ZIMBABWE

Humanitarian Gaps

2013

United Nations

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ZIMBABWE - Reference Map

OCHA

National capital
Provincial capital
District capital
Populated place
International boundary
Provincial boundary
District boundary

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Map data sources: CGIAR, United Nations Cartographic Section, ESRI, Europa Technologies, UN OCHA.

I. Executive Summary

The humanitarian situation in Zimbabwe has continued to improve and remains largely stable. This is due to the concerted effort by the Government of Zimbabwe, donors and other stakeholders to address the humanitarian needs arising from the challenges that the country faced over the last decade. Alongside these efforts, over the last three years, the recovery and development actors under the leadership of the Government of Zimbabwe have also continued to make steady investment; results are now beginning to bear fruit.

Despite these positive gains, humanitarian challenges remain. These include food insecurity mainly caused by drought—the impact of which is more visible in the south of the country—and sporadic outbreaks of waterborne diseases. In addition, a wide range of highly vulnerable groups such as the chronically ill, returned migrants, asylum seekers and those in displacement-like situations continue to require humanitarian aid.

However, the level and complexity of some of these needs require medium- to long-term interventions that address the root causes of the crisis. To this end, efforts are already in place to either address the identified needs or create a suitable policy environment to enable appropriate response to the needs. These include the Government's economic recovery blueprint through the Medium Term Plan for 2011-2015, the 2012-2015 ZUNDAF, and other ongoing development programmes.

Against this background, the Government and the humanitarian community have agreed to continue addressing the remaining humanitarian needs through humanitarian coordination and resource mobilization mechanisms. At the same time, other needs that were previously being addressed through humanitarian structures will now be addressed through recovery and development mechanisms. Under this agreed structure, certain activities in the area of food, health, WASH and protection will continue to be addressed through humanitarian structures, whereas activities in agriculture, education, nutrition, livelihoods and institutional capacity-building and infrastructure will largely be addressed through recovery and development mechanisms. The Government will become increasingly involved in both the remaining cluster coordination structures and the sectoral coordination arrangements in 2013.

The present appeal contains ten high-priority humanitarian projects valued at US$131,419,709 in the areas of food, health (including nutrition), WASH and protection.[1] More than 80% of this appeal will be for the Food Cluster. These projects have been prioritized based on strict criteria arrived at after extensive consultations with all the relevant stakeholders. Alongside the planned responses in the four areas, a modest Emergency Response Fund (ERF) managed by OCHA on behalf of the humanitarian community will be in place. The objective of the ERF will be to provide timely and predictable funding to unforeseen humanitarian needs that may arise in the course of the year and is appealing for $5 million.

The approach that the humanitarian community adopted in the current appeal is aimed at ensuring that all the remaining humanitarian needs in the country are addressed while at the same time consolidating the gains that the country has made towards recovery and development through the appropriate mechanisms.

[1] All dollar signs in this document denote United States dollars. Funding for this appeal should be reported to the Financial Tracking Service (FTS, fts@un.org), which will display its requirements and funding on the current appeals page.

Zimbabwe Humanitarian Dashboard (as of 12 November 2012)

Key Figures

4-5 thousand
Forcibly returned Zimbabweans seeking assistance

32% of children <5
Are stunted, 3% are wasted, 10% underweight
(ZDHS 2010-11)

4,000 deaths among children <5
From diarrhoea per year

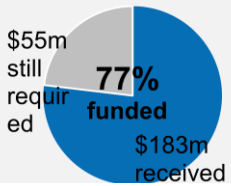
Baseline

Population (CSO 2011)	12.3 million
GNI per capita (UNDP HDR 2011)	$376
Life expectancy (UNDP HDR 2011)	51.4 years
Under-five mortality (ZDHS, 2010-11)	84 (per 1,000 live births)
Global acute malnutrition rate (NNS, 2010)	2.4%
% of children under 5 who are stunted (ZDHS,2010-11)	32%
% of pop. without improved water sources & sanitation facilities (ZDHS, 2010-11)	33% (water) 63% (sanitation)

2013 requirements

$131.42 million

$238 million requested in 2012



Situation Description

Outlook:

- Over 1.6 million people are expected to need food assistance at the peak of the lean season from January to March 2013. Ongoing drought in the southern part of the country will continue into 2013 according to meteorological forecasts and is expected to further increase food security needs.
- Although at much lower levels than previous years, Zimbabwe continues facing outbreaks of cholera, typhoid and acute diarrhea in both urban and rural areas. With only one-third of the population having access to clean water combined with a limited capacity of health structures, large-scale disease outbreaks remain a risk.
- The possibility of a situation necessitating humanitarian intervention cannot be categorically ruled out should the anticipated political process occur in an atmosphere of generalized or localized violent disturbances.

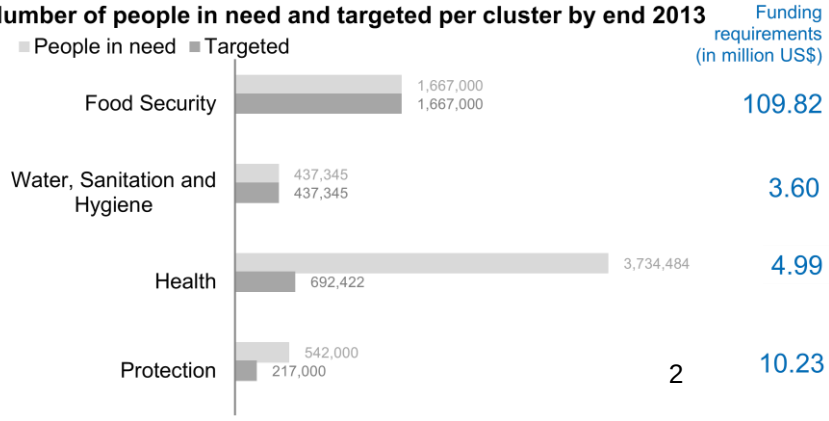
Most-affected groups:

- Food-insecure rural and urban households
- Migrants who have been forcefully returned from neighboring countries.
- Asylum-seekers from the Horn of Africa and Great Lakes region.
- Displacement-affected populations, children suffering from chronic and acute malnutrition, rural populations without access to basic WASH and health services, HIV/AIDS affected.

Most-affected areas:

- Matabeleland North and South, Midlands, Masvingo and parts of the Mashonaland and Manicaland Provinces.

2013 Planning Figures



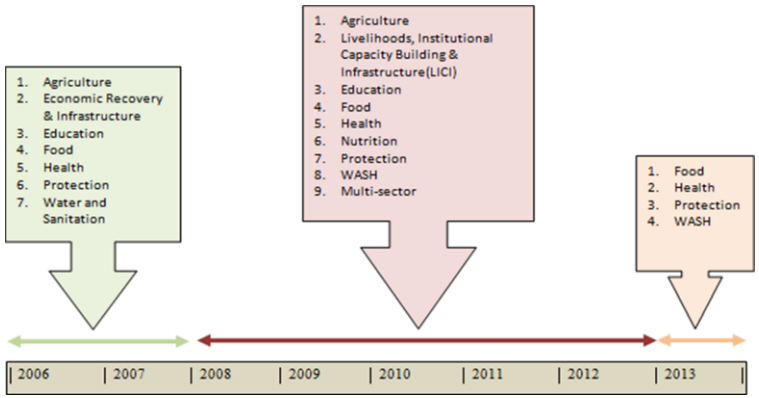
2013 Humanitarian Gaps target populations

Health	Protection
692,000	217,000
WASH	**Food**
437,000	1,600,000

Strategic Objectives of the 2013 Appeal

1. To maintain a minimum and coordinated response capacity in the Food, Health, Protection and WASH Clusters to address the most urgent, residual humanitarian needs in the country which need resolution in 2013, and for which organisations have the capacity to respond.
2. To assist in strengthening Government and other local capacity to coordinate, prepare for and respond to ongoing and future emergency situations.

Overview of Sectors/Clusters in Humanitarian Appeal Processes (2006-13)



Zimbabwe Humanitarian Dashboard (as of 12 November 2012)

Evolution of Needs

Food

- Poor weather patterns reduced the national cereal harvest by 33% this year. In light of this, food insecurity in Zimbabwe in 2013 is projected to be comparably worse than any period over the past three years. Almost one in five people living in rural areas will not be able to meet their basic food requirements.
- Large numbers of labour-constrained individuals and decreased purchasing power has significantly contributed to the number of people who require seasonal targeted food assistance. A large percentage of vulnerable rural farmers still depend on NGO and Government-subsidized agricultural inputs.

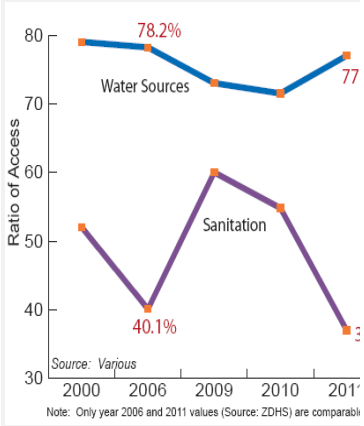
Health and WASH

- Zimbabwe continues to be vulnerable to outbreaks of epidemic-prone diarrhoeal diseases such as cholera, typhoid fever and dysentery. The country has reported annual cholera cases since 1998. Humanitarian response capacity is needed, particularly in high-density urban centres and vulnerable rural areas.
- Rates of diarrheal disease throughout the country have consistently exceeded epidemic thresholds over the past 12 months.
- Decreased dietary intake combined with high rates of disease predispose the population to development of malnutrition.

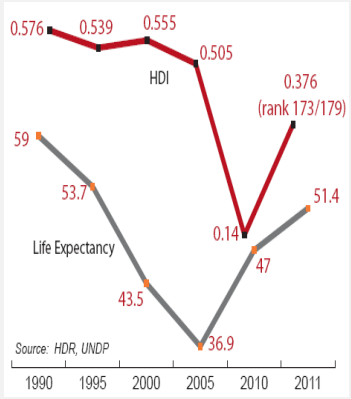
Protection and migration-related

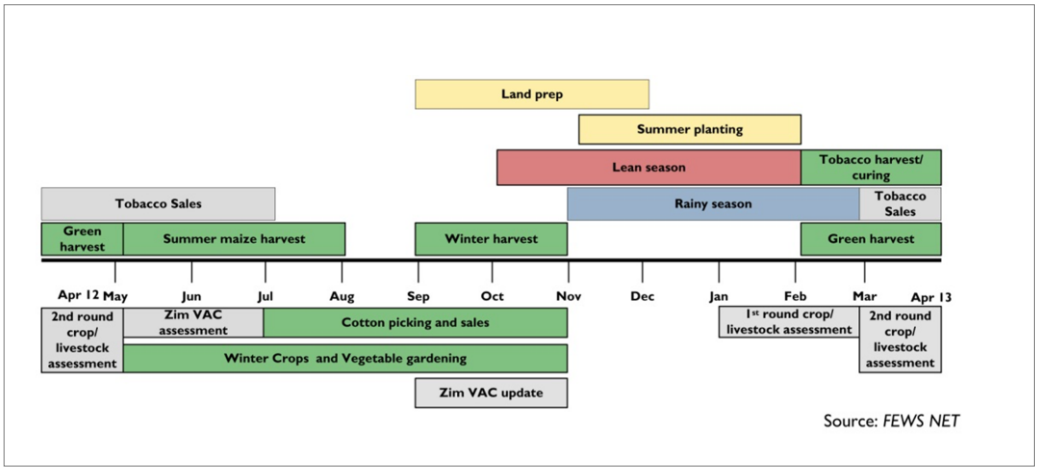
- Although recovery and development programs have made noticeable progress in addressing longer-term protection needs, a significant number of highly vulnerable groups, including displacement- and migration-affected populations, continue requiring humanitarian aid. Manicaland (Chipinge, Mutasa), Masvingo (Chiredzi), Mashonaland Central, Midlands, Mashonaland West, Harare, Bulawayo Metropolitan, Matabeleland North and Matabeleland South are hosting a significant number of highly vulnerable, mobile and displacement-affected groups, including children, people with disabilities, elderly, single-headed households, child-headed households and survivors of violence (e.g. sexual and gender-based violence).
- Vulnerable Zimbabweans deported from Botswana and South Africa via Beitbridge and Plumtree due mainly to their un-regularised status in these countries continue to require time-critical humanitarian aid in food, urgent medical and protection services, transport home and information on safe migration, and information on or treatment for HIV/AIDS, SGBV and counter-trafficking.

Population Access to Improved Water Sources & Sanitation



Human Development Index & Life Expectancy Trends





Additional basic humanitarian and development indicators for Zimbabwe

Sector	Indicators	Most recent data	Previous data or pre-crisis baseline	Trend *
Health	Maternal mortality (per 100,000 live births)	960 (ZDHS, 2010-2011)	612 (ZDHS, 2005-2006)	⇩
	Infant mortality (<1 age) (per 1,000 live births)	57 (ZDHS, 2010-2011)	60 (ZDHS 2005-2006)	⇧
	Under 5 mortality (per 1,000 live births)	84 (ZDHS, 2010-2011)	82 (ZDHS 2005-2006)	⇩
	Neo-natal mortality ratio (per 1,000 live births)	31 (ZDHS, 2010-2011)	24 (ZDHS 2005-2006)	⇩
	Crude death rate (per 1,000)	29 (UNICEF, 2010)	20 (ZDHS 2005-2006)	⇩
	HIV prevalence (age 15-49)	18% Female 12% Male (ZDHS 2010-2011)	21% Female 14.5% Male (ZDHS 2005-2006)	⇧
	Maternity care – pregnant women who received antenatal care from skilled provider (%)	90% (ZDHS 2010-2011)	94.5% (ZDHS 2005-2006)	⇩
	Child health – children 12-23 months fully vaccinated (%)	65% (ZDHS 2010-2011)	53% (ZDHS 2005-2006)	⇧
	Number of cholera cases / fatality rate	19 / 0 (Cluster lead, 3-27 May 2012)	1,140 / 3.9% (2011) 66,773 / 4.04% (2009) (EPI, MoHCW/WHO)	⇧
Nutrition	Chronic malnutrition (stunting)	32% (ZDHS 2010-11)	34% (FNC 2010) 35% (ZDHS 2005-2006)	⇧
	Nutrition – children under 5 years who are wasted (moderate to severe %)	3% (ZDHS 2010-2011)	2% (MIMS, 2009)	⇩
Food Security	% households according to food consumption score 35+	80.6% of CAP 2012 targeted		
WASH	Population with access to an improved water sources (%)	77% (ZDHS 2010-2011)	78.2% (ZDHS 2005-2006)	⇩
	Population with access to improved sanitation facilities	37% (ZDHS 2010-2011)	40.1% (ZDHS 2005-2006)	⇩
Human Development	Human Development Index	0.376 ranked 173/179 (UNDP HDR 2011)	0.505 ranked 145 (UNDP HDR 2005)	⇩
	Life expectancy	51.4 years (UNDP HDR 2011)	36.9 years (UNDP HDR 2005)	⇧
	Gross national income per capita	$376 (UNDP HDR 2011)	$189 (UNDP HDR 2005)	⇧
	% population living less than $1 per day	56.1% (2008, UNDP HDR 2011)	56.1% (UNDP HDR 2005)	⇔

*** The symbols mean: ↑ situation improved; ↓ situation worsened; ↔ situation remains more or less the same.**

Table I: Summary of requirements (grouped by cluster)

Consolidated Appeal for Zimbabwe 2013
as of 15 November 2012

Cluster	Requirements ($)
COORDINATION AND SUPPORT SERVICES	2,765,981
FOOD	109,829,799
HEALTH	4,990,000
PROTECTION	10,233,929
WATER,SANITATION AND HYGIENE	3,600,000
Grand Total	**131,419,709**

Compiled by OCHA on the basis of information provided by appealing organizations.

Table II: Summary of requirements (grouped by appealing organization)

Consolidated Appeal for Zimbabwe 2013
as of 15 November 2012

Appealing Organization	Requirements ($)
DWHH	2,600,000
IOM	12,223,929
OCHA	2,765,981
UNICEF	1,000,000
WFP	109,829,799
WHO	3,000,000
Grand Total	**131,419,709**

Compiled by OCHA on the basis of information provided by appealing organizations.

II. Review of humanitarian response in 2012

The matrix below summarizes the achievements and progress made to date in achieving the overall strategic objectives measured against indicators and targets as outlined in the 2012 CAP and the subsequent Mid-Year Review.

