
Final report prepared

By

IWSD in collaboration with the SAG

Noma Neseni, Hygiene and Sanitation Specialist
Edward Guzha, Environmental Health Officer
July 2009
# Table of Contents

Acronyms 5

Acknowledgements .......................................................................................................................... 6

Executive summary .......................................................................................................................... 7

1.0 BACKGROUND ..................................................................................................................... 15

2.0 METHODOLOGY .................................................................................................................. 15

3.0 FINDINGS AND LESSONS LEARNT .................................................................................. 17

3.1 Transmission .......................................................................................................................... 17

4.0 INTERVENTIONS ................................................................................................................. 18

4.1 Social mobilisation ............................................................................................................... 20

4.2 Health and Hygiene Promotion .......................................................................................... 20

4.3 IEC Materials ....................................................................................................................... 21

4.4 NFI distribution ..................................................................................................................... 21

4.5 Safe water supplies .............................................................................................................. 23

4.6 Safe Sanitation ...................................................................................................................... 23

4.7 Sound Environmental Management ..................................................................................... 23

4.8 Co-ordination ....................................................................................................................... 24

4.9 Capacity Building ................................................................................................................ 26

4.10 Revitalisation of partners .................................................................................................. 26

4.11 Monitoring .......................................................................................................................... 26

5.0 CROSS CUTTING ISSUES .................................................................................................. 27

5.1 Needs of Vulnerable Groups ............................................................................................... 27

5.2 Gender Consideration ......................................................................................................... 28
5.3 Religious and Cultural Beliefs ................................................................. 28
5.4 Response Capacity .................................................................................. 29
5.6 Information Management ....................................................................... 29
5.7 Resources ............................................................................................... 29
5.8 Advocacy ................................................................................................. 29
5.9 What did not work ................................................................................... 30
6.1 Cultural barriers ...................................................................................... 30
6.2 Religious Barriers .................................................................................... 30
6.3 Missed Opportunities .............................................................................. 31
8.2 Priority Actions where donor funding should be directed ......................... 34
9.0 CONCLUSIONS AND RECOMMENDATIONS ........................................ 34
9.1 Social Mobilization and Hygiene ............................................................ 34
9.2 Blanket NFI Distribution ........................................................................ 35
9.3 Safe Water Supplies .............................................................................. 35
9.4 Safe Sanitation ........................................................................................ 36
9.5 Sound Environmental Management ....................................................... 37
9.6 Coordination ........................................................................................... 37
9.7 Capacity Building ................................................................................... 38
9.8 Revitalization of Partners ...................................................................... 39
9.9 Monitoring .............................................................................................. 39
9.10 Cross cutting Issues ............................................................................. 39
9.11 Religious and cultural beliefs ................................................................. 40
9.12 Response Capacity ................................................................................ 40

WASH cluster 2008/9 Cholera response evaluation and preparedness planning report
9.13 Advocacy .......................................................................................................................... 41
9.14 Resources .......................................................................................................................... 41
9.15 Information management ................................................................................................. 42
9.16 Barriers and constraints to the programme ..................................................................... 42
9.17 Opportunities missed by the WASH cluster .................................................................. 43
9.18 Priority Steps in preparation for the anticipated cholera epidemic ............................... 43
10.0 REFERENCES .................................................................................................................. 45

List of figures

Figure 4.1 (Source: IOM May 2009) Trainers Trained on cholera control

List of tables

Table 4.1 Strategies and interventions in the cholera Response

Table 5.1 Cholera disaster risk reduction plan

Table 8.1 Cholera disaster risk reduction planning steps

Annexes

Annex 1: Terms of reference

Annex 2: Acknowledgements and list of people interviewed.

Annex 3: Methodology, tools and questionnaires used.

Annex 4: Synopsis of the Field visit areas and Scenarios found before cholera outbreak

Annex 5: Minutes of the cholera response evaluation workshop held at Unicef 9-10 June 2009

Annex 6: Emergency Preparedness and Response Plan for Bulawayo

Annex 7: Chegutu cholera preparedness plan
Acronyms

AIDS Acquired Immune Deficiency Virus
BRA Bulawayo Resident Association
CFR Case Fatality Rate
CPU Civil Protection Unity
CSO Central Statistic Office
CTC Central Statistics Office
C4 Cholera Control and Command Centre
DEHO District Environmental Health Officer
DNO District Nursing Officer
DMO District Medical Officer
DWSSC District Water and Sanitation Sub- Committee
EM Evaluation Mission
HTH Hydro Tetra Chloride
JMP Joint Monitoring Programme
FGDs Focus Group Discussions
HIV Human Immune Virus
HR Human Resources
SAG Strategic Advisory Group
RBZ Reserve Bank of Zimbabwe
UNICEF United Nations International Children Fund
NCU National Co-ordination Unity
NAC National Action Committee
NFIs Non Food Items
PEHO Provincial Environmental Health Officer
PMD Provincial Medical Officer
MOH &CW Ministry of Health and Child Welfare
MSF-H Medicine San Frontier Holland
OCHA Organisation for Co-ordination of Humanitarian Assistance
ORS Oral Rehydration Salts
SC Alliance Save the Children Alliance
RTE Real Time Evaluation
IWSD Institute of Water and Sanitation Development
IRWSSP Integrated Rural water Supplies and sanitation Programme
CDC Centre for Disease Control
INGO International Non Governmental Organisation
IEC Information Education Communication
NGO Non Governmental Organisation
GoZ Government of Zimbabwe
GNU Government of National Unity
WHO World Health Organisation
WASH Water Sanitation and Hygiene
ZINWA Zimbabwe National Water Authority
Acknowledgements

The Evaluation Mission would like to thank the WASH cluster co-ordination together with the Strategic Advisory Group (SAG) for the confidence they have put in the team by giving it this great responsibility to carry out a learning focussed evaluation of the WASH cluster response to the cholera outbreak. Special thanks go to Dr L. Nyagwambo, IWSD Research Assistants and support staff. The team would like to thank UNICEF and its donors for providing financial support for this activity. Many thanks go to the organisations that made the mission successful. A detailed list in annexed as annex 1.

Disclaimer

All the statements and conclusions reached are based on the opinions of the individual evaluators and do not represent the opinion or official position of UNICEF, MOH & Child Welfare, IWSD, WHO CDC or WASH cluster.
Executive summary

As from August 2008 to May 2009 Zimbabwe experienced the worst cholera epidemic described as the worst in Africa with a cumulative cholera case load of 98,592 by July 2009. The number of cumulative deaths was 4,288, with 2,631 community deaths in mid-July. The cumulative Case Fatality Rate (CFR) remained high at 4.3%. The cholera epidemic affected 57 of the 62 districts and it came against a backdrop of broken down and anachronistic water and sanitation infrastructure characterized by burst sewer systems and water pipes, often resulting in sewerage contaminating water before it reaches household level. The challenge of limited safe water and frequent water cuts forced people to resort to unsafe sources including shallow wells, ponds and dams among others. This still remains a challenge amid fears that if these structural problems are not addressed there will be another large scale epidemic. In the revised Consolidated Appeal for 2009, partners in the water, sanitation and hygiene (WASH) cluster estimate that six million people in Zimbabwe have limited or no access to safe water\(^1\). Further, some rural areas have extremely low latrine coverage, resulting in unhygienic practices that lead to the contamination of water sources during the rainy season. A combination of these factors increases the risk of populations contracting cholera.

The 2008-9 cholera epidemic occurred when government institutions were at their weakest point to respond effectively and health systems had all collapsed. Consequently a number of multi national, bilateral aid organisations, local and international NGOs responded to the epidemic. Under the guidance of OCHA, the Water sanitation and Hygiene Cluster (WASH) together with Health cluster provided assistance to the government. Having invested heavily into the cholera response, in terms of financial support, time input, material and human resources, the WASH cluster would like to evaluate their response actions with the intention of improving their strategies and preparedness for the 2009-2010 anticipated cholera outbreak. The evaluation report is therefore supposed to synthesize the strategies that worked and why, those that did not work and the reasons, suggesting steps for improving the preparedness planning and make recommendations on future interventions.

The Evaluation Mission (EM) used purposive sampling approach collecting information from key informants and communities through structured questionnaires interviews and Focus Group Discussions (FGD) respectively. Evaluation sites were selected based on higher and lower (CFR), geographical position and case recurrent events. The field visit sites were Chitungwiza, Chegutu, Mudzi, Bulawayo and Mutare rural and urban.

\(^1\) FAO Zimbabwe economic Report

WASH cluster 2008/9 Cholera response evaluation and preparedness planning report
synopsis of each of the visited sites is annexed as annex 2. A two day workshop involving cluster members, donor community and government provided valuable lessons.

