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Zimbabwe Monthly Situation Report

Issue Number

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HIGHLIGHTS

- *The Reserve Bank of Zimbabwe has authorised payment in foreign currency by UN agencies and their partners. This measure should enhance the operations of humanitarian stakeholders in Zimbabwe;*
- *The IASC Country Team has decided to shift to emergency mode in response to the recent collapse of the basic social services infrastructures;*
- *Cholera outbreak now affecting nine out of ten provinces in the country;*
- *Zimbabwe Consolidated Appeal Process 2009 officially presented to the Government of Zimbabwe and the donor community on 25 November 2008;*
- *The Zimbabwe Emergency Response Fund re-activated through a general call for proposals and 12 projects recommended by the ERF Advisory Board for funding of in total US$1.9 million.*

SITUATION OVERVIEW

Access and Security

Several humanitarian agencies expressed concern about the on-going difficulties encountered in obtaining Temporary Employment Permits (TEPs) for their international staff. Furthermore, humanitarian agencies continued to report ad-hoc impediments posed to their activities in the field imposed by local authorities, though this does not seem to be part of a centralised approach.

The security situation in Zimbabwe has become more tense, with numerous reports on looting by large crowds in the cities, as well as violent incidents whereby dissatisfied soldiers attack the general public. The crime rate continues to grow and many reports are received of humanitarian workers being the victim of a robbery or assault.

Logistics

Advocacy efforts with the Governor of the Reserve Bank of Zimbabwe (RBZ) led by the Humanitarian Coordinator on behalf of the humanitarian community finally resulted in the authorisation by the RBZ for the UN and its partners, to pay for services and purchases in Zimbabwe with foreign currency. This outcome is a major step forward and will allow humanitarian agencies to scale up their activities and disburse funds that were previously inaccessible. It is expected that the agencies will still be faced with the challenge in gaining full access to all their foreign currency deposited with Zimbabwean banks, but the RBZ authorisation will surely facilitate a large part of the operations.

The logistical capacity of humanitarian agencies active in the response to the cholera outbreaks has been largely overstretched. The IASC CT has therefore tasked WFP to assist these agencies with the coordination of the logistics to ensure the timely delivery of equipment, drugs and other materials to cholera affected areas and health facilities. WFP as the lead agency for logistics has drafted a Terms of Reference and identified appropriate transport and warehouses. The funding for an increased logistical capacity will need to be addressed urgently to enable the quick start-up of activities.

Main Developments

In November 2008 the humanitarian community witnessed the rapid deterioration, and in some cases full collapse, of basic social services systems. Schools are mostly deserted and the likelihood of the return of students and teachers at the beginning of the new term mid February 2009 is extremely low. The main three Harare-based public hospitals closed their doors. Emergency surgery, obstetrics or other life-saving operations were no longer taking place, resulting in dozens, if not hundreds, of silent deaths. Water supply in the urban areas was further compromised, with even those parts of Harare that were previously serviced without disruption now went without water for days on end. Apart from the dilapidated infrastructure, the main reason for the plunge in water supply was the chronic lack of water treatment chemicals.

Recent verification exercises undertaken by the food aid partners indicate that the number of vulnerable households is considerably higher than previously assumed based on the Crop & Food Security Assessment Mission report of April/May 2008. The expected gap in the food pipeline in January 2009 has forced WFP to lower the food allocation per beneficiary for the November 2008 distribution. There are anecdotal reports that beneficiaries are using part of the distributed food to plant their land. The opposite has also been noticed, i.e. people eating seeds that were provided as food rather than agricultural inputs. The food aid agencies are following up on these cases.

The cholera outbreak mushroomed throughout the country and by end November 2008 nine out of ten provinces were affected. The largest affected areas in November 2008 were Chitungwiza, Harare City, Mudzi, and Beitbridge. In

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particular the spread of cholera to Beitbridge further raised the alarms, as this city is a major hub for intense cross-border movements both into and out of Zimbabwe. The average case fatality rate (CFR) for cholera in November 2008 stood at 4%, well above the international accepted standard of 1%.

