HIGHLIGHTS (7 May 2020)

- The first imported COVID-19 case was reported on 21 March 2020 and local transmission started on 24 March. As of 5 May, 34 COVID-19 cases were confirmed, including four deaths.

- A malaria outbreak, with over 226 deaths reported since 1 January 2020 throughout the country, creates an additional burden to an already fragile health system.

- Over 2 million 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 1,989 in January to 1,852 in February and 1,708 in March in the entire country.

- The national GBV Hotline recorded 1,273 GBV calls since the beginning of the lockdown on 30 March with an overall increase of over 100 per cent compared to pre-lockdown trends.

A woman carries her allocation of maize at a WFP food distribution in Shamva. WFP has rolled out health and safety measures to curb the spread of COVID-19 across all its food distributions in the country.

KEY FIGURES

- 7M people in need
- 5.6M people targeted
- 47 partners operational

FUNDING (2020)

- $0 Required
- $63.8M Received
- 0% Progress

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BACKGROUND (7 May 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 Zimbabwe Vulnerability Assessment Committee (ZimVAC) 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 5 May, the Ministry of Health and Child Care (MoHCC) in Zimbabwe had reported 34 confirmed COVID-19 cases including four deaths, with cases reported in five provinces including 13 cases in Harare and 12 cases in Bulawayo, and a total of 11,647 screenings and diagnostic tests done. With the first cases reported in Zimbabwe as of 21 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. This was reviewed and extended by two weeks until 3 May. On 1 May, the Government announced the easing of lockdown regulations which allowed formal industry and commerce to resume operations, having met the specified regulations including mandatory testing and screening of employees. These measures will be in effect until 17 May.

The country is currently facing a malaria outbreak that is creating an additional burden to an already fragile health system. From 1 January to 26 April 2020, more than 236,365 malaria cases and 226 deaths have been reported. During the week from 20 to 26 April, a total of 33,171 malaria cases and 21 deaths were reported representing a 220 per cent increase in cases compared to similar period in 2019. The number of health facilities reporting malaria outbreaks remain on the rise, with highly affected provinces being Manicaland, Mashonaland East and Mashonaland Central.

In addition to the commitments to the HRP recorded above through the Financial Tracking System (FTS), a number of pledges are in the process of being realized. This includes $13 million from the European Commission for which a call for proposals has been launched, $44 million COVID-19 funding announced by the UK Ambassador, and a further $20 million CERF allocation to WFP for Social Protection programming. The Government of Japan also announced the commitment of $15.3 million in emergency funding including $14.8 million to WFP, $455,000 to UNICEF and $96,000 to IOM.

CLUSTER STATUS (6 May 2020)

Camp Coordination and Camp Management / Shelter and NFIs
43,352

displaced people in camps & host communities

**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, Chimanimani, Mutare and Buhera. DTM assessments will also generate information to support COVID-19 response and inform multisectoral needs including guidance on preventative measures such as establishment of adequate sanitary facilities for handwashing in camps and host communities.

- Communities surveillance is being strengthened through local leaders to ensure detection of early symptoms of COVID-19, isolation and treatment.

**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 (7 May 2020)

![Status Icon]

**Education**

<table>
<thead>
<tr>
<th>853K</th>
<th>35,312</th>
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<tbody>
<tr>
<td>children targeted</td>
<td>people reached (as of end of March)</td>
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#### Needs

• 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. The combined effect of the humanitarian crisis and COVID-19 pandemic is expected to have a far reaching implications for the protection and wellbeing of children as well as their readiness for school, attendance and participation in learning.

• Before the onset of the COVID-19 epidemic, estimates by the education cluster were 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), would need emergency or specialized education services in 2020. This includes more than 853,000 children in acute need, such as: children enrolled in school; orphans and other vulnerable children, including children with disabilities and children living with HIV and those in need of school feeding.

• While Zimbabwe closed schools to contain the spread of COVID-19 and protect school populations, prolonged closure represents major risks for children, teachers and schools communities. Without a well-resourced response, the combined impact of these crises risks having a lasting negative 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. The cluster is targeting 3.5 million learners in early childhood education, primary level and secondary level through prioritization of activities.

#### Response

**HRP Activities:**

• As of end of March 2020, a total of 35,312 people benefited from various activities implemented by the Cluster through operational partners, 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).