Important lessons derived from the evaluation are as follows:

- The 2008/09 cholera epidemic started in Zimbabwe and quickly spread to the rest of the country through human to human contact as a result of unhygienic practices at public gatherings such as funerals, church gatherings and in the home.

- Religious beliefs and unhygienic practices also played a crucial role in spreading the disease.

- Water scarcity, use of unsafe water, burst sewers, lack of access to sanitation and unhygienic environments have all contributed to the cholera epidemic and form some of the underlying causes for the propagation of the vibrio cholerae bacteria.

- More importantly all the evaluation informants seems to agree that unhygienic environment characterised by water scarcity, sewer burst and overflows created a conducive environment for the cholera epidemic.

- The various interventions employed during the cholera all contributed one way or the other in containing further spread of the epidemic. However without addressing the fundamental structural causes such as lack of water and poor sanitation, there will be another outbreak in the 2009-2010 rain season.

- Provision of water at the peak of the epidemic has been necessary, and contributed significantly to the control of the epidemic. This strategy has widely been used in urban and rural areas and has included water trucking, drilling of boreholes, and rehabilitation among others.

- While the blanket NFI does not immediately demonstrate health impact, it contributed significantly to psycho social support and convenience. Most urban households, used to running water did not have containers with which they could use to collect water from the public standpoints. Soap was also scarce in the shops and unaffordable. The chlorine tablets gave a sense of comfort to users and indeed if used properly would improve quality of water. Most households reported that afraid of death they indeed used the aqua tabs

- There are some interventions that did not work as well as expected such as setting up of CTCs in schools which was condemned, person to person transmission at
CTCs where the foot baths were not regularly changed, disposing of wastes from the CTCs.

- Other challenges were in the distribution of NFIs. While some agencies such as Oxfam had their own stocks of NFIs pre-positioned and distributed as far back as October, the blanket NFI distribution was late and effectively started end of January up to May.

- The exit strategies for some of the WASH interventions were not clear and thus some communities still expect water treatment tablets and soap. In some instances household treatment did not always work well with communities either using too much or not using at all (religious sects). Bucket chlorination of domestic water was not seen as practical and comprehensible given the technical requirements of determining the chlorine demand and level of residual chlorine which could not be done easily by the community. The existing strategy for volunteers has also not been clear (how to let them go graciously so that when needed they can also come back?)

The EM concluded that no single strategy or technical intervention worked more than the other in controlling the cholera outbreak rather a combination of software and hardware interventions had complimented each other to combat the disease. Social mobilisation, awareness creation, health and hygiene promotion, all efforts to improve water quality and quantity were seen as key interventions that were more widely used and easily implementable. The WASH cluster added much value to the co-ordination through collaboration with health, nutrition and protection clusters, sharing information and capacitating partners to respond. Below is a summary of the key interventions implemented by the cluster in order of their wider application, cost effectiveness and perceived effectiveness in controlling the outbreak.

---

2 Harare city reported that they had difficulties in disposing wastes from the temporal latrines. Putting in the sewer would have meant spreading the vibrio cholerae bacteria, super chlorination before disposal would kill the treatment processes at the plan, digging and burying would also pollute the environment and underground water.
<table>
<thead>
<tr>
<th>Interventions</th>
<th>Conclusion</th>
<th>Recommendations</th>
<th>Actions to be taken</th>
</tr>
</thead>
</table>
| Social mobilisation, health and hygiene promotion and distribution of IEC | Was considered most effective in bringing behaviour change that reduced the spread of cholera. This included door to door campaigns, traveller information, print and electronic media campaign, Revitalization of volunteers and health workers, posters, fliers etc | ▪ There is need to maintain the momentum and not slacken because the epidemic has gone down.  
▪ Need to mobilise the grass-root health and hygiene promotion network.  
▪ Decentralise IEC material production and distribution for relevancy  
▪ While emergency interventions are in progress to also promote community based management of health and hygiene through PHHE | ▪ Re-orientation of redundant health and hygiene extension staff. Structured training of volunteers for longer period  
▪ Remodel medium of communication and the messages through for example:  
  - Use of billboards which will also reduce the amount of paper used and will ensure dissemination.  
  - Use of radio blitz that will be 30 second reminders of health and hygiene messages.  
  - Messages written on the buckets and water tanks.  
  - Messages targeted for children written on exercise books.  
  - Promotion of environmental clubs for schools.  
  - Up scaling the Community health clubs. |
| Information management                            | Information exchange between the C4, health and WASH clusters was helpful in directing response but was not always timely and correct Information with other clusters such as logistics cluster and protection was weak, Information to and | ▪ Need to capacitate the districts with communication  
▪ Extension staff need to be provided with cell phones and air time to improve communication | ▪ Capacitating decentralised WASH and health sub-cluster at provincial and district levels with resources and Information Communication Technologies (ICT)  
▪ Set up district focal persons who will act as information centres collecting and sharing information. |

WASH cluster 2008/9 Cholera response evaluation and preparedness planning report
<table>
<thead>
<tr>
<th>from the districts was not always timely</th>
<th>District Civil protection Units (CPUs) tasked with emergency response and coordinated through the District Administrators office to assist clusters by sending timely information and this will be in line with revitalized response organs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water treatment chemicals supplies</td>
<td>Increased supply of chemicals and reduction of pollution to the main water supply source</td>
</tr>
<tr>
<td>Assisted in relieving pressure on local authorities but was not adequate especially for Harare. There is inadequate qualified staff for application of chemicals and therefore this is not always in compliance with regulations.</td>
<td>Need for emergency training of water treatment operators so that there is compliance</td>
</tr>
<tr>
<td>Safe water supplies</td>
<td>In the short term WASH cluster should continue with water trucking, borehole drilling and rehabilitation</td>
</tr>
<tr>
<td>Helped to improve access to safe adequate water at a time when there was the greatest need and sphere standards stipulate access to water of sufficient quantity</td>
<td>In the medium term there is to address the structural problems through rehabilitation of water treatment</td>
</tr>
<tr>
<td></td>
<td>Resources mobilisation for Harare water source pollution control and chemical purchases and increased cost recovery</td>
</tr>
<tr>
<td></td>
<td>In the short-term develop a special short curriculum and deliver 3-5 days accelerated training for water and waste water operators so that they are better able to apply chemicals and manage treatment plants</td>
</tr>
</tbody>
</table>

WASH cluster 2008/9 Cholera response evaluation and preparedness planning report
<table>
<thead>
<tr>
<th>NFI distribution</th>
<th>Plants in urban areas and where necessary construction of new plants.</th>
<th>Preventive maintenance(^3).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Plans should also consider decentralized treatment as this localizes problems</strong></td>
<td>In the medium term WASH may consider reviving the three tier maintenance system which not only is responsible for major repairs but also for information collection.</td>
</tr>
<tr>
<td></td>
<td><strong>In the medium term WASH may consider reviving the three tier maintenance system which not only is responsible for major repairs but also for information collection.</strong></td>
<td>Rehabilitation of water infrastructure to ensure sustainable safe water supplies in the long term.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation of water infrastructure to ensure sustainable safe water supplies in the long term.</strong></td>
<td>Resource mobilization for rehabilitation of water treatment plants and decentralization of plants.</td>
</tr>
<tr>
<td></td>
<td><strong>Resource mobilization for rehabilitation of water treatment plants and decentralization of plants.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Was necessary in the light of the fact that soap was unavailable, urban communities had no water containers with which to collect water from public standpoints and that water quality had to be improved through treatment. The NFI was appreciated by communities, gave some psycho social support but came late in some places after the disease had progressed</td>
<td>Revise NFI kit and increase the soap bars.</td>
</tr>
<tr>
<td></td>
<td><strong>WASH cluster should revise the NFI kit increasing hygiene and water quality improvement enabling items such as soap.</strong></td>
<td>Include disinfectant soap which may be used for cleaning clothing, vomits and improves hand washing effectiveness.</td>
</tr>
<tr>
<td></td>
<td><strong>It is also recommended that the cluster talks to the local manufactures so that the items can be locally manufactured.</strong></td>
<td>Preposition supplies at traditional cholera prone district such as Chegutu, Mudzi, Beitbridge, Chitungwiza, Mwenezi, Zaka, and Chivi. Based on scenario settings also pre-position stocks in risky areas.</td>
</tr>
<tr>
<td></td>
<td><strong>Build local NFI production capacity through capital.</strong></td>
<td></td>
</tr>
</tbody>
</table>

