NOVEMBER 2013

VCA REPORT- DZIVARESEKWA AND HATCLIFFE, HARARE NORTH DISTRICT URBAN DRR

ZRCS

IFRC

Contents

Executive Summary 2

CHAPTER ONE 4

INTRODUCTION AND BACKGROUND 4

Introduction 4

Harare North District 4

Zimbabwe Red Cross Society 4

Vulnerability Capacity Assessment (VCA) 5

CHAPTER TWO 6

RESEARCH METHODS 6

The VCA Process 6

CHAPTER THREE 8

VCA FINDINGS 8

Introduction 8

DZIVARASEKWA ..... **Error! Bookmark not defined.**

Dzivarasekwa 1 9

Dzivarasekwa 2 10

Dzivarasekwa 3 10

Kuwadzana Phase 3 11

HATCLIFFE 11

Old Hatcliffe 1 11

Old Hatcliffe 2 12

Consortium 12

CHAPTER FOUR 14

COMMENTS AND RECOMMENDATIONS 14

Short-Term Recommendations 14

Long-Term Recommendations 15

Capacities in the District 15

Conclusion 16

Executive Summary

The Zimbabwe Red Cross Society (ZRCS) with support from the IFRC and Partner national societies undertook an Urban Vulnerability Capacity Assessment (VCA)[1] between November 25 and 3 December 2013 with the aim of embarking on an Urban Disaster Risk Reduction (DRR) programme to tackle urban vulnerability while at the same time strengthening resilience in two urban communities of Harare North district. The broader objectives of the project include enhancing capacity of Zimbabwe Red Cross to deliver, coordinate and advocate for disaster risk management, while at the same time, building stronger communities (Knowledgeable, organized and prepared, connected, protected), resilient to impacts of potential disasters.

Essentially, these broader objectives would be achieved in three phases: 1] Development of a framework of partnerships with the National Society's (NS) stakeholders; 2] Conducting the vulnerability capacity assessment/multi-hazard risk assessment; and 3] Implementation of community-level urban DRR community action plans through the province.

The expected outcomes of the programme include:

- Increased capacity of ZRCS to implement DRR measures to improve livelihoods security of vulnerable groups.
- Improved livelihoods security and increased capacity of the targeted communities to implement DRR measures to reduce their vulnerability to urban risks.
- Increased access to safe water and sanitation facilities, increased knowledge, and improved attitudes and practices (KAP) in prevention or treatment of selected/predominant ailments (diarrhoea, HIV and injuries).

Across the targeted areas, communities identified the following:

Table 1 Summary of findings- Hatcliffe and Dzivarasekwa

Hazards	Risks	Vulnerabilities	Capacities
• Uncollected refuse at dumping sites • Unsafe drinking water- usually contaminated with raw sewage at source and few alternative sources • Pot holes and unregulated road networks close to schools and market places • Storm sewers blocked by refuse	• Flooding • Epidemics out breaks • Crime(GBV/rape murder, child abuse, housebreaks and theft. • Road	• Poverty • Disabilities • Few schools and Limited levels of education, mainly primary schools are present, no vocational	• Urban agriculture • Poly clinic (though only 1 clinic per targeted community, which could certainly be considered a vulnerability if there is a serious outbreak or even for responding to the HIV

[1] *VCA is a method of investigation into the risks that people face in their locality, their vulnerability to those risks and their capacity to cope with and recover from disasters.*

• Bursting sewer pipes • Overcrowded housing • Threats to safety and security due to poor street lighting and cover provided by urban agriculture • High incidence of illegal structures selling beer illegally, locally known as *Mashabhini* • High levels of poverty in the face of high levels of unemployment culminating in redundant youth with limited hope for a better future • High dropout rates, especially for girls, in school, particularly at higher/secondary school levels • Substance abuse	accidents • HIV/AIDS • Malnutrition and food insecurity	training facilities • Limited healthcare service capacities • Bad road networks • Limited opportunities for alternative livelihoods • Defragmented governance and selective mandates	epidemic currently) • Manpower/human resources in form of community members • Committed local government officials • Modern communication technologies- cell phones and internet • Social capital within some sections of the community driven by commonality of interests, lifestyles and shared values

CHAPTER ONE

INTRODUCTION AND BACKGROUND

Introduction

This chapter introduces the Harare North District by placing it into a national map and then provides detailed District Profile, as well as characteristics of the targeted wards. Within this chapter, the project plan will also be discussed, Vulnerability Capacity Assessment will also be defined and its objectives will be listed.

