United Nations CERF Central Emergency Response Fund

RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS SOMALIA RAPID RESPONSE CHOLERA 2016

RESIDENT/HUMANITARIAN COORDINATOR	**Peter de Clercq**

REPORTING PROCESS AND CONSULTATION SUMMARY

a. Please indicate when the After Action Review (AAR) was conducted and who participated.

An AAR was not conducted as at the time of reporting as the Humanitarian Country Team (HCT) in Somalia was grappling with the effects of a drought that threatened to escalate into a famine and were thus were heavily engaged in the planning for a scale up of activities to respond to the crisis.

b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report was discussed in the Humanitarian and/or UN Country Team and by cluster/sector coordinators as outlined in the guidelines.

YES ☐ NO ☒

While the report may not have been discussed, the trends of the Acute Watery Diarrhoea (AWD) /cholera outbreak were tracked by WHO in collaboration with the government and partners and shared with the HCT and within the relevant participating clusters. In addition, the results of the intervention were referred to in the analysis of the trend of the current AWD- related drought conditions.

c. Was the final version of the RC/HC Report shared for review with in-country stakeholders as recommended in the guidelines (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?

YES ☐ NO ☒

Though the report was shared with the HCT prior to submission, as mentioned earlier, CERF contributions to the outbreak response and results of the interventions (as part of response updates) were shared during monthly coordination meetings with government agencies and with the HCT during the humanitarian coordination forum led by OCHA.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: Fill in		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	1,879,031
	COUNTRY-BASED POOL FUND (*if applicable*)	600,000
	OTHER (bilateral/multilateral)	3,834,534
	TOTAL	**5,713,565**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 06/06/2016			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	16-RR-CEF-075	Health	914,003
WFP	16-RR-WFP-038	Health	379,028
WHO	16-RR-WHO-030	Health	586,000
TOTAL			**1,879,031**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	1,514,024
Funds forwarded to NGOs for implementation	365,007
Funds forwarded to government partners	
TOTAL	**1,879,031**

HUMANITARIAN NEEDS

A major spike in reported cases of acute watery diarrhoea (AWD) and cholera[1] in southern and central Somalia triggered the need to significantly scale up a response to contain the outbreak. By the end of May 2016, the number of reported cases had risen to a total of 8,838, 160 per cent higher than those reported for the whole of 2015, and was projected to increase to 75,000 (15,000 severe and 60,000 moderate cases) over the next six months. The data, collected from 247 routine sentinel surveillance health facilities, also

[v1] Cholera is an infectious disease that causes severe watery diarrhoea, which can lead to dehydration and even death if untreated. It is caused by eating food or drinking water contaminated with a bacterium called *Vibrio cholerae*.

showed that 5,176 of the cases were children under age five. They also constituted 65 per cent of the 437 deaths that had been reported.
The aggregated case fatality rate (CFR) of 4.98 was more than double the threshold of 2, which would be considered an emergency by WHO among internally displaced persons (IDPs) and rural population. Similarly, the attack rates of between 1.3 and 1.9 were above the threshold of 1 for emergencies according to WHO protocols.

By the end of May AWD/cholera cases had been confirmed in 11 districts across the most affected regions including Banadir, Bay, Hiraan, Lower Juba, Lower Shabelle, Middle Juba and Middle Shabelle. Of particular concern was the confirmation of the outbreak in districts such as Jamaame, Juba region where 77 per cent (10 of 13) of stool samples had tested positive for the bacteria *Vibrio cholera* in a region that had not reported cholera over the past two years. In addition, the cholera outbreak had a high spill over rate to neighbouring districts and was likely to spread further, with very high transmission rates and deaths. Worryingly, most of the affected districts were characterized by access impediments, insecurity and population movements. Seasonal migration of people from and into surrounding districts also posed significant challenges in controlling the outbreak. Anecdotal information suggested that the number of cases was under-reported as many people did not seek treatment at health facilities and there were limited reporting mechanisms outside the urban and semi-urban areas. Health services' coverage in these districts was limited and the availability and capacity of existing partners was inadequate to respond to the outbreak.

Access to safe and clean drinking water, a key requirement to controlling the outbreak, remained a major challenge in the affected locations. Control of the outbreak was further compounded by the limited awareness of safe hygiene practices and inadequate sanitation facilities. Poor hygiene practices included the poor handling of water during collection, transportation or storage resulting in contamination; and lack of handwashing with soap at critical times. The resulting poor disposal of infectious human waste highly increased the risk of further contamination of water and subsequent increase in new cases, control challenges and new deaths.

