HIGHLIGHTS (29 Apr 2020)

- The first imported COVID-19 case was reported on 21 March 2020 and local transmission started on 24 March. As of 27 April, 32 COVID-19 cases were confirmed, including four deaths.

- A malaria outbreak, with over 200 deaths reported since 1 January 2020 throughout the country, creates an additional burden to an already fragile health system.

- About 750,000 people received food or cash assistance in April. Distributions were delayed due to the implementation of COVID-19 protection measures.

- The number of children treated for acute malnutrition reduced from 952 in January to 741 in February and 354 in March.

- The national GBV Hotline recorded 972 GBV calls since the beginning of the lockdown on 30 March with an overall increase of over 70 per cent compared to pre-lockdown trends.

KEY FIGURES

<table>
<thead>
<tr>
<th>People in Need</th>
<th>People Targeted</th>
<th>Operational Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>7M</td>
<td>5.6M</td>
<td>47</td>
</tr>
</tbody>
</table>

FUNDING (2020)

- Required: $715.8M
- Received: $63.7M
- Progress: 9%

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Zimbabwe Humanitarian Response Plan 2020

https://fts.unocha.org/appeals/921/summary
BACKGROUND (29 Apr 2020)

Situation Overview

The 2020 Zimbabwe Humanitarian Response Plan (HRP), launched on 2 April 2020, indicates that 7 million people in urban and rural areas are in urgent need of humanitarian assistance across Zimbabwe, compared to 5.5 million in August 2019. Since the launch of the Revised Humanitarian Appeal in August 2019, circumstances for millions of Zimbabweans have worsened. Drought and crop failure, exacerbated by macro-economic challenges and austerity measures, have directly affected vulnerable households in both rural and urban communities. Inflation continues to erode purchasing power and affordability of food and other essential goods is a daily challenge. The delivery of healthcare, clean water and sanitation, and education has been constrained and millions of people are facing challenges to access vital services.

There are more than 4.3 million people severely food insecure in rural areas in Zimbabwe, according to the latest Integrated Food Security Phase Classification (IPC) analysis, undertaken in February 2020. In addition, 2.2 million people in urban areas, are "cereal food insecure", according to the most recent Vulnerability Assessment Committee (ZimVA) analysis. Erratic and late 2019/2020 rains forebode the possibility of a second poor harvest. Nutritional needs remain high with over 1.1 million children and women requiring nutrition assistance. At least 4 million vulnerable Zimbabweans are facing challenges accessing primary healthcare and drought conditions trigger several health risks. Decreasing availability of safe water, sanitation and hygiene have heightened the risk of communicable disease outbreaks for 3.7 million vulnerable people. Some 1.2 million school-age children are facing challenges accessing education. The drought and economic situation have heightened protection risks, particularly for women and children. A year after Cyclone Idai hit Zimbabwe, 128,270 people remain in need of humanitarian assistance across the 12 affected districts in Manicaland and Masvingo provinces. There are 21,328 refugees and asylum seekers in Zimbabwe who need international protection and multisectoral life-saving assistance to enable them to live in safety and dignity.

As of 27 April, the Ministry of Health and Child Care (MOHCC) in Zimbabwe had reported 32 confirmed COVID-19 cases including four deaths, with cases reported in five provinces including 14 cases in Harare and 10 cases in Bulawayo, and a total of 6,834 screenings and diagnostic tests done. With the first cases reported in Zimbabwe as of 20 March, and the recent increase of COVID-19 transmission in the region, the Government of Zimbabwe is strengthening and accelerating preparedness and response to the COVID-19 outbreak. Following the declaration of COVID-19 as a national disaster on 19 March 2020, the Zimbabwe National Preparedness and Response Plan for COVID-19 was launched with an initial eight pillars of coordination, the creation of a national COVID-19 Response Task Force and the formation of the Inter-Ministerial Committee. The Government of Zimbabwe declared a 21-day nationwide lockdown starting on 30 March 2020 ensuring the continuity of essential services, which was extended by two weeks on 19 April.

The country is currently facing a malaria outbreak that is creating an additional burden to an already fragile health system. From 1 January to 19 April 2020, more than 203,000 malaria cases and 205 deaths have been reported following 201 outbreaks throughout the country, mostly from malarious provinces, such as Manicaland, Masvingo and Mashonaland East.