Harare North District

Harare, Zimbabwe's capital city, is made up of 7 districts containing slightly more than 2 million people and representing about 16.2 % of Zimbabwe's population. Within the District of Harare North, (certainly to the northern part of the city and housing most of the city's oldest affluent suburbs) are two low income settlements that were historically established to cater for the domestic workers providing labour to the affluent within their vicinity. These two are Hatcliffe, further north, and Dzivaresekwa, southern most. Dzivaresekwa suburb has 5 sections comprised of Dzivaresekwa 1,2,3,4 and Kuwadzana Phase 3. Dzivaresekwa represents one area that was worst hit by the 2008 Cholera outbreak and is serviced by a poly clinic, a police station, 3 primary and 2 high schools. Dzivaresekwa is serviced by about 8 public boreholes, and 3 of which are now dysfunctional.

Table 2 Population statistics- Hatcliffe and Dzivaresekwa

Ward	Households	Population
DZIVARASEKWA (40)	10 922	45 180
HATCLIFFE (42)	11 658	45 355
Total	22 580	90 535

On the other hand, Hatcliffe is made up of 4 sections, namely Old and New Hatcliffe, Cooperatives and Consortium. In this suburb are 3 primary schools and 2 secondary schools. This suburb mainly came as a result of cooperative housing schemes. In Hatcliffe, there are about 15 boreholes, some of which are now dysfunctional. There is also an old small dam that was used for watering livestock during the time when the residential area was still a farm owned by the Harare City Council. However, currently the dam poses numerous hazards to the community, an issue we will return to shortly.

Zimbabwe Red Cross Society

The Zimbabwe Red Cross (ZRCS) is a part of a family of 189 national societies throughout the world that makes up the International Federation of the Red Cross/Red Crescent (RC/RC) Movement. Since its inception through the ZRCS Act of 1981, the ZRCS's ambitions has been to assist the most vulnerable members of society defined as those that are at greatest risk from situations that threaten their capacity to live with an acceptable level of social and economic security and human dignity. Like any RC/RC National Society, ZRCS is guided by the 7 fundamental principles of the RC/RC Movement including

humanity, impartiality, neutrality, voluntary service, universality, unity and independence. The National Society depends on a country wide volunteer support base and branch network consisting of Red Cross oriented community volunteers who support the work of the Red Cross.

Consistent with its mandate and vision, Zimbabwe Red Cross Society with support from the IFRC, intends to implement, in Harare North District, an Urban Disaster Risk Reduction (UDRR) Project focusing on National Society capacity development and building community resilience to disasters. The overall goal is to reduce the number of deaths, injuries, and socio-economic impacts caused by disasters by strengthening the Zimbabwe Red Cross Society and building safer, more resilient communities.

To this effect, the Zimbabwe Red Cross Society, cognizant of the hazards and risks associated with the Urban centres, chose Harare as the priority urban pilot centre, while Provincial and District Administrators in Harare selected Harare North, specifically Dzivaresekwa and Hatcliffe, as pilot sites of choice based on the perceived level of poverty in the two areas.

Vulnerability Capacity Assessment (VCA)

VCA is basically a method of investigation into the risks that people face in their locality, their vulnerability to those risks and their capacity to cope with and recover from disasters. The IFRC describe the VCA 'as an integral part of disaster preparedness that can contribute to the creation of community-based disaster preparedness programmes at the rural and urban grassroots level. This tool has been argued as enabling local priorities to be identified and defined, leading to the design of actions that contribute to disaster reduction'[2].With the VCA, local people and communities become the focus, not only as recipients of funding, but ideally as active participants in the development initiative. When applied to disaster preparedness, such methods can encourage participation, so that people become more completely involved in the identification of risks and in the design of programmes and actions to prepare for disasters. (IFRC, 2006)

[2] *International Federation of the Red Cross and Red Crescent Societies, What is VCA? An introduction to vulnerability capacity assessment, Geneva, Switzerland, 2006*

CHAPTER TWO

RESEARCH METHODS

This chapter outlines operational definitions and research methods that were used to gather information for the VCA. It was important to define and clarify the operational definitions to be used in the VCA, as well as the methods for data collection.