STRATEGIC OBJECTIVE 1: "SUPPORT THE POPULATION AFFECTED BY EMERGENCIES THROUGH THE DELIVERY OF QUALITY ESSENTIAL BASIC SERVICES"		
INDICATORS	**TARGETS (%)**	**ACHIEVED AS OF NOVEMBER 2012 (%)**
Percent of public health alerts assessed and responded to within 72 hours.	100	100
Improved access to quality basic and comprehensive emergency obstetric and neonatal care (EmONC) including for adults.	95	70
Percent of WASH-related alerts assessed within 48 hours and responded to within 72 hours.	100	100
Percent of new, accessible displacements assessed within 72 hours.	100	60
Number of returned and stranded migrants offered humanitarian aid through the existing modalities.	100	100
Percent of asylum seekers having access to territory and refugee-status-determination procedures.	100	100
STRATEGIC OBJECTIVE 2: "SAVE AND PREVENT LOSS OF LIFE THROUGH NEAR-TO-MEDIUM-TERM RECOVERY INTERVENTIONS TO VULNERABLE GROUPS, INCORPORATING DRR FRAMEWORK"		
INDICATORS	**TARGETS**	**ACHIEVED AS OF OCTOBER 2012**
Percentage of rural health institutions in 20 targeted districts with adequate wash facilities.	90% facilities)	90% of health institutions provided with water during emergencies
Number of schools with repaired/rehabilitated water sources and sanitation facilities.	100 schools	38 schools have had water sources repaired, rehabilitated or sunk (38%)
Number of schools with repaired/rehabilitated safe learning structures.	100 schools	25 schools rainstorm-damaged between October 2011 and March 2012 repaired/rehabilitated to provide safe and secure school infrastructure (25%)
STRATEGIC OBJECTIVE 3: "SUPPORT THE RESTORATION OF SUSTAINABLE LIVELIHOODS FOR VULNERABLE GROUPS THROUGH INTEGRATION OF HUMANITARIAN RESPONSE INTO RECOVERY AND DEVELOPMENT ACTION WITH A FOCUS ON BUILDING CAPACITIES AT NATIONAL AND LOCAL LEVEL TO COORDINATE, IMPLEMENT AND MONITOR RECOVERY INTERVENTIONS"		
INDICATORS	**TARGETS**	**ACHIEVED OF OCTOBER 2012**
Food consumption score.	35% or better	78%
Number of vulnerable migrants receiving quick-impact reintegration assistance.	5,000	0

Review of Humanitarian Funding

The achievements of 2012 were largely possible due to consistent support by the donors to the various programmes. As at 19 November the Zimbabwe CAP was 77% funded at $183 million. The spread of funding across the clusters was varied, with Food being the best funded and Education being the least funded as indicated in the table below.

Funding also remained uneven across the various clusters with an average funding level of 45% (up from 29% at the MYR), with Agriculture (91%, $29 million) being the best funded in percentage terms and Food (87%, $111 million) in terms of funds contributed. Education (5%, only $248,207) was funded the worst, showing that critical gaps still remain. A third of the programmes in the 2012 CAP received no funding at all, including key programmes such as management of acute malnutrition, and protection-related activities.

Continued coordination between OCHA's CAP Section in Geneva and OCHA-Zimbabwe substantially contributed to a reduction in the funding which the donor and/or recipient reported as being not for actions planned by the clusters in the CAP (FTS Table H). Due to the flexibility of the programme-based approach on reporting (both in dollar terms and in which clusters allocate the funds), there was a marked reduction in the current funding outside the CAP compared to previous years. What is currently funded outside the CAP, as contained in Table H, includes largely un-earmarked funds from humanitarian donors whose allocation will be specified once details are available. Other contributions that will remain outside the CAP include those to the Red Cross Movement and bilateral government-to-government contributions.

It is likely that some of the various transition funds have supported actions, albeit by implementers that may not be explicitly humanitarian, that were among those planned by certain clusters. (Most clusters proposed various sorts of urgent rehabilitation actions in 2012 to address the greatest risks, and these actions have characteristics of both humanitarian and transition.) In theory then, those resources from the transition funds should have been counted as CAP funding, or else the cluster funding requests reduced accordingly. However for various reasons, clusters did not complete this exercise. It is acknowledged, therefore, that funding in 2012 is under-stated relative to what the 2012 CAP said needed to be done.

Year	Original requirements ($)	Revised requirements ($)	Funding received ($)	% funded	Funding reported 'outside' CAP ($)	Total funding to Zimbabwe (CAP + 'outside') ($)	Outside' CAP funding as % total funding
2006	276,670,374	425,812,834	273,431,388	64%	102,297,481	375,728,869	27%
2007	214,476,053	395,551,054	229,183,189	58%	107,856,104	337,039,293	32%
2008	316,561,178	583,447,922	400,468,563	69%	71,596,692	472,065,255	15%
2009	549,680,117	722,198,333	456,361,623	63%	185,781,560	642,143,183	29%
2010	378,457,331	478,399,290	227,859,057	48%	90,042,160	317,901,217	28%
2011	415,275,740	478,582,358	220,466,857	46%	9,033,674	229,500,531	4%
2012	268,376,059	238,444,169	183,422,288	77%	24,726,605	208,148,893	12%
Totals	**2,419,496,852**	**3,322,435,960**	**1,991,192,965**	**60%**	**591,334,276**	**2,582,527,241**	**23%**

Source: donor and recipient organization reports to FTS as of 19 November 2012

Table of funding to programmes

Cluster	Programme title	Original requirements ($)	Revised requirements ($)	Funding ($)	Unmet requirements ($)	% Covered
Agriculture	Provision of basic agricultural inputs and extension support to male and female smallholder farmers in the communal sector	27,450,000	27,450,000	23,652,085	3,797,915	86%
	Improve crop and livestock productivity, control crop and livestock diseases and promote market linkages in the small holder farming sector.	3,750,000	3,750,000	5,627,970	-1,877,970	150%
	Strengthened coordination mechanisms and early warning systems	1,125,397	1,125,397	0	1,125,397	0%
	Sub total for Agriculture	**32,325,397**	**32,325,397**	**29,280,055**	**3,045,342**	**91%**
Coordination and Support Services	Cluster coordination support in Zimbabwe	1,300,000	650,000	0	650,000	0%
	Humanitarian coordination and advocacy in Zimbabwe	2,859,930	2,859,930	1,123,719	1,736,211	39%
	Sub total for Coordination and Support Services	**4,159,930**	**3,509,930**	**1,123,719**	**2,386,211**	**32%**
Education	Education in Emergency Network and sector coordination	1,949,200	979,600	0	979,600	0%
	Emergency school WASH rehabilitation and hygiene kits for girls	1,870,000	935,000	0	935,000	0%
	Emergency school infrastructure rehabilitation	5,610,000	2,755,000	248,207	2,506,793	9%
	Sub total for Education	**9,429,200**	**4,669,600**	**248,207**	**4,421,393**	**5%**
Food	Assistance for food-insecure vulnerable groups	127,710,380	127,710,380	113,672,227	14,038,153	89%
	Sub total for Food	**127,710,380**	**127,710,380**	**113,672,227**	**14,038,153**	**89%**
Health	Strengthening the early warning and response to outbreaks and other public health emergencies in Zimbabwe.	9,688,608	9,688,608	8,004,681	1,683,927	83%
	Improving emergency reproductive health services in Zimbabwe by strengthening the service delivery and referral system for essential maternal and newborn health care, focusing on the following elements: implementation of minimum initial service package (MISP) and EmONC.	7,000,000	3,500,000	1,287,001	2,212,999	37%
	Sub total for Health	**16,688,608**	**13,188,608**	**9,291,682**	**3,896,926**	**70%**

Cluster	Programme title	Original requirements ($)	Revised requirements ($)	Funding ($)	Unmet requirements ($)	% Covered
LICI	Emergency livelihoods restoration	10,300,000	10,300,000	5,114,124	5,185,876	50%
	Sub total for LICI	**10,300,000**	**10,300,000**	**5,114,124**	**5,185,876**	**50%**
Multi-Sector	Humanitarian aid to returnees, third-country nationals including unaccompanied minors and migration affected communities in border regions	12,200,000	6,100,000	3,461,572	2,638,428	57%
	Protection, assistance and durable solutions to refugees and asylum seekers in Zimbabwe	4,862,544	4,862,544	1,544,070	3,318,474	32%
	Sub total for Multi-Sector	**17,062,544**	**10,962,544**	**5,005,642**	**5,956,902**	**46%**
Nutrition	Nutrition analysis, coordination and oversight	600,000	910,000	0	910,000	0%
	Treatment of acute malnutrition	4,000,000	1,220,000	0	1,220,000	0%
	Prevention of acute malnutrition through emergency infant and young child feeding	1,000,000	413,000	352,274	60,726	85%
	Sub total for Nutrition	**5,600,000**	**2,543,000**	**352,274**	**2,190,726**	**14%**
Protection	IDP protection, assistance and durable solutions	11,000,000	9,400,000	4,245,602	5,154,398	45%
	Child protection	5,500,000	1,000,000	500,000	500,000	50%
	Human Rights and rule of law programme	1,500,000	1,000,000	0	1,000,000	0%
	Gender-based violence prevention and response	3,500,000	1,340,000	0	1,340,000	0%
	Sub total for Protection	**21,500,000**	**12,740,000**	**4,745,602**	**7,994,398**	**37%**
WASH	Sector disaster risk management & coordination	1,350,000	1,350,000	1,243,830	106,170	92%
	Emergency preparedness and response	6,000,000	6,000,000	5,790,840	209,160	97%
	Restore water, sanitation and hygiene services in rural districts and peri-urban settings	16,250,000	13,144,710	5,872,548	7,272,162	45%
	Sub total for WASH	**23,600,000**	**20,494,710**	**12,907,218**	**7,587,492**	**63%**
	Sub total for Cluster Not Yet Specified	**-**	**-**	**1,579,855**	**n/a**	**n/a**
	Grand Total	**268,376,059**	**238,444,169**	**183,320,605**	**55,123,564**	**77%**

Source: donor and recipient organization reports to FTS as of 19 November 2012

III. Humanitarian needs in 2013

Although the humanitarian situation in Zimbabwe has continued to improve over the past years, residual humanitarian challenges remain requiring continued attention of humanitarian actors. The ongoing drought in the southern part of the country, which is likely to continue into 2013 according to meteorological forecasts, is increasing needs for food and livestock. Conditions for the upcoming rainy season are difficult to forecast, but reports suggest drought conditions may persist through the current planting season (FAO, ACWG Journal, August 2012).

The ZIMVAC estimates that over 1.6 million people will become food-insecure at the peak of the hunger season from January to March 2013. Although at much lower levels than previous years, Zimbabwe continues facing outbreaks of cholera, typhoid and acute diarrhea in both urban and rural areas. With only one-third of the population having access to clean water combined with a limited capacity of health structures, large-scale disease outbreaks remain a risk.

The impact of over a decade of socio-economic challenges continues to fuel migration of Zimbabweans to neighbouring countries in search of livelihoods. Many of the affected migrants have no means to obtain correct travel documentation and are exposed to the risks and dangers of irregular migration such as rape, robbery, human trafficking and sexual exploitation and in many cases end up being deported. Between 4,000 and 5,000 Zimbabweans forcibly returned from South Africa and Botswana seek voluntary humanitarian aid in centres managed by humanitarians monthly. Many unaccompanied minors are also assisted in these centres with food, emergency health assistance, protection assistance, shelter, family tracing and reunification. The vast majority of the forcibly returned migrants, including unaccompanied minors, are returned to areas severely affected by the ongoing drought. The additional pressure on scarce resources combined with the loss of livelihoods leaves thousands of families exposed and in need of protection. Similarly, the humanitarian partners will continue to address the needs of the displaced or those in displacement like situation as well as stranded third-country nationals and asylum seekers from the Great Lakes and Horn of Africa.

3.1 Food

Food Cluster beneficiaries			
Category of people in need	Beneficiaries targeted in cluster projects (end-year target)		
	Female	Male	Total
Rural food-insecure	866,840	800,160	**1,667,000**

The 2012 ZIMVAC confirmed high levels of food insecurity especially in districts in the south. According to this assessment, approximately 1.6 million people will not be able to meet their food needs at the peak of the lean season from January to March 2013. Almost one in five people living in rural areas will not be able to meet their basic food requirements and will therefore need food assistance. Food Sector partners seek to provide assistance to these transitory and chronic food-insecure people to protect lives and livelihoods as well as preserve their nutritional status. The affected include people living with HIV/AIDS, the aged, orphans and vulnerable children with little or no access to viable coping mechanisms.

The assessment has identified Masvingo, Matabeleland North and South, and parts of Mashonaland, Midlands and Manicaland provinces as worst-affected areas. The districts projected to have the highest proportion of food-insecure households at the peak are Gwanda (57%), Mangwe (53%), Kariba (49%), Zaka (39%), Chiredzi (36%) and Mt. Darwin (36%). In

addition, many of the districts with the highest proportion of food insecurity also receive the highest number of vulnerable Zimbabweans who were forced to return from South Africa and Bostwana. According to the ZIMVAC, the current food security situation was largely caused by a mid-season drought in the 2011/2012 farming season as well as constrained access to inputs and a reduction in size of area planted. The 2012 Second Round Crop and Livestock Assessment report indicated that this year's cereals harvest was 1,076,772 MTs which is one-third lower than last year and the lowest since 2009. It estimates that the national cereal harvest reduced by 33% this year. In light of this, food insecurity in Zimbabwe in 2013 is projected to be comparably worse than any period over the past three years.

Economic challenges, including a lack of diversified livelihoods and the rising cost of living, have also contributed to the food and income-insecurity situation, which is expected to worsen as the lean season progresses. Although in most instances food is readily available on the market, vulnerable households cannot afford to purchase it. WFP's weekly monitoring of markets attests that food prices did not drop after the 2012 harvests in April as is the norm but remained high particularly in the southern parts of the country.

According to the 2010-2011 ZDHS, 32% of children under five are stunted (short for their age), 3% are wasted (thin for their height) and 10% are underweight (thin for their age). Children living in rural areas are worse off across all indicators compared to children living in urban areas. In rural areas, 33.4% of children under five are stunted, 3.2% are wasted, and 10.2% are underweight, while in urban areas, 27.5% of children under five are stunted, 2.1% are wasted and 8.1% are underweight. Although the levels have not yet reached emergency thresholds, the situation is likely to worsen if food insecurity further deteriorates.

The lean season, which normally starts late in the year, has this year started much earlier, with people already unable to meet their food needs as early as June 2012. WFP's sub-offices around the country have reported signs of distress, including high food prices, empty silos and granaries. People harvested very little particularly in the south and many have already consumed what they had produced. As a result of the low yields, employment opportunities have also significantly dwindled as farmers do not have spare grain to trade in exchange for casual labour. Grazing pasture and water is also limited, thus compromising the livelihood opportunities of households that are depended on livestock.

The majority of the vulnerable are resorting to negative coping mechanisms which have started much earlier than in other years, all pointing to a critical food security situation. Distress sales of as low as $150 per head of livestock have been observed down from the regular market prices of between $400 – $500, further eroding resilience of vulnerable households to future shocks. In the absence of food assistance, vulnerable households are left with no option but to skip or reduce the size and number of meals taken per day as most of the rural population has little or no access at all to cash or other viable coping options.

The Government has launched programmes such as the Grain Loan Scheme in response to the food insecurity situation whereby the vulnerable get cereal assistance. However, the programme often faces logistical challenges owing to resources constraints.

3.2 Water, Sanitation and Hygiene

Background

WASH Cluster beneficiaries			
Category of people in need	**Beneficiaries targeted in cluster projects (end-year target)**		
	Female	**Male**	**Total**
Emergency WASH support to populations at risk of water-borne diseases	227,420	209,925	**437,345**

The humanitarian response by national institutions and the international community over the past four years addressing outbreak of water-borne diseases has substantially improved water and sanitation services, both in rural and urban areas. Incidences of cholera and other WASH-related diseases have declined throughout Zimbabwe, except in vulnerable areas in the eastern and south-eastern parts of the country, as well as in high-density urban and peri-urban areas where situations contributing to outbreaks have not yet been fully addressed.