CLUSTER STATUS (29 Apr 2020)

Camp Coordination and Camp Management / Shelter and NFIs

43,352 displaced people
Needs

- More than 43,000 people remain displaced in camps and host communities. Out of the total number of IDPs, 198 Cyclone Idai-affected households (909 people) are living in four camps, where living conditions are exposing them to serious protection and health risks.
- Shelter support is needed for those remaining in the camps and for affected and displaced people accommodated in host communities or in makeshift structures already worn out for the protracted crisis.
- As relocation of internally displaced people (IDP) in camps is not feasible in the short term and it is anticipated that IDPs will remain in the camps for a period of six to nine more months, there is an urgent need to upgrade the camp infrastructure.
- The Government has asked support to replace tents by semi-permanent transitional shelter structures.
- The COVID-19 pandemic has exacerbated the need to establish adequate hygiene facilities and handwashing stations in camps and host communities.
- There is a lack of COVID-19 related information and guidance on preventive measures.
- Two identified isolation facilities are not fully equipped for the COVID-19 response.
- Reinforced surveillance needs to be strengthened through community leaders.
- There is a need to increase mental health and psychosocial support (MHPSS) tailored for COVID-19 distress for IDPs and affected host communities.

Response

- Technical support for the Government in developing a camp exit strategy and operationalization of the permanent relocation plan is ongoing.
- Construction of new houses and rehabilitation in host communities is underway respecting restriction measures due to COVID-19.
- In Buhera, CRS continues shelter interventions and 303 houses have completed rehabilitations. World Vision has completed the full rehabilitation of 600 houses and minor rehabilitations in 500 houses.
- PPE and COVID-19 awareness preventive measures have been incorporated in all activities to ensure protection of both beneficiaries and program personnel.
- The continuous remote monitoring of IDPs through DTM assessments to track mobility, vulnerability and needs, as well as health risks associated with COVID-19, remains a high priority. IOM has started a new round of DTM trainings and village assessments in Chipinge, Chirumanzi, Mutare and Buhera.

Gaps

- Upgrade of camp infrastructure, shelter rehabilitation and reconstruction remains a high priority. People living in crowded conditions and makeshift structures without appropriate access to basic services such as water and health treatment are more exposed to health risks and this could facilitate the spread of COVID-19.

CLUSTER STATUS (29 Apr 2020)
The humanitarian crisis in Zimbabwe is expected to have far-reaching implications for school readiness, attendance and participation. The Education Cluster estimates that, of the more than 3.4 million children of school going age (3 to 12 years), at least 1.2 million (35 per cent), will need emergency and specialized education services in 2020. This includes more than 853,000 children in acute need, such as: children not enrolled in school; orphans and other vulnerable children, including children with disabilities and children living with HIV, and those in need of school feeding.

The education system in Zimbabwe was already stretched before the COVID-19 pandemic as a result of multiple crises, including the impact of Cyclone Idai last year, the economic crisis coupled with hyperinflation and the ongoing drought. Without a well-resourced response, the combined impact of these crises risks having a lasting negative impact on children’s education and increasing drop outs. Without a conducive and disease-free school environment, COVID-19 poses a risk to children's health and wellbeing.

Since 1 January 2020, the cluster partners were able to reach 35,312 people through various activities, including psychosocial support to learners (15,458), distribution of school kits (7,182), construction/rehabilitation of latrines (6,215), hygiene packs/dignity kits (3,500), school feeding (3,291), community mobilization (1,878), teacher training on psychosocial support and disaster risk reduction to teachers (1,500), rehabilitation and construction of classrooms (570) and school fees interventions (29).

Cluster partners have implemented additional activities to mitigate the current COVID-19 pandemic. The response is aligned to the developed cluster COVID-19 response strategy, which earmarks key activities that will be undertaken to ensure continued learning targetting 3.5 million learners have so far reached 6,350 people: 5,500 distributions of Information, Education and Communication (IEC) materials in print a SMS/Texts have been distributed and an additional 500 printed materials are awaiting circulation.

