World Health Organization

Proposal for funding WHO emergency operations in Zimbabwe

I. BASIC DATA

1.	**Project Title**:	Responding to the cholera outbreak in Zimbabwe		
2.	**Country**:	Zimbabwe	**Beneficiary Population:**	Affected population of Zimbabwe and neighbouring countries (South Africa, Botswana, Zambia, Namibia, Mozambique)
3.	**Starting date:**	05.12.2008	**Amount (US$)**:	6,047,319
4.	**Applying Organization:**	World Health Organization		
5.	**Bank account:**	UBS AG Case Postale 2600, 1211 Geneva 2 World Health Organization Geneva Swift code: UBSWCHZH80A		
6.	**Account number US$:**	No.: 240-C0169920.3 IBAN account code: CH31 0024 0240 C016 9920 3	**Account number Euro:**	No.: 240-C0169920.1 IBAN account code: CH85 0024 0240 C016 9920 1
7.	**Project Objectives**: • Reduce the spread of the epidemic by: strengthening case reporting and response mechanisms, ensuring safe isolation and infection control practices in health structures, reinforcing community mobilization and ensuring access to safe water and sanitation. • Strengthen coordination of the national response: by establishing coordination mechanisms including a Cholera Command and Control Centre, and recruiting a Coordinator for the overall Health Cluster response. • Decrease mortality by: ensuring early detection, improving targeting of responses, improving access to health care, and appropriate case management of cholera patients. •			
8.	**ESTIMATED DURATION OF THE PROJECT: SIX MONTHS**			

II. BACKGROUND AND OVERVIEW

EXECUTIVE SUMMARY

The aim of this project is to respond to the cholera outbreak in Zimbabwe that has now spread to nine out of 10 provinces and threatens to further destabilize a country severely weakened by food shortages, the ongoing political crisis, and the dramatically deteriorated health care and water supply systems. Moreover, the outbreak has spread beyond Zimbabwe's borders into South Africa and Botswana.

The present proposal sets out WHO's plans to respond to the epidemic, in collaboration with its partners, by establishing a "Cholera Command and Control Centre" in support of the Ministry of Health and Child Welfare (MoHCW). This team will guide, monitor and evaluate outbreak response interventions. In addition, the team will provide technical guidance and support in ensuring access to safe water sources and sanitation at 62 district hospitals throughout Zimbabwe. WHO's strong relationship with the MoHCW and its convening and technical role in health makes it ideally placed to guide the "Cholera Command and Control Centre."

PROBLEM STATEMENT

Zimbabwe is affected by a major cholera outbreak which began in August 2008. As of 5 December 2008 a total of 13 960 cases, including 589 deaths with a Case Fatality Rate (CFR) of 4.2%, have been reported. The majority of reported cases (56%) have occurred in Harare and suburbs (7563), Beitbridge (3245) on the border with South Africa, and Mudzi (1234), which borders Mozambique. Daily incidence and CFR are rising, indicating weaknesses in case and infectious disease management, as well as difficulty obtaining access to proper health care. The outbreak is taking on a subregional dimension, with cases spilled South Africa and Botswana. The outbreak is clearly due to the lack of safe drinking water, the inadequacy of sanitation, and the declining health care infrastructure due to the long-term crisis in the country.

BACKGROUND

Zimbabwe has been affected by cholera annually since 1998, but previous outbreaks have never reached the current scale. The increased number of cases reported is suspected to be an underestimation, as surveillance is not standardized and access to health care is compromised.

The current outbreak has strained an already overburdened health care system and resulted in a nationwide shortage of treatment materials, aggravated by the scarcity of health care providers and overall poor access to care. There is a high risk that the outbreak could expand further, as cholera can spread rapidly in areas without access to safe water and sanitation. Case fatality rates also can be very high in populations without rapid access to simple treatment measures. The risks are particularly high in populations already weakened by poverty and poor nutrition.

The current situation in Zimbabwe is due to a chronic aggravation of the country's prevailing conditions, with drastic deterioration of the health care infrastructure and an increased risk of communicable disease outbreaks. Cholera is easily preventable by ensuring access to safe water and appropriate hygiene measures, and deaths from cholera can be prevented through quick access to simple, standardized treatment regimens.

