RESIDENT/HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS

NIGER

RAPID RESPONSE

CHOLERA

2018

18-RR-NER-32834

RESIDENT/HUMANITARIAN COORDINATOR	**Bintou Djibo**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

The AAR meeting did not take place because the Humanitarian Country Team has consolidated over the years a different methodology for this process. As for past CERF Rapid Response windows, the reporting form was circulated via email across recipient agencies to collect their inputs.

b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report on the use of CERF funds was discussed in the Humanitarian and/or UN Country Team.

YES ☒ NO ☐

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

YES ☐ NO ☒

The report was only shared with the recipient agencies and the rest of the members of the Humanitarian Country Team to collect and integrate their feedbacks on the document.

PART I

Strategic Statement by the Resident/Humanitarian Coordinator

3,821 cases of cholera including 78 deaths (lethality 2%) were recorded in 2018 from July 5 to November 19 according to the health authorities. The evolution of mortality and morbidity related to the cholera outbreak prompted the humanitarian coordinator to request a CERF fund to control the spread of the epidemic and to eliminate it. The funds allocated were used to meet the most urgent needs and to reduce the case fatality rate. Humanitarian actors were able to distribute medicines and hygiene kits and improve access to safe drinking water to relieve the afflicted and save lives. Sensitization and training activities were also conducted to halt the evolution of the epidemic in the affected areas and other unaffected areas. A total of 574,970 people was assisted by these funds.

1. OVERVIEW

18-RR-NER-32834 TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)	
a. TOTAL AMOUNT REQUIRED FOR THE HUMANITARIAN RESPONSE	**11,455,145**
FUNDING RECEIVED BY SOURCE	
CERF	2,274,186
COUNTRY-BASED POOLED FUND (*if applicable*)	0
OTHER (bilateral/multilateral)	0
b. TOTAL FUNDING RECEIVED FOR THE HUMANITARIAN RESPONSE	**2,274,186**

18-RR-NER-32834 TABLE 2: CERF EMERGENCY FUNDING BY PROJECT AND SECTOR (US$)			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	18-RR-CEF-116	Water Sanitation Hygiene - Water, Sanitation and Hygiene	806,924
WFP	18-RR-WFP-065	Coordination and Support Services - Common Humanitarian Air Services	473,472
WHO	18-RR-WHO-046	Health - Health	993,790
TOTAL			**2,274,186**

18-RR-NER-32834 TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Total funds implemented directly by UN agencies including procurement of relief goods	**1,816,399**
Funds transferred to Government partners*	42,272
Funds transferred to International NGOs partners*	98,891
Funds transferred to National NGOs partners*	316,624
Funds transferred to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**457,787**
TOTAL	**2,274,186**

** These figures should match with totals in Annex 1.*

2. HUMANITARIAN CONTEXT AND NEEDS

The Cholera outbreak was officially declared by Niger Ministry of Public Health on 15 July 2018. The first three cases were residents of Nigeria from Jibiya Local Government Area in Katsina State on the border with Niger. The cases, coming from the same family, reportedly had an onset of symptoms in Jibiya LGA before seeking treatment on 5 July 2018 at a health facility in a bordering town in Niger. Vibrio cholerae O1 Inaba was confirmed in stool samples from all three cases. From Madarounfa, the outbreak moved to eleven more districts: Maradi commune, Guidam Roumji, Dakoro, Aguié (Maradi region), Damagaram Takaya, Mirriah (Zinder region) and Gaya (Dosso region), Madaoua, Birni Koni, Keita, Malbaza (Tahoua region). These areas were among the most affected districts during previous outbreaks with the last major outbreak reported in Niger in 2014 involving more than 2,000 cases. These areas were classified as high-risk areas for the spread of cholera given the presence of local risk factors such as poor hygiene and sanitary conditions coupled with large volumes of population movements and trade between these districts and neighbouring areas in Nigeria. With the ongoing rainy season and the increase in cases in the neighbouring Katsina State in Nigeria, the potential for further spread of the disease both within Niger and across the border with Nigeria was high. The population in the capital city Niamey, as well as neighbouring Benin were at-risk of being affected, especially after the confirmation of cases in Dosso region, a major trading hub between the border with Benin and the capital city Niamey.

