RESIDENT/HUMANITARIAN COORDINATOR REPORT 2012 ON THE USE OF CERF FUNDS ZIMBABWE

RESIDENT/HUMANITARIAN COORDINATOR	**Mr. Alain Noudehou**

PART 1: COUNTRY OVERVIEW

I. SUMMARY OF FUNDING[1]

TABLE 1: COUNTRY SUMMARY OF ALLOCATIONS (US$)		
Breakdown of total response funding received by source	CERF	2,006,304
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	896,097
	OTHER (Bilateral/Multilateral)	220,924,666
	TOTAL	222,930,970
Breakdown of CERF funds received by window and emergency	**Underfunded Emergencies**	
	First Round	0
	Second Round	0
	Rapid Response	
	Drought	2,006,304

II. REPORTING PROCESS AND CONSULTATION SUMMARY

a. Please confirm that the RC/HC Report was discussed in the Humanitarian and/or UN Country Team and by cluster/sector coordinators as outlined in the guidelines.

YES ☒ NO ☐

The report was discussed at the Inter-Cluster meeting of 19 February, 2013.

b. Was the final version of the RC/HC Report shared for review with in-country stakeholders as recommended in the guidelines (i.e. the CERF recipient agencies, cluster/sector coordinators and members and relevant government counterparts)?

YES ☒ NO ☐

Report was shared with members of the HCT and discussed on 20 March 2012. The final version was also shared in December 2013.

[1] Does not include late 2011 allocation.

PART 2: CERF EMERGENCY RESPONSE – DROUGHT (RAPID RESPONSE 2012)

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response:		***78,900,000***
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	2,006,304
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	500,000
	OTHER (Bilateral/Multilateral for WFP)	69,893,696
	TOTAL	**78, 900, 000**[2]

TABLE 2: CERF EMERGENCY FUNDING BY AGENCY (US$)			
Allocation 1 – Date of Official Submission: 15 October 2012			
Agency	**Project Code**	**Cluster/Sector**	**Amount**
WFP	12-WFP-076	Food	2,006,304
Sub-total CERF Allocation			**2,006,304**
TOTAL			**2,006,304**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of Implementation Modality	**Amount**
Direct UN agencies/IOM implementation	1,605,653
Funds forwarded to NGOs for implementation	400,638
Funds forwarded to government partners	0
TOTAL	**2,006,291**

Throughout 2012, the humanitarian situation in Zimbabwe continued to be stable but fragile because most of the underlying factors giving rise to the crisis were not conclusively addressed by interventions undertaken in the previous years. Humanitarian planning for 2012 spanned across all sectors, and strategies were developed to meet the needs of people affected by food insecurity, disease outbreaks and Internally Displaced Persons (IDPs) including migrants, asylum seekers, refugees and other vulnerable groups. From the onset of 2012, food security was identified as a key response area as 40 per cent of the CAP funding requirements addressed food security needs. Timely provision of agricultural inputs resulted in increased planted acreage and a slight improvement in food security in 2011. However, uneven rainfall distribution and a dry spell in the middle of the 2011/2012 agricultural season affected six of the country's

[2] This includes $6.3 million Advance Finance yet to be repaid

ten provinces and forestalled a potential good harvest that could have reduced the food aid needs. The 2011 Zimbabwe Vulnerability Assessment Committee (ZimVAC) indicated that approximately 1 million people (12 per cent of the population) required food assistance at the peak of the 2011/2012 'lean' season. However, the situation took a turn for the worse as documented in the 2012 ZimVAC assessment which indicated that food insecurity in Zimbabwe for the 2012/2013 lean season would start much earlier in the season, and would be 60% higher than the previous year. It estimated that nearly one in five rural people in Zimbabwe – approximately 1.6 million people - would require emergency food assistance during the peak of the 'hunger season' between January and March 2013. Contributing factors to this significant spike in food insecurity included late and erratic rains, constrained access to inputs, and a reduction in planted area reducing the national cereal harvest by 33 per cent in 2012. The Second Round Crop and Livestock report indicated that the 2012 cereals harvest was 1,076,772 MT, one-third lower than that of 2011 and the lowest since 2009. The deteriorating situation was monitored by WFP staff around the country who started reporting signs of distress, including high food prices, empty silos and granaries as well as adoption of negative coping strategies such as a reduction in the size or number of meals per day and distress sales of livestock, pointing to an increasingly critical situation from June 2012 onwards.

In September 2012, WFP and the Government began implementing the Seasonal Targeted Assistance programme in the areas with the highest proportion of food insecurity. Assistance was scaled up until the peak period (January – March 2013) when 1.4 million people were being supported by the programme with monthly household food rations.

II. FOCUS AREAS AND PRIORITIZATION

CERF funding was used to provide food assistance to 182,173 people from December 2012 through March 2013 through WFP's Seasonal Targeted Assistance (STA) programme, which aimed to protect lives, livelihoods and enhance self-reliance in vulnerable households affected by the drought in Zimbabwe in 2012. Some 38,498 people received cash transfers to purchase their cereals from local markets, thereby supporting the local economy and allowing more flexibility and choice for the beneficiaries, and 143,675 people benefitted from CERF providing part of the associated costs of the Government of Zimbabwe's 35,000 MT grain contribution towards a joint programme with WFP.

Geographic targeting of the STA programme was based on the ZimVAC rural livelihood assessment, which identified Masvingo, Matabeleland North and South, and parts of Mashonaland, Midlands and Manicaland provinces as the areas worst affected in terms of food security in 2012/2013. The districts that had the highest proportion of food insecure households are Gwanda (57 per cent), Mangwe (53 per cent), Kariba (49 per cent), Zaka (39 per cent), Chiredzi (36 per cent) and Mt. Darwin (36 per cent). All these were targeted for food assistance.

ZimVAC estimated that the number in need of food assistance would incrementally increase over the 2012/2013 lean season as follows: a) July – September 2012: 753,218 people b) October – December 2012: 1,184,701 people c) January – March 2013: 1,667,618 people.

According to the Zimbabwe Demographic Health Survey (ZDHS) 2010-2011, 32 per cent of children under the age of 5 years are stunted (short for their age), 3 per cent are wasted (thin for their height) and 10 per cent are underweight (thin for their age). Rural children are worse off across all indicators than children living in urban areas. In rural areas, 33.4 per cent of children under 5 years are stunted, 3.2 per cent are wasted, and 10.2 per cent are underweight, while in urban areas, 27.5 per cent of children under 5 are stunted, 2.1 per cent are wasted and 8.1 per cent are underweight.

Gender considerations were factored into WFP's activity planning. The implementing partners regularly collected gender-disaggregated data and WFP promoted the established and accepted practice of women's participation in activity management. Also, distribution sites were, where possible, located in the vicinity of strategic public facilities, such as schools, in order to minimize risks, especially to women. The high level of women as recipients of food assistance was expected to have increased the delivery of food and use at household level without diversion.

III. CERF PROCESS

WFP's Seasonal Targeted Assistance (STA) programme formed part of the priority interventions in the Food Cluster response plan of the 2012 CAP in Zimbabwe, which was developed by the Food Assistance Working Group. In April 2012, the Ministry of Agriculture, Mechanisation and Irrigation Development released the Second Round Crop and Livestock report which highlighted the significant decrease in national cereals harvest by 33 per cent. However, the ZimVAC report which identified the 1.6 million drought affected people needing food assistance was only released in July 2012, after the CAP Mid-Year Review in June.

After the release of the ZimVAC report in July 2012, the deteriorating food security situation in Zimbabwe was discussed extensively in meetings at the HCT, with NGOs, Government representatives, World Bank and other donors. Additionally, WFP held a donor meeting in late July to present the prevailing food crisis and to appeal for resources. The Government established an interim inter-ministerial task force in response to the food crisis, and WFP was an active participant in one of the sub-groups discussing the humanitarian response and planning the use of the 35,000 MT of Government grain.

The proposed STA intervention under this grant was carried out within the above coordination frameworks, including key NGO co-operating partners involved in programme implementation, such as: World Vision, UMCOR, Save the Children, CARE, ADRA, Christian Care, ORAP, Goal, Africare and Plan International. A unanimous consensus was reached on the overall beneficiary caseload, in line with the ZimVAC findings.

After the release of the ZimVAC report, the Humanitarian Country Team was appraised of the situation and later WFP leadership notified the Humanitarian Coordinator of the need to apply for CERF funding under the Rapid Response Window. In order to ensure that a consolidated appeal was sent, the HC enquired from all agencies if they required funding to response to the drought. FAO expressed an interest and submitted a joint proposal but during the review process, it was established that FAO had raised adequate resources and their part of the appeal was dropped. WFP proceeded to conclude the application and received the grant.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR				
Total number of individuals affected by the crisis: 1,667, 000				
The estimated total number of individuals directly supported through CERF funding by cluster/sector	**Cluster/Sector**	**Female**	**Male**	**Total**
	Food	103, 219	95, 279	198, 498

The beneficiary caseload for the STA programme is based on the ZimVAC findings. In 2012, ZimVAC determined that 1,667 million people would be in need of food assistance during the peak of the lean season, January to March 2013, which was 667,000 more than the previous year.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	**Estimated Reached**
Female	103,219	94,730
Male	95,279	87,443
Total individuals (Female and male)	198,498	182,173
Of total, children under 5	33,745	30,969

The original proposal stipulated that approximately US$1 million would cover the associated costs of 8,000 MT of grain contributed from the Government of Zimbabwe. This is the volume calculated by WFP at the time of the CERF contribution confirmation when it was foreseen that WFP could provide the logistical support as a special operation, not on the basis of Full Cost Recovery. Eventually, by the time the Government of Zimbabwe in-kind contribution was formally registered in the WFP system, the principle of Full Cost Recovery applied which means that the budgeted associated costs from CERF needed to include all standard WFP budget lines (for example, Direct Support Costs, Indirect Support Costs, and Other Direct Operating Costs). This meant that 5,747 MT of Government grain could be covered using the CERF funds. Only 92% of the planned beneficiaries were reached because of the lower MT distributed.

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

YES ☒ PARTIALLY ☐ NO ☐

Despite being confirmed well into the implementation of the STA programme, the CERF contribution was one of the first to be received in WFP account that helped roll out the assistance in a timely manner and avoid ration cuts.

b) Did CERF funds help respond to time critical needs[3]?

YES ☒ PARTIALLY ☐ NO ☐

The CERF funds contributed to avoiding future ration cuts.

c) Did CERF funds help improve resource mobilization from other sources?

YES ☒ PARTIALLY ☐ NO ☐

During the monthly Food Assistance Working Group meetings, confirmed contributions were announced. Donors took note of where funds were coming from, and said they were glad that several sources had been approached and various funds granted.

d) Did CERF improve coordination amongst the humanitarian community?

YES ☐ PARTIALLY ☒ NO ☐

Strong humanitarian coordination is already in place in Zimbabwe, so there is little that any partner or funding could improve.