Through the Health Cluster, the following partners are actively involved in the response to the outbreak: MoHCW, WHO, UNICEF, UNFPA, OCHA, World Vision, World Vision, Plan International, ICRC, IFRC and IOM along with MSF-Spain/Holland/Luxemburg and numerous local non-governmental organizations.

UN Office for the Coordination of Humanitarian Affairs

ZIMBABWE Areas Affected by Cholera Outbreaks (August - December 2008)

2 December 2008

Chinhoyi City

Kariba (Mola and Kariba Urban)

Mazowe (Concession and other)

Goromonzi

HARARE (Budirio and Other Subarbs)

Kadoma Urban

Chitungwiza

Marondera Urban

Gweru Urban (Mkoba)

Mutare Urban

Chimanimani

Zvishavane

Bulawayo Urban

Masvingo (Mushandike)

Beitbridge Town

MASHONALAND CENTRAL

MASHONALAND WEST

MASHONALAND EAST

HARARE

MANICALAND

MIDLANDS

MATABELELAND NORTH

BULAWAYO

MATABELELAND SOUTH

MASVINGO

Mbire

Hurungwe

Mt. Darwin

Rushinga

Kariba

Makonde

Mudzi

UMP

Gokwe North

Binga

Zvimba

Nyanga

Gokwe South

Chegutu

Kadoma

Marondera

Lupane

Nkayi

Kwekwe

Hwedza

Chikomba

Mutasa

Mutare

Bubi

Chirumhanzu

Gweru

Tsholotsho

Shurugwi

Buhera

Gutu

Umguza

Insiza

Bikita

Bulilima

Umzingwane

Zaka

Mangwe

Matobo

Mberengwa

Chipinge

Gwanda

Mwenezi

Chiredzi

Beitbridge

Affected Areas

- Cholera Affected Area
- Province Boundary
- District Boundary

Number of Deaths

- ★ No Reported Deaths
- 1 - 50
- 51 - 100
- 101 - 150
- 151 - 180

Data Sources

Map data from Department of the Surveyor General (DSG)

Data on outbreaks from WHO and MoHCW

(includes new outbreaks with unconfirmed cases)

Map prepared by OCHA Zimbabwe IMU

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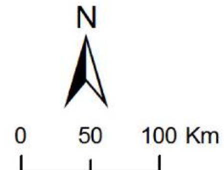

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

PROJECT BENEFICIARIES

The project beneficiaries are the population of Zimbabwe, as nine of 10 provinces are reported to be affected. The direct beneficiaries are those affected by cholera, with currently almost 14 000 suspected cases reported and expected to be considerably higher. The indirect beneficiaries are those who do not become infected due to control of the outbreak and prevention of future outbreaks. Affected persons are likely to be the most vulnerable and poorest people in the population.

III. Programme Goal and Objectives

A. OVERALL (LONG-TERM) GOAL

This project's long-term goal is to reduce morbidity and mortality in the population of Zimbabwe by strengthening overall control of the cholera outbreak through enhanced coordination of response efforts being provided by UN agencies, non-governmental organizations and the MoHCW. The goal of a "Cholera Command and Control Centre" is to support the MoHCW's efforts to bring the epidemic under control as soon as possible.

B. SPECIFIC PROJECT OBJECTIVES

The objectives of the response are to:

- Reduce the spread of the epidemic by:
  - Strengthening case reporting and response mechanisms
  - Coordinating cholera response activities by all partners
  - Ensuring safe isolation and infection control practices in health structures (including funerals)
  - Reinforcing community mobilization activities
  - Ensuring access to safe water and sanitation in 62 district hospitals

- Strengthen coordination of the national response by:
  - establishing coordination mechanisms including a Cholera Command and Control Centre
  - recruiting a Coordinator for the overall Health Cluster response.

- Decrease mortality by :
  - Ensuring early detection of cases
  - Improving targeting of responses
  - Ensuring adequate care through appropriate case management and feeding practices for cholera patients.
  - Reinforcing the health care system.

C. COORDINATION NEEDS WITH FIELD PARTNERS

The response to these outbreaks must be viewed as an emergency measure to be undertaken within the context of a severely deteriorated health care and civil environment. The response should be multi-sectoral in support of the MoHCW and partners agencies, including: UNICEF, UNFPA, OCHA, World Vision, MSF-Spain/ Holland/ Luxembourg, World Vision, IFRC, IOM and local non-governmental organizations intervening in the field. Close coordination with other clusters, particularly the Water, Sanitation and Hygiene Cluster, is a pre-requisite to success.