The humanitarian community has spent over $90 million since the cholera outbreak in 2008/2009. Investments through the Emergency Response and Risk Reduction programme managed by UNICEF have contributed immensely to improving water service delivery systems in Harare and 20 urban councils and several growth centres under the ZINWA. Potential major disasters have been contained and many utilities, including Harare, are now able to provide more reliable water services. However, sewage networks and treatment plants have not yet been properly rehabilitated. Untreated sewage continues to flow freely into rivers and streams upstream of water reservoirs/dams and sewage overflows from blocked sewers continue to pose serious health hazards. Frequent interruptions of electric power supply to water treatment plants and pumping stations often disrupt water operations and contribute to water supply shortages and disease outbreaks.

In 2012, unlike in the preceding years, most of the WASH disease outbreaks occurred in urban and peri-urban areas. These include the typhoid outbreaks in several wards in the city of Harare, in Chitungwiza, in Zvimba and in Bindura. Current water shortages in major cities such as Bulawayo can potentially lead to water-borne diseases if not addressed. Breakdown of water and sewerage systems have been among the major contributing factors for these outbreaks. In contrast, in rural areas there has been only one major WASH-related disease outbreak in 2012—the cholera outbreak in Chiredzi. This is in sharp contrast to 2011, when 10 rural districts mostly in the south eastern part of the country were affected by cholera outbreaks. Chipinge and Chiredzi were among those seriously affected.

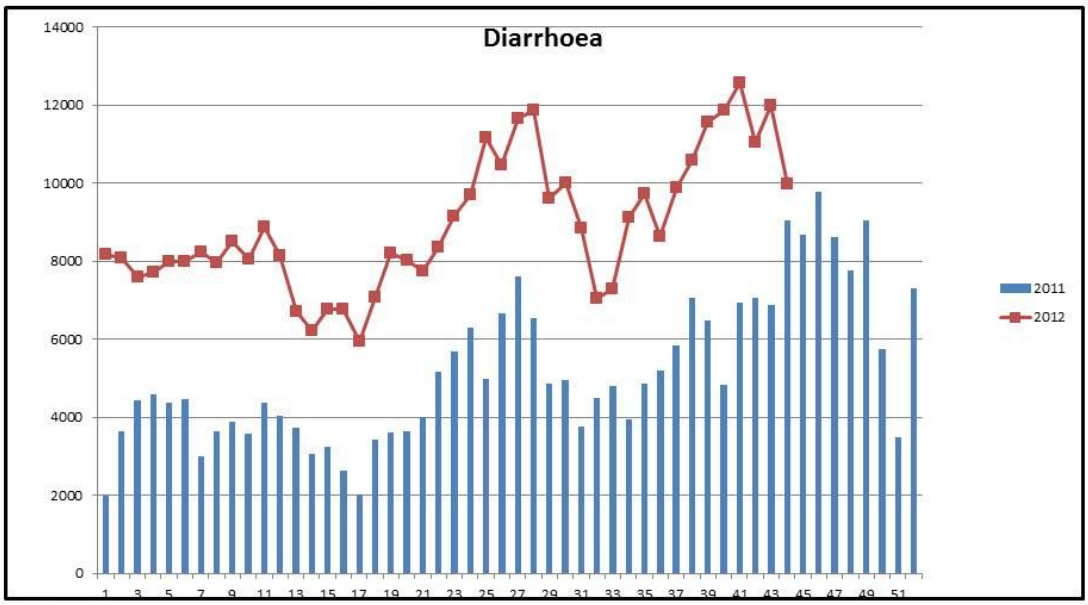
WASH-related diseases trend analysis show that diarrhoeal and dysentery cases in 2012 have been approaching emergency thresholds as shown in the charts below (see charts overleaf). This trend needs to be controlled and arrested in 2013.

Needs

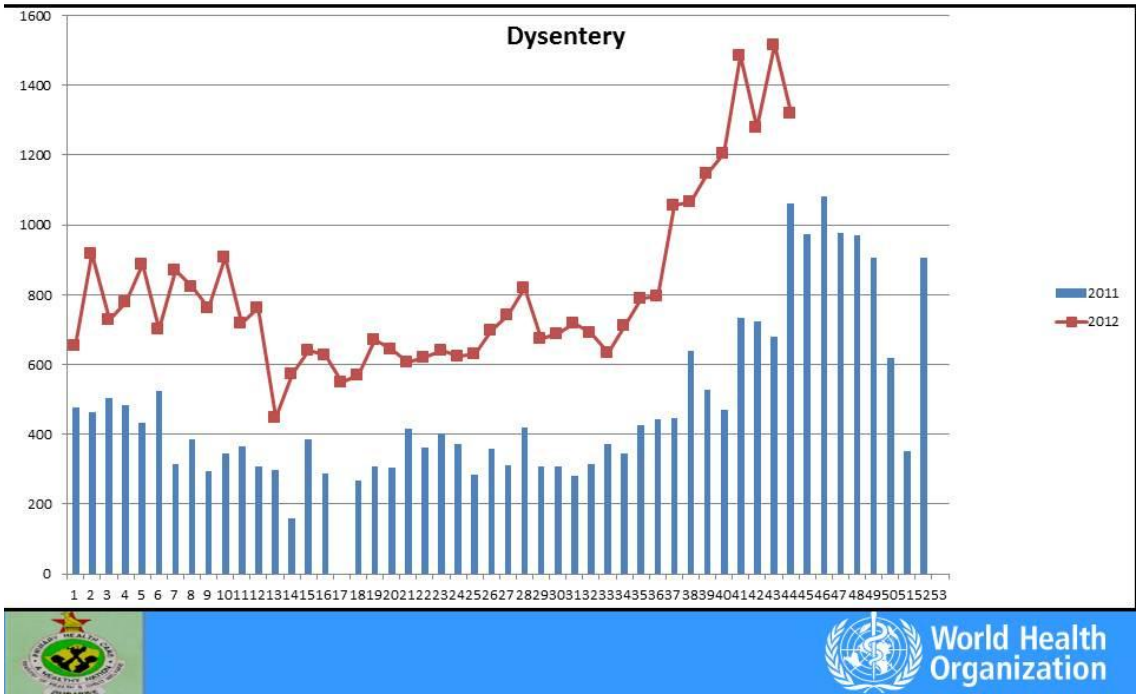
A number of WASH recovery and development programmes have recently been launched or are in the process of being finalized. However, it will take some time before people on the ground start benefitting from these projects. In the meantime there will still be a great need for humanitarian aid not only to respond to WASH-related disease outbreaks affecting vulnerable girls, women, boys and men particularly in high density urban centres and vulnerable rural areas but also to sustain and consolidate the gains made so far in these vulnerable communities.

Similarly, some urban areas including Bulawayo continue to have water challenges and might need support in 2013.

Diarrhoeal cases: Comparison of 2012 and 2011



Comparison of Dysentery 2012 and 2011 cases



In light of the above, WASH Cluster activities for 2013 will focus mainly on emergency response with particular emphasis on women, girls, boys and men in vulnerable urban and rural areas. It will be limited in scope and the target group will be those at high risk to water-borne diseases (such as cholera, typhoid and diarrhea) and with specific emphasis on school children, women attending clinics, IDPs and mobile and other vulnerable populations. In this context, there is a need to undertake a mapping of under-served and areas not served for WASH. These areas carry highest risk and need to be prioritized for emergency response.

3.3 Health

Background

Health Cluster beneficiaries			
Category of people in need	Beneficiaries targeted in cluster projects (end-year target)		
	Female	Male	Total
Population at risk from acute malnutrition, disease outbreaks and other public health emergencies (including 115,783 children)	360,059	332,363	**692,422**

The overall impact of Zimbabwe's decade-long economic decline and cuts in public health expenditure detrimentally affected the health system. This resulted in deterioration of health care facility infrastructure at all levels, resulting in reduced access to basic health care. In addition, key activities such as outreach services, referral of patients, drug distribution, surveillance, and monitoring and evaluation of local health centres were hampered by shortage of transport, poor road network and lack of communication. Moreover, the flight of human resources further compounded the decline in critical public health programmes and quality and coverage of services such as emergency preparedness and response. The economic downturn also resulted in declines of water and sanitation coverage in both urban and rural areas.

Should rains in affected areas fail again this year, the food security situation will undoubtedly reach critical levels. Food frequency data from the WFP monitoring system suggests that drought conditions have already contributed to decreased dietary intake in affected areas – an unusual occurrence this early in the traditional lean season. In addition to compromised dietary intake, rates of diarrheal disease throughout the country have exceeded epidemic thresholds nearly every week for the past 12 months (WHO, Weekly Surveillance System Report, Weeks 1 through 37). These high rates of disease place an already stressed population at even greater risk for development of malnutrition. Nutrition emergencies are slow-onset events that typically evolve from degradation in one or both of these determinants over the course of months. The two primary determinants of malnutrition are therefore already present and likely to rise.

Needs

Epidemiological reports by the MoHCW as well as outbreak response reports by WHO and partners indicate that Zimbabwe continues to be vulnerable to outbreaks of epidemic-prone diarrheal diseases such as cholera, typhoid fever, rotavirus and dysentery. In 2011, ten out of the country's 62 districts, namely Bikita, Buhera, Chimanimani, Chegutu, Chipinge, Chiredzi, Kadoma, Murehwa, Mutare and Mutasa, reported 1,140 cholera cases and 45 deaths, giving a crude case fatality rate (CFR) of 4.0%. Of these cases, 870 (76%) were reported from Manicaland Province while 697 (80%) of the cases were reported from Chipinge district alone.

As at 21 October 2012, the typhoid fever outbreaks in Harare, Chitungwiza, Bindura and Zvimba had reached a cumulative figure of 4,940 cases and three deaths since reports were first received on 11 October 2011. From 2 May to 19 June 2012 Chiredzi district reported 22 cases and one death from cholera.

The frequent occurrence of diarrheal disease outbreaks has been attributed to the fact that the major risk factors identified through various assessments have not yet been fully addressed in both urban and rural areas. The surveillance system which is the basis for early warning and detection of outbreaks is still functioning at less than the recommended thresholds. As of week 27 of 2012, the average completeness and timeliness of weekly reporting for the year stood at 77.3% and 69%, respectively against a threshold of 80% for both parameters.

Integrated disease surveillance and response is the most critical strategy for improving disease surveillance and response to outbreaks and other public health emergencies. However, training of health workers in this strategy has not been rolled out to all districts. Only Chimanimani district health workers were trained in 2012. Establishment rapid response teams and training of health staff in case management are the important interventions in improving outbreak response at districts level. In 2012, RRTs were trained in 19 districts and case management in 25 districts out of the country's total of 62.

In order to address delays in detecting and responding to outbreaks and other public health emergencies, the Ministry of Health and Child Welfare (MoHCW) launched the National Health Emergency Operations Centre (NHEOC) in May 2012. The NHEOC will provide coordination of the national rapid response team, the Department of Civil Protection (DCP), relevant UN agencies and partners in the response to health emergencies and will take over functions of the Cholera Command and Control Centre that had been fulfilling this role from 2008. Staff, dedicated funding and standard operating procedures for the centre are not yet in place. The NHEOC is a mechanism that will need to be supported if the MoHCW and its partners are to provide effective responses to health emergencies as they occur.

Zimbabwe continues to have a high prevalence of HIV infection. The adult HIV prevalence observed by the 2010-11 Zimbabwe Demographic Health Survey (ZDHS) is 15%. The rate is higher among women aged 15-49 years (18%), compared with 12% among men in the same group. In the 2005-2006 ZDHS the HIV prevalence in adult males and females stood at 18%. While the HIV prevalence has been declining, its levels are still high such that it places a high economic burden on an already stretched health system and increases vulnerability of populations to effects of outbreaks.

Malnutrition

The combination of decreased dietary intake associated with rising food insecurity and high rates of disease are very likely to result in increased rates of acute malnutrition in affected areas (Minutes, Emergency Nutrition Technical Working Group, June 7, 2012). As food insecurity and rates of diarrheal disease increase progressively between October 2012 and March 2013 (the traditional lean season), rates of malnutrition are expected to follow a similar trajectory. Under similar food security conditions in 2006 and 2007, rates of acute malnutrition reached national emergency thresholds (7%) as early as November (MoHCW, Zimbabwe National Nutrition Surveillance Assessments, November 2006 and November 2007.)

The identification and treatment of acute malnutrition is straightforward and highly effective if identified early enough. In Zimbabwe, however, the capacity to monitor nutrition trends and

provide state-of-the-art treatment is severely constrained. Standard admissions data are unavailable in most parts of the country, and a high proportion of facilities in drought-affected areas fail to meet minimum treatment competency criteria (as defined by the number of trained staff, availability of essential equipment, and the availability of therapeutic food products). According to Round 13 of the Vital Medicines and Health Services Survey (MoHCW, ECHO, UNICEF, DFID, 2012), the proportion of facilities capable of treating SAM ranges between just 10 and 30%.

To prevent excess morbidity and mortality associated with rising rates of malnutrition, cluster partners will support the government in achieving two key objectives over the course of the upcoming lean season:

1. Timely recognition of rising rates of malnutrition to inform both programme and geographic targeting of drought response activities.
2. Development of malnutrition treatment infrastructure capable of accommodating the increased caseload resulting from drought and disease events

To accommodate the expected rise in the numbers of malnourished children in affected wards, cluster partners will pre-position key supplies and equipment, and ensure MoHCW staff are competent to treat SAM. They will also ensure the Government's ability to rapidly identify concerning trends and take action.

The Health Cluster will continue to nurture its close interaction/coordination with the MoHCW to ensure the alignment of the Humanitarian Appeal 2013 Health Cluster priorities with the MoHCW priorities and strategic direction. The interventions will address the critical gaps; restore basic and life-saving services by strengthening the existing MoHCW systems and structures and by reinforcing weak components of the health care delivery system with a focus on the most vulnerable rural and peri-urban districts.

3.4 Protection

While progress has been made to cater for various long-term protection needs in recovery and development frameworks and programmes, there remain a significant number of vulnerable people affected by various shocks, including displacement and migration, of concern to the Protection Cluster requiring humanitarian aid and immediate durable solutions.

Protection Cluster beneficiaries			
Category of people in need	**Beneficiaries targeted in Cluster projects (end-year target)**		
	Female	**Male**	**Total**
Vulnerable people affected by various shocks	65,000	60,000	125,000
Vulnerable people in mixed-migratory flows and returnees	19,000	73,000	92,000
Totals	**84,000**	**133,000**	**217,000**

Third-country nationals, mixed migrants and returning Zimbabweans:

Zimbabweans being forcibly returned from South Africa and Botswana constitute a very vulnerable group in need of immediate humanitarian aid. Since January 2012 over 45,000 forcibly returned Zimbabweans required humanitarian aid at the respective borders. Of the more than 31,000 migrants (87% male, 13% female, arriving at a monthly average of 3,560 people) deported from South Africa and processed through the support centre in Beitbridge, 91%

requested and benefited from humanitarian aid. Of the more than 14,000 migrants (75% males, 25% females) deported from Botswana and processed through the support centre in Plumtree, 85% requested and benefited from humanitarian aid. The effects of the drought and the vulnerability to water and food-borne diseases in the areas of high return pose an additional risk on the affected population and the surrounding communities. The protection partners will strengthen collaboration with WASH, Health, and Food Clusters to address these issues.

Third-country nationals entering Zimbabwe in a mixed-migratory flow via the border with Mozambique include an extremely vulnerable group of asylum seekers and mixed migrants, in urgent need of protection and referral to the Tongogara Refugee Camp to lodge asylum claims. From January to September 2012 over 4,700 third-country nationals sought assistance at the Nyamapanda Temporary Reception Centre. Of the beneficiaries, 58 were unaccompanied minors needing specialized care and protection.

Providing specialized care and attention to unaccompanied minors continues to be a challenge against inadequate resources. Between January and September 2012, a total of 638 unaccompanied minors were assisted (166 in Plumtree, 414 in Beitbridge and 58 in Nyamapanda).

Effective coordination and training of cross-border stakeholders and strengthening the capacity of local authorities in DRR continue to be required to reduce the number of protection incidents and improve migrants' access to essential services and assistance. The Zimbabwe Republic Police Victim-Friendly Unit and other service providers at the border requires support to provide care for victims of rape and other forms of sexual assaults, and to ensure speedy access to medical and emergency treatments like post-exposure prophylaxis.

A total of 92,000 people of concern in mixed-migratory flows including 7,500 third-country nationals, 84,500 returned Zimbabweans and mixed migrants have been targeted to receive humanitarian aid in 2013, based on trends in 2012.