V. V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT

Lessons Learned	Suggestion for Follow-Up/Improvement	Responsible Entity
Timely review and submission of application at the country level. The WFP application was delayed due to a requirement for the Humanitarian Coordinator to ensure that only one application per crisis was submitted. FAO was slow in processing their part of the application and ultimately dropped the request when they raised almost 80% of the funds required as CERF request while being reviewed. This resulted in further revision of the submitted application and further delays.	Clearer guidance from OCHAHQ on joint submissions. If a joint proposal is being submitted, but one agency is delaying the process, then a decision should be made to submit the proposals separately. This would avoid delaying proposal submission, and consequently delaying contribution confirmation.	OCHAHQ
Timely release of funds enables partners to run a credible intervention.	WFP CO was impressed by swift release of funds once the grant was confirmed. Monies reached WFP account before other resources that had been confirmed some weeks prior to WFP signing LOU with CERF.	CERF

[3] *Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns; locust* control)

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons Learned	**Suggestion for Follow-Up/Improvement**	**Responsible Entity**
More timely confirmations of contributions by all donors and funding sources.	In 2012, it was the first time that Government grain was allocated for humanitarian assistance. This was a unique arrangement, and donors were reluctant to confirm contributions. Looking ahead, it is hoped that donors are more comfortable with the arrangement and can find ways to speed up internal processes and decision making.	All stakeholders
Government dedicating more time to planning.	As the arrangement with the Government was unique and a first time experience, there were delays in implementation. In future, sufficient time needs to be allocated to proper planning.	Government

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF Project Information			
1. Agency:	**World Food Programme**	5. CERF Grant Period:	01/11/12 – 01/05/2013
2. CERF project code:	12-WFP-076	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Food		☒ Concluded
4. Project Title:	Assistance to Food-Insecure Vulnerable Groups		
7.Funding	*a. Total project budget:*		US$ 78,900,000
	b. Total funding received for the project:		US$ 72,400,000
	c. Amount received from CERF:		US$ 2,006,293

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	103, 219	94,730	Please see no.11 below.
b. Male	95, 279	87,443	
c. Total individuals (female + male):	198, 498	182,173	
d. Of total, children under 5	33, 745	30,969	

9. Original project objective from approved CERF proposal

To protect lives and livelihoods, and enhance self-reliance in vulnerable households affected by this year's drought and consequential seasonal food shortages.

10. Original expected outcomes from approved CERF proposal

The expected outcome is improved food consumption over the assistance period for targeted emergency-affected populations. The SMART indicators are as follows:

- Household food consumption score:
  - Target: Food consumption score exceeds 35 (a score of 35 or more indicates acceptable food consumption)
- Number of women, men, girls and boys receiving food and non-food items, by category and as % of planned:
  - Target: 100%
- Tonnage of food distributed, by type, as % of planned
  - Target: 100%

11. Actual outcomes achieved with CERF funds

- Food Consumption Score: 82%. The food consumption score exceeded the threshold of 35 for 82% of assisted households.
- Number of women, men, girls and boys receiving food and non-food items, by category and as % of planned: 92% %
- Tonnage of food distributed, by type, as % of planned: 72%

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

The original proposal stipulated that approximately US$1 million would cover the associated costs of 8,000 MT of grain contributed from the Government of Zimbabwe. This is the volume calculated by WFP at the time of the CERF contribution confirmation when it was foreseen that WFP could provide the logistical support as a special operation, not on the basis of Full Cost Recovery. Eventually, by the time the Government of Zimbabwe in-kind contribution was formally registered in the WFP system, the principle of Full Cost Recovery applied which means that the budgeted associated costs from CERF needed to include all standard WFP budget lines (for example, Direct Support Costs, Indirect Support Costs, and Other Direct Operating Costs). This meant that 5,747 MT of Government grain could be covered using the CERF funds. Only 92% of the planned beneficiaries were reached because of the lower MT distributed.

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 1

If 'NO' (or if GM score is 1 or 0): WFP active promoted the already established and accepted practice of women's participation in activity management. Measures were in place to ensure that at least 50% of the community participants were women. Experience in programming in Zimbabwe has shown that women are the food and cash entitlement holders for up to 80% of food and cash distributions to households. Food/cash distribution committees were established in a way that at least 50% of decision making positions were held by women.

14. M&E: Has this project been evaluated?	YES ☐ NO ☒

WFP undertook a vulnerability characteristic using 13 variables. The survey collected two indicators for food security; Food Consumption Score (FCS) and Coping Strategies Index (CSI). The ***Coping Strategies Index*** (CSI) measures the ***frequency*** and ***severity*** of actions taken by households in response to the presence or threat of shortfalls in food supply. An increase in the CSI indicates worsening food security. A lower score implies reduced stress on the household and thus, implying better food security.

The mean CSI score of 5 for the beneficiary households was significantly lower than that of non-beneficiary households at 7. This shows the positive impact of food assistance in reducing stress on households with regards to food access. The mean CSI for beneficiaries during the review month was the same as December 2012.

Comparing beneficiaries across the programme activities STA food only group had the highest mean CSI of 6.4 while household's under the Health and Nutrition programme had the lowest mean CSI of 3.2.

Please see attached report.

PART 2: CERF EMERGENCY RESPONSE – MULTIPLE EMERGENCIES (UNDERFUNDED ROUND II 2011)

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response:		***479,000,000***
Breakdown of total response funding received by source	Source	Amount
	CERF	6,021,312
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	0
	OTHER (Bilateral/Multilateral)	$216,000,000 CAP 2011 funding)
	TOTAL	

TABLE 2: CERF EMERGENCY FUNDING BY AGENCY (US$)			
Allocation 1 – Date of Official Submission: 19 August 2011			
Agency	**Project Code**	**Sector**	**Amount**
FAO	11-FAO-035	Agriculture	361,638
WHO	11-WHO-051	Health	747,618
IOM	11-IOM-036	Health-Nutrition	666,996
IOM	11-IOM-035	Agriculture	600,000
IOM	11-IOM-034	Multi-Sector	500,002
UNICEF	11-CEF-047	Water and Sanitation	1,399,999
IOM	11-IOM-033	Multi-Sector	500,532
WFP	11-WFP-053	Food	400,000
UNHCR	11-HCR-042	Multi-Sector	497,550
UNFPA	11-FPA-040	Protection/ Multi-Sector	346,977
Sub-total CERF Allocation			6,021,312
TOTAL			**6,021,312**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of Implementation Modality	**Amount**
Direct UN agencies/IOM implementation	2,650,474
Funds forwarded to NGOs for implementation	3,370,838
Funds forwarded to government partners	0
TOTAL	6,021,312

In 2011 the Zimbabwe CAP remained underfunded most of the year giving rise to two allocations through the CERF Under Funded window allocations. The second allocation sought to meet emergency needs in key sectors such as: food security; addressing the needs of asylum seekers, migrants and other vulnerable groups that needed protection; prevention of and rapid response to disease outbreaks; and response to natural disasters.

Food security was compromised following a protracted dry spell during the agricultural season which affected six of the country's 10 provinces from February to March 2011. The worst affected regions included Gwanda, Bulilima districts (Matabeleland South) and Matobo and Hwange (Matabeleland North) districts. The drought destroyed agro-ecological livelihoods and resulted in humanitarian needs for populations unable to recover from the overall negative effects of the continued socio-economic challenges faced in the country. Regarding nutrition status, national rates of chronic and acute childhood malnutrition stood at 35 per cent and 2.4 per cent respectively. Despite improvements in food security up to 2010, Zimbabwe continued to face a substantial national cereal deficit. Based on estimates of acute malnutrition in 2010 (2.4% Global Acute Malnutrition), with 0.6 per cent severe acute malnutrition (SAM), it was estimated that over 65,000 children under the age of 5 years suffered acute malnutrition of which about 16,000 have SAM and the rest about 49,000 moderate acute malnutrition (MAM). Delivery of life saving care for acute malnutrition was prioritized during the first and second round of UFE 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. Humanitarian partners planned interventions on the basis of the fact that a sudden deterioration in the food security or health situation 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.

Another key area of intervention was offering adequate humanitarian assistance to increased numbers of Zimbabweans being deported from South Africa from 1 August 2011 for not regularizing their stay in that country. The numbers of people requiring Protection assistance in the country were anticipated to rise to approximately 15,000 per month or more following a decision by South Africa to discontinue accepting asylum applications from third country nationals who transited through Zimbabwe unless they had identity documents. Zimbabwe is a transit and destination country for refugees, asylum seekers and migrants (as well as trafficked persons), primarily fleeing conflicts, human rights abuses and serious economic challenges from places such as Burundi, the Democratic Republic of Congo, Somalia and Ethiopia

Further, the deterioration of Zimbabwe's health and WASH infrastructure, contributed to continued disease outbreaks. A cholera outbreak that had started in September 2010 spilled into 2011 and continued to pose a challenge despite concerted efforts by all partners. The sporadic cholera outbreaks were an indication of the compromised state of water, sanitation and hygiene services. The Ministry of Health and Child Welfare (MoHCW) and the World Health Organisation (WHO) reported that ..."from week 1 to week 25 of 2011, ten (10) out of the 62 districts, namely: Bikita, Buhera, Chimanimani, Chegutu, Chipinge, Chiredzi, Kadoma, Murewa, Mutare and Mutasa, reported cholera cases". A total of 1,140 cholera cases and 45 deaths were reported by 17th July 2011, giving a crude case fatality rate of 4.0 per cent, much above the WHO threshold of 1 per cent. The majority of cases 870 (76%) were reported from Manicaland province where 697 (80 %) of the cases were reported from Chipinge. The last cholera cases reported were from Chiredzi district in week 25 of 2011.

II. FOCUS AREAS AND PRIORITIZATION

An agriculture intervention by FAO was designed as a livelihoods support programme for drought affected food insecure households in Matabeleland South Province (Matobo, Umzingwane, Mangwe districts). According to the ZimVac 2011 rural assessment report, Matabeleland South was one of the provinces estimated to have the highest proportion of food insecure people in the 2011/2012

consumption year (16% of the people in Matabeleland South were estimated to be food insecure during the lean season from January to March 2012). The Second Round Crop Assessment carried out in April 2011 indicated widespread crop failure. This combined with the increasing levels of vulnerability and impoverishment jeopardized the food security situation of many families. The intervention by FAO aimed to improve nutrition and strengthen the dietary diversity and communal resilience capacity through the cultivation of a variety of crops and small stock production. Diversification of the diet was especially important because of increased stunting levels being reported in the country. The Zimbabwe national nutrition survey conducted in 2010 showed a national stunting level of 33.8 per cent among children aged 6 – 59 months. The same survey also indicated that less than 10 per cent of children aged 6 – 24 months were consuming the recommended minimum acceptable diet for their age.

A second agriculture intervention by IOM targeted the most vulnerable households by livelihoods and food security in drought affected districts through interventions such as spot repair of water points and the provision of livestock and drought resistant crops. The selected districts of Gwanda and Bulilima (Matabeleland South) and Hwange and Matopo (Matabeleland North) had been severely affected by the severe drought because a majority of the vulnerable communities in these areas largely depend on livestock and crops. CERF funding enabled the Cluster partners to provide immediate and life-saving responses to the affected areas in a timely manner. The communities identified sustainable and time sensitive interventions including borehole drilling and rehabilitation to support their gardens and livestock activities to address the challenges that had been brought about by the drought. Given that these areas are drought prone, any sustainable interventions required reliable water supplies for their gardens, animals and also for household consumption. The CERF funds were utilized to respond to emergency needs of those districts that are not covered under any other governmental and non-governmental humanitarian initiatives.

