLE	Assistance to food insecure vulnerable groups	Total Funding Received for Project 3	$ 121,293,532
STATUS OF CERF GRANT	Completed	Amount disbursed from CERF	$ 400,000

Beneficiaries	Targeted	Reached
Individuals	16,950	9,025
Female	8,814	4,693
Male	8,136	4,332
Total individuals (Female and male)	16,950	9,025
Of total, children under 5	3,390	1,805
TOTAL	16,950	9,025[23]

Gender Equity

The project mainly benefited women and girls who were 52 per cent of the target population. The project also equally benefited men and boys who were 48 per cent of the targeted population, this reflects on the general population figures in Zimbabwe.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
Ensure sustained access to basic food aid rations for 16,950 highly vulnerable food insecure beneficiaries.	▪ 9,025 patients supplied with fortified blended food (CSB+). ▪ Food support provided to 9,025 vulnerable household hosting chronically ill patients, increasing their access to food. ▪ Protection of livelihoods for 45,125 beneficiaries assisted.	Monthly food distribution reports. Monthly post distribution monitoring reports. Monthly nutrition trackers and food security monitoring

[23] WFP- The planned targeted beneficiaries could not be reached due to resource constraints.

WHO - HEALTH

CERF PROJECT NUMBER	11-WHO-051	Total Project Budget	$ 13,507,381.
PROJECT TITLE	Cholera outbreak response in Chipinge district in Manicaland province, and Chiredzi in Masvingo province.	Total Funding Received for Project	$ 747,965.
STATUS OF CERF GRANT	All funds have been committed for project implementation	Amount disbursed from CERF	$ 747,965.

Beneficiaries	Targeted	Reached[24]
Individuals	692,422	
Female	360,069	
Male		
Total individuals (Female and male)	692,422	
Of total, children under 5	115,738	
TOTAL	566,323	

Gender Equity

Gender mainstreaming is applied in project implementation. Generally, it was realized that women are more vulnerable as they are mainly the care givers when family members are sick. Pregnant women, children under 5 years and the elderly are the most vulnerable groups.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
WHO Procure and distribute supplies.	Purchase of emergency supplies ▪ WHO has purchased and received most of the emergency medicines and other supplies, including laboratory reagents, detergents and disinfectants.	Commodities purchased and delivered to districts.
Train health staff in Chimanimani, Chipinge and Chiredzi Districts in surveillance.	Training of health staff in the three districts in surveillance skills. ▪ The training has been scheduled for the first quarter, 2012.	Reports of training carried out in the districts.
Train health workers in Chimanimani district in case management.	Training of health workers in Chimanimani in case management ▪ Training of health workers in case management in Chimanimani is scheduled for the first quarter, 2012.	Reports of case management training carried out in Chimanimani.
Print disease surveillance training materials	Printing of disease surveillance training materials ▪ Quotations for printing the materials have been done. Printing to commence within one week.	Printed materials in place and distributed.
MDM Train health staff in case management.	Training of health staff in case management ▪ Training of 51 nurses in Chipinge will start from 19-24 March, 2012.	Reports of training in Chipinge district.
80 VHWs trained in PHHE	Training VHWs in PHHE ▪ 76 VHWs have already been trained in PHHE.	Reports of training of VHWs in PHHE.
100 community leaders trained in PHHE.	Training of 100 community leaders in PHHE ▪ 61 community leaders have already been trained. 39 to be trained.	ORPs set up and functional in Chipinge.
Provide and distribute supplies Oral Rehydration points Established.	Setting up of ORPs ▪ All health facilities in Chipinge have functional ORPs.	Commodity distribution reports.
Cholera management commodities distributed.	Distribution of cholera management commodities ▪ Transportation was provided for the distribution of cholera management.	Reports of social mobilization activities carried out.

[24] The number of beneficiaries reached has not been provided by the WHO.