Vulnerable and mobile populations affected by natural and socio-economic shocks:

Although recovery and development programmes have made noticeable progress in addressing longer-term protection needs, a significant number of highly vulnerable groups, including displacement and migration affected populations, continue requiring humanitarian aid. Manicaland (Chipinge, Mutasa), Masvingo (Chiredzi), Mashonaland Central, Midlands, Mashonaland West, Harare, Bulawayo Metropolitan, Matabeleland North and Matabeleland South are hosting a significant number of highly vulnerable and displacement- affected groups, including children, children and adults living with HIV, people with disabilities, elderly, single-headed households, child-headed households and survivors of violence (e.g. sexual and gender-based violence). A total of 125,000 men, women, boys and girls of the most vulnerable groups of people affected by natural and socio-economic shocks, have been targeted to receive humanitarian aid, in the various locations identified above, by Protection Cluster partners in 2013.

Regular gender-based violence (GBV) programme interventions have yet to reach some of the most vulnerable people in the country. In particular women and children exposed to, or recovering from, displacement-like situations remain particularly vulnerable to GBV. This is due partly to the fact that a combination of loss of income and livelihoods has resulted in these groups resorting to risky livelihood strategies to cover social needs (for example to pay school fees) and has severely compromised living conditions.

VI. Common Humanitarian Action Plan

4.1 Setting humanitarian priorities

While humanitarians continue to address the needs outlined above, commendable efforts by the Government, donors and other stakeholders have led to the country making steady progress towards recovery and development over the past years. As such, there is overall consensus amongst partners that humanitarian structures and tools need to evolve and adapt to this changing context. In view of this, over the past months and following careful consultations with all partners, including representatives from Government, donors, NGOs and UN agencies, a number of changes have been proposed to modify the humanitarian planning and coordination arrangements for next year. All these changes were approved by key stakeholdres at the humanitarian appeal workshop on 9 October.

In a joint effort and as tasked by the HCT, UN agencies and NGOs supported by OCHA and the UN Resident Coordinator's Office developed a new and more focused criteria for identification of priority humanitarian actions in Zimbabwe. The agreed criteria form the basis for the humanitarian planning process in Zimbabwe for 2013 and have been used by clusters to assess residual urgent needs and discuss most appropriate coordination mechanisms to be adopted in 2013.

The criteria are as outlined below:

1) For emergency interventions, projects must meet the following criteria:

- Interventions are supported by an up-to-date evidence-base (survey data, assessments).
- Interventions aim to reduce risk of excess mortality (life-saving actions) and/or address the basic humanitarian needs of the targeted populations, including both physical and psychological.
- Interventions address significant increases in vulnerability of affected populations due to new shocks that exceed community coping capacity and government resources for response (including drought, new arrivals/returnees, newly displaced, etc).
- Interventions are short-term and time-bound (<12 months from inception to completion; the project must yield results within this timeframe).

2) For strengthening national preparedness and response capacity, projects must meet the following criteria:

- Interventions contribute to developing the national capacity in disaster preparedness and response, with specific focus on preparedness, including strengthening disaster early warning and surveillance systems.
- The interventions are within the framework of strengthening Government-led national capacity for DRM led by the Department of Civil Protection with relevant line ministries, together with civil society, and in line with national plans.
- The interventions are conducted in close collaboration with Government, other national entities and development partners.

Based on these criteria, humanitarian partners came up with analysis of needs and risks as indicated in the table below:

Brief overview of remaining humanitarian needs in Zimbabwe forming the basis for 2013 humanitarian response

Clusters	Residual current humanitarian gaps	Strengthening national capacity	Identified risks
Agriculture	None	NEWU and early warning; DCP and MoAMID; FNC	Low productivity, limited private sector, inadequate safety-nets
Education	None	Expand DRR in schools; Strengthen link between MoESAC and DCP; EEPRN and EMIS; School grants	Lack of sufficient Government funding for strengthening school systems
Food	1.6 million affected by acute food insecurity (Jan-Mar 2013); Some chronically food-insecure (in absence of safety-net, social assistance); Innovative approaches to food assistance	DCP and FNC; DRM Strategy; Scaling up cash transfers as DRR response	n/a
Health	Support for health surveillance and response to disease outbreaks and other public health emergencies	Operationalize the NHEOC; MoHCW and DCP; EHA at sub-national level	High risk for diarrhoeal disease outbreaks. Poor capacity for early detection and rapid response to public health emergencies. Poor health systems capacity for service delivery Completeness and timeliness of surveillance system not consistent Health sector coordination
LICI	None	Significant contribution to strengthening resilience; DRM Strategy must include 'economic opportunities' that reduce vulnerabilities	n/a
Nutrition	None	Establish national nutritional surveillance system; Analysis of multi-sectoral food and nutrition insecurity at sub-national level; Referral and treatment of malnourished through MoHCW Rapid Response Teams	Underlying causes of malnutrition not addressed; Capacities for response limited; High HIV/AIDS prevalence

Clusters	Residual current humanitarian gaps	Strengthening national capacity	Identified risks
Protection	Short-term immediate assistance for: • Returnees • Asylum seekers • 'Displaced/mobile' • Recovery assistance to 'displaced/mobile' populations • Ongoing support to SGBV prevention and response programmes for children and women in migrant sending areas and at national scale	Preparedness for mass returnees/mass influx; Integrate protection into Ministries/sectors	Lack of government funding for running receptions centres. Increase in mobility caused by food situation, situation in neighbouring countries. Impact of water-borne diseases on return areas
WASH	Response to 'life-threatening' water and food borne outbreaks including in schools; in under-served and unserved urban and peri-urban areas	DRR in WASH policy; DCP/CPU and MoWRDM; National NGOs	Systemic disrepair; Over-reliance on one emergency donor; Partial coverage of development programmes

Source: table adapted from the document "Strengthening Inter-linkages between Humanitarian and Development Programmes in Zimbabwe; Mapping of key Humanitarian, Recovery and Development Interventions and Analysis of Gaps", developed jointly by the RCO and OCHA (5 Oct 2012).

4.2 Coordination arrangements

In the course of discussions and consultations over the past months, key partners agreed to focus the coordination of humanitarian response in 2013 around four clusters, namely:

Food (Lead: WFP)

WASH (Lead: UNICEF, Co-lead: Oxfam)

Health (Lead: WHO)

Protection (Lead: UNHCR, Co-Chair: IOM)

In view of this, the following clusters will be deactivated by the end of 2012:[2]

Nutrition (Lead: UNICEF)

Education (Lead: UNICEF; Co-lead: Save the Children)

Agriculture (Lead: FAO)

Livelihood, Institutional Capacity-building and Infrastructure (Lead: UNDP, Co-Lead: IOM)

Given the transitional context in Zimbabwe, the HCT in close collaboration with Government and development partners, is strengthening partnerships for sustainable recovery; while at the same time maintaining the commitment and readiness to address remaining humanitarian needs.

Activities carried out under the four clusters to be deactivated will continue (as needed) within other and more appropriate national coordination mechanisms. Over time, and depending on

[2] As a transitional measure, nutritional needs will continue to be addressed through the Health Cluster.

how the humanitarian needs and context evolve, the four remaining clusters will also transition into national recovery and development coordination mechanisms. UN agencies are committed to support these these emerging national coordination mechanisms through their respective country programmes under the overall framework of the ZUNDAF.

Humanitarian Clusters in 2013

Cluster	Government counterpart	Cluster lead	Cluster members and other humanitarian stakeholders
Food	MoLSS	WFP	ADRA , Africare, CARE, COSV, CRS, Christian Care, Concern, GOAL, HAZ, IOM, IPA, Mashambanzou Care Trust, NRC, ORAP, Oxfam-GB, Plan International, SC, USAID, WVI and other partners
Health	MoHCW	WHO	ACF, ADRA, Africare, Action Aid, CARE Zimbabwe, CDC, CH, CRS, CWW, DAPP, Elizabeth Glaser Paediatric AIDS Foundation, GOAL, Humedica, IMC, IOM, IRC, MDM, Plan International, SC, Sysmed, ZRCS, UNFPA, UNICEF, WHO, WVI and other partners
WASH	ZINWA, MLURD, city and urban councils	UNICEF and co-Lead Oxfam	ACF, Africa 2000 Network, Africare, CAFOD, CARE International, Christian Care, Concern, CPT, CRS, DAPP, Dialogue on Shelter, FCTZ, GAA, GOAL, IMC, IOM, IRC, IRD, ISL, IWSD, MDM, Medair , MeDRA , Mercy Corps, MERLIN, Mvuramanzi Trust, SDC, Oxfam UK, PENYA Trust, Plan, PSI, SNV, UNICEF, WVI, ZimAHEAD, Zimbabwe Thamaso, ZCDA, Zvitambo
Protection	MoRIIC, OPC, Ministry of Justice	UNHCR and IOM	ANPPCAN, Caritas, CARE, CESVI, Childline, Christian Aid, Christian Care, Coalition Against Child Labour, Counselling Services Unit, COSV, CRS, GAPWUZ, GOAL, FST, Forum for African Empowerment, Habakkuk Trust, Help/Germany, Help Age, Helpline, Help Initiative, Halo Trust, Humanitarian Reform Project, Human Rights and Development Trust, IMC, IRC, ISL, Island Hospice, LCEDT, LFCDA, MSF Belgium/Holland, MDM Zimbabwe, Mercy Corp, MeDRA, Miracle Missions, MTLC, Musasa Project, NANGO, New Hope Foundation, NRC, OXFAM Australia/GB, Pacesetters, Padare, REPSSI, ROKPA Support, SC, SOS Children's Village, Southern Africa Dialogue, TAAF, Tear fund, Transparency Int'l, UMCOR, Victims Action Committee, WAG, WEG, WVI, ZCDT, ZACRO, ZLHR, ZWLA, UNICEF, IOM, UNFPA, WFP, PI, Care Zimbabwe, CP trust, LRF, MoLSS, MoHA, MoHCW, UN Women.

4.3 Most likely scenario for 2013

The most likely scenario is based on the projection that while the political activities in Zimbabwe will intensify in 2013, culminating in anticipated elections likely to be held in the course of the year, both the country's economy or the wider humanitarian situation will not be significantly affected. Appeals to shun violence and respect to rule of law have been publicly repeated at the highest level and echoed by various levels of the political leadership of the Government as well as civil society. Political tension could, however, build up prior to and during the constitutional referendum and the subsequent general elections. The humanitarian community desires that no major displacement or other humanitarian emergency re-surface in Zimbabwe. However, the possibility of a situation necessitating humanitarian action cannot be ruled out should the anticipated political processes in the coming year (i.e. referendum and elections) occur in an atmosphere of generalized or localized violent disturbances.

The food security situation in Zimbabwe will possibly deteriorate compared to 2012 as a result of a continued drought. Other weather-related calamities like floods remain a risk. The country is expected to experience sporadic disease outbreaks; another outbreak of cholera during the rainy season (October-January) cannot be ruled out. Health response is expected to improve thanks to gradual improvement in availability of drugs and improved capacity of the health sector to respond to outbreaks as a result of more donor support through the transition funds. Similar progress is less likely in the WASH sector, where insufficient infrastructure development and maintenance may require continued and sustained interventions. Flows of asylum seekers, stranded or forcibly returned migrants and unaccompanied minors being groups of particular concern, are expected to continue on the increase. It is important to note that a potential increase in acute humanitarian needs due to disease outbreaks, natural and disasters, and a difficult socio-economic situation remains a concern.

4.4 Humanitarian strategy for 2013

The humanitarian strategy in 2013 will continue to effectively address residual urgent humanitarian and early recovery needs through a structurally lighter, more focused and evidence-based humanitarian appeal in 2013 under four remaining clusters.

In view of the ongoing transition process and in response to proposals from different partners, humanitarian partners decided to have a structurally lighter humanitarian appeal document in 2013. This will replace the fully fledged CAP model from previous years which is no longer deemed necessary in the Zimbabwe context. With the continued support of all stakeholders towards recovery programmes, the 2013 humanitarian appeal is potentially the last such appeal in Zimbabwe.

In light of the proposed lighter humanitarian planning and coordination mechanisms, a system to ensure swift response to unforeseen humanitarian needs remains important. As such the HCT has mandated the HC and OCHA to expand the scope and the strategic positioning of the existing ERF to address urgent unforeseen needs that may arise in the course of 2013.

In addition to addressing urgent needs, humanitarian activities will also strengthen national preparedness and response capacities, in particular in support to the DCP. Throughout the many discussions over the past months, the collaboration between the Government and the humanitarian community has been excellent. Humanitarian actions, where possible, should contribute to strengthening the national resilience to disasters and will be conducted in close

collaboration with the Government, other national entities and development partners. OCHA and UN agencies have been working closely with DCP in reviewing the contingency plan and strengthening the national preparedness and response capacities, including at provincial and district level. This process will continue in 2013.

The humanitarian community will respond to the needs under two broad strategic objectives listed below whose indicators and targets are clearly spelt out under the various cluster response plans:

Strategic objective 1: To maintain a minimum and coordinated response capacity in the Food, Health, Protection and WASH Clusters to address the most urgent residual humanitarian needs in the country which need resolution in 2013, and for which organizations have the capacity to respond.

Strategic objective 2: To assist in strengthening Government and other local capacity to coordinate, prepare for and respond to ongoing and future emergency situations.

V. Cluster Response Plans

5.1 Food

Cluster lead agency	**UNITED NATIONS WORLD FOOD PROGRAMME**
Funds required	**$109,829,799 for one project**
Contact information	**Ms. Liljana Jovceva (Liljana.Jovceva@wfp.org)**

CLUSTER OBJECTIVE 1: SAVE LIVES AND PROTECT THE LIVELIHOODS OF HOUSEHOLDS THAT ARE MOST AFFECTED BY SEASONAL AND TRANSITORY FOOD SHORTAGES IN AFFECTED AREAS **Output: food and NFIs including cash and/or vouchers distributed in sufficient quantity and quality to targeted women, men, girls and boys under secure conditions**	
INDICATORS	**TARGETS**
Percentage of households whose food consumption score exceeds 21	80%
Number of women, men, girls and boys receiving food and NFIs, by category and as percent of planned	100%
Percent of planned tonnage distributed	100%
Percent of planned NFIs distributed	100%
CLUSTER OBJECTIVE 2: IMPROVE THE NUTRITIONAL WELL-BEING OF VULNERABLE GROUPS (CHRONICALLY ILL; CHILDREN UNDER FIVE AND PREGNANT AND NEW MOTHERS)	
INDICATORS	**TARGETS**
Percentage of households whose food consumption score exceeds 21	80%
Number of patients who started food assistance at body mass index <18.5 who have attained body mass index >18.5 in two consecutive measures	Nutrition recovery rate met for 80% of projects
CLUSTER OBJECTIVE 3: STRENGTHEN GOVERNMENT AND COMMUNITY CAPACITY TO MANAGE AND IMPLEMENT HUNGER REDUCTION APPROACHES	
INDICATORS	**TARGETS**
Joint food assistance programmes with Government	Number of joint programmes implemented
Food purchased locally	Food purchased locally as per cent of food distributed in-country

5.2 Water, Sanitation and Hygiene

Cluster lead agency	**UNITED NATIONS CHILDRENS' FUND**
Funds required	**$3,600,000 for two projects**
Contact information	**Mr. Belete Woldeamanuel (bwoldeamanuel@unicef.org)**

CLUSTER OBJECTIVE 1: RAPID AND EFFECTIVE LIFE-SAVING HUMANITARIAN RESPONSE TO THE WASH NEEDS OF GIRLS, WOMEN, BOYS AND MEN AFFECTED BY WASH-RELATED EMERGENCIES **Output: provision of timely response to WASH-related disasters in order to reduce mortality and morbidity amongst affected populations**	
INDICATORS	**TARGETS**
Percent of outbreak alerts investigated through appropriate mechanisms within 24 hrs of alert	100%
Percent of affected communities access emergency basic WASH services and supplies as required within 48 hrs of alert	100%
CLUSTER OBJECTIVE 2: BUILDING CAPACITIES OF AND CREATING AN ENABLING ENVIRONMENT FOR VULNERABLE COMMUNITIES IN THE TARGETED LOCAL AUTHORITIES FOR WASH DISASTER RISK MANAGEMENT **Output: strengthened disaster risk management and response capacities built in local authorities and community institutions**	
INDICATORS	**TARGETS**
Local authorities have a DRR component integrated into their district development plan	Nine urban councils and two rural district councils
Early warning systems, emergency preparedness and resourced response plans are in place within local authorities for wash related emergencies	Nine urban councils and two rural district councils
Local authorities have adopted humanitarian principles, protocols as part of their standard operating procedures during emergencies	Nine urban councils and two rural district councils
CLUSTER OBJECTIVE 3: IMPROVE SECTOR COORDINATION, INFORMATION AND KNOWLEDGE MANAGEMENT AND MAINSTREAM STANDARDS AND SYSTEMS FOR ER & DRR **Output: strengthened coordination mechanisms and knowledge management systems and sector standards mainstreamed among EHA partners and in government ministries and local authorities**	
INDICATORS	**TARGETS**
Percent of national WASH Cluster coordination meetings conducted at the end of each month and minutes disseminated to partners	100%
Percent of all consortia members comply with agreed minimum standards in their emergency response and basic infrastructure construction activities	80%
Percent of tools for assessment, monitoring, evaluation and reporting are institutionalized within the EHA and being used nationally	100%