A Health-Nutrition support project by IOM for the treatment of malnutrition was selected as part of Zimbabwe's efforts of scaling up CMAM services nationwide. In Matabeleland, 6 out of 14 districts offer services, leaving critical gaps in coverage in vulnerable districts. Matabeland South Province has over the years experienced repeated droughts and food shortage resulting in children being prone to disease and/or malnutrition. This project aimed to pre-position access to this life saving service within reach of these drought affected communities who are at heightened vulnerability due to the food insecure environment. Based on the prevalence of SAM and MAM established during the 2010 Zimbabwe National Nutrition Survey, within a population of 689,719 people in the 7 targeted districts (*Hwange, Matobo, Tsholotsho, Bubi, Nkayi, Beitbridge and Umguza*) in Matabeleland North and South Provinces, an estimated 1,076 children with SAM and 3,228 with MAM will be reached during the life span of this project.

On the choice of interventions by WHO, Chipinge and Chimanimani Districts in Manicaland Province and Chiredzi District in Masvingo Province were selected for the intervention because of continued reports of cholera outbreaks on an annual basis. The areas also suffered an unacceptably high case fatality rate of more than 1 per cent. The three districts had the lowest number of health staff trained in IDSR, and community surveillance was not being implemented as Village Health Workers were not trained, and EHTs had no transport. This situation led to the high morbidity and mortality rates. Emergency stocks were in short supply; hence response to the outbreaks was compromised.

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WASH interventions were selected to partially overlap with health interventions in Chipinge and Chiredzi districts where cholera was prevalent at the time of this allocation as well as two bordering districts of Buhera and Bikita. The risk of cholera spreading from the former two districts to the latter two was therefore high because of high population mobility in the four districts and influx of people into the area for diamond mining in Chipinge district. The *Save* Valley, which covers parts of the four districts, was both flood and drought prone. Vulnerability in the area was high, and livelihoods and health status precarious. Poor hygiene and sanitation practices, which were in some areas also linked to traditional beliefs, were putting these populations at risk of cholera transmission. In Chipinge, some district authorities noted the direct correlation of areas of low water coverage, saline water points and cholera as a result of people drawing and drinking raw water from the *Save* River. Thus community-centred and gender-sensitive water supply and hygiene promotion interventions would have a major impact on preventing further morbidity and mortality from cholera and other WASH related diseases in the high risk areas and would help build resilience to The CERF project was implemented in two districts of Manicaland Province *(Buhera and Chipinge);* and two districts of Masvingo Province *(Bikita and Chiredzi)* which were among the hardest hit by the recent cholera outbreak and were always at risk of cholera.

Zimbabwe is a transit and destination country for refugees, asylum seekers and migrants (as well as trafficked persons), primarily fleeing conflicts, human rights abuses and serious economic challenges from places such as Burundi, the Democratic Republic of Congo, Somalia and Ethiopia. As of 1 August, IOM initiated the biometric registration of refugees and asylum seekers arriving at the centre and the system will provide more accurate figures. Despite the GoZ directive for not allowing third country nationals to transit through Zimbabwe, there is still a high influx of migrants - mainly Somalis and Ethiopian - through illegal crossing points at the border between Mozambique and Zimbabwe.

On internal displacement, a project implemented by IOM aimed to respond quickly to the displacements that continued countrywide even though significant numbers were recorded in Midlands, Mashonaland Central and Mashonaland West. The project noted that there has

been a continual increase in displacements and evictions compared to the previous 2009-2010 period. The displaced communities were in need of shelter, water and health facilities among others due to their residence in an illegal settlement.

The other intervention undertaken by UNHCR focused on core emergency life-saving humanitarian activities for Asylum seekers and refugees made vulnerable through migration flows into Zimbabwe. Priority was given to their legal, physical material protection and humanitarian assistance. They received legal, physical and psychological protection as well as food, shelter, health and NFIs.

UNFPA collaborated with UNICEF and IOM on a project increasing GBV survivor's access to holistic response services by providing one-stop referral, support, and response centres. As per the joint UNFPA/UNICEF/IOM GBV Assessment report, these centres were located in Makoni, Mudzi, and Mberengwa which had been identified as having the most significant gaps in service provision and access to care for GBV survivors.

Regarding food intervention, WFP prioritised critical food needs of an estimated 369,000 vulnerable people in 21 districts 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 through the PRRO 200162. Prior to receiving the grant, WFP had to reduce the rations of these households by more than half, Due to limited donor funding. Such ration cuts have 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.

Overall, most of the interventions funded through the second allocation of CERF funds were designed to be complementary with a view to supporting emergency interventions in this vulnerable region. To maximize on synergies, sectors sought to concentrate efforts in the same geographic areas in order to achieve greater impact.

III. CERF PROCESS

With guidance from the Humanitarian Country Team and OCHA, the Inter Cluster Forum met after the announcement of the availability of CERF funds. The ICF reviewed the funding gaps as reflected in the CAP for 2011 and identified the geographical areas of intervention. Recent assessment results and information from government stakeholders and partners operating on the ground were also used to prioritise interventions. A CERF time line was agreed on at a special ICF meeting called to discuss distribution of the grant with all cluster leads and the information shared with the HCT. The HCT endorsed the grant allocation to agencies and identification of the areas of intervention.

As all eight clusters were active in the country, the cluster leads made announcements of the grants at all monthly cluster meetings and partners were invited to become partners in the implementation of the projects. In addition to this, IOM carried out community and stakeholder sensitization meetings during the process of selection of projects to be funded under agriculture. In addition to the cluster meetings in Harare, IOM and UNHCR worked in close collaboration with the Mudzi District local authorities to identify the urgent needs that would benefit from the grant as the needs were greater than the allocated amounts. In the case of WASH, a further quick assessment was conducted in order to identify the areas which would benefit most from the grant. This assessment was coordinated between WASH and Education cluster members and focused on institutions in high cholera attack rates 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 consideration for funding. Implementing partners were selected on the basis of 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). There was strong involvement with local authorities such as the Provincial and District Ministry of Health Authorities, Environmental Health Technicians (EHTs) and the District Water and Sanitation Sub-Committees (DWSSC). Members of the MoESAC, MoHCW and the District Development Fund (DDF) were involved in the assessment of the institutions, supervision of works, and involved in training the committees for operation and maintenance. Harmonization of works at institutions was achieved through collaboration between the WASH Cluster's clinic technical working group as well as the Education Cluster's technical working group on school WASH.

Overall, gender component was put into consideration while developing the interventions because the country had a resident Gender Advisor at the time of the grant who reviewed the projects ability to meet the different needs of women (especially women headed households), men and children.

Agencies developed the projects and OCHA assisted to compile the *chapeau* which was submitted by the Humanitarian Coordinator to the CERF Secretariat. The CERF Secretariat reviewed and advised individual agencies on changes required in their application after which funds were disbursed to individual agencies.

IV. CERF RESULTS AND ADDED VALUE

Table 4: Affected Individuals and Reached Direct Beneficiaries by Sector				
Total number of individuals affected by the crisis:				
The estimated total number of individuals directly supported through CERF funding by cluster/sector	**Cluster/Sector**	**Female**	**Male**	**Total**
	Agriculture	4,100	2,035	6,135
	Health	360,059	332,363	692,422
	Health-Nutrition	91,019	443	91,462
	Multi-Sector	5,831	13,544	19,375
	Water and Sanitation	133,314	99,790	233,104
	Food	4,693	4,332	9,025

In WASH, the intervention surpassed the targeted population owing to the following reasons; some hygiene promotion activities covered some community members outside the targeted beneficiary areas when the project implementers took advantage of impromptu gatherings (e.g. community meetings, food-for-work gatherings, etc) and held hygiene sessions. Hygiene Club approach increased contact with beneficiaries. Also, in most cases, the facilities provided for schools, e.g. boreholes ended up serving both the targeted schools and surrounding communities. The selection process for participating districts was facilitated by the WASH Cluster's Strategic Advisory Group (SAG). The following information was utilized to arrive at an estimate of the targeted population at risk of cholera: WHO/MoHCW Epidemiological Updates which indicated, through a historical analysis, the communities (wards) within the district that were susceptible to cholera; census estimates were then used to project the populations in these areas. MoESAC data on schools and enrolment facilitated an estimation of number of school children to be reached in the target area.

The beneficiary figures for asylum and third country national were based on the number of migrants assisted at IOM's Nyamapanda Reception and Support Centre. All migrants arriving at the border were registered and were provided with assistance and the majority being from the Great Lakes region and Horn Africa. No major challenges were encountered and the figure of expected caseloads is based on average monthly arrivals at the centre. With regards to cases of new displacement, the beneficiary figures were based on the actual number of households that were provided with IOM emergency humanitarian assistance following their displacement and IOM and partners had access to all the targeted caseloads.

On Food, WFP used absolute numbers of beneficiaries receiving CSB procured through the CERF grant. This number was obtained through output reports and food distribution reports prepared by partners and consolidated by WFP while for the nutrition activities, the number of beneficiaries who were reached by Village Health workers during community mobilization activities were not well captured and reported on. This resulted in the discrepancy between planned and reached figures. The majority of beneficiaries who were reached with nutrition education and group counselling were reached through community mobilization activities.

For Agriculture intervention, the number of beneficiaries was determined by the availability of small livestock and available resources. The programme could not go beyond these numbers as the team anticipated supply problems of small stock. As a result of limited water supply to sustain gardening activities in some wards the target reached with a 3% deficit. The programme targeted more women than men because traditionally women are responsible for rearing small stock and vegetable production.

This was the criteria used for selection of beneficiaries for livelihoods (agriculture) support.

- households affected by loss of harvest, livestock and other livelihood assets.
- Good access to water
- households with sufficient labour to cultivate a household garden
- households with capacity to keep small livestock
- priority to households with handicapped, chronically ill or disabled members;
- priority to households with orphaned children
- priority to elderly and child-headed households (household head above the age of 60 or below 16)
- priority to single woman headed households

For protection, UNHCR and its implementing partners have a data base of all asylum seekers that were profiled, registered, assisted with shelter materials and screened for medical reasons. The data base also has a record of all asylum seekers and refugees that received food on a monthly basis during the reporting period. All the records were extracted from the data base. In addition, asylum seekers and refugees that were assisted with transportation from Beit bridge, Mutare and Harare to Tongogara refugee camp have their records entered in the data base that UNHCR has. The data base was therefore the source of information that was inputted in the report.

Under a GBV project by UNFPA, the dignity of many women who visited Musasa Centre was restored and many women took legal action or obtained protection orders against the perpetrators of violence against them. With CERF funding, Standard Operating Procedures were developed through a participatory process involving government and other stakeholders. In addition to this, traditional leaders were informed about international and regional treaties that Zimbabwe is signatory to and the country's obligation to ensure that the rights enshrined therein were observed. Part of the training facilitated examination of cultural practices that perpetuate Gender Based Violence.