The VCA Process

Resource materials were accessed from the IFRC website and previous ZRCS VCA Reports. Given that the VCA tools were traditionally designed for use in rural settings, the process was also adapted to the urban context and the prevailing situation in Harare North where the Urban VCA was going to be carried out in 2 suburbs, precisely within eight sections. The following steps were followed:

Setting up a VCA team and VCA objectives

The VCA Team was set up comprising members from the ZRCS Head Office (including PMER, Disaster Management, Health and Social Services, and Livelihoods and Food Security), IFRC Zone Office Disaster Management Unit, ZRCS Mashonaland Central provincial Office and Government Officials from the District Administrator's office. The VCA Team was guided by the Terms of reference [appended] which had specific objectives.

Planning the VCA (Sensitizations, developing data collection tools, doing desk/literature review)

The Mashonaland Central Provincial office led sensitization activities to the relevant stakeholders from various areas of specialty and domains of responsibility in the targeted communities. Data collection templates were developed to collect information. Particular attention was paid to the data collection instruments so that they were flexible and enabled participants to provide information in guided semi-structured manner. In tandem with this, the multidisciplinary VCA team contacted a one-day review of tools to exploring possible modifications relevant to the urban context. Equally, the multi-sectoral approach adopted to discuss the VCA tool proved more than path breaking and provided much valuable insights in to the nature and extends of vulnerability in urban contexts. On the other hand, the VCA tool training programme provided an opportunity for volunteers to participate in theoretical and practical exercises prior to supporting the VCA in the targeted communities.

On the field, Rapid Rural Appraisal techniques were adapted in the field for quick data collection. Face to face interviews with key stakeholders were done to sensitize them and get an overview of common epidemic outbreaks, hazards and capacities. Additionally, purposive sampling was used that involved sections in the two targeted suburbs. Six interviews were done with stakeholders as tabulated in table 5. Focus Group Discussions (FGD) were carried with 3 to 4 groups in each of the sampled sections. The groups were composed of community leaders, men, women and the youth

Participatory Data Collection with communities and stakeholders

Various participatory data collection methods were used through, but not limited to, simulations, group exercises, interviews and observations. The VCA activities with community members included conducting ranking exercises with overall groups in each respective community, followed by focus group discussions (women, men, local leaders, youth) that centred on particular aspects, including social (Venn diagram), individual (seasonal calendar), economic (seasonal calendar), natural (community mapping) and physical (community mapping). Key informant interviews were also conducted and represented multiple various sectors in the target communities, including interviews with the District Administrator, health workers, District Education Officer, district police and environmental health technicians for both Hatcliffe and Dzivaresekwa.

Systematizing, analyzing and interpreting the data.

Information gathered was presented by group leaders from each of the volunteer groups in each targeted community and discussed by the whole group. Information collected from Focus group discussions and key informant interviews were systematically presented in tables. Related information on vulnerabilities, risks, hazards and capacity were interpreted and consolidated in the report.

Report compilation, returning information to the communities and stakeholders, and deciding priorities and actions for transformation

VCA findings were consolidated, and the report will be shared in the second phase of the VCA where stakeholders and communities will comment and adopt the report, before development of community action plans.

Programme Implementation: Risk reduction projects with the community, turning vulnerabilities into capacities through practical actions.

After adoption of comments on the report, community action plans will be mainstreamed in the Programme's Risk reduction activities developed with the communities.

Limitations of the study

Mobilization of community members in the New Hatcliffe area did not yield the much desired attendance, an issue that could see some of their concerns and priorities, Vulnerabilities and capacities, hazards and risks being underscored. In a bid to get a true reflection of the situation in New Hatcliffe, the VCA team had to do a thorough community check, travelling through the streets within the New Hatcliffe locality and this was certainly complimented by additional random personal interviews, authorities such as councillors, police and the City Council.