Without urgent intervention for containment, the outbreak was likely to spread further, with the number of cases escalating above the existing and immediate surge capacity to avert a high number of avoidable deaths. While health and WASH supplies were available to cover an estimated caseload of 500 severe and 12,000 moderate cases, the projections of 75,000 cases over the coming months necessitated a significant and rapid scale up of the response. CERF funding was instrumental in supporting the required response, particularly given the unacceptably high death and transmission rates.

II. FOCUS AREAS AND PRIORITIZATION

The scale of the outbreak and its rapid development threatened to overwhelm existing response capacity. The overall humanitarian response strategy whose objective was to reduce mortality and morbidity due to the AWD/Cholera outbreak, proposed a joint multi-partner response to the most affected locations with the highest caseload and notable increase in trends in reported deaths. The strategy was developed collaboratively by the Health and WASH clusters, national and regional authorities, WHO and UNICEF, and local and international humanitarian partners. The response would be implemented primarily by the Health and WASH clusters with complementary support from the Logistics cluster.

The priority actions were both consistent with standard treatment protocols for cholera which stipulate complementary WASH and health activities as the disease is largely water borne, and were specific to the Somalia context. Measures included ensuring effective surveillance, early case detection and referral, and effective case management in parallel with ensuring access to safe drinking water and sanitation, and hygiene promotion. Specific activities included:

- Enhancing early warning surveillance with active case finding
- Training for health staff and partners on cholera case management,
- Opening/installation of Cholera Treatment Centres (CTCs) in key locations with adequate level of supplies,
- Distribution of one hygiene kit (soap, aqua tabs, bucket and jerry can) per severely affected household,
- Distribution of 200 aqua tablets per household in the affected areas,
- Hygiene promotion: leaflets, radio messages and hygiene promoters visit.

The strategy targeted 75,000 (15,000 severe and 60,000 mild/moderate) cases over the next five to six months (May to October), with the peak period between the end of July and the beginning of August. The numbers were based on WHO projections based on previous years' information and data, and included all seven affected regions namely Banadir, Bay, Hiraan, Lower and Middle Juba, and Lower and Middle Shabelle.

The strategic objective of the CERF request was to stabilize the alarming situation by containing the outbreak. This would be achieved by reducing the incidence of morbidity and mortality due to AWD/Cholera among 27,500 (5,500 severe and 22,000 mild/moderate) cases in the seven worst affected districts in Banadir, Lower Juba and Lower Shabelle regions in Somalia over a four-month period. This also coincided with the projections that 60 percent of the projected cases would occur then. An estimated 390,000 people were also expected to indirectly benefit from hygiene promotion activities and temporary access to safe water. Though CERF funds would be used only where access was assured namely Jamaame and Kismayo (Lower Juba); Wadajir, Hodan (Banadir); and Afgooye, Marka and Baarawe (Lower Shabelle), agencies would not only support partners with ongoing activities in the targeted areas but also support them to increase their staff presence in satellite referral and treatment posts. Interventions in inaccessible areas such as Middle Juba were undertaken by the International Committee for the Red Cross (ICRC) which had successfully negotiated access.

CERF funds were used to support time-critical complementary response activities planned by the Health and WASH clusters including

- Early detection and referral (HEALTH)
- Effective case management (HEALTH)
- Ensuring access to safe drinking water (WASH)
- Meeting transport costs for movement of essential supplies to targeted affected areas (LOGISTICS)
- Supporting operational costs for implementing partners (through submitting UN agency) (HEALTH and WASH)
- Replenishment of WASH and Health supplies (HEALTH and WASH)

Through partially funding a comprehensive and effective response involving the interruption of transmission, protection of those at risk and treatment of those with the disease, CERF would help stabilise and contain the outbreak.

III. CERF PROCESS

The warning of a new AWD/ Cholera outbreak was first flagged by WHO following the analysis of data from the Emergency Awareness and Response Network (EWARN) and reports from health and WASH partners implementing programmes in the affected regions.

A small task force comprising UNICEF, WHO, the WASH and Health Clusters, and OCHA met twice to discuss the situation and agree on the response strategy. The task force was also in coordination with other humanitarian actors responding to the outbreak, ensuring the widest possible coverage and debating how to address potential gaps. The task force was in contact with the Federal Ministry of Health (MoH) with which coordination meetings were planned in May. Consultations were also ongoing at regional cluster coordination mechanisms, and with local health authorities in the affected areas.