5.3 Health

Cluster lead agency	**WORLD HEALTH ORGANIZATION**
Funds required	**$4,990,000 for three projects**
Contact information	**Dr. Lincoln Charimari (charimaril@zw.afro.who.int)**

CLUSTER OBJECTIVE 1: REDUCE EXCESS MORBIDITY AND MORTALITY DUE TO ACUTE MALNUTRITION, DISEASE OUTBREAKS AND OTHER PUBLIC HEALTH EMERGENCIES IN 2013 **Output 1: strengthened capacity for early warning and early detection of acute malnutrition, disease outbreaks and other public health emergencies.**	
INDICATORS	**TARGETS**
Percent of sentinel sites submitting complete weekly data on time	80%
Number of targeted districts with health staff trained in IDSR	Three
OUTPUT 2: STRENGTHENED CAPACITY FOR TIMELY RESPONSE TO ACUTE MALNUTRITION, DISEASE OUTBREAKS AND OTHER PUBLIC HEALTH EMERGENCIES.	
INDICATORS	**TARGETS**
Percent of public health emergencies assessed and responded to within 72 hours	100%
Number of districts with EPR plans	Three
Number of districts with trained Rapid Response Teams	Three
Percent of laboratories in targeted districts with adequate reagents and other supplies	100%
Number of targeted districts with CFR within WHO limits for all disease outbreaks	Three
Number of targeted districts with health staff trained in case management	Three
CLUSTER OBJECTIVE 2: ENSURE THAT THE NATIONAL HEALTH EMERGENCY OPERATIONS CENTRE IS FULLY ESTABLISHED AND SUPPORTED **Output: strengthened inter-sectoral coordination mechanisms**	
INDICATORS	**TARGETS**
Fully functional National Health Emergency Operations Centre	NHEOC in place

5.4 Protection

Cluster lead agency	**UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES** (Co-Chair International Organization for Migration)
Funds required	**$10,233,929 for two projects**
Contact information	**Mr. Shubhash Wostey (wostey@unhcr.org)** **Mr. Andrew Gethi (agethi@iom.int)**

Cluster objectives and output targets

CLUSTER OBJECTIVE 1: STRENGTHENED CAPACITY OF GOVERNMENT, COMMUNITIES, AND OTHER STAKEHOLDERS FOR EMERGENCY PREPAREDNESS AND RESPONSE TO RESIDUAL AND NEW PROTECTION SHOCKS **Output: support provided for authorities, communities and other stakeholders in preparedness and response**	
INDICATORS	**TARGETS**
Percent of preparedness and humanitarian response plans supported	100%
Percent of preparedness awareness campaigns supported	100%
Number of trainings for authorities and communities	10
Percent of residual and new shocks responded to	80%
CLUSTER OBJECTIVE 2: STRENGTHENED PROTECTION ENVIRONMENT AND ENHANCED SUSTAINABLE PROTECTION SOLUTIONS FOR THE MOST VULNERABLE/ MOBILE GROUPS OF PEOPLE, ESPECIALLY WOMEN AND CHILDREN, AFFECTED BY NATURAL AND SOCIO-ECONOMIC SHOCKS **Output: provision of sustainable protection solutions for identified beneficiaries**	
INDICATORS	**TARGETS**
Percent of protection structures and coordination mechanisms maintained	100%
Number of community-based plans initiated and completed	20
Percent of requests to support durable solutions initiatives assessed and supported	80%
Percent of children assisted with emergency, specialized care/attention and durable solution assistance (disaggregated by age-gender and type of assistance)	60%
Percent of durable solutions beneficiaries assisted with material and other support	80%
Percent of children assisted with emergency, specialized care/attention and durable solution assistance (disaggregated by age-gender and type of assistance)	60%
Percent of reported survivors of GBV including children, receive comprehensive multi-sectoral services (disaggregated by age-gender and type of assistance)	100%
Percent of support for requests for issuance of civil status documentation	100%

CLUSTER OBJECTIVE 3: ENHANCED NATIONAL CAPACITY TO ENABLE ASYLUM SEEKERS, UNACCOMPANIED MINORS AND OTHERS ARRIVING IN ZIMBABWE IN MIXED-MIGRATORY FLOWS, TO ACCESS TIME-CRITICAL HUMANITARIAN AID, PROTECTION SOLUTIONS AND ACCEPTABLE TREATMENT THROUGH PROPER RECEPTION PROCEDURES AND FACILITIES **Outputs: humanitarian and protection needs of vulnerable migrants are fully addressed.** **Migration management stakeholders have improved capacity for migration-related disaster risk reduction and addressing needs of migrants**	
INDICATORS	**TARGETS**
Percent of returned migrants requesting, receive humanitarian aid (disaggregated by type of assistance i.e. health, protection, food, transport, including travel health, assistance age and gender).	100%
Percent of unaccompanied minors receiving humanitarian aid (disaggregated by type of assistance i.e. food, shelter, emergency health counselling and pre and post family reunification)	100%
Percent of children receiving humanitarian aid (disaggregated by age-gender and type of assistance i.e. food, shelter, emergency health counselling and pre and post family reunification)	100%
Percent of third-country nationals requesting receive humanitarian aid (disaggregated by type of assistance i.e. health, protection, food, transport, including travel health, assistance age and gender).	100%
Number of training and coordination meetings for border authorities	15
Percent of reported survivors of GBV receive comprehensive multi-sectoral services	100%

Annex 1: List of response projects

FOOD

Appealing Agency	WORLD FOOD PROGRAMME (WFP)
Project Title	Assistance to Food-insecure Vulnerable Groups
Project Code	ZIM-13/F/55416
Sector or cluster	FOOD
Objective	To protect lives and livelihoods, and enhance self-reliance in vulnerable households in response to seasonal food shortages.
Beneficiaries	Total: 1,667,000 people Women: 866,840
Implementing Partners	Government of Zimbabwe – Ministry of Labour and Social Services; World Vision; Christian Care; CARE; GOAL; UMCOR; AfriCare; Plan International; Save the Children; ORAP; Help Germany; Catholic Relief Services; ADRA
Project Duration	Jan 2013 - Dec 2013
Funds requested	**$109,829,799**
Gender Marker code	1 - The project is designed to contribute in some limited way to gender equality
Contact details	Liljana Jovceva, liljana.jovceva@wfp.org, +263772 278957

Needs

The 2012 ZimVAC rural livelihoods assessment estimates that over 1.6 million people living in rural areas will be unable to meet their food requirements at the peak of the hunger season from January to March 2013. The situation is aggravated by the absence of proper protection mechanisms, combined with the eroded purchasing power in rural areas. From WFP's regular monitoring, as well as reports from FEWSNET, the food security situation began deteriorating in mid-2012 and is likely to worsen. As a result of the late and erratic rains, particularly in the southern parts of the country, people harvested very little and many have already consumed what they did produce. Further as a result of the low yields, employment opportunities have also significantly reduced as farmers do not have spare grain to trade in exchange for casual labour. Livestock feed is also limited, further compromising the livelihood opportunities of these households. Distress sales of as low as US$150 per beast have been observed, down from a regular market price of between US$450 - US$500. Most vulnerable households have no option other than to skip or reduce their daily dietary intake as the majority has no access at all or have limited access to cash or viable coping options.

Activities or outputs

Under a Protracted Relief and Recovery Operation (PRRO) 200162, WFP implements the Seasonal Targeted Assistance programme to respond to the needs of food-insecure households (taking in account specific needs of women, men, and children) from September 2012 until March 2013, when people can rely on their own production from the next harvest in April 2013.

WFP implements a year-round Health and Nutrition programme, which targets HIV/TB patients, malnourished pregnant/breastfeeding mothers, and children under 5. The programme assists with the individual client's nutritional rehabilitation, whilst a Social Safety Net programme, implemented simultaneously with the Health and Nutrition targets the client's food-insecure households and provides a monthly family food basket. The Social Safety Net programme also supports households hosting migration affected people and returnees.

In addition, WFP implements a Food-for-Assets programme aimed at building community resilience through creation of community productive assets. Participants benefit from food received during the duration of creating the asset and the community benefits from the asset created in the long run.

Indicators and targets

The expected outcome is improved food consumption over the assistance period for targeted emergency-affected populations

Requested budget	
Budget Items	**$**
Commodities	51,642,859
Transport, handling and storage	30,669,069
Staff costs	12,201,277
Implementing or operating costs	8,131,467
Administrative costs	7,185,127
TOTAL	**109,829,799**

WATER, SANITATION AND HYGIENE

Appealing Agency	UNITED NATIONS CHILDREN'S FUND (UNICEF)
Project Title	Emergency WASH Support to affected women and children
Project Code	ZIM-13/WS/53585
Sector or cluster	WATER, SANITATION AND HYGIENE
Objective	Rapid and effective humanitarian response to the WASH needs of the affected women, men and children.
Beneficiaries	Total: 437,345 at risk from water borne disease. Women: 227,420 Other group: 209,925 males
Implementing Partners	German Agro Action (GAA), Oxfam, Mercy Corps, *Action Contre la Faim* (ACF)
Project Duration	Jan 2013 - Dec 2013
Funds requested	**$1,000,000**
Gender Marker code	1 – The project is designed to contribute in some limited way to gender equality
Contact details	Belete Wouldeamanuel, bwoldeamanuel@unicef.org, +263703941

Needs

Significant risk to WASH-related disease still remains for women and children in Zimbabwe as evidenced by localized cholera and typhoid outbreaks in 2012. Since 10 October 2011, Harare City experienced an outbreak of typhoid fever that spread to Chitungwiza City, Mashonaland Central (Bindura district), Mashonaland West (Zvimba and Chegutu districts), Midlands (Chirumanzu district) and Mashonaland East (Marondera) Provinces. WHO and the Ministry of Health epidemiological update of week 177 reports that as of the 19th of August 2012, the national cumulative number of cases was 5,037 and 3 deaths (CFR= 0.06%).

A lesson from the WASH cluster evaluation of 2009 was that effective response to new outbreaks requires early information of the outbreak, and late procurement and transportation translated to late distribution of essential supplies in the control of the outbreak. An evaluation of the household water treatment during an outbreak of typhoid fever in Harare, Zimbabwe (2011–2012) found that the reported uptake of chlorine-based water treatment tablets was good, but sustained use of these products was poor. Multiple types of chlorine tablets were distributed and the respondents reported dosage varied largely, indicating confusion about how to correctly use the tablets. The study conducted by the Centres for Disease Control in collaboration with partners in the Social Mobilization group found that households that reported using any point of use water treatment (PoUWT) products before the outbreak and households that received typhoid prevention messages and free PoUWT products were more likely to: 1.) Report treating water since the outbreak onset; 2.) Have treated stored water on the day of survey; and 3.) Have free chlorine residual in their stored water, in at least one of the suburbs.

Knowledge of WaterGuard was widespread but use of WaterGuard was uncommon; knowledge and use of WaterGuard were not associated with uptake of distributed products. The evaluation recommended government officials and NGOs work together to improve coordination of response activities to ensure standardized hygiene non-food items product distribution and usage instructions.

Throughout 2012, UNICEF in partnership with the Environmental Health Alliance (EHA) co-operated on emergency preparedness and response with stand-by arrangements with pre-identified WASH and health cluster partners. Guidance on the rationalization of the actual package of non-food items was obtained from the UNICEF-led WASH Cluster where discussion

centred on moving towards market driven approaches for hygiene non-food item distribution given current positive developments in the private sector.

EHA monitoring information suggests that this co-operation between UNICEF and EHA was successful in that out of 29 WASH-related emergency events, response to community WASH needs was initiated within an average of 26.07 hours. The Southern Africa Regional Climate Outlook forum 16 predicts that between October to December 2012, the northern half of Zimbabwe will experience increased chances of normal to above-normal rainfall and the south western half of Zimbabwe increased chances of below-normal to normal rainfall. Between January to March 2013, in the northern half of Zimbabwe, there are increased chances of normal to above-normal rainfall and in the south western half, increased chances of normal to below-normal rainfall. The expected rainfall may translate to localized flooding or acute water stress in some communities. Throughout 2012, UNICEF also collaborated with the international organization for Migration on the provision of non-food item support for newly displaced women, men and children. Possible protection needs may arise from future politically motivated violence during the constitutional referendum and elections and call for strengthened preparedness for emergency WASH service provision.

Activities or outputs

- Emergency Alert Assessment and Response

  Preparedness is proposed for emergency alert assessment and response as per the UNICEF's Core Commitments to the humanitarian needs of women and children and in the form of stand-by agreements with select EHA partners as well as stand-by contracts for water, sanitation and hygiene services from private sector suppliers. Minimum contingency stocks for up to 25,000 households will also be supported to facilitate UNICEF and partner's rapid response with life-saving interventions.

- Effective co-ordination of humanitarian response with other stakeholders and local authorities. UNICEF is the cluster lead agency and proposes to facilitate effective humanitarian co-ordination in the sector. Co-ordination will be targeted at developing the national capacity in disaster preparedness and response, with specific focus on preparedness, including strengthening disaster early warning and surveillance systems. This is within the framework of strengthening Government led national capacity for disaster risk management led by the Department of Civil Protection with relevant line ministries, together with civil society, and in line with national plans.

Indicators and targets

- 100 % provision of water within 72 hours from time of emergency notification to provision of water by partners, taking into account specific needs of women, men, and children.

- Strengthened sector co-ordination on humanitarian emergency.

Requested budget	
Budget Items	**$**
Staff costs	100,000
Implementing costs	830,000
Administrative costs	70,000
TOTAL	**1,000,000**

Appealing Agency	DEUTSCHE WELTHUNGERHILFE E.V. (GERMAN AGRO ACTION) (DWHH)
Project Title	Emergency WASH Response by Environmental Health Alliance (EHA) composed of German Agro Action (DWHH), MercyCorps, ACF, and Oxfam
Project Code	ZIM-13/WS/54409
Sector or cluster	WATER, SANITATION AND HYGIENE
Objective	To address WASH related emergency needs and build resilience and capacity to respond to outbreaks across Zimbabwe
Beneficiaries	Total: 437,345 people
Implementing Partners	EHA and UNICEF
Project Duration	Sep 2012 - Aug 2013
Funds requested	**$2,600,000**
Gender Marker code	1 - The project is designed to contribute in some limited way to gender equality
Contact details	Ajay Paul, A.Paul@welthungerhilfe.co.zw, +263 772406251

Needs

29% of Zimbabweans live in urban areas and the rate of urbanization is estimated to be 4% per annum. Following the political and economic crisis of the 2000s in Zimbabwe, access to urban water supply went down from 97% in 1990 to 60% in 2008 and access to urban sanitation went down from 99% in 1990 to 40% in 2008 (WSP 2010). The urban water and sanitation services subsector continues to face severe challenges and constraints resulting in limited and erratic water supply and a growing environmental pollution problem. These constraints include:

- Aging infrastructure (over 50 years) throughout from storage and treatment to pumps and conveyance systems resulting in high physical losses;
- Overloaded, aged, and in some cases non-functioning sewage treatment plants;
- Power outages especially for pumping and treatment plants;
- Large deficits in funding for O&M, rehabilitation, and expansion;
- Widespread skills flight and limited capacity;
- Low cost recovery rates due to billing and collection challenges including faulty or non-existent meters as well as a much reduced willingness and ability to pay for unreliable services particularly in high density housing areas;
- A tariff setting process that is not evidence-based resulting in un-economic tariffs;
- An outdated legal framework, lack of adherence to existing legislation and weak policy implementation;
- A breakdown of the 'parallel development' process through which urban expansion was managed in the past is resulting in some new settlements without access to water and sewerage systems.