In this initial phase of outbreak control operations, various health sector actors are deploying resources to Zimbabwe. But some of these responses are not being adequately coordinated through either the MoHCW or the cluster coordination mechanism. The health cluster has identified numerous gaps in ongoing cholera response efforts, and consequently, there is an urgent need to establish a strengthened structure with diverse expertise in cholera and other diseases control, otherwise known as a "Cholera Command and Control Centre."

D. ACTIVITIES AND CONCEPT OF OPERATIONS (STRATEGY)

The overall coordination body for humanitarian response in health is the Health Cluster, for which no designated coordinator currently exists. The appointment of a Health Cluster Coordinator would help bring clarity and guidance to the multiple interventions underway and being planned in Zimbabwe. This Health Cluster Coordinator would be the ideal link between the overall Health Cluster and the specialized "Cholera Command and Control Centre" (CCCC) envisaged to be established within the MoHCW to support its response to the epidemic.

CHOLERA COMMAND AND CONTROL CENTRE

The Cholera Command and Control Centre situated at the MoHCW will:

- Provide strong health sector leadership and coordination for the cholera outbreak response through technical and financial support to the MoHCW and Provincial Health Offices;
- Standardize reporting of cases to understand their distribution, to guide treatment priorities, and inform prevention messages;
- Strengthen the Health Cluster Coordination and Inter-Cluster Collaboration to address public health emergencies and other health issues challenging the Zimbabwean health system;
- Enhance the capacity of 62 district hospitals for improved responsiveness to the cholera outbreak and preparedness for other public health emergencies by ensuring the availability of safe water supply and sanitation facilities.

The Cholera Command and Control Team will:

- be a specialized international outbreak response team that will be set up with an initial focus to strengthen the MoHCW National Task Force;
- be a mechanism that will guide, coordinate, monitor and evaluate the cholera responses of multiple UN agencies and other humanitarian organizations in Harare;
- organize rapid assessments at the periphery with the immediate focus on the four reportedly most affected areas: Harare region (Budiriro), Beitbridge, Chitungwize and Mudzi.
- mobilize the simultaneous and coordinated deployment of additional resources from both within Zimbabwe and outside to strengthen the provincial task forces.

HEALTH CLUSTER COORDINATION

WHO will set up an operations room in the WHO country office to act as a focal point for Health Cluster coordination, information collection and analysis. This operations room will also support the Health Cluster response and collaborate closely with the other clusters involved in the cholera response.

CHOLERA RESPONSE STRATEGY

The response should cover needs in the areas of epidemiology, surveillance and response, water and sanitation, infection control, social mobilization, and logistics. This coordinated approach will involve close collaboration with national public health authorities, as well as authorities from other sectors including NGOs and UN agencies, such as UNICEF.

Responding to and preventing the further spread of the outbreak beyond Zimbabwe's borders will require strong coordination with neighbouring countries.

WHO and partners must take urgent steps to improve case management. The Health Cluster has estimated that there could be 60 000 new cholera cases within the next 12 months. In response, WHO estimates that 50 additional cholera treatment centres (CTCs) will need to be set up and/or to remain functional to treat new cases throughout the country during the next two months. MoHCW field staff and partners will need to be trained in cholera case management, guidelines for which must be produced and distributed. Additional drugs and materials will need to be procured.

Shortages of aluminium sulphide have caused Harare's water system to shut down on several occasions. While bore hole wells are suitable for rural areas and health facilities, they may not appropriate for high-density urban areas, where there is a high probability of contamination. Trucking of water supplies to urban populations, where fuel is at a premium, should be undertaken only a last resort. Urban water systems need to be safely restarted as soon as possible: this requires rapid provision of water purification chemicals in large quantities. This task should be coordinated by the Government, supported by the WASH Cluster.

The emphasis must be on rapidly addressing the known risk factors for transmission of cholera. Immediate priorities include:

- Providing strong health sector leadership and coordination, in close collaboration and consultation with the WASH Cluster and other partners;
- Ensuring standardized reporting of cases to guide treatment priorities and inform prevention messages;
- Improving access to health care;
- Ensuring access to safe water;
- Ensuring adequate sanitation facilities;
- Ensuring standardized case management to reduce mortality;
- Providing treatment and prevention materials;
- Installing infection control practices;
- Managing waste;
- Managing dead bodies;
- Developing and implementing a mass communications strategy for social mobilization.