Based on the response strategy and the projection of caseload over the coming six months, a concept paper detailing the genesis of the outbreak, response strategy and resources available, ongoing response and challenges in delivery, partner capacities and resources required were presented to the HCT. Due to the time critical need to respond to the rapidly evolving epidemic, the task force recommended the application for CERF funds from its rapid response window. As mandated by the CERF guidelines, OCHA presented the recommendations to the HCT for endorsement, emphasising that CERF could only cover part (up to 30 percent) of requirements and remaining needs would have to be met from other sources of funding. Following endorsement by the HCT, the decision was made to seek CERF funding for a period of three to four months which coincided with the peak period of the outbreak. The decision making mechanism differed somewhat from that of the local pooled fund, the Somalia Humanitarian Fund (SHF), in which the HC approved the request for funding for AWD/cholera response in Kismayo from the WASH and Health Clusters. Similar to the CERF process, however,

clusters provided analytical input that informed the final decision-making process and OCHA as the pooled fund secretariat, facilitated the application process.

To foster effectiveness, the response would be jointly implemented by multiple agencies in the targeted areas. These included WHO, the lead agency for health and under whose mandate disease surveillance/early warning and outbreak response fall, and UNICEF, the leading primary health care provider and lead WASH agency. WFP through the Logistics Cluster would fill identified logistics gaps through delivering emergency life-saving emergency supplies and strategically mobilise staff to the most affected areas.

In spite of efforts thus far, lack of access and partners' presence in certain affected areas continued to hamper the response and humanitarians advocated for better access to deliver life-saving supplies. The WASH and Health clusters, together with UNICEF and WHO, assessed the response capacity in these areas through their current partners and would only use partners with whom they had partnership agreements, were already responding to the outbreak and had the capacity to scale operations upwards. To mitigate access restrictions, the WASH cluster would use its regional supply hub network to deliver supplies in as close proximity to affected areas as possible and rapidly deploy supplies within 72 hours when access opened up. To mitigate risks associated with delays in off-shore procurement of supplies, and ensure the timely implementation of activities, UNICEF planned to use available stocks and replenish these with CERF funding. Finally, to ensure seamless implementation of response and maintain coordination, the task force would continue to meet weekly to review progress.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR[1]

Total number of individuals affected by the crisis: 75,000

Cluster/Sector	Female			Male			Total		
	Girls (below 18)	**Women** (above 18)	**Total**	**Boys** (below 18)	**Men** (above 18)	**Total**	**Children** (below 18)	**Adults** (above 18)	**Total**
Health	8,548	14,556	**23,104**	9,913	15,506	**25,419**	18,461	30,062	**48,523**

[1] *Best estimate of the number of individuals (girls, women, boys, and men) directly supported through CERF funding by cluster/sector.*

BENEFICIARY ESTIMATION

The beneficiary numbers were estimated based on the available surveillance data compiled through the weekly early warning surveillance system from the AWD/cholera affected districts. All cholera treatment centres and other health facilities compiled and reported the disaggregated weekly AWD/cholera data to the regional and central surveillance offices at MoH for aggregation into weekly situation reports with WHO support. It is likely that these numbers include those from the additional 40 facilities that received Rapid Diagnostic Kits that WHO distributed as shown in the results framework.

The number of beneficiaries reached with Diarrhoeal Disease Kits (DDK) is estimated based on Health Cluster standards. The maximum beneficiaries per kit are defined in the guidelines for Interagency Emergency Health Kits (IAEHK). As per these guidelines, each DDK is designed for 100 severe cases (cholera treatment), 400 mild or moderate cases (oral rehydration unit) and 100 patients affected by Shigella dysentery. Age and gender disaggregation are estimated based on the 2016 Multiple Indicator Cluster Survey (MICS) i.e. male adults: 25 per cent; female adults: 31 per cent; boys (5-18): 11 per cent; girls (5-18)13 per cent; boys <5: 9 per cent; and girls <5: 11 per cent.

Recalling that CERF funds were also used to replenish kits that had already been used (5 for UNICEF and 10 for WHO), making a total of 70 kits that were available for the response, the number of those that directly benefitted from the DDK totalled 35,000 and are shown below.