\(^3\) Preventive maintenance ensures that the surroundings are clean, there are no backflows, and overheads components are greased and tightened.
| Water quality monitoring | Was helpful in informing authorities on the poor water quality even in protected sources but was more reactive | WASH cluster should institute a routine water quality monitoring program from all sources from which people get their water | ▪ Capacity building for the whole water quality monitoring network from grassroots up to national levels.  
▪ Assist EHTs with transport for water quality testing  
▪ Purchase and supply extension workers simple hand held water quality monitoring kits |
|---|---|---|---|
| Sound environmental management | Was left in the hands of local authorities who did not have capacity to deliver. Some NGOs and churches assisted with clean up campaigns with communities doing the work. In some instances e.g. Oxfam helped with emptying of bins. ZimAhead led clean up campaigns in Mutare through Community health clubs. | ▪ There is need to build capacity of municipalities to manage solid waste and train local communities to manage their waste at a local level.  
▪ There is also need to advocate for waste separation so that waste is treated as a resource.  
▪ As an interim and where possible communities should be encouraged to do their own household waste separation and management through digging | ▪ Financial and human resource capacity building for local authorities to deal with solid waste  
▪ Community training on solid waste management at household level  
▪ Use school environmental and community health clubs to promote solid waste management  
▪ Social mobilisation groups to also create awareness and promote household solid waste management. |
| Sanitation improvements | Construction, rehabilitation of latrines and de blocking of sewer pipelines was undertaken in a limited way. Unsafe disposal of faecal matter contributes to the spread of vibrio cholerae and currently this scenario is present in both rural and urban areas. | The WASH cluster should advocate government for opening up of a menu of technologies that are affordable and safe. WASH cluster to also promote incremental improvements through community management of their own sanitation. Where public latrines are still in existence, WASH should promote community Based Management (Mercy corps is already doing this in Mutare and training sanitation committees.) | Conduct advocacy with government for alternative sanitation technologies in rural areas. Advocate for sustainable sanitation which would include decentralised waste water treatment so as to localize problems should they occur. Promote incremental sanitation improvements such as being promoted through the sanitation ladder or Community Led Total Sanitation (CLTS) Resource mobilization for rehabilitation of waste water treatment plants Carry out CBM training for committees that will manage public latrines. |
1.0 BACKGROUND

Zimbabwe has been facing an economic decline since early 2000 and this is characterised by high inflation which once peaked to 230 million percent, and an economy that contracted by 76% in the last seven years (www.coronationfinacila.com), breakdown of basic services such as access to safe reliable water supplies in sufficient quantities, decline in sanitation coverage and access for both urban and rural areas, breakdown in health care services, education and telecommunications. Zimbabwe is trailing in all the millennium development goals and the attainment of the targets is unlikely (us.oneworld.net/guides/zimbabwe/development). More than 83% of the population live on less than US$2 per day and this has affected ability to pay for services and a reduced service delivery capacity by different public sectors.

As a consequence of the economic decline, there has been some exodus of human resources migrating to neighbouring countries and overseas seeking better livelihood for their families. The reduction in human capital coupled with inadequate financial capital and weakened organisational capacities has led to inability to meet regular maintenance needs of the countries basic service network such as water and sanitation. The collapse in the country’s infrastructure has rendered it susceptible to WASH related disease outbreak such as cholera which has become an endemic disease since the 90s. To date the cholera outbreak has affected all the provinces of the country with an estimated 98,444 people affected (C4, May 2009). Given an estimated population projection of 13,200,000 (CSO, 2002) according to WSSCC this will mean that 0.7% was affected. The cumulative deaths to date (2nd of June) have increased to 4,282. Again this will mean 0.03% of the population. Case fatality rate has remained stable at 4.4. While June has continued to see a steady decline in both cases and deaths in most areas, hotspots are still being reported. While there has been massive response from Humanitarian aid agencies in terms of material, support, human resources and financial assistance, it is anticipated that without addressing the underlying problems of improved access to safe water and sanitation, there will be cholera outbreaks at least in the month of October 2009 going onwards.

2.0 METHODOLOGY

Sampling

- A purposive sampling was undertaken to determine which of the sites would be visited. This was guided by the following criteria
• Centres or sites with the highest case load and Case Fatality Rate (CFR), such as Chitungwiza and Chegutu
• Boarder line rural and urban centres with the highest attack rates and flares such as Kotwa in Mudzi
• Centres where cholera has been contained and kept outside such as Bulawayo
• Areas that had a multiplicity of response partners such as Chitungwiza

Data collection The following data collection methods have been used:
• Literature review and desk study focussing on published and grey literature
• Focussed Group Discussions (FGD) with men/women and children
• Key responded interviews with humanitarian aid agencies, WASH partners and funding partners, government ministries (questionnaires are attached as annex 3)
• Observation among visited communities (on hygiene behaviours).
• Participatory Evaluation where participatory approaches were used to elicit responses on what worked and what did not work and why as well as identification of strategic actions in preparation for the next cholera outbreak.
• Special targeted interviews for the vulnerable groups the elderly and children
Detailed methodology is annexed as annex 3

2.1 Limitations

The evaluation was carried out hurriedly so as to catch the institutional memory of the short-term contract staff that is already winding down their activities. Most of the information is anecdotal and is not substantiated by quantitative surveys. Most of the monitoring information largely refers to inputs and outputs and not necessarily outcomes.

In some provinces the team spent a lot of time trying to get clearance and access to what is largely public information in respect to cholera. Communities are also eager to respond to questions and it was noted that this is linked to some expectation that they would be some hand outs (as has been the norm in the past) this therefore may compromise the authenticity of information being given – communities may answer in the politically correct manner hoping that this would elicit more handouts.

Most of the information has largely been anecdotal as there have been no concrete surveys carried out.
3.0 FINDINGS AND LESSONS LEARNT

3.1 Transmission
The E M identified number of transmission routes to the 2008/09 cholera outbreak which were linked to the faecal oral transmission as outlined below:

- Faecal oral transmission through use of unsafe contaminated water Insufficient water has led to use of unsafe water from unprotected wells or surface water from rivers
- Unsafe excreta disposal including vomits- sewerage overflows that were also contaminating water sources
- Uncollected solid waste which also contained faecal matter
- Poor hygiene practices as a result of /inappropriate none washing of hands
- Person to person contamination within the household (caregivers)
- Person to person infection at gatherings perpetuated by poor hygiene practices
- Person to person infection within the CTC and during transportation

- Cultural beliefs e.g. that dead people particularly the elderly have to be buried at the rural home and also that all bodies should be washed and viewed before burial. In some culture the spouse is also expected to spend the night with the corpse.
- Religious beliefs and practices such as the Johane Marange apostolic sect which does not believe in hospitalisation and medication. This therefore meant that when cases eventually got to the hospital they were already beyond help. Also the sect is said to have set up parallel CTCs near

17

WASH cluster 2008/9 Cholera response evaluation and preparedness planning report
rivers where they were treating patients with surface water. (Interview with Mutare CPU) The burials were also held in secret at night, unsupervised and in shallow graves.

- Belief in witchcraft meant that a lot of patients initially visited traditional doctors instead of the hospital. This would lead to person to person contamination and delayed case management.

- Vulnerability such as HIV and AIDS, nutritionally deprived, elderly, and the children. These would be in an already weakened state and therefore succumb to the diarrhoeal disease.

- Search for sustaining livelihoods. Communities have been moving about cross border and internally in search of livelihoods to sustain their families. This contributed in spreading the disease fast to different parts of the country.

- Delays in declaration of cholera outbreak as a disaster led to some delays in harnessing human, material and financial resources. At some community level, they indicated that when they heard that there is no cholera they continued using their shallow wells.

The implication for the WASH cluster is that the interventions have to target both the water, sanitation and hygiene related transmission routes as well as the cultural traditional and religious beliefs. This will mean working with and through the traditional and religious leaders.

### 4.0 INTERVENTIONS

To support the broad strategies that were employed by the WASH cluster a number of software and hardware technical interventions were implemented, below is a summary of the strategies and a description of some of the technical interventions used.
Table 4.1 Strategies and interventions in the cholera Response

<table>
<thead>
<tr>
<th>Strategies and intervention used</th>
<th>Coordination and partnerships</th>
<th>Advocacy which was at community level, local authority provincial, national and international level.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe water supplies</strong> which included:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation of boreholes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Drilling of boreholes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Water tanking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Water trucking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Water treatment at household level, point level and at plant level (supplying water treatment chemicals to LA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bacteriological and chemical water quality monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safe sanitation</strong> which included:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation of public latrines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Construction of alternative sanitation systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sewer decongestion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rehabilitation of sewer pipe lines</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sound environmental management</strong> which largely composed of removal of solid waste, clean up campaigns, removal of waste dumps from the street corners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouraging communities to use alternative disposal means such as pits/burning</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disinfection</strong> of affected households and CTCs. This involved spraying using HTH. The spraying was done on suspected contaminated areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Distribution of NFI's</strong> which initially was done on the basis of vulnerability and on admission and discharge from the CTC. Later this was done on a large scale blanket distribution Oxfam started off with people who were sick then followed out to the houses that had a sick person and then later blanket NFI (which was too late started January to May 2009)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social mobilization</strong> which was at national, district, ward, village and household level. This included:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Production and dissemination of IEC materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Awareness raising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mobilization of communities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Distribution of NFIs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rehabilitation of boreholes**

**Drilling of boreholes**

**Water tanking**

**Water trucking**

**Water treatment at household level, point level and at plant level (supplying water treatment chemicals to LA)**

**Bacteriological and chemical water quality monitoring**

**Rehabilitation of public latrines**

**Construction of alternative sanitation systems**

**Sewer decongestion**

**Rehabilitation of sewer pipe lines**

**Advocacy** which was at community level, local authority provincial, national and international level.

**Monitoring**

This has involved tracking progress in the cholera response.