A political solution has still not been reached and the prospects for an early resolution to the political differences between the ruling and opposition parties are getting more and more unlikely. Most agencies acknowledged the fact that the country has further slid down the path of crisis and that all agency activities should therefore shift focus to addressing emergency needs only.

HUMANITARIAN RESPONSE

Food Security

The rainfall season has started in most areas of the country. Forecasts for November 2008 – January 2009 predict high chances for a normal to above-normal start. However, the critical shortage of inputs is thwarting chances for a good harvest. The two Government plans (to assist 500,000 vulnerable households and 500,000 hectare) are facing considerable shortage of inputs and it is highly unlikely that targets will be met.

The humanitarian agencies active in agriculture are assisting about 370,000 households with seed and fertiliser distributions, fairs and provision of conservation farm training. This represents about 25% of all communal households. Considering the dire situation in terms of inputs availability, the assistance falls short of requirement.

Reports on seed consumptions have not been substantiated by the Agriculture & Food Security Monitoring System (AGRITEX/FEWSNET/FAO), which recorded very low incidence of such cases. At the same time, anecdotal evidence of households using grain (from harvest or food aid) for planting will need to be further investigated.

As of 21 November 2008, nearly 5.7 million people were registered under the Vulnerable Group Feeding Programme (VGF). Of those registered, 4.2 million are eligible for food aid in the month of December 2008. The number of people confirmed to be in the worst food insecure categories (1 and 2) and presently eligible for assistance is much higher than initially anticipated by the results from the Crop and Food Supply Assessment Mission and the planning figures within the budget revision of WFP's overall food programme. Registrations are still on-going.

Due to significant resource constraints, WFP cut the cereal ration from 12 kg to 10 kg and the pulses from 1.8 kg to 1 kg per person per month in November 2008. Preliminary figures, as of 21 November 2008, show that WFP has assisted over 2 million beneficiaries in November 2008: approximately 1.8 million under the VGF and nearly 300,000 beneficiaries under the Safety Net (SN). WFP planned to assist approximately 4 million beneficiaries in November 2008.

The December 2008 strategy for WFP includes putting a cap on household members to distribute food assistance to a maximum of 6 members per household. If WFP applies capping on 4.2 million registered beneficiaries who are eligible at present, WFP will provide circa 3.7 million rations to 4.2 million people (reduced ration as for November 2008 distributions). Coping strategies are deteriorating further among the population. Strategies currently include skipping meals, reducing rations, using tree bark or soil as a cereal supplement and consuming seeds received for planting.

C-SAFE planned for a significant scale-up in November including Safety Net coverage and the resumption of MAP in Mutare. The consortium planned to assist over 1.2 million beneficiaries, of which over 700,000 are under the Safety Net, with nearly 13,000 MT of food. C-SAFE plans to adjust and expand both programmatically and geographically in the coming months and will be revising its plan and revisiting issues of targeting and resource allocation. Due to limited resources and to reach a greater number of people, C-SAFE decided to cap the household size in November to a maximum of 5 members per household.

Protection

There were no confirmed reports of political violence received during the reporting period, although there have been reports in the media of sporadic incidents in recent weeks. No reports have been received on displacements, and there were no unusual cross-border movements.

The Protection Working Group co-chaired by IOM, UNHCR, UNICEF and Save the Children UK intends to hold a workshop in January 2009 to reflect on its activities in 2008, and to look forward to 2009 and in particular identify modalities for the implementation of its Protection Strategy and Action Plan, submitted to the HC / RC in October 2008 for his review.

The Protection Working Group has submitted and reviewed projects under the Emergency Response Fund (ERF), and provided technical advice for consideration by the ERF Advisory Board. Projects submitted included the provision of psycho-social and other support to victims of political violence, including to children.

