

HIGHLIGHTS (21 Aug 2020)

- As of 20 August, 5,745 COVID-19 cases and 151 deaths were confirmed, with 80 per cent in the four provinces of Harare, Bulawayo, Midlands and Matabeleland South.
- From 1 April to 19 August, 15,776 Zimbabwean migrants returned from neighbouring countries, with over 1,457 returnees being quarantined.
- WFP projects that food insecure people will rise to 3.3 million from 2.2 million in urban areas, and to 5.3 million from 3.7 million in rural areas from October to December 2020.
- Dams that supply Bulawayo City are at just 25.6 per cent capacity with a deficit of 17 million litres of water per day for the city's residents.



Two beneficiaries sharing food out after collecting their monthly food basket at a WFP food distribution site in Mutare. WFP/Claire Nevill

KEY FIGURES

7M
people in need

5.6M
people targeted

47
partners operational

FUNDING (2020)

\$800.8M Required

\$151.2M Received

19% Progress

FTS: <https://fts.unocha.org/appeals/921/summary>

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BACKGROUND (21 Aug 2020)

Situation Overview

The United Nations and humanitarian partners revised the Humanitarian Response Plan (HRP) in July to update the response to the COVID-19 outbreak integrating a multisectoral migrant response and reprioritizing humanitarian cluster responses. The [updated COVID-19 Addendum](#) requires US\$85 million to respond to the immediate public health crisis and the secondary impacts of the pandemic on vulnerable people, in addition to the \$715 million required in the HRP.

[The 2020 Zimbabwe Humanitarian Response Plan \(HRP\)](#), launched on 2 April 2020, indicates that 7 million people in urban and rural areas are in urgent need of humanitarian assistance across Zimbabwe, compared to 5.5 million in August 2019. Since the launch of the Revised Humanitarian Appeal in August 2019, circumstances for millions of Zimbabweans have

worsened. Drought and crop failure, exacerbated by macro-economic challenges and austerity measures, have directly affected vulnerable households in both rural and urban communities. Inflation continues to erode purchasing power and affordability of food and other essential goods is a daily challenge. The delivery of health care, clean water and sanitation, and education has been constrained and millions of people are facing challenges to access vital services.

There are more than 4.3 million people severely food insecure in rural areas in Zimbabwe, according to the latest [Integrated Food Security Phase Classification \(IPC\) analysis](#), undertaken in February 2020. In addition, 2.2 million people in urban areas, are “cereal food insecure”, according to the most recent [Zimbabwe Vulnerability Assessment Committee \(ZimVAC\) analysis](#) with a new ZimVAC assessment conducted between 10 and 21 July 2020. WFP projections indicate that the number of food insecure Zimbabweans is likely to increase by almost 50 per cent by the end of 2020. About 8.6 million people, including 5.3 million people in rural areas and 3.3 million people in urban areas, or 60 per cent of the population is expected to be food insecure due to the combined effects of drought, economic recession and the COVID-19 pandemic. Nutritional needs remain high with over 1.1 million children and women requiring nutrition assistance. Child malnutrition, including acute malnutrition or wasting, is also expected to increase due to steep declines in household incomes, changes in the availability and affordability of nutritious foods, and interruptions to health, nutrition, and social protection services. The impact of COVID-19 is likely to result in at least an additional 15,000 children being wasted, in addition to the 100,000 children expected to be wasted this year.

At least 4 million vulnerable Zimbabweans are facing challenges accessing primary health care and drought conditions trigger several health risks. Decreasing availability of safe water, sanitation and hygiene have heightened the risk of communicable disease outbreaks for 3.7 million vulnerable people. Some 1.2 million school-age children are facing challenges accessing education. The drought and economic situation have heightened protection risks, particularly for women and children. Over a year after Cyclone Idai hit Zimbabwe in March 2019, 128,270 people remain in need of humanitarian assistance across the 12 affected districts in Manicaland and Masvingo provinces. There are 21,328 refugees and asylum seekers in Zimbabwe who need international protection and multisectoral life-saving assistance to enable them to live in safety and dignity.

As of 20 August 2020, Zimbabwe had confirmed 5,745 confirmed COVID-19 cases (vs 4,339 on 5 August; 926 on 9 July; and 287 on 10 June), including 151 deaths (vs 84 deaths on 5 August; 12 deaths on 9 July and four deaths on 10 June) since the onset of the outbreak. The four provinces of Harare, Bulawayo, Midlands and Matabeleland South account for 80 per cent of cases in Zimbabwe, with 75 per cent of all confirmed cases being local cases. Harare has the highest number of cases per capita followed by Bulawayo and Matabeleland South, and the highest number of deaths per capita followed by Bulawayo.

In order to strengthen the National COVID-19 response, the Government Cabinet decided on 18 August that a Technical Steering Committee with experts from all the sectors involved in the response will be constituted, and that the COVID-19 response is to be merged into a single response plan comprising the Command Centre, Office of the COVID-19 Chief Coordinator and Ministry of Health and Child Care. In addition to previously announced lockdown regulations, the postponement of the planned reopening of schools on 28 July and extra measures on 21 July, the Government Cabinet directed on 18 August that: business hours which were ending at 3 p.m. be revisited to end at 4:30 p.m. and the curfew to start at 8 p.m. instead of 6 p.m; public transport drivers have to undergo regular COVID-19 PCR tests; and public transport buses will be allowed a dedicated lane at roadblocks to expedite their passage. A total of 15,776 migrants have returned to Zimbabwe from neighbouring countries as of 19 August, with the large majority or 90 per cent of returnees arriving through the three points of entry of Beitbridge border post, Plumtree and Harare International airport. The number continues to increase daily, with a projection of 20,000 new arrivals in the next coming months with inclusion of those from northern countries, such as Zambia, Malawi, Tanzania and Ethiopia. Further, 1,457 returnees were quarantined in government operated centres on 18 August, with the large majority or 80 per cent of returnees quarantined in the five provinces of Harare, Matabeleland South, Bulawayo, Masvingo and Mashonaland West.

On 5 August, the UN Secretary-General urged the Government of Zimbabwe to ensure the protection of all fundamental human rights, notably the freedom of opinion and expression and the right to freedom of peaceful assembly and association, in accordance with Zimbabwe's human rights obligations.

In addition to the commitments to the HRP recorded above through the Financial Tracking System (FTS), a number of pledges are in the process of being finalized, including \$30 million for the HRP and \$14 million for the COVID-19 response from the United Kingdom, \$18 million from the United States, \$14 million from the European Commission, and \$200,000 from Canada. In addition, carryover funding of agencies from 2019 will be reflected in FTS.

CLUSTER STATUS (21 Aug 2020)



Camp Coordination and Camp Management / Shelter and NFIs

43,352

displaced pple in camps & host communities



Needs

- More than 43,000 people remain displaced in camps and host communities. Out of the total number of IDPs, 198 Cyclone Idai-affected households (909 people) are living in four camps, where living conditions are exposing them to serious protection and health risks.
- Those remaining in the camps and those affected and displaced people accommodated in host communities or in makeshift structures already worn out for the protracted crisis need shelter support.
- Since the beginning of lockdown, Chipingwe are the among the high migrant/ returnee receiving districts. Communities continue to receive large numbers of migrants within Zimbabwe, who were forced to return to their rural homes as effects of lockdown became more adverse in towns and cities.
- Identified health facilities in the districts do not have adequate resources making it not feasible for IDPs to receive health care of treatment when needed.
- There is a need for advocacy with Government to strengthen community-based reporting structures/referral mechanisms to ensure migrants returning to IDPs communities are screened and not exposing already vulnerable people.