In addition, response activities include the roll out of Education Cannot Wait (ECW) projects on COVID-19, procurement of 60,000 storytelling books for children and development of radio programming which is expected to start by early May.

In preparation for the reopening of schools, guidelines are being developed to ensure the safe provision of food in schools, with support planned for learners to ensure safe reintegration back to school including disinfection of schools.

Despite the national lockdown and technical challenges related to communication, partners have continued to convene weekly virtual meetings, with additional technical working groups operationalizing the COVID-19 Strategy.

As partners plan to respond fully to all needs created by the COVID-19 epidemic, funding constraints militate against implementation of activities and outlined priorities.
In addition to the lack of financial resources, Government personnel are facing internet connectivity challenges, which has implications for virtual meeting coordination and the delivery of results.

CLUSTER STATUS (29 Apr 2020)

Food Security

4.4M people targeted

750K people received assistance in April

Needs

- According to the 2020 Humanitarian Response Plan, a total of 6 million people in rural and urban areas are in urgent need of food assistance across Zimbabwe both in rural and urban areas.
- In addition, 2.8 million small holder farmers are in need of season-sensitive emergency crop and livestock input assistance.
- Measures taken by the Government to mitigate to COVID-19 outbreak, in particular a country-wide lockdown, the restriction of cross-border movements and stringent conditions on humanitarian actors’ activities, might impact negatively food security across Zimbabwe. Those impacts are likely to trigger an increased reliance on negative coping strategy and reduced livelihoods opportunities for the most vulnerable.

Response

- The second Crops and Livestock Assessment verification exercise is being undertaken by teams in the field, involving individual farm visits and meetings with extension staff at various levels and key informants such as District Coordinators on the overall district food security situation.
- FSL Cluster partners are implementing comprehensive COVID-19 prevention and mitigation measures during all interventions, including respect of social distancing and adequate use of PPE, handwashing for both beneficiaries and staff, and dissemination of information and prevention messages related to COVID-19.
- For the April 2020 cycle, delayed by two weeks due to the implementation of COVID-19 protection measures, cluster partners reached a total of 750,000 beneficiaries with in-kind food or cash distributions.
- For March, despite operational constrains as a result of the new protocols for operating during the COVID-19 outbreak, FSL Cluster partners reached 3.92 million beneficiaries with either in-kind food or cash assistance.
- Earlier in February, a total of 3.9 million people were reached with either food or cash assistance, and 840,000 people with agriculture inputs, advisory services or community assets rehabilitation.
- In January, a total 2.9 million of people were reached with cash or food distributions, and 740,000 people with emergency agriculture support for food security and resilience to repeated exposure to multiples shocks and stresses.

Gaps
While Cluster partners have procured PPE materials, the quantities received are not adequate to meet the needs country-wide, which jeopardizes partners ability to continue distributions from one week to another.

Some agricultural activities, such as fielding of consultants and training activities, have been temporarily suspended, and only limited critical activities are taking place.

**Cluster Status (29 Apr 2020)**

- **Health**
  - People targeted: 3M
  - COVID-19 cases (as of 29 April): 32

**Needs**

- The country is currently facing a malaria outbreak. From 1 January to 19 April 2020, more than 203,000 malaria cases and 205 deaths have been reported following 201 outbreaks throughout the country, mostly from malarious provinces, such as Manicaland, Masvingo and Mashonaland East. This outbreak creates an additional burden to an already fragile health system. The surge in malaria cases is noted from the week ending on 8 March.

- As of 27 April, Zimbabwe has reported 32 COVID-19 cases, including four deaths and five recoveries since the onset of the outbreak, with cases reported in five provinces including: Harare (14), Bulawayo (10), Mashonaland East (4), Mashonaland West (3), Matabeleland North (1). The first imported case was reported on 21 March 2020 and local transmission started on 24 March.

- There are close to 2 million patients with chronic non-communicable diseases while 1.2 million people are living with HIV/AIDS in Zimbabwe. This group of people are more susceptible to more severe COVID-19 illness requiring hospitalization and intensive medical care. People with pre-existing chronic illness (including people living with HIV), older persons, women, people with disabilities, older persons, migrants, IDPs and refugees all face risks related to COVID-19, requiring immediate gender-sensitive and age-sensitive action. In addition, people living in urban informal settlements are at increased risk of contracting COVID-19 due to inadequate access to essential health care, clean water and sanitation services and crowded living conditions.