In addition, the bridge connecting Niger to Benin across the Niger River close to Gaya town had collapsed on 5 September, making difficult to maintain economic and personal links with the other countries in the region.The contemporary upsurge of cholera cases in Borno State in Nigeria also puts at-risk the population in Diffa Region given the porous borders and mass movement in this area. As of October 1, 2018, a total of 3,692 cases and 68 deaths had been reported in 12 districts of Maradi, Dosso, Zinder and Tahoua regions, while several other regions are at risk. Among them, more than 70% are aged 5 years and more. Females represented 56% of the cases (source: DRSP, WHO, October 2018). The high lethality rate observed was explained by delays in case detection. The absence of a functional community-based surveillance mechanism and an active case-finding mechanism increased the delay in diagnosis and case management. The quality of care was insufficient because of lack of supervision of actors involved in the response. Case investigations were not systematic. There was no effective joint monitoring mechanism at entry points and in border communities. There was therefore a pressing need to strengthen the quality of the surveillance and the quality of care. On 11 September 2018, WHO conducted a risk assessment and classified the risk of the epidemic spreading as very high at the national level and high at the regional level. Up to those findings, the epidemic represented a major threat for Niger, but also for the neighbouring countries in the Lake Chad Basin.
WHO also conducted a second risk analysis following the rapid spread of the epidemic. The result escalated the epidemic to grade 2 of the emergency response frameworks. An incident management system was set up and USD 695,000 were mobilised from the Contingency Fund for emergency (CFE). Support was provided to the Ministry of Public Health for the development of the National Response Plan. As a result, a WHO country support plan was developed based on MOH national response plan which emphasized on strengthening coordination, strengthening epidemiological surveillance including laboratory, improving communication and community engagement as well as strengthening prevention and infection control activities. Beyond the ongoing situation, the proximity with the Nigerian border, particularly for some of the affected health districts in the Maradi and Tahoua regions, and with Benin and Burkina Faso for Gaya (Dosso region) raised issues of cross-border monitoring, and greatly increased the risk of spread to the bordering areas of Benin and Burkina Faso, requiring urgent action to mitigate these risks.
The WASH response was limited due to insufficient financial, technical and material capacities, including supplies. Five health areas of the health district of Madarounfa and several at risk quarters of Maradi town had still not benefited from a WASH response. The health districts of Aguié and Dakoro (Maradi region) and of Konni, Malbaza, Madaoua (Tahoua region) were also left without any WASH response. The financial resources and supplies (household water treatment products, soap, cans) mobilized by UNICEF and partners to ensure the first urgent responses amounted to only US$789,771, leaving significant gaps in the WASH needs to be covered in order to tackle the epidemic.
Thus, CERF funding was sought as the best placed instrument to unlock the required response. The overall project aimed at reducing the mortality and morbidity while preventing cholera new infections at community level through the implementation of WASH-related interventions, including community-based and communication activities. The government and humanitarian partners developed a comprehensive response plan for the provision of needed urgent assistance in the sectors of Health,

Water and Sanitation including Protection and Logistics. The Health and WASH sectors were prioritized as key sector of intervention for these objectives.
The targeted population was distributed as follows:

- For Health interventions, 574,970 people from the sanitary districts of Madarounfa, Maradi city, Guidam Roumdji, Dakoro, Aguie, Mirriah, Malbaza, Birni N'Konni, Keita, Madaoua, Damagaram Takaya and Gaya;
- For WASH interventions, 177,084 people from the districts of Madarounfa, Birni N'Konni, Madaoua, Keita and Gaya;

3. PRIORITIZATION PROCESS

Through this CERF Rapid Response application, the HC, HCT and implementing partners aimed to respond to the most pressing humanitarian needs of the vulnerable populations affected by the Cholera outbreak. The planned interventions under this CERF grant detailed below were designed to complement each other to provide an integrated, basic response and contribute to prevent the geographic spread of the epidemic to other localities of Niger and neighbouring countries.
The process that resulted from this strategy included consultations with the UN cluster leads and agencies operating in the regions affected by the Cholera outbreak. In view of the rapid spreading of the outbreak in the regions affected, OCHA held several meetings with all ICC and HCT partners to discuss priority needs and disseminated communications on the latest developments. The HC prioritized the sectors and projects targeted by this CERF application. The selection of the clusters combined several factors and criteria, including the severity and level of urgency of the new humanitarian needs to kick-start activities in the prioritized sectors considered in this submission.

The main objectives of the **Heath** sector were to reinforce the coordination of the response, to strengthen capacities in early case detection, as well as the quality of care, risk communication and infection prevention measures and ensure the surveillance at entry points and border locations.

The Water, Sanitation and Hygiene (WASH) cluster aimed to reduce the mortality and morbidity while preventing cholera new infections at community level through the implementation of WASH-related activities including community-based and media communication. Indeed, the cluster planned to ensure access of 177,084 people living in affected or high-risk cholera areas to safe water and favourable hygiene practices to prevent new infections and the propagation of the outbreak. It was expected that the capacities of 50 health centres in 5 cholera affected health districts of Dosso, Maradi and Tahoua regions would have been strengthened to practice appropriate disinfection of affected households. Additionally, WASH cluster partners agreed to uphold five minimum commitments for the protection and dignity of the affected population during humanitarian crises, which would have helped strengthening their accountability.

As to **Logistics**, CERF funds was used to increase the number of regular UNHAS flights per week to Cholera-affected areas in Niger. This ensured a quick increase in time-critical activities to reduce fatality rates and further spreading of the outbreak to other areas of Niger and within the affected areas. The number of Niamey-Zinder-Maradi-Niamey flight rotations per week was increase from three rotations to five rotations. It was estimated that the increased needs for passenger travels to contain the Cholera outbreak would last 3 months (12 weeks). Allowing for a two-week preparation of the implementation of the augmented flight schedule, this means a total of 44 additional rotations were needed (2 additional rotations for 11 weeks).

4. CERF RESULTS

Through this US$2,274,186 CERF Rapid Response application, the HCT and implementing partners responded to the most pressing humanitarian needs of the vulnerable populations affected by the cholera outbreak in Niger. CERF made it possible to control the spread of the epidemic to other regions. In addition, mortality and morbidity related to the epidemic have been reduced and the spread has been mastered.

A total of 3,882 cases were treated to health sector. Otherwise, **WHO** and the Ministry of Health provided training of 50 health workers and 1000 community health workers in the 12 affected health districts on cholera early case detection, training of 50 health workers and 1000 community actors on cholera surveillance; training on 183 health workers on cholera case management; investigating 15% of cholera new cases.

UNICEF and its partners provided 23,611 households in the regions of Dosso, Maradi, and Tahoua with basic hygiene kits including household water treatment products (PUR or Aquatabs), and insured the consumption of safe water through the chlorination of 121 wells and boreholes, water containers at 49 water points as well as chlorine regular measurement for 4,145 households and water supply systems; trained 25 disinfection brigades in the 70 health care facilities equipped with disinfection materials, and disinfected 47 cholera-affected households and their surroundings; conducted awareness and hygiene promotion activities with the support of 296 community volunteers, 5,963 community radio broadcasts and 140 video projections for the adoption of cholera preventive measures in high-risk areas, benefitting 203,783 people, and distributed soap to 21,204 cholera-affected households and their surroundings and soap with 1,200 handwashing devices to 350 schools in affected areas.