**COVID-19 Activities:**
- World Vision Zimbabwe is currently preparing to print supplementary reading materials and numeracy kits which will include laminated levelled reading cards, and paper print copies of 25 African Storybook OER titles. Current funds are available to print for eight schools in the initial phase. The organization is pre-positioning handwashing supplies (soap, buckets) and PPE supplies to support 16 schools in catchment areas and doing follow-ups on child protection cases reported which may require home visits. Recently, WVI conducted a text-based survey for teachers to assess Covid-19 awareness, communication channels and support to learners at home that will guide programmatic work towards responding to COVID-19 pandemic. WVI is currently planning to rollout a mobile-based learning platform called VIAMO in Chipinge and Chimanimani for numeracy and Literacy for ECD A & B. The project is targeting 4,500 children (100 children per school). Additional planned activities include working with a team of teachers to rapidly develop a learner study resource for Grade 7 in Mathematics and English subjects and expanding support for the current pilot activities to target 266 schools. WVI is currently targeting girls to keep them safe through setting up grassroot networks and dispatching key messages.

- Plan International is currently in the process of securing agreements with service providers that will include community and national radio stations programs and national television and mobile network providers in readiness for rolling out Education Cannot Wait (ECW) activities. Plan International has completed consolidation of radio, television and mass SMS messaging schedules which will be rolled out across the country.

- UNICEF is in the process of delivering 1,000 sets of story books to satellite schools and parents will be able to pick up the books at the school. The books will allow children to read and learn during school closure and be accompanied by a guide for parents on how to support their children to study. An additional 60,000 sets of books are currently being printed and will be distributed once printing is finalized. Furthermore, UNICEF will provide an equal amount of psychosocial support (PSS) materials to children and their parents. Together with Ministry of Primary and Secondary Education (MoPSE), UNICEF continues to support the education response and the ongoing development of the radio education programme, which is expected to start next week.

- CARE International plans to undertake the following activities in Bikita and Zaka Districts: provision of disinfectant chemicals and washing liquid soap and sanitizers for teachers and learners and conducting of water quality monitoring. In Chivi and Mberengwa districts, CARE plans to support the Ministry of Social Welfare (MSW) to conduct abuse follow ups and psychosocial support provision for survivors of abuse and their care givers. Additionally, CARE plans to procure PPEs for frontlines workers (MSW) to ensure safety measures when conducting follow ups and provision of water buckets, washing soaps to promote health and sanitation practices, providing sanitary pads for girls during homesteads visits and support of remote virtual learnings via what's ups platforms too.

- UNHCR is expanding water reticulation system into schools within refugee camps and surrounding communities where the camps are located of to enable access of portable water by students once learning resumes; UNHCR also plans to establish handwashing stations in schools within the refugee camp too. Furthermore, UNHCR plans to do printing and distribution of IEC materials as soon as learning resumes to enable access of information on COVID-19 to students.

### Gaps

- Inadequate human and financial resources: While partners have supported the development of the Education Cluster COVID-19 Preparedness and Response Plan, many face human and financial resource constraints to respond to the urgent needs of learners.

- Reduced mobility and access: Both partners and Government staff are facing fiscal and technical constraints to enable staff to work remotely and respond to the needs of learners. To add to the challenge, the lockdown has also reduced the mobility of staff, with implications for the implementation of response activities. While Government issued some letters following the initial lockdown, some partners are facing renewed mobility challenges during the
second phase of the lockdown. Time-critical solutions to focus on learners who cannot access digital or radio lessons, due to coverage or household considerations are minimal and need to be addressed further to enhance response.

**CLUSTER STATUS (7 May 2020)**

**Food Security**

- **4.4M** people targeted
- **2.01M** 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 rural areas.
- In addition, 2.8 million small holder farmers are in need of season-sensitive emergency crop and livestock input assistance.
- Animal disease control operations have been scaled down (e.g. dipping) as livestock owners are reluctant to bring animals in congregated areas. Although vaccines for poultry are available in country, there is a shortage in the rural areas as cold chain facilities are limited. Imports of veterinary drugs have experienced a pipeline breakage due to air freight difficulties.
- Due to the current lockdown, government extension workers are reporting for duty but many are not mobile as public transport in the rural areas is very limited. Some extension officers have also reported resistance of farmers in allowing extension officers onto farms. There is a need to support the government extension workers on a larger scale, as well as to try to strengthen dissemination of COVID-19 crisis communication.