Response

- Leading the Shelter/CCCM cluster, IOM has been advocating for durable solutions for displaced populations to ensure that basic needs of IDPs and host communities are addressed and included in the COVID-19 national response plan.
- Since the beginning of the COVID-19 outbreak, IOM through its Displacement Tracking Matrix (DTM) tool, has reprogrammed its activities using innovative and remote methodology to continue monitoring mobility trends, needs and vulnerabilities of the IDPs in camps and host communities as well as health risks associated with COVID-19.
- IOM is assisting already vulnerable communities and displaced populations from protracted crisis through a new shelter intervention that will assist IDPs in camps and host communities by ensuring appropriate housing space and decongestion of displacement sites with poor living conditions, to avoid the spread of the virus and provide a dignified way of living after over one year of displacement.

- The Government of Zimbabwe is accelerating the preparation of land and services at the new relocation site in Vumba. Providing technical capacity to the Government, IOM is supporting the relocation process and assist with camp coordination and camp management ensuring that IDPs have access to basic services. An IOM tent was set up in each of the IDP camps to coordinate the response to provide in land support to IDPs, and facilitate enhanced coordination between IDP communities and government authorities, increasing communications, to operationalize the relocation process.
- Feedback mechanisms and support lines are in the progress targeting in IDPs in camps and host communities to ensure feedback is facilitated and protection issues are addressed, and to guarantee accountability to affected populations (AAP).
- A camp exit strategy will be put in place and land reparation conducted to ensure host communities have the appropriate space.
- PPE and COVID-19 awareness preventive measures have been incorporated in all activities to ensure protection of both beneficiaries and program personnel.
- In Cyclone Idai affected areas, support to displaced people continued with the provision of transitional shelters, repairs kits and rehabilitations. Constrains are arising due to the increase of need of IDPS, that are selling the construction materials provided, due to the bad economic situation, and the lack of livelihoods to provide an income and food source.

↔ Gaps

- There is an urgent need to ensure IDPs have access to medical services and health facilities, and to increase mental health and psychosocial support (MHPSS) tailored for COVID-19 distress for IDPs and affected communities.
- IDPs are still in need of food since the last food distributions by the NGO World Vision in April 2020, as well as more non-food items (NFIs) such as blankets, winter clothing, soap etc. Camp coordination remains a challenge as no partner or government stakeholders have been facilitating the process.
- Reinforced surveillance needs to be strengthened through community leaders. There is need for more COVID-19 awareness campaigns in the camps to ensure communities are educated on health and preventive measures, particularly since surrounding communities are receiving migrants' returnees, and the need to cope with the socio-economic impact and the loss of livelihoods resulting in increased cross border trading activities.

CLUSTER STATUS (21 Aug 2020)



Education

853K

children targeted

359,764

people reached under COVID-19 response



Needs

- Zimbabwe's education system has been negatively impacted by multiple crises, including Cyclone Idai, economic challenges, floods and droughts and, most recently, the COVID-19 pandemic. Before the onset of COVID-19, the Education Cluster estimated that out of the more than 3.4 million school-going age children (3 to 12 years), at least 1.2 million (35 per cent), would need emergency and specialized education services in 2020. These included more than 853,000 children in acute need (children not enrolled in school; orphans and other vulnerable children, including children with disabilities and children living with HIV and children in need of school feeding).
- The combination of the COVID-19 pandemic and prevailing humanitarian conditions is now having far-reaching consequences for the demand and supply of education services. Zimbabwe closed schools on March 24, 2020 in an effort to contain the spread of COVID-19 and to protect school populations. However, this has effectively caused disruption of the education of more than 4.6 million learners (3 to 18 years), with adverse impacts on their protection and well-being as well as their attendance and participation in learning. The reopening of schools, previously planned for 28 July 2020, has been deferred indefinitely. The situation of children continues to deteriorate with the prolonged closures likely to have a major and negative affect on children's learning, physical, social and mental health and well-being.
- While the education sector has developed alternative education strategies to ensure continuous learning among children, evidence from a recent survey by the Education Cluster shows that 56 per cent of the 19,512 responding children do not have access to learning materials to study at home; while a significant number do not have access to radio and television to enable them to access radio lessons. Similarly, 62 per cent out of 17,943 respondents indicated that children do not have anyone to support them in learning while many caregivers and parents are ill-equipped to academically support learning at home. These findings demonstrate that prolonged school closures are becoming a threat to hard-won educational achievements for years to come as this will exacerbate existing vulnerabilities and inequalities among children, especially girls, children with disabilities, those in rural areas, orphans and vulnerable children, as well as those from poor households and fragile families.
- The cluster is targeting 3.5 million learners in early childhood education, primary level and secondary level through prioritization of activities designed to restore access to safe, quality formal or non-formal early learning, early childhood education (ECD).

➔ Response

- As of end of July 2020, a total of 77,038 people benefited from various activities implemented by cluster partners as part of the 2020 Humanitarian Response Plan while 359,764 people have been reached through COVID-19 related activities. The following specific activities have been accomplished:
- A cumulative total of 380 radio lessons has now been developed, with an average of 40 lessons (ECD to grade 7) being broadcast on a weekly basis.
- 24,000 ECD storybooks have been converted into braille, printed and distributed in addition to 60,000 copies of "My Story" ECD Workbooks and 60,000 copies of caregiver guides.
- A webinar on SOPs was conducted (by MoPSE) for all senior staff at headquarters and sub-national level, in preparation for re-opening of schools. Eligibility criteria for utilization of Emergency School Feeding Grant have been developed for use by the 100 schools that will benefit from Emergency School Improvement Grants for school feeding in Gokwe North, Makoni and Masvingo districts. the grant will be disbursed before school reopening.
- A GPE funded project will commence by the end of August in the six districts of Bikita, Zaka, Chimanimani, Chipinge, Mutare and Buhera; benefitting over 2,400 teachers and 54,000 children in 139 schools.
- Viamo Mobile Learning platform was launched in Chipinge covering 20 schools and 45 Schools in Chimanimani Districts in total targeting 2,500 learners.

- Establishment of study circles in 109 schools reaching 5,963 marginalized learners towards ensuring continued while at home.
- A total of 2,697 learners have so far used IGATE digital platform that provides learning materials (reading and number cards, study guides and story books).
- Preparation for school reopening is ongoing with the distribution of 38 tanks of 1,000 litres foot-operated handwashing tanks to schools in Nyanyadzi, Chimanimani/Mhakwe, Chihota, Makoni districts. Additionally, sanitizers, liquid soap, disinfectants, face masks, infrared thermometers, branded masks and school desks were distributed too.
- With the sector continuing with its preparations for the re-opening of schools for final examination classes for Primary and Secondary Education, the developed and approved guidelines that were put in place for the June 2020 examinations will be used for the holding of the final examinations in November/December.

Gaps

- *Inadequate human and financial resources:* Partners continue to reel under the challenges of inadequate human and financial resource constraints to respond to the urgent needs of learners.
- *Reduced mobility and access:* In the context of the reviewed and tightened lockdown measures, both partners and Government staff are facing mobility challenges to implement response activities. Meanwhile, fiscal and technical constraints also make it difficult to introduce remote working to respond to the needs of learners. Time-critical solutions to focus on learners who cannot access digital or radio lessons, due to coverage or household considerations are needed to enhance response.