Through this CERF Rapid Response grant, **WFP** provided UNHAS flight rotations to facilitate access to cholera affected areas in the regions of Dosso, Maradi, Zinder and Tahoua between November 2018 and January 2019. During the reporting period, UNHAS maintained its flexibility, a demand-driven flight schedule, often including multi-stop rotations, to help the humanitarian community meet the diverse needs of the country, including in affected areas by the cholera outbreak. During the same period, on average, Maradi the area mostly affected by the cholera outbreak was served about two times a week. In total, UNHAS carried out 31 flight rotations that included a stopover in Maradi. Of these 31 rotations, 11 also included a stop in Tahoua and seven also in Zinder two other Cholera affected areas.

5. PEOPLE REACHED

The **health** project assisted a total of 574,970 including 293,235 females (167,144 under 18 years old and 126,091 over 18 years old) and 281,735 males (160,589 under 18 years old and 121,146 over 18 years old). Regarding the **WASH** project, a total of 231,455 people including 125,323 females (46,538 under 18 years old and 78,785 over 18 years) and 106,132 males (45,542 under 18 years old and 60,590 over 18 years) were assisted from four affected regions of Maradi, Tahoua, Dosso and Zinder.
The combination of all efforts contributed to the containment of the epidemic, with no new case registered since mid-November 2018 in the affected health districts and countrywide. For the **WASH** sector, partners were positioned in each geographic area (health district) targeted for assistance, which allowed for summing the achievements of the different partners by activity and by target for overall results.
To avoid duplication, the activity figure with the highest number of beneficiaries is considered. The number of people reached by the assistance was obtained by cumulating the beneficiaries of the different activity / target partners.
For **health** sector, the beneficiary populations of this project are the populations of the health districts (departments) in the risk areas targeted by the project where we have provided epidemiological surveillance, sensitization of the entire population and the management of all the cases detected with medicines that have been ordered through this CERF project. As a result, the entire target population benefited from both surveillance and care.
With regard to duplicates, for treatment, we consider each new case detected and treated as a beneficiary, so the notion of duplication does not apply because we count the beneficiary for each "disease episode" which is different from activities, for example, NFI distribution.

18-RR-NER-32834 TABLE 4: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SECTOR[1]									
Cluster/Sector	**Female**			**Male**			**Total**		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Health - Health	167,144	126,091	**293,235**	160,589	121,146	**281,735**	327,733	247,237	**574,970**
Common Support Services - Common Logistics	0	0	**0**	0	0	**0**	0	0	**0**
WASH - Water, Sanitation and Hygiene	46,538	78,785	**125, 323**	45,542	60,590	**106,132**	92,080	139,375	**231,455**

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

18-RR-NER-32834 TABLE 5: TOTAL NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING[2]									
	Female			**Male**			**Total**		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Planned	167,144	126,091	**293,235**	160,589	121,146	**281,735**	327,733	247,237	**574,970**
Reached	167,144	126,091	**293,235**	160,589	121,146	**281,735**	327,733	247,237	**574,970**

[2] *Best estimates 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.*

18-RR-NER-32834 TABLE 6: PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY CATEGORY		
Category	**Number of people (Planned)**	**Number of people (Reached)**
Refugees	0	0
IDPs	0	0
Host population	0	0
Affected people (none of the above)	574,970	574,970
Total (same as in table 5)	**574,970**	**574,970**

6. CERF's ADDED VALUE

a) Did CERF funds lead to a fast delivery of assistance to people in need?

YES ☒ PARTIALLY ☐ NO ☐

CERF funds helped to establish early action to contain the epidemic in the affected regions and avoid its spread to new regions and districts. CERF funds have also helped to assist those affected and eliminate the epidemic.

b) Did CERF funds help respond to time-critical needs?

YES ☒ PARTIALLY ☐ NO ☐

CERF funds helped to contain the cholera epidemic by cutting the chain of transmission at the community level through WASH activities and by preventing the emergence of new cases, thus avoiding additional deaths. CERF funds were very useful and played a critical role in filling the existing financial gap for cholera-related interventions and strengthening the implementation capacities to overcome the outbreak. The rapidity with which the CERF funds have been allocated helped implementing activities in a short delay.Thus, these funds have enabled to provide appropriate response in a timely manner for critical needs.

c) Did CERF improve coordination amongst the humanitarian community?

YES ☒ PARTIALLY ☐ NO ☐

For the sectors, humanitarian coordination and information management are done through the national Cluster co-led by the concerned Ministries and UN agencies, as well as the regional epidemic management committees in affected areas.
The availability of CERF funds made it possible to mobilize implementing partners based on a call for tender conducted in close collaboration with the clusters and the Ministries. The transparency of the process reinforced the trust towards the Clusters members and accountability of the implementing partners. The number of actors involved in the response and prevention activities increased the need for strong coordination to ensure synergy and complementarity of interventions. Intersectoral WASH and Health meetings were also organized as well as cross-border meetings with Nigeria.

d) Did CERF funds help improve resource mobilization from other sources?

YES ☒ PARTIALLY ☐ NO ☐

UNICEF mobilized additional funds from Direct Aid to complement CERF funds.

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

CERF funds allowed the reinforcement of the accountability of the humanitarian community towards people affected by epidemics by saving lives and preventing the spread of epidemics, especially in a context of limited funding.

7. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT	
Lessons learned	**Suggestion for follow-up/improvement**
Rapid mobilization of partners to respond to the cholera epidemic can contain it quickly and prevent its spread to other areas.	The Rapid Response funds activation process should be made easier for epidemics with high mortality risk such as cholera.

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Inadequate community-based cholera surveillance has led to the spread of the epidemic	Strengthen the community-based surveillance system.	The Ministry of Health through the directorate in charge of epidemic oversight and response.
The prevalence of open defecation and bad hygiene and sanitation practices in affected and at-risk areas highly contributed to the spread of the cholera epidemic.	Promote the implementation of community-led total sanitation and awareness activities in cholera hotspots.	The Ministry of Water and Sanitation and the regional directorates of water and sanitation
Insufficient water points contributed to the spread of the cholera epidemic.	Prioritize the construction of new water points in cholera hotspots.	The Ministry of Water and Sanitation and regional directorates of water and sanitation

PART II

8. PROJECT REPORTS

8.1 Project Report 18-RR-CEF-116 – UNICEF

1. Project Information			
1. Agency:	UNICEF	**2. Country:**	Niger
3. Cluster/Sector:	Water Sanitation Hygiene - Water, Sanitation and Hygiene	**4. Project Code (CERF):**	18-RR-CEF-116
5. Project Title:	WASH cholera emergency response in affected and high-risk areas in Niger		
6.a Original Start Date:	24/10/2018	**6.b Original End Date:**	23/04/2019
6.c No-cost Extension:	☒ No ☐ Yes	if yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☒ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 4,000,000
	b. Total funding received for agency's sector response to current emergency:	US$ 1,837,691
	c. Amount received from CERF:	US$ 806,924
	d. Total CERF funds forwarded to implementing partners	**US$ 457,787**
	of which to	
	▪ Government Partners	US$ 42,272
	▪ International NGOs	US$ 98,891
	▪ National NGOs	US$ 316,624
	▪ Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF RR grant, UNICEF and its partners provided 23,611 households in the regions of Dosso, Maradi, and Tahoua with basic hygiene kits including household water treatment products (PUR or Aquatabs), and insured the consumption of safe water through the chlorination of 121 wells and boreholes, water containers at 49 water points as well as chlorine regular measurement for 4,145 households and water supply systems; trained 25 disinfection brigades in the 70 health care facilities equipped with disinfection materials, and disinfected 47 cholera-affected households and their surroundings; conducted awareness and hygiene promotion activities with the support of 296 community volunteers, 5,963 community radio broadcasts and 140 video projections for the adoption of cholera preventive measures in high-risk areas, benefitting 203,783 people, and distributed soap to 21,204 cholera-affected households and their surroundings and soap with 1,200 handwashing devices to 350 schools in affected areas.

The project assisted a total of 231,455 people including 125,323 females and 106,132 males and allowed the reduction of the morbidity and mortality due to the cholera epidemic while preventing new infections. The combination of all efforts contributed to the containment of the epidemic, with no new case registered since mid-November 2018 in the affected health districts and countrywide.

3. Changes and Amendments

As a very few new cases of cholera were recorded during the implementation of the project, the emphasis was put on prevention and community resilience activities, reaching thousands of people (various WASH actors, communities), therefore contributing to control the epidemic on a long-term basis.

4. People Reached

4.a Number of people directly assisted with CERF funding by age group and sex

	Female			Male			Total		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Planned	49,672	43,254	**92,926**	47,724	36,434	**84,158**	97,396	79,688	**177,084**
Reached	46,538	78,785	**125, 323**	45,542	60,590	**106,132**	92,080	139,375	**231,455**

4.b Number of people directly assisted with CERF funding by category

Category	Number of people (Planned)	Number of people (Reached)
Refugees	0	0
IDPs	0	0
Host population	0	0
Affected people (none of the above)	177,084	231,455
Total (same as in 4a)	**177,084**	**231,455**

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	As a very few new cases of cholera were recorded during the implementation of the project, the emphasis was put on prevention and community resilience activities, reaching thousands of people (various WASH actors, communities), therefore contributing to control the epidemic on a long-term basis.

5. CERF Result Framework

Project Objective	Contribute to the reduction of morbidity and mortality due to cholera epidemic while preventing new infections at community level in three regions (Maradi, Tahoua, Dosso) affected by cholera in Niger

Output 1	177,084 people (including 92,926 women and 84,158 men) living in affected or high-risk cholera areas have access to safe water and favourable hygiene practices to prevent new infections and the propagation of the outbreak			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 1.1	% of newly declared cholera patients' concessions (and neighbouring concessions), including public places at risk, disinfected according to the national protocol.	80%	100%	Implementing partners reports Field mission reports of the regional directorates of water and sanitation
Indicator 1.2	Number of households benefiting from a basic hygiene kit (water treatment product, soap)	3,162	23,611	Implementing partners reports Field mission reports of the regional directorates of water and sanitation

Indicator 1.3	% of the water quality tests (residual chlorine) in households conform to the standards (≥ 0.2 mg/l)	80%	88%	Implementing partners reports Field mission reports of the regional directorates of water and sanitation
Indicator 1.4	Number of schools in the targeted area equipped with hand washing devices and soap and implementing daily awareness and hygiene promotion activities	400	350	Implementing partners reports Field mission reports of the regional directorates of water and sanitation
Explanation of output and indicators variance:		The project had planned to distribute basic hygiene kits to 3,162 households but, in the end, a total of 23,611 households benefitted from them. The reason for this significant increase is the following: there was a very small number of new cholera cases registered, therefore, the project was reoriented towards prevention activities by covering population living in areas at high risk for cholera to prevent a new outbreak. The project had planned to equip 400 schools with handwashing devices and soap, but it reached 350 schools, which is the actual number of schools in the targeted area. In addition, 40 health centres in the region of Maradi were also equipped with handwashing devices and soap.		