- Critical COVID-19 needs include the shortage of personal protection equipment (PPE); lack of equipped isolation facilities for treatment of severe COVID-19 patients; lack of specialized human resources, e.g. anesthetists, for treatment of COVID-19 patients; the need for mass scale up for contact tracing, scale up testing (with global shortage of test kits) for 4,000 suspect cases, and scale up of risk communication; and preparedness of health workers.

**Response**

- Following a rapid assessment of the national health system, 13 hospitals in the country have been designated as COVID-19 hospitals. Each of the 10 provinces will have at least one designated COVID-19 hospital while efforts are underway to increase isolation capacity, both within health facilities as well as by utilizing potential community level facilities. A total of 92 potential isolation centres covering all 64 districts have been identified and assessments to determine gaps conducted.
In an effort to improve detection of COVID-19 at various levels, the Ministry of Health and Child Care (MOHCC) applied a new strategy for testing for all people meeting the COVID-19 case definition, travelers from countries with COVID-19 local transmission, contacts, people with flu-like symptoms and pneumonia and frontline health-care workers. As of 29 April 2020, a total of 6,834 screenings and diagnostic tests were done by MOHCC at national and provincial levels. MOHCC started decentralizing testing for COVID-19 with the National TB Reference Lab in Bulawayo.

As part of strengthening surveillance at all levels, WHO and health partners supported MOHCC with contact tracing in the affected provinces, with 624 listed being followed up on at various levels. In addition, the Provincial Health Executive Team received training on surveillance, with the cascading of these trainings to lower level structures starting as of 29 April.

The Government of Zimbabwe has introduced mandatory quarantine for travellers arriving from countries with local transmission of COVID-19. In Harare, ZIPAM in Darwendale and Belvedere Teachers College are being used for travelers coming through RGM airport. In Bulawayo, Polytechnic College and United College of Education are used as quarantine facilities for returnees coming from Botswana.

Training of Provincial level structures on case management and infection prevention and control (IPC) is ongoing, with 1,182 frontline health workers trained nationwide on case management as of 13 April; 58 IPC trainers having completed the Training of Trainers in IPC and the training being cascaded nationwide; 31 clinicians at Chinhoyi Provincial Hospital as well as 135 clinicians and 115 support staff at Parirenyatwa Central Hospital trained on IPC as of 20 April 2020.

A total of 180 Village Health Workers (VHWs) in Kariba, Gweru, Gokwe North and Gokwe South have been trained during the week of 20 April. The training includes information of COVID-19 relevant at the community level, including referral of suspected patients, tips for parents and IPC in households and communities.

**Gaps**

- It is critical that the capacity of the health system to test, isolate and treat all cases of suspect, confirmed and probable COVID-19 cases is enhanced. To this end, there is an urgent need to: increase the number of beds in the health facilities nation-wide for isolation of suspect, confirmed and probable cases; increase availability of medical equipment including ventilators, patient monitors as well as medical supplies and consumables required for the management of cases; increase the availability of laboratory supplies and consumables; increase the availability of personal protective equipment for all health workers involved in the management of cases; increase the capacity to safely refer patients by ambulance.

- As at 23 April, preparation of the first wave of public health facilities with capacity to manage severely ill COVID19 patients were not yet complete. Priority gaps to get facilities operational that are able to manage severely ill patients include suitability of infrastructure to minimize risk of infection for health workers and availability of equipment.

- In addition, it is key that all health workers are trained in infection prevention and control (IPC) as well as case management of suspect, confirmed and probable cases, and are provided hazard pay to all front-line health workers.

- Additional decentralized testing facilities including National Virology Lab, African Institute of Biomedical Science and Technology (AiBST), Gweru and Mutare Hospitals, earmarked to start testing, require support with reagents and laboratory equipment.