By and large, this has been the first time that ZRCS has conducted a VCA in the urban setup within the context of disaster and risk reduction. Several differences were noted between the rural contexts and the urban ones which provided the VCA team with a different way of seeing and approaching different, and at times divergent, worldviews and contexts.

CHAPTER THREE

VCA FINDINGS

Introduction

This chapter presents the findings of the VCA in both suburbs of Dzivaresekwa and Hatcliffe, Harare North District. In highlighting the vulnerabilities, capacities, hazards and risks associated, findings of the various tools used for the VCA, the categories of vulnerability and capacity highlighted in the first chapter of this report are used. Additionally, cross-cutting issues are presented for each suburb before area-specific findings are presented.

Dzivaresekwa

The cross-cutting hazards emerging from the FGDs, interviews and direct observation in Dzivaresekwa area were the accumulating dump sites reaching the extent of blocking storm sewers, unavailability of safe water for domestic purposes prompting residents to use shallow wells (often filled with contaminated water), bursting sewer pipes prompting raw sewage to flow through houses and streets, access roads without speed humps posing a threat to children and other road users.

These hazards have seen the community grappling with disasters such as epidemic outbreaks including cholera and typhoid (among other abdominal ailments), road accidents involving motorists and pedestrians, prostitution and the spread of HIV/AIDS, increasing burden from HIV/AIDS, child abuse, flooding in households in low lying areas. During the rainy season, residents of Dzivaresekwa are highly vulnerable to disasters such as typhoid and cholera with the last significant month-long outbreak being recorded in December 2012. Despite households noting malaria as another disaster they face, records at Rujeko Poly Clinic suggest to the contrary, as cases of malaria are rare and far between with the majority of patients who are tested for malaria coming out negative. Additionally, there seems to be a general consensus among health personnel that typhoid now has greater prevalence than cholera, as Rujeko clinic in Dzivaresekwa recorded about 8 cases of typhoid in October 2013 as opposed to anon-occurrence of cholera cases in the year.

Vulnerability is high amongst the elderly, child-headed households, disabled people, orphaned and vulnerable children (OVCs), the unemployed youth, and children under the age of 5. Vulnerability in the area is also increased by some livelihood practices including selling of food in the streets, as well as the erratic water supply[3] which would leave people without option but to queue as reported sometimes 10 to 20 hours for their turn to get borehole water on a daily basis. This situation has further increased the vulnerability of women and girls, who in the first place have water fetching roles traditionally/culturally assigned to them. This situation on other hand has provided a lifeline for some of the unemployed youth who now thrive on selling water at various prices. Essentially, the level of vulnerability is exacerbated by the alarming levels of poverty in the area.

---

[3] FGD participants on the 28th November 2013 in Dzivaresekwa noted that for the whole month their taps had running water only on three days.

Capacities in the areas could be represented by the existence of infrastructure such as a clinic, community halls, schools that could disseminate vital hygiene promotion information, manpower/human resources (in the form of high school and tertiary education graduates domiciled in the community and who can't get gainful employment elsewhere) and collective action that could be harnessed towards solving some of the overarching issues. In the Dzivaresekwa area, Medicins sans Frontiers (MSF) is working with health institutions to compact typhoid. In this respect, clinic officials reported that when they start receiving cases of typhoid, they alert MSF who will swiftly respond with their mobile clinic. On the other hand, Dzikwa Trust, a local organization is helping out OVCs with school fees, uniforms and lunch at school. Despite the existence of a polyclinic in Dzivaresekwa, the clinic has a catchment of three wards, representing a population marginally above 99000, prompting clinic staff to be overwhelmed by the patient caseload. In as much as these represent crosscutting issues in the Dzivaresekwa suburb are concerned, we now turn to the area specific issues pertinent to each section.

Prominent area specific issues

Dzivaresekwa 1

Disaster ranking by the community FGDs in the Dzivaresekwa 1 area showed that typhoid was most common. This was equally supported by the health officials in the district, who noted that typhoid was the greatest challenge they were facing. HIV/AIDS and crime/murder emerged as the second and third most common/prevalent disasters for the area.