CLUSTER STATUS (21 Aug 2020)



Food Security

4.6M

people targeted

600K

people received assistance in July

Needs

- According to the 2020 Humanitarian Response Plan, a total of 6 million people are in urgent need of food assistance across Zimbabwe both in rural and urban areas. In addition, 2.8 million small holder farmers are in need of season-sensitive emergency crop and livestock input assistance.
- The increased rural and urban caseload due to COVID-19 of 200,000 is bringing the total target to 4.6 million people, according to the HRP COVID-19 Addendum. A further revision of rural food assistance needs will be undertaken when data from the forthcoming assessments are available.
- COVID-19 containment measures, in particular lockdowns, have severe socio-economic consequences. It is expected that the drastic loss of livelihoods will trigger a sharp increase in food insecurity across the country. WFP internal analysis forecasts that food insecure people will rise to 3.3 million from 2.2 million in urban areas, and to 5.3 million from 3.7 million in rural areas from October to December 2020.

- According to the preliminary results of the quarantine centres assessment conducted by INGOs in June and July 2020, low dietary diversity is a concern in the majority of the assessed quarantine centres. Further, no protection ration such as CSB+ is distributed to people with special dietary needs such as pregnant and lactating women or children under age 5.
- According to the Ministry of Agriculture, as of 5 August 2020, maize stocks were at 106,278 metric tons, which is sufficient for one month of national consumption only. The situation is worse compared to the same time last year when 346,331 metric tons of maize were in stock.
- According to WFP July Food Security Outlook, prices of basic food commodities increased by an average of 19 per cent over the month of July 2020. All commodities recorded an average price increase of 20 per cent, except sugar beans that witnessed a 10 per cent increase. These price increases are against a backdrop of decreasing income due to the COVID-19 pandemic and economic challenges.


➔ Response

- In July, the Food Security Cluster partners reported reaching over 600,000 people with either in-kind food distribution, cash or vouchers modality in both rural and urban areas.
- The National Cash Working Group approved the updated Minimum Expenditure Basket (MEB) food basket transfer value for the Urban Cash-Based Transfer. Due to the combination of shocks such as hyperinflation and price increase, the transfer value rose from \$9 to \$12 per person per month. Further, considering the needs for improved hygiene measures due to the COVID-19 pandemic, soap was added to the MEB Food Basket.
- Although no further outbreaks of the African Migratory Locust (AML) in Zimbabwe have been reported, the National Agriculture Policy Framework Pillar 8, who is in charge of the AML, has identified a regional expert who will be engaging partners on potential response strategies. Further, the Regional and National projects on AML response strategy have been approved. The projects will focus on community surveillance supported by government and setting up Locust Control Units in government departments.
- After the ZimVAC assessments teams have finished field data collection in July, analysis and report writing continued during the reporting period.

↔ Gaps

- According to FTS, only 22.4 per cent of the total requested budget was committed as of 13 August 2020. The \$506 million budget was designed and adapted to COVID-19 measures to save lives through support to food access for acutely food insecure population and prevent further deterioration of living standards by providing emergency agriculture support.

CLUSTER STATUS (21 Aug 2020)



Health

3M

people targeted

5,745

COVID-19 cases (as of 20 August)

Needs

- As of 20 August 2020, Zimbabwe reported 5,745 confirmed COVID-19 cases (vs 4,339 on 5 August; 926 on 9 July; and 287 on 10 June), including 151 deaths (vs 84 deaths on 5 August; 12 deaths on 9 July and 4 deaths on 10 June) since the onset of the outbreak. The four provinces of Harare, Bulawayo, Midlands and Matabeleland South account for 80 per cent of cases in Zimbabwe, with 75 per cent of all confirmed cases nation-wide being local cases. The latest figures show that: cumulative cases curve remains on an upward trend with case fatality rate rising again standing at 2.66 per cent as of 19 August; Harare has the highest number of cases per capita followed by Bulawayo and Matabeleland South, and the highest number of deaths per capita followed by Bulawayo; more males have been affected when compared to females, with most COVID-19 cases being in the 20–40 years age groups, and more females affected as age rises; and most deaths are between 40 and 80 years of age, with more male deaths as age rises.
- The main challenges relate to (1) health-care workers, including persistent industrial action by nurses, notice to strike by additional health worker cadres, and increasing number of health workers infected with COVID-19; (2) COVID-19 response, including delayed implementation of national decisions aimed at scaling up community surveillance, contact tracing and community-level isolation facilities, insufficient capacity for hospitalization of moderate-severe ill COVID-19 patients, and delayed placement of orders of essential supplies (lab kits, PPE) including where funding is already available; and (3) delivery of essential health services, with declining coverage of essential services as of end June 2020, and 26 districts out of 63 districts reporting routine immunization coverage with Penta 3 < 80 per cent.
- There are close to 2 million patients with chronic non-communicable diseases while 1.2 million people are living with HIV/AIDS in Zimbabwe. This group of people are more susceptible to more severe COVID-19 illness requiring hospitalization and intensive medical care. People with pre-existing chronic illness (including people living with HIV), older persons, women, people with disabilities, older persons, migrants, IDPs and refugees all face risks related to COVID-19, requiring immediate gender-sensitive and age-sensitive action. In addition, people living in urban informal settlements are at increased risk of contracting COVID-19 due to inadequate access to essential health care, clean water and sanitation services and crowded living conditions.

Response

- Latest developments in the COVID-19 response include: (1) Finalization of a three-month COVID-19 response operational plan to cover period August-October 2020 (all sectors not just public health); (2) Increased number of rapid response teams in Harare and Bulawayo with 70 per cent of all recent new local cases in Bulawayo being known contacts of confirmed cases, and less 50 per cent of recent new local cases being known contacts of confirmed cases (range 10-50 per cent) in the other provinces; (3) Average daily PCR tests increased from 491/day during the third week of July to 1,225/day during the week of 27 July to 2 August; and (4) Appointments of the new Minister of Health and Child Care on 4 August and the new Permanent Secretary (PS) for the Ministry on 3 August.
- National COVID-19 response capacities in Zimbabwe continue to be scaled up: (1) Public Health priorities including enhancement of surveillance and testing in hotspot districts with highest infection, strengthening the isolation of confirmed cases, reinforcement of lock-down in areas with highest transmission (Bulawayo, Harare), and strengthening of quarantine of all returnees; (2) Multisectoral priorities with support for the most vulnerable (food, cash transfers, WASH); (3) COVID-19 resources tracking with GoZ COVID-19 response resources to be posted on a World Bank supported tracking platform/dashboard; (4) Support to health workers with ongoing negotiations to resolve ongoing nurses industrial action.

- Conditions associated with the lockdown, extended indefinitely with review every two weeks, include: use of screening test (rapid diagnostic tests) for employees resuming work; compulsory use of face masks by all public place; mandatory quarantine for all travellers arriving in Zimbabwe for seven days followed by polymerase chain reaction (PCR) testing and then an additional seven days voluntary quarantine. In addition to previously announced lockdown regulations, and extra measures on 21 July, the Government Cabinet directed on 18 August that: business hours which were ending at 3 p.m. can now end at 4:30 p.m. and the curfew starts at 8 p.m. instead of 6 p.m; public transport drivers have to undergo regular COVID-19 PCR tests; and public transport buses are allowed a dedicated lane at roadblocks to expedite their passage.
- In view of the surge in positive local cases, Cabinet approved on 18 August guidelines to help families manage COVID-19 cases at home. Furthermore, in order to curtail the spike in infections Zimbabwe and the requirement of a more robust testing regime, the Cabinet directed for the production of PCR Primers and Viral Transport media through the National University of Science and Technology (NUST).
- In order to strengthen the national COVID-19 response, Cabinet decided on 18 August that the following measures will be taken: (a) a Technical Steering Committee with experts from all the sectors involved in the response will be constituted with a clear defined terms of reference; (b) the COVID-19 response is to be merged into a single response plan comprising the Command Centre, Office of the COVID-19 Chief Coordinator and Ministry of Health and Child Care.
- Following the presentation of the Minister of Health and Child Care of a report on the ongoing restructuring of the Ministry of Health and Child Care, on 18 August the Government approved the introduction of four pillars in the health delivery system, namely: Pharmaceuticals and Biopharmaceuticals product manufacturing; Biomedical Engineering, targeting the manufacturing of ventilators, hospital beds and other essential equipment; Biomedical Science and Laboratory Science, incorporating research on pathogens and the manufacturing of consumables such as reagents; and Public Health Strategy and Guidelines Formulation.