**Capacity building** at national, district and sub district levels. Capacity building given to partners. Implementers and volunteers.

**Revitalization and incentivisation** of local structures and personnel which included providing incentives, fuel transport, paper and food packs.

**Production and dissemination of IEC materials**

**Awareness raising**

**Mobilization of communities**

**Distribution of NFIs**
4.1 Social mobilisation

Social mobilization involved the general mobilization of stakeholders, partners, donors, government and the general public to become aware of the disease and to take appropriate actions to stop its further spread. One of the key outcomes of social mobilization efforts has been the mobilization of human and material resources to combat the spread of cholera at national level. Figure 4.1 below gives a rough picture of the TOTs available for cholera preparedness and response compared with the minimum desirable levels.

![Figure 4.1 (Source: IOM May 2009) Trainers Trained on Cholera Control](image)

To reach previous desirable staffing levels that will provide a health and hygiene safety net that had kept the community safe for the past three decades 620 extension staff need to be mobilised and oriented each month for a total of 10 months to reach out to 13.5 million people. Gaps in health and hygiene promotion extension staff who will in turn train volunteers still exist and partners need to continue to reach desirable levels. The evaluation established mobilisation of volunteers by partners improved staffing levels from below 50% to above 80% in all relevant government departments particularly the Health and Child welfare ministry (Key informants interviews, 2009).

4.2 Health and Hygiene Promotion

A network of volunteers was mobilised and trained to carry out health and hygiene activities using a variety of methods (house-to-house visits, dramas, and focus group discussions) to promote hand washing, safe water management, and cholera transmission routes among other things. The Volunteers were also mandated to disseminate IEC materials that included flyers, stickers and posters. Most of the volunteers in the urban areas were being paid allowances by International Non Governmental Organisations (INGOs) and those in the rural areas were not being paid.
Generally a high level of awareness has been created in all the locations visited with 96% knowing how cholera is transmitted and prevented (FGD discussion, May 2009). A related evaluation by Oxfam GB however found significant levels of behaviour change in cholera priority areas with 82.6% washing hands before eating 62.2% after defecation, 4% demonstrated that they could not wash their hands 56% indicated one adult per household had been to a cholera health awareness meeting where 66% indicated that hand washing was discussed 41% indicated sanitation and latrine use was discussed, and 57% heard about how to keep water safe (Oxfam GB, Feb, 2009).

4.3 IEC Materials

The following Key IEC materials that were produced during the cholera outbreak include:

- Advisory pamphlets on cholera outbreak in Zimbabwe,
- Cholera pocket guide for community health workers,
- Hand washing guidelines fliers,
- Oral rehydration information fliers
- Cholera alert pamphlets,
- Poster on cholera alert in Zimbabwe,
- Malaria pamphlets,
- Water treatment guideline fliers.

The evaluation was informed that hundreds of thousands of these materials were given out (UNICEF official personal interview, June 2009) unfortunately the presence of these materials are not readily evident at community level. At the onset of large scale social mobilization there were different and sometimes contradicting messages. The central production of materials also resulted in errors for instance one poster found in Bulawayo had 19 translation errors and could not be used. Another example was in that some posters used case definition of cholera which says children under the ages of five will not be affected and yet this age group was actually contracting and dying of cholera.

4.4 NFI distribution

Some organisations had pre-positioned their limited NFI stocks and started distribution as far back as October (Oxfam GB). The Blanket NFI distribution whose kit included a soap bar, aqua tabs and bucket was necessary given the prevailing situation that soap was scarce and not easily available. The urbanites used to tap water did not have buckets that
they could use for collecting water from public standpipes and in rural areas the buckets were likely to perpetuate contamination by their nature of wide open mouth. The NFIs also provided psycho social support, convenience and a feeling to the communities that someone cared. The impact of the NFI distribution in the spread of cholera has not been measured and is not clear.

What seems to be clear is that the blanket NFI distribution came in late for most areas after the peak of the outbreak. The table below summarises the dates when the blanket NFI distribution started.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Town</th>
<th>Highest case load</th>
<th>Dates</th>
<th>Month of first distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unicef</td>
<td>Bulawayo</td>
<td>120</td>
<td>21-27 December</td>
<td>January 2009 (no Blanket NFIs)</td>
</tr>
<tr>
<td>Mercy Corps</td>
<td>Mutare</td>
<td>251</td>
<td>8-14 February</td>
<td>March 2009</td>
</tr>
<tr>
<td>Oxfam</td>
<td>Mudzi</td>
<td>217</td>
<td>18-24 January</td>
<td>February 2009</td>
</tr>
<tr>
<td>Oxfam</td>
<td>Chitungwiza</td>
<td>180</td>
<td>7-13 December</td>
<td>October 2008 (Oxfam stocks January 2009 blanket NFI)</td>
</tr>
<tr>
<td>Concern World Wide/GAA</td>
<td>Chegu愉</td>
<td>618</td>
<td>21-27 December</td>
<td>February 2009</td>
</tr>
</tbody>
</table>

Several issues contributed to this delay among which are:

- The supply chain delayed the delivery of the NFIs which in most cases were sourced from outside the country. Even companies in South Africa were unable to cope with demand. The chain also involved goods arriving in Harare or Bulawayo and then being

Experience from Mercy Corps

Mercy corps indicated that they had put in a proposal for rehabilitation of latrines and borehole drilling. They were told by UNICEF that they would do NFI distribution. The turn around time for the proposal was six weeks and in that waiting period they could not staff without a concrete agreement. When they eventually got the materials there were some logistical problems of having to hire cars, warehouses etc. the registration also took some time. Overall the organisation felt that they had not been prepared and had no capacity for NFI distribution. Collecting the supplies from the warehouses was also time consuming.
transported to the areas where they were needed.

- The cluster members did not have experience in distribution of NFIs and most did not have the human and logistical capacity needed. Mercy Corps for instance indicated that they were prepared for development projects and did not have human, financial logistical capacities to distribute NFI.

- At community level there was also need to register recipients and ensure that there is equity in the distribution.

4.5 Safe water supplies used as primary barrier to the faecal transmission route seem to have worked very well and is appreciated by the communities that have been using unsafe water or are deprived of water at all. The sphere standards and indeed the WASH cluster standard outline and emphasize the importance of safe water provision during and epidemic. While communities have complained of smell due to the residual chlorine after using aqua tabs, it appears from the reports that the chlorination tablets were indeed used. During the FGDs we could say that 90% of respondents reported using the tablets and the motivation was that there was fear of death. Some isolated cases were reported where users were inappropriately using the aqua tabs like placing tablet in a cooking pot so as to have cholera free sadza (this was reported in Budiriro and Mutare). One of the major issues that still have to be resolved is the operations and maintenance of urban boreholes (which is a new phenomenon). In rural areas communities have been using the community based management approach (though of course the back up system expected from DDF has been weakened)

Urban municipalities have also been assisted with chemicals for water treatment plants. A major concern is that with the high attrition rate of skilled manpower, municipalities are using temporal semi-skilled personnel. The application of chemicals is compromised.

4.6 Safe Sanitation

While safe sanitation is also an important primary barrier, it does not seem to have been undertaken on a large scale. There was some rehabilitation of public latrines, decongestion of sewers (Oxfam) training of committees for management of public facilities (Mercy Corps), construction of pit latrines (Mvuramanzi Trust).

4.7 Sound Environmental Management

This intervention which included removal of wastes from street corners and encouraging communities to have a cleaner environment was appreciated by the community.
time of the evaluation, the concern was over the sustainability of that action (as waste was starting to build up again).