Activities	**Description**	**Implemented by**
Activity 1.1	Signing of MoUs with selected implementing partners	UNICEF
Activity 1.2	Distribution of basic hygiene kits including water treatment products (PUR in communities using surface water sources and Aquatab in communities with modern water points) to ensure household water treatment (HWTS) for 25,298 households	ISCV, CISP, VP and ADESA
Activity 1.3	Systematic disinfection of cholera affected households (and surrounding concessions), public places and sources of contamination (chlorination of wells and boreholes close to suspected outbreaks of cholera) for 3,162 households	ISCV, CISP, VP and ADESA
Activity 1.4	Community mobilization, awareness and hygiene promotion for the adoption of preventive measures in high-risk areas (hand-washing with soap and water treatment promotion) at household level, in public places for 177,085 people through local radios, community volunteers, and video films projections	ISCV, CISP, VP and ADESA
Activity 1.5	Chlorination of water in transport containers at 100 water points (wells, boreholes, hydrants, etc.), cholera treatment centres in affected areas	ISCV, CISP, VP and ADESA in collaboration with DRHA of Maradi, Dosso and Tahoua regions
Activity 1.6	Monitoring of water quality (measurement of the level of residual chlorine) at household level and in water supply systems	ISCV, CISP, VP and ADESA in collaboration with DRHA of Maradi, Dosso and Tahoua regions
Activity 1.7	Hygiene awareness and promotion, including the provision of hand washing devices and soap in 400 schools in the affected areas	ISCV, CISP, VP and ADESA in collaboration with DRHA of Maradi, Dosso and Tahoua regions

Output 2	The capacities of 50 health centres in 5 cholera affected health districts of Dosso, Maradi and Tahoua regions are strengthened to practice appropriate disinfection of affected households			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 2.1	Number of health centres in affected regions equipped with disinfection material and with strengthened capacities for the disinfection of households respecting the standards for isolation of cases	50	30	Implementing partners reports
Explanation of output and indicators variance:		The difference between the target number of health centres (50) and the number achieved (30) is explained by the fact that other partners had already positioned themselves to equip some of the health centres targeted by UNICEF in Maradi and Tahoua regions. The unused funds were redirected to equip the health centres covered by this CERF funding with additional equipment for the management of biomedical waste, hygiene materials (metal, toasting and plastic bins, plastic bucket, wheelbarrows, brooms, dishcloths, bleach, soap, aquatabs) and communication materials in addition to disinfection and protection equipment.		

Activities	**Description**	**Implemented by**
Activity 2.1	Provision of equipment and disinfectants (pulverizators, HTH and hygiene kit) for 50 health centres and districts in affected areas;	ISCV, CISP, VP and ADESA in collaboration with Health Districts and health centres in target areas
Activity 2.2	Setting up and training of disinfection brigades in 50 health centres and health districts	ISCV, CISP, VP and ADESA in collaboration with Health Districts and health centres in target areas
Activity 2.3	Distribution of soap for 6,324 cholera affected and surrounding households	ISCV, CISP, VP and ADESA in collaboration with Health Districts and health centres in target areas

Output 3	The coordination of the WASH and communication response is strengthened			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 3.1	Number of bi-weekly coordination meeting held under the leadership of the Ministry of Water and Sanitation (Regional directorate of water and sanitation) in each affected region	8	10	Reports and presentations of the regional epidemic management committees and the regional directorates of water and sanitation.
Indicator 3.2	Percentage of implementing partners of each health district participating in the coordination meetings	100%	100%	Reports and presentations of the regional epidemic management committees and the regional directorates of water and sanitation.
Indicator 3.3	Number of bi-weekly coordination reports developed and shared by region	8	9	Reports and presentations of the regional epidemic management committees and the regional directorates of water and sanitation.

Explanation of output and indicators variance:	No significant variance compared to the initial planning.	
Activities	**Description**	**Implemented by**
Activity 3.1	Organization of bi-weekly coordination regional/district level meetings	Regional directorates of public health Regional directorates of water and sanitation
Activity 3.2	Elaboration and sharing of the coordination meetings' reports	Regional directorates of public health Regional directorates of water and sanitation

6. Accountability to Affected People

A) Project design and planning phase:

This project was designed to strengthen the ongoing response to the cholera outbreak in Dosso, Maradi, and Tahoua. The feedback received from people previously affected by cholera and the ones at risk of being affected, as well as the challenges linked to the criticality and rapid spread of the outbreak were considered in the design and the planning phase of the project, based on field implementation lessons learnt and monitoring missions.

In addition, to strengthen the accountability of the WASH Cluster partners, they signed up to five minimum commitments for the protection and dignity of the people affected by humanitarian crises. The results and recommendations of a study on the consideration of protection in WASH interventions carried out in Diffa were capitalized and considered during the implementation of this CERF-funded project.

B) Project implementation phase:

As most of the interventions of the project were community-based, the affected and/or at-risk population was thoroughly informed about the activities that were going to be conducted to overcome the epidemic and they were involved in the implementation of most of the activities. 296 community volunteers were mobilized and trained for the intervention and played a key role with regards to information and awareness raising for the population in affected or at-risk areas to adopt and maintain good WASH practices. Their mobilization and active participation in the activities were essential factors of success.