Carry out Social mobilization activities in the community.	Supporting VHWs to carry out PHHE ▪ The activity has yet to be carried out.	Reports of various interventions supported at the community level.
Community level interventions supported.	Interventions at the community level ▪ Transportation was provided to EHTs to enhance fieldwork. Transportation will be provided to EHTs until the end of May, 2012.14 knapsack sprayers were provided to EHTs for the decontamination of health facilities.	Reports of the various coordination activities carried out
Coordination	Coordination activities ▪ Airtime (USD10/month) provided or a period of five months- November 2011 to March 2012. Airtime to be provided until the end of May 2012. ▪ Transportation was provided to MOHCW staff for a period of five months from November 2011 to March 2012. This will continue until May, 2012. ▪ One Joint meeting between Chiredzi and Chipinge was held on 1 March, 2012 in Chiredzi. These meetings will be carried out monthly. Two supervisory support visits were carried out. These will be carried out regularly until the end of the project.	Reports of joint support and supervision visits by WHO, MOHCW and MDM. Reports by MDM
SAVE THE CHILDREN Train health workers in case management	Case management training for health workers ▪ 26 health workers were trained in case management from 18-20 January 2012. Training focused on early detection, investigation and management of epidemic prone diarrhoeal diseases (typhoid, cholera, dysentery), and laboratory confirmation.	Commodity delivery reports.
Supply, procurement and distribution	Supply procurement and distribution ▪ WHO procured supplies which are yet to be delivered to Save the Children.	
Social mobilization	Social mobilization ▪ A TOT was held for 19 EHTs to train PHHE. 30 PHHE tool kits were purchased and distributed.	Activity reports on social mobilization by SC.
Community level interventions	Community level interventions ▪ 39 VHW and community leaders were trained. ▪ EHTs were provided with fuel for social mobilization and PHHE activities in the community. ▪ IEC materials on diarrhoeal diseases were produced and will be used in social mobilization. ▪ Three cholera alerts were received and investigated in January, 2012. However lab results were negative.	Activity reports of community level interventions by SC.
Coordination	Coordination ▪ Coordination meetings were held with the district health executive in January, 2012. Next meeting scheduled for March, 2012. ▪ One joint meeting was held for both Chipinge and Chiredzi DHE representatives, MDM, Save the Children and ACF on 1 March, 2012. Joint support and monitoring visits are being conducted during training of communities.	Reports of the various coordination activities carried out Reports of joint support and supervision visits by WHO, MOHCW and SC.

IOM – HEALTH/NUTRITION

CERF PROJECT NUMBER	11-IOM-036	Total Project Budget	$ 5,907,463
PROJECT TITLE	Delivery of life saving care for acute	Total Funding Received for Project	$ 2,928,751
STATUS OF CERF GRANT	Ongoing	Amount disbursed from CERF	$ 666,996

Beneficiaries	Targeted	Reached*
Individuals	511,960	
Female	365,551	
Male	324,168	
Total individuals (Female and male)	511,960	
Of total, children under 5	89,663	
TOTAL	511,960	

TO NOTE: This project is composed of two primary phases (1) capacity building of the targeted health facilities to ensure provision of medical services to patients presenting with serve acute malnutrition, and (2) comprehensive CMAM service delivery through the health facilities targeted in phase 1. Phase 1 of this project will be completed in the first quarter of 2012, followed by the commencement of phase Therefore the number of beneficiaries reached will be included in the 2012 report.

Gender Equity

Both boys and girls benefited in the project as the service was needs based.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

Ensure access to comprehensive CMAM services for more than 689,719 people, including 89,663 young children, between October 2011 and June 2012.

Specific Targets:
Ensure delivery of CMAM services in 126 rural health centres and 12 referral facilities serving approximately 689,719 people in the districts of Nkayi ,Bubi, Umguza, Hwange, Tsholotsho, Mukoko, and Beitbrdige.

Objective 2: Deliver appropriate timely care to approximately 4,304 acutely malnourished children between October 2011 and June 2012 (approximately 1,076 children with SAM and 3,228 with MAM).