In order to prepare for the UNICEF 120-day Emergency Response Plan, a consultation workshop was conducted in Harare with over 40 participants from POS partners and sub grantees. The workshop covered a wide variety of child protection in emergencies concepts including: psychosocial support in emergencies, violence against children, family separation, and code of conduct for humanitarian workers and cholera education. The same workshop will be carried out

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in Mutare and Bulawayo in the first and second week of December 2008, respectively.

UNICEF and WFP have agreed to partner in providing training on the IASC code of conduct on protection from sexual exploitation and abuse for humanitarian workers. A total of five training sessions are planned for Harare, Masvingo, Mutare, Gweru, Bulawayo for newly employed WFP field monitors as well as its cooperative partners engaged in on-going food distribution nationwide. UNICEF child protection specialists provided half day training on code of conduct in Harare, Masvingo and Mutare.

Health

Zimbabwe's overall health service has been steadily declining for the last five years, with a virtual collapse of services in most major hospitals in Harare and other provinces due to industrial action by health personnel. Field observations indicate that the depletion of human resources in the health sector has reached unprecedented heights and is even resulting in the cessation of life-saving health services. The cholera outbreak is going on unabated with the total number of cases reaching 11,735 with 484 deaths (Case Fatality Rate (CFR) of 4.1%) reported on 1 December 2008.

Areas recording high CFRs have been demonstrating weaknesses in treatment seeking, case management and/or infection control practices. Cholera cases have also been reported on either side of Zimbabwe's border with Botswana, Mozambique and South Africa, demonstrating the sub-regional extent of the outbreak. In South Africa, the Ministry of Health has confirmed over 160 cholera cases, including three deaths. The cholera outbreak has further strained Zimbabwe's overburdened health care system, resulting in further nationwide shortage of medicines and other materials for treatment and aggravating the scarcity of health care providers and poor access to overall care. There is a high risk that the outbreak can spread quickly into areas with no access to safe water and sanitation. CFRs may rapidly escalate in populations without rapid access to simple treatments.

The MoHCW and WHO, together with its health partners (UNICEF, IOM, OXFAM-GB, Médecins du Monde, ICRC, ACF, MSF–Spain, MSF–Holland & MSF–Luxemburg, Plan International, GOAL, Save the Children-UK and others), have agreed upon a comprehensive and coordinated cholera response operational plan to address the needs of the population in the affected areas, emphasizing a multi-sectoral response. The response must be viewed as an emergency measure within the context of a severely deteriorated health care system and civil environment and its objectives are to:

1. Reduce the epidemic spread by:
- Ensuring access to safe water and sanitation conditions, particularly in health facilities;
- Reinforcing community mobilization;
- Ensuring safe isolation and infection control practices in health structures (including funerals);
- Strengthening Health Cluster coordination.

2. Decrease mortality by:
- Ensuring early case detection;
- Improving access to health care;
- Ensuring adequate care, including feeding support.

The response should cover needs in the domains of epidemiology, surveillance and response, water and sanitation, infection control, social mobilization and logistics. This coordinated approach will involve close collaboration with public health authorities in Zimbabwe and neighboring countries, as well as NGOs and United Nations agencies. An Inter-Agency Rapid Assessment Team must be established to investigate and confirm outbreaks. The emphasis must be on rapidly addressing the known risk factors for cholera transmission. Immediate priorities include: 1) standardized case reporting to understand their distribution, guide treatment priorities, and inform prevention messages; 2) ensuring access to safe water and sanitation; 3) standardized case management to reduce mortality; 4) producing treatment and prevention materials, as well as prevention messaging campaigns to mitigate the risk to populations.

The Health Cluster lead and partners are monitoring and responding to the outbreaks reported in multiple areas. WHO and MoHCW are collaborating to provide the cholera case and mortality data by district used in daily and weekly cholera situation reports issued by OCHA. At the Health Cluster meeting on 25 November 2008, several gaps were identified in the detection, assessment, organization of response, case management and surveillance and information management. WHO, on behalf of the Health Cluster, produced a document titled "Zimbabwe Health Situation: Let us show our Leadership and act NOW!" which on 25 November 2008 was handed to and endorsed by MoHCW. The document called for an emergency response to the cholera outbreak.