**Response**

- Implementation of agriculture and livelihoods projects continues on a limited scale with regard to input distributions which were pre-positioned before the lock down. However, there is a break in the pipeline due to tender delays as suppliers are battling to collect stock. To ensure continuity of planned projects, FSL Cluster partners are developing remote extension options such as the use of WhatsApp platforms and radio. The Karima Mari mobile application has proved to be very effective. However, most farmers do not have access to Smart Phones.
- For the April 2020 cycle, a two-week delay was experienced due to the implementation of COVID-19 protection and mitigation measures. Despite this, Cluster partners reached a total of 2.01 million people 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 people 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**

- According to data reported in the March 5W, a total of 1.6 million people targeted with in-kind or cash distribution are at risk of discontinued support due to upcoming end of projects. In addition, the COVID-19 outbreak has led to the suspension emergency agriculture and livelihoods support projects benefitting 220,000 vulnerable farmers.
- 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.
- Private sector companies engaged in agriculture are operational as the 'exemption permit' process is working well. However, most companies are operating with skeletal staff and reporting a large slowdown in business due to fall in demand for products. Some companies are reporting difficulties in accessing raw materials from China and other places due to air freight restrictions. The microfinance operations are huge challenges are defaults on repayments are becoming more evident. This will have a knock-on effect for farmers obtaining credit for the next planting season.

**CLUSTER STATUS** (6 May 2020)

Health

3M people targeted

34 COVID-19 cases (as of 5 May)

**Needs**

- The country is currently facing a malaria outbreak. From 1 January to 26 April 2020, 236,365 malaria cases and 226 deaths were reported. During the week from 20 to 26 April, a total of 33,171 malaria cases and 21 deaths were reported, representing a 220 per cent increase in cases compared to similar period in 2019. The number of health facilities reporting malaria outbreaks remains on the rise, with highly affected provinces being Manicaland, Mashonaland East and Mashonaland Central. This outbreak creates an additional burden to an already fragile health system.
- As of 5 May, Zimbabwe has reported 34 COVID-19 cases, including four deaths and five recoveries since the onset of the outbreak, with cases reported in five provinces including: Harare (13), Bulawayo (12), Mashonaland East (54), Mashonaland West (3), Matabeleland North (1). Of the 34 cases, 14 (41 per cent) are imported cases and 20 (59 per cent) are due to local transmission. The most recent confirmed case was reported on 28 April 2020, 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.

- For returnees, there is a need to improve isolation tents, for quarantine facilities to develop SOPs and provide basic services including food, water and improved wash infrastructure, and medical services to reinforce thermal scans and testing, health care, counselling and psychological support.

**Response**

- Conditions associated with the extended lockdown up to 17 May 2020 include: use of screening test (rapid diagnostic tests) for employees resuming work; compulsory use of face masks by all public place; mandatory quarantine for all travellers arriving in Zimbabwe for seven days followed by PCR testing and then an additional seven days voluntary quarantine.

- Intensified active surveillance is ongoing with 556 health facilities in six provinces assessed since 28 April 2020; 208 communities identified with reports of clusters of acute respiratory illness/Influenza like illness; and Rapid Response Teams (RTTs) assessing identifies clusters and collecting samples from laboratory testing.

- 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.

- National Public Health Care capacities have been scaled up in four areas:
  1. Laboratory: Rapid scaling up of testing (screening-RDT and confirmatory-PCR); Mandatory PCR testing for all health workers, all contacts, all hospitalized patients and uniformed forces; Prioritization of PCR testing for symptomatic patients with respiratory illness;
  2. Points of Entry: Additional potential sites for venues, including hotels, being assessed to increase capacity for mandatory quarantine;
  3. Risk Communication: Continued engagement and capacity building of the media, local artists, religious leaders; dissemination of messages; and

- National Clinical Care capacities continue to be scaled up with assessments of 80 hospitals/Health facilities completed in all 10 provinces, the national case management operational plan finalized based on the health facility assessment report, and models of care and services defined at all levels. The operational plan is complemented by national clinical guidelines clarifying patient handling and referral pathway and procedures.
• IPC training for health workers was conducted in Manicaland with 71 health workers and support staff from Mutambara Mission Hospital (COVID-19 designated district hospital) and 30 from surrounding primary care clinics trained, bringing the cumulative number of health workers trained to 906. Training in Mashonaland East and Matabeleland South is planned as of 4 May. With national IPC Guidelines and the National COVID-19 Guidelines for Health Worker Screening developed and pending approval, health worker screening and self-assessment is ongoing at all HCFs.

• With training of Health Care Workers on case management continuing in all provinces with support from the INGOs World Vision and Save the Children, 180 health care workers were trained in Bulawayo province, and 100 in Binga and Kariba.

• Assessment of all nominated COVID-19 isolation facilities in the country was completed with the list of selected facilities along with budget for refurbishments finalized.

