ANNUAL REPORT OF
THE HUMANITARIAN/RESIDENT COORDINATOR
ON THE USE OF CERF GRANTS

Country	**Zimbabwe**
Humanitarian / Resident Coordinator	**Dr Zacarias Agostinho**
Reporting Period	**January to December 2008**

I. Executive Summary

In 2008, Zimbabwe continued to face major economic and humanitarian challenges, as a result of both adverse weather conditions and a protracted political stalemate compounding the effects of a high prevalence of HIV/AIDS. Towards the middle of the year, food, safe water, health and protection needs increased. By the close of 2008, some 7 million people were dependent on food aid, cholera had spread throughout the country, and of inadequate agriculture inputs had raised fears that the success of the farming season was in jeopardy.

In order to meet growing needs, the Humanitarian Country Team (HCT) approached CERF for $7 million in rapid response funding for food, medicines, water treatment chemicals, agricultural inputs and education support. The funds were also used to meet the humanitarian needs of people who had been displaced for various reasons over the last few years. A total of $ 2 million was allocated to support food and nutrition activities for Zimbabweans as well as refugees in the country at the Togongara Camp and nutrition support for children under five years. An additional $ 5 million assisted WFP to avert a pipeline break at a time when an estimated 3.8m people relying on food aid.

In addition, some $ 4.5 million had been allocated to the country through the underfunded window to support efforts in the following sectors: water, sanitation and health (WASH), Health, Protection (Multi-sector) and Telecommunications. CERF funded WASH and Health interventions were critical in saving lives especially during the cholera outbreak that spread to all 10 provinces by December 2008. It was helpful that funding for WASH and health activities was released under the Underfunded Emergency window earlier in the year, as it allowed the implementing partners to target responses where cholera cases had been reported or were expected. The funds were used to provide basic essential services that the Government or local authorities were unable to provide. The outbreak turned out to be the severest in the country's history and the funds, as they were already available, served to mitigate the effects.

As Mobile and Vulnerable Populations (MVPs) are generally found in areas that are socially marginalized and underserved in terms of basic social services, including reproductive health services, the CERF funds were utilised to provide teaching materials, sexual and reproductive health services and agricultural inputs in late 2008. The funds assisted the MVPs to restart livelihoods and provided basic services for this vulnerable category of the population.

The difficult operating environment is illustrated through UNICEF's inability to spend some of the funds for both health and WASH because of extreme inflationary rates and Government insistence on use of local currency, which was devaluating on nearly hourly basis. Internally, a transfer request by the Country Office to its headquarters was not affected.

Funds passing through the rapid response window were released very quickly, enabling most of the agencies to undertake and complete life-saving projects such as procurement of food in a timely manner. As illustrated in the report, CERF funds were instrumental in reinforcing coordination between UN agencies, Government (especially in health interventions) as well as with NGO implementing partners. The prioritization process brought together members of the IASC to agree by consensus, priority areas fro funding and action.

Total amount of humanitarian funding required and received during the reporting year	**REQUIRED:** **RECEIVED:**			**$ 583,447,992** **$ 399,367,525**
Total amount requested from CERF	**FUNDS (IN TOTAL REQUESTED):**			$ 16,482,132
Total amount of CERF funding received by funding window	**RAPID RESPONSE:** **UNDERFUNDED:** **GRAND TOTAL:**			$ 6,988,475 $ 4,493657 $ 11,482,132
Total amount of CERF funding for direct UN agency / IOM implementation and total amount forwarded to implementing partners	**UN AGENCIES/IOM:** **NGOS:** **GOVERNMENT:** **OTHER:** **TOTAL(Must equal the total CERF funding allocated)**[i]			$10,481,657.5 $ 982,810.14 $ 17,664.36 $0 **$ 11,482,132**
***Approximate* total number of beneficiaries reached with CERF funding (disaggregated by sex/age if possible)**	**TOTAL**	**under 5 years of age**	**Female (If available)**	**Male (If available)**
	5,215,331	560,195	556475	574,995
Geographic areas of implementation targeted with CERF funding (please be specific)	Throughout the country.			

II. Background

Since 2001 the country has been plagued by an ailing economy leading to chronic shortages of basic agricultural inputs such as seeds, fertilizer, fuel and diminished extension services as well as unreliable rainfall which translated into dismal food production. In 2008, Zimbabwe's food security was threatened by very low cereal and small grains production; by December 2008, the number of people requiring food assistance was 3.8 million people.

Politically motivated violence led to internal displacements, destruction of property and loss of lives. particularly from May to June 2008 when the Government imposed a ban on NGO operations throughout the country. An exemption for life-saving activities, the provision of ART/medical supplies through hospitals and institutional/school feeding programmes provided a window for humanitarians to implement projects but this was at times seriously compromised by random restrictions imposed by local authorities and law enforcement structures. On 29 August 2008, the Government lifted the suspension allowing all NGOs and Private Voluntary Organisations (PVOs) to resume operations. However, many humanitarian aid partners found it difficult to deliver adequate assistance due to the soaring global food prices in a country with one of the highest inflation rates levels in the world. In August 2008, the official inflation rate was estimated at 231 million percent, the highest ever recorded in history.

The importance of safe water and sanitation for both rural and urban populations was underscored by the frequency of cholera outbreaks in the country. Between January and mid - February 2008, the country had reported 124 cases of cholera and 13 deaths (CFR-10.5percent) mostly affecting high density peri-urban areas where the most vulnerable people live. Bulawayo City, the second-largest in Zimbabwe was under constant water cuts and

rationing, due to inadequate water treatment chemicals. Cholera cases were reported again August 2008 to March 2009. as a result of breakdown of social services including closure of main referral hospitals due to Government inability to pay salaries or provide essential medicines. Lack of foreign currency to procure water treatment chemicals that were being purchased from abroad contributed to the spread of cholera. In addition to this, the education sector was collapsing due to high teacher attrition since the Government could no longer raise money for their pay. As a result of all these factors, Zimbabwe suffered its worst cholera outbreak ever in 2008.

Sectors prioritization

The Humanitarian Coordinator convened the Inter Agency Standing Committee (IASC) which comprises NGOs, UN agencies and the Red Cross Movement, to identify priority areas whenever a request was to be made to the CERF. During one allocation process, , members of the IASC were asked to identify critical areas which were adversely affected by the food and oil price increase, and to prioritize them in relation to the size of the affected population as well as funding gaps in the 2008 CAP for Zimbabwe. The IASC identified the following priorities: food aid, agriculture and nutrition. Food aid had a funding shortfall of $ 118,653,423. Agriculture was also identified as a key area as crop Production during the 2007/08 agricultural season was poor; the harvest is expected to cover less than half of the country's annual cereal requirements by that time, the CAP had attracted only 5 percent funding. Finally, nutrition support, which had a shortfall of 93 percent, was also prioritized. The IASC asked the three prioritized sectors to consult with their respective partners and develop proposals to be submitted through the Humanitarian Coordinator to the CERF Secretariat. Throughout the process, the NGOs were consulted, both as members of the IASC and at the cluster level.

For the underfunded window grants, the process followed was quite similar to the one described above. The following sectors were identified and funds distributed as follows: a) Emergency Telecommunications: $770,000; b) Health: $1,600,000: c) WASH: $1,000,000: d) Multi-sector/MVP: $1,000,000; f) Education: $630,000. Relevant sector working groups were notified of the outcome and met to discuss and agree on priority projects and amounts per project, based on CAP projects that met the criteria. After submission, the IASC evaluated each project to ensure that it was life-saving and if it met the other CERF criteria. Recommendations for improvement or justification were provided for each project. All projects were approved subject to a few corrections.

Regarding the $ 5 million allocation for WFP, the organisation approached the HC who informed the IASC of the intended application. The IASC approved the request and it was forwarded to the CERF secretariat with an initial request of $ 10 million. The CERF could only provide $ 5 million which the agency accepted.