In response, the Health Cluster and partners have continued procuring necessary kits and supplies. WHO has been airlifting emergency stocks of supplies from United Nations Humanitarian Resource Depot in Dubai and mobilizing additional drugs and supplies through South Africa. WHO headquarters is deploying a full outbreak investigation and response team, including logisticians, epidemiologists, social mobilization, communications officer and specialists in water and sanitation.

A minimum of US$2 million in financial support is required to cover the cost of health response activities for the next three months, including: cholera and diarrhoeal disease kits; emergency health kits; water purification equipment; 10 portable laboratory kits for diagnosis; personnel (including for epidemiological control and Health Cluster coordination); cholera

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treatment training.

At the request of local authorities and MoHCW, IOM will support the establishment of a CTC at Victoria Falls and conduct an assessment of the situation in Muzarabani in the northern part of Mashonaland Central. In the border area, Beitbridge, where IOM runs a reception and support centre for returning migrants, the organization has mobilized and trained 40 Community Health Volunteers to help with health education and hygiene promotion activities. It is also engaged in active case finding, reporting and hospital referrals. IOM is supporting 50 Community Education Volunteers and is supplying local health centres with drugs and other materials. The CTC at the IOM Beitbridge reception centre has so far treated 15 suspected cholera cases, with no deaths. In Manicaland, IOM is supporting local authorities and the MoHCW with the provision of drugs, two vehicles for outbreak management and two IOM nurses to assist in the cholera response. IOM continues to monitor the situation for mobile and vulnerable populations (MVPs) through a network of 125 Community Health Volunteers that provide alerts on suspected cases. In addition to and in coordination with MSF Luxembourg and other partners, IOM is establishing three CTCs in Makoni and Mutare.

In order to support the response to the cholera outbreak UNICEF continued to provided tents, cholera beds, IV fluids, buckets, Oral Rehydration Salt (ORS), fuel (3,000L per province), blankets, sodium hypochloride, gloves and IEC material in Mudzi, Chitungwiza, Harare (Budiriro & Beatrice infectious hospital), Kadoma, Chegutu, Bulawayo, Beitbridge, Chinhoyi, Kariba, Binga, Masvingo, Mashonaland East, Manicaland. A rapid assessment team was dispatched to Mudzi and Beitbridge to assess the situations and provide support.
To address the severe lack of transport and fuel that is jeopardizing the Expanded Programme on Immunisation, fuel was disbursed to each district (600 – 900L per district) while each province was given 800 – 1,000L of fuel (total 50,000L) for EPI outreach and supervision. Five EPI vehicles from Gokwe North and South were serviced/repaired to enable the outreach and supervisory visits.

The national Child Health Days (CHD), that was to take place 8 – 12 December 2008, has been forcibly postponed until further notice due to the cholera outbreak. It was set to immunize between 1.5 and 1.7 million children under five against the seven deadly childhood disease in addition to providing Vitamin A supplements. Discussions with the MoHCW on the way forward will take place soon.

The distribution of essential medicines from Harare regional stores to the NatPharm branch stores is ongoing. Branches in Mutare, Bulawayo, Chinhoyi, Masvingo and Gweru have been receiving consignments starting 1 November 2008. Distribution to facilities from NatPharm is also ongoing and currently all NatPharm branches have managed to attain 100% cumulative coverage of all clinics for items received to date from September 2008. A challenge with human resources and transport at the regional stores needs to be addressed.

Mobile and Vulnerable Populations

The IOM Migration and Health Unit partnered with OCHA and the Civil Protection Unit to sensitize flood prone communities on emergency preparedness and response on HIV and Gender-Based Violence. From 17 – 21 November 2008 two teams went to Tsholotsho where they met 25 community leaders at Sipepa and about 73 community members at Chikwalakwala in Chiredzi.