• Contact tracing in Bulawayo, Harare, Mashonaland East, Mashonaland West and Matabeleland North is ongoing with 1,230 contacts being monitored from the 34 confirmed cases, and 18 contacts having become confirmed COVID-19 cases during the 14 day follow up. A total of 655 contacts have completed 14 days of being followed up, with the proportion of contacts still within 14 days of exposure that were followed up as of 4 May 2020 being 100 per cent.

• A health preparedness and response plan was developed for Points of Entry (POEs) with dissemination of POE-specific standards operating procedures (SOPs) for detection, notification, isolation management and referrals of travelers/ irregular migrants suspected to have COVID-19. IOM is scaling up its interventions to cover all POEs and ensure health standards are met with a human rights-based approach to assist returning migrants with the adequate resources.

• Assessments of all POEs in Zimbabwe were conducted to identify the needs, gaps and capacities to respond to the COVID-19 pandemic following the guidelines established in the Zimbabwe National Response Plan and the International Health Regulations 2005 (IHR) and to ensure standards are met for the assistance to returnees and stranded migrants. In addition, the IOM DTM team continues to conduct flow monitoring activities at Beitbridge border post (South Africa) tracking mobility trends, needs and vulnerabilities, and a population mobility mapping (PMM) exercise detecting risk hot spots to reinforce surveillance activities in the border posts and communities of origin.

• IOM provided 980 tarpaulin tents and 250 Non-Food Items (NFI) kits to reception centres in the key border posts of Beitbridge, Plumtree and Chirundu, to set up isolation facilities and assist vulnerable returning migrants.

**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.

• Clinical equipment gaps include: 1) with 129 ventilators required, there is a gap of 108; 2) with 132 patient monitors required, there is a gap of 110; 3) with 176 suction machines required there is a gap of 167. With the updated total budget of US$37 million under the national case management plan, there is a funding gap of $32 million.
CLUSTER STATUS (7 May 2020)

Nutrition

606K people targeted

5,549 acutely malnourished children treated in Q1

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) program as reported during the past weeks in the 25 priority districts under the HRP. Nationally, from January to March 2020, a downward trend was observed in Severe Acute Malnutrition (SAM) admissions into the integrated Management of Acute (IMAM) program (DHIS Q1 2020) from 1,989 in January to 1,852 in February, and to 1,708 in March 2020. In total, 5,549 children were treated.

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.
- Lack of personal protective equipment (PPE) for the community volunteers and supervisors implementing nutrition in emergencies life-saving activities still posing a challenge on the implementation of the nutrition lifesaving interventions.
- Gaps continue on the availability of internet and data to enable partners not only work from home but also and participate in virtual coordination meetings during the lockdown due to COVID-19 pandemic.
- Change of modalities and approaches will lead to the elongation of the duration of the implementation of the nutrition in emergencies activities compared to the time previously planned.

CLUSTER STATUS (7 May 2020)

Protection (Child Protection)

422K people targeted

20,554 children reached w/psychosocial activities

Needs
The acceptability to CP and GBV services and the ability of women and children access these services has decreased during the lockdown. There are increasing calls for GBV shelters to be explicitly designated as essential services which will continue to provide services during the lockdown periods while observing rules social distancing, isolation and hand sanitisation.

There is limited access to justice for the general populace since only urgent matters, initial remands and bail hearings are being considered. This has resulted in increase in child protection cases relating to their welfare including maintenance cases, access rights, custody and guardianship of children.

Challenges in unifying children in conflict with law released and street children because of difficulties in finding their legal guardians. There is risk that the current crisis and its economic impact leads to abandonment of vulnerable children.

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.

**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 shared with partners is facilitating the continuity of essential child protection and GBV services, including case management and provision of Mental and Psychosocial Support (MHPSS) for children and vulnerable communities.

- The child helpline has recorded a 43 percent 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 national GBV hotline has also recorded a sharp increase in GBV cases reported since the lockdown (800 per cent increase).

- 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.

- UNICEF working with the MoPSLSW and Child Protection Society (CPS) to provide tracing and reunification services to 62 unaccompanied children in quarantine facilities at the borders.

- 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.
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.

Gaps

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.

Need to strengthen coordination efforts among actors at border quarantine facilities to ensure reception centers are well equipped with IEC and PSS materials, food and more hygiene materials in addition to provision of training to front line workers who are interacting with children to ensure they have the necessary knowledge and skills related to GBV and CP risk mitigation, Prevention of Sexual Exploitation and Abuse (PSEA), child safeguarding, and safe referral practice.