HAZARD	DISASTER	RANK	VULNERABILITIES	CAPACITIES
Uncollected refuse and unsafe drinking water	Typhoid outbreaks since September 2011	1	• Lack of health education for the young and adults • Limited ability to look for clean water by the old and the disabled • limited number and capacity of health workers who can't cover the whole area	• Good roads for transportation of mobile water
HIV/AIDS	HIV related deaths and the burden coming with looking after the HIV orphans	2	• Dropout rate from secondary school for girls (many engaging in risky behaviour, eg. prostitution) is high. • Existence of numerous illegal beer outlets that sell illicit beer at affordable prices promoting drunkenness and irresponsible behaviour in an area where HIV/AIDS prevalence is high. • Poverty and unemployment • Limited number of community members conducting testing and seeking treatment • Limited health facilities to adequately cover the catchment area	• Poly clinic for health education, testing, counselling and referrals • Health education in clinics and schools • Presence of ADRA (NGO) doing nutritional support for clients on ARVs • Presence of ARVs at clinic (though not sufficient supply)
Cultivated spaces without proper lighting	Crime and murder	3	• Poor street lighting • Cultivated/Agricultural areas/fields where culprits are hidden from sight • Finishing late at work/returning home walking after dark	• Presence of a police station

In addition to the three highlighted most common disasters, through the FGDs it emerged that road accidents were also noted as common.

Dzivaresekwa 2

The most common disasters in Dzivaresekwa 2 were diarrhoea, drug abuse and malnutrition.

HAZARD	DISASTER	RANK	VULNERABILITIES	CAPACITIES
Unsafe drinking water and sewer bursts	Diarrhoea	1	• Inability to collectively manage water sources • Use of contaminated water sources • Limited health promotion campaigns •	• Relatively higher water table that makes borehole drilling easier
Unemployed youth/Lack of employment opportunities	Drug abuse	2	• Redundancy of youth • Lack of counselling • Drug pipeline/accessibility of drugs	• Police station within the vicinity, though the community notes with concern the likelihood of their gainful involvement in the activities related to drug abuse hence the alleged 'voluntary' failure to curb the crime.
Lack of food	Malnutrition	3	• Limited land for urban agriculture • Unemployment and lack of means to raise money for food • Lack of external nutritional support	• Good social relations with people in farming regions especially new farmers from whom residents get maize among other basic farm commodities

Dzivaresekwa 3

HAZARD	DISASTER	RANK	VULNERABILITIES	CAPACITIES
Unsafe drinking water and sewer bursts	Abdominal ailments such as typhoid	1	• Lack of health education for the young and adults • Use of contaminated water sources • Limited health promotion campaigns	• Ability to manage water points collectively through formation of water point committees •
Lack of food	Malnutrition	2	• Unemployment and lack of means for survival • Limited land resources for agriculture/production of food • Bylaws forbidding urban agriculture • Massive acquisition of land by corporate bodies and individuals for establishing settlement gainfully.	• Vending to raise money for food
HIV/AIDS	HIV related deaths and the burden of HIV orphans, challenges in accessing treatment during	3	• Existence of numerous illegal beer outlets that sell illicit beer at affordable prices promoting drunkenness and irresponsible behaviour in an area where HIV/AIDS prevalence is high	• Poly clinic • Health education in clinics and schools • Presence of some NGO doing nutritional support for clients on ARVs

	disasters		• Poverty and redundancy	

Kuwadzana Phase 3

HAZARD	DISASTER	RANK	VULNERABILITIES	CAPACITIES
Unsafe drinking water and sewer bursts	Abdominal ailments such as cholera and typhoid	1	• Lack of health education for the young who eat dirty fruits at school • Limited ability to look for clean water by the elderly and the disabled • Limited number and capacity of health workers who can't cover the whole area	• Ability to manage water points collectively through formation of water point committees
Cultivated spaces without proper lighting	Crime and murder	2	• Poor street lighting • Cultivated areas/Agricultural areas/fields where culprits are hidden from sight • Finishing late at work/walking home after dark	• Police station within the proximity, but their patrols in such areas need to be intensified
Blocked storm sewers	Flooding in houses	3	• Uncontrolled refuse disposal • Houses in lower terrains/altitude into which flood water flows • Poor storm sewer system that is also clogged with waste	• Manpower to decongest storm sewers

Hatcliffe

The most common hazards and disasters coming out of the Hatcliffe suburb, as prioritised by community members participating in the VCA exercise include diarrhoea infections, road accidents, dog bites, HIV/AIDS and malnutrition. Equally noted as previously rare but currently commonplace in Hatcliffe is the prevalence of gender based violence.