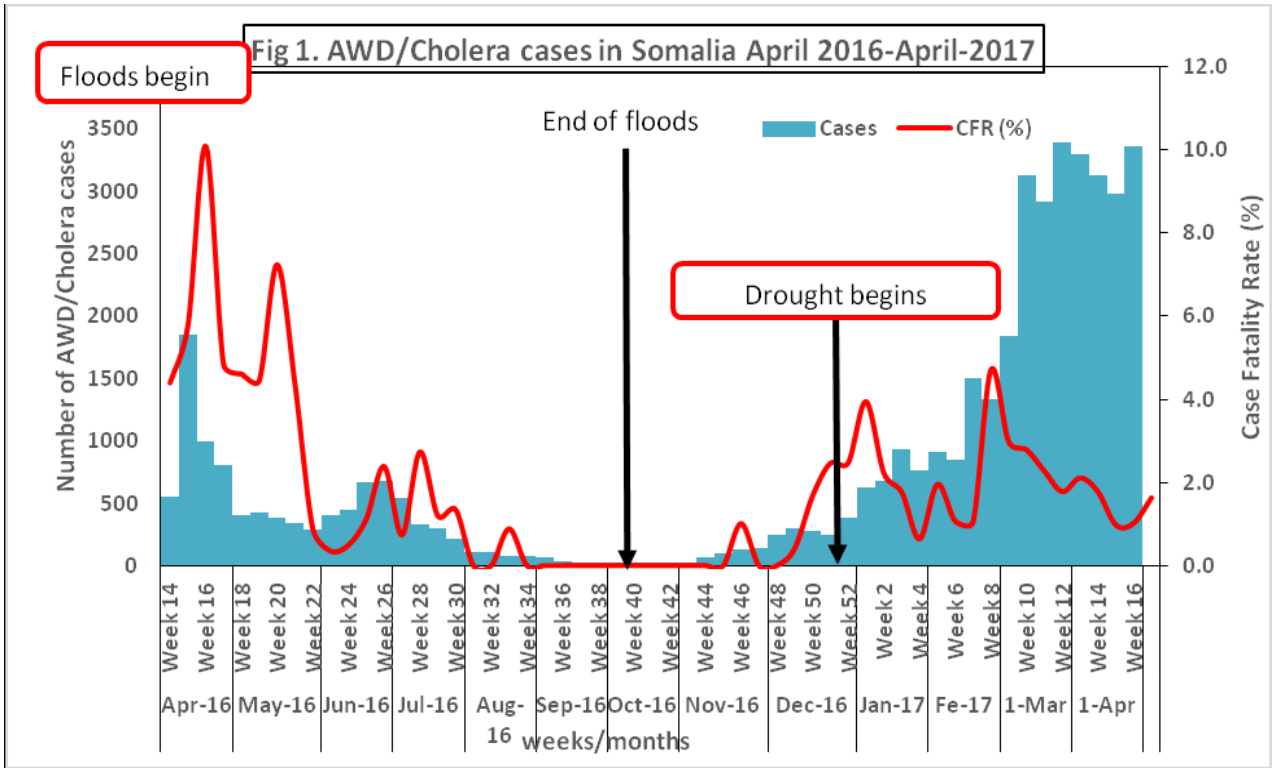
TABLE 5: TOTAL DIRECT BENEFICIARIES REACHED THROUGH CERF FUNDING[2]			
	Children (< 18)	**Adults** (≥ 18)	**Total**
Female	8,400	10,850	19,250
Male	7,000	8,750	15,750
Total individuals (Female and male)	**15,400**	**19,600**	**35,000**

[2] *Best estimate of the total number of individuals (girls, women, boys, and men) directly supported through CERF funding. This should, as best possible, exclude significant overlaps and double counting between the sectors.*

CERF RESULTS

CERF funds played a significant role in containing the AWD/Cholera outbreak in the critical four-month window resulting in a reduction in the number of cases and CFR to 1.25% at the end of the project period from 4.98% reported at the time of the CERF application. While timely treatment is effective, the primary cause is poor access to WASH services that makes the bacteria present in the environment and can easily be transmitted to the next victim. The CERF grant assisted in addressing some of these key causes, including poor water access and poor hygiene and sanitation facilities and services. The health and WASH interventions were life-saving as they disrupted the contamination route and led to an overall reduction in the case fatality rates, as depicted in the below graph.

FIGURE 1: AWD/Cholera cases in Somalia (April 2016- January 2017)



Source: AWD/Cholera Weekly Situation Report , April 13-17, 2017

CERF funding also enabled

- the treatment of 35,000 people (7,000 severe, 28,000 moderate) and using DDK. Together with the rapid diagnostic kit, an estimated 48,523 people received treatment.
- UNICEF provided WASH services to 400,000 people in AWD/cholera hotspots in Banadir, Lower Shabelle and Lower Juba regions. Of these, 34,200 (5,700 households) were reached through the distribution of hygiene kits and hygiene promotion activities.
- an estimated 12,400 persons in the areas most affected by the outbreak benefited from the protection of 31 shallow wells and installation of hand pumps to ensure safe water supply; and an estimated 56,000 people benefited from the 140 shallow wells that were chlorinated regularly during the project period. In addition, eight health facilities and cholera treatment centres (CTCs) and four internally displaced people (IDP) locations were provided with WASH facilities to help control infection.