WHO will establish sub-offices in key provincial locations to support coordination between the MoH and partners. Whenever possible, WHO will establish sub-offices in coordination with other UN agencies. However, in some locations WHO may need to establish stand-alone offices. The sub-offices will be staffed with national staff, including a focal point for coordination, a data collection officer and a driver. The sub-offices will be furnished with standard communications and IT equipment, a vehicle, and funds to cover running costs.

A critical risk factor in all operations will be the availability of subsidies (from donors) for government staff so that they are available to work in the cholera response programme.

The situation in Zimbabwe is fluid and potentially volatile: this proposal reflects the current situation but flexibility is required as the situation is expected to evolve. Moreover, resources and activities may be reprogrammed based on the results of further field assessments.

This proposal has taken into consideration related funding requests that have been made by the WASH Cluster.

E. INPUTS

Teams of health care and allied experts must be rapidly deployed to ensure that the necessary human resources are available. These teams will be deployed immediately to strengthen both the MoHCW and the Health Cluster in the short-term, while additional national resources are mobilized.

At central level as part of the “Cholera Command and Control Team,” this means deploying an international team composed of:

- Team Leader/Coordinator
- Epidemiologists with a public health specialization
- Social mobilization specialist
- Water and sanitation expert with experience in cholera control and a focus on infection control in health care facilities
- Case management expert
- Security officer
- Administrative support staff
- Logisticians with specialized experience in cholera control
- Media officer to manage the flow of external communications
- 1 focal point to collect information from all persons, and develop and manage information flows

As a result of initial rapid assessments in the affected provinces, it may be necessary (and should be planned for) to deploy teams at the provincial level comprising:

- Team Leader/Coordinator
- Epidemiologists with a public health specialization
- Social mobilization specialist
- Water and Sanitation expert with experience in cholera control and a focus on infection control in health care facilities
- Logisticians with specialized experience in cholera control

The following equipment and supplies will be required to attain the expected results of the project:

EMERGENCY HEALTH SUPPLIES

- Ringers Lactate
- ORS
- Chlorine
- Body bags
- Disinfectants
- Protective equipment for health workers
- Camping equipment and supplies
- Antibiotics: Ciprofloxacin, Erythromycin, Doxycycline

OPERATIONS

- VHF radio communication sets
- Satellite phones
- Base HF radio and installation
- AT&T broadband internet access facility
- Vehicles (3) 4x4 fitted with HF radio communication facility
- Fuel

- Running costs for the teams
- Running cost for reactivation MoHCW coordination mechanisms
- Laptops with portable printers (5)
- Heavy duty colour printers (2)
- Laser jet printers (2)
- Office furniture, equipment and supplies

F. TIMEFRAME FOR COMPLETION OF THE WORK

The initial period for the response is estimated to be six (6) months.

G. INDICATORS/MEANS OF VERIFICATION

- Case fatality rate due to cholera and other disease outbreaks below acceptable thresholds by WHO standards;
- Surveillance system allowing regular flow of information is in place with 75% completeness and 75% timeliness by end of project;
- 100% of the alerts are assessed within 72 hours of receiving report with at least 10% of initial cases tested by appropriate laboratory investigation at the beginning of the outbreak;
- Weekly epidemiological update is published and disseminated electronically by the health information unit of the MoHCW;
- Health Cluster Bulletin published and disseminated weekly with updates on the health situation, health cluster, donor and government activities, as well as relevant humanitarian news;
- A document on Zimbabwe's national health profile (for 2008) is compiled based on existing information captured by the health information system;
- An assessment report on how operational district health systems are is published; the document will be a useful guide for recovery and transitional interventions;
- MoHCW holds monthly National Task Force and Inter-Agency Coordination Committee on Health meetings and minutes of meetings are shared with all humanitarian agencies;
- All outbreaks investigated and managed in accordance with established procedures and protocols.