↔ Gaps

- The increase in local transmission is contributed by: delayed case detection due to gaps in surveillance, contact tracing and quarantine of contacts; gaps in isolation of confirmed cases; and sub-optimal implementation of infection prevention and control practices in health facilities, crowded institutions such as prisons, education facilities.
- It is critical that the capacity of the health system to test, isolate and treat all cases of suspect, confirmed and probable COVID-19 cases is enhanced. To this end, there is an urgent need to: increase the number of beds in the health facilities nation-wide for isolation of suspect, confirmed and probable cases; increase availability of medical equipment including ventilators, patient monitors as well as medical supplies and consumables required for the management of cases; increase the availability of laboratory supplies and consumables; increase the availability of personal protective equipment for all health workers involved in the management of cases; increase the capacity to safely refer patients by ambulance.
- Priorities include: (1) Government action to urgently address health workers concerns-allowances and occupational safety, strengthen sub-national coordination and partnership using including lessons learned from recent emergencies (2018 Cholera outbreak; 2019 Cyclone Idai response), decentralize response operations particularly in hotspot areas to ward, health facility and community level, and implement recommendations to ensure delivery of essential services; (2) strengthening of public health capacities to explore opportunities to scale up capacities for active surveillance, contact tracing, isolation and quarantine among stakeholders beyond Government (private sector, civil society, CBOs, and to learn lessons from engagement of private sector in COVID-19 laboratory testing; and (3) support from international partners to provide continued material, financial and technical support, continue to share best practices, and continued advocacy for effectiveness, transparency, effective monitoring and accountability.

CLUSTER STATUS (21 Aug 2020)



Nutrition

606K

people targeted

544,143

children screened in 25 districts in July

Needs

- Approximately 95,000 children under age 5 are suffering from acute malnutrition, with the national global acute malnutrition (GAM) prevalence at 3.6 per cent (ZimVAC rural 2019). Eight districts recorded GAM prevalence of over 5 per cent. Since early April and the beginning of the harvesting season, the country overall has not experienced a nationwide increase in malnutrition. However, pockets of increased cases of malnutrition particularly in Epworth and Gutu and Mutare districts remain a concern and are closely monitored. Of particular concern is an expected increase in child malnutrition, including wasting, due to steep declines in household incomes, changes in the availability and affordability of nutritious foods, and interruptions to health, nutrition, and social protection services. According to recent global estimates, the current situation would lead to an additional 14,250 children being malnourished in Zimbabwe resulting from increased food insecurity.
- The nutrition status of children in Zimbabwe is further compounded by already existing sub-optimal infant and young child feeding practices including very poor dietary diversity at 15 per cent and with only 7 per cent having attained the minimum acceptable diet (ZIMVAC, 2020).
- The number of pellagra cases reported has continued to increase in Zimbabwe in June. As per routine data, 1,082 pellagra cases were recorded between January to May 2020, which is double compared to the 547 cases over the same period last year (DHIS2, May 2020). Following increases from 86 pellagra cases in March to 141 cases in April and 224 in May, 244 cases were reported for June 2020. The numbers of pellagra cases are likely to continue increase as food insecurity in the country deepens and household income for accessing diversified diets continues to be depleted by the impact of COVID-19 lockdown and economic crisis.
- Due to the drought-induced food insecurity, the majority of the households in the country require food assistance to facilitate adequate dietary intake and prevent deterioration of the nutrition status of children, women and the general community. Already nationally 56 per cent of women consume less than five groups of foods recommended.

Response

- Treatment of acute malnutrition, a very critical life-saving intervention, has been prioritized by the Nutrition Cluster. Screening of children under age 5 for acute malnutrition has continued in the current COVID-19 lockdown following adoption of family and mother led mid-upper arm circumference (MUAC) which aims at limiting the risk of infection by community health workers involved in screening. In July 2020, 544,143 children were screened for acute malnutrition with 87 per cent of the children being screened at community level in 25 nutrition priority districts. Of those screened in July, 758 were admitted for treatment of moderate acute malnutrition (MAM) and 291 were admitted for treatment of severe acute malnutrition (SAM). Nationally, 10,341 children were admitted for treatment of SAM between January and June 2020. The unexpected decrease in admission of children for treatment of acute

malnutrition that was recorded in April has since improved with 1,643 children being admitted in May compared to 1,168 the previous month of April. In June, the number of children admitted was 1,352 showing a similar trend to what was seen in the past 3 years which is experienced after the harvest season.

- The Nutrition Cluster is prioritizing the improvement of the quality of care provided in the Outpatient Therapeutic Programme (OTP) and in stabilization centres owing to the continuous mentorship and capacity building of health workers.
- Approximately 5,160 village health workers were trained on active screening which has resulted in increased admission and treatment of children with acute malnutrition. Additionally, 1,135 health-care workers have been trained on integrated management of acute malnutrition (IMAM) in April, May and June 2020 resulting in improved quality of care for malnourished children. Also, 217 lead mothers were trained on infant and young child feeding (IYCF) in Chiredzi increasing the number of community volunteers leading mother care groups. More health care workers and community health workers are still being capacitated to support the emergency. Implementation modalities adjustment are progressively rolled-out to ensure infection prevention and control. Specifically, the Paediatric Association of Zimbabwe (PAZ) is developing remote training materials aiming at strengthening the capacity of health workers and clinicians working in hard to reach areas through the e-learning platform.
- Promotion of appropriate IYCF and care practices in the emergency context is ongoing with support of nutrition partners, namely ADRA, GOAL, Save the Children, Nutrition Action Zimbabwe (NAZ), Organization for Public Health Interventions & Development (OPHID, Plan International and World Vision. In July 2020, 257,381 pregnant and lactating women and caregivers of children under age 2 were reached with counselling support and an estimated 2 million people have been reached through the nine episodes of the radio show “Live Well: The Health and Nutrition Show” on topics related to nutrition, health and HIV in the context of COVID-19.
- The micronutrient supplementation of Vitamin A reached 548,424 children from 6-59 months (55 per cent of the cluster target on Vitamin A supplementation). Vitamin A coverage had dropped by 50 per cent in April due to the disruption in services delivery following the COVID-19 lockdown which restricted movement of mothers and children and most were not able to go to health facilities for fear of COVID-19 infections. In May and June however with the relaxing of lockdown conditions, a continuous improvement was noticed with 85,947 children having received Vitamin A in May and 88,579 children in June. Vitamin A supplementation continues both at health facility and community levels.
- The RapidPro SMS reporting, an innovation of UNICEF in conjunction with the MoHCC was initiated in April 2020 and is operational in 25 targeted districts and two acute malnutrition hotspots with districts reporting on weekly basis on seven high frequency nutrition indicators.
- Following the ZIMVAC 2020 seasonal assessment, with field data collection across both urban and rural settings conducted during the period 10 to 21 July, with the aim of measuring food and nutrition security situation and the socio-economic impact of COVID-19. Data analysis and report writing will be completed by end of August and the report shared with all stakeholders.
- The Ministry of Health and Child Care, together with partners WFP, UNICEF, UNAIDS and ILO, continues strengthening integration and dissemination of health and nutrition messages to the general public using a coordinated approach.
- WFP in collaboration with UNICEF and MoHCC continued providing the emergency response for screening, SBCC and provision of preventive rations into June in order to deter the detrimental effects of COVID-19 on the nutritional status of beneficiaries, (i.e., children under age 5 and pregnant and lactating women). The Preventive rations will be discontinued from July 2020 until next lean season.