III. Implementation and results

Rapid Response Window

1. Coordination and implementation arrangements

In 2008, WFP held monthly Food Aid Coordination Meetings together with donors, implementing partners, and other stakeholders to coordinate food assistance and agree on monthly operational strategies for food intervention. Throughout the period that the project was implemented, WFP worked together with partners to implement the Community Based Targeting Methodology. The methodology was used in the selection of beneficiaries for the vulnerable group feeding (VGF) and the Mobile and Vulnerable Populations (MVP) Intervention. The Community and Household Surveillance (CHS) in November 2008 show that when comparing by beneficiary status, four out of five sub-offices had a higher percentage of

beneficiaries that were highly vulnerable when compared to non-beneficiaries. During the course of the VGF, WFP worked closely with partners to ensure targeting efficiency in order to reduce exclusion and inclusion errors. Furthermore, WFP also set up reporting mechanisms for Incident Management Reporting for CPs to inform WFP management of any incidents occurring and for WFP to follow up on any pending issues.

For the home based care (HBC) and anti retro-viral treatment (ART) activities under the Safety Net Programmes (SN), WFP and cooperating partners implemented a new selection/targeting criterion for the Health Based-Safety Net (HB-SN) activities to link with the medical objective. The entry/exit criterion was introduced to improve targeting and therefore secure adequate assistance to the beneficiaries to enable them to improve their health status. The new HB-SN registries allow only eligible clients to receive food rations as per the PRRO's implementation guidelines. This is a change from the old PRRO 10310.0, to improve assistance to beneficiaries and accountability.

Agriculture received $ 580,642 through IOM for interventions to benefit Mobile and Vulnerable People (MVPs). The beneficiaries were identified through Stakeholder Orientation meetings. Such meetings brought together potential beneficiaries, local government structures, the related line ministries and local authorities. The meetings assisted in reducing inclusion error, ensuring community-accepted targeting for the interventions and ultimately increased access to the MVP households in all the areas. Targeting was by the community and per intervention, using an agreed upon selection criterion. The NGO implementing partners, UN, particularly FAO Agricultural Coordination Working Group, improved the quality of IOM's programming as they made networking easier, provided access to lessons learnt by other organisations in their Agricultural Inputs Support project. FAO coordinates monthly meetings where project lessons learnt presentations are done.

Under Nutrition, UNICEF undertook two projects during the reporting period. In early 2008, CERF funded a nutrition project that supported one emergency Nutrition specialist to boost the offices capacity in coordination with NGOs and also pre-positioning of supplies for therapeutic feeding. Food items were purchased and transported by through the UNHCR Regional procurement office in South Africa. Chronic shortages of food in the country necessitated procurement from outside the country. Christian Care, the implementing partner for food in the project was responsible for the warehouse management and the distribution of the food to the beneficiaries.

2. Project activities and results, including actual beneficiaries

With the lifting of the NGO field operation suspension in late August 2008, WFP immediately started registrations under the seasonal Vulnerable Group Feeding (VGF) programme in September, 2008. Food distributions under the programme started by October and targeted vulnerable, food insecure households in rural areas. The programme aimed to provide a monthly food ration in the most vulnerable areas during the peak hunger months from October, 2008 to March, 2009. By December 2008, WFP assisted an estimated 3.7 million people in need of food assistance through its VGF programme bringing the total number of people assisted to 4 million, including the safety net (SN). Given the worsening food security situation in the country, the programme improved food consumption of vulnerable households and minimized asset depletion and the use of negative coping mechanisms. Through the community household surveillance (CHS) conducted in November 2008, it was found that food assistance improved household food accessibility patterns among the beneficiary households compared to non-beneficiaries. Beneficiary households fared better in terms of the level of coping, consumption patterns and disposal of assets than non-beneficiary households. Fewer beneficiaries were employing coping strategies (44 percent) than non-beneficiaries (62 percent) in November 2008. Disposal of assets was lower among beneficiaries and (16 percent) of beneficiaries had poor consumption compared to (41 percent) of non-beneficiaries.

To support the "MVP communities with agricultural inputs and technical training for increased yields", project, IOM partnered with six implementing partners benefited more than 33,900 households in 22 districts and 40 wards of the country. The 33,900 beneficiaries of the programme received seeds for maize, sugar beans, soybean, sweet potatoes and cotton; basal and top dressing fertilizers. Households in high rainfall areas received 5kg of seed maize, 25kg basal fertilizer and 25kg of top dressing fertilizer. In medium potential areas they received 5kg seed maize and 25kg top dressing fertilizer.

The beneficiaries participated in farmer field schools and field demonstrations, and field days were used as training and motivational tools for the beneficiaries. These were prominent tools in the agriculture inputs support project, mushroom and household nutrition gardens.

Private Sector Initiatives

In pursuit of establishing private sector partnerships, IOM and its partners, in consultation with private sector companies has embarked on a pilot market linkages project with Cargill (an established cotton buying company for 50 households interested in pursuing cotton farming as emergency livelihoods.

Under the Nutrition project, over 9,000 children with severe acute malnutrition were managed for acute malnutrition in 2008 with low mortality rates of below 10 percent being achieved for admissions to CMAM.

Seven food items (maize meal, vegetable oil, beans, corn soya blend, rice, salt, and sugar) were purchased by UNHCR from South Africa to feed 2,931 refugees (1,223 women and 1,427 children under 17 years) for two months. The food provided 2,186 kcal/p/day and no malnutrition was reported among our beneficiaries.

UNHCR procured 178MT of food through its regional procurement office in Pretoria. Seven food items (maize meal, vegetable oil, beans, corn soya blend, rice, salt, and sugar) were purchased, transported and distributed to 3,279 refugees in the Tongogara Refugees camp including few medical and protection cases in urban areas. The food reached 3,279 refugees (1,261 women and 1,451 children under 17 years, and 52 chronically sick people) for one month. The food provided 2,186 kcal/p/day.

3. Partnerships

FOOD SECURITY

In 2008, WFP worked with 17 cooperating partners, thirteen international and four local. In partnership with WFP, cooperating partners register the beneficiaries, perform verifications to ensure there were no errors in registrations, distribute the food, and then monitor, and evaluate the operations.

WFP undertook joint monitoring activities with cooperating partners. This season, less registration monitoring was conducted due to the fact that the registration was increasing in most districts. The registration figures were much higher than initially anticipated according to the CFSAM report, therefore more emphasis was placed on verifications and distribution monitoring exercises.

IOM partnered with five organizations in the implementation of the programme. This very important strategic partnership enabled IOM to reach out to 33,904 households effectively. Distribution of inputs was done with no incidents and the training was swift and this is attributable to the partnerships that exist.

For the Agriculture project, IOM and its implementing partners collaborated with Agritex in the field for the purposes of training the beneficiaries and monitoring of the crop in the field. The collaboration increased acceptability of the project by the community leadership as well as the government structures at the District and Provincial levels.

IOM also collaborated with FAO where they coordinated the information on the project for presentation to donors and the Agricultural Working Group forums. FAO spearheaded the development of the data collection instruments for monitoring the programme since December, making it possible to report on the extent of usage of inputs and shall also make it easy to report on the post harvest.

IOM and its implementing partners entered into strategic key partnerships with the Zimbabwe National Soya bean Commodity Association, Agribiotec and Cargill for purposes of enhancing the capacities of the targeted beneficiaries in the production of soya bean, sweet potatoes and cotton respectively. The proceeds were to be used to enhance the nutritional status and incomes in the household.

Christian Care was the implementing partner in the warehouse management and food distribution. The project benefited from the organization's expertise in the food distribution.

4. Gender-mainstreaming

FOOD SECURITY

In food security programmes, most Final Distribution Point (FDP) committees were managed and controlled by women. All Cooperating Partner agreements made an explicit commitment to collect gender disaggregated data. In addition, with the assistance of grant funds, trainings were offered to partner staff and communities on aspects of gender, male involvement and HIV and AIDS.