IV. Logical Framework

Objectives	Measurable indicators	Means of verification	Important assumptions
GOAL: *Reduce morbidity & mortality due to cholera and other public health emergencies*	*Case fatality rate due to cholera and other disease outbreaks below WHO accepted thresholds*	Epidemiological reports; Health Information System	**(Goal to supergoal)** No major natural disaster or civil conflict occurs
PURPOSE: *Control the ongoing cholera and anthrax outbreak in Zimbabwe within six months*	Duration of the outbreak Attack rate Case fatality rate	Epidemiologic reports; Health cluster reports	**(Purpose to Goal)** Food and population water supply and sanitation challenges are addressed by relevant clusters & the GOZ
OUTPUTS: 1. Command and control centre established; 2. National & provincial health cluster coordination strengthened; 3. National emergency stock of drugs, equipment and supplies is maintained; 4. 62 district hospitals have safe water supply and sanitation facilities;	Activity reports of the Cholera Command and Control Centre (CCCC); Minutes of meetings of the health clusters; Stock inventory and procurement reports No. of district hospitals with functional bore-holes and sanitation facilities;	Health cluster Bulletin Monthly reports Stock & financial records; Joint DFID/WHO monitoring visits	**(Outputs to purpose)** The current socio-political and economic does not worsen; the roll-out of health staff retention schemes does not delay beyond the scheduled date of January 2009
ACTIVITIES: 1. *Recruitment* 2. *Procurement* 3. *Office set up* 4. *Assessments* 5. *Training* 6. *Regular meetings* 7. *Monitoring & evaluation*	**INPUTS:** 6,047,319	Financial outturn report as agreed in grant agreement	**(Activity to output)**

V. Summary budget

Function	Requirement	Cost USD
I. Staff costs		
	Team Leader/Coordination (P5), Epidemiologist x2, Field Staff Costs, Social Mobilization Expert x1, Water Sanitation Expert x2, Case Management Expert x1, National Health Cluster Coordinator x1, Regional Health Cluster Coordinators X2	834,790
	Security Officer x 1, Logistics Officer x2, Media Officer x1	230,000
	NPOs x 10 for coordination at provincial level	260,000
	Office staff costs	
II. Operations		
A. Strengthen WCO to support MOH in coordination and operations	1. Open & run Cholera Command & Control Center and Health Cluster Secretariat (including offices x 10 for 10 provincial NPOs) including provision of operational support	700,000
B. Case investigation, surveillance and epidemiological analysis	1.Mobile Support Emergency Units for surveillance for adequate field operation and monitoring of interventions	799,000
	2.Communication equipment and running costs	87,000
	3. Consumables	50,000
	4. National emergency stockpiling (of diarrheal diseases, health and trauma kits) to be distributed via operational NGOs;	2,000,000
C. Field emergency training cost	Training of field staff on case management	55,910
D. Emergency Health Guidelines	Production and distribution of case management guidelines	30,000
E. Reduce case load and case fatality at community level	Community based contact tracing, hygiene promotion and social mobilization through reactivating the village health workers program of the MOHCW	250,000
F. Field operational and evaluation costs		
III. Acquisitions	Procurement of drugs, miscellaneous medical supplies and kits	200,000
	3 MOSS-compliant vehicles and fuel costs	155,000
IV. Subtotal		5,651,700
V. Progamme Support Cost (7%)		395,619
Total		6,047,319

Annex 1. TERMS OF REFERENCE

Background/Rationale

Outbreaks of cholera have occurred in Zimbabwe; currently, there have been several reports on dramatic increase of cases of cholera in nine of ten provinces.

1. **Terms of Reference for Health Cluster Coordinator (HCC)**

Background

The cluster approach has been introduced as a part of “humanitarian reform” aimed at improving the effectiveness of humanitarian response by ensuring greater predictability and accountability, while at the same time strengthening partnerships between NGOs, international organizations, the International Red Cross and Red Crescent Movement and UN agencies. The other, complementary elements of the reform are: strengthening the humanitarian coordinator (HC) system; and improving humanitarian financing. The aim of a country-level Health Cluster is to ensure a more coherent and effective humanitarian response by all international, national and local actors operating in the health sector in areas affected by crisis.

Overall role of the HCC

The Health Cluster Coordinator will ensure the good performance of the country Heath Cluster, promoting and upholding the Humanitarian Principles and the Principles of Partnership. The country Health Cluster performance, in turn, will be monitored and evaluated according to the extent by which the activities and programmes of the cluster partners meet the health needs of the crisis-affected populations.