Remote management of child protection cases remains a challenge in Tongogara Refugee Camp. There is growing need for UNHCR in collaboration with all implementing partners to develop a strategy on COVID-19 Case Management response. This strategy will provide guidance on; prioritization of the current case load to promote effective response, adoption of flexible and adaptable case management processes given the limited interaction with persons of concern, strengthening links between child protection and health services and referral pathways.

CLUSTER STATUS (7 May 2020)

Protection (Gender-based Violence)

845K people targeted

8,093 people reached

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 extended lockdown continues to impact on the women’s and girls ability to access basic family resources (e.g fetching water, accessing food), generating and increasing tension within the household, which leads to increased risks of exposure to intimate partner violence (IPV) and sexual exploitation and abuse. The national GBV Hotline (Musasa) has recorded a total of 1,273 GBV calls since the beginning of the lockdown (30 March – 29 April), with an overall increase of over 100 per cent compared to the pre-lockdown trends. The most dominant forms are physical violence (36 per cent of total cases) and physiological violence (34 per cent), followed by economic violence (20 per cent) and sexual violence (10 per cent). About 90 per cent of cases are IPV cases.
Partners operating in Harare province continue to face challenges with clearances, and in particular movements restrictions for non-medical GBV staff. There is need to enhance sensitization of security forces patrolling the urban spaces during the extended lockdown, in order to ensure freedom of mobility of both GBV service providers and GBV survivors. Its was reported that in some instances, movements limitations have negatively impacted on the access of SGBV medical assistance within the 72 hours critical framework for administration of PEP. Some SGBV service providers located at health facilities have also reported increasing requests for operational space shrinking to accommodate the expansion of COVID-19 health response preparedness.

Access to justice remains constrained during the extended lockdown, with negative impact on access to termination of pregnancies within the legally adequate time frame from eligible rape survivors.

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 6,628 individuals (2,574 male, 4,061 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, including behavior change facilitators. Only 38 women and girls were reached with community-based PSS interventions, including at W/G safe spaces, and 1,038 GBV survivors (1,038 female, 49 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.

Community based GBV surveillance is strengthening through the gradual establishment of two way communication channel between community volunteers and hotline for remote for remote PSS. This mechanism facilitates timely and up to date information flow on referral pathways adjustments and service availability in specific areas and contributes increased timeliness of GBV survivors referrals to both static and mobile essential services.

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 and faith-based organizations spaces) to accommodate vulnerable women, while also exploring self-manufacturing of masks and other basic protective items.

**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 Centers continues to face challenges related to clearance for staff mobility and availability of PPE for COVID-19 prevention.
CLUSTER STATUS (7 May 2020)

Water, Sanitation and Hygiene (WASH)

2,7M
people targeted

243K
people reached

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 564 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 22 boreholes were rehabilitated in 6 high density areas within Harare (Mafakose, Mabyuku, Glen Norah, Kambuzuma and Dzivarasekwa) reaching 11,000 people. Cumulatively 62 boreholes have been rehabilitated reaching 31,000 people in Harare’s high-density water constrained areas.

- Around 240,000 litres, cumulatively has been trucked into 6 Harare suburbs (Warren Park, Budiriro, Kambuzuma, Glen view, Glen Norah Hatcliffe) reaching 12,000 people.

- More than 522,858 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 887 WASH related NFI kits to the Harare City Council, the two-quarantine centers-Belvedere Teachers College & ZIPAM and Beitbridge to support water treatment and hand washing for the returnees and in marketplaces. Cumulatively, 2,372 kits have been distributed in six districts including Harare Province.

- WASH hygiene kits have been distributed to 562 households in Glenview, cholera hotspots areas, reaching 1,500 people to support handwashing activities to reduce the transmission of COVID-19.

- A total of 12,264 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.

- In collaboration with the Ministry of Health and Child Care (MoHCC), 66 priority isolation facilities have been identified for WASH strengthening interventions, with IPC/WASH supplies (e.g. soap, mops, handwashing stations, waste management bins, gloves, chlorine solutions) being procured to support 50 isolation facilities.
UNICEF has developed a roadmap with potential implementing partners for WASH interventions in health care facilities, including activities, timelines budgets, supplies and training needs as well as WASH assessments tool for healthcare facilities to better understand the detailed needs and strengthen the WASH condition of isolation facilities.

## Gaps

- Funding for the COVID-19 response is still low 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, there is still delayed implementation because of the lockdown. In addition, there is increased cost of doing business due to duty of care that needs to be observed for staff and stakeholder.
- An increase in the cost for some of the crucial WASH commodities is being noted likely attributed to the increase in production and freight costs along with delays in replenishment of materials.

## 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.