Faced with these challenges, local authorities have been unable to provide basic services resulting in typhoid outbreaks nationally and, in particular, affecting the Greater Harare (urban) area in 2011 and continued into 2012. Nationally, the case load is approximately 4,923 reported cases (as of July 2012) of which 3,994 cases were recorded in Greater Harare. While the CFR (0.04%) remains below internationally accepted standards, the frequency of outbreaks and their duration once they start is an indication of deficits in the provision of basic services and infrastructure. A significant concern remains the possibility of a small, localised outbreak spreading to national scale.

According to the EHA response tracking database and the WHO Epidemiological Bulletin, the index cases of recent WASH related outbreaks have usually been residents of highly populated and poor, under-served and unserved urban areas.

Emergency urban rehabilitation works supported by AusAID and the German Government have focused on existing infrastructure and not an augmentation of supply to the under-served and unserved areas. Residents of these areas continue to rely on sub-surface water from shallow wells, often used without any form of household treatment. As open defecation is widely practised, water from shallow wells is contaminated and poses a significant threat to health. One of the key findings from research by the Centre for Disease Control indicated that knowledge of key hygiene behaviours was high (88.7%) and that the main barrier to practice was the unavailability of water.

Activities or outputs

- Rapid assessment in and planned response reports from areas affected by WASH emergencies within 24 hrs, taking in account specific needs of women, men, and children.
- Safe communal water supplies conforming to SPHERE minimum standards provided to affected populations and institutions within 48 hrs.
- Emergency communal sanitation conforming to SPHERE minimum standards provided to affected institutions (clinics, MVP camps etc.) within 72 hrs.
- Detailed needs assessment including capacity and gaps analysis conducted in 10 urban councils and two rural district councils.
- 10 urban councils and two rural district councils have WASH disaster risk reduction plans developed including geospatial mapping, EWS, EPR resource plans.
- Appropriate resourcing (materials and trainings) and integration of 9 urban councils and two rural district councils disaster risk reduction plans within district development plans as part of LRRD continuum.
- Institutionalization of common tools used for assessment, monitoring, evaluation and reporting of ER within the WASH Cluster and nationally (EOC).

Indicators and targets

- Provision of timely response to WASH related disasters in order to reduce mortality and morbidity amongst affected populations, taking in account specific needs of women, men, and children.
- Building capacities of and creating an enabling environment for vulnerable communities in the targeted local authorities for WASH disaster risk management

Requested budget	
Budget Items	**$**
Staff costs	1,045,000
Implementing or operational costs	1,160,000
Administrative costs	395,000
TOTAL	**2,600,000**

HEALTH

Appealing Agency	WORLD HEALTH ORGANIZATION (WHO)
Project Title	Strengthening capacity for early warning and early action in response to public health emergencies
Project Code	ZIM-13/H/54465
Sector or cluster	HEALTH
Objective	Reduce excess morbidity and mortality due to disease outbreaks and other public health emergencies.
Beneficiaries	Total: 3,730,000 men, women, boys and girls in 29 districts and two cities
Implementing Partners	MoHCW, IOM, EHA Partners (IMC, IRC, Goal, SC)
Project Duration	Jan 2013 - Dec 2013
Funds requested	**$2,000,000**
Gender Marker code	0
Contact details	Dr Lincoln Charimari, charimaril@zw.afro.who.int, +2637727755629

Needs

Present challenges and resource constraints within the public health sector have resulted in limited health service delivery particularly amongst rural and peri-urban marginalized populations including those who reside in hard to reach, unplanned and under-served areas. Some specific concerns include a health system characterized by inadequate human and material resources, lack of preparedness to manage Public Health Emergencies, challenged health information system, limited access to basic health services in some areas as well as poor referral services compounded by weak communication system.

These challenges negatively affect the capacity to adequately predict, detect and respond to the frequent occurrence of epidemic prone diseases. Service delivery is therefore compromised in the event of an emergency when demands for health services and outreach activities increase, overwhelming both the health work force as well as exhaust commodities. The prevalence of risk factors within the country for recurring disease outbreaks and acute emergencies warrants the need to retain the capacity to support the MOHCW through the NHEOC in their efforts to strengthen preparedness and early warning systems; and to efficiently and effectively execute a rapid response to emergency events resulting in public health consequences. In order to reduce the detrimental public health impacts of emergencies, early warning systems must become operational to allow early and correctly targeted actions.

The gaps related to the prevention, preparedness and response to disease outbreaks and other public health emergencies that have been identified include: frequent occurrence of outbreaks such as cholera with high CFR; the re-emergence of typhoid fever outbreaks since 2010; limited capacity in data management including collection, analysis, dissemination, utilization and documentation; weak community based surveillance system; limited availability of emergency buffer stocks; unavailability or incomplete EPR plans; limited capacity in monitoring and evaluation of PHE interventions an lack of knowledge on Disaster risk reduction and disaster risk management concepts which lead to poor management of disasters.

Activities or outputs

Activities under this program focus on bolstering preparedness and rapid response mechanisms in areas vulnerable to epidemic prone diseases and natural disasters; enabling improved response to outbreaks thereby containing the spread of disease and reducing the severity of the impact amongst the affected communities. Additionally, response to public health emergency

interventions will aim to fill existing gaps in 29 districts and 2 cities by capacitating communities, health staff and district health officers in disease surveillance and case management.

- Train key cadres within the national health system including clinical and health information personnel, community health workers and members of the health executive teams in areas of case management, integrated disease surveillance and response, and information management.
- Provide direct and technical support for conducting outreach activities in emergency affected and vulnerable areas for information dissemination, immunization campaigns, primary health service delivery and psycho social interventions.
- Support essential inputs needed for an effected emergency response including medical supplies, communication materials and logistics.
- Revitalize regular information sharing and coordination mechanisms including at the community, district and provincial levels for disaster risk reduction and response planning.

Indicators and targets

- Strengthened capacity for Epidemic Prone Disease Surveillance and response to public health emergencies at community, district, provincial levels and national levels.
- Improved case management at all levels of the health system (from community to provincial) in response to epidemic prone diseases and other public health emergencies.

Requested budget	
Budget Items	**$**
Implementing or operating costs	1,600,000
Staff costs	200,000
Administrative costs	200,000
TOTAL	**2,000,000**

Appealing Agency	WORLD HEALTH ORGANIZATION (WHO)
Project Title	Diarrhoeal disease outbreak preparedness and response in Chimanimani, Chipinge and Chiredzi Districts.
Project Code	ZIM-13/H/54467
Sector or cluster	HEALTH
Objective	To reduce morbidity and mortality due to diarrhoeal disease outbreaks in Chipinge, Chimanimani and Chiredzi districts by December, 2013.
Beneficiaries	Total: 692,422 people Children: 115,783 Women: 360,059 Other group: 332,363 men
Implementing Partners	MOHCW and Save the Children
Project Duration	Jan 2013 - Dec 2013
Funds requested	**$1,000,000**
Gender Marker code	0
Contact details	Dr Lincoln Charimari, charimaril@zw.afro.who.int, +2637727755629

Needs

The socio-economic decline of the last decade has led to reduced health system performance, poor water and sanitation coverage in rural areas and frequent diarrhoeal disease outbreaks. Training in early detection, social mobilization, preparedness and response will improve health worker skills in outbreak detection and response. This project will focus on Chipinge, Chimanimani and Chiredzi Districts which are among the most vulnerable districts. Epidemiological reports by the Ministry of Health and Child Welfare (MoHCW) and the World Health Organization (WHO) and partners indicate that Zimbabwe continues to be vulnerable to outbreaks of epidemic prone diarrhoeal diseases such as cholera, typhoid fever, rotavirus, dysentery and common diarrhoea. The high CFR (4 per cent) among cholera cases in Chipinge and Chiredzi in 2011 was cause for concern. According to the WHO guidelines, case fatality rate (CFR) should be 1 per cent or less during an outbreak. Training in surveillance and response, social mobilisation, improved coordination and procurement of essential commodities will improve preparedness and response to disease outbreaks and other public health emergencies in the three targeted districts.

Monitoring and evaluation through joint national, provincial and district RRTs will be conducted during the project to ensure timely and effective implementation of the project. Coordination has also been shown to play a pivotal role in project implementation, and this area will be strengthened.

Activities or outputs

The project aims to strengthen preparedness and response through training of health staff in case management, RRTs and IDSR, strengthening coordination, procurement and distribution of emergency supplies, monitoring and evaluation. Social mobilization will be implemented throughout the project. This project will be implemented in Chipinge, Chimanimani and Chiredzi Districts which are among the most vulnerable districts. The main activities are as follows:

- Training health staff in case management in the three districts.
- Conducting IDSR training for all health staff in the 3 districts for early detection and response.
- Training of rapid response teams in the three districts.
- Conducting social mobilization sessions in the communities of the three districts.

- Strengthening coordination by increasing capacity of district health teams and joint supervision in the field.
- Procuring emergency supplies, including laboratory supplies.

Indicators and targets

- All health staff trained in case management, IDSR, and RRT teams trained/strengthened in the 3 districts.
- Medical and laboratory supplies purchased and distributed in the 3 districts.
- Improved coordination through strengthening of DHTs and joint monitoring and evaluation.
- Community surveillance strengthened through social mobilization.
- Reduced CFR due to diarrhoeal disease outbreaks.

Requested budget	
Budget Items	**$**
Staff costs	200,000
Implementing or operating costs	648,619
Project monitoring and reporting	85,961
Project support costs (7%)	65,420
TOTAL	**1,000,000**

Appealing Agency	INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM)
Project Title	Nutrition Response to the 2012/2013 drought
Project Code	ZIM-13/H/55420
Sector or cluster	HEALTH
Objective	Prevent excess nutrition-related morbidity and mortality resulting from drought-related events during the 2012/2013 hunger season
Beneficiaries	Total: 677,250 people Children: 450,000 Women: 227,250
Implementing Partners	Emergency Nutrition Network (IOM, UNICEF, SC, Goal, ACF, IMC)
Project Duration	Dec 2012 - Apr 2013
Funds requested	**$1,990,000**
Gender Marker code	2a - The project is designed to contribute significantly to gender equality
Contact details	Natalia Perez, NPerez@iom.int, +263 772102095

Needs

While survey data from Zimbabwe indicates generally moderate rates of acute malnutrition, rates of malnutrition vary widely throughout the year, and the risk of deterioration remains high. Malnutrition results from two primary determinants: Poor dietary intake (as influenced by food security and feeding practices), and illness. These determinants are intimately related – a poorly nourished child is more likely to be of high risk to contract or develop disease, and an ill child is more likely to become undernourished. Nutrition emergencies typically evolve from degradation in one or both of these determinants.

Drought events during the 2012/2013 agricultural season have resulted in high levels of acute food insecurity in large parts of the country. While food insecurity is not uncommon in the affected areas, it is uncommon to see food insecurity at the high levels observed this year. Food frequency data suggests that drought conditions have already contributed to decreased dietary intake in affected areas, despite being very early in the traditional lean season. In addition to compromised dietary intake, rates of diarrheal disease throughout the country have consistently exceeded epidemic thresholds over the past 12 months. These two factors, decreased dietary intake and high rates of disease, place the population at increased risk for development of malnutrition over the coming 6 months.

Although food security actors are mounting an aggressive drought response, this work is often complicated by targeting issues and breaks in the food aid pipeline. Nutrition stakeholders are therefore predicting an increase in rates of acute malnutrition in drought-affected areas.

Three percent of children in Zimbabwe suffer from acute malnutrition. Small differences are observed by sex with 4 percent of male children being wasted compared with 2 percent of female children, however this difference is not statistically significant. Any interventions aiming to address acute malnutrition will have to be done indiscriminate of sex of the child. Acute malnutrition is a very good predictor of mortality the risk of death in moderately malnourished boys and girls is 2.5 times that of their non-malnourished counterparts, and the risk of death in a severely malnourished boys and girls is nearly 10 times that in their non-malnourished counterparts. A malnourished child is also more susceptible to outbreak-related disease events.

The identification and treatment of acute malnutrition is straightforward and highly effective. In Zimbabwe, however, the capacity to identify trends in rates of malnutrition, and provide state-of-the-art treatment is severely constrained. According to the 2012 Vital Medicines Availability and Health Services Survey, a high proportion of facilities in drought-affected areas fail to meet minimum treatment competency criteria as defined by the number of trained staff, availability of essential equipment, and the availability of therapeutic food products.

Activities or outputs

- Provide training and administrative support to Food and Nutrition Security Committees in high-risk districts and provinces to ensure timely analysis of nutrition and food security data.
- Facilitate the formulation of drought-response strategies.
- Create awareness through sensitizing workshops and distribution of information materials on drought response targeting women and men separately in respect of the role that each has in the household with regard to health and nutrition of children.
- Procure and mobilize equipment and supplies for distribution to all health facilities in high-risk wards so that these have the necessary nutrition equipment and supplies in place to provide state-of-the-art therapeutic care for malnourished children (community-based management of acute malnutrition).
- Train health workers at all health facilities in high-risk wards to ensure that they meet the minimum threshold for trained personnel in the clinical management of acute malnutrition, and supplementary feeding for the moderately malnourished (community-based management of acute malnutrition).

Indicators and targets

- Coverage of Outpatient Treatment Program (OTP): >70% in urban and rural areas.
- All OTP facilities recording a defaulter rate <15% for both males and females.
- All OTP facilities recording Death rate <5% for both males and females.
- All OTP facilities recording Average length of stay in OTP < 60days for both males and females.
- All OTP facilities recording a rate-of-weight gain >4g/kg/day for both males and females.
- 100% of health facilities in high-risk wards have at least one staff member who received refresher training on community-based management of acute malnutrition.
- 100% of targeted communities are reached with awareness materials.

Requested budget	
Budget Items	**$**
Operational Costs	1,300,000
Programme Support Costs	440,000
Staff Costs	250,000
TOTAL	**1,990,000**

PROTECTION

Appealing Agency	INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM)
Project Title	Humanitarian aid and strengthening resilience and DRR for communities made vulnerable by the effects of natural and socio-economic shocks.
Project Code	ZIM-13/P-HR-RL/54470
Cluster	PROTECTION
Objective	To strengthen capacity of government and communities including the most vulnerable groups of people, especially women and children for emergency preparedness and response to residual and new protection shocks and enhance the protection environment and enhanced sustainable protection solutions.
Beneficiaries	Total: 25,000 households Women: 68,750 Other group: 56,250 males
Implementing Partners	NRC, World Vision, Christian Care, IOM, ZCTDA, CPS, SC, FST, UNFPA
Project Duration	Jan 2013 - Dec 2013
Funds requested	**$5,961,429**
Gender Marker code	2a - The project is designed to contribute significantly to gender equality
Contact details	Natalia Perez, NPerez@iom.int, +263 772102095

Needs

Major strides have been made in 2012 by government and local authorities to find durable solutions for situations of protracted effects of natural, and socio-economic shocks. Many displacements have been responded to appropriately and prevention of displacement has taken place. There is, however, the potential for new shocks or events that may result *inter alia* in new displacements and other protection concerns. In many of the displaced communities, women and children further become vulnerable as they experienced SGBV. Members of newly displaced households (including vulnerable men, women and children and the chronically ill) are in need of lifesaving humanitarian aid (food, shelter, medical attention) and possibly psychosocial interventions to address emotional distress where needed. Access to these services needs to be offered within a protective environment that prevents further risk to the beneficiaries and empowers them to manage their own protection. Community-based planning is an inclusive and consultative process that empowers communities to actively participate in interventions relevant to them and strengthens resilience against natural and socio-economic shocks.

Activities or outputs

- Conduct profiling of affected households/persons; case-by-case documentation.
- Strengthen the existing early warning and early response mechanism for new shocks.
- Provide emergency and interim assistance in form of non-food items, food, emergency shelter and cash-transfers taking into account the needs of men, women and children.
- Establish referral mechanisms for major protection needs (health, psychosocial, education, legal), especially for women and children who have experienced SGBV utilizing trained male and female counsellors.
- Coordinate and support provision of transport and temporary accommodation where required in accordance with the gender-specific needs.
- Provide training on emergency preparedness and response and on psychosocial assistance to affected populations.

- Mainstream disaster risk reduction through community-based planning in areas that have potential and those affected by displacement.
- Support community-based planning initiatives to ensure medium-term protection and phasing into durable solutions of beneficiaries.
- Assist vulnerable individuals' access to civil status registration/documentation.