### 4.8 Co-ordination

The WASH cluster was already strongly coordinated before the outbreak meeting monthly to give and update and producing WASH atlases that indicated who is doing what when and where. This in itself meant that there was a fairly cohesive group that could be readily mobilised to respond to the cholera outbreak. Coordination and use of partnerships has been the lynchpin of effective response to the cholera outbreak. While consensus building does take a lot of time, the consequences of not effectively coordinating are far greater. The WASH/Health cluster meetings at the peak of the outbreak added value to the responses. The platform was used to inform, share information and decide on actions (avoiding duplication of efforts.) In some districts (e.g.) Mutare, there is a strong CPU that was meeting daily and this included all Manicaland cluster members. Three Sub-clusters exist at provincial levels and these also seem to have added value to the cholera response. WASH focal persons where they were in existence provided the necessary link between WASH cluster and local partners. Most respondents expressed satisfaction with the Cluster coordination noting that it added value by sharing information and harnessing resources. The meetings also usually had clear activities that needed to be undertaken and roles allocated. The use of the Strategic Advisory Group that focussed on certain policy and strategic issues was found useful. The SAG is output oriented and actions agreed on are usually undertaken. Concern has been that the SAG is comprised of and driven by interested individuals often on short term contracts and when they leave there will be problems of sustainability. The WASH cluster also used technical groups such as social

<table>
<thead>
<tr>
<th>WASH cluster value addition</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the two day participatory workshop one of the strengths that were frequently sited was the WASH coordination. This was collaborated by key responded interviews where they were all satisfied with coordination and wanted this replicated across the country.</td>
</tr>
</tbody>
</table>

**See minutes of the workshop annexed as annex 5**

<table>
<thead>
<tr>
<th>Effectiveness of the cluster response on the cholera disaster of 2008/9</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 6.2% said it was very well coordinated (2 out of 32 respondents)</td>
</tr>
<tr>
<td>• 68.8% said there were a few shortfalls, but job well done under the current environment (22 out of 32 respondents).</td>
</tr>
<tr>
<td>• None said that it was a one man show.</td>
</tr>
<tr>
<td>• 15.6% said there was no proper coordination (5 out of 32 respondents) and;</td>
</tr>
<tr>
<td>• 9.4% said that the response was slow (3 out of 32 respondents)</td>
</tr>
</tbody>
</table>

_Evaluation by Edmore Tondlana, OCHA, 2009_
mobilisation, community based management (CBM) who carry out tasks on behalf of and report to the cluster. This is an efficient and effective way of operating.

It was revealed that overall co-ordination of humanitarian assistance for UN agents was being handled by Organisation for the Co-ordination of Humanitarian Assistance (OCHA), but most organisations interviewed did not feel the organisational role of OCHA. UNICEF through WASH Cluster co-ordinator was responsible for the co-ordination of the WASH partner’s response to the cholera outbreak. The National Action Committee (NAC) through the National Co-ordination Unit (NCU) did not play a major role in the cholera outbreak as they felt it was more of an urban problem.

The Evaluation Mission learnt that national co-ordination meetings were attended mostly by NGOs on a more regular basis with most government ministries attending occasionally. The NFI evaluation also made similar findings where 86% of the NGOs interviewed attended regularly but complained of gaps in terms of inter-cluster co-ordination information sharing and poor linkages between national and district levels with some partners complaining that decisions taken at national level were not readily disseminated to lower levels (UNICEF, 2009) The cholera response evaluation workshop also identified limited government involvement in the co-ordination and calls on cluster members to capacitate government structures at district and provincial levels to ensure greater involvement. Isolated incidence of competition for resources, visibility and unwillingness among partners to share crucial information were observed in some provinces (Evaluation workshop presentations, June 2009).

In Matebeleland co-ordination of the WASH cluster activities was being done by UNICEF, support to the preparation of an emergency preparedness plan for the Matabeleland region was given by Family Impact International. In Matebeleland south province, the Ministry of Health and Child welfare took the lead in co-ordinating the response. A team from the province actually went to Beitbridge to initiate the response process. According to the acting Provincial Environmental Health Officer (PEHO) they quickly rushed to the scene but were found wanting without any material and financial resources to respond to the cholera outbreak.

The Evaluation mission learnt that although CPU headed by the District Administrator with the technical advice from the District Medical Officers and his/her staff were willing to co-ordinate the cholera response, they were crippled by lack of material and human resources

Most partners at all levels expressed satisfaction with national meetings where clear role classification, follow up on all action points and outstanding issues were being followed up on time. NFI evaluation provided a rough rating of the partnership and collaboration with UNICEF of the six key organisations that were asked to rate the relationship, 33%
rated it as good and fair while 67% of the organisations interviewed rated it as poor siting poor communication, lack of focal persons and delays in signing Protection Co-operation Agreement (UNICEF, NFI evaluation May 2009). The WASH cluster added value to the response by providing weekly updates of the situation, mobilising partners to participate in the response and providing crucial linkages to partner’s material and financial resources.

While there was a logistics cluster, not many WASH members were aware of its operations and how it could facilitate their own activities.

4.9 Capacity Building

As part of the response, the cluster organised capacity building as and when needed for different levels. At the national level, training on emergencies was undertaken before cholera outbreak as part of the preparedness plan. Other trainings have been targeted at extension workers and volunteers. Some of the capacity building needs are in the following areas:

- PHHE for extension workers, NGO partners as well as village level extension workers.
- Emergency training for treatment plant operators especially chemical application
- Training on proposal development so that members are able to get bankable proposals.

4.10 Revitalisation of partners

The cluster has been working with and through local partners such as municipalities, EHTs and other public bodies. An important and yet sometimes overlooked aspect of the response action is that some cluster members have had to spend their resources assisting their local partners with such items as fuel, food packs, writing materials etc. This revitalization is also part of the process of strengthening partners.

4.11 Monitoring

- The cluster has been monitoring the cholera response through weekly updates, monthly meetings and partners are expected to provide information on WWW. .
5.0 CROSS CUTTING ISSUES

The Evaluation Mission assessed how cross cutting issues such as protection, gender needs of vulnerable people, religious and cultural groups were being addressed in the cholera response. Below is a summary of the key assessment results and analysis of the EM findings:

- The sphere standards as the WASH cluster guidelines have stressed the importance of addressing protection, gender and the vulnerable. The evaluation mission did not get clear evidence that there had been a deliberate move to address these issues.

- The evaluation workshop identified cases of children who leave for schools in the morning coming back in the evening only to find their parent or caregivers dead and buried because of cholera (Evaluation workshop, June 2009). It also came out during the evaluation that programming has not been informed by age and sex disaggregated data or a vulnerability assessment.

- A massive doxycycline prophylaxis in some provinces has been reported and may have contributed to complacency around good hygiene practices. Concerns have been raised about side effects in pregnant women and young children where Doxy has been freely available on the market (OCHA, 2009). The EM realised lack of protection for women and men who are being asked by the local authorities to clean up and decongest sewer blockages without protective clothing. This is exposing the already vulnerable communities to new infections.

5.1 Needs of Vulnerable Groups

The WASH cluster did not have clear guidelines on targeting the vulnerable groups during the outbreak as no vulnerability criteria was done prior or during the outbreak. The Evaluation Mission took note of attempts by IOM, OCHA, UNICEF, WFP and the Ministry of Labour and Social Welfare to address the needs of institutionalised vulnerable groups.

The cholera epidemic has further exacerbated the already devastating psychosocial impact of HIV and AIDS in communities and families. The renewed erosion of family livelihoods may result in families adopting coping mechanisms that put their children at risk of abuse, exploitation and other harm (SC Alliance, 2009).

The evaluation workshop noted with concern that HIV and Aids was not put into consideration and patients were treated in the same way in terms of medication, water supplies and food distribution during the response. It was noted that the elderly, blind and disabled relied largely on family support system which was itself compromised due to poor socio-economic environment, the response left the vulnerable groups unattended.
The other concern raised during the evaluation workshop was the absence of child friendly NFIs, IEC material, beds at CTC and psychosocial support systems for the affected health staff and relatives. These issues need to be considered in the event of another outbreak.

### 5.2 Gender Consideration

Cholera epidemic affected men and women differently in number of ways; women played their traditional role of caring for the sick in all the assessed areas exposing them further to the epidemic. The need of more water to improve hygiene in the home of the infected and affected meant extra burden for the women and girl children who were reported to be going to fetch water three times more than usual. Despite the incapacitating effect of cholera, the evaluation mission did not find adequate representation of women and girls in cholera response structures at provincial, district and ward level in both urban and rural programs. Women in Harare Chegutu and Chitungwiza reported that their income generating activities IGAs were stopped by the authorities resulting in serious loss of household incomes making the families more vulnerable since they could no longer afford to buy food, soap and aqua tabs which were very critical items in the fight against cholera. Of particular interest is the fact that more men and boys were affected by the epidemic in Chegutu and Harare. According to the key informants this was due to the fact that men miss health and hygiene promotion opportunities which normally take place during the day when they are out for work while boys scavenge rubbish heaps in search for plastics and wire to make toys. In addition men are exposed to very unhygienic environments in the Beer Halls where the majority of water and sanitation facilities are dysfunctional, the risk is exacerbated by communal sharing of beer mugs.