The following area-specific disasters, vulnerabilities and capacities were noted throughout the three sections of Hatcliffe where FGDs were conducted.

Old Hatcliffe 1

HAZARD	DISASTER	RANK	VULNERABILITIES	CAPACITIES
Disused dam	Drowning	1	• Dam without a fence • Road used at night by people coming from the bar outlets • Suicidal tendencies by members of the community	• Police public relations department that can do public safety awareness campaigns
Unsafe drinking water and sewer bursts	Abdominal ailments such as cholera and typhoid	2	• No alternative sources of water • Limited access to water treatment tablets and when they are available lack of health education on their importance • Few and broken down boreholes • No/very limited water from taps maintained by the city council	• Some functional boreholes • Health education in clinics and schools
Unsafe roads/ no speed humps	Road accidents	3	• Unregulated roads close to schools and markets • Lack of law enforcement • Limited road safety education in schools	• Manpower to erect muddy speed humps on roads

Old Hatcliffe 2

HAZARD	DISASTER	RANK	VULNERABILITIES	CAPACITIES
Deep uncovered wells	Collapsing wells during excavation	1	• There are no other alternative sources of water except few distant boreholes • Some boreholes are dysfunctional • Loose soils • Limited borehole drilling knowhow	• Existence of some boreholes that could be rehabilitated
HIV/AIDS	HIV related deaths and the burden HIV orphans	2	• Existence of numerous illegal beer outlets that sell illicit beer at affordable prices promoting drunkenness and irresponsible behaviour in an area where HIV/AIDS prevalence is high • Poverty and redundancy	• Poly clinic • Health education in clinics and schools • Presence of some NGO doing nutritional support for clients on ARVs
Cultivated spaces without proper lighting	Crime and murder	3	• Poor street lighting • Poor roads prompting public transport to leave riders at unsafe distant places • Cultivated areas/fields where culprits hidden from sight • Finishing late at work/walking home after dark	•

Consortium

HAZARD	DISASTER	RANK	VULNERABILITIES	CAPACITIES
Deep uncovered wells	Collapsing wells during excavation	1	• There are no other feasible alternative sources of water • Some boreholes are dysfunctional • Loose soils • Limited borehole drilling knowhow	• Existence of some boreholes that could be rehabilitated
HIV/AIDS	HIV related deaths and the burden HIV orphans	2	• Existence of numerous illegal beer outlets that sell illicit beer at affordable prices promoting drunkenness and irresponsible behaviour in an area where HIV/AIDS prevalence is high • Poverty, unemployment and redundancy causing young girls to engage in prostitution	• Poly clinic • Health education in clinics and schools • Presence of some NGO doing nutritional support for clients on ARVs • Existence of Burial Societies and other social support groups
Cultivated spaces without proper lighting	Crime and murder	3	• Poor street lighting • Poor roads promoting public transport to leave them at unsafe distant places • Cultivated areas/fields where culprits hidden from view • Finishing late at work/walking home after dark	•

Additionally, the Venn diagrams used in the social category suggested that social networks within the community represent capacity. In this respect, relatives were noted as giving social and financial support

in times of disasters, complimented by engaging in other livelihood activities such as vegetable trading, firewood sales, trading small wares that are bought in the town or at the Mupedzanhamo flea market in Mbare suburb to the south of the town.