- There is a need for strengthening contact tracing for the confirmed cases in view of local transmission; strengthening capacity for entry screening of all arrivals at the international airports and key points of entry following confirmation of imported cases; intensifying in-country surveillance in view of border closures, deportations and migration from urban to rural areas.
CLUSTER STATUS (29 Apr 2020)

Nutrition

606K people targeted
354 acutely malnourished children treated (Mar)

Needs

- Approximately 100,000 children under age 5 are suffering from acute malnutrition, with a national global acute malnutrition (GAM) prevalence rising from 2.5 per cent of reported in ZimVAC 2018 to 3.6 per cent in ZimVAC 60 districts rural 2019. A total of 8 districts recorded GAM prevalence of over 5 per cent.
- From the newly released ZimVAC 2020, the national GAM prevalence remained more or less the same (3.7 per cent) with Matabeleland North (5.7 per cent) and Mashonaland Central (5.3 per cent) recording the highest. The National SAM prevalence is 1.45 per cent which is not acceptable according to prevalence cut off values for public health significance (ZimVAC 2020).
- The nutrition status of children in Zimbabwe is further compounded by sub-optimal infant and young child feeding practices including very poor dietary diversity at 15 per cent and with only 7 per cent having attained the minimum acceptable diet.
- Due to the drought-induced food insecurity, most of the households in the country require food assistance to facilitate adequate dietary intake and prevent deterioration of the nutrition status of children, women and the general community. Already nationally 56 per cent of women consume less than five groups of foods recommended.
- Due to the lockdown, the Nutrition Cluster might see a spike in cases of acute malnutrition due to limited economic activities especially in the urban areas, yet the interventions have been targeting rural areas. Impact can also be felt in rural areas due to limited availability of remittances from local sources and the diaspora during the lockdown period.

Response

- Active screening continues for early detection, referral and treatment of children with acute malnutrition.
- Procurement and pre-positioning of life-saving therapeutic foods has been provided at all public health facilities in the country.
- Micronutrient supplements including Vitamin A are provided.
- Support and counselling have been given to mothers and caregivers of children under age 2 in IYCF-e.
- Capacity building is provided for health workers and partners in nutrition in emergencies and nutrition communication for the emergency response at community level.
- Accountability to affected populations was facilitated through community dialogues.
- Due to the Government country-wide lockdown to reduce the spread of COVID-19, the nutrition in emergencies intervention lifesaving activities have slowed down. Limited movements have limited the nutrition data reported from implementing partners (IPs), as staff are working from home and cannot collect some of the information from health
facilities/VHWs.

- There have been reduced admissions in the Integrated Management of Acute Malnutrition (IMAM) programme (DHIS Q1 2020) program from 952 in January to 741 in February, to 354 in March, including 201 girls and 153 boys.
- Cluster partners have received authorization to support MoHCC in providing the life-saving treatment of children with acute malnutrition during lockdown.
- Guidelines on mother-led mid-upper arm circumference (MUAC) in the context of COVID-19 were developed and shared, as well as nutrition key messages on infant and young child feeding.
- Efforts were initiated to sensitize and build the capacity of community health workers (CHWs) on mother-led MUAC for early detection of acute malnutrition and treatment of wasting at the community level, including training on low/no-touch assessment, simplified treatment protocols, remote supervision and key messages on COVID-19.
- With the Nutrition Cluster finalizing the importation of initial contacts onto the RapidPro system with scheduled messages go to both health facilities and volunteer health workers (VHWs), the first message to report was shared on 27 April for health facilities to report data for the week of 20 to 26 April 2020.

Gaps

- Limited funding to meet the needs of the response remains the main challenge for the emergency nutrition projects.
- Reporting of nutrition information has been affected by COVID-19 and the lockdown resulting in the lack of MAM data. Lack of disaggregated data on children with disabilities remains a gap as these data are not routinely collected.
- There is a knowledge gap in the context of COVID-19 pandemic and in nutritional messages or information to the community and health workers.
- There is a lack of personal protective equipment (PPE) for the community volunteers and supervisors implementing nutrition in emergencies life-saving activities.
- Gaps continue for the availability of internet to enable partners to not only work from home and participate in virtual meetings during the lockdown due to COVID-19 pandemic.