Enhanced Commitments to Women (ECW) Indicators

ECW	Planned percentage	Actual percentage
Proportion of women in leadership positions in food management committees	75	61
Proportion of women receiving household food rations at distribution point in GFD	75	54
Proportion of household food entitlements (on ration cards or distribution list) issued in women's name in GFD	75	53

For the IOM agriculture project, Sexual and Gender-Based Violence (GBV), HIV and AIDS, cholera issues were mainstreamed in all activities. IEC materials were distributed, and some demonstrations on the health and hygiene issues were done.

UNHCR policy is equal representation/participation of men and women in food distribution of food and other service. 50 percent female participation was ensured and achieved in the distribution of food.

5. Monitoring and evaluation

FOOD SECURITY

WFP uses a variety of tools to monitor food assistance in Zimbabwe, to include:

- **Registration Monitoring** is undertaken to assess the fairness and transparency of registration processes and make necessary adjustments.

- **Verification Monitoring** assists in checking household eligibility and ascertains registration efficiency;
- **Food Distribution Monitoring** is undertaken by observation and assesses whether a distribution process has been executed according to WFP's standard operating procedures;
- **Exit Surveys** are used to randomly interview food recipients on exit from a distribution and capture beneficiaries' perception of the distribution process and satisfaction with their ration.
- **Post Distribution Monitoring** is conducted two weeks after a CP has completed its distribution, it explores Food Aid Outcomes.

Over the last 12 months, WFP has refined the process of registration monitoring and trained many partners also to implement the same. The ability to use the knowledge gained within the community to improve the registration process has led to positive results. Given extremely high caseloads and the disruption due to the elections and the suspension of NGO field activities, WFP had to significantly rely on the verification process in order to arrive at a more correct number of beneficiaries. This exercise helped WFP and its partners to refine the targeting to benefit the most vulnerable.

WFP monitored the impact of the food programme closely and also tracks the vulnerability of the population. WFP ran the 13th round of community and household surveillance to understand the impact of food aid and possible future needs among the food insecure. This data will be combined with ZimVAC and other assessments that are monitoring crop harvests, livelihoods, etc. to form a full picture of needs for Apr 09 – Mar 10 consumption year.

IOM and its implementing partners monitored the rapid response agriculture project using the overall MVP Programme Framework which includes monitoring tools, assessment forms and links to the programmatic database. In addition, through the Agricultural Working Group, monitoring information was shared to ensure that partners are taking cognisance of other's success and challenges.

Before providing assistance, IOM conducted assessments to ensure that the caseload is mobile and vulnerable and can be assisted by IOM. The results of the assessments were similar in most of the sites visited. The main problems identified by the community were: lack of household utensils, clothing, blankets, shelter, vulnerability to HIV and AIDS, shelter, health assistance and deficient or absence of water and sanitation facilities

UNHCR maintained presence of two field officers in the camp to monitor and ensure delivery of assistance to the targeted beneficiaries. 100percent access to assistance by beneficiaries was reported. Community participation in the food distribution also ensured beneficiary access to assistance. The food distributed met the daily dietary requirements and there were no reported cases of malnutrition among the beneficiaries.

Underfunded Emergency

1. Coordination and implementation arrangements

UNICEF implemented WASH projects in partnership with: World Vision Zimbabwe; Practical Action; Oxfam GB; Africare; Christian Care; Mercy Corps; and IOM. The NGOs, in collaboration with the respective local authorities, were responsible for the day-to-day implementation and management of the project and direct service provision at community level, including community capacity development, while UNICEF provided technical and logistical support. In addition, there was collaboration and networking with a number of NGOs (MSF, ACF, and Churches of Bulawayo). The arrangements proved to be very effective as they enabled coordinated response, complementarity and minimisation of duplication.

Under health, the country received five grants for supporting health interventions that were executed by the United Nations Children's Fund (UNICEF), the World Health Organization

(WHO), the United Nations Population Fund (UNFPA) and IOM, four of which were under the Underfunded Emergency Window and one under Rapid Response Window (nutrition). UNICEF also took the opportunity to report on two projects funded in 2007 but completed in 2007 and 2008.

UNICEF conducted the procurement and provided logistical support for the distribution of IV fluids to all 62 districts in Zimbabwe through the coordination of the National Pharmaceutical Company, which is responsible for distribution of medicines in Zimbabwe. The coordination was also through the Ministry of Health and Child Welfare which helped to identify priority districts within the provinces. Although the cholera outbreak that was later to devastate most parts of the country had not been foreseen, the preparatory work undertaken by WHO and its partners was later instrumental in providing assistance to people affected by the outbreak. Other partners included NGOs and some UN Agencies like UNICEF, UNFPA, IOM and UNHCR. NGOs like MSF, GOAL Zimbabwe, World Vision International, Save the Children UK, Merlin, The Zimbabwe Red Cross, ICRC and IFRC were involved in implementing various aspects in cholera response according to their respective mandates. A matrix of who does What Where and When (WWWW) was developed so that areas of operation of all the health partners are known in order to avoid duplication in response to the cholera outbreaks.

UNICEF, WHO and MOHCW agreed to revitalise the immunization programme through the provision of:

1) Cold chain equipment to health facilities that did not have them;
2) Back-up mechanisms for cold chain maintenance due to the continued electricity power cuts, and;
3) Fuel for outreach services.

A project supporting the Food and Nutrition Council (FNC) in conducting a Combined Micronutrient and Nutrition Surveillance Survey (CMNSS) that was approved for implementation in 2007 was pushed forward to 2008 with the consent of the CERF Secretariat due to late release of the funds. The surveillance system is supported by the Ministry of Health and Child Welfare (MoHCW) for data collection and the Central Statistics Office (CSO) for data analysis. UNICEF and WFP provided technical support. The FNC is responsible for coordination. Results, especially levels of acute malnutrition, were published and disseminated in a timely manner and were used to inform the humanitarian response.

At the height of the political violence, IOM and its partners made use of the MVP working group to discuss the arising Victims of Political Violence (VPV) needs. Through a participatory framework, IOM continuously assessed the humanitarian needs and responded in the quickest way possible, ensuring the protection of the most vulnerable groups. IOM was also designated as the District Focal Agency for Health (DFAH); namely Beitbridge, Chiredzi, Hwange, Kariba, Makoni, Mutare, Zvimba and border areas were closely coordinated with the Ministry of Health and Child Welfare (MoHCW), HCT and the Zimbabwe Health and WASH Clusters under the technical support from the Cholera Command and Control Centre (C4).

HEALTH

In a health intervention spearheaded by UNFPA for Mobile and Vulnerable populations, the following partners worked closely together:

- The **Ministry of Health and Child Welfare** played a central role in identifying the most critical commodities and by facilitating necessary clearances for the entry of drugs into the country and permitting onward distribution.
- **UNFPA** brought its strength in procurement and logistic management
- **IOM** identified needy institutions and facilitated access the services for the most vulnerable.

CERF funding made possible close collaboration among the above stakeholders both at the central level for planning and at the field level for smooth implementation and monitoring. Close

coordination enabled the timely completion of all the planned activities and high standards of implementation were maintained.

EDUCATION

Through CERF funding, IOM, Save the Children UK (SCUK) and Save the Children Norway (SCN) received funding to address some aspects in the education sector.[1] IOM assisted in the identification of the schools affected by displacements, while Save the Children Alliance provided the educational expertise, such as the development of M&E tools and the guidance during the trainings on essential life skills.[2] **The project is to end in May 2009 following a no cost extension granted by the CERF Secretariat.**

As a result of the limited access to beneficiaries from the month of April to August 2008, IOM liaised with various stakeholders including the UN, the Government of Zimbabwe and the NGO sector to improve the situation. Although there were no major positive outcomes the MVP working group scaled up meetings to weekly instead of monthly meetings. Through a participatory framework, IOM continuously assessed the humanitarian needs and responded in the quickest way possible, ensuring the protection of the most vulnerable groups.

CERF funding has strengthened capacity to implement underfunded activities. With regard to HIV and GBV mainstreaming activities, MVP communities are keen to participate in community-based interventions, they actively showcase their understanding of the issues and what they are doing to address these issues. With regards to community based committees, several of these were failing to raise funds to enable them to carry out their functions effectively. Examples include water point committees which needed contributions for the maintenance of water points. Some beneficiaries were unable to contribute given the difficult operating environment.