The project paid attention to the specific needs of women, accounting for 56% of the overall cholera cases registered in 2018. This was done during the distribution of hygiene kits and the conduction of awareness-raising activities.

Teachers and students took part in the implementation of activities, mostly in schools, including handwashing with soap and awareness-raising on cholera. They also contributed to amplifying the messages in households. Moreover, the feedback received from the community members, community volunteers, teachers, students, and caregivers were considered and used to adapt the response when needed and also to document the lessons learnt from the outbreak for the future.

C) Project monitoring and evaluation:

The monitoring of the compliance with the five minimum protection commitments by the Global WASH Cluster was ensured during the supervision of activities in the field. Partners were asked to report on these commitments.

In addition to supervision missions conducted by government staff, UNICEF carried out programmatic visits in affected areas to ensure the quality and effectiveness of the response. Bi-weekly coordination meetings served to reinforce the monitoring of the response and identify potential bottlenecks in order to address them.

A final multi-stakeholders capitalization workshop was organized for 81 actors involved in the response (ministries of health and water and sanitation, regional, district and municipal level WASH, health and communication actors of the regions of Dosso, Maradi, Tahoua and Zinder- one of the regions affected by cholera but not covered by this CERF fund) to draw lessons from the management of the 2018 epidemic to be better prepared for the future.

7. Cash-Based Interventions

Did the project include one or more Cash Based Intervention(s) (CBI)?

Planned	Actual
No	No

8. Evaluation: Has this project been evaluated or is an evaluation pending?	
No external evaluation of the project was planned, but a final capitalization workshop was organized with the participation of 81 actors involved in the response to draw lessons from the 2018 outbreak. On one hand, the high prevalence of open defecation and the insufficiency of safe drinking water, as well as the absence of community-based cholera mechanisms, were identified as the major factors linked to the spread of the outbreak, and several recommendations were formulated for improvement. On the other hand, the rapid disinfection of households with proven cases and of water points and the adoption of household water treatment methods as well as the good collaboration of regional and local authorities and the coordination of the interventions enabled to contain the epidemic.	EVALUATION CARRIED OUT ☐ EVALUATION PENDING ☐ NO EVALUATION PLANNED ☒

8.2 Project Report 18-RR-WHO-046

1. Project Information			
1. Agency:	WHO	**2. Country:**	Niger
3. Cluster/Sector:	Health - Health	**4. Project Code (CERF):**	18-RR-WHO-046
5. Project Title:	Rapid response to cholera outbreak in Niger		
6.a Original Start Date:	15/09/2018	**6.b Original End Date:**	14/03/2019
6.c No-cost Extension:	☒ No ☐ Yes	if yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☒ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 6,629,480
	b. Total funding received for agency's sector response to current emergency:	US$ 695,000
	c. Amount received from CERF:	US$ 993,790
	d. Total CERF funds forwarded to implementing partners	**US$ 0**
	of which to:	
	▪ Government Partners	US$ 0
	▪ International NGOs	US$ 0
	▪ National NGOs	US$ 0
	▪ Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance

The project was implemented as planned. This CERF funding has helped to reduce morbidity and mortality related to this cholera outbreak and thus save lives. This include management of 3,882 cholera cases but also prevent further spread of cholera to non-affected areas. Through this CERF grant, WHO and the Ministry of Health (MoH) provided training of 50 health workers and 1000 community health workers in the 12 affected health districts on cholera early case detection, training of 50 health workers and 1000 community actors on cholera surveillance; training on 183 health workers on cholera case management; investigating 15% of cholera new cases.

This CERF funding helps WHO to provide drugs and medical supplies which contributed to proper case management, lethality has been maintained at 2% saving 98% of a sure death if treatment was not given in time. Ten (10) Cholera Central Reference kit, forty (40) cholera community kits, twenty (20) cholera periphery kit, forty (40) cholera investigation kit, twenty (20) cholera laboratory kit (100 samples each) and ten (10) cholera hardware kits to manage cholera cases were procured and delivered.

The project assisted a total of 574,970 inhabitants from four affected regions Regions of Maradi, Tahoua, Dosso and Zinder.

3. Changes and Amendments

There were no changes or amendments.

4. People Reached

4.a Number of people directly assisted with CERF funding by age group and sex

	Female			Male			Total		
	Girls (< 18)	Women (≥ 18)	Total	Boys (< 18)	Men (≥ 18)	Total	Children (< 18)	Adults (≥ 18)	Total
Planned	167,144	126,091	**293,235**	160,589	121,146	**281,735**	327,733	247,237	**574,970**
Reached	167,144	126,091	**293,235**	160,589	121,146	**281,735**	327,733	247,237	**574,970**

4.b Number of people directly assisted with CERF funding by category

Category	Number of people (Planned)	Number of people (Reached)
Refugees	0	0
IDPs	0	0
Host population	0	0
Affected people (none of the above)	574,970	574,970
Total (same as in 4a)	**574,970**	**574,970**

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	There were no discrepancies.

5. CERF Result Framework

Project Objective	Support the efforts of the Government of Niger to reduce the morbidity and mortality associated with the current cholera epidemic, to prevent the geographic spread of the epidemic to other localities in Niger and to neighbouring countries.

Output 1	Early case detection capacities are strengthened (at entry points and border locations) including laboratory			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 1.1	50% of affected regions and districts have a responsive surveillance system with a community component for early detection of the epidemic	50 % (2)	50%	Cholera outbreak evaluation report
Indicator 1.2	50 health workers and 1000 community actors are trained on cholera surveillance;	1050	1050	Cholera outbreak evaluation report
Indicator 1.3	At least 10% of new cases of cholera are investigated;	10 % (50)	15%	Cholera outbreak evaluation report
Explanation of output and indicators variance:		Epidemiological investigations were conducted by WHO and MoH, up to 15% of new cases.		