CLUSTER STATUS (29 Apr 2020)

Protection (Child Protection)

422K people targeted

20,554 children reached w/psychosocial activities

Needs

- Economic stress, further increased by the impact of COVID-19 lockdown on those dependent on the informal economy for their survival, anxiety surrounding the COVID-19 outbreak and living in lockdown without access to basic services, increases stress in households, psychosocial distress and depression in children and caregivers, resulting in increased risk of sexual and other forms of violence and abuse, and separation from caregivers for survival.
With COVID-19 and the lockdown in Zimbabwe, the child helpline has recorded a 43 per cent increase on the daily average calls, with 41 per cent directly related to violence against children and SGBV. About 75 per cent of the perpetrators were people within the child’s home environment.

The few social cash transfer and food deficit mitigation measures that are operational, do not benefit children living in institutions resulting in dire circumstances for a group of extremely vulnerable children.

Children on the streets are being rounded up and moved outside of urban centres to places of safety, including residential care facilities and training centres. These centres lack the bare minimum of basic services to maintain adequate personal hygiene and services to care for them.

There is limited access to justice as a result of the Practice Direction 1 of 2020 on Court Operations that took effect on 30 March 2020, limiting access to courts and the right to be heard within a reasonable time through the suspension of filing new cases, all processes and pleadings for the duration of the national lock down. Subject to existing limitations, only initial remands, urgent applications and bail applications may be entertained. It remains unclear whether GBV cases and court orders for the termination of pregnancy fall under the “critical” cases that courts will handle during the lockdown.

Response

Since January 2020, 20,554 children (46 per cent boys and 54 per cent girls) have benefited from structured psychosocial activities.

A revised letter by the Ministry of Public Service, Labour and Social Welfare for CSOs to cover the extended 14-day lock down period is facilitating the continuity of essential child protection services, including case management and provision of Mental and Psychosocial Support (MHPSS) for children and vulnerable communities.

With the number of cases on violence against children and SGBV on the rise during the lock down period, and survivors failing to report and access services as trapped with their perpetrators, child protection partners are attending to critical sexual abuse cases by providing community cadres with airtime credit for mobile follow up support and reporting of new cases.

COVID-19 guidelines for Community Child Care Workers (CCWs) developed with support of UNICEF will be disseminated through the Department of Social Welfare (DSW) nationwide. These guidelines will be used by CCWs conducting child protection home visits in their communities with emphasis on prioritization of critical child protection cases while adhering to social distancing and handwashing requirements.

The Department of Social Welfare (DSW), with the support of Child Protection Society in Harare and Scripture Union in Bulawayo, Masvingo, Mutare and Gweru, has provided alternative care arrangements for 156 separated children (6 female and 150 male) who were living on the streets including reunification of 55 children with their care givers.

Rehabilitation services in the form of counselling and family tracing has commenced in all centres. Family assessments and reunification are being put on hold pending authorities’ announcement of lifting of travel restrictions due to the COVID-19 lockdown. With children in alternative care facilities lacking recreational activities, UNICEF is releasing pre-positioned recreational kits to the five centres.

UNICEF is finalizing partnership agreements to conduct MHPSS for front line workers, children and caregivers, establish parenting programs to build resilience of caregivers during lockdown and isolation, and to support remote case management services and care and rehabilitation of children with disabilities, from an explicit COVID-19 perspective. UNICEF is also locally procuring PPE for CSOs.

The opening of family support trust (FST) clinics is facilitating access to medical services for SGBV/violence against children survivors. The clinics are attending an average of four to five cases per day which requires urgent legal action for instance termination of pregnancies.
• A taskforce was put in place to review proposed COVID-19 child protection messaging and ensure harmonization.

Gaps

• With limited availability of public transport and police vehicles, the major concern is that some of the children who need child protection services from organizations such as REPSSI and FST, may be failing to access services.

• There is a lack of COVID-19 related information in accessible formats for persons with disabilities, especially for the deaf and hard of hearing, and the blind or partially blind people.

CLUSTER STATUS (29 Apr 2020)

Protection (Gender-based Violence)

845K people targeted

7,175 people reached

Needs

• GBV threats continue to intensify in scale and scope while the population is exposed to degenerating food insecurity, compounded by economic hardship and the COVID-19 movement restriction measures.

• GBV exacerbation continues to be recorded, as an indirect consequence of COVID-19 infection, prevention and control (IPC) measures. The national GBV Hotline has recorded a total of 972 GBV calls since the beginning of the lockdown (30 March – 22 April), with an overall increase of over 70 per cent compared to the pre-lockdown trends.