↔ | Gaps

- Limited funding to meet the needs of the response remains the main challenge for the emergency nutrition projects. Nutrition cluster HRP 2020 response activities have only been funded with \$3.5 million against the \$18.8 million required.
- There is a knowledge gap in the context of COVID-19 pandemic and in nutritional messages or information to the community and health workers.
- Lack of personal protective equipment (PPE) for the community volunteers and supervisors implementing nutrition in emergencies life-saving activities is still posing a challenge for the implementation of the nutrition lifesaving interventions.
- Due to the high demand of MUAC tapes for family-led MUAC, some mothers have not yet received MUAC tapes which is hindering the progress of the programme.
- General lack of transport, travel and movement restrictions, fear of contracting COVID-19 infections, and prioritization of emergency life- saving interventions over routine critical nutrition services have increased the risk of eroding the gains made over the years.

CLUSTER STATUS (21 Aug 2020)



Protection (Child Protection)

422K

people targeted

53,064

children reached w/psychosocial activities



Needs

- Women and children are facing access challenges because of cost of transportation in urban areas, lack of public transport in rural areas medical facilities which are not easily accessible due to infection of staff, access fees for certain medication, such as antiretroviral drugs (ARV), stigma and teasing at roadblocks, especially for sensitive services such as post-rape care.
- There is a need for advocacy for waiver of access fees for children, adolescents and young mothers when accessing antiretroviral medication.
- There is limited access to justice for clients who need to attend court as they are turned back at roadblocks by security personnel despite the fact that they are producing the required court documentation that ought to facilitate their presence in court for the hearing of their cases including sexual violence and abuse cases (SGBV).
- The closure of the Registrar's General Office which currently has very few staff working has resulted in challenges and delays in the age determination for children in conflict with the law who do not have birth certificates who have to remain in detention until it can be confirmed that they are minors.
- Quarantine measures have placed new stressors on parents and caregivers as a result of children's prolonged stay at home due to school closure and loss of livelihood due to COVID-19 induced economic challenges.

→ Response

- Since January 2020, 47,589 children, including 5,475 children with disabilities (45 per cent boys and 55 per cent girls) have benefitted from structured child protection and psychosocial support (PSS) activities. Child Protection Society (CPS) working with the Ministry of Public Service, Labour and Social Welfare (MoPSLSW) has provided tracing and reunification services to 479 unaccompanied and separated children (UASC) with 167 children who were previously living on the streets and 133 children referred by Department of Social Welfare (DSW) from quarantine facilities at the borders being reunified. During the reporting period, tracing of relatives for three unaccompanied minors (two girls and a boy) aged between 15 to 17 from South Africa was successfully completed, with them residing in the Bulawayo quarantine center awaiting reunification.
- With the increase in the number of cases nationwide, children have become more anxious and restless. As a result of the extended lockdown, families are suffering from hunger, domestic violence and mental health problems. This has made children more vulnerable to various forms of abuse including child marriages, teen pregnancies and neglect. Through the Child helpline, 250 cases were documented during the reporting period with 44 per cent being directly related to gender-based violence and violence against girls.
- A meeting was held with the Victim Friendly Unit (VFU) in response to the reported challenges faced by SGBV survivors who encounter difficulties while passing through police roadblocks to get to court. Numbers to provincial police offices that can be called should any stakeholder or their client have difficulties passing through roadblocks have been shared and this will aid to facilitate the continued access to services for children, adolescents and women including persons with special needs. To address the challenges that parents and caregivers are facing during COVID-19, 4 radio programmes which are part of the, "Live Well: Parenting in COVID-19 Series" were aired on SKYZMETRO FM at 11:30 a.m. The radio sessions are aimed at dissemination of positive parenting messaging to foster child protection and resilience in the face of COVID-19 which include interactive sessions with live call ins and WhatsApp messaging. The radio broadcasts covered topics on the effects of COVID-19 on children and different coping mechanisms for adolescents including discussions drugs and substance abuse and its effects, aired on 4, 11 and 13 August respectively.
- MoPSLSW has received support for the deployment of an additional 4 social workers in Manicaland, Bulawayo, Matebeland South (Beitbridge) and Masvingo provinces. To help address the need for recreational materials for children in quarantine facilities 21 recreational kits and 9 Early Childhood Development Kits have been distributed to 21 quarantine facilities across 8 provinces.
- The MoPSLSW continues to provide support to Child Protection partners who are experiencing challenges at security roadblocks with letters at both Provincial and District level to facilitate the continuity of essential Child Protection and GBV services, including case management and provision of Mental and Psychosocial Support (MHPSS) for children and vulnerable communities and access to justice.
- To facilitate the release of children in detention who do not have birth certificates Magistrates are applying the Provision in the Criminal Procedure and Evidence Act that allows them to estimate the age of children which has facilitated court rulings and the eventual release of these children.

↔ | Gaps

- There is a lack of COVID-19 related information in accessible formats for persons with disabilities, especially for the deaf and hard of hearing, and the blind or partially blind people.
- Due to the time take to get past security checkpoints child protection partner staff are getting late and sometimes only manage to get to court after the proceedings have been concluded which makes it impossible for them to provide the required support to clients including survivors of sexual violence and abuse cases (SGBV). Child Protection partners have reported the existence of unauthorized roadblocks being set up an issue that has been taken up by the MoPSLSW for discussion with the Zimbabwe Republic Police (ZRP) as it prevents continued delivery of essential Child Protection and GBV services.

- The scarcity of personal protective equipment (PPE) has had a direct impact on the ability to continue conducting in person visits for critical cases that cannot be followed up remotely. There is also a need to provide child friendly PPE including masks.
- Quarantine facilities, residential care centres and other places of safety where children who were previously living on the streets and children returning from Botswana and South Africa have been placed, lack the bare minimum of basic services to maintain adequate personal hygiene, recreation and services to care for them. In addition, there is a lack of non-food items with specific items to cater for the needs of infants in support of mothers with children under age 2 in quarantine facilities.
- Child protection has only received 8 per cent funding of the total \$9.6 million that is required. Without this funding, partners continue to face challenges in ensuring the mental health and well-being of all frontline workers. This includes access mental health and psychosocial care, provision of recreational materials for use by children in quarantine facilities, addressing stigma, additional vehicles to facilitate the movement of clients and procurement of adequate PPE to ensure COVID-19 prevention measures are adhered to when conducting home visits for critical cases that cannot be followed up remotely. While partners acknowledge the need to fill this gap the lack of resources remains a limiting factor.

CLUSTER STATUS (21 Aug 2020)



Protection (Gender-based Violence)

845K

people targeted

109,141

people reached w/GBV risk mitigation & resp.