The structure of the health cluster at country level

The lead agencies of country clusters are designated by the HC in consultation with the Humanitarian Country Team (HCT), and submitted to the Emergency Relief Coordinator for final endorsement in consultation with the lead agencies of the 11 Global Clusters.

The Country Representative of the designated health cluster’s lead agency, while maintaining the reporting lines of her/his own organization, reports and is accountable to the HC for what pertains the responsibilities and functions outlined by the document: *“Generic ToRs of the Cluster Lead Agencies at country level”*. This includes ensuring that views and plans of the health cluster partners reach and are considered by the HC and the IASC country team

The Health Cluster Coordinator reports, and is responsible to, the Country Representative of the health cluster’s lead agency in all cases, even if s/he is a staff member of a partner agency on secondment or loan.

Depending on the nature and extent of the crisis, the country’s context, the structure of the overall international humanitarian response, and the operational capacities of the health cluster’s members, peripheral health hubs with designated zonal health cluster focal point agencies may need to be set up to better respond to the needs of the affected populations.

‘Summary of duties

All opportunities and capacities for health are recognized and integrated in an inclusive strategy:

1. Identify and make contact with all health sector stakeholders, including national health authorities, national and international organizations and civil society.

2. Hold regular coordination meetings with country health cluster members, building when possible on an existing health sector coordination forum.

3. Represent the Health Cluster in inter-cluster coordination mechanisms at country/field level, contribute to jointly identifying critical issues that require multisectoral responses, and plan the relevant synergistic interventions with the other clusters concerned.

Health outcomes and health determinants are recognized, agreed upon and monitored:

4. Ensure collecting data and regularly updating the health sector section of the 3W (Who's doing What, Where) database managed by OCHA, and for sharing and discussing this information with health cluster partners and the other clusters.

Health determinants are addressed and avoidable mortality and morbidity are equitably reduced:

5. Ensure that humanitarian health needs and gaps in response are identified by planning and coordinating joint, inter-cluster, initial rapid assessments adapting to local context the IRA tool developed by the Health, Nutrition and WASH Global Clusters, as well follow-on more in-depth health sub-sector assessments, as needed, and regular situation monitoring/surveillance.

6. Assess and monitor the availability of health services in the crisis areas using GHC Health Resources Availability Mapping (HeRAMS) tool, including services provided by all health actors.

7. Lead the health cluster members and contribute to the overall analysis of the health-sector data collected (see points 3, 4 and 5) including joint gap analysis, priority setting, and planning the response to address the un-covered major gaps (including, when necessary, the activation of the Provision of Last Resource mechanism).

8. Provide leadership and strategic direction to Health Cluster Members in the development of the health sector components of FLASH Appeal, CHAP, CAP and CERF proposals and other interagency planning and funding documents, and in preparing and maintaining a health-sector contingency plan for potential new events.

Health action is sustainable and transition/exit strategies are in place:

9. Promote the use of the Health Cluster Guide to ensure the application of common approaches, tools and standards by all health cluster participants taking into account the need for local adaptation. Where necessary, advocate for the adherence to guidelines and best practices adopted by the global health cluster and the wider humanitarian community.

10. Identify urgent training needs in relation to technical standards and/or protocols for the delivery of key health services to ensure their adoption and uniform application by all Health Cluster participants. Coordinate the dissemination of key technical materials and the organization of essential workshops or in-service training.

11. In a protracted crisis or health sector recovery context, ensure appropriate links among humanitarian actions and longer-term health sector plans, incorporating the concept of 'building back better' and specific risk reduction measures.

Qualifications

Education:

Essential: Degree in medicine and/or Public Health.

Experience:

Essential: Minimum of 6 years international field experience, of which at least 3 in managing and coordinating health programs in chronic and acute, sudden-onset emergencies.

Skills:

Competencies

- Ability to prioritize, organize, manage and adapt management style according to need;

- Excellent communication and negotiation skills and ability to convene stakeholders and facilitate a policy process among UN, NGOs, national health authorities and donors;

- Producing results;

- Fostering integration and teamwork;

Functional Skills

- In-depth knowledge of emergency relief policies and practices within the UN, other UN Specialized Agencies, donor agencies, national and international NGOs;

- Sound knowledge and experience about national disaster prevention and preparedness programs;

Languages:

Essential: Excellent knowledge of written and spoken English, French or Spanish (as appropriate);

Desirable: Working knowledge of a second international/UN and/or local language.