UNHCR received the funds at a critical moment when their refugee programme had attracted no funds as at the end of the first quarter of 2008 when the project urgently required funding to meet the critical basic needs of refugees in the country, including food, water and sanitation. Food items were purchased and transported by UNHCR through UNHCR Regional procurement office in South Africa. Chronic shortages of food in the country necessitated procurement from outside the country. Christian Care, UNHCR Implementing Partner for food in the project was responsible for the warehouse management and the distribution of the food to the beneficiaries. The same Implementing Partner was responsible for the water and sanitation activities.

The cluster approach to addressing telecommunications in Zimbabwe has required extensive network management and coordination between agencies. Information management was centralised to ensure that duplication of call signs and selcalls did not occur. The following steps were taken as soon as the project was approved:

(a) Allocation of selcalls and call signs to all UN agencies and NGOs (Non governmental organisations) by the TCO (Technical Coordinator). This involved gaining an understanding of every agency's expected operational size.
(b) Creation of a call sign and selcall database, which ensured that all allocations for UN and NGOs were centralised.

To allow the UN and NGOs to communicate effectively across the whole country and to each other, a common HF frequency plan was implemented.

[1] The project is in technical collaboration with UNICEF to make sure all national standards are met for the project as well as close collaboration with local authorities

[2] All (implementing) partners within the project (including IOM) participated in training on *"Child Protection in Emergencies"* facilitated by SCUK and UNICEF in September 2008 whereby the key elements of addressing the needs of children within emergencies were introduced.

2. Project activities and results, including actual beneficiaries

WATER, SANITATION AND HEALTH (WASH)

CERF funding assisted in responding to the crucial needs of the affected populations and in mitigating the adverse effects of the humanitarian situation in Zimbabwe through various lifesaving WASH interventions.

Following are lists of the sorts of activities undertaken and their results: Coordination of WES related humanitarian interventions through the WASH Cluster and regular update and dissemination of the existing intervention analysis document (Who, what and where Atlas); **In Bulawayo**, the drilling and equipping of 10 new boreholes, flashing, repair, and equipping 50 existing boreholes, motorizing 14 high yielding boreholes, repairing of overhead tanks, training of 84 water point committees, provision of water borne sanitation facilities for 33 households. **In Harare and Epworth peri-urban settlement,** training of 30 local artisans (latrine builders and pump mechanics), construction of 842 household ecological sanitation facilities; health and hygiene promotion; training of 188 hygiene promoters, reaching women and school children with hygiene promotion. **In Chiredzi, Buhera and Chipinge districts,** rehabilitating 75 boreholes in Chiredzi, Buhera and Chipinge rural communities, and training of 43 water point committees and refresher courses for 76 village pump mechanics as well as construction of 15 latrine squat holes at rural health centres. The interventions benefited some 624,975 people for sanitation and improved access to safe water supply to 140,000 vulnerable people in Bulawayo Kadoma and Hopley and 60,000 in Chiredzi, Chipinge and Buhera districts among others.

HEALTH

For the Health interventions, the IV fluids procured by UNICEF through the CERF-funded *Essential Medicines Programme* were distributed to all districts, reaching over 200,000 beneficiaries. As the quantity of IV fluids was substantial, stocks were still available at the time of the onset of cholera in August 2008 which proved beneficial for the early response management of cholera patients.

For the immunization project, a total of 10 generators were procured and are in the process of being distributed to 10 identified districts. Moreover, 65 refrigerators were procured and distributed to 65 health facilities while 66,307 litres of fuel was procured for the outreach programme. Due to challenges with vehicles, the fuel is yet to be used.

CERF funding for the November 2008 CMNSS is in line with the CERF proposal and activities conducted included procurement of anthropometric equipment, training of enumerators, questionnaire reproduction, data collection, enumerator team field supervision, data entry and data cleaning and analysis. The expected output of providing information on child nutritional status was met. Complementary funding was used to produce and disseminate the CMNSS report.

In order to meet the emergency health needs of MVP communities in isolated or mobile areas that have limited access to health care, IOM used CERF resources to run a mobile clinic. The mobile clinic is active in seven peri-urban areas of Harare and remote MVP communities in Manicaland. In the wake of the unprecedented cholera outbreak in August 2008, the CERF funding helped strengthen the mobile clinic team, which was actively engaged in training and supporting 470 Community Health Volunteers resulting in an outreach of 9,400 households (47,000 people) with health education and hygiene promotion services. Mobile clinic outreach services reached 27,000 individuals with basic primary health care services. 860 people directly treated by IOM following outbreaks of cholera, anthrax, scabies, malaria and diarrhoea during first half of 2008.

Two water points (borehole) were established in Makonde and Chiredzi districts serving a population of 1,982 households. Some 22 districts supported by IOM under their project in addition to purchase and distribution of medical supplies, drugs, deployment of nurses at CTCs, training of public health and hygiene promoters, logistics support, incentives for health staff at CTCs and the establishment of 2 CTCs exclusively run by IOM at the Beitbridge and Plumtree Reception and Support Centres, respectively. The programme is part of an overall effort by IOM t to help support the MoH collapsed health system and strengthen its capacity.

At least 160,000 people were reached through a 20-day campaign on Public Health and Hygiene Promotion targeting mobile populations during the holiday season, when many people move within the country as well as to neighbouring countries or overseas, the mobility may play an even more important role in spreading the disease further.

One Diarrhoea Disease kit (DDK) , one Emergency Health Kit (EHK) and IV Fluids were distributed to each of the affected provinces (Mashonaland East, West and Central Provinces) through project undertaken by WHO. Two of the kits were kept at national level as strategic stock. About 100,000 beneficiaries were reached, especially through social mobilization at community level. IEC materials were printed and distributed. Cholera control guidelines were also printed and distributed to health staff in the health institutions and Cholera treatment centres (CTC and CTU).

An estimated 25,000 women and girls in the reproductive age group were direct beneficiaries of the reproductive health project. An additional 25,000 members of the MVP community are estimated to have indirectly benefited. This implies that 100 percent of target beneficiaries as planned have been reached through the project. The project distributed drugs and supplies for managing labour and to manage post partum haemorrhage; critical bed linen, baby blankets and patient blankets; and Manual vacuum aspiration kits to promote safe abortion. IEC materials for MVPs on reproductive health, HIV/AIDS and gender-based violence were also distributed.

FOOD SECURITY

Under the CERF-funded activities for refugees, UNHCR procured food, transported it, and facilitated distribution to beneficiaries. Another component of the project was improvement of water supply and sanitation services in the camp for the benefit of 2,931 refugees. 2,931refugee (1,223 women and 1,427 children under 17 years) and 40 chronically sick people were reached with seven food items (maize meal, vegetable oil, beans, corn soya blend, rice, salt, and sugar) for two months. The food provided 2,186 kcal/p/day. Given the challenges associated with hyperinflationary environment (231million, the highest recorded during the year) it was not possible to respond to the water and sanitation needs as planned. The programme however managed to build 10 double VIP toilets in the camp in an effort to respond to the sanitation gap in the camp. The ten toilets benefited 40 families or 200 people in the camp. To a limited extent there was a small improvement in the sanitation sector, and a lot more effort is still needed in this area. Again given the very prohibitive costs in drilling and equipping a new borehole as envisaged, the programme was only able to carry out two major repairs to the two boreholes in the camp to improve the supply of safe water in the camp. Improvement to the water supply in the camp was critical as it also averted the crisis associated with the outbreak of cholera during the year. The majority of the cases that came for medical assistance were from surrounding areas/ local community. During the first half year, safe water supply per person per day reached the UNHCR standard of 20litre level from the 15litre level at the beginning of the year. At the end of the year, the level went down to 16litre level mainly due to national power problem.