Table 5: Planned and Reached Direct Beneficiaries through CERF Funding

	Planned	Estimated Reached
Female	838,148	606,984
Male	765,847	456,619
Total individuals (Female and male)	1,603,995	1,063,603
Of total, children under 5	234,643	257,521

Through the WASH CERF funded intervention, 44 boreholes were drilled and 92 boreholes were rehabilitated at schools, clinics and in the community in four (4) cholera affected districts (Bikita, Buhera, Chipinge and Chiredzi). Nine piped water schemes were rehabilitated at 3 schools and 6 clinics in Buhera and Chipinge. 566 latrines and 90 hand-washing facilities were constructed and 210 latrines rehabilitated (at 60 schools and 21 clinics) in the 4 districts. 175 one-bag version household latrines (uBVIPs) constructed in Chipinge district with the 1-bag subsidy provided through the project. Safe and adequate water supply was ensured for 133,314 women and girls as well as 99,790 men and boys. In total, 81 institutions (60 schools and 21 clinics) and their communities were reached with WASH facilities and hygiene promotion messages, benefiting some 233,104 people (57.2 per cent of who were women and girls; and 48,053 under-fives). Among the beneficiaries were over 5,000 men, women and children within the catchment areas of the beneficiary clinics. The table below suggests that the CERF intervention contributed to the reduction in cholera morbidity and mortality in the beneficiary districts.

Reported cholera cases and deaths.

Agriculture intervention by FAO reached 97 percent of the planned individuals. The number was reduced because some of the targeted wards in Mangwe had limited water points to sustain gardening activities.

Health interventions assisted to bring cholera under control in the affected districts. Case fatality rate was reduced from 4 per cent to zero between November 2011 and June 20112 in affected areas in Chipinge and Chiredzi districts. 100 per cent of targeted health staff were trained in case management in both districts. All health facilities (100 per cent) were well stocked with emergency medical and other supplies and 100 per cent health staff was trained in surveillance (Rapid Response Teams) in Chiredzi, Chimanimani and Chipinge districts. More than 200 per cent of targeted community health workers were trained in basic cholera management skills in Chiredzi and Chipinge districts by June, 2012. Women were the majority of people providing care to the affected members of the family, and special consideration was focussed on them when training VHWs. Pregnant women, children, the elderly and the immune-compromised were considered vulnerable groups.

For the Multisector project in Nyamapanda, the decline in the number of TCNs (especially from Somalia) assisted at the Nyamapanda Reception Centre was attributed to the increased refugee camps in Eastern and Southern Ethiopia , especially Dollo Ado Region between 2011 and 2012. The decline to TCNs seeking assistance in Zimbabwe could be further attributed to its geographical location. Tanzania, bordering eight other countries within Eastern and Southern Africa receives a bulk of immigrants various to, from and through its territory. Due to its political stability it has also been hosting a large refugee population from neighbouring countries. Positive political

developments within the region over the last two years, and the ongoing resettlement programmes for Refugees to the United States and other European countries, has seen more out-processing of the TCNs from Tanzania reducing the inflows to Zimbabwe and ultimately South Africa. Nevertheless, the reduced caseload did not result in reduced costs of operations at the Reception centre, which was granted full status by the GoZ through a Mixed Migratory Flows Forum meeting in March 2012. The lack of competitiveness in service provision like transport and catering occasioned an increase in operational costs for the project although it has managed to address the humanitarian needs of the arriving TCNs.

For the IDP project, it had been projected that the emergency response would assist at least 1000 newly displaced households consisting of approximately 5000 individuals and the Bulawayo Hyde park relocation had initially targeted 300 households consisting of 1,500 individuals hence the combined target of 6,500 beneficiaries. However IOM reached a total of 1,038 households with emergency humanitarian NFI assistance following their displacement giving a total number of people reached under this objective to 6,747 against a target of 5000. The Hyde Park housing project reached a total of 197 households, giving a total of 1,125 individual beneficiaries against an initial target of 300 households and 1,500 individual beneficiaries. The total number of beneficiaries under objective 1 and objective 2 is therefore 7, 929 individuals. The reduction in the number beneficiary households in the Bulawayo Hyde park IDP relocation project was as a result of the reduced land size that was made available for IDP relocation by the Bulawayo city authorities. The average family sizes for beneficiaries assisted in objective 1 and objective 2 was 6, against a planning average family size of 5.

Through the project implemented by UNHCR, 5400 asylum seekers were profiled and registered. 1065 asylum seekers went through the status determination committee and were also assisted with legal and physical protection. The status determinations committee held 8 sessions during the reporting period. In addition, 3000 asylum seekers received monthly food rations and NFIs during the reporting period. 505 asylum seekers and refugees were transported from border posts in Mutare, Beitbridge and Harare. Asylum seekers and refugees had access to health delivery system at Tongogara Refugee camp and other referral hospitals across the country. A training session jointly facilitated by UNHCR and IOM on status determination was held with government officials.

With CERF Funds, UNFPA set up three one stop centres catering for survivors of Gender Based Violence. The project met its set objectives and the equipment procured for the intervention, such as computers and other hospital tool used for investigating GBV cases continue to be used by the police and hospitals in order to provide information to the Magistrate Courts prosecuting GBV cases in Mudzi, Makoni and Mberengwa. Stakeholders in these areas formed a GBV coordination forum that meets four times a year to coordinate and analyze GBV cases and activities in the target areas.

During implementation of the project, GBV survivors reported to have faced transport problems to access the services because rural areas surrounding the one stop centres are hard to reach and do not have adequate public transport system. Some of survivors failed to raise enough money for bus fares. Even the Zimbabwe Republic Police is also facing transport problems to help the survivors to access the services.

A Nutrition intervention by IOM recorded a significant discrepancy between the targeted population and those provided with assistance because of under-reporting by the implementing partners which unfortunately was not identified as a weakness during the life of the project. In general, the reported reached number of beneficiaries was far below the planned figures. The figures provided through the MOHCW monitoring tools only related to the number of beneficiaries who were admitted into the CMAM program and their families who benefited from the health and nutrition education and counselling provided to the family care-giver. The figures reported as reached (92,462) were therefore lower than the planned (689,719) because the volunteers failed to report the number of beneficiaries that were reached through mass nutrition education and group counselling activities. Volunteers only reported children they referred to the health facilities after identifying them to be malnourished and failed to adequately report those whom they reached with nutrition education as well as those whom they screened and found to be well-nourished. 1,503 children were admitted into the program during the intervention period against an expected caseload of 1,440 (70 per cent of the total number of children had acute malnutrition) i.e. approximately 100 per cent of the expected caseload was reached; it is reasonable therefore to assume that active case finding by volunteers was done exceptionally well though gross under-reporting occurred with regards to clients who were not identified as malnourished. Figures that were captured for males were mainly from the male health workers and CMAM volunteers (443) who were trained on CMAM; however the figures of males reached through outreached activities were not well captured, hence not reported.

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

YES ☒ PARTIALLY ☐ NO ☐

The majority of the clusters noted that 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 the relevant stakeholders to respond to the needs of these households in a timely manner.

Had it not been for this funding, there was no immediate alternative source of funding to support WASH facilities and services provided under CERF. In all the four (4) districts, the CERF funds helped to facilitate the construction and completion of critical WASH facilities

faster than if the communities were mobilising resources on their own and hence promoted the prevention of water-borne diseases. Awareness of disease causation and etiology was raised among the beneficiaries. In Chipinge, the innovative adoption and promotion of low cost (1-bag version uBVIP latrines) led to swift delivery of assistance to beneficiaries in the project area, resulting in individual households constructing 175 uBVIPs for themselves.

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b) Did CERF funds help respond to time critical needs[4]?

YES ☒ PARTIALLY ☐ NO ☐

WASH: The CERF project started just before the peak of the cholera 'season' (October to December 2011) and project implementation continued during the remainder of the cholera-risk period ensuring that needs were addressed at the most critical time. The CERF contribution to cholera prevention/mitigation suggests that the intervention addressed in a timely manner critical WASH needs for the beneficiary institutions and communities.

Agriculture: Following the identification of the areas and prioritization of the needs based on needs assessment and information from government stakeholders and partners operating on the ground, CERF responded to the identified needs in a timely manner. As the 2012 rainfall season was below normal rainfall in the targeted areas, these timely interventions helped in supporting food insecure households as well in availing water for both domestic and productive use.

Protection: The humanitarian situation for asylum seekers and migrants at Nyamapanda border post has been improving through CERF funding as all arrived beneficiaries that needed humanitarian assistance at the border post are direct to the Temporary Reception Centre and provided food (cooked mails), medical attention, shelter to rest, clean water and sanitation facilities, NFIs and transportation to Tongogara Refugee Camp to seek and process their asylum in Zimbabwe. The total number assisted reflects the weight of the CERF funds to address critical needs. Medical assessments for the TCNs were found to be very critical. Previously, migrants had been affected by diseases such as malaria, fatigue and lack of basic sanitation. UNHCR noted that CERF funding was instrumental in addressing the urgent and life-saving underfunded needs that was critical for people fleeing from conflict zones who needed a safe place and psychological counselling from the trauma experience back home and during flight.

Multi-sector (targeting IDPs): The project was able to reach all the target newly displaced households and provided the much needed urgent humanitarian assistance.

Health: Nutrition noted that the short lead time in disbursement of funds responded adequately to the emergency situations where timely response to acute malnutrition was critical.

c) **Did CERF funds help improve resource mobilization from other sources?**

YES ☒ PARTIALLY ☐ NO ☐

Following up on the last reporting period, information from the partners showed that they managed to engage other donors to build on the CERF funded projects. The Swedish Cooperative Centre (Agriculture) sourced for other funds to expand on the gardens project and support the increased access to markets for the garden produce. CARE and WVI secured complementary funding from other donors to address/improve WASH needs. In Chiredzi, the community mobilised some funds, for example to hire labour for the excavation of pits especially in areas where hard rock morphology demanded specialised labour and tools. (Hard rock surfaces were encountered at 5 schools). All this complementary funding was secured courtesy of the availability and momentum created by CERF funding. Regarding the Health-Nutrition intervention, the planning process for utilization of CERF funds served as a platform for dialogue with Spain, which ultimately led to their CMAM funding of about $1.2 million. In Protection, resource mobilization in support of the humanitarian operations at the reception centre continued and other donors including SIDA, CIDA and Japan provided an input into the running of the centre. However, in some instances, no other funding was forthcoming for the period covered by this grant

d) Did CERF improve coordination amongst the humanitarian community?

YES ☒ PARTIALLY ☐ NO ☐

Interventions undertaken using funds from the CERF contributed to increased coordination as the selection of areas and the identification of partners for the project brought a number of stakeholders together. There are partners implementing similar projects that

[4] Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns; locust control)

reported on progress in the monthly LICI, WASH, Protection and Agriculture meetings as well some coordination platforms such as the Matabeleland NGO forum.