Activities	**Description**	**Implemented by**
Activity 1.1	Organize per month 4 active case searches in affected and at-risk areas through field visits coupled with risk communication;	WHO deployed teams and MoH

Activity 1.2	Organize by month 4 active surveillance for cholera cases in border localities with Nigeria through field visits coupled with risk communication;	WHO deployed teams and MoH
Activity 1.3	Organize the epidemiological investigation of at least 10% of the new cases notified	WHO deployed teams and MoH
Activity 1.4	Strengthen sentinel surveillance at 5 entry points in Maradi, Gaya, Tahoua and Diffa;	[WHO deployed teams and MoH]
Activity 1.5	Train 500 community health worker on community-based cholera surveillance in 250 villages in risk areas	[WHO deployed teams and MoH]
Activity 1.6	Providing regions with 150 carry-blair media and 500 cholera rapid diagnostic tests	[WHO deployed teams and MoH]

Output 2	Quality of care, risk communication and infection prevention measures are strengthened			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	All support structures have drugs and medical supplies and procedures for case management	100 % CTC	100%	Donation Certificate and report of receipt of medicines and medical equipment by the health district
Indicator 2.2	120 health workers are refreshed on cholera management in affected and at-risk areas	120	183	Training report
Explanation of output and indicators variance:		In total 183 health workers from affected health districts and at-risk areas attended the training		

Activities	**Description**	**Implemented by**
Activity 2.1	Provide CTCs, ORPs and other support structures with medicine, medical supplies and standard operating procedures, SoPs/Protocols/Guidelines;	WHO
Activity 2.2	Establish 50 oral rehydration points in villages in affected districts	WHO and MoH
Activity 2.3	Refresh 120 health workers on cholera management in affected and at-risk areas	WHO and MoH

6. Accountability to Affected People

A) Project design and planning phase:

During the situation assessment and epidemic risk analysis exercises to determine urgent needs among affected people, WHO used the bottom-up approach for collecting information from the affected population. The WHO teams and the Directorate of Surveillance and Response to Epidemics (DSRE) used key people from the community and members of partner organizations grouped into the national committee for epidemic management (CNGE), the health cluster and the country humanitarian team (EHP) for needs identification and action planning. A national response plan has been developed. All this information has enabled WHO to define the priority needs and ultimately the writing of this project.

B) Project implementation phase:

This project was implemented in partnership with the Ministry of Health, especially with the office in charge of epidemiological surveillance response to epidemics (DSRE), and the regional public health directorates of the regions of Maradi, Tahoua, Dosso and Zinder. WHO provided cholera treatment kits (drugs and medical supplies). The Regional Public Health Departments oversaw making available drugs

and medical supplies provided by WHO in the various health districts where cholera treatment was organized in the 4 affected regions. A team of international and national WHO experts together with MoH experts conducted supervision to make sure that drugs and medical supplies are correctly used, and guidelines are correctly implemented.

C) Project monitoring and evaluation:

Project monitoring and evaluation has been conducted by WHO throughout epidemiological surveillance and shared to partners during the outbreak period and a special evaluation was carried out at the end of the epidemic. Finds were disseminated to all stakeholders and presented during a special feedback meeting (MoH, health cluster). An After-action Review (AAR) is planned to be conducted in August 2019 in order to identify best practices and weaknesses for improvement in the years to come.

7. Cash-Based Interventions

Did the project include one or more Cash Based Intervention(s) (CBI)?

Planned	Actual
No	No

8. Evaluation: Has this project been evaluated or is an evaluation pending?

There was an evaluation carried out. The followings are the main key findings:

- The risk factors are identical to those of previous epidemics and always correlated to poverty: lack of drinking water, deleterious environment and risky behaviours;
- The response has been limited for too long to the medical component in treatment centers set up. This reduced the global lethality to 2%, but also allowed the epidemic to last 21 weeks and spread in four regions.
- Despite the existence of coordination mechanisms within the MoH and within the United Nations system, everyone in their field has been slow to make the right decisions, to mobilize adequate resources and to implement the necessary activities.
- • Challenges remain the same and risk factors are still ubiquitous. The way forward is a better management in the first hours following appearance of a suspected case especially in 'at risk' districts

EVALUATION CARRIED OUT ☒

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☐

8.3 Project Report 18-RR-WFP-065

1. Project Information			
1. Agency:	WFP	**2. Country:**	Niger
3. Cluster/Sector:	Coordination and Support Services - Common Humanitarian Air Services	**4. Project Code (CERF):**	18-RR-WFP-065
5. Project Title:	Increase of regular flight rotations to respond to Cholera outbreak		
6.a Original Start Date:	30/10/2018	**6.b Original End Date:**	29/04/2019
6.c. No-cost Extension:	☒ No ☐ Yes	if yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☒ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 32,400,000
	b. Total funding received for agency's sector response to current emergency:	US$ 25,900,000
	c. Amount received from CERF:	US$ 473,472
	d. Total CERF funds forwarded to implementing partners	**US$ 0**
	of which to:	
	▪ Government Partners	US$ 0
	▪ International NGOs	US$ 0
	▪ National NGOs	US$ 0
	▪ Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance

Through this CERF Rapid Response Grant, WFP provided UNHAS flight rotations facilitating access to Cholera-affected regions – i.e. the regions of Dosso, Maradi, Zinder, and Tahoua – between November 2018 and January 2019. In the given period, UNHAS maintained its flexible, demand-driven flight schedule, often including multi-stop rotations, to serve the humanitarian community in responding to various needs in the country, including in areas affected by the Cholera outbreak.