### 5.3 Religious and Cultural Beliefs

The following religious and cultural practices were identified as contributing to the spread of cholera: shunning medical treatment by some apostolic faith groups, sitting and washing diarrhea patience in flowing rivers to regain lost bodily fluids, washing the dead and viewing the body before burial and cultural beliefs that a dead person spirit will come back as an avenging spirit if his/her body is not washed or viewed before burial.

In some parts of the country there are still beliefs that the severity and quick death due to cholera is linked to witchcraft, this could have impacted negatively on hygiene behaviour and early treatment seeking (SC Alliance, 2009).

The evaluation workshop also identified lack of knowledge among some traditional healers on cholera and called on the WASH cluster to develop health and hygiene promotion programs targeting religious and traditional groups.
5.4 Response Capacity
Most organisations did not have sufficient response capacity to respond to the cholera outbreak. This is defined in terms of human resources, material resources and financial. Some of the organisations were dealing with regular development work and were not really emergency oriented. Due to this limitation, the cluster did solicit for support from the region and from the globe. What is clear also is that the cluster adapted quickly and was able to respond to the outbreak.

5.6 Information Management
The cluster generated a lot of information that was shared and disseminated among members. There exist a number of documents studies monitoring reports with different partner organisations. What seems to have been a weakness is the analysis of the information so that it can be effectively used. The cluster also relied on information coming from the C4 for their response. The information was sometimes inaccurate and sometimes late in coming due to absence of staff at local clinic and poor communication systems. The outbreak in Chitungwiza as in Chegutu took about ten days before the cluster received information. Thus late information and incorrect information affected timeliness of response.

5.7 Resources
The cluster was able to harness material and financial resources for responding to the cholera outbreak. The CERF provided a funding mechanism through which partners could apply and get resources for responding to the cholera. When discussing with partners most expressed satisfaction with the amount of resources that they had. The turnaround time for proposal approval could however be improved. (one partner indicated that it took 6 weeks for the money to be approved and this would not be appropriate during an emergency)

One of the other comments was that it also took a lot of time to get NFIs from UNICEF due to some procedures that had to be followed. Overall there were adequate resources and the cluster together with UNICEF played a major role in harnessing resources.

5.8 Advocacy
The cholera outbreak came soon after the NGOs ban had been lifted. There was some suspicion between government and NGOs. The cluster together with OCHA and UNICEF has had to do a lot of advocacy with government (leading to declaration of cholera as an emergency), with Urban Municipalities leading to alternative sources of
At the international level, the cluster did a lot of advocacy so as to harness resources for the cholera response.

At national level government policy did not allow the use of ORS at community level for diarrhoea management. Through advocacy by the Wash cluster ORS has been used at community level for cholera control.

5.9 What did not work
Evaluation workshop participants and key informants identified a few things which they thought did not work well during the cholera response, below is a list of some of the things;

- Setting up CTC at schools was halted and PMDs have instructed the partners to stop the practice
- Beneficiary perspectives and their involvement in planning and design of the programmes are missing in the cholera response.
- Absence of a clear exit strategy and communication particularly with respect to distribution of aqua tabs
- Bucket chlorination of domestic water treatment comprehensible given the technical requirements of determining the chlorine

6.0 BARRIERS AND CONSTRAINTS TO IMPACT

6.1 Cultural barriers
- Cultural beliefs that the corpse of an elderly should be washed and viewed before burial.
- The cultural practice of shaking hands at funerals propagated the spread of disease.
- The culture of cooking and eating at gatherings

6.2 Religious Barriers
- The Johane Marange sect does not believe in medication and therefore was not taking the cholera infected patients to CTCs. This sect is widely found in
Mutare ad could perhaps explain the propagation of the virus in rural Mutare and the high community deaths.

- Some religious gatherings in conditions where there was no safe sanitation also propagated the spread of cholera. In Rusape, the district had to use the police to enforce the public health act which discourages gatherings during an epidemic.

**Contextual**

- The use of improperly trained and inexperienced volunteers compromised quality of information as some volunteers were reportedly telling people that aqua tabs and ORS can be used as prophylaxis drugs against cholera

- The major limitation of the approach was that centralisation of collection points at schools resulted in limited access for some members of the community particularly the elderly, the sick and those who would be at work when the water is delivered, these according to the evaluation ended up collecting water from unsafe sources

- High capital cost requirement of the water trucking intervention meant less collection points for the community and therefore compromised access for household use.

- Lack of capacity of central government to mobilise financial and material resources and delays in declaring a national disaster.

**Physical**

- Malfunctioning of most health institutions at the time of the outbreak caused delays in response

- ZESA power cuts had sometimes affected mass media health and hygiene information broadcast.

**6.3 Missed Opportunities**

**Missed opportunities**

- WASH programme failed to utilise the resources that they had in Chegutu, Chipinge and Zaka to respond to the Cholera outbreak yet water, sanitation and hygiene
programme was already in the country and the EU had funds that also indicated under utilization.

- Government of Zimbabwe missed a good opportunity to mobilise meaningful International Financial Support for urban water and sanitation infrastructure rehabilitation by refusing to declare the cholera epidemic as a national disaster and only declaring emergency at a later stage after immense pressure.
- The programme has largely ignored the issue of school children perhaps because the epidemic came during school holidays. This is a missed opportunity as there has been no learning in that area.
- There exist government water and sanitation structures at provincial, district, wards and village level. These were opportunities to revitalize and use them.
- Government missed an opportunity to engage with the civil society in a meaningful manner and take charge of the response process. This missed opportunity largely emanated from the fact that acceptance of the cholera epidemic would have meant acceptance of failure in the WASH.

7.0 PUBLIC HEALTH ACT
The Public Health Act empowers the Ministry of Health and Child welfare and local authorities to monitor or prohibit movement of people and food, selling of food in public places during a disease outbreak. This was not invoked during the 2008/09 outbreak due to socio economic conditions that were prevailing. Had the appropriate provision of the Public Health Act been evoked cholera could have been controlled earlier. It is anecdotally reported that the cholera epidemic went up in and around Christmas (figures from Chegutu, Mutare, Mudzi). In other countries like Mexico, faced with the H1N1 flu, the president gave an order shutting down the country and the strategy seems to have worked in controlling the spread. Even in the UK there are considerations to close schools so as to control the spread.

8.0 PREPAREDNESS PLAN
The WASH cluster evaluation noted that given the time constraints, it was not going to be possible to develop a preparedness plan during the workshop. What was therefore agreed on was to develop steps towards preparedness planning and to identify priority actions.
Table 8.1 Cholera disaster risk reduction planning steps

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Steps</th>
<th>Lead</th>
<th>Involved</th>
<th>When</th>
<th>RSCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>• Projection of cases</td>
<td>WASH Coordinat or</td>
<td>- OCHA</td>
<td>End of June</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gap analysis</td>
<td></td>
<td>- Cluster</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Risk mapping</td>
<td></td>
<td>- Health clubs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proposals</td>
<td></td>
<td>- Partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Donors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hygiene Promotion</td>
<td>• Review of IEC materials</td>
<td>SOD MOB</td>
<td>Education cluster</td>
<td>End of July</td>
<td>Cooperation from actors</td>
</tr>
<tr>
<td></td>
<td>• Identify gaps – KAP studies</td>
<td></td>
<td>University</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop appropriate IEC materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• School health master training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Communication channels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Learning HIV and AIDS communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lobby for mass media</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guidelines/standards</td>
<td>• Which ones exist</td>
<td>WASH cluster</td>
<td>- Partner</td>
<td>End of July</td>
<td>KAP studies</td>
</tr>
<tr>
<td></td>
<td>• Review them/improve</td>
<td></td>
<td>- Health clubs</td>
<td></td>
<td>IEC materials</td>
</tr>
<tr>
<td></td>
<td>• Share</td>
<td></td>
<td>- Global cluster</td>
<td></td>
<td>Funding</td>
</tr>
<tr>
<td></td>
<td>• Develop new ones</td>
<td></td>
<td>- Leads/organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Ministries / unity government</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity building of WASH members</td>
<td>• Identify capacity gaps and weaknesses</td>
<td>WASH cluster Coordinat or</td>
<td>- partners</td>
<td>Ongoing</td>
<td>TWIGS</td>
</tr>
<tr>
<td></td>
<td>• Crosscutting focal persons</td>
<td></td>
<td>- global cluster</td>
<td>December</td>
<td>Existing guidelines</td>
</tr>
<tr>
<td></td>
<td>• Addressing gaps training plans</td>
<td></td>
<td>- donors</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Establishing a rapid response team</td>
<td></td>
<td>- government</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Civil Protection Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water supply and sanitation</td>
<td>• Preposition tanks, bladders</td>
<td>WASH cluster coordinat or</td>
<td>- DFA</td>
<td>August</td>
<td>funds</td>
</tr>
<tr>
<td></td>
<td>• pipes, chemicals, slabs</td>
<td></td>
<td>- DDF</td>
<td>and ongoing</td>
<td>partnerships</td>
</tr>
<tr>
<td></td>
<td>• Rapid supply – trucking and storage</td>
<td></td>
<td>- Partners</td>
<td></td>
<td>facilitators</td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation of boreholes and public toilets</td>
<td></td>
<td>- Watsan committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sewer de-blocking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WASH cluster 2008/9 Cholera response evaluation and preparedness planning report
8.2 Priority Actions where donor funding should be directed