The process fostered collaboration between Implementing Partners (IPs) and WASH stakeholders, e.g. WASH and Education Clusters, MoESAC, MoHCW, among others. By the same vein, Implementing Partners (IPs) went through a rigorous selection process of the beneficiary institutions and communities, in liaison with DWSSCs (multi-sectoral committees) and community leaders/structures. UNICEF coordinated several meetings concerning the CERF project where information was shared coupled with CERF establishment as a standing agenda item for the WASH cluster. The IPs, as members of the National WASH Cluster, shared relevant information on CERF activities at the monthly cluster meetings. The IPs (both CARE and WVI) reported that coordination was improved through a series of meetings conducted with the DWSSC, learning visits to other districts and provinces, periodic reports and verification field visits and facilitation of participatory monitoring visits conducted with full representation of Government line ministries. Regular (monthly) meetings with district council representatives and other NGOs prevented duplication of activities

Under Protection it was observed that the District Administration and other local stakeholders, from whom the original request to set up the centre originated, continued to support operations of the centre. This led to the centre being a hub for coordination with various humanitarian partners such as UNHCR, MSF and other IOM missions to get a better understanding of migratory flows and formulation of better responses. UNHCR closely coordinated with other UN agencies such as OCHA and IOM in the programming and resource allocation for targeted beneficiaries Cooperation and support was also sought from the Government through the Immigration Department, Department of Social Services and Home Affairs in ensuring protection and assistance to the People of Concern. Our Implementing partners Department of Social Services and Christian Care also played a critical role in the coordinated efforts benefiting the People of Concern

With regard to scaling up of CMAM activities, it was noted that the funding greatly improved coordination among the humanitarian community. 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 catalyse the cluster's CMAM Working Group, which continues to meet regularly to address common implementation concerns and challenges

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT

Lessons Learned	Suggestion For Follow-Up/Improvement	Responsible Entity
To realise the impact of livestock related intervention, the project cycle must be at least a year.	Future small stock project must extend beyond a year.	OCHA
Women are most experienced in rearing livestock.	Future projects should continue targeting Women.	FAO /Donor
Use of mobile phones for beneficiary registration seems to be effective.	Extend the use of mobile phones/Nokia Data Gathering in future projects.	FAO/WV

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS

Lessons Learned	Suggestion For Follow-Up/Improvement	Responsible Entity
There are significant and recurring food insecurity needs in these drought prone areas.	There is a continued need for the country team to consistently monitor the situation and respond to the needs in drought affected districts.	UN Country Team

There is need for facilitating community-led process and stakeholder coordination to ensure community ownership of the project.	Implementing partners need to sensitize local authorities and target authorities on community-led planning, implementation and follow-up mechanism.	IOM, WFP, WHO, UNICEF
High HIV positivity rates among children with severe acute malnutrition indicate a great need for integration of paediatric ART, PMTCT and CMAM programmes.	Scale up integrated programmes to ensure that screening of malnutrition is done in Paediatric ART programmes and that HIV screening is done routinely in CMAM programme and that referral pathways are established. Incorporate this aspect in respective training programmes.	IOM
Extensive support and supervision of CMAM in the health centres and home visits have improved program delivery to the population. and expectations.	It is essential to provide a budget for extensive support and supervision and home visits for this community-based programme. Frequent review meetings and non-monetary incentives will go a long way in ensuring that community volunteers maintain their momentum and programme execution.	IOM
The availability of IT equipment improved reporting.	It is essential to take advantage of the information technology to facilitate easier and timely reporting.	WASH cluster, IPs
Mixed migratory flows are unpredictable and capricious in nature. The need for uniformity in the countries along the path of migration in relation to medical service could be enhance.	Regional approach to mixed migratory flows and a follow up to the Dar es Salaam conference.	Humanitarian Actors at Regional level, GoZ

PROJECT RESULTS

TABLE 8: PROJECT RESULTS- FAO-035			
CERF Project Information			
1. Agency:	**FAO**	5. CERF Grant Period:	**27.09.2011 – 30.06.2012**
2. CERF project code:	11-FAO-035	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Agriculture		☒ Concluded
4. Project Title:	Improved dietary diversity for drought affected households through livestock production and gardening		
7.Funding	*a. Total project budget:*	US$ 80,603,794 (Agriculture cluster requirements)	
	b. Total funding received for the project:	US$ 46,353,219 (Agriculture cluster funding)	
	c. Amount received from CERF:	US$ 361,638	

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	10,028	9,719	
b. Male	9,256	8,972	
c. Total individuals (female + male):	19,284	18,690	
d. Of total, children under 5			Children were indirect beneficiaries of the project

9. Original project objective from approved CERF proposal

- 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 Matebeleland South by June 2012.
- 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.
- Improve small stock production and garden outcome through farmer training.

10. Original expected outcomes from approved CERF proposal

- Improved dietary diversity for beneficiary households within 6 months.
- 3,214 households will receive small stock of which 1,607 will receive guinea fowl and 1,607 will receive rabbits within 6 months.
- 3,214 households will receive gardening inputs within 6 months.

11. Actual outcomes achieved with CERF funds

- 3,115 households engaged in vegetable and small stock production. This partially improved dietary diversification.
- 3,115 households received small stock (indigenous chickens, guinea fowls and rabbits) within 6 months.
- 3,115 households received gardening inputs within 6 months.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

Improved dietary diversity for beneficiary households within 6 months- This outcome was partially achieved because challenges were experienced in the procurement of small stock hence they were distributed at the end of the project. As a result, benefits of the small stock component were realized outside the project time frame.

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2a

If 'NO' (or if GM score is 1 or 0):

The programme targeted more women than men because traditionally women are responsible for rearing small stock and vegetable production

14. M&E: Has this project been evaluated? A post distribution evaluation was conducted.	YES ☒ NO ☐

If yes, please describe relevant key findings here and attach evaluation report or provide URL**:**

A total of 7 monitoring visits were conducted. The objectives of the monitoring were to verify beneficiary selection, check the quality of inputs distributed and training. Monitoring of the project was done at beneficiary registration, at training and during distribution of livestock and inputs. In addition a post distribution monitoring survey was done. The results of the post distribution evaluation showed that the timing of livestock distribution was appropriate. In addition the quality of animals and inputs supplied were of a good quality. Information from the monitoring was shared internally, with service provider (NGO), Government Technical Units and Farmers. The findings from the monitoring visits were used to inform programming e.g providing technical advice on housing and general livestock (guinea fowls, indigenous chickens and rabbits) and crop management. In addition it helped in identifying training gaps and informed livestock availability within the districts.

TABLE 8: PROJECT RESULTS- WHO-051

Cerf Project Information

1. Agency:	WHO	5. CERF Grant Period:	18.10. 2011 – 30.06.2012
2. CERF project code:	11-WHO-051	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project Title:	Cholera outbreak response in Chipinge and Chimanimani Districts in Manicaland Province, and Chiredzi in Masvingo Province.		

7.Funding		
	a. Total project budget:	US$ 13,505,381 (Health cluster requirements for project)
	b. Total funding received for the project:	US$ 2,499,885 (Health cluster funding for project)
	c. Amount received from CERF:	US$ 747,965

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	360,059	360,059	All beneficiaries planned for were reached by the project. The population figures were taken from the estimated 2011 population extrapolated from the 2002 population census.
b. Male	332,363	332,363	
c. Total individuals (female + male):	692,422	692,422	
d. Of total, children under 5	115,738	115,738	

9. Original project objective from approved CERF proposal

To reduce morbidity and mortality caused by cholera in Chipinge, Chimanimani and Chiredzi Districts from a CFR of 4 per cent in September 2011 to ≤1 per cent by June 2012.

10. Original expected outcomes from approved CERF proposal

- 100 per cent (health staff (67 persons) at RHCs in Chipinge and Chimanimani in Manicaland Province, and Chiredzi Districts trained in cholera case management. Save the Children (SCF) will cover Chiredzi while MdM will cover Chipinge.
- Case Fatality Rate due to cholera reduced from 4 per cent to <1 per cent between September, 2011 and June, 2012. This will be a direct result of improved case management skills from the training and the provision of cholera commodities.
- Health facilities in Chipinge and Chiredzi adequately stocked with cholera management commodities from September 2011 to June 2012. WHO will be responsible for the procurement and distribution of the commodities to the affected districts.
- 400 community health workers trained in community based cholera outbreak management skills by June, 2012. Training of health workers in case management will be among the first activities to be carried out, and it is hoped that most of the training will have been done in the first three months of project implementation. As in case management, SCF will work in Chiredzi while MdM will be in Chipinge.

- 100 per cent health staff trained in surveillance in Chipinge, Chimanimani and Chiredzi Districts.
- Women were the majority of people providing care to the affected members of the family, and special consideration was focussed on them when training VHWs. Pregnant women, children, the elderly and the immuno-compromised were considered vulnerable groups.

11. Actual outcomes achieved with CERF funds

Procure and distribute supplies:
Procurement of laboratory reagents and equipment and cholera management commodities for all the three districts was carried out by WHO. All health facilities in Chipinge, Chimanimani and Chiredzi were adequately stocked.

IDSR Training in Chimanimani:
WHO supported training of 48 health staff in Integrated Diseases Surveillance and Reponse in Chimanimani District. The trained staff included doctors, nurses, environmental health, laboratory scientists, health promotion officers, health services administrators and health information officers. The main objectives of the IDSR training was to build capacity among health staff to integrate multiple surveillance systems, improve use of health information for decision making, improve the flow of information between and within verious levels of the health care system, encourage community participation and strengthen laboratory involvement in diagnisis and confirmation of cases.

Training of Health workers in case management:
Case management training for diarrhoeal diseases including cholera was conducted for 30 health staff in Chimanimani, 46 in Chiredzi and 45 in Chipinge districts. All the 48 clinics and 3 hospitals in Chipinge district established oral re-hydration points. The case fatality rate of below 1 per cent was achieved during the project period.

Support and supervision:
A joint Rapid Health Assessment mission was carried out to Chipinge and Chiredzi District. This mission included MOHCW HQ staff, Masvingo and Manicaland Provincial Staff, OCHA, MDM and save the Children.

Social mobilization:
In Chiredzi, a total of 19 Environmental health technicians were trained and are expected to cascade similar trainings in their respective areas of operation targeting school health masters, VHWs and religious objectors using the PHHE strategy, which is an important component in behaviour change and in the reduction of cholera transmission. Following the TOT training, 252 community based health care workers merged with community leaders, church leaders and school health master were trained in PHHE 50 health clubs were formed.

In Chipinge, MDM asked for permission to divert from the original plan and renovated the Village Health Worker Training School. MoH&CW and CRDC asked for beds, mattresses, cooking utensils, fencing of the compound, repairs of the roofs, painting, electrification of the conference hall and dormitories, and MDM honoured that request. However, social mobilization activities in Chipinge did not suffer as the VHWs and MOHCW staff were already conducting full scale social mobilization activities in the field through other sources.

Community level Intervention:
In Chiredzi, Save the Children conducted PHHE sessions in 5 villages reaching 640 people (186 males and 454 females). In addition, 53 volunteers were trained to operate as surveillance agents and ORS holders. In Chipinge, MdM provided 14 knapsacks (sprayers) to MoH&CW for the 14 EHT's in the district to do disinfection. The sprayers were put in use to disinfect the homesteads of the 5 suspected cases. EHTs were provided with fuel for the motorcycles to do contact follow-up and health education in the community.