TELECOMMUNICATIONS

One of the main components of the telecommunication project was the standardisation of procedures, and the subsequent development of a standard training curriculum. This was

achieved by compiling existing procedures into a Communication Centre (COMCEN) Standard Operational procedure (SOP) which was approved / endorsed by the UNDSS. Additionally training packages were prepared for the SOP implementation:

- User training, including all the material required by UN staff and NGOs.
- Driver / passenger training, which includes extensive documentation on the use of HF and mobile VHF radios, as well as vehicle tracking procedures.
- Radio operator training, which is the largest and most comprehensive training package, including all aspects of radio communications.

To implement the telecommunication project and ensure long term success of the project, partnerships were established with UNICEF, UNDP and UNDSS. Due to the CERF component being in place this allowed WFP-FITTEST to work closely with the aforementioned agencies, thus ensuring common standards were implemented across the whole UN and NGOs

Under the IOM education intervention, a total of 33 schools including Early Childhood Development (ECD) Centres in displaced communities were assisted in Mutare, Makoni, Chipinge, Victoria Falls, Bulawayo, Harare, Rushinga, Mberengwa, Bikita and Tsholotsho based on agreed upon vulnerability criteria. The majority of the selected schools had not received any form of assistance since they were displaced; in some cases assistance had been minimal due to lack of funding for education in the country. An estimated 20,945 students and 525 teachers received assistance under this project.[3] Supplies included textbooks, stationary and recreational materials, emergency refurbishment of schools (including water and sanitation facilities) and provision of essential life-saving skills in emergency, HIV and AIDS prevention, psycho-social support, Gender Based Violence (GBV), health and hygiene as well as child protection are being provided to teachers and affected communities including School Development Committee (SDC) members

MULTI-SECTOR

IOM project **(08-IOM-005)** helped to save the lives of vulnerable people affected by floods through the provision of a comprehensive assistance package that comprised shelter, NFIs, emergency and environmental health, water and sanitation facilities to 1250 households, as well as HIV/AIDS and GBV mainstreaming. Since the flood affected areas are also malaria prone ones, all assisted households were also given two treated mosquito nets each.

In HIV, AIDS and GBV

- Increasing availability of HIV and GBV prevention information in MVP communities. Five training workshops on sexual and reproductive health were held for 155 community health volunteers from the displaced communities and 64 Behaviour change facilitators
- In these communities IOM also supported the national World AIDS Day Commemorations with materials support in the form of banners, t-shirts and participating in the 24-hour radio show on HIV and AIDS that took place on the 1st of December 2008.

<u>In shelter and WASH</u>

- 30 h/h in Muzarabani and 45 h/h received provision of emergency and semi-permanent shelter options for those in need;
- 76 H/H in Muzarabani Improving access to clean water and sanitation facilities, as well as training on hygiene promotion as a strategy for promoting community stabilisation and reintegration.

[3] These figures are based upon the official school enrolment during the second term in 2008 from the selected schools; the project will revise the actual number of beneficiaries (students and teachers) when all activities have finished.

EDUCATION

Through CERF funding, IOM, Save the Children UK (SCUK) and Save the Children Norway (SCN) received funding to address some aspects in the education sector.[4] IOM assisted in the identification of the schools affected by displacements, while Save the Children Alliance provided the educational expertise, such as the development of M&E tools and the guidance during the trainings on essential life skills.[5] **The project is to end in May 2009 following a no-cost extension granted by the CERF Secretariat.**

3. Partnerships

In Zimbabwe, WASH cluster coordination (UNICEF being the Cluster Leader) has helped to build strong partnerships among WASH players among the NGOs, UN agencies, donors, government and communities. UNICEF currently has projects with 12 NGOs of whom 6 are under the CERF component of humanitarian response. The partnerships have helped to improve service delivery and coordination at field level. The ability to respond to cholera is a good example for effectiveness of the partnership between UNICEF and NGOs partners. During recent cholera outbreak, UNICEF worked very closely with NGOs and managed to build a strong partnership. The areas covered under CERF funded project had added advantage as the NGOs were able to respond effectively.

UNICEF and WHO partnered to secure the procurement of IV fluids by using the same coordinating and distribution mechanism through NatPharm therefore avoiding duplication. The MOHCW was also a key partner by identifying the areas of need and liaising with NatPharm who were doing the distribution. As the essential medicines programme was also running at the same time, trucks that were distributing the other essential medicines were used for distribution of IV fluids. In addition, MSF and World Vision International were instrumental in assisting the Ministry of Health and Child Welfare in transporting supplies to Provinces in which they were operational.

Cholera outbreak response was coordinated through the Health Cluster led by WHO as the cluster lead. To respond to cholera epidemics a close collaboration was established between WASH (Water, Sanitation and Hygiene) WASH cluster, and regular consultation and information sharing between the two established. The recent mapping of health actors throughout the country has made coordination much more effective, and duplication minimized. In Chitungwiza- where the first case of cholera was reported, IOM provided nursing staff that was working under MSF-Holland and all responses were in coordination with the Ministry of Health and Child Welfare. The collaboration and division of responsibilities might have contributed to rapid containment of the outbreaks at the time. The health cluster formed a small working group comprising the World Health Organization, International Committee of the Red Cross and International Organization for Migration, which conducted a rapid assessment of ongoing cholera response interventions and developed an operational plan. The plan was adopted by the health cluster, which includes representatives from other clusters and donor agencies.

As indicated under coordination and implementation arrangements, the project saw close collaboration between UNFPA, IOM and the Ministry of Health and Child Welfare.

The FNC is responsible for nutrition surveillance in Zimbabwe and UNICEF has supported the FNC since 2004. This arrangement gives surveillance credibility and the information generated is used by both government and the humanitarian community. Comprehensive monitoring of the nutrition situation in Zimbabwe would not be possible if the government did not take the lead.

[4] The project is in technical collaboration with UNICEF to make sure all national standards are met for the project as well as close collaboration with local authorities

[5] All (implementing) partners within the project (including IOM) participated in training on *"Child Protection in Emergencies"* facilitated by SCUK and UNICEF in September 2008 whereby the key elements of addressing the needs of children within emergencies were introduced.

UNICEF has provided funding and technical support and without this the surveillance system would have collapsed. Increasingly this partnership arrangement has been challenging mostly due to the resource constraints of the FNC but despite this the objective of providing bi-annual nutrition information continues to be achieved.

The implementation process also involved the participation of national faith and community based organisations with strong links with the assisted communities. These organisations have limited capacity to respond to emergencies and IOM provided as much support as required as contribution to their capacity building. After the provision of the assistance, IOM undertook a post-assistance monitoring exercise to get more information on the specific assistance provided. Christian Care was our Implementing Partner in the above activities and the project benefited immensely from their expertise in the food distribution, water and sanitation activities.

1. Gender-mainstreaming

CERF-funded projects in Zimbabwe were designed with due consideration of gender mainstreaming issues. Water and sanitation programmes, for example, were designed to suit the needs of women and girls. During planning, implementation and monitoring, community consultations were carried out and efforts were made to consult both men and women in the communities. The project provides benefits to all in communities without any discrimination to men or women, girls and boys.

Another example was the establishment of water points within the MVP communities. This practice greatly reduced the burden among girls and women of walking long distances to fetch water. In addition, provision of safe water within MVP communities opened space for the pursuit of other livelihood activities. Women were trained as water point committee members in recognition of their role in water management and utilization at the household level. There was a concerted effort to ensure that both male and females were identified and trained as hygiene promoters, thereby mitigating the problem of the feminization of volunteerism.

For the WHO interventions, it was observed that women are the major care-givers at community and household level and also have a bigger presence at health promotion gatherings than men. It was there important to ensure that social mobilization and education in home management of diarrhoea and hygiene education targeted women in particular.

UNFPA projects directly targeted women and girls of child bearing age with obstetric complications. During the sensitization workshops for stakeholders working in MVP communities, the importance of involving boys and men in the campaign was stressed. Even during the inter-personal communication sessions with health workers; the role of families in contributing to maternal health particularly in addressing the first and second delays was emphasized.