IOM Specific Targets:
Provide direct medical assistance to approximately 4,304 children with severe acutre malnutrition.

ACTUAL OUTCOMES

To be reported in the 2012 CERF report.

- Project on track for ensuring delivery of CMA services in 126 rural health centers and 12 referral facilities in the districts of Nkayi ,Bubi, Umguza, Hwange, Tsholotsho, Mukoko, and Beitbrdige. These facilities serve an estimated 689,719 people.

To be reported in the 2012 CERF report.

Project Geographic Coverage:
Matabeleland North Province: Hwange, Nkayi, Tsholotsho, Bubi, Umguza districts.
Matabeleland South Province: Matobo and Beitbridge districts.

MONITORING AND EVALUATION MECHANISMS

Standard tools were developed for use at health facility level. CMAM statistics were being collected on a monthly basis from health facilities and consolidated at the district, provincial and national levels.

NGOs partners were conducting site support visits jointly with MOH on a monthly basis

UNFPA – PROTECTION/HUMAN RIGHTS/RULE OF LAW

CERF PROJECT NUMBER	11-FPA-040	Total Project Budget	$ 800,000
PROJECT TITLE	Emergency response to and prevention of gender-based violence	Total Funding Received for Project	$ 496,977[26]
STATUS OF CERF GRANT	Ongoing (30 June 2012)	Amount disbursed from CERF	$ 346,977

Beneficiaries	Targeted	Reached[25]
Individuals	396,945	
Female	203,194	
Male	193,751	
Total individuals (Female and male)	396,945	
Of total, children under 5	0	
TOTAL	396,945	

Gender Equity

The project mainly focuses mainly on women and girls, as these are especially vulnerable to politically-motivated sexual violence.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
Strengthen the availability and accessibility of life saving, survivor cantered GBV prevention and response services to vulnerable women and girls Buhera, Headlands, Mutoko, Mudzi, Makoni and Mberengwa districts.	Establishing of one-stop centres in Mutoko, Headlands and Buhera ▪ Assessments to identify needs for strengthening service provision have been planned. ▪ Procurement of essential RH commodities has been initiated. Strengthening the prevention of politically-motivated GBV at the community level ▪ Awareness raising activities are ongoing in selected communities Plugging urgent gaps in running one-stop centres in Mudzi, Makoni and Mberengwa ▪ Awareness raising activities are ongoing in selected communities	Quarterly visits. Project documentation to capture first phase has been initiated. GBV Information system at district level is being used to monitor activities and reported cases on a monthly basis.

[25] UNFPA - 3,680 women have been reached with services. Approximately 165,000 women and 53,310 men were reached through awareness raising. Therefore, 221,990 individuals were reached.
[26] It remains unclear whether this applies to CERF funding or, all funding received.

IOM – PROTECTION

CERF PROJECT NUMBER	11-IOM-034	Total Project Budget	$ 3,000,000
PROJECT TITLE	Provision of emergency assistance to the most vulnerable internally displaced persons in Zimbabwe	Total Funding Received for Project	$ 720,002
STATUS OF CERF GRANT	Ongoing[28]	Amount disbursed from CERF	$ 500,002

Beneficiaries	Targeted	Reached
Individuals	6,500	3,025
Female	3,500	1,575
Male	3,000	1,450
Total individuals (Female and male)	6,500	3,025
Of total, children under 5	650	300
TOTAL	6,500	3,025[27]