During the week ending 21 November 2008 food was distributed to MVPs in various districts across the country. In Mashonaland West, 295 households were assisted with food in Zvimba district, 415 households in Kadoma, 580 households in Hurungwe and 848 households in Makonde district. In Harare district, 141 households were assisted with food. In Manicaland 867 households in Mutare district. Each house received entitlements of 50kg cereals, 5kg pulses and 3kg vegetable oil for the month.

In Manicaland 1,854 households were assisted with agricultural inputs in Chipinge, 1,562 households in Mutare district, 479 households in Makoni. In Mashonaland West 193 households were assisted with hoes, in Hurungwe district 1,186 households with agricultural inputs and 934 households in Makonde district. In Harare 195 households were also assisted with agricultural inputs. The distribution of agricultural inputs is anticipated to be completed by 1 December 2008.

In Mashonaland central, four model houses were constructed in Muzarabani Chadereka village. These demonstration houses were constructed at Nzoumvunda Highlands. In Mt Darwin there was monitoring of brick molding and one demonstration house was constructed. In Matabeleland North in Tsotsholo two model houses were constructed and the houses are now at roof level. In Manicaland, there was monitoring of house construction in Chibuwe and Masimbe in Chipinge. Building materials were also distributed to 141 households in Chibuwe in Chipinge. Training of lead builders was conducted in Tsolotsho and two toilets were constructed in the same area.

Following reports of displacements in Chishawasha at Manressa farm, IOM, EFZ and WFP undertook an assessment. Findings revealed that 65 households were affected following the burning down of their homesteads by local authorities. As a result 65 households are in need of shelter and non food items.

IOM is supporting the Department of Social Services in Harare Hospital to provide assistance to a stranded migrant mother and two children from the Democratic Republic of Congo (DRC). IOM is working closely with its office in the DRC to facilitate the process and ensure a smooth return.

Nutrition

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The Combined Micronutrient and Nutrition Surveillance Survey was successfully conducted during 8 – 18 November 2008 while data entry was completed on 1 December 2008. Preliminary data should be available for dissemination by the third week of December 2008. The survey sampled 5,900 households nationally (4,100 children 6-59 months weighed and measured) with provincially representative figures. Women's nutritional status, anemia status, vitamin A deficiency and urinary iodine of women and children were assessed. School aged children where assessed for Helminths.

An emergency technical sub-working group has been formed for the nutrition cluster to inform the nutrition response to the deteriorating humanitarian situation. The group meets weekly and issues being addressed include: nutrition and the cholera response, rapid nutrition assessments, nutrition linkages to food support, treatment of acute malnutrition and infant feeding in emergencies. Agreements around on-site food assistance to staff and patients in cholera treatment centres are nearly finalized. Functioning treatment sites for acute malnutrition are being mapped to facilitate referral of discharged malnourished cholera patients for treatment. To increase capacity to undertake rapid nutrition assessments as needed a common assessment tool is being developed to be used by cluster members intending to undertake nutrition assessments in their areas of operation and the training of a multi-agency team of enumerators based on the tool is planned in the new year. UNICEF will provide technical support to partners conducting assessments. Referral mechanisms of discharged malnourished children and their families with existing food assistance programmes are being developed. Until now the emphasis on discharge was referral to HIV services and linkages to food security interventions as most cases of acute malnutrition are HIV related. But with critical food insecurity linkages to food assistance is increasingly important. UNICEF continues to support to the MoHCW to scale up the treatment of acute malnutrition however the shift in approach is from a health system strengthening model to direct emergency support with more physical support to the MoHCW to carry out nutrition activities. Nutrition cluster partners supporting or interesting in supporting the treatment of severe malnutrition are developing modalities to respond to the current situation and funding proposals to support these modalities. UNICEF and SC-UK are working on developing a TOR and identifying a consultant to advise on programming around infant feeding in emergencies.

In line with the UNICEF 120-day emergency plan and recommendations from a review of nutrition coordination UNICEF has created two positions, one as dedicated Nutrition Cluster Coordinator and one as a UNICEF Emergency Nutritionist.