Indicators and targets

- 18,000 households (of which 500 being single-headed and child-headed households) (49,500 females,
- 40,500 males) affected by shocks receive emergency humanitarian aid (in accordance with gender-specific requirements) within 72 hours of referral.
- Humanitarian partners have improved early warning and preparedness capacity.
- 7000 households (of which 200 being single-headed and child-headed households) (19,250 females and 15,750 males) affected by shocks assisted towards durable solution to their humanitarian needs.

Requested budget	
Budget Items	**$**
Operational Costs	3,874,929
Programme Support Costs	1,311,514
Staff Costs	774,986
TOTAL	**5,961,429**

Appealing Agency	INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM)
Project Title	Humanitarian aid to returnees and stranded third-country nationals including unaccompanied minors
Project Code	ZIM-13/P-HR-RL/54473
Sector or cluster	PROTECTION
Objective	To enhance national capacity for third-country nations, unaccompanied minors and other migrants arriving in Zimbabwe in mixed-migratory flows, to access time-critical humanitarian aid and protection solutions facilities.
Beneficiaries	Total: 92,000 forced returnees Children: 10,000 Women: 19,000 Other group: 73,000 males
Implementing Partners	Ministry of Labour and Social Services, Ministry of Health, Ministry of Home Affairs, Matabeleland AIDS Council
Project Duration	Jan 2013 - Dec 2013
Funds requested	**$4,272,500**
Gender Marker code	2a - The project is designed to contribute significantly to gender equality
Contact details	Natalia Perez, NPerez@iom.int, +263 772102095

Needs

A high number of Zimbabweans being forcibly returned from neighbouring countries as well as increased numbers from mixed migration flows including third-country nationals continue to face urgent humanitarian needs upon entry to Zimbabwe. The rampant food crisis in the region, in particular in the high migrant-sending districts of Zimbabwe; the increasing anti-migrant sentiments in neighbouring countries; and the crisis in the Horn of Africa and the Great Lakes Region all contribute to an expected increase of the inflow of forcibly returned Zimbabweans and third-country nationals into Zimbabwe in search of protection and humanitarian aid in 2013. This population arrives with no food, money nor water and some with life-threatening health conditions that require immediate medical attention. This translates into an urgent need for shelter, food, health, water and sanitation, referrals, protection counselling and transport assistance for the affected population with the most vulnerable groups being women, children and youth (18-24 years). At least 85% of the vulnerable third -country nationals arriving in the country and requiring humanitarian aid are young males.

Activities or outputs

Returned migrants (including unaccompanied minors)

- Provide returned migrants (male, female, children, youth, and the disabled) with food; emergency health/medical care; transportation; safe migration information; prevention, treatment and care of HIV/AIDS; prevention and response to sexual and gender-based violence; and facilitate access to referral services and transportation.
- Provide food, shelter, emergency health care and counselling and pre and post-family reunification for unaccompanied minors.
- Provide support for outreach activities in affected areas of return disease outbreak response, primary health service delivery targeting female and child- headed households.
- Provide capacity building on migration management to stakeholders including for disaster risk reduction.

Stranded third-country nationals, asylum seekers,

- Establish a referral mechanism to legal authorities and health facilities for cases of abuse.

- Provide psychosocial counselling and referral services to minors, adults and survivors of sexual abuse especially women, children and those with special needs.
- Provide health checks, temporary shelter, food, non-food items and transport assistance to Tongogara Refugee Camp.

Indicators and targets

- Humanitarian needs related to food, health, shelter, transportation and protection needs of vulnerable 19,000 female and 73,000 male migrants are fully addressed and gaps are identified and referred to relevant governmental and non-governmental partners
- Humanitarian and protection needs of vulnerable of 10,000 children are addressed.
- Migration management stakeholders have improved capacity for migration related disaster risk reduction and addressing the needs of 19,000 female and 73,000 male migrants.

Requested budget	
Budget Items	**$**
Operational Costs	2,792,500
Staff Costs	570,000
Programme Support Costs	910,000
TOTAL	**4,272,500**

COORDINATION AND SUPPORT SERVICES

Appealing Agency	OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS (OCHA)
Project Title	Humanitarian Coordination Support in Zimbabwe
Project Code	ZIM-13/CSS/55503
Sector or cluster	COORDINATION AND SUPPORT SERVICES
Objective	• To improve the coherence and effectiveness of country-level humanitarian coordination by supporting the Humanitarian Coordinator and the entire humanitarian community in strategic planning, programming, and decision-making. • To coordinate the international humanitarian relief response by reinforcing coordination mechanisms, by supporting national response structures and by strengthening existing capacities. • To advocate for a principled humanitarian action, the adherence to international humanitarian law and human rights law and unimpeded access to populations affected by crisis. • To build a shared situational awareness by providing access to critical data and information to the humanitarian community and the general public. • To support transparent and targeted humanitarian financing through the establishment of pooled funding mechanisms and the management of CERF allocations.
Beneficiaries	Primary beneficiaries: All present and incoming international and national humanitarian stakeholders, including international Search and Rescue teams, International Organizations, NGOs, Red Cross Movement. Indirect beneficiaries: disaster/crisis affected populations that benefit from well-coordinated humanitarian aid.
Implementing Partners	HCT members, NGOs, Government Counterparts
Project Duration	Jan 2013 - Dec 2013
Funds requested	**$2,765,981**
Gender Marker code	1 – The project is designed to contribute in some limited way to gender equality
Contact details	Paul Thomas, thomasp@un.org, +263772125303

Needs

Although the humanitarian situation in Zimbabwe has continued to improve over the past years, urgent humanitarian challenges in Food, Water, Sanitation and Hygiene, Health, and Protection (the four remaining clusters) require continued attention of humanitarian partners in a coordinated manner. Activities previously carried out under other clusters (Nutrition, Agriculture, Education, and Livelihoods) will start taking place within more appropriate national coordination mechanisms like working groups and sectors, but may require continued support in the coming year to ensure effective coordination and transition between humanitarian and national recovery/development coordination mechanisms. In view of this OCHA will continue its coordination role and ensure that residual humanitarian needs continue to be addressed while optimizing complementarity between humanitarian and recovery/development activities.

In addition to addressing urgent needs, humanitarian activities will also strengthen national preparedness and response capacities, in particular in support to the Department of Civil Protection (DCP). Humanitarian interventions, where possible, will contribute to strengthening the national resilience to disasters and will be conducted in close collaboration with the Government, other national entities and development partners. OCHA and UN Agencies have been working closely with DCP in reviewing the contingency plan and strengthening the national preparedness and response capacities, including at provincial and districts level and this process will continue in 2013.

Activities or outputs

- Support a needs-based response through improved situation analysis and tailored analytical information products, taking into account specific needs of boys, girls, women and men.
- Update information management tools and products in accordance with the current and evolving context and best practices and as required by different stakeholders
- Support the HC in providing systematic and periodic reviews of humanitarian response and coordination mechanisms
- Strengthen cluster coordination capacities, including at national and provincial levels
- Support regular humanitarian coordination meetings with HCT, donors, NGOs, government counterparts
- Strengthen national preparedness and response capacities through contingency planning and regular updating of early warning indicators
- Build capacity of humanitarian partners, including OCHA staff, to support humanitarian and early recovery responses effectively
- Support national coordination mechanisms where needed at national and provincial levels
- Support coordination and promote linkage between humanitarian, recovery and development activities
- Advocate for humanitarian funding and coverage of funding gaps

Indicators and targets

- Clusters, ICF and HCT monitor and address urgent humanitarian needs in country in an effective and timely manner, taking the needs of boys, girls, women and men into account.
- Residual urgent needs in national coordination mechanisms (sectors, working groups, etc) are adequately addressed.
- National contingency plan in place and regularly updated.
- Adequate humanitarian funding for identified priority needs.
- Updated information products that meet the needs of humanitarian clients.
- Shared vision between humanitarian, recovery and development actors on key issues affecting the country and way forward.

Requested budget	
Budget Items	**$**
Staff	2,075,636
Operational	408,392
Programme support	281,953
TOTAL	**2,765,981**

Appealing Agency	EMERGENCY RESPONSE FUND (OCHA) ERF (OCHA)
Project Title	Emergency response Fund (ERF) for Zimbabwe - projected needs $5 million
Project Code	ZIM-13/CSS/55640
Sector or cluster	COORDINATION AND SUPPORT SERVICES
Objective	To provide the humanitarian community with a flexible, timely and predictable humanitarian financing tool to address sudden and unforeseen spikes and address gaps in urgent humanitarian needs.
Beneficiaries	Primary beneficiaries: All present and incoming international and national humanitarian stakeholders, including international Search and Rescue teams, International Organizations, NGOs, Red Cross Movement. Indirect beneficiaries: disaster/crisis affected populations that benefit from a well coordinated humanitarian aid.
Implementing Partners	UN agencies, national and international NGOs
Project Duration	Jan 2013 - Dec 2013
Funds requested	**$0**
Gender Marker code	0
Contact details	Paul Thomas, thomasp@un.org, +263772125303

Needs

In view of the lighter humanitarian appeal process in 2013, a system to ensure swift response to unforeseen humanitarian needs and gaps remains essential. As such the Humanitarian Country Team (HCT) has mandated the HC and OCHA to expand the scope and the strategic positioning of the existing ERF to address urgent needs that fall outside the 2013 appeal or funding gaps on the identified needs.

The ERF remains the only funding mechanism for response to urgent humanitarian interventions in the country. Interventions funded under the ERF are short term with an implementation period not exceeding six months. Being a pooled fund of un-earmarked contributions from various donors, the ERF operates with greater flexibility and speedier approval processes than other transitional or developmental funds.

In 2013, the ERF for Zimbabwe will continue to support short term but high impact humanitarian response projects. ERF resources can be accessed by international and national actors. Projects considered for funding are evaluated against criteria developed by the ERF Board to ensure that they contribute to saving lives, are based on the latest needs assessments, and take the needs of boys, girls, women and men into account when planning. Funding decisions will continue to be taken through ERF Advisory Board in consultation with representatives of key stakeholders from local and international NGOs as well as UN agencies. The Advisory Board is chaired by the HC and is composed of three representatives from UN Agencies, one national and one international NGO. OCHA Zimbabwe will continue to provide secretariat support to management of the fund.

Activities or outputs

- Provide rapid, flexible and predictable funding to urgent and unforeseen humanitarian needs in 2013, taking the needs of boys, girls, women and men into account.

Indicators and targets

- Predictable and timely response to urgent and unforeseen humanitarian activities in 2013.

Table III: List of Appeal projects (grouped by sector)

Consolidated Appeal for Zimbabwe 2013
as of 15 November 2012

Project code (click on hyperlinked project code to open full project details)	Title	Appealing agency	Requirements ($)
COORDINATION AND SUPPORT SERVICES			
ZIM-13/CSS/55503/119	Humanitarian Coordination Support in Zimbabwe	OCHA	2,765,981
ZIM-13/SNYS/55640/8487	Emergency response Fund (ERF) for Zimbabwe - projected needs $5 million	ERF (OCHA)	-
Sub total for COORDINATION AND SUPPORT SERVICES			**2,765,981**
FOOD			
ZIM-13/F/55416/561	Assistance to Food Insecure Vulnerable Groups	WFP	109,829,799
Sub total for FOOD			**109,829,799**
HEALTH			
ZIM-13/H/54465/122	Strengthening Capacity for Early Warning and Early Action in Response to Public Health Emergencies	WHO	2,000,000
ZIM-13/H/54467/122	Diarrhoeal disease outbreak preparedness and response in Chimanimani, Chipinge and Chiredzi Districts.	WHO	1,000,000
ZIM-13/H/55420/298	Nutrition Response to the 2012/2013 Drought	IOM	1,990,000
Sub total for HEALTH			**4,990,000**
PROTECTION			
ZIM-13/P-HR-RL/54470/298	Humanitarian assistance and strengthening resilience and DRR for communities made vulnerable by the effects of natural and socio-economic shocks.	IOM	5,961,429
ZIM-13/P-HR-RL/54473/298	Humanitarian Assistance to Returnees and Stranded Third Country Nationals (TCNs) including Unaccompanied Minors (UAMs)	IOM	4,272,500
Sub total for PROTECTION			**10,233,929**
WATER,SANITATION AND HYGIENE			
ZIM-13/WS/53585/124	Emergency WASH Support to affected Women and Children	UNICEF	1,000,000
ZIM-13/WS/54409/5006	Emergency WASH Response by Environmental Health Alliance (EHA) composed of German Agro Action (DWHH), MercyCorps, ACF, and Oxfam	DWHH	2,600,000
Sub total for WATER,SANITATION AND HYGIENE			**3,600,000**
Grand Total			**131,419,709**

Compiled by OCHA on the basis of information provided by appealing organizations.

Table IV: Summary of requirements (grouped by gender marker)

Consolidated Appeal for Zimbabwe 2013
as of 15 November 2012

Gender marker	Requirements ($)
2a-The project is designed to contribute significantly to gender equality	15,989,910
1-The project is designed to contribute in some limited way to gender equality	115,429,799
Grand Total	**131,419,709**

Compiled by OCHA on the basis of information provided by appealing organizations.

Annex 2: Donor response to the 2012 Consolidated Appeal

Table V: Summary of requirements and funding (grouped by cluster)

Consolidated Appeal for Zimbabwe 2012
as of 15 November 2012

Cluster	Original requirements	Revised requirements	Carry-over	Funding	Total resources available	Unmet requirements	% Covered	Uncommitted pledges
	($)	($)	($)	($)	($)	($)	%	($)
	A	B	C	D	E=C+D	B-E	E/B	F
AGRICULTURE	32,325,397	32,325,397	-	29,280,055	29,280,055	3,045,342	91%	-
COORDINATION AND SUPPORT SERVICES	4,159,930	3,509,930	147,027	976,692	1,123,719	2,386,211	32%	-
EDUCATION	9,429,200	4,669,600	-	248,207	248,207	4,421,393	5%	-
FOOD	127,710,380	127,710,380	39,843,026	73,829,201	113,672,227	14,038,153	89%	-
HEALTH	16,688,608	13,188,608	-	9,291,682	9,291,682	3,896,926	70%	-
LIVELIHOODS, INSTITUTIONAL CAPACITY BUILDING INFRASTRUCTURE	10,300,000	10,300,000	-	5,114,124	5,114,124	5,185,876	50%	-
MULTI-SECTOR	17,062,544	10,962,544	-	5,005,642	5,005,642	5,956,902	46%	-
NUTRITION	5,600,000	2,543,000	-	352,274	352,274	2,190,726	14%	-
PROTECTION	21,500,000	12,740,000	-	4,745,602	4,745,602	7,994,398	37%	-
WATER,SANITATION AND HYGIENE	23,600,000	20,494,710	-	12,907,218	12,907,218	7,587,492	63%	-
CLUSTER NOT YET SPECIFIED	-	-	1,649,915	(70,060)	1,579,855	n/a	n/a	-
Grand Total:	**268,376,059**	**238,444,169**	**41,639,968**	**141,680,637**	**183,320,605**	**55,123,564**	**77%**	**-**

Compiled by OCHA on the basis of information provided by donors and appealing organizations.

Funding: contributions + commitments
Pledge: a non-binding announcement of an intended contribution or allocation by the donor. ("Uncommitted pledge" on these tables indicates the balance of original pledges not yet committed.)
Commitment: creation of a legal, contractual obligation between the donor and recipient entity, specifying the amount to be contributed.
Contribution: the actual payment of funds or transfer of in-kind goods from the donor to the recipient entity.

The list of projects and the figures for their funding requirements in this document are a snapshot as of 15 November 2012. For continuously updated information on projects, funding requirements, and contributions to date, visit the Financial Tracking Service (fts.unocha.org).