Gender Equity

In responding to new displacement cases, verification process takes place in order to ensure that assistance is appropriate for addressing the different needs of women, men, girls and boys.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
Address the protection needs of newly displaced populations through the provision of emergency humanitarian assistance.	▪ Ongoing monitoring of 17,000 households countrywide. ▪ Verifications, assessments of newly displaced communities in Midlands ,Manicaland, Masvingo, Mash West, Mash Central, Harare and Mash East. ▪ Procurement of 340 standard NFI packs. ▪ Advocacy with authorities in the Midlands, Manicaland, Mash East for access to affected communities.	IOM and IDP sub-cluster members are coordinating to verify, assess, and provide assistance for newly displaced communities in the Midlands ,Manicaland,Masvingo, Mashonaland West, Mashonaland Central, Harare and Mash East.
Provide life-saving assistance to meet the acute emergency needs of vulnerable communities through emergency relocation assistance.	▪ A technical working committee consisting of BCC, IOM and World Vision International has been formed to spearhead operations. ▪ Community sensitisation at the host community site. ▪ Allocation of land for 300 households that will be relocated by BCC. ▪ Pegging of the allocated household plots is ongoing. ▪ Part of the construction materials have already been transported to Bulawayo. ▪ Registration of beneficiary households is ongoing.	IOM and the Implementing partners are monitoring the project together with the technical working committee. Monthly technical working committee meetings will be done to review progress.

[27] The decrease in the number of beneficiaries were caused by the limited availability of land, number of beneficiaries in the relocation component and also by the increase in cost of NFIs.

[28] CERF. This is the second no-cost extension request from IOM for CERF projects approved in 2011. The first case was a three-month extension for the rapid response project 11-IOM-014 to carry out emergency repair of flood-affected schools. From 2011, two out of eight IOM projects, totaling 34 per cent of funding provided by the CERF to IOM, have required extensions. Both projects required additional time to allow for proper consultation with local stakeholders, including authorities and beneficiaries. These delays have put into question IOM's implementation and risk management capacity in Zimbabwe.

IOM – MULTI-SECTOR

CERF PROJECT NUMBER	11-IOM-033	Total Project Budget	$ 3,000,000
PROJECT TITLE	Life-Saving Humanitarian Response to refugees and asylum seekers	Total Funding Received for Project 3	$ 850,000
STATUS OF CERF GRANT	Ongoing[29]	Amount disbursed from CERF	$ 500,000

Beneficiaries	Targeted	Reached
Individuals	13,500	5,476
Female	200	227
Male	13,300	5,176
Total individuals (Female and male)	13,500	5,476
Of total, children under 5	200	68
TOTAL	13,500	5,476

Gender Equity

Third Country Nationals from Somalia, Ethiopia, DRC, Burundi and Gabon benefited from the project and 473 were male, whilst 26 were female. Women and children were provided with separate shelter from adult males within the centre and provided with need-specific protection including the prevention of SGBV

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL

To provide immediate humanitarian and protection assistance to refugees and asylum seekers at Nyamapanda Border post.

To provide appropriate support for addressing the legal, physical and material protection and humanitarian assistance to asylum-seekers/refugees transferred from Nyamapanda to TRC.

ACTUAL OUTCOMES

- 5,476 migrants and asylum seekers received food, health, protection counselling, safe migration information and temporary shelter (with water and sanitation facilities) for resting.
- Safe migration information on rights and obligations were translated into different languages (Amharic, Somali, Swahili and Arabic) and distributed to beneficiaries.
- NFIs were given to all asylum seekers and refugees (soap, blankets, towels, toothpaste, toothbrush, sanitary pads, underwear as part of the sanitary kit for women).
- Counselling and NFI assistance for beneficiaries abused along the journey with special attention given to women, children and unaccompanied minors.
- Asylum seekers and refugees were provided with immediate medical assistance, mainly against malaria, acute respiratory infection, diarrhea, injuries and skin disease.
- 227 male and 5,176 female asylum seekers and refugees were provided with voluntary transportation to TRC.
- A transit centre for asylum seekers and refugees is functional and providing assistance to asylum seekers and refugees.
- 5,476 asylum seekers and refugees (227 female and 5,176 male) were provided with humanitarian assistance within 24 hours of arrival.

MONITORING AND EVALUATION MECHANISMS

Registration all migrants and asylum seekers received assistant at the reception.

Weekly field visit to monitor the operation at centre.

Weekly reporting of the number of migrants and asylum seekers transported to Tongogara refugee camp.