CERF's ADDED VALUE

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?
YES ☒ PARTIALLY ☐ NO ☐

CERF funds contributed to a rapid and timely delivery of life-saving assistance to people affected by AWD/cholera. Without the CERF support, there would have likely been a higher case fatality rate. The allocation supported the timely delivery of DDKs to treat severe and moderate cases of AWD/cholera as the outbreak spiked in affected communities. The training of health workers on case management assisted in having the required health professionals to detect and treat cases at community level and refer cases to CTCs in a timely manner. CERF funds also enabled the procurement of WASH hygiene kits to support the timely expansion of AWD/cholera prevention activities across the affected districts. CERF funds also allowed humanitarian partners to promptly access logistics services in order to deliver critical aid cargo to the people in need.

b) Did CERF funds help respond to time critical needs[2]?
YES ☒ PARTIALLY ☐ NO ☐

According to WHO data, more than 15,600 AWD/cholera cases were reported in 2016 across Somalia, with a majority of children under-5 affected. AWD/cholera is endemic in Somalia and if not responded to quickly, is fatal and kills within hours. The CERF allocation proved critical in avoiding an expansion of the outbreak, as well as an increase in malnutrition rates. The response was implemented without delay thanks to the timely support of CERF and the most immediate needs of vulnerable communities were met. CERF funds enabled UNHAS to prioritise and fast track all cholera response requests.

c) Did CERF funds help improve resource mobilization from other sources?
YES ☒ PARTIALLY ☐ NO ☐

In addition to CERF funds that provided support for the initial AWD/cholera response, UNICEF received complementary funding (US$ 1,738,800) from the Office of Foreign Disaster Assistance (OFDA). WHO also reported receipts of $1,495,734 from its headquarters.

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ PARTIALLY ☐ NO ☐

CERF funds enhanced coordination amongst partners in the development of joint proposals (WFP, WHO and UNICEF) and sharing of information throughout the implementation period. The response was coordinated and implemented jointly with the regional MoH, Health

[2] Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns, locust control, etc.).

and WASH Clusters leading to complementarity and an efficient use of resources. In addition, participating agencies and implementing partners shared information monthly to ensure there was no duplication of activities in areas of operation and the progress made, at both the federal and regional levels through their respective clusters and humanitarian coordination forum led by the government agencies and OCHA.

e) If applicable, please highlight other ways in which CERF has added value to the humanitarian response

The timeliness of the CERF funding critically ensured that the outbreak was contained during the peak period ensuring continued capacity to respond.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
There is continued and regular population displacement due to conflict and natural causes leading to increasing numbers of IDPs congesting in urban areas. This exerts pressure on existing WASH facilities and services resulting in increased AWD/cholera outbreaks.	In most of the areas where interventions were implemented, longer term solutions need to be sought for the cyclic challenges of AWD/cholera outbreak during drought and flood events.	WASH and Health Clusters
Due consideration should be given to clan conflicts; it was reported that some communities could not seek medical attention due to insecurity.	In non-emergency/development programmes, consideration should be given to clan dynamics in support of the provision of services and establishment of facilities.	WASH, Health and Protection Clusters
Having multiple channels for hygiene promotion proved to be effective in containing the AWD/cholera outbreak. This should be incorporated in non-emergency response activities.	Ensure diverse and locally acceptable hygiene promotion methodologies that takes into consideration local contexts.	UNICEF and WASH Cluster
Cost-recovery mechanism for Logistics services for humanitarian agencies need to be improved. The inter-agency estimations on transport needs are rarely accurate.	The Logistics Cluster recommends the application of a cost-recovery mechanism for the transportation of humanitarian personnel and cargo. In addition, the Logistics Cluster advocates funds for the provision of logistics services to augment the Government capacity.	WFP/UNHAS

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	WHO UNICEF WFP	**5. CERF grant period:**	20/05/2016- 19/11/2016
2. CERF project code:	16-RR-WHO-030 16-RR-CEF-075 16-RR-WFP-038	**6. Status of CERF grant:**	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Health		
4. Project title:	Emergency Response to the Cholera outbreak in South Central Somalia		

7.Funding				
	a. Total project budget:	US$ 6,183,517	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 3,834,534	▪ *NGO partners and Red Cross/Crescent:*	US$ 365,007
	c. Amount received from CERF:	US$ 1,879,031	▪ *Government Partners:*	

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (below 18)	4,125	4,125	8,250	8,400	7,000	15,400
Adults (above 18)	9,818	9,432	19,250	10,850	8,750	19,600
Total	13,943	13,557	27,5003	**19,250**	**15,750**	**35,000**[4]

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs	2,750	3,500
Host population	24,750	31,500
Other affected people		

3 This target reflects the estimated number of severe and mild/moderate cases to be reached by this project. An additional 390,000 people will be reached via the WASH interventions, namely messages on AWD/Cholera.