Coordination, monitoring and evaluation:
- 3 inter-district coordination meetings took place between Chiredzi and Chipinge DHE representatives together with MDM from Chipinge, Save the Children from Chiredzi as the health partner and ACF as the WASH partner.
- A National Rapid Response Team comprised of WHO, PMU, Provincial Authorities and Director, EDC, made a Rapid Health Assessment on Preparedness and Response capacity in Chiredzi and Chipinge Districts.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

MDM asked for permission to divert from the original plan of conducting social mobilization and instead renovated the Village Health Worker Training School. MoH and CW and CRDC asked for beds, mattresses, cooking utensils, fencing of the compound, repairs of the roofs, painting, electrification of the conference hall and dormitories, and MDM honoured that request after seeking for permission to do

so. When the Ministry of Health and Child Welfare requested MDM to renovate the Village Health Worker Training School in Chipinge, the issue was discussed at the Health Cluster Strategic Working Group Meeting. A decision to reprogramme one of the activities to allow for renovation of the VHW school was taken. However social mobilization did not suffer as Village Health Workers and Health Staff were already carrying out this activity in the field. Rehabilitation of the VHW school added value to the community level health delivery system as more VHWs were encouraged to come for training in a more comfortable environment.

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2a

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated?	YES ☒ NO ☐

If yes, please describe relevant key findings here and attach evaluation report or provide URL**:**

Summary:

- 56 Village Health Workers and members of the community had been trained in PHHE in Chipinge District.
- Social mobilization was being carried out in the community by VHWs and Health Staff.
- Cholera cases had gone down. There were two suspected cases at the clinic.
- Bore holes were the main source of water.
- Multidisciplinary committees were coordinating cholera outbreak response activities in both Chiredzi and Chipinge..
- Emergency response commodities were available.
- Chipinge and Chiredzi Health staff was trained in case management.

TABLE 8: PROJECT RESULTS-036			
CERF Project Information			
1. Agency:	IOM	5. CERF Grant Period:	22.09.2011 - 30.06.2012
2. CERF project code:	11-IOM-036	6. Status of CERF grant:	☐ On-going
3. Cluster/Sector:	Health Nutrition		☒ Concluded
4. Project Title:	Delivery of Life Saving Care for Acute Malnutrition in drought affected populations in Matabeleland North and South Provinces.		
7.Funding	*a. Total project budget:*		US$ 5,907,463 (Nutrition cluster requirements for project)
	b. Total funding received for the project:		US$ 4,073,768 (Nutrition cluster funding for project)
	c. Amount received from CERF:		US$ 666,996

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	365,551	91,019	Number of beneficiaries who were reached by Village Health workers during community mobilisation activities were not well captured and reported on. This resulted in the high discrepancy between planned and reached figures. The majority of beneficiaries who were reached with nutrition education and group counselling were reached through community mobilisation activities; unfortunately these figures were not reported well.
b. Male	324,168	443	
c. Total individuals (female + male):	689,719	91,462	
d. Of total, children under 5	89,663	89,569	

9. Original project objective from approved CERF proposal

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

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).

a)

10. Original expected outcomes from approved CERF proposal

1. By the end of the project period, all eligible health facilities in target districts will be competent in the management of SAM (i.e. they will have the requisite number of trained personnel and will meet minimum requirements for performance in applying admission, treatment, and monitoring protocols;
2. By the end of the project period, at least 70 per cent of the expected caseload in the catchment areas of supported facilities, identified and enrolled in the program.
3. By the end of the project period CMAM implementing facilities in target districts will meet minimum quality criteria, including:

a) The proportion of exits from OTP and SC who have died will be less than 10 percent

b) The proportion of exits from OTP and SC who have defaulted will be less than 15 percent

c) The proportion of exits from OTP and SC who have recovered will be greater than 75 percent

11. Actual outcomes achieved with CERF funds

1. By the end of the project period 117 (over 80 per cent) eligible health facilities in the target districts were competent in the management of Severe Acute Malnutrition (SAM) with at least 2 staff members competent in CMAM. A total of 452 health workers, and 268 auxiliary staff at health facilities became CMAM competent and successfully established CMAM centres at their respective health facilities.
2. By the end of the project period **119 per cent** of the expected caseload in the catchment areas had been identified and enrolled into the program. This high coverage rate may be this owing to changes in population movement and settlement patterns since the last census hence the utilization of a denominator that is no longer accurate hence the coverage that is higher than 100 per cent
3. By the end of the project period CMAM implementing facilities in target districts will meet minimum quality criteria, including:

   a) The proportion of exits from OTP and SC who have died was ***5 per cent (less than 10 per cent)***

   b) The proportion of exits from OTP and SC who have defaulted was 15 per cent

   c) The proportion of exits from OTP and SC who have recovered was 79 per cent. (**Greater than 75 per cent**)

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

There was no significant discrepancy between planned and actual outcomes in the CMAM program. However the number of beneficiaries who were reached through community-mobilisation activities (active case finding, nutrition screening and nutrition) were not well captured and reported in some cases The majority of beneficiaries who were reached with nutrition education and group counselling were reached through community mobilisation activities; unfortunately community volunteers failed to report this data effectively and consistently.This resulted in the high discrepancy between planned and reached figures

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 1

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated?	YES ☐ NO ☒

The project was being monitored using IOM's M&E tools on a mothly basis through monitoring missions between IOM and its partners. Partners also submitted monthly M & E reports as well as end of project reports

TABLE 8: PROJECT RESULTS -			
CERF Project Information			
1. Agency:	IOM	5. CERF Grant Period:	22.09.2011 – 30.06.2012
2. CERF project code:	11-IOM-035	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Agriculture		☒ Concluded
4. Project Title:	Emergency Livelihoods Restoration for Vulnerable Communities in Drought affected areas in Matabeleland		
7.Funding	*a. Total project budget:*		US$ 80,603,794 (Agriculture cluster requirements)
	b. Total funding received for the project:		US$ 46,353,219 (Agriculture cluster funding)
	c. Amount received from CERF:		US$ 600,000

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	10,000	9,960	
b. Male	5,000	5,140	
c. Total individuals (female + male):	15,000	15,100	
d. Of total, children under 5	500	500	

9. Original project objective from approved CERF proposal

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

10. Original expected outcomes from approved CERF proposal

- At least 3,000 households in Gwanda, Bulilima, Hwange and Matobo benefit from restored livelihoods options;
- At least 3,000 households have improved food security status;
- Targeted communities benefit from improved access to water required for livelihoods activities.

11. Actual outcomes achieved with CERF funds

- 3,020 HH from the prioritized districts are directly benefiting from CERF funding;
- Targeted districts benefit from rehabilitated agricultural infrastructure, emergency support to revitalise gardening activities in Gwanda and Bulilima as well as small livestock restocking.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): **If 'NO' (or if GM score is 1 or 0):** Ensuring that reports have disaggregated gender data and ensuring that project committees are gender sensitive.

14. M&E: Has this project been evaluated?	YES ☐ NO ☒
The project was being monitored using IOM's M&E tools. The project was monitored on a mothly basis with joint missions between IOM and its partners. Partners also submitted monthly M & E reports as well as end of project reports.	

TABLE 8: PROJECT RESULTS - IOM-034

Cerf Project Information

1. Agency:	IOM	5. CERF Grant Period:	22.09.2011 - 30.09.2012
2. CERF project code:	11-IOM-034	6. Status of CERF grant:	☐ On going
3. Cluster/Sector:	Multisector		☒ Concluded
4. Project Title:	Provision of Emergency Assistance to the most vulnerable Internally Displaced Persons in Zimbabwe		

7.Funding		
	a. Total project budget:	US$11,300,000 (Protection cluster requirements for project)
	b. Total funding received for the project:	US$ 4,913,085 (Protection cluster requirements for project)
	c. Amount received from CERF:	US$ $720,002 US$ 500,002

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	3,500	4,326	The resettlement project (objective 2) initially planned to assist 300 HH but the only available land from Bulawayo City council was 197 stands each measuring 2,000 square metres. This resulted in the reduction of the numbers to suit the available land. A no-cost extension and reprogramming of activities was requested from and approved by the CERF.
b. Male	3,000	3,603	
c. Total individuals (female + male):	6,500	7,929	
d. Of total, children under 5	650	956	

9. Original project objective from approved CERF proposal

- Address the protection needs of newly displaced populations through the provision of emergency humanitarian assistance;
- Provide life-saving assistance to meet the acute emergency needs of vulnerable communities through emergency relocation assistance.

10. Original expected outcomes from approved CERF proposal

- 300 Households from Killarney and Trenance are resettled and 1,000 newly displaced households are provided with emergency assistance each month for 9 months within a week.

11. Actual outcomes achieved with CERF funds

Objective 1

- 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 1,038 standard NFI packs. 500 NFI packs bought with CERF funds whilst 538 were co funded by other

donors;
- Assistance with NFI packs to 6,747 individuals;
- Advocacy with authorities in Midlands, Manicaland, Mash East for access to affected communities.

Objective 2
- Allocation of land for the 197 households by Bulawayo City Council;
- Construction of 197 temporary shelters;
- Construction of 74 emergence shelters;
- Construction of 6 boreholes;
- Relocation of 197 households to Hydepark.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

The number of households assisted changed from 300HH due to the availability of the land that could not accommodate all the households apart from the 197 assisted. Also, the number of boreholes changed from targeted 3 to 6 based on instruction from Bulawayo City Council not to use city water for the construction and also due to non-availability of alternative water source (rivers, dams, and ponds) in surrounding area. A no-cost extension and reprogramming of activities was requested from and approved by the CERF.

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? YES ☐ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2a. Gender was mainstreamed through the provision of gender sensitive targeted assistance for women and girls, for example sanitary wear was an integral part of NFI assistance, women as primary care givers were encouraged to register for assistance on behalf of their households.

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated? YES ☐ NO ☒

If yes, please describe relevant key findings here and attach evaluation report or provide URL**:**

TABLE 8: PROJECT RESULTS

Cerf Project Information

1. Agency:	UNICEF	5. CERF Grant Period:	22.09.2011 – 30.06.2012
2. CERF project code:	11-CEF-047	6. Status of CERF grant:	☐ On-going
3. Cluster/Sector:	Water, Sanitation and Hygiene Promotion (WASH) and Education		☒ Concluded
4. Project Title:	Emergency WASH Assistance to Vulnerable Communities and Populations in Institutions in Cholera Affected Areas		

7.Funding		
	a. Total project budget:	US$ 8,400,000 (WASH cluster requirements for project)
	b. Total funding received for the project:	US$ 8,400,000 (WASH cluster funding for project)
	c. Amount received from CERF:	US$ 1,399,99

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	86,639	133,314	In general, more beneficiaries than planned were reached because of the following: Some hygiene promotion activities covered some community members outside the targeted beneficiary areas when the project implementers took advantage of impromptu gatherings (e.g. community meetings, food-for-work gatherings, etc) and held hygiene sessions. Hygiene Club approach increased contact with beneficiaries. Also, the facilities provided for schools, e.g. boreholes ended up serving both the targeted schools and surrounding communities.
b. Male	74,651	99,790	
c. Total individuals (female + male):	161,290	233,104	
d. Of total, children under 5	23,692	48,053	

9. Original project objective from approved CERF proposal

This proposed intervention is for emergency water supply, sanitation and hygiene promotion assistance to at risk populations in institutions as well as communities within Cholera affected areas of Chiredzi, Chipinge, Bikita and Buhera Districts. The objective of the intervention is to reduce the risk of WASH related disease morbidity and mortality to vulnerable boys and girls, men and women in institutions as well as communities in Cholera affected areas.