• The extended lockdown continues to impact on the women's and girls’ ability to access basic family resources (e.g. fetching water, accessing food), generating an increase of tensions within the household, which leads to increased risks of exposure to intimate partner violence (IPV). Various sources have reported that the re-opening of some productive sectors, such as the mining sector, poses an increased risk of sexual exploitation and abuse in some hotspots as vulnerable women and girls might resort to transactional sex in exchange for cash or basic goods.

• GBV service facilities remain unequipped for COVID-19 IPC measures, which poses high risks of infection for both staff and clients. Furthermore, access to GBV services is constraint due to the limited freedom of mobility and reduced availability of public transport means during lockdown.

Response

• Since 1 January 2020, the GBV sub-cluster partners have assisted a total of 5,755 individuals (2,234 male, 3,528 female) with community-based GBVIE risk mitigation and PSEA outreach, integrated in various community-based mechanisms and with the support of a workforce of 225 community volunteers, included behaviour change facilitators. These were provided with sensitization on PFA to enhance their support to identified GBV survivors within communities and timely referrals to specialized services. The set up and operationalization of Safe spaces for women and girls continued in 9 drought most critically affected districts, although service uptake was slowed down
by the COVID-19 lockdown measures. In addition, 381 women and girls were reached with community-based PSS interventions, including at W/G safe spaces, and 1,039 GBV survivors (1,002 female, 39 male) were assisted with multi-sectoral GBV services, through static One Stop Centres, Shelters and health clinics.

- Under the leadership of the Ministry of Women Affairs, Community, Small and Medium Enterprises, and technical support by UNFPA, clearance letters for continuation of GBV essential service provision during the lockdown continued to be issued at provincial level to all registered GBV service providers, with GBV specialized essential service provision continuing to gradually resume.

- Key interventions within the GBV sub-cluster continue to focus on scaling up mobile service delivery; equipping all static and mobile GBV facilities (one-stop centers (OSCs), shelters and safe spaces) with COVID-19 IPC supplies; transport support for referral of survivors to higher level of care, including those with suspicious symptoms to COVID-19 dedicated response health facilities; scaling up remote psychosocial support (PSS), through increased capacity of GBV hotlines; increased GBV COVID-19 impact surveillance, MHPSS support for GBV service providers, community based communication for COVID-19 and GBV impact risks mitigation, capacity building of inter-cluster frontline responders on COVID-19 and GBV.

- GBV sub-cluster partners continue to explore alternative modalities to cater for the increased needs of most vulnerable women and girls. These include the requalification of community spaces (e.g. training centres) to accommodate homeless women.

- About 700 stockpiled dignity kits were distributed to critical GBV service providers and facilities (e.g. OSCs, Shelters) to cater for the immediate COVID-19 prevention needs. The kits include basic hygiene items and toiletries, such as soap, washing powder, as well as sanitary wear, underwear and other toiletries to ensure dignity and reduce the risk of exposure to exploitation.

### Gaps

- Protracted lockdown measures and the consequent impact on income access contributes to de-prioritization of GBV services, under-reporting and life threatening consequences for GBV survivors.

- The setup of new mobile One Stop Centres is facing challenges related to clearance for staff mobility and availability of PPE for COVID-19 prevention.

- Despite the provision of clearance letters at provincial level to all registered GBV service providers, some challenges have been encountered in Harare Province.

- With GBV specialized essential services gradually resuming, the unavailability of PPE continues to be a challenge for full operationalization.

### CLUSTER STATUS (29 Apr 2020)

**Water, Sanitation and Hygiene (WASH)**

<table>
<thead>
<tr>
<th>People Targeted</th>
<th>People Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,7M</td>
<td>243K</td>
</tr>
</tbody>
</table>
Needs

- In rural areas, of the 55,593 water sources tracked by the rural water information management system (RWIMS), only 30 per cent have water, and are functional and protected, which increases the risk of WASH-related diseases, especially in 23.8 per cent of households lacking improved access. About 16 per cent of households travel more than a kilometre to fetch water from the nearest primary water source.