Monthly report achievements and challenges.

[29] While the project is still ongoing until June 2012, the beneficiary figures reached so far is dramatically low (less than 4 per cent of budgeted figures). It remains unclear whether the funds, if unspent, will be reimbursed.

UNHCR – MULTI-SECTOR

CERF PROJECT NUMBER	11-HCR-042	Total Project Budget	$ 5,060,273
PROJECT TITLE	Protection and Assistance for Refugees, Asylum Seekers and Refugee Returnees	Total Funding Received for Project 3	$ 3,149,058
STATUS OF CERF GRANT	Completed (30 June 2012)	Amount disbursed from CERF	$ 747,551

Beneficiaries	Targeted	Reached
Individuals	5,400	5,400
Female	1,242	1,242
Male	4,158	4,158
Total individuals (Female and male)	5,400	5,400
Of total, children under 5	781	781
TOTAL	5,400	5,400

Gender Equity

All refugees, asylum seekers from DRC, Rwanda, Burundi, Ethiopia and Somalia and all new arrivals from the Horn of Africa passing through Tongogara refugee camp were assisted, taking into account the gender balance, with priority given to women and children.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
To provide immediate humanitarian and protection assistance to refugees and asylum seekers arriving primarily through Nyamapanda and other crossing points, as well as those in detention centres in Zimbabwe, through monitoring the borders and assessing the life-saving protection needs and the humanitarian situation.	To provide immediate humanitarian and protection assistance to refugees and asylum seekers: ▪ All asylum seekers/refugees who arrived to Tongogara Refugee Camp from Nyamapanda border post, Mutare and Kariba/Karoi were initially registered by the camp authorities, and were provided by UNHCR and partner agencies, with standard food ration, medical assistance through the camp clinics, were accommodated in transit/temporary shelter. Asylum seekers and refugees in camp received standard food, non-food items, health, WASH and initial/temporary shelter assistance prior to inclusion into the general camp programmes. Shelter construction materials (500 doors, other miscellaneous requirements enough for 500 houses) were procured to alleviate accommodation problems caused by the influx of asylum seekers. ▪ Newly arriving asylum seekers/refugees were initially registered by camp authorities upon their arrival to the camp, which is a prerequisite to receive humanitarian assistance. UNHCR facilitated timely and required flow of information to the central and camp authorities. However, of over 5800 new arrivals received in Tongogara refugee camp in 2011, an overwhelming majority abandoned the camp spontaneously. ▪ UNHCR, the camp authorities and partner agencies provided refugees, asylum seekers and new arrivals with food, health, information on assistance and services available in the camp. ▪ Appropriate and the safe transportation of new asylum seekers and refugees from border areas as well as detention centres to the Tongogara refugee camp, were arranged in close coordination among UNHCR, IOM, partner agencies and the relevant authorities during the reporting period.	UNHCR conducted monitoring visits to various border areas including Chirundu, Nyamapanda, Beitbridge and Mutare. UNHCR staff in the camp constantly monitored and offered support and guidance to implementing partners within the camp in delivering assistance and services. Implementing partners regularly held meetings to evaluate assistance service delivery to refugees and asylum seekers, and to identify and address key challenges.
To provide appropriate support for addressing the legal, physical and material protection and humanitarian assistance to asylum-seekers/refugees transferred from Nyamapanda, detention centres and Waterfalls Medical Facility to TRC.	Legal, physical protection and humanitarian assistance provided ▪ UNHCR conducted border monitoring and immigration liaison missions to Nyamapanda, Mutare, Harare and Beitbridge, liaised with immigration and other authorities in identifying and releasing asylum seekers and refugees to Tongogara refugee camp. Regular coordination and consultations were held with IOM. Thus, effective coordination among relevant stakeholders (national and local authorities, partner agencies) in ensuring access to territory and providing humanitarian/protection response to asylum seekers and refugees was enhanced. ▪ Through continuous engagement and a formal training organized by UNHCR on RSD in 2011, relevant government authorities (immigration, police, social services, state security, members of the Zimbabwe Refugee Committee) were further sensitized on international and national principles and legal provision relating to the treatment of asylum seekers and refugees in Zimbabwe. While the 'understanding' of these authorities has increased, there is a need for continuous constructive engagement with government counterparts to further-solidify the international protection of asylum seekers and refugees in Zimbabwe.	Periodic and ad-hoc monitoring reports were submitted by UNHCR field teams and partner agencies on progress, challenges and achievements, and recommended actions.