2. Team Leader Outbreak Response Team Zimbabwe

The response to the cholera outbreak in Zimbabwe is a joint, multi-sectoral, response in support of the Ministry of Health and Child Welfare (MoHCW) and the WHO country office, working under the umbrella of the Health Cluster. This coordinated response involves close collaboration with national public health authorities, NGOs, nutrition and WASH sectors; and with other UN agencies such as UNICEF. Coordination with neighbouring countries will also be beneficial.

The outbreak response team includes the following functions: epidemiology, water and sanitation and infection control, social mobilization, case management, security and logistics.

The objectives of the response are to:

- Reduce the epidemic spread by:
  - Ensuring access to safe water and sanitation conditions
  - Reinforcing community mobilization

    - Ensuring safe isolation and infection control practices in health structures (including funerals)
- Decrease Mortality by:
    - Ensuring early detection of cases
    - Improving access to health care
    - Ensuring adequate care through appropriate case management and feeding practices for those under treatment

Immediate priorities include:

- Standardized reporting of cases to understand their distribution, to guide treatment priorities, and to inform prevention messages
- Ensuring access to safe water and sanitation and standardized case management in health care facilities
- Provision of treatment and prevention materials
- Prevention and reporting messaging campaigns for the populations

Overall planning and co-ordination of the national outbreak response efforts are the responsibility of the host government. Under the supervision of the WR Zimbabwe and in close collaboration with the Health Cluster lead, EHA focal points, IST, WHO AFRO and HQ, the incumbent responsibility is:

- To provide overall management, technical leadership and co-ordination for the international outbreak response team in accordance with the agreed terms of reference.
- To ensure the integration and co-ordination of the international outbreak response team activities in support of national control efforts and existing public health infrastructure.
- To strengthen partnership with the MoHCW and national counterparts, WR office, Health Cluster partners, NGOs, IGOs and other UN agencies.
- To define individual roles and responsibilities within the international outbreak response team, identify immediate priorities and address practical matters in the field.
    - providing detailed technical briefing to team members upon their arrival
    - field logistics, e.g. field equipment, transport, food, translators, etc.
    - security arrangements, including contingency and evacuation plans
    - planning of epidemiological and surveillance activities
    - planning of laboratory services including the transport of samples, etc.
    - existing measures to control the outbreak, by the MoHCW, NGOs, etc.
    - health education and social mobilization
    - planning of applied research activities and publications
- To establish a technical co-ordination committee to ensure good communication and joint evaluation and planning between teams
- To establish together with the local staff procedures for information management early in the response:

    Information management includes:
    - data management for surveillance and response activities
    - daily reporting on operations/logistics, status on outbreak control, security issues etc.
    - regular reporting to MoHCWand WHO on surveillance and response activities
    - communications with the media
- To consult with the MoHCW and WRO to establish agreed upon procedures for:

    Epidemiological reporting to MoHCWand WHO
    - content/detail/format (cases, deaths, tables, graphs, comment)
    - frequency (daily and weekly)
    - method (e-mail, fax, etc.)
    - required clearances (signatures)

    Communication with the media

- interactions with local and national media
- interactions with the international media

- To take the responsibility for media relations (at the request of national authorities and WR) or to designate this responsibility to a specified team member
  - *No other individual team member should communicate with the media without explicit consent of the international team leader or the designated person responsible for media relations*
  - *Established processes for information management should be adhered to strictly and should be adjusted only after mutual consent of the international team leader and* MoHCW
- To plan the rotation of the team members in consultation with WHO, MoHCWand local health authorities and ensure adequate hand-over period in the field between the in-coming and out-going team members
- To advice the international team members about the *Code of Conduct for Team Members of an International Outbreak Response*
- To debrief the MoHCW, WRO and other involved agencies at the national level.
- To submit a preliminary outbreak response report (hard and electronic copies) to MoH and WRO prior to departure form Zimbabwe at the end of mission.