- Despite no reported cases of cholera, there is an ongoing typhoid outbreak with 488 cases and two deaths recorded in high-density suburbs of Harare.

- Urban centres face critical water treatment chemicals’ shortages and despite electricity power cuts having reduced over the lockdown period, water supplied to residents continues to be lower than the average water demand resulting in the continuation of water rationing.

Response

- About 26,000 people were reached with safe drinking water supply through trucking 120,000 litres of water into six Harare suburbs (Warren Park, Budiriro, Kambuzuma, Glen view, Glen Norah and Hatcliffe) reaching 6,000 people and through the rehabilitation of 40 boreholes around Harare’s high-density water constrained areas reaching 20,000 people.

- More than 522,800 people in 11 districts of Zimbabwe (Harare, Buhera, Chimanimani, Chipinge, Mutare, Marondera, Norton, Masvingo, Zaka, Binga and Norton) were reached with messages on COVID-19 prevention and the importance of hand washing with soap through mass media- radio jingle and road show campaigns in communities.

- Partners distributed 1,485 WASH NFI kits (buckets with tap, jerry cans, soap, aqua tabs and IEC materials) in five districts (Harare, Nyanga, Chimanimani, Beitbridge, and Chipinge) to support handwashing activities and treatment of water for drinking.

- More than 10,700 people were reached with handwashing campaigns to reduce the transmission of COVID-19 in markets, public spaces and boreholes in Harare, Chegutu and Gweru urban.

Gaps

- Resource mobilization for the COVID-19 response is still ongoing and partners have reallocated existing budgets to support the COVID-19 response, which has a bearing on the ongoing drought response and cholera preparedness.

- While partners have managed to get clearance to operate within the lockdown, external factors mostly around supply chain constraints due to international and regional markets closure which affect the local market for other WASH related products continue to affect activities.

- Constraints are still being felt for the supply of PPE due to the closure of borders and the increased demand of the materials globally.

CLUSTER STATUS (29 Apr 2020)

General Coordination
**Needs**

- An emergency of this complexity and magnitude requires the close coordination of all stakeholders. The interaction with Government and frontline ministries, UN agencies and operational partners is vital in rolling out the multisectoral humanitarian support to complement Government’s interventions.

- Continuous tracking of response progress, funding availability and resource capacity is key to ensure that critical gaps are identified and dealt with.

- There is a need for increased coordination and information management under the government-led COVID-19 coordination structure with humanitarian and development partners, including communication of priority needs and gaps under the 10 pillars.

**Response**

- A Standing Cabinet Committee, under the stewardship of the Minister for Local Government and Public Works, is tasked with overseeing the Government’s response efforts and coordinates with the humanitarian partners through the office of the UN Resident Coordinator. At the technical and operational level, the Department of Civil Protection (DCP) coordinates the overall Government response with OCHA and UN cluster lead agencies, and interacts with Provincial and District administrations.

- On 19 March 2020, the Zimbabwe National Preparedness and Response Plan for COVID-19 was launched with an initial eight pillars of coordination, the creation of a national COVID-19 Response Task Force and the formation of the Inter-Ministerial Committee. Overall high-level coordination and planning is led by the Permanent Secretary for the Ministry of Health and Child Care (MOHCC) working with permanent secretaries of other ministries in support of the Inter-ministerial COVID-19 Task force, with weekly high level coordination meetings on Tuesdays in the Emergency Operations Centre.

- Humanitarian partners and donors meet bi-weekly (and ad-hoc if necessary) under the Humanitarian Country Team (HCT), chaired by the UN Resident Coordinator. Individual sectors also meet on a regular basis and are chaired and co-chaired by the relevant line ministries and humanitarian cluster lead agencies. Inter-cluster coordination meetings take place (bi-)weekly chaired by OCHA. Due to the COVID-19, all meetings are being held virtually.

**Gaps**

- Only 11 per cent of the total requested has been committed, and this critical funding gap hinders operational coordination of the response.

- Continuity of coordination personnel/expertise is not assured, and this presents operational difficulty where frequent personnel turnover is required during the HRP time frame.

- Despite that the nationwide lockdown to curb the spread of COVID-19 ensures the continuity of essential services, including humanitarian cluster activities, implementation and coordination have been constrained.