	▪ Newly arriving asylum seekers and refugees were allowed by authorities to enter the territory of Zimbabwe in 2011. There is no known report of refoulement (i.e. forced return or deportation of asylum seeker or refugees to a country where their life, safety or liberty could be at risk). ▪ Asylum seekers were initially registered by camp authorities upon their arrival to the camp, which is a prerequisite to (receive assistance and) undergo the Refugee Status Determination Process managed by the Zimbabwe Refugee Committee of the Government of Zimbabwe. UNHCR facilitated timely and required flow of information to the central and camp authorities. ▪ UNHCR, the camp authorities and partner agencies provided refugees, asylum seekers and new arrivals with protection counselling (on their access to assistance, services and activities, refugee status determination process, rights and obligations), temporary shelter, and information on available social services available in the camp. Where required and feasible, age/gender sensitive arrangements were made for accommodation of the relatively smaller number of vulnerable women and children among the new arrivals. Foster care arrangements were made for vulnerable unaccompanied children upon their arrival at Tongogara refugee camp. ▪ The capacity at the camp for provision of facilities with appropriate conditions of reception and inclusion in regular camp assistance including for new arrivals from Nyamapanda, Mutare and Kariba/Karoi, was enhanced through the construction of a reception centre to better accommodate new arrivals.	

UNICEF – WATER AND SANITATION

CERF PROJECT NUMBER	11-CEF-047	Total Project Budget	$22,152,801
PROJECT TITLE	Emergency WASH assistance to vulnerable communities and populations in institutions in cholera affected areas	Total Funding Received for Project	$ 1,399,999
STATUS OF CERF GRANT	Ongoing	Amount disbursed from CERF	$ 1,399,999

Beneficiaries	Targeted	Reached
Individuals	184,982	1,890
Female	86,693	1,269
Male	74,651	621
Total individuals (Female and male)	161,290	1,890
Of total, children under 5	23,692	223
TOTAL	184,982[30]	2,113

Gender Equity

The project benefited approximately 2,113 people, 60 per cent of whom were female and 11 per cent were children under 5 years.

OBJECTIVES AS STATED IN FINAL CERF PROPOSAL	ACTUAL OUTCOMES	MONITORING AND EVALUATION MECHANISMS
Risk of WASH-related disease morbidity and mortality among vulnerable boys and girls, men and women in institutions as well as communities in cholera-affected areas reduced.	Supply of safe & adequate water to schools & clinics Preparatory works in the form of assessments, identification of water points needing rehabilitation and, coming up with (BOQ) and procurement of spares and construction material for rehabilitation works have been completed. ▪ 20 water point committees have been trained in operation and maintenance of water point. Provide safe excreta disposal facilities Preparatory works in the form of assessments, identification of beneficiary households and institutions for latrine construction and, coming up with (BOQ) and procurement of construction material have been completed. ▪ 20 latrine builders have been trained. ▪ Five household latrines since have been completed with the rest in various stages of construction. Promote appropriate hygiene practices to communities and institutions affected by WASH-related disease outbreaks, droughts, floods and displacements ▪ 18 school health masters and 10 village health workers were equipped with skills on hygiene promotion and participatory health and hygiene education techniques.	UNICEF has enshrined the project monitoring mechanism, which included as part of the PCA. This included the frequency of field visits, quality assurance visits (end of project field monitoring and financial spot checks.