[4]This figure reflects the number of severe and mild/moderate cases reached by this project. An additional 400,000 people were reached through WASH hygiene promotion messages

Total (same as in 8a)	**27,500**	**35,000**
In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	N/A	

CERF Result Framework			
9. Project objective	Reduce morbidity and mortality due to acute watery diarrhoea and cholera among 27,500 people in seven affected districts of Banadir, Lower Juba and Lower Shabelle, Somalia		
10. Outcome statement	AWD and cholera outbreak contained and no new cases reported		
11. Outputs			
Output 1	55 Kits procured and distributed to designated partners and health facilities for timely access to patients		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of DDK procured, imported and warehoused at appropriate locations for the cholera response	55	50
Indicator 1.2	Number of Diarrheal Disease Kits (DDK) transported to cholera affected areas and provided to implemented partners for immediate response	55	55
Indicator 1.3	Number of facilities and locations with Rapid Diagnostic Test kits	20	65
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Procure, import and warehouse 55 Diarrheal Disease Kits for immediate response, preposition and replenishment	UNICEF (20 kits), WHO (35 kits)	UNICEF (15 kits) WHO (35 kits)
Activity 1.2	Provide implementing partners with DDK for immediate response	UNICEF (20 kits), WHO (35 kits)	UNICEF (20 Kits) WHO (35 kits)
Activity 1.3	Procure 20 Rapid Diagnostic Kits and distribute them as needed	WHO	WHO
Output 2	27,500 cases of AWD/Cholera are referred in a timely manner and effectively treated		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Case fatality rate (CFR) reduced to Zero or below 1%	CFR below 1 per cent	1.25%
Indicator 2.2	Number of cases treated	>95% of target (>26125)	>100% of target (35,000)
Indicator 2.3	Number of health workers trained on case management	200	280[5]

[55] UNICEF additionally trained 50 health workers and WHO trained 230 as the needs were higher than envisaged.

Output 2 Activities	Description	Implemented by (Planned)	Implemented by (Actual)
Activity 2.1	Detect cases in the community early and refer them for treatment	WHO	WHO
Activity 2.2	Train health workers on recommended protocols for treatment of cholera	WHO	WHO/UNICEF
Output 3	390,000 persons affected or at risk of AWD/cholera infection receive means to practice safe hygiene, sanitation and household water treatment to prevent AWD/cholera transmission		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	Number of households provided with a hygiene kit	16,500	17,902[6]
Indicator 3.2	Number of persons reached with messages on AWD/cholera prevention[7]	390,000 persons	400,000 persons
Indicator 3.3	Number of health facilities/CTCs assisted with sanitation and hygiene facilities	10	12 (8 health facilities/CTCs and 4 in IDP locations)
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Procurement and replenishment of 7,000 hygiene kits distributed to affected persons	UNICEF	UNICEF
Activity 3.2	Distribution of 5,500 hygiene kits	UNICEF, ADRA, SCC, SAREDO, New Ways, other Cluster partners	UNICEF, Adventist Development and Relief Agency (ADRA), Somalia Community Concern (SCC), Samajwadi Rehabilitation and Development Organisation (SAREDO), New Ways, Norwegian Refugee Council (NRC), Juba Foundation, International Medical Corps (IMC), Cooperazione E Sviluppo (CESVI), Humanitarian Initiative Just Relief Aid (HIJRA), Polish Humanitarian Action (PAH), Shabelle Community Development Organization (SHACDO), Danish Refugee Council (DRC), Mercy Corps
Activity 3.3	Dissemination of Hygiene education and awareness messages through radio and IEC materials in seven target districts	UNICEF, ADRA, SCC, SAREDO, New Ways, other Cluster partners	UNICEF, ADRA, SCC, SAREDO, New Ways, Juba Foundation
Activity 3.4	Train 350 community hygiene promoters who will conduct household hygiene promotion visits	UNICEF, ADRA, SCC, SAREDO, New Ways, other Cluster partners	UNICEF, ADRA, SCC, SAREDO, New Ways, Juba Foundation

[6] Of the 17,902 kits distributed in this action, CERF supported procurement of 6,700 (200 more than planned); the rest were from UNICEF's resources. Of the kits procured through CERF 5,700 were distributed to 34,200 beneficiaries and the remaining 1,000 kits used to replenish those distributed earlier on.