Needs

- Risks of gender-based violence continue to intensify in scale and scope while the population is exposed to degenerating food insecurity, compounded by economic hardship and the COVID-19 movement restriction measures.
- The national GBV Hotline (Musasa) has recorded a total of 4,047 GBV calls from the beginning of the lockdown on 30 March until 15 July (1,312 in April, 915 in May 2020, 776 in June, 753 in July, and 315 from 1 to 12 August), with an overall average increase of over 70 per cent compared to the pre-lockdown trends. About 94 per cent of the calls are from women. In July, an increase in psychological violence was recorded (55 per cent of total cases) as compared with previous months. Other dominant forms remain physical violence (22 per cent of total cases) followed by economic violence (15 per cent) and sexual violence (8 per cent). About 90 per cent of cases are intimate partner violence.
- Increased concerns of exposure to gender-based violence continue to be recorded at points of entry, as a result of the increasing afflux of returnees and unavailability of protection sensitive quarantine facilities to host them. Stigmatization at Points of entry as well as at quarantine facilities is increasing, as a result of the increased number of national cases and the resulting fear of infection in host communities. Furthermore, as a result of increased "border jumping" and smuggling in persons, exacerbation of exposure to Sexual exploitation and abuse is expected on the increase. Instances of retaliation against community members who report illegal migration have been recorded. Priority needs include availing NFIs that ensure dignity of the most vulnerable, psychosocial support as well as

disseminate critical information on available GBV multi-sectoral services. The needs for sensitization of quarantine centres personnel on the establishment of complaints mechanisms, psychologic first aid and GBV referral pathways remains critical.

- Despite GBV services being recognized as essential services within the new lockdown phase, movement restrictions are still faced by GBV survivors in some districts, where there are reports of harassment at roadblocks and requests for unnecessary passes for survivors trying to access essential GBV services. The need for continuous sensitization of security personnel deployed at roadblocks on freedom of movement of GBV staff and survivors remains critical.
- Reduced public transport availability remains a challenge in urban, peri-urban and rural areas for survivors of GBV to access timely multisectoral services.
- In most impoverished areas, de-prioritization of GBV services is increasingly recorded as a consequence of the protracted lockdown, as access to daily income sources for household sustenance remains constrained.
- The curfew measures enforced since 22 July continue to generate reduced access to GBV services, especially in rural and remote areas, as mobile teams in some districts have reduced operations hours to ensure safety of clients returning home after accessing services, as well as to ensure return at base before 6 p.m. Some GBV sub-cluster partners have reported increasing requests at roadblocks for COVID-19 negative testing proof as a prerequisite to allow mobility of service providers. There is need for clarity on the protocol of mandatory testing for essential service providers in order to ensure timely availability of life-saving GBV services.
- Closure of health facilities resulting from the current health sector crisis has also contributed to reduces accessibility of SGBV services, compromising timely access to post rape treatment.
- Indirect GBV risks continue to be generated by the new monetary policy measures, as in some districts shops and service providers are requesting hard currency payments and the inability to use mobile transactions modalities generates increased risks of resorting to transactional sex.
- The obligation for all citizens to wear masks in public spaces continues to result in further constraints for those who do not have access to supplies and exposes vulnerable women and girls to increased risks of harassment.
- In some religious groups, misconceptions on COVID19 generate conflicting priorities among the group members, contributing to unprotected gatherings, disrespect of IPC measures, as well as indirect risk of further exposure to GBV for those who do not abide to the sects' expectations for fear of contracting the virus.

→ Response

- Since 1 January 2020, the GBV sub-cluster partners have assisted 94,374 individuals (36,239 male, 58,137 female) with community-based GBViE risk mitigation and PSEA outreach, integrated in various community-based mechanisms and with the support of a workforce of 225 community volunteers, including behaviour change facilitators. In addition, 6,464 women and girls were reached with community-based PSS interventions, including at W/G safe spaces, and 8,301 GBV survivors (6,418 female, 1,883 male) were assisted with multisectoral GBV services, through mobile one-stop centres (OSC).
- GBV Sub-Cluster partners with Support from UNFPA continue to work closely with the Ministry of Women affairs, Community, Small and Medium Enterprises Development, to address GBV staff clearance and to ensure freedom of mobility for GBV survivors seeking support during the lockdown.
- The mobile service provision model continued to enhance service uptake in areas where public transport remains unavailable. GBV Sub-cluster partners continue to coordinate their efforts with the Food Security and WASH clusters partners, for the setup of mobile OSCs and safe spaces near food distribution points and community boreholes. The Mobile OSCs teams have strengthened their interaction with Zimbabwe Republic Police (ZRP) and the Victim Friendly Units (VFU) to ensure timely referrals of GBV survivors at points of entry and in areas nearby quarantine facilities.

- GBV community surveillance and mobile service providers have also strengthened their presence at food distribution points, mining areas, water points, permitted community gatherings, contributing to increased availability of safety nets, complaints mechanisms and timely referrals to GBV services in critical hotspots.
- Alternative transport fees support to survivors, including those with disabilities and their caregivers, also continues to facilitate access to services.
- Access to data bundles and airtime for community facilitators engaged in GBV surveillance continued to be supported to ensure direct interaction with hotlines operators and continuous timely referrals.
- Digital messages on GBV during COVID-19 continue to be disseminated through social media and radio (the Let's talk GBV radio programme is airing every Saturday at 11 AM live on ZTN and social media platforms), with a particular focus on domestic violence, PSEA, the GBV referral pathway, SGBV reporting within 72 hours in order to access Post Exposure Prophylaxis (PEP).
- The GBV Sub-cluster, under the overall technical guidance of UNFPA, continued to collaborate with IOM and the Points of Entry pillar to ensure the integration of GBV risk mitigation and response, and PSEA into the SOPs and training modules for the quarantine facilities staff trainings.
- On 6 August, 40 protection cluster partners, including inter-cluster protection focal points, were trained on the same guidelines prepared for quarantine facilities staff on GBV risk mitigation and response, PSEA. The information disseminated during the training will reinforce dissemination of messages on GBV risk mitigation referrals within and around quarantine facilities, directly from GBV specialized partners working in POE districts.

↔ Gaps

- The full re-operationalization of GBV facilities continues to face challenges related availability of basic PPE and delayed delivery of COVID-19 IPC supplies.
- Underfunding remains a critical barrier to the achievement of GBV SC targets, with only 7 per cent of the HRP requirements funded, while the COVID-19 interventions are currently ongoing only through re-programming of other existing funding, and with less than 5 per cent of requirements met.

CLUSTER STATUS (21 Aug 2020)



Water, Sanitation and Hygiene (WASH)

2.7M

people targeted

2.3M

people reached



Needs

- Over 3.7 million people are in need of WASH support under the 2020 Humanitarian Response Plan, along with 7.3 million people in need, under the COVID-19 Addendum. Under the HRP, partners are targeting more than 4 million people across rural (77 per cent) and urban (23 per cent) areas, while under the COVID-19 Addendum, partners are targeting an additional 2.1 million people.