10. Original expected outcomes from approved CERF proposal

The WASH emergency response would ensure safe and adequate water supply for 86,639 women and girls as well as 74,651 men and boys and within schools, clinics and surrounding communities as well as facilitating sufficient excreta disposal, basic equipment for sanitary upkeep of clinics and toilets. This is envisaged to contribute to the effective management of WASH related disease outbreaks, droughts, floods and displacement. Functional WASH services in clinics are critical to the delivery of emergency and other life-saving clinical health services and within schools reduce risk to diseases and improve learning spaces.

11. Actual outcomes achieved with CERF funds

- The WASH emergency response ensured safe and adequate water supply for 133,314 women and girls as well as 99,790 men and boys, within clinics and surrounding communities (including water supply and sanitation for 32,867 boys, 34,092 girls, 1,096 male teachers and 954 female teachers within schools).
- 44 boreholes were drilled and 92 rehabilitated at schools, clinics and in the community in four (4) cholera affected districts (Bikita, Buhera, Chipinge and Chiredzi).
- 9 piped water schemes we rehabilitated at three schools and six clinics in two of the cholera-affected districts (Buhera and Chipinge) in Manicaland Province.
- 566 latrines and 90 hand-washing facilities were constructed and 210 latrines rehabilitated at 60 schools and 21 clinics in the 4 districts.
- 175 one-bag version household latrines (uBVIPs) were constructed in Chipinge district with the 1-bag subsidy provided through the project.
- In total, 81 institutions (60 schools and 21 clinics) and their communities were reached with WASH facilities and hygiene promotion messages, benefiting some 233,104 people (57.2 per cent of whom were women and girls; and 48,053 under-fives; as well as 66,959 school children – 50.9 per cent of whom were girls). Among the beneficiaries were over 5,000 men, women and children within the catchment areas of the beneficiary clinics.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

Some hygiene promotion activities covered some community members outside the targeted beneficiary areas when the project implementers took advantage of impromptu gatherings (e.g. community meetings, food-for-work gatherings, etc) and held hygiene sessions. Hygiene Club approach increased contact with beneficiaries. Also, in most cases, the facilities provided for schools, e.g. boreholes ended up serving both the targeted schools and surrounding communities.

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): f 'NO' (or if GM score is 1 or 0): 1

- Project design ensured that beneficiaries were disaggregated by both sex and age (male and female; under 5 children). All the IPs were required to report this gender-disaggregated data for all the programme reports.
- At schools, separate toilets were constructed for boys and girls. The siting of sanitation facilities was in secure locations e.g. within perimeter of school or clinic premises.
- The sanitation facilities (toilets) also afford the girls with necessary privacy to manage their menstrual hygiene in private and the hand-washing facilities provide for hand-washing after using the latrines.
- Of the 233,104 benefiting from hygiene promotion messages, over 5,000 men were reached.
- Water points and sanitation facilities which were constructed/rehabilitated were within 200 meters of the institutions thereby cutting down on water collection duties for women and children who traditionally are responsible for the majority of manual and management work for water and sanitation services at the household level.

14. M&E: Has this project been evaluated? YES ☐ NO ☒

The project was too short for an evaluation. However, UNICEF enshrined the project monitoring mechanism and this was included as part of the Project Cooperation Agreement. This monitoring mechanism outlined the frequency of field visits and quality assurance visits (as well as end of project field monitoring and financial spot checks). Participatory monitoring visits were also conducted by the WASH Cluster Coordinator, representatives of various government line ministries and this was crucial in building relations, creating bonds, building trust and transparency and at the same time creating a conducive environment of openness and constructive criticism. There was close coordination and networking between UNICEF and the national WASH cluster with the CERF interventions regularly featured within the monthly WASH cluster meetings as well as updates of the UNOCHA Humanitarian Bulletin. Secondary data on the state of WASH services in clinics was routinely available from the Vital Medicines Availability and Health Services Survey (VMAHSS) rounds 9, 10 and 11 which took place during the implementation period. The incidence of Cholera was also monitored in collaboration with the health cluster through the WHO and MoHCW weekly Epidemiological updates. UNICEF also assigned one WASH officer who was fully committed to this intervention and conducted regularly monthly monitoring visits. As an example, two joint monitoring visits were successfully completed from the 28th to 31st of May 2012. Quality assurance visits by project teams were conducted from the 16th to 26th July and a final end of project quality assurance visit from 16th to the 26th July 2012.

TABLE 8: PROJECT RESULTS

CERF Project Information

1. Agency:	WFP	5. CERF Grant Period:	20.09.2011 – 30.06.2012
2. CERF project code:	11-WFP-053	6. Status of CERF grant:	☐ On-going
3. Cluster/Sector:	Food		☒ Concluded
4. Project Title:	Assistance to Food Insecure Vulnerable Groups		

7.Funding	*a. Total project budget:*	US$ 167,694,962 (Food cluster requirements)
	b. Total funding received for the project:	US$ 112,643,814 (Food cluster funding)
	c. Amount received from CERF:	US$ 400,000

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	8,814	8,814	
b. Male	8,136	8,136	
c. Total individuals (female + male):	16,950	16,950	
d. Of total, children under 5	3,390	3,390	

9. Original project objective from approved CERF proposal

Ensure sustained access to basic food aid rations for 16,950 highly vulnerable food insecure beneficiaries.

10. Original expected outcomes from approved CERF proposal

- 16,950 patients supplied with fortified blended food (CSB+)
- Increased accessibility of food for most vulnerable households especially those that are hosting malnourished chronically ill patients
- Livelihoods protected and chances of sale of essential livelihoods assets diminished for 67,800 people

11. Actual outcomes achieved with CERF funds

- 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

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): f 'NO' (or if GM score is 1 or 0): 2

- Project design ensured that beneficiaries were disaggregated by both sex and age (male and female; under 5 children). All the Partners were required to report this gender-disaggregated data for all the programme reports.
- Clients reached through clinics were both males and females
- The reported outcomes were sex desegregated

14. M&E: Has this project been evaluated?	YES ☐ NO ☒

If yes, please describe relevant key findings here and attach evaluation report or provide URL: N/A

TABLE 8: PROJECT RESULTS

CERF Project Information

1. Agency:	IOM	5. CERF Grant Period:	20.09.2011 – 30.06.2012
2. CERF project code:	11-IOM-033	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Multisector		☒ Concluded
4. Project Title:	Continued Life Saving Humanitarian Assistance for Refugees and Asylum Seekers		

7.Funding		
	a. Total project budget:	US$ 5,060,273 (cluster requirements for project)
	b. Total funding received for the project:	US$ 3,580,658 (cluster requirements for project)
	c. Amount received from CERF:	US$ 500,532

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	200	263	The number of beneficiaries reached was 600 per month as opposed to the planned migrant flows. The difference is attributed to a variety of factors but chiefly the migration management policies in countries where the migrants pass through in the course of their movement southward with Mozambique deporting the stranded migrants.
b. Male	13,300	5,783	
c. Total individuals (female + male):	13,500	6,046	
d. Of total, children under 5	200	90	

9. Original project objective from approved CERF proposal

To contribute towards provision of life-saving assistance to groups made vulnerable through mixed migration flows into Zimbabwe.

10. Original expected outcomes from approved CERF proposal

- A Transit centre for asylum seekers and refugees in Nyamapanda border area is functional and has the necessary capacity to provide assistance to asylum seekers and refugees.
- Asylum seekers /refugees arriving through Nyamapanda border post are registered and receive humanitarian assistance within 24 hrs of arrival.
- Asylum seekers/ refugees receive food, health, protection counselling, safe migration information and temporary shelter (with water and sanitation facilities) for resting.
- Referral pathway in place, and fully functional for protection case referrals.
- Refugees/asylum seekers provided with transportation to TRC provided, inclusive of fitness to travel assessment.
- A safe migration strategy on the rights and responsibilities of migrants and asylum seekers designed and disseminated to the beneficiaries.
- Coordinated humanitarian/protection response mechanism in place, with border officials, police, authorities and social services actively playing their respective role.

11. Actual outcomes achieved with CERF funds

- A transit centre was established and officially opened by GoZ in August 2012 and is fully operational.
- 6,046 asylum seekers (5,783 Male, 263 Female) registered and were provided with humanitarian assistance.

- All asylum seekers received safe migration information, sanitation and temporary shelter; 41,545 meals were provided and 1,300 migrants were assessed for medical conditions and referred to the local hospital.
- 5,996 stranded migrants (5,703 male; 263 female) assisted with transport to Tongogara refugee camp. All migrants received fitness to travel checks.
- Two workshops, one on mixed migratory flows and the operating modalities of the Nyamapanda centre and another on counter trafficking were conducted.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

The number of beneficiaries reached was 600 per month as opposed to the planned migrant flows. The difference is attributed to a variety of factors but chiefly the migration management policies in countries where the migrants pass through in the course of their movement southward with Mozambique deporting the stranded migrants.

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2a

If 'NO' (or if GM score is 1 or 0):

Although the proportion of female beneficiaries is significantly lower than male, the project provided gender-specific assistance in terms of separate water and sanitation facilities, shelter and non-food items for mothers and children under 5 years.

14. M&E: Has this project been evaluated?	YES ☐ NO ☒

Monitoring was conducted through an established database and post-assistance questionnaires that were adminstered for the beneficiaries. An Evaluation has not yet been undertaken.

TABLE 8: PROJECT RESULTS- UNHCR-042

CERF Project Information			
1. Agency:	UNHCR	5. CERF Grant Period:	01.09.2011- 06.2012
2. CERF project code:	ZIM-11/MS/37525/ 11-HCR-042	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Multi-Sector		☒ Concluded
4. Project Title:	Protection and Assistance for Refugees, Asylum Seekers and Refugee Returnees		

7.Funding		
	a. Total project budget:	US$ 5,060,273 (cluster requirements for project)
	b. Total funding received for the project:	US$ 3,580,658 (cluster funding for project)
	c. Amount received from CERF:	US$ 497,550

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	1,242	1,242	
b. Male	4,158	4,158	
c. Total individuals (female + male):	5,400	5,400	
d. Of total, children under 5	810	810	

9. Original project objective from approved CERF proposal

Specific objective I: 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.

Specific objective II: 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.

10. Original expected outcomes from approved CERF proposal

- Registration activities, information and counselling on protection procedures, assistance and services available in TRC for asylum/refugees;
- Provision of voluntary transport assistance in safety and dignity from detention centres and medical facility to TRC as required;
- Provision of protection counselling to asylum seekers/refugees as required;
- Capacity development and awareness raising for government counterparts on protecting the rights and assisting asylum seekers/refugees;
- Reception of new arrivals and eventual integration into the community;
- Improvement/repair of initial/temporary reception facilities including temporary housing and WASH facilities at the TRC and the Waterfalls Medical Facility;
- Provision of transport assistance to asylum seekers/refugees from detention centres in Zimbabwe (except for

Nyamapanda covered by IOM) to the Tongogara Refugee Camp;

- Provision of life saving food – including both initial supplies at reception and inclusion in regular monthly food distribution as required;
- Provision of life saving health services at TRC including initial health screening and/or follow-up treatment/services based upon border assessments and/or referrals to available governmental and non-governmental service providers as required;
- Provision of life-saving Non-food Items (e.g., blankets, kitchen sets, sleeping mats, sanitary materials, etc.) for settlement in TRC as required;
- Provision of temporary emergency shelter by providing construction package (Roofing materials, roofing twine, plastic sheeting, doors and bolt lock) for refugees/asylum seekers and returnees.