The Evaluation workshop identified the following priority actions:

- Strengthening district co-ordination structure, mechanism and NGOs capacities
- Social mobilisation health, hygiene promotion, IEC material production and distribution
- Rehabilitation of rural and urban water and sanitation infrastructure
- Revitalisation of community health and hygiene network
- Monitoring and evaluation mechanisms

9.0 CONCLUSIONS AND RECOMMENDATIONS

Key informants and communities both agreed that no single strategy of technical intervention had worked more than the other in controlling the cholera outbreak rather a combination of software and hardware interventions had complimented each other in combating the disease. Social mobilisation, awareness creation, health and hygiene promotion all efforts to improve water quality and quantity supply were sited as key interventions that were more widely spread and easily implemented. There are many studies that still need to be conducted for learning and these include but not limited to:

- Impact assessments of interventions
- The use of NFIs
- Monitoring and evaluation
- Capacity building needs
- The impact of hygiene education in the containment of the outbreak,
- The link between existence or non existence of EHTs and cholera,
- The gender dimensions of the outbreak etc.

Some of the main conclusions and recommendations are as follows:

9.1 Social Mobilization and Hygiene

Social Mobilization and Hygiene promotion that started after the epidemic seems to have been effective in creating awareness, educating and informing communities. This seems to have worked well and it targeted a cross section of the community. The use of multiple communication channels such as door to door campaigns, radio, television posters meant that even the illiterate, young, elderly, disabled got to hear the message.
One of the recommendations is that hygiene promotion be continued with of course different approaches and different messages.

Targeted messages for school children will be necessary.

The general conclusion is that as a strategy, social mobilization, health and hygiene worked well and that it should continue as preparations are being made for the anticipated next round of cholera.

A wide range of IEC materials were produced and distributed throughout the country but people feel production and pre-testing should be decentralised to provincial level so that ethnic, cultural and language issues are best dealt with local level. The IEC materials produced in printed form came at a time when paper was a sought after commodity. This could explain in part why the materials disappeared. Paper was being used as a record keeping instrument, toilet paper, wrapping wares and goods, to start a fire etc. the messages could be written on buckets, tanks billboards and even radio blitz.

9.2 Blanket NFI Distribution

The conclusion is that while NFIs did not have an immediate clear impact in stopping the spread of cholera, it was necessary in providing convenience, support to the communities and has been appreciated by the beneficiaries. The cost benefit analysis of the human, material, time and financial inputs versus impact still has to be understood. This evaluation did not quantify those details.

If this intervention is being considered for the anticipated outbreak in 2009 it will be necessary to start pre positioning supplies, revising the kits to increase soap bars and consider disinfectant soap and perhaps building capacity of the local industry. The buckets may also come with hygiene messages.

9.3 Safe Water Supplies

In conclusion it is noted that safe water supplies is one of the important interventions that has to be in place as the WASH cluster prepares for the next round of cholera outbreak. There are clear short terms, medium and long term measures in the safe water supplies. As part of the emergency response, short term measure there is need to preposition tanks, rehabilitate boreholes, prepare logistics for water tinkering, prepare water chlorination whether bucket or household, train water operators who apply chemicals at treatment plants and supply chemicals to municipalities. As a medium to long term...
measure, it will be necessary for the cluster to harness resources for rehabilitation of urban water supplies, expansion and building of new plants.

- There is clear need for advocacy so that funding agencies consider emergency rehabilitation of water supply systems. This seems to have been the root cause of the start of the cholera outbreak. Without addressing this fundamental structural problem; cholera will continue to be endemic in the country.

- There is also need to repackage the chlorination tablets so that those religious sects that are against the use of tablets will use chlorine without necessarily feeling that they are taking tablets.

- As a preventive measure, it will be necessary to identify hot spots that are also often without water and supply water before the outbreak.

- The supply of water treatment chemicals provided a great relief for local authorities to build their capacities to supply adequate safe water to the urban community however the intervention proved to be unsustainable due to high capital demand and inherent high pollution levels in some urban areas. The WASH cluster should focus on advocacy and awareness on controlling and monitoring pollution.

9.4 Safe Sanitation

The conclusion that was drawn from talking to communities key respondents is that open defecation; unsafe sanitation burst sewers contributed to the cholera epidemic. Without addressing this problem, cholera will continue being endemic in the country. Again as in safe water there are short term measures, medium to long term measures that can be undertaken by the cluster. In the short term, there is need for awareness through social mobilization on safe sanitation, assistance to local authorities to attend to burst sewer pipelines and to advocate government to open up to alternative sanitation technologies. Government and Local authorities have been reluctant to allow alternative sanitation systems that would be cheaper and at the same time be safe means of disposing faecal matter.

As part of the response actions, it may be necessary to advocate for alternative sanitation systems in rural and urban areas. Advocating for incremental sanitation improvements such as through sanitation ladder or Community Led Total Sanitation particularly in rural areas would be one of the transitional mechanisms for moving from an emergency mode towards development.
In the medium to long term it is necessary to advocate for resources for emergency rehabilitation of waste water treatment plants, sewer pipes particularly for urban areas.

There is also need to consider a move towards sustainable sanitation one which will involve decentralization of treatment plants. Currently if one central treatment plant has a problem then the whole city has a problem.

### 9.5 Sound Environmental Management

The main conclusion is that there were small localised initiatives to environmental management. Given the low sanitation coverage, solid waste management becomes an important factor in disease propagation since communities are using flying toilets thus it is an important aspect in cholera.

Assisting the local authorities with transport and fuel may assist as an \textit{interim measure}. Some organisations were already doing that e.g. OXFAM GB but it was not standardised. Mobilizing communities for a cleaner environment will be more sustainable as they are the ones dumping. Household waste management seems to be also working (as seen in Mutare where the campaign has been on using pits for decomposing waste and also burning). Social mobilization for waster separation and use will in the long term be a more sustainable and environmentally friendly approach.

### 9.6 Coordination

The conclusion that is drawn is that the WASH cluster at national level played a significant coordination role that added value to the WASH cholera response. Among activities that added value were;

- Advocacy with government
- Harnessing financial, material and human resources for cholera response
- Sharing of information through also linking with the health cluster
- Capacity development of organisations for cholera response
- Strategic advice to cluster members

And in the three regions where sub clusters exist there was value addition in coordination responses, sharing information, in the case of Bulawayo developing a response plan. What seems to have been a challenge is that the WASH cluster was viewed as being Harare based and there will be need to decentralize to all provinces as well as having focal persons in all districts. Furthermore the cluster responded to the cholera at a time when government was weak and incapacitated and this was necessary. In the future there should be more linkages to the civil protection unit (CPU) that is mandated with emergency response. This seemed to have worked well in Mutare where Mercy Corps
assisted their counterparts with fuel and with Concern where they worked with the District water and sanitation sub committee as well as the City Council.

Other conclusions are that:

- Having a dedicated WASH coordinator is necessary and it does help in the follow up of WASH responses.

- Clearly defined Terms of reference for coordinating units are important and provided by which evaluation can be obtained. The WASH, Health, Logistics, and technical advisory groups SAG, Social Mobilization all had their clear TORs.

- Having the technical working groups is also important as they focus on specific issues and advise the WASH cluster.

- Notably the WASH cluster, the SAG, and the Social Mobilization have been driven by dedicated individuals who are result oriented. The challenge is sustaining these groups and continuing to have dedicated people willing to give their time. Most of the WASH cluster members or even SAG is on short term contracts.

- The recommendations are that there will be need to strengthen local coordination mechanisms particularly at district level. Coordination does need resources but currently the institutions mandated with this responsibility do not have resources. Current coordination has been strong at the national level but weak at the local level.

- Information management needs improvement starting with gender segregated data collection and analysis (Evaluation workshop, 2009).

- WASH to set up district WASH focal persons in all districts.

- WASH to facilitate the setting up of sub clusters in all provinces

- The SAG also appoint in its committee staff on long term contracts so as to improve institutional memory and sustainability

- Where feasible the sub clusters and focal WASH organs work with the district/province CPU and committees

9.7 Capacity Building

There was no large scale capacity building programme at the WASH cluster level. However some training was rolled out for the extension workers and volunteers. There are some training needs in respect to development of bankable proposals, monitoring and evaluation, community based management chemical application among others.