In a cost-efficient manner, UNHAS conducts flight rotations with multiple stops, serving several flight destinations in one go. The number of rotations and the frequency by which a destination is served is based in close consideration of user demands and resource availability. Between November 2018 and January 2019, on average, Maradi – the area mostly affected by the cholera outbreak - was served about two times a week. In total, UNHAS carried out 31 flight rotations that included a stopover in Maradi. Of these 31 rotations, 11 also included a stop in Tahoua and seven also in Zinder – two other Cholera-affected areas.

Feedback received from users in 2018 indicates high satisfaction with the UNHAS service in Niger, an online survey found 90 percent satisfaction for all categories (service, responsiveness, flight schedule, etc.).

3. Changes and Amendments

The CERF Rapid Response Grant was formulated in September/October, when the number of new Cholera cases peaked. In September, over 400 new cases were registered in some weeks. The hotspot of the epidemic was the Maradi region, but the virus had spread to Tahoua, Dosso and Zinder regions and in mid-September WHO issued a warning about a high risk of spreading into further regions of Niger.

In the beginning of October, the amount of new cases dropped rapidly to below 50 per week and to below 5 cases by the end of the month. By the end of November 2018, no new cases were registered. No new regions were affected.
Consequently, the demand for flight rotations to respond to the Cholera epidemic also dropped. While in August, September and October 2018, UNHAS was reacting to an unusual high demand for flights to Maradi and Tahoua, from November 2018 to January 2019 the demand for flights to Maradi and Tahoua had dropped to pre-Cholera epidemic levels.

4. People Reached

4.a Number of people directly assisted with CERF funding by age group and sex

	Female			Male			Total		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Planned	0	0	**0**	0	0	**0**	0	0	**0**
Reached	0	0	**0**	0	0	**0**	0	0	**0**

4.b Number of people directly assisted with CERF funding by category

Category	Number of people (Planned)	Number of people (Reached)
Refugees	0	0
IDPs	0	0
Host population	0	0
Affected people (none of the above)	0	0
Total (same as in 4a)	**0**	**0**
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	

5. CERF Result Framework

Project Objective	Provision of Humanitarian Air Service in Niger

Output 1	Increased demand of travel and cargo transport by air to Cholera-affected territories in Niger is met throughout the duration of the Cholera outbreak response (3 Months)			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 1.1	MT of assistance airlifted	10,000	1,018	UNHAS flight statistics (cargo lifted to Maradi, Tahoua, Zinder and Niamey)
Indicator 1.2	Passengers transported	500	983	UNHAS flight statistics (Maradi, Tahoua and Zinder)
Indicator 1.3	Number of Cholera-affected beneficiaries assisted	6,000	3,822	WHO statistics

				(Total Cholera cases in Niger in 2018)

Explanation of output and indicators variance:	The results of indicator 1.1 shows that the need for transportation of medical equipment and other humanitarian assistance items was lower than expected, too. The Cholera outbreak was largely contained after October, and no further areas were affected, thus there was no need to put in place additional Cholera treatment centres. The results of indicator 1.2 shows that despite the positive evolution of the outbreak many aid workers still had to travel into the area to provide humanitarian assistance, linked either directly to the Cholera outbreak or to address the negative effects on the livelihoods of the population in affected areas. The low quantity of MT of assistance airlifted (see result of indicator 1.3) shows that the Cholera outbreak affected less people than expected at the proposal stage.

Activities	**Description**	**Implemented by**
Activity 1.1	Drafting and dissemination of updated flight schedule	UNHAS
Activity 1.2	Regular flight rotations Niamey-Maradi-Niamey (incl. stopovers in Zinder and Tahoua)	UNHAS

6. Accountability to Affected People

N/A

7. Cash-Based Interventions

Did the project include one or more Cash Based Intervention(s) (CBI)?

Planned	**Actual**
No	No

8. Evaluation: Has this project been evaluated or is an evaluation pending?

CERF fund was used to ensure an increase of flight rotations during the Cholera epidemic on a specific leg of UNHAS flight schedule. UNHAS operations in general are constantly evaluated but no specific evaluation of this increase in flight rotations was deemed necessary. UNHAS is considered a critical service by the whole humanitarian community in Niger, in order to respond quickly and in an efficient manner to shocks and multisectoral humanitarian needs. The fact that UNHAS was already active at the time of the Cholera outbreak allowed a more efficient response, and the CERF funding contributed to sustain this service for humanitarian partners addressing cholera-outbreak related assistance.
WFP's Aviation Security Unit carried out an evaluation mission in October 2018, recommending some adjustments of passenger and bag handling procedures. A second evaluation mission was carried out by WFP's Aviation Quality Assurance unit in December to assess compliance with UNHAS standard operation procedures.

EVALUATION CARRIED OUT ☐

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☒

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner
18-RR-CEF-116	Water, Sanitation and Hygiene	UNICEF	NNGO	$154,980
18-RR-CEF-116	Water, Sanitation and Hygiene	UNICEF	INGO	$98,891
18-RR-CEF-116	Water, Sanitation and Hygiene	UNICEF	NNGO	$65,758
18-RR-CEF-116	Water, Sanitation and Hygiene	UNICEF	NNGO	$95,886
18-RR-CEF-116	Water, Sanitation and Hygiene	UNICEF	GOV	$36,353
18-RR-CEF-116	Water, Sanitation and Hygiene	UNICEF	GOV	$2,708
18-RR-CEF-116	Water, Sanitation and Hygiene	UNICEF	GOV	$3,211