[7] Messages will be disseminated via through radio spots, and IEC materials such as leaflets as per district communication plan

Activity 3.5	Provide 28 gender sensitive sanitation facilities with hand washing facilities in 10 health facilities	UNICEF, ADRA, SCC, SAREDO, New Ways, other Cluster partners	UNICEF, ADRA, SCC, SAREDO, New Ways, Juba Foundation
Activity 3.6	Conduct hygiene promotion activities through household visits by community health workers/promoters (CHW/P) in the seven affected districts (50 (CHW/P) per district)	UNICEF, ADRA, SCC, SAREDO, New Ways, other Cluster partners	UNICEF, ADRA, SCC, SAREDO, New Ways, Juba Foundation
Output 4	56,000 persons have access to safe water through chlorination of water sources and use of water disinfection tablets; protection of open wells		
Output 4 Indicators	**Description**	**Target**	**Reached**
Indicator 4.1	Number of shallow wells chlorinated in affected areas and Free Residual Chlorine (FRC) is maintained at 0.5mg/l throughout[8]	140	140
Indicator 4.2	Number of people in areas affected by AWD/cholera outbreak assisted with sustained access to safe water supply through protection of open shallow wells	12,000	12,400
Indicator 4.3	Number of health facilities / CTCs treating AWD/cholera cases provided with water storage facilities	10	10
Output 4 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 4.1	Procurement of emergency supplies (chlorine, hand pumps for repairing/protection of open shallow wells and water bladders.	UNICEF	UNICEF
Activity 4.2	Daily chlorination[9] of 140 wells in affected areas maintaining appropriate FRC levels	UNICEF, ADRA, SCC, SAREDO, New Ways, Cluster partners	UNICEF, ADRA, SCC, SAREDO, New Ways, Juba Foundation
Activity 4.3	Conduct water quality surveillance in seven districts affected by the AWD/cholera outbreak	UNICEF, ADRA, SCC, SAREDO, New Ways, Cluster partners	UNICEF, ADRA, SCC, SAREDO, New Ways, Juba Foundation
Activity 4.4	Rehabilitate 30 open shallow wells in areas affected by AWD/cholera outbreak	UNICEF, ADRA, SCC, SAREDO, New Ways, Cluster partners	UNICEF, ADRA, SCC, SAREDO, New Ways, Juba Foundation
Output 5	Heath and WASH emergency supplies delivered to seven districts affected by AWD/Cholera		
Output 5 Indicators	**Description**	**Target**	**Reached**
Indicator 5.1	Weight delivered of health and WASH supplies to 7 districts	349.3mt/1,551.8 m3	50.315mt/163m3
Output 5 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**

[8] This will be measured using chlorine strips after chlorination of the well

[9] Daily chlorination: the frequency to be increased if FRC becomes lower than 0.5mg/l

Activity 5.1	Contract and manage a cargo plane	Logistics Cluster / UNHAS	Logistics Cluster / UNHAS
Activity 5.2	Contract and manage a truck fleet	Logistics Cluster	Logistics Cluster
Activity 5.3	Store and transport emergency supplies from Mogadishu and deliver to the destination points and deliver to the cooperating partners	Logistics Cluster	Logistics Cluster
Output 6	Transport 30 humanitarian staff to targeted AWD/Cholera affected areas		
Output 6 Indicators	**Description**	**Target**	**Reached**
Indicator 6.1	Number of rotations[10] provided per location as planned	6	0
Output 6 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 6.1	Contract and manage a fix- wing plane for staff transport (different from the cargo plane)	Logistics Cluster/UNHAS	Logistics Cluster/UNHAS
Activity 6.2	In collaboration with OCHA, the Health and WASH Clusters, plan the necessary rotations according to the prioritized needs	Logistics Cluster/UNHAS	Logistics Cluster/UNHAS
Activity 6.3	Provide aviation services to transport humanitarian staff to and from the identified locations	Logistics Cluster/UNHAS	Logistics Cluster/UNHAS

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

UNICEF

Output 1

UNICEF had envisaged to procure and distribute a total of 20 DDKs however pre-positioned stocks were available and therefore only 15 were procured, but 20 were distributed. Savings made partially supported air transportation to hard-to-reach areas, such as Kismayo in Lower Juba region.