Another UNFPA focussed on ensuring that children's protection needs were met by not only engaging the respective school headmasters, teachers and SDC members, but also by making sure that children themselves were part of the project by engaging them as much as possible in discussions and decision-making processes whereby boys and girls are equally heard. Other ways of gender mainstreaming included the process of identifying school improvement , while ensuring that issues affecting girls, such as the distribution of sanitary pads, were given due consideration. Teachers and community members were encouraged to participate in the training programme for ensuring gender balance as much as possible.

As a cross-cutting issue, mainstreaming sessions of HIV and AIDS, GBV and protection were held in the displaced communities. Various fora such as NFI distribution sites and group discussions in the various shelter and sanitation facilities construction sites proved to be the ideal places for mainstreaming activities. Additionally information was disseminated through multiple strategies including awareness workshops using discussions, role plays and Information Education and Communication (IEC) materials. During the mainstreaming sessions,

beneficiaries were also sensitized on their entitlements and on the Code of Conduct for Humanitarian actors in emergency situations, in order to minimize the risk of sexual abuse and exploitation. The intervention also supported one community, Hopley Farm in peri-urban Harare to organize and commemorate 16 Days of Activism against Gender Based Violence.

UNHCR policy is equal representation/participation of men and women in food distribution and other service. 50percent women participation was ensured and achieved in the distribution of food, and 50percent of the toilets constructed were allocated for use by women.

5. Monitoring and evaluation

Monitoring and evaluation of CERF-funded projects was based on a data collection and analysis system maintained by all agencies. At the agency level, a database of all materials procured, a distribution plan and a database of all project interventions are maintained. Data on field level activities was collected from Field Activity Reports submitted by the partners. All partners conducted a joint post-assistance monitoring.

IOM interventions were monitored using Field Activity Report (FARs**) -** forms which are completed upon the conduct of all field activities. Training workshops are specifically evaluated by the attending participants who assess each of the training sessions and other logistical issues. Additionally, in all areas where the IOM Emergency Assistance programme is implemented, a random Post Assistance Monitoring (PAM) survey was conducted. Periodic field visits were made for inspections and monitoring the projects whilst they were under implementation.

UNHCR maintained presence in camps to monitor and ensure delivery of assistance to the targeted beneficiaries. 100 percent access to assistance by beneficiaries was reported. Community participation in the food distribution also ensured beneficiary access to assistance. The food distributed met the daily dietary requirements and there were no reported cases of malnutrition among the beneficiaries.

In the WASH cluster, partner agencies submitted quarterly reports to the WASH cluster in order to keep it informed about the implementation status of the project. In addition, UNICEF staff made periodic field visits to monitor the progress and conduct joint monitoring field visits with implementing partners. Based on the current experience, the monitoring and evaluation mechanisms were not adequate to monitor the progress and impact of the project on the project results, despite regular sharing of information during cluster meetings.

In Nutrition surveillance during the November 2008 round, each province was allocated a supervision team who visited the data collection teams in their province during the data collection to ensure consistency and quality of data collected. UNICEF was responsible for monitoring the quality of data analysis. Monitoring was carried out through participation in the distribution, field visits and spot checks to ensure the IV fluids reached the beneficiaries. Quarterly monitoring visits to provinces and districts were done in partnership with MOHCW and WHO. Same approach was adopted during the cholera outbreak areas to make assessments and identify gaps. Appropriate corrective measures were carried out as soon as possible in order to improve response. National, provincial and district health executive teams participate in these missions.

IOM Zimbabwe developed a comprehensive monitoring and evaluation framework for the MVP Programme which consisted of assessment tools, registration information and monitoring tools. In addition, frequent monitoring visits, regular meetings with beneficiaries and partners were conducted.

UNFPA also practiced sound monitoring and evaluation of its programmes. With support from a private company specializing in distribution of commodities, UNFPA ensured smooth distribution

of commodities and goods received. Vouchers were signed by the officer in charge and were meticulously received from each of the institution. During the course of the year, UNFPA undertook two monitoring visits to the field along with the Ministry of Health and Child Welfare to selected institutions in the country. The monitoring team found good stock management and accountability for the commodities distributed.

UNFPA utilized opportunities such as meetings and trainings to interact with Provincial and District health personnel to learn about their experiences with the drugs and commodities distributed. Given the current hyper-inflationary environment, the cost of drugs had gone beyond the reach of many people in Zimbabwe, especially among the most vulnerable rural folk. The drugs procured through this project have provided a temporary relief to the most vulnerable women that access health services through public health institutions.

This project complimented IOM's emergency assistance to MVPs programme. A monitoring mechanism was put in place through IOM's implementing partners in the field to ensure that the drugs and commodities are made available to the most vulnerable.

IV. Results

.

Sector/ Cluster	CERF projects per sector (Add project nr and title)	Amount disbursed ($)	Number of Beneficiaries (by sex/age)	Implementing Partners and funds disbursed	Baseline indicators	Expected Results/Outcomes	Actual results and improvements for the target beneficiaries
Water Sanitation and Hygiene (WASH)	**Provision of Emergency Safe Water Supply, Sanitation and Hygiene Education to Targeted Vulnerable Populations in Urban and peri-urban Areas of Zimbabwe**	$934,600	90,000	▪ World Vision Zimbabwe Emergency Water Supply and Sanitation $481,863 ▪ Practical Action Emergency Water and Sanitation Project in Bellapaise (Epworth) $370,000 ▪ UNICEF Provision of Emergency Safe Water Supply, Sanitation and Hygiene Education to Targeted Vulnerable Populations in Urban and peri-urban Areas of $82,407.07		▪ Reduce morbidity/ mortality due to water and sanitation related diseases amongst targeted populations. ▪ Improve health and hygiene behaviour and practices amongst target communities. ▪ Improve access to adequate water and safe sanitation facilities of the targeted populations.	▪ Improved access to safe disposal of human excreta for 730 families (3,650 people) through the provision of 730 ecological household latrines at Epworth- Bellapaise peri-urban settlement. ▪ Improved hygiene behaviour and practices amongst the 3,975 affected communities in Epworth -Bellapaise. ▪ Improved hygiene promotion skills amongst 18 community hygiene promoters and technical skills amongst 30 community latrine builders. ▪ Improved hygiene awareness amongst the 3,100 population Epworth and 84,000 in Bulawayo. ▪ Reduced incidence of diarrhoea amongst the residents of Bulawayo with the diarrhoea epidemic effectively brought under control. ▪ Improved access to safe water supply to 68,000 vulnerable people in Bulawayo through rehabilitation of 50 boreholes, motorisation of 14 boreholes and drilling of 10 new boreholes.

Water and Sanitation	**CERF Grant for Underfunded Crisis for Provision of Safe water supply, sanitation facilities and hygiene education to targeted vulnerable populations in urban and rural areas of Zimbabwe. (08-CEF-011-A)**	$919,599. (983,950 per CERF figures)	535,800 vulnerable population urban and rural areas of Zimbabwe.	▪ Oxfam GB Emergency Public health intervention in Kadoma $265,900 ▪ Africare Gokwe South community water project $80,183 ▪ Christian Care Emergency water supply and sanitation project for Hopley and Hatcliffe $112,458 ▪ UNICEF Provision of Safe water supply, sanitation facilities and hygiene education to targeted vulnerable populations in urban and rural areas of Zimbabwe $229,522 NB UNICEF did not exhaust grant.		▪ Increase safe water supply for drinking and household use for 50,000 people. ▪ Improve household and personal hygiene behaviours and practices among 535,800 targeted population. ▪ Train volunteer hygiene promoters (170) providing hygiene promotion and education services locally benefiting 535,800 people. ▪ Improve access to safe sanitation facilities for 3,240 people. ▪ Increase community involvement and participation the prevention of WASH related diseases.	▪ Completion of drilling 20 new boreholes (Kadoma) and continuous maintenance of 11 boreholes(Hopley) ensured access to safe water to 56,000 vulnerable people. ▪ 112 households (672 people) with access to safe sanitation facilities in Hopley. ▪ 170 volunteer hygiene promoters provided hygiene promotion and education in Kadoma, Hopley and Hatcliffe Extension. ▪ Water point committees for 20 water sites trained and preventive maintenance provided.