2. <u>Social Mobilization/Health Promotion Expert for Cholera Prevention</u>

In collaboration with the MoHCW, under the supervision of the WHO Country Office and team leader of the outbreak response team, to conduct the following activities:

- Assess the situation regarding the social mobilization component of outbreak response and control interventions through undertaking rapid appraisals to:
  - understand current perceptions and communication efforts relative to prevention of high-risk human behaviour in regions with outbreaks of cholera.
  - Identify socio-cultural beliefs and practices that could facilitate and/or hinder public health outbreak control measures.
- Develop an integrated social mobilization/communication strategy with clearly delineated behavioural goals to reduce the risks in the community.
- Report to MoHCW/WHO on findings, and assist the Outbreak Response Team/International Team and national authorities on effective and feasible social mobilization activities in areas affected by the outbreaks.

Candidate specifications

Education and special training

University degree in social sciences and/or communication.

1. **Experience (length and type)**
   Extensive experience in strategic communication planning and implementation for behavioral impact in health and in establishing relationships with Government and UN counterparts and partners at country level.
2. **Knowledge, abilities and skills**
   Proven knowledge and skills in: communication, social mobilization, and rapid appraisal techniques; an understanding of the roles of pertinent disciplines and an ability to co-ordinate different inputs into a strategic communication campaign; excellent interpersonal skills; strong organizational skills; and an ability to work effectively in multicultural environment.
3. **Languages**
   English

3. Communicable Disease Epidemiologist / Public Health Specialist
Under the supervision of the outbreak response team leader and of the WR Zimbabwe and in close collaboration with EHA focal points, IST, WHO AFRO and HQ, the incumbent will be responsible for :

1. Strengthening the system of surveillance and response for cholera, in collaboration with local authorities and partners, including assistance with
   - coordination of surveillance partners,
   - standardizing the case reporting process,
   - collection, analysis, interpretation and dissemination of data,
   - maintain database of alerts and assessments
   - technical and operational support for investigation and control activities;
   - support of case management and training of providers; and
   - feedback of results to reporters.
2. Further investigating reported cases of cholera and to implement control and prevention measures as necessary;
3. Organizing laboratory submission of specimens and diagnosis if necessary;
4. Ensuring epidemic preparedness measures are in place, e.g. stockpiles of antibiotics, rehydration solutions, ORS, body bags, disinfectant, etc. This should be done in close interaction with implementing partners, NGOs, MoHCWand other UN agencies;
5. Supporting training on surveillance, epidemic preparedness and response as necessary;
6. Producing daily and weekly epidemiological report, in collaboration with MoHCWand partners

4. Water Sanitation & Hygiene / Infection Control Technical Officer
In the context of the emergency response operations to Cholera Outbreak in Zimbabwe and under the supervision of the outbreak response team leader and the WHO Representative in Zimbabwe the incumbent will perform the following tasks:

Before departure:

- Briefing on the general situation in Zimbabwe (by HAC and HSE)
  a. Update on the current global water and sanitation situation
  b. Map of sites with cholera cases
  c. Map with WASH interventions, partners involved and contacts
  d. Map with health interventions, partners involved, their role and contacts names
  e. WHO interventions
  f. List and map of emergency isolation sites for cholera treatment (CTC) + WASH support in place.
- Emergency WASH briefing with the Water, Sanitation, Hygiene and Health unit at HQ
- Review of the intervention as described below.

After arrival and in close coordination with the WHO Zimbabwe team, EHA focal points, IST, WHO AFRO and HQ

- Liaise with WASH partners
- Define acute WASH needs in CTC and health facilities taking care of cholera patients (WHO responsibility under the Health Cluster).
- Define and mobilize the necessary resources (staff, equipment) for a rapid response and long term investment.
- In coordination with the WASH partners and the WHO team, foresee what might be coming priorities and needs and plan for an appropriate response.
- Attends WASH and Health coordination meetings and provide technical expertise.
- Provide daily feedback to WR, EHA and HQ

Profile
Education and Experience

- Education: Graduate degree in Water, Sanitation and Hygiene (WASH)
- At least eight years of consecutive and demonstrably progressive experience in WASH in emergency settings
- Good knowledge of the UN inter-agency coordination Cluster
- Good understanding of the NGOs working environment.

Competencies
- Ability to work as a team member.
- Ability to work with competing priorities, tight deadlines and under pressure.
- Experience of working with WHO, UN or International Organizations is an asset.
- Proven experience of humanitarian action in complex environments

Languages
Excellent knowledge of English with a good working knowledge of French.