WASH
Zimbabwe is currently experiencing the largest cholera outbreak in the nation's history. In Beitbridge, ACF are coordinating the WASH cluster response as per cluster plan, as well as providing the main water and sanitation intervention at this time. UNICEF participated in a joint agency/sector rapid assessment where, as well as ensuring delivery of essential supplies for the CTC and WASH response, the team was able to advise on coordination and management issues in the border town, as well cross the border to liaise with South African Health officials in Musina, which is also experiencing a cholera outbreak. Two truck loads of supplies were provided, the first with medical and WASH materials to support partners on the ground – MSF-Spain, ACF, MoHCW, Oxfam GB. The second truckload contained additional supplies together with fuel and food provided by the Government of Zimbabwe.

In Harare, mainly in Budirio, response is being carried out jointly by GAA, ACF, UNICEF, PSI and Oxfam GB with their partners, including Zimbabwe Red Cross and Zimbabwe Project Trust. GAA, ACF and UNICEF continue to provide trucked water to 30 tanks and bladders that have been located in strategic points in Budiriro and surrounding suburbs, with an average of 360,000 litres delivered daily (Budiriro demand alone is 405,000 and Glenview areas targeted 240,000 litres) in addition to providing the CTC with water. Moreover, UNICEF provided 560,000 water purification tablets (WPT) together with IEC materials and through four partners has scaled up hygiene promotion and awareness in Budiriro and surrounding suburbs. PSI is main partner in social marketing and free distribution of water purification tablets in Budiriro.

Nationwide over one million WPTs have been distributed through social marketing and free distribution. WASH materials have been sent to all other areas requesting support, either through MSF or directly to MoHCW or Council health authorities. In Bulawayo, where a total of 48 cases have been recorded, a rapid response by the WASH sub cluster appears to have contained the spread of cholera – at least for the moment. A major challenge has been fuel for the hygiene and sanitation teams.
In Chitungwiza 30,000 litres of water per day is trucked for the affected community (five outlet points) and the two CTUs.

In line with the UNICEF Zimbabwe 120-day emergency plan WASH has identified the following additional human resources to assist with its implementation: 1) international Emergency WASH Officer (while recruiting this position the section will be assisted by a secondment from another UNICEF office); 2) two additional national consultants; 3) Logistics Assistant; 4) replacement WASH Cluster Coordinator, as the current coordinator left on contract break early December 2008.

To simplify distribution of both WASH and health items and to rapidly respond to requests from the field, the office has developed a "cholera kit" of most commonly required items sufficient for an establishment of a CTC receiving 100 patients.

Education
The Education Working Group during their ordinary meeting at the Ambassador House on 20 November 2008 expressed concern over the conduct of the 2008 examinations, the fact that fewer children were sitting for the examinations as parents / guardians were reported to be withdrawing children as not much guided learning took place in 2008. Partners shared disturbing situational analysis of education delivery services on the ground. There was general consensus that

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the situation as presented on the ground looked dire. The partners reported that exams were being held under non-conducive circumstances, including: exams lasting into the night; headmen supervising the writing of examinations; inadequate supervision of both public and internal exams, and; absence of officials to receive exam papers.
Partners also reported that teachers had resorted to the informal sector to make a living while other teachers have mentally resigned from the school set-up and are offering private lessons to children in exchange for foreign currency. At the same meeting, concern was shared on the reports coming from the education sector and partners expressed their willingness as a group to support the opening of schools in 2009, particularly in view of the teacher and children's non-attendance to school as experienced in term III of 2008 and the unilateral closure of some schools before the prescribed time in 2008. In view of the above observation, the Education Working Group requested a meeting with the Minister of Education to discuss the way forward.

Early Recovery
In line with the L-shaped model from Cluster Working Group on Early Recovery, the Early Recovery Cluster in Zimbabwe was established. Twenty-three organizations working in early recovery are part of the cluster in addition to an Early Recovery focal point from each other cluster. The Early Recovery Cluster is planning for its first meeting where it will develop its Terms of References and work-plan for the coming year.