[30] UNICEF - At the time of reporting, two thirds of the implementation period had already elapsed yet the number of beneficiaries reached was very low.

ANNEX 2. CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS – NATIONAL AND INTERNATIONAL NGOS AND GOVERNMENT PARTNERS – **UNDERFUNDED EMERGENCIES ROUND 1 and 2**

CERF PROJECT CODE	CLUSTER/ SECTOR	AGENCY	IMPLEMENTING PARTNER NAME	PARTNER TYPE	TOTAL CERF FUNDS TRANSFERRED TO PARTNER US$	DATE FIRST INSTALLMENT TRANSFERRED	START DATE OF CERF FUNDED ACTIVITIES BY PARTNER	Comments/ Remarks
11-IOM-014	Education	International Organization for Migration (IOM)	Plan International	INGO	53 537.70	15/06/2011	1/06/2010	The submission of proposal, budget and work plan from the partner as well as IOM internal procedure to approve MoU took long and delayed the transfer of first instalment.
11-IOM-014	Education		Save the children and	INGO	105 356.10	15/06/2011	1/06/2010	
11-IOM-014	Education		World Vision	INGO	53 096.00	20/06/2011	1/06/2010	
11-FAO-035	AGRICULTURE	FAO	World Vision Zimbabwe	INGO	62,696	06/02/2012	09/01/2012	
11-IOM-035	LICI	IOM	CARITAS	NNGO	121 195.93	15/11/2011	01/11/2011	The submission of proposal, budget and work plan from the partner as well as IOM internal procedure to approve MoU took longer than expected and delayed the transfer of first instalment, however, the partner prefinaced some activities from 1st of May.
11-IOM-035	LICI	IOM	SCC	INGO	121 192.44	10/11/2011	01/11/2011	Same as above.
11-WFP-053	Food	WFP	WVI	INGO	902,014,31	4/05/2011	01/01/2011*	
11-WFP-053	Food	WFP	HELP Germany	INGO	168,062,01	10/4/2011	01/01/2011*	
11-WFP-053	Food	WFP	GOAL	INGO	665,633,13	3/3/2011	01/01/2011*	
11-WFP-053	Food	WFP	Plan International	INGO	750,887,90	3/3/2011	01/01/2011*	
11-WFP-053	Food	WFP	Africare	INGO	502,402,28	4/05/2011	01/01/2011*	
11-WFP-053	Food	WFP	ORAP	NGO	676,618.35	3/3/2011	01/01/2011*	
11-IOM-005	Nutrition	IOM	Plan International	NGO	269,506.00	27/04/2011	01/05/2011	
11-IOM-036	Nutrition	IOM	World Vision Save the Children	NGO's	443,106.17	14/11/2011 04/11/2011	01/11/2011 01/11/2011	
11-CEF-008-A	Nutrition	UNICEF	GOAL	INGO	343,461.00	09/06/2011	05/05/2011	
11-CEF-008-A	Nutrition	UNICEF	World Vision	INGO	231,821.00	18/05/11	18/05/2011	
11-FPA-010	Health	UNFPA	GOAL	INGO	72,804	8/6/2011	8/6/2011	
11-FPA-010	Health	UNFPA	IMC	INGO	143,808	8/6/2011	8/6/2011	
11-FPA-010	Health	UNFPA	Plan	INGO	189.859.16	17/6/2011	17/6/2011	Due to low performance (consistent low expenditure rates