It is necessary to identify gaps and needs and roll out a capacity building plan before the outbreak. During the outbreak, partners will be too busy responding. The capacity
building needs seems to be greatest at the community level (volunteers) and at the district level

9.8 Revitalization of Partners
At the time of the cholera epidemic, government institutions and public bodies were incapacitated financially, materially and human skills. The situation has not significantly changed and the WASH cluster will have to take the lead in the response and in assisting their counterparts.

*Without a change in the economy of Zimbabwe, it will be necessary for the cluster to plan for and budget local partners who may be willing, have the necessary knowledge on local conditions but do not have resources to participate in the response*

9.9 Monitoring
Due to the nature of activities during the outbreak most of the partners ended up just monitoring inputs and outputs and not so much as trying to track and understand the outcomes of their actions. This has remained a weakness. Thus even during the evaluation, it was difficult to get information collected through surveys or quantified. Most of the monitoring information has remained anecdotal.

- It will be necessary to have some technical backstopping to those partners who need it for monitoring the response. Capacity building for monitoring will also be a necessity.
- There is still a lot that happened or did not happen that needs to be understood and further studies may be necessary. Process research may be necessary

9.10 Cross cutting Issues
There was no clear strategy and no Cluster guidelines on dealing with cross cutting issues. Each organisation depended on their own policies e.g. Save the Children Alliance who looked at Child Protection. Gender, disabilities, elderly and children were not given special attention.

- There is need for a clear strategy on how to deal with the cross cutting issues of gender, those living with HIV and Aids, the vulnerable who maybe the disabled, elderly and protection of children.
- Children have suffered in this cholera outbreak (from a health side there were no cholera beds for children) from the WASH perspectives there were no clear
strategies targeted at children. This may have been influenced by the fact that schools were closed when there was the outbreak. The possibility is that the next outbreak could be during school term.

9.11 Religious and cultural beliefs

The EM concluded that religious and cultural beliefs were some of the main drivers of the cholera epidemic and the WASH cluster will have to take these into account when planning and implementing interventions.

- Interventions to take into account the religious and traditional beliefs which if not considered can derail the response actions. Some of such interventions can include the use of liquid chlorination as opposed to tablets which are unacceptable to some religious sects. The distribution of NFIs could also be through and with the religious leaders.

- The IEC materials should specifically target cultural practices such as funeral management after death.

- As part of the preparedness planning, known sects should be approached and consulted as to their preferences.

9.12 Response Capacity

The EM concluded that government, Local authorities were not prepared for the cholera epidemic. The WASH cluster while having prepared did not anticipate the scope and scale and were therefore taken by surprise. Some indicated that having been oriented for development projects were not sufficiently equipped as emergency organisations. What is noticed is that the cluster quickly adapted and responded.

- There is need to tap into this adaptive capacity and strengthen cluster members in preparation for the next cholera outbreak. This would mean having contingency funds that could be accessed easily and utilised, further training of partners on emergency, developing a data bank of volunteers who can be called on at short notice to come and assist (not volunteers at extension level but at higher implementation levels).

- One lessons drawn from Bulawayo is that when they heard that there was an outbreak of cholera in Harare they travelled to Chinhoyi to learn about cholera, how to set CTC and even case management.
Implementing partners that intend to assist in the next cholera response should also go through a learning process as they prepare themselves.

9.13 Advocacy

There are several advocacy messages targeted at different groups and these are the donor community who are being called upon to support the short term and medium to long term measures to government to create an enabling frame and to the local leaders who can either make or break response actions. Specifically it is recommended that

As part of future preparedness planning, the cluster needs to do more advocacies with government for more openness in information sharing, access to information by partners and declaration of disasters and emergencies when they do occur

- Targeted advocacy to religious and traditional leaders will be necessary
- There is also need to advocate the funding and implementation of structural improvements to water and sanitation facilities, on an ongoing basis, to respond to the emergency as well as mitigate future risks.
- Advocate for harmonisation of pieces of legislation relating to environmental public health and promulgation of relevant regulations and statutes to deal with cholera and other communicable diseases
- ZIMRA should expedite customs clearance and importation of goods and materials coming into the country for humanitarian work
- Government should open more space for humanitarian NGOs and facilitate their quick registration
- UNICEF should facilitate the signing of various agreements and memorandums of understanding fast enough to allow NGOs to respond to humanitarian emergencies

9.14 Resources

As a general conclusion, there were adequate financial and material resources to respond to the cholera epidemic. However the main concern has been the turn around time between application and disbursement of funding. During an epidemic, a turn around time of more than 24 hours is already too long. For some organisations it took six weeks.
As part of the planning process, it is necessary to already start harnessing resources and allocating these in accordance to priority needs/gaps such as purchase of stocks for pre positioning. OCHA could take a leading role in that respect.

There is need for some contingency funds that will not require long drawn proposals but can be used for quick responses or assessments in the event that an alert has been raised.

While donor community has responded to the emergency response they have been reluctant in investing in capital costs for structural rehabilitation. Yet without addressing these fundamental problems cholera will be endemic in the country. Cluster should harness resources for water and waste water treatment rehabilitation.

9.15 Information management
In conclusion information sharing between the WASH cluster members was strong and welcome. The weekly updates were appreciated. Information across the other cluster was not always timely or correct, information from the districts took too long or was outright incorrect affecting cumulative figure’s

Improvement in information management is necessary for cluster response to be effective and efficient. There may be need to assist local level partners with communication means such as radios, cellphones etc.

There is also need to improve information dissemination with local level partners. Where there were no WASH focal persons/organisations information was not free flowing.

To link with the Health cluster that has pre positioned computers so that the WASH cluster can also send weekly updates to the districts.

9.16 Barriers and constraints to the programme
The EM concluded that the barriers to the WASH Cluster intervention impact were cultural, religious contextual and physical.

As a recommendation these need to be taken into account when planning interventions

---

4 UNICEF WES chief noted that there was even need to go back and correct wrong figures.
9.17 Opportunities missed by the WASH cluster
There were some missed opportunities from the government and from the WASH cluster. These opportunities include the use of local level structures, dialogue with civil society

- As a recommendation, the workshop evaluation recommended that the next step priority areas be focussed on strengthening local structures.

9.18 Priority Steps in preparation for the anticipated cholera epidemic
As a conclusion the workshop evaluation recommended the following priority steps for action and funding.

- **Strengthening district coordination** structures and mechanisms. Given the current situation where the point of impact is the local level which is often unable to respond due to eroded capacity, it will be necessary for the cluster to strengthen the coordination structures and mechanism at the local level. This would ensure that all provinces have WASH focal persons and all districts equally have WASH focal organisations or persons. To also work with the CPU developing preparedness plans and response interventions.

- **Fund raising**- this is crucial in responding to the epidemic and will be a priority of the Cluster collectively and organisations in their individual capacity.

- **Staffing** pre-positioning staff that are also trained in emergency response is important. This may also mean training existing staff and organisations and re-orienting them to emergency response.

- **Advocacy** this should be carried out at all levels and with different groups. There is need for advocacy with government, donors, traditional and religious leaders.

- **Strengthening capacity of NGOs.** It was noted through the evaluation that most local NGOs did not have the requisite response capacity and therefore needed strengthening before the next outbreak.

- **Recognising and utilising community** capacity through revitalisation of community health and hygiene network

- Monitoring and evaluation mechanisms to be put in place.

- **Water and sanitation infrastructure** rehabilitation and development. This is noted as the underlying cause of the cholera outbreak and without addressing this we will have the endemic cholera.
Other recommendations are that:

- WASH and Health cluster should develop a country specific cholera guideline that will provide an indicator /trigger when to respond and when to scale-up, considering the endemic nature of cholera in Zimbabwe.

- Furthermore, there is need for strategic planning on preparedness at ward, district, provincial and national levels to avert similar outbreaks in future.

- Government need to harmonise various laws dealing with environmental public health and develop clear regulatory statues to deal with disease epidemics.
10.0 REFERENCES

1. GAA/ Welt hunger Hygiene Promotion Manual
2. GAA And ECHO 2009, Zvimba Community Based Cholera Educator Training
3. Gamuchirai Chituri, 2008 Marked behaviour change A case study of Tembo village in Mudzi with predominantly apostolic faith Johane Marange
5. Gamuchirai Chituri, 2008 Oxfam GB Rude awakening
6. OCHA 2008/2009 Monthly situational reports
7. Peta Sandson 2003, Desk review of real time experience
8. Save the Children Alliance April 2009 Rapid Assessment of Protection Issues within Zimbabwe’s Cholera Epidemic and Response
12. Harare City Council, UNICEF 2008 Assessment of cholera knowledge awareness Risks perception related behaviour and contextual barriers
14. Linda Farirai, March 2009 (grey literature), Kadoma Rural Volunteers cholera training
15. UNICEF 2007, Wash related Non Food Items NFIs. New York

18. Various WASH cluster reports