- Access to safe water in rural areas remains a challenge with only 30 per cent of the 55,709 water sources tracked by the Rural Water Information Management System (RWIMS), providing water from a protected source.
- According to the Zimbabwe National Water Authority (ZINWA), the national dam level average as of 16 July was at 46.4 per cent, while the average levels for this time of year are usually 68.8 per cent. Dams that supply Bulawayo City are at just 25.6 per cent capacity and there is a deficit of 17 million litres of water per day for the city's residents. Flows in major rivers have significantly declined, with no flows in Runde, Gwayi and Mzingwane Rivers. These shortages also affect hydropower generation, which in turn affects urban water supply and treatment and causing water rationing which impacts people's ability to maintain good hygiene practices.
- In Matabeleland South, boreholes are reported to be without water due to the ongoing drought.
- An outbreak of diarrhoeal disease is ongoing, but subsiding in the area of Luveve in Bulawayo, with 1,962 cases and 12 deaths reported as of 27 July. The cumulative figures for typhoid as of 19 July is 696 cases and 10 deaths across all provinces.
- With the local transmission of COVID-19 cases now surpassing imported cases (3,596 and 1,152 respectively as of 10 August), there is an urgent need to ensure all HCFs have adequate WASH services and IPC measures in place. There is also an increasing risk that some WASH services will be discontinued where WASH Sector staff fall sick or are quarantined.
- Parirenyatwa, Chitungwiwa and Harare Hospital currently have no incinerators and the accumulation of medical waste poses a serious health hazard to the staff and patients of these facilities. A further five new incinerators are required by the Harare City Health Department, while five more need rehabilitating in order to manage the city's solid waste effectively. According to RWIMS, 44 per cent of rural health facilities do not have functioning incinerators, while 3.5 per cent have no functioning toilets and 12 per cent have no handwashing facilities.
- From an assessment of quarantine centres undertaken by IOM and WHO, only 62 per cent of centres have running water, while only 40 per cent of handwashing stations had soap. About 57 per cent of centres were not following routine cleaning and disinfection of surfaces and PPEs were lacking. The identification of new quarantine centres has been challenging after schools used as quarantine centres were closed. In five provinces, 20 new centres have been identified but all require significant rehabilitation. Urgent attention is required to identify and address the specific WASH-related IPC needs in new and existing centres.
- A total of 165 schools across 10 provinces have been prioritized as needing new boreholes by the MoPSE. According to RWIMS, 53 per cent of schools have no existing handwashing facilities and 21 per cent of schools have no safe sanitation facilities.

➔ Response

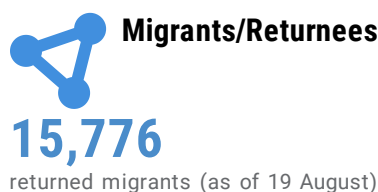
- Since 24 July, HRP partners have reached 99,882 people with access to safe water and 161,956 people have received sanitation and hygiene messages. A total of 24,122 people have been assisted with hygiene items through the distribution of 4,009 hygiene kits, while 11,350 people of concern, received face masks. 24,150 people have been reached through the construction of 161 handwashing facilities.
- Since 24 July, HRP COVID-19 partners have reached 12,500 people with access to safe water and 40,750 people with sanitation and hygiene messaging. 6,325 people have been supported with hygiene items through the distribution of 1,387 hygiene kits. 35,369 people have been reached through the construction of 634 handwashing facilities and 2 HCFs have received PPE kits.
- Since 24 July, the Government and partners outside of the HRP have drilled two boreholes in two provinces for an estimated 500 persons (one in Matabeleland South and one in Manicaland); rehabilitated 105 boreholes in 3 provinces for as estimated 26,250 people (one in Matabeleland South and 14 in Manicaland); and rehabilitated one piped water system in Matabeleland South for 1,500 people.

- Since 24 July, Government and partners have constructed a total of 1,890 handwashing stations in Mashonaland East, for an estimated 113,400 people, at markets, public spaces and at boreholes to reduce the transmission of COVID-19 in communities.

↔ Gaps

- There has been no change in funding during the past two weeks for the WASH Cluster's HRP with only 3 per cent (\$1.8 million) of the funding being realized. For the COVID-19 response, funding has increased from 8 per cent to 13.6 per cent (\$983,086). Significant gaps across all areas of the WASH response remain due to the lack of funding.
- Although 2.3 million people have been reached with WASH activities under the HRP and COVID response, this is predominately through mass media hygiene campaigns, and 1.6 million of the people reached with hygiene are in just 5 Districts: Harare (889,000 people reached), Gweru (108,840), Chimanimani (107,777), Mutare (417,000) and Mutare Urban (147,000). Over 3.7 million people in 49 of the 85 targeted Districts have not received essential messaging for COVID-19 and other key public health risks.
- Excluding hygiene promotion activities, 384,641 people have been reached with safe drinking water, 114,341 with hygiene kits and 114,493 with handwashing facilities.
- Under the HRP and COVID-19 response, just 16.5 per cent of the 2.3 million targeted with access to safe drinking water have been reached, leaving 1.9 million people in 20 of the 35 targeted Districts with no support at all.
- For hygiene kits under the HRP and COVID-19 response, just 12 per cent of the targeted 939,650 people have been reached and more than 165,000 hygiene kits are still required for 825,000 of the most vulnerable people. Just 17 out of 66 targeted Districts have received support with 48 Districts remaining.
- Only 10 per cent of the targeted health facilities have been reached in just 3 of the targeted 35 districts. 268 targeted health care facilities still have no identified partner to provide support with institutional hygiene kits including soap, cleaning materials disinfectants and PPE.
- 2,929 planned handwashing facilities for public places and institutions have yet to be constructed and 30 of the 36 Districts targeted are yet to receive any support to improve hand-hygiene.
- 165 schools require new water sources while 785 schools need institutional hygiene kits before reopening.
- The identification of quarantine centres still remains a challenge. Although WASH partners have assessed 57 quarantine centres, there still remain 39 potential centres unassessed while partners wait for a definitive list of all quarantine centres. Sixty quarantine centres require essential WASH hygiene items and 22 need support with access to safe water.
- Social distancing remains a major challenge in both rural and urban areas, which partners have so far been unable to address through Risk Communication and Community Engagement activities.
- Waste management in quarantine centres and health care facilities remains a challenge due to a lack of waste disposal vehicles, fuel and incinerators.
- PPE equipment in health care facilities and quarantine centres is in short supply. Fuel shortages, particularly for government agencies, is affecting the WASH Sector's ability to implement activities across all Districts.
- Business continuity plans are required by WASH sector partners to ensure that essential WASH services can continue as COVID-19 cases increase.

SECTOR STATUS (21 Aug 2020)



Needs

- As of 19 August, a total of 15,776 migrants (vs 14,044 on 5 August, 10,808 on 7 July; and 6,892 on 9 June), including 8,719 men, 6,743 women and 314 children, have returned to Zimbabwe from neighbouring countries through ten main Points of Entry (PoEs), namely Beitbridge, Plumtree, Kazungula, Victoria Falls Land border, Victoria Falls airport, Chirundu, Forbes, Sango, Nyamapanda and Harare airport, since the onset of COVID- 19 and the imposed restrictive measures, due to the socio-economic impact of the pandemic, the lack of access to livelihoods and support from host governments.
- The large majority or 90 per cent of returnees arrived through the three points of entry of Beitbridge border post (7,793), Plumtree (3,295), and Harare International airport (3,242). The number of reported returnees continues to increase daily, with a projection of 20,000 new arrivals in the next coming months with inclusion of those from northern countries such as Zambia, Malawi, Tanzania and Ethiopia.
- As of 18 August, 1,457 returnees were quarantined in centres operated by government, including 703 men, 648 women, 41 girls and 65 boys. The large majority or 80 per cent of returnees were quarantined in the five provinces of Harare (518), Matabeleland South (225), Bulawayo (151), Masvingo (147), Mashonaland West (124).
- With the number of COVID-19 local transmission increasing there is a need to reinforced surveillance, contact tracing and community health education.

Response

- On arrival, returnees are screened, RDT tested and transferred to provincial quarantine facilities nearest to their places of destination, in order to avoid overcrowding of returnees and provide basic services. On 18 August, the Cabinet directed that migrants who are PCR negative on arrival will no longer be detained but be put on home quarantine and reviews will be conducted by the Rapid Response Teams in that locality. Those who test positive on arrival will be placed in isolation centres.
- Through the POE Pillar, Government and UN agencies continue to coordinate the cascade of the training of trainers (TOT) of 17-19 June by the MoHCC, to the 10 provincial teams representing all provincial quarantine centres, including all the relevant stakeholders managing the provincial quarantine facilities, to ensure a better coordination and enhance the provision of basic services in the centres, ensuring International Health Regulations (IHR) are respected and reinforcing IPC, to avoid further transmissions.
- IOM has set up an isolation facility within the Beitbridge border post for real time separation of COVID-19 symptomatic travellers during entry screening within the Port of Entry. The facility will provide temporary holding and management before transfer to designated isolation facilities within the district.