CHAPTER FOUR

COMMENTS AND RECOMMENDATIONS

The findings highlighted in the previous chapter reveal hazards and disasters which can be summed up as revealing inadequate resources deployed in key sectors such as health, social services, water and sanitation and infrastructural development. This situation has left the communities of Dzivaresekwa and Hatcliffe vulnerable to impending disasters. In the area of health, issues such as typhoid and cholera outbreaks are prevalent within the two areas. In addition, pressing issues related to Water and Sanitation exist, including lack of access to clean water and inadequate toilet facilities in public places. Inadequately built infrastructure including roads, bridges and overburdened clinics and schools have left the Harare North communities vulnerable and at risk. Set against this background, what is the way forward in enhancing the capacity of Harare North District in terms of disaster preparedness? This report suggests the following in working towards the attainment of the above mentioned goal:

Short-Term Recommendations

a) As a starting point, there is need to open up avenues for cooperation and building community-wide relationships and partnerships with all stakeholders and government as a gateway to their engagement

b) There must be multi-stakeholder cooperation in provision of clean water to the communities, and this can be achieved in the short term through rehabilitation of dysfunctional boreholes while drilling of new additional boreholes takes centre stage in the short to mid-term.

c) There is need to train communities to manage their resources and affairs collectively. This can be achieved through setting up and training water point and refuse management committees as well as management committees for other area specific issues

d) There must be massive effort put in by the government and other stakeholders, including the NGO sector, on Community awareness in areas such as Water and Sanitation and health concerns, such as HIV/AIDS, cholera and typhoid.

e) Emergence Nutrition support programmes supporting vulnerable households are critical in the pilot areas. The government of Zimbabwe and the WFP could partner in this regard to ensure the reduction of malnutrition within the urban areas. This programme could be wider than the current NSART programme being implemented by a local NGO, ADRA, for and on behalf of the WFP and the Government of Zimbabwe.

f) There is need for the Zimbabwe Red Cross Society to increase their volunteer base in both areas so that volunteer coverage is increased. This can be achieved through adopting a massive recruitment and first-aid training drive.

g) There is need for a holistic disaster management plan, one that is shared by key stakeholders and a community-based short- and long-term strategy.

h) There is need to engage the Traffic Safety Council of Zimbabwe among other road safety related stakeholders to comprehensively take stock of the current state of road safety in the respective areas, while at the same time re-evaluating and monitoring the dissemination of road safety information in schools.

i) Engage the city council to consider building speed humps on road closer to schools, clinics and other public areas

j) There is need for training community members by the Government and the NGO Sector on local resource mobilization and community coping mechanisms.

Long-Term Recommendations

a. The government of Zimbabwe, particularly the Ministry of Local Government and Public works through the Harare city council should ensure adequate provision of safe water in Harare North through the construction and rehabilitation of water delivery pipelines and storage facilities to ensure access to tapped water for all households, while at the same time erecting boreholes at focal points in each area for domestic use during times of emergency.

b. The engagement of the government, through the Ministry of transport to ensure Infrastructural Development and the construction of Sound and safe road networks with a possibility for ceding ownership to the communities.

c. There is also need for the government to revisit the laws governing the operations of cooperatives *vis-a-vis* the Urban Councils Act and the associated by-laws with a view of bringing sanity provision of water and sewer services in housing cooperatives' areas before construction of houses begin.

d. The government, private sector and the NGO sector need to make partnerships with various communities with a view to provide suitable livelihood options/support for the highly vulnerable groups normally burdened by the scourge of the HIV/AIDS pandemic among other vulnerable groups including unemployed youth, child- and single-headed households

e. There is need for community programmes that focus on building resources or safety nets that develop opportunities for revolving funds. These funds can then be used in the provision of critical resources to people in need.

Capacities in the District

In the implementation of the above mentioned recommendations, the local capacities listed below can be used in the attainment of the short- and long-term recommendations:

a. Manpower in the form of hard working men, women and youth.

b. Trained First Aiders in the suburbs

c. Availability of infrastructure

d. High social capital

Conclusion

Being an experimental process and at a generalised level, the urban VCA has brought to the fore various challenges that are faced by the urban populace, previously thought to be unique only to the rural communes. In particular, the Urban Vulnerability and Capacity Assessment exercise has created an invaluable awareness in the Harare North district on the prevailing risks, hazards and capacities in the area and thus provides a platform for informed planning, implementation and monitoring of priority projects identified by the communities themselves. In this respect, the basis for fighting vulnerability and enhancing both household and institutional capacities has been laid.