Water and Sanitation	**CERF Grant for Underfunded for (WASH) Support to Rural Hospitals, Health clinics and Surrounding communities in Zimbabwe.** **(08-CEF-027)**	$231,769 (247,987 as per CERF records)	60,000 vulnerable people in Chiredzi, Chipinge and Buhera districts	▪ Mercy Corps WASH Support to Rural Hospitals, Health Clinics and Surrounding Community $125,988 ▪ UNICEF Support to Rural Hospitals, Health clinics and Surrounding communities in Zimbabwe $6,753		▪ Improve sanitation facilities at 10 health hospitals and health clinics through the construction of 25 ventilated improved pit latrines to ease pressure on patient usage. ▪ Increase access to water through rehabilitation of water points/boreholes at 10 hospitals and health clinics. ▪ 90 additional communal boreholes rehabilitated increasing access to water for 45,000 people. ▪ 60 family wells rehabilitated benefiting 3600 people. ▪ 60 village pump mechanics trained and sustainable servicing communal water points. ▪ 75 health and hygiene clubs established and promoting good hygiene practices benefiting 27,000 people.	▪ 18,750 people are benefiting from improved access to safe water from the rehabilitated 75 boreholes in the 3 areas. ▪ Analysis of baseline data for Chiredzi Wards 1 to 5 and drawing up a priority list of borehole to be rehabilitated. ▪ 15 VIP squat holes under construction at health centres. ▪ 43 Water Point Committees Trained in water point management and maintenance. ▪ Refresher course for 76 VPMs in water repair and maintenance. ▪ Assessed Cholera requirements for the 3 districts and improved the MOH's and RDCs' capacity to fight the epidemic through repair of vehicles, motor cycles and provided fuel. ▪ Accessed and distributed NFIs and hygiene enabling materials to PMD Manicaland, to health centres in Makoni, Nyanga, Buhera, Chipinge and Chiredzi districts.
Health	**PBA/SM/2007/0387 'Zimbabwe Food and Nutrition Surveillance System'**	$186,064		FNC/MoHCW/CSO Most costs paid directly by UNICEF FNC $6,560		▪ Information on child nutritional status- report produced, information dissemination presentations on child nutritional status and household food security status.	▪ Report on November 2008 CMNSS included information on child nutrition status, food security, care practices, water and sanitation and health. Report produced and distributed widely though cluster mechanisms and donor meetings.

Health	**PBA SM/07/0423**	$510,523.78	200,000	UNICEF		▪ Access to health services and reduction of mortality from diarrhoea and other conditions.	▪ Over 200,000 beneficiaries were reached in 10 provinces. Also fluids were used for treatment of cholera patients, for administration of drugs for other illnesses such as malaria and general treatment of the sick in health facilities.
Health	**"Reaching the vulnerable children and women of child bearing age with immunization to prevent EPI target disease outbreaks"** ***(08-CEF-011-B)***	$280,380 ($300,000 as per CERF figures)	380,953 under 1 children and 2,580,648 women of child bearing age	MOHCW		▪ Maintain cold chain in 65 health facilities and 10 district vaccine stores. ▪ Conduct outreach in 10 low performing districts.	▪ 10 district vaccine stores equipped with generators to avert vaccine damage to power cuts and 65 health centres equipped with cold chain equipment to store vaccines appropriately.
IOM Health	**Addressing Community and Environmental Health Needs of Mobile and Vulnerable Populations (08-IOM-006)**	$250,000	7,414 MVP households (32,198)	Help Age Zimbabwe, Zimbabwe Community Development Trust (ZCDT), Practical Action, Integrated Sustainable Livelihoods, St Gerard's No funds to implementing partners, just to Coordination (USD 4000)	MVP communities have limited access to health and hygiene information and services MVP households have no access to safe water sources for household use MVP communities have limited access to HIV/AIDS, gender based violence information and services	▪ Contribute to improved health conditions in selected MVP communities. ▪ Increase access to potable water and sanitation. ▪ HIV/AIDS and GBV prevention information made available to target communities.	▪ Trained and supported 470 Community Health Volunteers resulting in an outreach of 9,400 households (47,000 people) with health education and hygiene promotion services. ▪ Mobile clinic outreach services reached 27,000 individuals with basic primary health care services. ▪ 860 people treated by IOM following outbreaks of cholera, anthrax, scabies, malaria and diarrhoea during first half of 2008. ▪ Two water points (borehole) established in Makonde and Chiredzi districts serving a population of 1,982 households. ▪ Project supported unprecedented cholera response in 22 districts with medical supplies, drugs, deployment of nurses at CTCs, training of public health and hygiene promotion, logistics support, incentives for health staff at CTCs and the establishment of 2 CTCs exclusively run by IOM at the

							Beitbridge and Plumtree Reception and Support Centres, respectively. ▪ A 20-day campaign on Public Health and Hygiene Promotion 160,000 people.
Health	**Addressing emergency sexual and reproductive health needs of mobile and vulnerable populations (MVPs) in Zimbabwe (08-FPA-006)**	$300,199	50,000 including 25,000 women and girls as direct beneficiaries	Technical support: IOM and MOHCW	N/A as the project aimed at making available EMONC drugs and commodities in health institutions.	▪ Improve the availability and accessibility of life saving sexual and reproductive health commodities for mobile and vulnerable populations.	▪ Procurement of EMONC drugs and commodities and targeted IEC contributed to a better reproductive health service delivery for 50,000 MVPs in Zimbabwe.
Health	**Strengthen Response to diarrhoea diseases Outbreaks in Affected Area (08-WHO-010)**	$400,180	100,000	Funds managed entirely by WHO		▪ Case fatality rate. ▪ Reduce morbidity due to cholera. ▪ Availability of cholera supplies. ▪ IEC and guidelines printed and distributed. ▪ Timely response.	▪ Case Fatality Rate reduced to less than 1percent. ▪ Morbidity due to cholera reduced. ▪ Cholera supplies purchased and distributed. ▪ IEC materials and cholera control guidelines printed and distributed. ▪ Supplies delivered within 48 hours after request.
Nutrition	**"Hospital and Community Management of Acute Malnutrition (CMAM) in Zimbabwe" (08-CEF-070)**	$280,509 ($299,999 as per CERF figures)	9,000 severely malnourished children mostly under 5 years of age.	Food and Nutrition Council ($17,664.36), Ministry of Health and Child Welfare, World Vision International and MSF Belgium-supplies (227,289.190)	Mortality and morbidity associated with severe acute malnutrition above 50 percent.	▪ Increase in number of children accessing treatment for severe malnutrition. ▪ Decrease in mortality and morbidity in children admitted to the CMAM programme. ▪ Increased access of NGOs to therapeutic feeding commodities through Natpharm.	▪ 9,000 children accessed treatment for acute malnutrition. ▪ Mortality rate for CMAM are between 5 and 10percent. ▪ 2 NGOs accessed therapeutic feeding commodities through Natpharm.