11. Actual outcomes achieved with CERF funds

- Transportation was provided to a total of 505 individuals from Harare, Mutare and Beitbridge Border post.
- The population benefited from the timely registration and profiling system with the year 2012 realizing 5,400 asylum seekers, mainly for DRC, Ethiopia and Somalia. The PoC also received legal and physical protection and counselling services as required. The status determination process tremendously improved in 2012 with eight (8) Zimbabwe Refugee Committee (ZRC) status determination sessions being completed in which 480 applications were considered comprising of 1,065 individuals inclusive of dependents.
- One training session for Government border Officials was conducted jointly with IOM at Nyamapanda border post and one was held in Harare for Government Refugees Status Determination Committee.
- New Arrivals were assisted with temporary shelter on arrival and later provided with shelter material to construct own houses. Vulnerable cases were helped to build shelter units.
- UNHCR procured, transported and distributed food, and NFIs that reached 3,000 people. The standard food basket recommended 2,100 kcal per person per day for the asylum seekers and was met. The NFIs included blankets, soap, sanitary ware, kitchen sets and sleeping mats.
- Refugees and Asylum seekers benefited from the health delivery system and facilities in Tongogara Refugee Camp and referral centres during the reporting period.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	NO X

If 'YES', what is the code (0, 1, 2a, 2b):

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated?	NO X

The project was not evaluated though it was being monitored. The monitoring included tracking of the number of asylum seekers that needed to go through the status determination sessions, tracking of those vulnerable cases namely the elderly, the sick and unaccompanied children that needed sheltered to be constructed on their behalf. Again, monitoring activities included continuous screening of those with health issues and provide the needed health care as well as supplementary food baskets. Other health cases were also referred to specialists and central hospitals to enable them to access specialists' services.

TABLE 8: PROJECT RESULTS			
Cerf Project Information			
1. Agency:	**United Nations Population Fund (UNFPA)**	5. CERF Grant Period:	28/09/2011 – 31/06/2012
2. CERF project code:	**ZIM-11/P-HR-RL/39547**	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	**Protection (GBV)**		☒ Concluded
4. Project Title:	Emergency Response to and prevention of Gender Based Violence		
7.Funding	*a. Total project budget:*		US$ 800,000
	b. Total funding received for the project:		US$ 150,000
	c. Amount received from CERF:		US$ 346,977

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	203 194	246 000	Target beneficiaries were exceeded.
b. Male	193 751	215000	
c. Total individuals (female + male):	396 945	461 000	
d. Of total, children under 5	N/A	N/A	

9. Original project objective from approved CERF proposal

Strengthen availability and accessibility of life saving, survivor centred GBV prevention and response services to vulnerable women and girls in Buhera, Headlands, Mutoko, Mudzi, Makoni and Mberengwa

10. Original expected outcomes from approved CERF proposal

- Community's response to GBV is rapid and gender sensitive by setting out community initiatives on GBV prevention and response by the community protection structures.
- Increased availability of comprehensive package (health, lega, psycho social, safety) of GBV services for children and adult survivors at community level
- Increased access to GBV services at community level, through persons reached by mobile counseling and legal aid clinics and persons assisted to reach life saving support services.

11. Actual outcomes achieved with CERF funds

a) The project increased GBV survivor's access to a comprehensive life-saving response by providing critical medical, legal, safety and psycho-social services. In case needed, survivors were offered to stay in safe spaces at either district or provincial level to protect them from being traced and suffering further violence.
b) The project also strengthened existing community structures to prevent and respond to GBV. This was done through sensitization of community leaders, gender focal points, health service providers, Police and Courts.
c) Finally, the project addressed urgent gaps at the 3 previously established one stop centers in Mudzi, Makoni and Mberengwa districts (located in Midlands, Manicaland and Mashonaland East provinces), which are politically sensitive areas too. The

centres are running smoothly and independently.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

N/A

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2b

If 'NO' (or if GM score is 1 or 0): N/A

14. M&E: Has this project been evaluated?	YES ☒ NO ☐

If yes, please describe relevant key findings here and attach evaluation report or provide URL**: Fill in**

The project has been evaluated as part of the evaluation of the relevance, effectiveness, efficiency and sustainability of GBV friendly services in Zimbabwe. The evaluation was conducted in 2011. The major findings were:-

1. **Community Based Referral System:** There is need to strengthen the community-based system of tackling GBV through training of traditional, religious and political leaders on GBV and how to effectively deal with the problem. Community awareness programmes, using the stepping stones approach[5], also need to be intensified to cover as many areas as possible.

2. **The Coordinated Multi-Sectoral Referral Model:** this model should be adopted in situations where there are inadequate facilities and human and financial resources to set up one-stop centres. The adoption of this model should be informed by a thorough assessment of the targeted area. The model can be applied to both urban and rural environments where service providers are located in geographically different areas. Where a decision has been made to adopt this model, the following measures should be taken to make it more effective:

    - Ensure that as many services as possible are provided under one roof or location by one service provider through multi-skill and multi-tasking training
    - If services are not provided under one-roof, then they should be within walking distance of each other
    - Service providers should agree on standard protocol and sign an agreement to that effect.
    - Strengthen coordination at both national and ground level

3. **One Stop Centre Model:** the adoption of this model must also be informed by an assessment of the targeted area to determine the suitability of the model in that particular context. Adopt the model where: there are adequate funds to support the related infrastructure; and where service providers have adequate personnel to second full time staff to the centres or alternatively where there are enough resources or donor support for outsourcing services that cannot be adequately provided by government departments. One stop centres should ideally be established in urban centres or growth points/business centres where most, if not all, the service providers are found within the same location and can therefore be brought under one roof. The centres should also be located where there are high GBV caseloads to avoid under utilisation of both centres and human resources committed specifically to service the centres. Where the above key conditions are not met, the adoption of the one stop centre model should be discouraged as prospects for sustainability are very low.

[5] This approach was found to be effective in tackling HIV/AIDS and gender issues under the UNFPA supported Behaviour Change Programme

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/ Sector	Agency	Partner Name	Partner Type	Total CERF Funds Transferred To Partner US$	Date First Instalment Transferred	Start Date Of CERF Funded Activities By Partner	Comments/ Remarks
11-FAO-035	Agriculture	FAO	World Vision	International NGO	62 695.46	5 December 2011	30/06/2012	Few implementing partners were available to partner with FAO on this project; this consequently delayed the start up of the project and hence delayed disbursement of funds.
11-WHO-051	Health	WHO	MDM	International NGO	181,280	20 October, 2011	1 November 2011	
ZIM-11/H/38040/5826	Health	WHO	Save the Children	International NGO	180,862	20 October, 2011	1 November 2011	
11-IOM-034	Protection	IOM	World Vision	INGO	328,042.28	18/10/11	1/10/2011	
11-IOM-035	LICI	IOM	CARITAS	National NGO	231,650	15/11/2011	01/11/2011	
11-IOM-035	LICI	IOM	SCC	International NGO	231,650	10/11/2011	01/11/2011	
11-CEF-047	WASH and Education	UNICEF	CARE Zimbabwe	International NGO	275,733.55	04/11/2011	18/11/2011	There were delays between release of funds by OCHA and disbursements to IPs due to partnership agreement process
11-CEF-047	WASH and Education	UNICEF	Christian Care	National NGO	384,783.85	14/10/2011	26/10/2011	Same as above
11-CEF-047	WASH and Education	UNICEF	World Vision International	International NGO	449,435.48	09/11/2011	17/11/2011	Same as above
11-CERF-047	WASH and Education	UNICEF	Africare	INGO	215,970.88	04/11/2011	11/11/2011	Same as above
Zim-11/P-HR-RL/39547	Protection	UNFPA	Women's Action Group	NGO	104,101	30 September 2011	30 September 2011	
Zim-11/P-HR-	Protection	UNFPA	Zimbabwe Lawyers	NGO	51,696	30 September 2011	30 September 2011	

RL/39547			Association					
Zim-11/P-HR-RL/39547	Protection	UNFPA	Musasa	NGO	111,366	30 September 2011	30 September 2011	
11-IOM-036	Nutrition	IOM	Save the Children	NGO	139,361.00	10 November 2011	10 November 2011	Legal processes with regards to the MOU development delayed the first disbursement; however, the first disbursements for both World Vision and Save the Children were disbursed within 10 days of signing the MOU.
11-IOM-036	Nutrition	IOM	World Vision	NGO	177,435.30	21 November 2011	21 November 2011	Same as above
12-WFP-076	FOOD	WFP	ORAP	LOCAL NGO	160,604.40	20 November 2012	15 December 2012	
12-WFP-076	FOOD	WFP	CARE	International NGO	374,743.60	3 December 2012	15 December 2012	
12-WFP-076	FOOD	WFP	GOAL	INTERNATIONAL NGO	120,453.30	3 December 2012	15 December 2012	
12-WFP-076	FOOD	WFP	CHRISTIAN CARE	LOCAL NGO	200755.50	3 December 2012	15 December 2012	
12-WFP-076	FOOD	WFP	UMCOR	INTERNATIONAL NGO	26,767.40	3 December 2012	15 December 2012	
12-WFP-076	FOOD	WFP	SAVE THE CHILDREN	INTERNATIONAL NGO	53534.80	3 December 2012	15 December 2012	
12-WFP-076	FOOD	WFP	PLAN	INTERNATIONAL NGO	133,837	10 November 2012	15 December 2012	
12-WFP-076	FOOD	WFP	AFRICARE	INTERNATIONAL NGO	66918.50	3 December 2012	15 December 2012	
12-WFP-076	FOOD	WFP	WORLD VISION	INTERNATIONAL NGO	200,755.50	3 December 2012	15 December 2012	
11-WFP-053	FOOD	WFP	GOAL	INTERNATIONAL NGO	4,462.18	23-September 2011	30 September 2011	
11-WFP- 053	FOOD	WFP	PLAN	INTERNATIONAL NGO	6,740.12	30-September-2011	30 September 2011	

11-WFP- 053	FOOD	WFP	WORLD VISION	INTERNATIONAL NGO	7,046.52	16 September 2011	30 September 2011	
11-WFP- 053	FOOD	WFP	AFRICARE	INTERNATIONAL NGO	7,132.11	20 September 2011	30 September 2011	
11-WFP- 053	FOOD	WFP	HELP FROM GERMANY	INTERNATIONAL NGO	2,225.22	23 September 2011	30 September 2011	

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AGRITEX	Department of Agriculture, technical Services and Extension
CBM	Community Based Maintenance
CERF	Central Emergency Relief Fund
DDF	District Development Fund
DWSSC	District Water and Sanitation Sub-Committee
EHT	Environmental Health Technician
IP	Implementing Partner
MoESAC	Ministry of Education Sports Arts and Culture
MoHCW	Ministry of Health and Child Welfare
NGO	Non-Governmental Organisation
SAG	Strategic Advisory Group
TOT	Training of trainers
TCNs	Third Country Nationals
uBVIP	Upgradeable Blair Ventilated Improved Pit (Latrine)
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation
WV	World Vision
WVI	World Vision International
WVZ	World Vision Zimbabwe