MEETINGS IN DECEMBER 2008

Meeting	Chair	Contact	Contact No/email	Dec
Donor meeting	Humanitarian Coordinator	Marcel Vaessen OCHA	*792681-6, 708085* vaessen@un.org *Bi-weekly on Fridays*	5 & 19 1030-1200 9th Floor, UN Takura Hse
IASC CT meeting	Humanitarian Coordinator	Marcel Vaessen OCHA	*792681-6, 708085* vaessen@un.org *Each Wednesday*	3, 10, 17 & 24 1100-1230 9th Floor, UN Takura Hse
Inter-Cluster Task Force meeting	OCHA	Muktar Farah OCHA	*792681-6, 708085* muktar@un.org *Each Tuesday*	9, 16, 23 & 30 1600-1700 UNICEF
Humanitarian Weekly Technical Coordination Meeting	OCHA	Pios Ncube OCHA	*792681-6, 708085* ncube2@un.org *Bi-weekly on Mondays*	1, 9 & 15 1400 – 1600 UNICEF
Protection WG	Rotating Chair	Mustafa Omer OCHA	*792681-6, 708085* muhumedomer@un.org *Bi-weekly on Wednesdays*	10 & 24 1100-1300 2nd Floor, UN Takura Hse
Logistics WG	WFP	Bahre Gessesse WFP	252471, 799215-20, 728840-4 bahre.gessesse@wfp.org	8 1400-1500 WFP
Water & Health Cholera Crisis Meeting	UNICEF/WHO	Peninnah Mathenge OXFAM GB Stephen Maphosa WHO	703941-2 731840 *bhenson@unicef.org* *Every other Wednesday*	10 & 24 1000 WHO
Nutrition TCG / Cluster	UNICEF	Dianne Stevens UNICEF & HKI Dora Panagides	703941/2, 731840 dstevens@unicef.org *First Friday of the month*	5 0900-1100 UNICEF
Health Cluster	WHO	Stephen Maphosa WHO	253724-30, 0912241491 maphosaS@zw.afro.who.int *Each Tuesday*	2, 9, 16, 23 & 30 1430-1600 WHO
Education WG	MoESC / UNICEF	Louise Mvono UNICEF	703941-2 731840 lmvono@unicef.org *2nd Wednesday of the month*	10 0900-1100, 18th fl Ambassador House
Agricultural WG / Cluster	FAO	Constance Oka FAO	253655-8, 011761901 Constance.oka@fao.org	18 0900 Celebration Centre
Food Aid WG	WFP	Jaspal Gill WFP	252471, 799215-20, 728840-4 jaspal.gill@wfp.org	TBA
MVP WG	IOM	Richard Machokolo IOM	*335044-8, 336899-49, 336916* rmachokolo@iom.int Every other last Tuesday of month	TBA
Matabeleland NGO Forum	OXFAM Canada	Norbert Dube OXFAM Canada	(09)62226, 011406201 *oxcan@mweb.co.zw* *First Friday of the month*	5 0900-1300 Bulawayo

COORDINATIONS ARRANGEMENTS

The following arrangements continue to be in place, to facilitate effective humanitarian coordination and in anticipation of resource mobilization:

1. WASH and Health Cluster agreed to meet bi-monthly in order to coordinate their response to cholera and continue with their sector weekly coordination meetings with partners.
2. Possible gap areas in coordination support are being monitored by the country IASC, as well as needs for surge capacity from HQ and the regional level. Agencies requested to look into the possibility of gearing up to emergency mode and divert available funds from development towards humanitarian aid;
3. WFP to coordinate local logistical support to the overall emergency operation and the cholera response in particular;
4. Daily cholera updates on figures and weekly cholera situation reports on gaps analysis and response issued by

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OCHA;

5. Weekly IASC CT Cholera meetings on Wednesdays;
6. Bi-weekly Donor/IASC CT meetings;
7. Inter-Cluster Task Force meetings led by OCHA on Tuesday afternoons (originally twice a week);
8. Agencies requested to look into the possibility of gearing up to emergency mode and divert available funds from development towards humanitarian aid.

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