Gaps

- There continues to be an urgent need to improve conditions for migrant returnees in provincial quarantine facilities, to provide basic services including water, medical services and MHPSS. In addition, there is a need for increased testing for personnel and quarantine residents and to reinforce security and surveillance to avoid the spread of the disease, since the majority of recently confirmed cases were among returnees. Further, provision of livelihood support for the returnees' post discharge from the quarantine facilities, is increasingly needed to support the reintegration into receiving communities, avoid rejection, stigmatization and social tension.
- With the new COVID-19 context situation, its socio-economic impact of COVID-19, and significant figures of returning migrants arriving in Zimbabwe, there is a need to increase health education and behavioural change in receiving and border communities to increase hygiene practices, avoid stigmatization and increased fear to reintegrate returning migrants, also increasing health education to improve community surveillance and detect border jumpers to be directed to the quarantine facilities.

CLUSTER STATUS (21 Aug 2020)



General Coordination



Needs

- An emergency of this complexity and magnitude requires the close coordination of all stakeholders. The interaction with Government and frontline ministries, UN agencies and operational partners is vital in rolling out the multisectoral humanitarian support to complement Government's interventions.
- Continuous tracking of response progress, funding availability and resource capacity is key to ensure that critical gaps are identified and dealt with.
- There is a need for increased coordination and information management under the government-led COVID-19 coordination structure with humanitarian and development partners, including communication of priority needs and gaps under the 10 pillars.
- There is need for standardization and coordination of community engagement activities within the response to promote learning and ensure humanitarian standards are adhered to in the response.

→ Response

- A Standing Cabinet Committee, under the stewardship of the Minister for Local Government and Public Works, is tasked with overseeing the Government's response efforts and coordinates with the humanitarian partners through the office of the UN Resident Coordinator. At the technical and operational level, the Department of Civil Protection (DCP) coordinates the overall Government response with OCHA and UN cluster lead agencies, and interacts with Provincial and District administrations.
- On 19 March 2020, the Zimbabwe National Preparedness and Response Plan for COVID-19 was launched with an initial eight pillars of coordination, the creation of a national COVID-19 Response Task Force and the formation of the Inter-Ministerial Committee. Overall high-level coordination and planning is led by the Permanent Secretary for the Ministry of Health and Child Care (MOHCC) working with permanent secretaries of other ministries in support of the Inter-ministerial COVID-19 Task force, with bi-weekly high level coordination meetings on Tuesdays in the Emergency

Operations Centre and operational inter-pillar coordination meetings on Wednesdays. In June 2020, the Permanent Secretary for MOHCC was appointed as Chief Coordinator of the COVID-19 response in the Office of the President and the Cabinet. On 4 August 2020, a new Minister of Health and Child Care was appointed by the President, with a new Permanent Secretary (PS) for the Ministry appointed on 3 August. On 18 August, in order to strengthen the National COVID-19 response, the Cabinet decided to merge the COVID-19 response into a single response plan comprising the Command Centre, Office of the COVID-19 Chief Coordinator and Ministry of Health and Child Care.

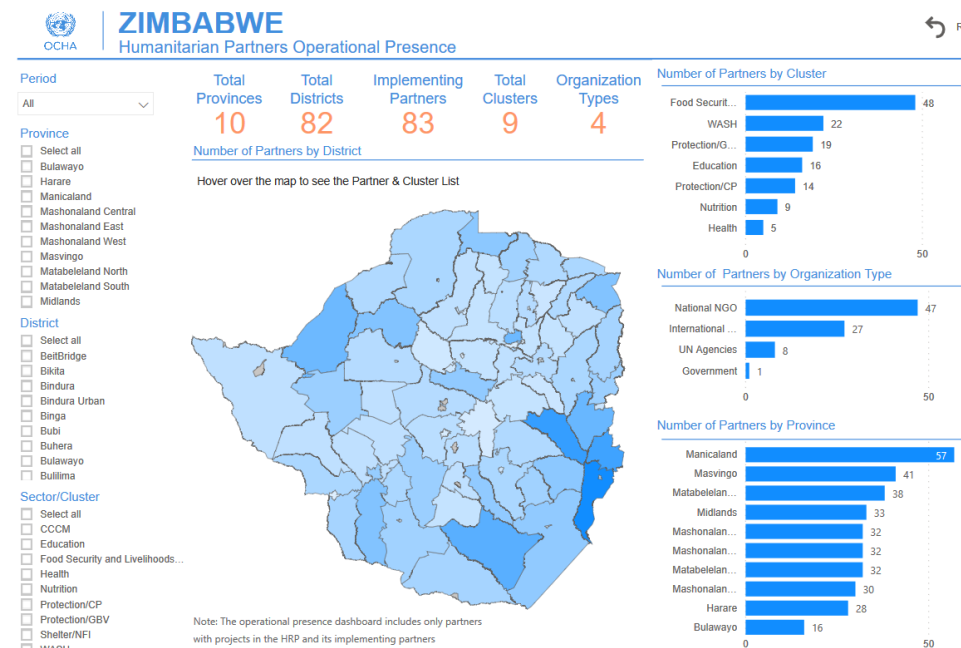
- On 17 July, a [COVID-19 Addendum](#) to the Zimbabwe Humanitarian Response Plan (HRP) was revised and updated integrating a multisectoral migrant returnees response, requiring \$85 million to respond to the immediate public health crisis and the secondary impacts of the pandemic on vulnerable people. This is in addition to the \$715 million required in the HRP. Zimbabwe has been included in the May July updates of the [Global Humanitarian Response Plan](#) (GHRP) as one of the countries requiring immediate support for prioritized COVID-19 interventions.
- Humanitarian partners and donors meet monthly (and ad-hoc if necessary) under the Humanitarian Country Team (HCT), chaired by the UN Resident Coordinator. Individual sectors also meet on a regular basis and are chaired and co-chaired by the relevant line ministries and humanitarian cluster lead agencies. Inter-cluster coordination meetings take place bi-weekly chaired by OCHA, supported by a gender advisor, as well as coordinators for PSEA and community engagement since June 2020. Due to the COVID-19, all meetings are being held virtually.
- A Community Engagement and Accountability (CEA) Technical Working Group was formed that will lead the implementation of identified priorities to strengthen community engagement and ensure that the needs of affected people are at the centre of response interventions.

Gaps

- Critical funding gap hinders operational coordination of the response. As of 18 August 2020, the Financial Tracking System (FTS) reports that the overall Zimbabwe HRP is 18.9 per cent funded with \$151.2 million, with an additional \$12.7 million funded outside this plan. The plan's main non-COVID-19 part is 18.1 per cent funded with \$129.7 million, whereas the COVID-19 Addendum and input to the Global HRP (GHRP) is 25.4 per cent funded with \$21.6 million.
- Only 11 per cent of the total requested has been committed, and this critical funding gap hinders operational coordination of the response.
- Continuity of coordination personnel/expertise is not assured, and this presents operational difficulty where frequent personnel turnover is required during the HRP time frame.
- Despite that the nationwide lockdown to curb the spread of COVID-19 ensures the continuity of essential services, including humanitarian cluster activities, implementation and coordination have been constrained.

INTERACTIVE (21 May 2020)

Partners Operational Presence



View this interactive graphic: <https://bit.ly/ZIMOrgPresence>

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