FOOD VGF	**Protracted Relief for Vulnerable Groups** **(08-WFP-077)**	$5,000,107	Female:364,320 Male:394,680 Under 5:125,387	All partners		▪ Protect livelihoods in crisis situations and enhance resilience to shocks.	▪ Fewer beneficiaries were employing coping strategies (44percent) than non-beneficiaries (62percent) in November 2008. Disposal of assets was lower among beneficiaries and (16percent) of beneficiaries had poor consumption compared to (41percent) of non-beneficiaries.
FOOD HB-SN	**Protracted Relief for Vulnerable Groups** **(08-WFP-094)**	$1,000,375	Female: 156,480 Male:169,520 Under 5:53,855	All partners		▪ Protect livelihoods in crisis situations and enhance resilience to shocks. ▪ To safeguard health and nutrition and enhance quality of life for targeted, chronically ill people through nutrition support linked with relevant health interventions.	▪ Fewer beneficiaries were employing coping strategies (44percent) than non-beneficiaries (62percent) in November 2008. Disposal of assets was lower among beneficiaries and (16percent) of beneficiaries had poor consumption compared to (41percent) of non-beneficiaries. ▪ By programme activity, children from ART beneficiary households are the most likely to be enrolled and attending school (90percent) followed by HBC (85percent).
Coordination and support services	**Provision of security telecommunication services to the humanitarian community in Zimbabwe 08-WFP-017**	$367,341	Total staff trained: 344	UNDP, UNICEF, UNDSS, FITTEST		▪ Ensure timely, predictable and effective common telecommunication services to assist humanitarian agencies and partners involved in humanitarian operations and support staff security. ▪ Ensure timely reporting and information exchange for decision making by establishing a common security telecommunication system. ▪ Promote efficient and appropriate use of telecommunication systems and services through advanced staff training.	▪ Inter Agency coordination. ▪ Upgraded radio rooms. ▪ . MOSS compliancy at security phase 2. ▪ COMCENs and radio network ready for any increase in security level (phase 3 capable). ▪ Reviewed existing VHF network and strengthened capacity and increased coverage. ▪ Allocated UN call signs and Selcall as per UN standards. ▪ Implemented VHF select V. ▪ UN common radio channels / rooms in

						▪ Provide a standard interoperable ICT platform and procedures for the overall humanitarian community in Zimbabwe to avoid duplication of efforts and costs amongst agencies. ▪ Maintain the existing common telecommunications systems at all times. ▪ Build in-country capacity.	use. ▪ UN radio operators. ▪ UNDSS common service TC technician. ▪ Radio Training for UN and NGO staff. ▪ Working in line with current UN working practices / standards.
Agriculture	**" Supporting the MVP communities with agricultural inputs and technical training for increased yields "** **(08-IOM-027)**	$580,642	30,904 MVPs, VPVs and vulnerable households of hosting communities.	Integrated Sustainable Livelihoods (ISL), Zimbabwe Community Development Trust (ZCDT), Evangelical Fellowship of Zimbabwe (EFZ), Help Age Zimbabwe (HAZ), Lead Trust (Z$35000)	More than 30 000 MVP households around the country are food insecure and have no access to agriculture inputs for the 2007/08 agriculture season.	▪ Increase household food security through the increased yields per unit area. ▪ Increase seed security within the MVP communities and ultimately strengthening the household coping mechanisms destroyed during the displacement.	▪ 33904 households increased household food security. ▪ Increased productivity and crop diversity increased nutrition.
Multi-sector	**Emergency assistance to Mobile and Vulnerable Populations in Zimbabwe (08-IOM-005)**	$800,000 02-04-2008	1250 households	IOM Direct implementation	Baseline	▪ Provide 1250 households with NFIs to meet their immediate needs; ▪ Provide chronically ill persons with supplementary food packs; ▪ Prevent and respond to HIV and GBV amongst MVPs Provision of building tools and materials ▪ Capacity Building through shelter construction trainings ▪ Provide transitional shelter	▪ 1250 households in Chipinge and Muzarabani received standard NFI packs and mosquito nets ▪ Produced 30,000 IEC materials on HIV and GBV. ▪ Conducted 2 refresher training workshops for community based Behaviour Change facilitators were held for 64 participants from 5 MVP communities in Hurungwe District. ▪ Conducted 5 training workshops on sexual and reproductive health in MVP communities held for 155 community health volunteers.

						units	▪ Supported national World AIDS Day Commemorations held in Bindura with materials support in the form of banners, t-shirts and participating in the 24 hour radio show on HIV and AIDS on 1st December 2008. ▪ Increased access to durable and safe shelter units.
IOM Education	**Increasing access to quality education for children of Mobile and Vulnerable Populations (MVP) communities (08-IOM-007)**	$630,000	21,470 direct beneficiaries 10,675 female and 10,795 male beneficiaries; including 20.945 primary schools students	Save the Children UK USD 231,280.00 and Save the Children Norway USD 132,00.00	Schools in MVP communities have limited learning and recreational material Poor infrastructure (classrooms, toilets, recreational	▪ Refurbishment of primary schools (including ECD centres) as well as water and sanitation facilities ▪ Strengthened teachers and community participation and knowledge in emergency preparedness, HIV and AIDS prevention, psycho-social support, sexual and gender-based violence (SGBV), health and hygiene and child protection	▪ Provided textbooks for the 33[6] selected primary schools (including ECD centres); (a total 27,139 text books procured and distribution to all 33 schools). ▪ 33 primary schools are in the process of receiving the educational and recreational materials such as exercise books, chalk, pens and sporting equipment as footballs. ▪ All the materials for school emergency refurbishment procured and partners are currently involved in the construction/refurbishment process of schools blocks, staff accommodation and water and sanitary facilities. ▪ The planning and tools for trainings and information sharing on life-saving skills, HIV and AIDS prevention, psycho-social support, SGBV, and health and hygiene developed. ▪ A total of 215 teachers and community members were trained on all thematic areas of the project covering 22 schools. 8 additional schools are in the process of receiving training[7].
Multi-sector	**Protection and Emergency Assistance to Refugees in Zimbabwe**	$214,000 +$107,000	3,159	Christian Care	No resources to provide encamped refugees with seven food items (maize meal, beans ,	▪ Improve living conditions for all beneficiaries in Tongogara Refugee Camp. ▪ Reduce malnutrition and related morbidity and mortality through provision of adequate basic food	▪ Food items comprising of maize meal, beans , vegetable oil, corn soya blend, rice, salt and sugar were purchased and transported from South Africa and reached 3,159 refugees, including women, children, and chronically ill, 10 Double VIP toilets were constructed in the camp, and major repairs were

					vegetable oil, corn soya blend, rice, salt and sugar) to ensure good nutrition and good health. Water supply (15l/p/day) for the refugees below the standard of 20l/p/day. Sanitation situation in the camp (10percent) well below the standard of 100percent.	commodities to the population in Tongogara camp. ▪ Control disease outbreaks through provision of adequate sources of clean/safe water supply, and basic sanitation and hygienic facilities/environment .	carried out on two boreholes in the camp. ▪ Food timely availed to the beneficiaries and no malnutrition was recorded among the beneficiaries. ▪ Water and sanitation facilities had a slight improvement. ▪ Overall, the intervention made a positive impact on the well being of the refugees in Zimbabwe.

Annex: Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retro-Viral Treatment
CFSAM	Crop and Food Supply Assessment Mission
CHS	Community Household Surveillance
CMNSS	Combined Micronutrient and Nutrition Surveillance Survey
COMCEN	Communication Centre
CP	Cooperating Partner
CSO	Central Statistics Office
CTC	Cholera Treatment Centre
DFAH	District Focal Agency for Health
ECD	Early Childhood Development Centres (ECD)
ECW	Enhanced Commitment to Women
EFZ	Evangelical Fellowship of Zimbabwe
FAO	United Nations Food and Agriculture Organisation
FDP	Final Distribution Point
FNC	Food and Nutrition Council
GBV	Gender Based Violence (GBV),
HAZ	Help Age Zimbabwe
HBC	Home Based Care
HB-SN	Health Based Safety Net
HH's	Households
HIV	Human Immuno Deficiency Virus
IEC	Information Education and Communication materials
INEE-	The Inter-Agency Network for Education in Emergencies (INEE)
IOM-	International Organization for Migration (IOM)
IP	Implementing Partner.
ISL	Integrated Sustainable Livelihoods
MoHCW	Ministry of Health and Child Welfare
MVP	Mobile and Vulnerable Populations
NFI	Non Food Item
NGOs	Non Government Organization
PAM	Post Assistance Monitoring
SB-SN	Social Based Safety Net
SC UK-	Save the Children UK (SCUK)
SCN-	Save the Children Norway (SCN)
SDC	School Development Committee (SDC)
SN	Safety Net
SOP	Standard Operational Procedure
TCO	Technical Coordinator
UNICEF	United Nations Children Fund (UNICEF)
VGF	Vulnerable Group Feeding
VIP:	Ventilated Improved Pit latrines
VPV	Victims of Political Violence
ZCDT	Zimbabwe Community Development Trust