Table VI: Summary of requirements and funding (grouped by appealing organization)

Consolidated Appeal for Zimbabwe 2012
as of 15 November 2012

Appealing organization	Original requirement	Revised requirement	Carry-over	Funding	Total resources available	Unmet requirements	% Covered	Uncommitted pledges
	($)	($)	($)	($)	($)	($)		($)
	A	B	C	D	E=C+D	B-E	E/B	F
UN Agencies and NGOs (details not yet provided)	268,376,059	238,444,169	-	-	-	n/a	n/a	-
ACF	-	-	-	806,223	806,223	n/a	n/a	-
ACF - France	-	-	-	1,905,655	1,905,655	n/a	n/a	-
CARE International	-	-	-	1,149,538	1,149,538	n/a	n/a	-
CRS	-	-	-	142,439	142,439	n/a	n/a	-
DWHH	-	-	-	6,109,503	6,109,503	n/a	n/a	-
ERF (OCHA)	-	-	1,649,915	(70,060)	1,579,855	n/a	n/a	-
FAO	-	-	-	21,099,500	21,099,500	n/a	n/a	-
FE Y ALEGRIA	-	-	-	101,559	101,559	n/a	n/a	-
GIZ	-	-	-	3,428,571	3,428,571	n/a	n/a	-
GOAL	-	-	-	1,420,714	1,420,714	n/a	n/a	-
IMC	-	-	-	1,243,830	1,243,830	n/a	n/a	-
IOM	-	-	-	7,605,615	7,605,615	n/a	n/a	-
IRC	-	-	-	714,286	714,286	n/a	n/a	-
IRD	-	-	-	1,572,950	1,572,950	n/a	n/a	-
JUH	-	-	-	707,214	707,214	n/a	n/a	-
Land O'Lakes	-	-	-	1,984,473	1,984,473	n/a	n/a	-
Mavambo Orphan Care	-	-	-	70,000	70,000	n/a	n/a	-
MC Scotland	-	-	-	725,366	725,366	n/a	n/a	-
Mercy Corps	-	-	-	1,095,732	1,095,732	n/a	n/a	-
MERLIN	-	-	-	573,557	573,557	n/a	n/a	-
NRC	-	-	-	969,557	969,557	n/a	n/a	-
OCHA	-	-	147,027	976,692	1,123,719	n/a	n/a	-
OXFAM GB	-	-	-	1,008,213	1,008,213	n/a	n/a	-
Plan	-	-	-	90,000	90,000	n/a	n/a	-
SACI	-	-	-	110,664	110,664	n/a	n/a	-
SC	-	-	-	1,287,001	1,287,001	n/a	n/a	-
Solidarmed	-	-	-	259,325	259,325	n/a	n/a	-
SWISSAID	-	-	-	1,782,159	1,782,159	n/a	n/a	-
UNHCR	-	-	-	1,544,070	1,544,070	n/a	n/a	-
UNICEF	-	-	-	6,133,330	6,133,330	n/a	n/a	-
WFP	-	-	39,843,026	73,718,537	113,561,563	n/a	n/a	-
WHO	-	-	-	707,214	707,214	n/a	n/a	-
WVI	-	-	-	707,210	707,210	n/a	n/a	-
Grand Total	**268,376,059**	**238,444,169**	**41,639,968**	**141,680,637**	**183,320,605**	**55,123,564**	**77%**	**-**

Compiled by OCHA on the basis of information provided by donors and appealing organizations.

Funding: contributions + commitments
Pledge: a non-binding announcement of an intended contribution or allocation by the donor. ("Uncommitted pledge" on these tables indicates the balance of original pledges not yet committed.)
Commitment: creation of a legal, contractual obligation between the donor and recipient entity, specifying the amount to be contributed.
Contribution: the actual payment of funds or transfer of in-kind goods from the donor to the recipient entity.

The list of projects and the figures for their funding requirements in this document are a snapshot as of 15 November 2012. For continuously updated information on projects, funding requirements, and contributions to date, visit the Financial Tracking Service (fts.unocha.org).

Table VII: Total funding per donor (to projects listed in the Appeal)

Consolidated Appeal for Zimbabwe 2012
as of 15 November 2012

Donor	Funding	% of Grand Total	Uncommitted pledges
	($)		($)
Carry-over (donors not specified)	41,639,968	23%	-
United States	41,099,530	22%	-
United Kingdom	24,915,332	14%	-
Allocation of unearmarked funds by UN agencies	23,283,858	13%	-
European Commission	19,065,754	10%	-
Japan	9,413,000	5%	-
Germany	5,501,020	3%	-
Switzerland	5,140,558	3%	-
Australia	4,922,000	3%	-
Canada	3,009,027	2%	-
Central Emergency Response Fund (CERF)	2,006,304	1%	-
Sweden	1,786,764	1%	-
Norway	1,262,261	1%	-
Luxembourg	275,229	0%	-
Grand Total	**183,320,605**	**100%**	**-**

Compiled by OCHA on the basis of information provided by donors and appealing organizations.

Funding: contributions + commitments
Pledge: a non-binding announcement of an intended contribution or allocation by the donor. ("Uncommitted pledge" on these tables indicates the balance of original pledges not yet committed.)
Commitment: creation of a legal, contractual obligation between the donor and recipient entity, specifying the amount to be contributed.
Contribution: the actual payment of funds or transfer of in-kind goods from the donor to the recipient entity.

The list of projects and the figures for their funding requirements in this document are a snapshot as of 15 November 2012. For continuously updated information on projects, funding requirements, and contributions to date, visit the Financial Tracking Service (fts.unocha.org).

Table VIII: Non-Appeal funding (per IASC standard sector)

Other Humanitarian Funding to Zimbabwe 2012
as of 15 November 2012

Sector	Funding	% of Grand Total	Uncommitted pledges
	($)		($)
AGRICULTURE	73,529	0%	-
COORDINATION AND SUPPORT SERVICES	75,311	0%	-
ECONOMIC RECOVERY AND INFRASTRUCTURE	559,006	2%	-
FOOD	14,000,000	57%	-
HEALTH	147,659	1%	-
MINE ACTION	484,717	2%	-
SHELTER AND NON-FOOD ITEMS	1,155,116	5%	-
WATER AND SANITATION	498,116	2%	-
SECTOR NOT YET SPECIFIED	7,733,151	31%	-
Grand Total	**24,726,605**	**100%**	**-**

Compiled by OCHA on the basis of information provided by donors and appealing organizations.

Funding: contributions + commitments
Pledge: a non-binding announcement of an intended contribution or allocation by the donor. ("Uncommitted pledge" on these tables indicates the balance of original pledges not yet committed.)
Commitment: creation of a legal, contractual obligation between the donor and recipient entity, specifying the amount to be contributed.
Contribution: the actual payment of funds or transfer of in-kind goods from the donor to the recipient entity.

The list of projects and the figures for their funding requirements in this document are a snapshot as of 15 November 2012. For continuously updated information on projects, funding requirements, and contributions to date, visit the Financial Tracking Service (fts.unocha.org).

Table IX: Total humanitarian assistance per donor (Appeal plus other*)

Zimbabwe 2012
as of 15 November 2012

Donor	Funding	% of Grand Total	Uncommitted pledges
	($)		($)
Carry-over (donors not specified)	41,639,968	20%	-
United States	41,597,646	20%	-
United Kingdom	24,915,332	12%	-
Allocation of unearmarked funds by UN agencies	23,283,858	11%	-
European Commission	19,999,087	10%	-
China	14,000,000	7%	-
Japan	10,913,000	5%	-
Germany	8,523,261	4%	-
Switzerland	6,772,767	3%	-
Australia	4,922,000	2%	-
Norway	3,547,923	2%	-
Canada	3,009,027	1%	-
Sweden	2,457,384	1%	-
Central Emergency Response Fund (CERF)	2,006,304	1%	-
Luxembourg	275,229	0%	-
Czech Republic	147,659	0%	-
Ireland	36,765	0%	-
Grand Total	**208,047,210**	**100%**	**-**

Compiled by OCHA on the basis of information provided by donors and appealing organizations.

Funding: contributions + commitments
Pledge: a non-binding announcement of an intended contribution or allocation by the donor. ("Uncommitted pledge" on these tables indicates the balance of original pledges not yet committed.)
Commitment: creation of a legal, contractual obligation between the donor and recipient entity, specifying the amount to be contributed.
Contribution: the actual payment of funds or transfer of in-kind goods from the donor to the recipient entity.

* Includes contributions to the Consolidated Appeal and additional contributions outside of the Consolidated Appeal Process (bilateral, Red Cross, etc.)

The list of projects and the figures for their funding requirements in this document are a snapshot as of 15 November 2012. For continuously updated information on projects, funding requirements, and contributions to date, visit the Financial Tracking Service (fts.unocha.org).

Annex 3: Acronyms and Abbreviations

ACF	*Action Contre la Faim* (Action Against Hunger)
ADRA	Adventist Development and Relief Agency
AMI	*Aide Médicale Internationale* (International Medical Aid)
ANC	antenatal care
ANPPCAN	African Network for the Prevention and Protection Against Child Abuse and Neglect
ARC	American Refugee Committee
ARI	acute respiratory infection
ART	antiretroviral therapy or treatment
ARV	antiretroviral (drugs)
AWD	acute watery diarrhoea
BCPR	Bureau for Crisis Prevention and Recovery
BEmOC	basic emergency obstetric care
BEmONC	basic emergency obstetric and neonatal care
BSFP	blanket supplementary feeding program
CAFOD	Catholic Agency for Overseas Development
CAP	consolidated appeal *or* consolidated appeal process
CARE	Cooperative for Assistance and Relief Everywhere
CCCM	camp coordination and camp management
CDC	(United States) Centers for Disease Control and Prevention
CEmONC	comprehensive emergency obstetric and neonatal care
CERF	Central Emergency Response Fund
CESVI	*Cooperazione e Sviluppo* (Cooperation and Development)
CFSA	Crop and Food Supply Assessment
CFSAM	Crop and Food Security Assessment Mission
CFSS	Comprehensive Food Security Survey
CFSVA	Comprehensive Food Security and Vulnerability Analysis
CfW	cash-for-work
CHAP	common humanitarian action plan
CHW	community health worker(s)
CMAM	community-based management of (severe) acute malnutrition
CMR	crude mortality rate
COOPI	*Cooperazione Internazionale* (International Cooperation)
CORDAID	Catholic Organization for Relief and Development Aid
COSV	*Comitato di Coordinamento delle Organizzazione per il Servizio Volontario* (Coordinating Committee for International Voluntary Service)
CPS	Child Protection Society
CPT	Citizen's Participation Trust
CPU	Civil Protection Unit
CRS	Catholic Relief Services
CWW	Concern Worldwide
DAPP	Development Aid from People to People
DCP	Department of Civil Protection

DDR	disarmament, demobilization and reintegration
DEWS	Disease Early Warning System
DFID	(United Kingdom) Department for International Development
DHS	Demographic and Health Survey
DHT	District Health Team
DRC	Danish Refugee Council
DRM	disaster risk management
DRR	disaster risk reduction
DTP	diphtheria-pertussis-tetanus
ECCE	Early Childhood and Care Education
ECD	early childhood development
ECHO	European Commission Directorate-General for Humanitarian Aid and Civil Protection
EFSA	Emergency Food Security Assessment
EHA	Environmental Health Alliance
EiE	Education in Emergencies
EMIS	Educational Management Information System
EmONC	emergency obstetric and neonatal care
EMOP	emergency operation (WFP)
EOC	essential obstetric care
EPR	Emergency Preparedness and Response
ERC	Emergency Relief Coordinator
ERF	Emergency Response Fund
ETC	emergency telecommunications
FAO	Food and Agriculture Organization of the United Nations
FCS	food consumption score
FCTZ	Farm Community Trust of Zimbabwe
FEWSNET	Famine Early Warning Systems Network
FNC	Food and Nutrition Council
FNSC	Food and Nutrition Security Committee
FST	Family Support Trust
FTS	Financial Tracking Service
GAA	*Welthungerhilfe* (German Agro Action)
GAM	global acute malnutrition
GAPWUZ	General Agricultural Plantation Workers Union of Zimbabwe
GBV	gender-based violence
GDP	gross domestic product
GNA	(ECHO) Global Needs Assessment
GNI	gross national income
GOAL	(Irish NGO; not an acronym)
HAZ	Hospitality Association of Zimbabwe
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HDI	Human Development Index
HDR	Human Development Report

HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IDP	internally displaced person/people
IDSR	Integrated Disease Surveillance and Response
IEC	information, education, and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IGAs	income-generating activities
ILO	International Labour Organization
IMAM	integrated management of acute malnutrition
IMC	International Medical Corps
IMF	International Monetary Fund
INEE	Inter-Agency Network for Education in Emergencies
IOM	International Organization for Migration
IPA	Interparty Political Agreement
IPC	Integrated Food Security and Humanitarian Phase Classification
IRC	International Rescue Committee
IRD	International Relief and Development
IRIN	Integrated Regional Information Networks
IRW	Islamic Relief Worldwide
ISDR	International Strategy for Disaster Reduction
ISL	Integrated Sustainable Livelihoods
IWSD	Institute of Water, Sanitation and Development
IYCF	infant and young child feeding
LCEDT	Livelihoods Community and Environmental Development Trust
LRRD	Linking Relief to Rehabilitation and Development
LRF	Legal Resources Foundation
MAM	moderate acute malnutrition
MDM	*Médecins Du Monde* (Doctors of the World)
Medair	Medical Environmental Development with Air Assistance
MeDRA	Methodist Development and Relief Agency
MERLIN	Medical Emergency Relief International
MICS	multiple indicator cluster survey
MIMS	multiple indicator monitoring survey
MISP	minimum initial service package
MMR	maternal mortality rate
MNCH	maternal, newborn and child health
MoAMID	Ministry of Agriculture, Mechanization and Irrigation Development
MoESAC	Ministry of Education, Sports, Arts and Culture
MoHA	Ministry of Home Affairs
MoHCW	Ministry of Health and Child Welfare
MoLSS	Ministry of Labour and Social Services
MoWRDM	Ministry of Water Resources Development and Management
MRE	mine risk education
MSEE	Minimum Standards for Education in Emergencies

MSF	*Médecins sans frontières* (Doctors Without Borders)
MT	metric ton
MTLC	Management, Technical, Learning and Coordination Unit
MUAC	mid-upper-arm circumference
MYR	Mid-Year Review
NAC/NCU	National Action Committee/National Coordination Unit
NANGO	National Association of Non-Governmental Organisations
NEWU	National Early Warning Unit
NFI	non-food item
NGO	non-governmental organization
NHEOC	National Health Emergency Operations Centre
NRC	Norwegian Refugee Council
OCHA	Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the High Commissioner for Human Rights
ORAP	Organization of Rural Associations for Progress
OTP	outpatient therapeutic programme(s)
OXFAM	Oxford Committee for Famine Relief
PENYA Trust	Practical empowerment networking youth organisation
PEP	post-exposure prophylaxis
PHC	primary health care
PHHE	Participatory Health and Hygiene Education
PI	Plan International
PLW	pregnant and lactating women
PLWHA	people living with HIV/AIDS
PMTCT	prevention of/preventing mother-to-child transmission
PoUWT	point-of-use water treatment
PRRO	protracted relief and recovery operation (WFP)
PSI	Population Services International
PU AMI	*Première Urgence Aide Médicale Internationale*
PWSSC	Provincial Water and Sanitation Sub-Council
RC/HC	Resident Coordinator / Humanitarian Coordinator
RCO	Resident Coordinator's Office
REPSSI	Regional Psychosocial Support Initiative
RUF	ready-to-use food
RUTF	ready-to-use therapeutic food(s)
SAM	severe acute malnutrition
SARCOF	Southern African Regional Climate Outlook Forum
SC	Save the Children
SDC	Swiss Agency for Development and Cooperation
SFP	supplementary feeding programme
SGBV	sexual and gender-based violence
SNV	*Stichting Nederlandse Vrijwilligers* (Netherlands Development Organization)
SOS	Support of Sowers

STD	sexually transmitted disease
STI	sexually transmitted infection
TAAF	The AIDS and Arts Foundation
TDH	*Terre Des Hommes*
TFC	therapeutic feeding centre
TFU	therapeutic feeding unit
UMCOR	United Methodist Committee on Relief
UN	United Nations
UNAIDS	UN Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UWSS	Urban Water and Sanitation Services
VAM	vulnerability assessment mapping
WAG	Women's Action Group
WASH	water, sanitation and hygiene
WB	World Bank
WEG	Women Empowerment Group
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision
WVI	World Vision International
ZACRO	Zimbabwe Association for Crime Prevention and Rehabilitation of the Offender
ZCDA	Zimbabwe Community Development Association
ZCDT	Zimbabwe Community Development Trust
ZCTDA	Zimbabwe Community Technology and Development Association
ZDHS	Zimbabwe Demographic Health Survey
ZimAHEAD	Zimbabwe Applied Health Education And Development
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZINWA	Zimbabwe National Water Authority
ZLHR	Zimbabwe Lawyers for Human Rights
ZRCS	Zimbabwe Red Cross Society
ZUNDAF	Zimbabwe United Nations Development Assistance Framework
ZVITAMBO	Zimbabwe Vitamin A for Mothers and Babies Project
ZWLA	Zimbabwe Lawyers for Human Rights

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