Output 2

The target of reducing the CFR from 4 per cent to below 1 per cent, was not reached; by project end it stood at 1.25 per cent in UNICEF targeted locations. Despite the slight difference, the intervention was deemed successful as the outbreak was contained and the case fatality rate significantly reduced.

Output 3

Savings made from budget lines related to water quality testing kits enabled UNICEF to procure 200 additional hygiene kits, enabling more beneficiaries to be reached.

At proposal design stage, it was envisaged to construct temporary emergency latrines in 10 health facilities. However, this was subsequently revised to include the construction of four latrines within the IDP settlement in Dalxiiska Camp, Kismayo. This was done

[10] A rotation is a return flight from Mogadishu to an affected location and back to Mogadishu. The fix-wing plane has a capacity of 15 passengers thus each rotation will carry up to 30 passengers.

to mitigate the risk of a major outbreak in the camp, known to be a main AWD/cholera hotspot.

WHO – As the outbreak evolved, more facilities than originally envisaged reported AWD cases necessitating the distribution of 40 more rapid diagnostic kits to meet the demand. This also meant additional numbers of health workers had to be trained (230 instead of the planned 200.

Although more severe and moderate/mild AWD/cholera patients received treatment, more deaths due to AWD/cholera were recorded within villages (within districts targeted by this intervention) controlled by *Al-Shabab* as there was limited access by the partners. To mitigate this, WHO delivered oral rehydration salts (ORS) which is the first line of management of dehydrated patients to health facilities that reported cholera cases through the polio volunteers operating in these areas. In addition, some polio volunteers established oral rehydration points (ORP) in their communities ensuring more persons accessed services despite security concerns.

WFP

Despite the accurate planning with the Health and WASH Clusters before proposal submission, the Logistics Cluster received below-estimate requests for cargo transport and no requests for staff transport during the implementation period.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

UNICEF: A joint selection of the beneficiaries to receive the hygiene kits and the DDK kits was conducted in collaboration with the MoH team. A selection committee comprising the village leadership, community representatives, health personnel, ministry officials and UNICEF implementing partners jointly undertook the selection and later supervised the distribution of the kits.

WHO has a presence in most of the target regions, and these staff continuously consulted affected populations during the planning and implementation of the project activities. Regular meetings to discuss the needs of the target communities were discussed with local authorities and community leaders were organized by WHO focal points.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
Due to the duration of the action and the nature of the activities, UNICEF did not plan an evaluation of the project. UNICEF relied on regular partner reports and its own supportive monitoring complemented with Third Party Monitoring to measure the results of the project. Third party monitoring reports corroborated results reported by the partners.	EVALUATION PENDING ☐
The cancellation of several WHO headquarter-led evaluation missions due to security concerns precluded conducting an evaluation. WFP did not conduct an evaluation. However, cargo movements were monitored during the response.	NO EVALUATION PLANNED ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
16-RR-CEF-075	Health	UNICEF	NNGO	$181,062
16-RR-CEF-075	Health	UNICEF	INGO	$24,425
16-RR-CEF-075	Health	UNICEF	NNGO	$27,804
16-RR-CEF-075	Health	UNICEF	NNGO	$51,204
16-RR-CEF-075	Health	UNICEF	NNGO	$50,512
16-RR-WHO-030	Health	WHO	NNGO	$15,000
16-RR-WHO-030	Health	WHO	NNGO	$15,000

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

ADRA	Adventist Development and Relief Agency
AWD	Acute Watery Diarrhoea
CERF	Central Emergency Response Fund
CESVI	Cooperazione E Sviluppo
CFR	Case Fatality Rate
CHP	Community Health Promoter
CHW	Community Health Worker
CSZ	Central South Zone
CTC	Cholera Treatment Centre
DDK	Diarrhoeal Disease Kits
EWARN	Early Warning and Response Network
FRC	Free Residual Chlorine
FTS	Financial Tracking Services
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HIJRA	Humanitarian Initiative Just Relief Aid
HK	Hygiene Kits
ICCG	Inter Cluster Coordination Group
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
IMC	International Medical Corps
M^3	Cubic Metres
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MT	Metric Tonnes
NRC	Norwegian Refugee Council

OCHA	Office for the Coordination of Humanitarian Affairs
ORP	Oral Rehydration Point
ORS	Oral Rehydration Salts
RSH	Regional Supply Hubs
SAREDO	Samawada Rehabilitation and Development Organisation
SCC	Somalia Community Concern
SHF	Somalia Humanitarian Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organisation