								in the first six months of the project as well as structural non-compliance with reporting requirements and late submission of documents) the last quarter disbursement for Plan was cancelled and reallocated to procurement of EmONC supplies and equipment (UNFPA) as well as to additional refurbishment activities in Hurungwe district (GOAL, because of relevant identified additional needs at Hurungwe district hospital and the high expenditure rate and quality of work of the organization).
11-IOM-034	Protection	IOM	World Vision Zimbabwe	NGO	325,294.84	30/11/2011	1/10/ 2011	The partner started activities through pre-financing as the agreements were still being worked out.
11-CEF-008-B	WASH	UNICEF	Christian Care	NGO	437,150.10	09/05/2011	01/05/2011	
11-CEF-008-B	WASH	UNICEF	Mercy Corps	INGO	296,053.96	09/05/2011	01/05/2011	
11-CEF-008-B	WASH	UNICEF	Mvuramanzi Trust	NGO	193,132.00	17/05/2011	01/05/2011	
11-CEF-008-B	WASH	UNICEF	Oxfam GB	INGO	240,102.00	10/05/2011	01/05/2011	
11-CEF-047	WASH	UNICEF	Care International In Zimbabwe	INGO	81,732.46	16/11/2011	01/05/2011	
11-CEF-047	WASH	UNICEF	World Vision	INGO	150,420.33	14/11/2011	01/05/2011	
11-CEF-047	WASH	UNICEF	Africare Zimbabwe	INGO	116,132.02	14/11/2011	01/05/2011	
11-CEF-047	WASH	UNICEF	Christian Care	NGO	151,659.35	20/10/2011	01/05/2011	

Funds from bilateral and multilateral donors complementing CERF projects

Project Code	Donors	Amount in US$
UNICEF (11-CEF-028)	DFID, Ausaid, Government of Korea and ECHO	3,000,000

Annex 3: ACRONYMS AND ABBREVIATIONS (Alphabetical)

ACF	Action Contre la Faim
BEmONC	Basic Emergency Obstetric and Neonatal Care
BOQ	Bill of Quantities
CAP	Consolidated Appeal Process
CBP	Community Based Planning
CDC	Centre for Disease Control
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CERF	Central Emergency Response Fund
CMAM	Community Management of Acute Malnutrition
CPC	Child Protection Committee
CTC	Cholera Treatment Centre
DDF	District Development Fund
DRR	Disaster Risk Reduction
DWSSC	District Water and Sanitation Sub-Committee
ECD	Early Childhood Development
ECHO	European Commission for Humanitarian Affairs
EERPJN	Emergency Education Response and Preparedness Joint Network
EHT	Environmental Health Technician
EmONC	Emergency Obstetric and Neonatal Care
ETF	Education Transition Fund
FAO	Food and Agriculture Organisation of the United Nations
GAM	Global Acute Malnutrition
GBV	Gender-Based Violence
GoZ	Government of Zimbabwe
HCT	Humanitarian Country Team
HTH	Calcium Hypochlorite (HTH)
IMC	International Medical Corps
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
IP	Implementing Partner
IPs	Implementing Partners
MAM	Moderate Acute Malnutrition
MoESAC	Ministry of Education Sport, Arts and Culture
MoHCW	Ministry of Health and Child Welfare
MoLSS	Ministry of Labour and Social Services
MoRIIC	Ministry of Regional Integration and International Cooperation
MWH	Maternity Waiting Home
NAC	National Action Committee
NFI	Non-Food Items
NGO	Non-Governmental Organisation
NHIS	National Health Information Systems

NTRC	Nyamapanda Transit Centre
OCHA	Office for the Coordination of Humanitarian Affairs
PMTCT	Prevention of Mother to Child Transmission of HIV
PMV	Politically Motivated Violence
RDC	Rural District Council.
RH	Reproductive Health
SAG	Strategic Advisory Group
SAM	Severe Acute Malnutrition
SCC	Swedish Cooperative Centre
SDC	School Development Committee
TBD	To be determined
TCN	Third Country Nationals
TRC	Tongogara Refugee Camp
UN	United Nations
UN	United Nations
UNICEF	United Nations Children's Fund
VMHSS	Vital Medicines and Health Services Survey
WASH	Water, Sanitation and Hygiene
WERU	WASH Emergency Response Unit
WHO	World Health Organisation
WVZ	World Vision Zimbabwe
ZimVac	Zimbabwe Vulnerability Assessment Committee
ZINWA	Zimbabwe National Water Authority
ZRP	Zimbabwe Republic Police