RESIDENT/HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS

RWANDA

RAPID RESPONSE

Ebola Readiness

2019

19-RR-RWA-33824

RESIDENT/HUMANITARIAN COORDINATOR	**FODE NDIAYE**

REPORTING PROCESS AND CONSULTATION SUMMARY	
a. Please indicate when the After Action Review (AAR) was conducted and who participated.	19 September 2019
The AAA took place on the 19 September with the two participating Agencies: WHO and UNICEF. The achievements and challenges around the project funded with the CERF grant were discussed during the meeting, as well as the methodology to issue the final report.	
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 ☐
N/A	
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 ☐
WHO and UNICEF shared and discussed the findings of the final reports with the Ministry of Health in Rwanda, who is the key implementing partner.	

PART I

Strategic Statement by the Resident/Humanitarian Coordinator
CERF grant enabled WHO, UNICEF and partners to address the most urgent needs on Ebola Virus Disease (EVD) preparedness at a time when no other funds were available. The CERF allocation was implemented by the UN Agencies in Rwanda from January to July 2019 to support the preparedness of the country for potential spread of the EVD outbreak in Rwanda from the Democratic Republic of Congo (DRC). The CERF grant was seed money and catalyst that enabled the scale up of priority EVD preparedness activities, by addressing the gaps in strengthening capabilities for detection and response to the EVD outbreak. WHO and UNICEF worked closely under the leadership of the Ministry of Health on key areas of achievements including enhancing capacity for prevention, early detection and timely response to potential EVD cases in the community and refugee population in Rwanda. More specifically, surveillance system and capacities for safe case management and containment of confirmed EVD cases were strengthened ; health care and frontline workers were protected through vaccination; medical equipment and supplies required for EVD prevention and control were availed ; EVD prevention and control messages and spots aired on radios and TVs reached populations across the country in both priority and non-priority districts resulting in increased awareness of EVD risks, prevention and control messages among the community and general population. This increased community awareness and understanding is critical for early detection and reporting and for implementation of timely and effective response. While the WHO intervention for risk communication and awareness creation through radio and TV spots reached young and older populations of Rwanda (15 years and above), with access to radios and TVs, the UNCEF strategy of focussing on children of school going age, other vulnerable population, and targeted household and community level mobilisation including strengthening WASH at community level were complimentary in ensuring the mobilization and creation of awareness among all potential "at risk" population. The capacities for EVD operational readiness to respond and contain potential EVD cases were further tested and strengthened through integrated drills and simulation exercises which were instrumental in identification of areas requiring further support. Overall, the project beneficiaries are estimated at 9,715,981 which is higher than the initial target, as the number priority districts changed from 12 to 15, due to the increased risk for potential spread of the outbreak during the implementation of the activities. The estimated figure includes both direct beneficiaries and indirect population reached through media outreach, on risk communication activities

1. OVERVIEW

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)	
a. TOTAL AMOUNT REQUIRED FOR THE HUMANITARIAN RESPONSE	**7,800,000**
FUNDING RECEIVED BY SOURCE	
CERF	1,798,007
COUNTRY-BASED POOLED FUND (if applicable)	N/A
OTHER (bilateral/multilateral)	2,166,140
b. TOTAL FUNDING RECEIVED FOR THE HUMANITARIAN RESPONSE	**3,964,147**

TABLE 2: CERF EMERGENCY FUNDING BY PROJECT AND SECTOR (US$)			
Date of official submission: 16/01/2019			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	19-RR-CEF-004	Water Sanitation Hygiene - Water, Sanitation and Hygiene	398,007
WHO	19-RR-WHO-002	Health - Health	1,400,000
TOTAL			**1,798,007**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Total funds implemented directly by UN agencies including procurement of relief goods	**1,583,743**
Funds transferred to Government partners*	162,537
Funds transferred to International NGOs partners*	0
Funds transferred to National NGOs partners*	51,727
Funds transferred to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**214,264**
TOTAL	**1,798,007**

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

2. HUMANITARIAN CONTEXT AND NEEDS

The Rwanda Ebola Virus Disease Early Action project was developed in response to the ongoing outbreak of Ebola Virus Disease (EVD) in the Democratic Republic of Congo (DRC) to ensure operational readiness capacities in Rwanda to timely detect, respond to and contain any potential spread of the outbreak from DRC. The DRC declared an outbreak of the EVD in August 2018, with the epi-centre in North Kivu and Ituri provinces. Major risk factors for spread beyond the national borders of the DRC included proximity to outbreak affected areas and large-scale movement of goods and people across borders with DRC. Rwanda, together with Uganda, South Sudan and Burundi, were assessed by WHO to have the greatest risk of potential spread based on current risk factors and were therefore classified as priority 1 countries for EVD scaled up preparedness activities.

Concerted efforts by the Government of DRC and partners to contain the outbreak encountered multiple challenges that included insecurity and limited population access with an observed increase in the number of reported cases, a widening of the affected geographical areas, coupled with persistent and increased risk of potential spread to Rwanda and other neighbouring countries like Uganda. With further limited access to affected communities to deliver the desired public health interventions for containment of the outbreak, the risk to spread was heightened. Some factors showed that the outbreak in DRC was not about to be contained, and there were persisting risks for Rwanda. This situation was further complicated by the electoral and political instability in DRC created massive population influx from DRC (including from the Ebola affected Provinces) into Rwanda with increased threat for introduction of the virus into Rwanda.
The Refugees and the Rwandese returnees from DRC were considered and integrated in the national EVD preparedness plan. Six refugee camps and four transit centers were within the priority areas of interventions and are benefiting from the EVD preparedness interventions. Interventions to date were focused on sensitization and awareness for EVD prevention and control, screening of new arrivals of refugees and Rwandese returnees and monitoring for fever while in transit centers, EVD surveillance, training on case detection and referral, and training on Infection prevention and control by respective pillars.

After the CERF proposal was endorsed, the persistence and spread of EVD in DRC closer Rwanda border and exportation of cases to Uganda, led to increase in high priority districts from 12 to 15, Points of Entry (POEs) requiring screening increased

from 18 to 21. The number of hospitals, health facilities, health workers, and beneficiary population considered in the EVD preparedness plan increased.
Therefore, as the EVD situation evolved, the National Preparedness and Contingency plan was revised based on prevailing risk levels, consequently increasing funding requirements from USD 3,500,000 to USD11,053926.

3. PRIORITIZATION PROCESS

Following discussions in the Rwanda UNCT and according to the National Preparedness and Contingency plan, the CERF grant was designed to support priority activities in 12 highest priority districts and 17 Points of Entry (PoE), six refugee camps and four transit centers have been identified as being most vulnerable to a potential outbreak. The districts include Burera, Gicumbi, Karongi, Kicukiro, Musanze, Nyagatare, Rubavu, Rusizi and Rutsiro. Three districts in Kigali were included due to possible entry, and thus vulnerability, through its airport. However, due to the evolving epidemiological picture, high priority districts increased from 12 to 15 and the points of Entry (POEs) requiring screening increased from 18 to 21. Consequently, the number of hospitals, health facilities, health workers, and beneficiary population all increased.

Specifically, CERF funds were dedicated to "support time critical, early action to ensure operational readiness for a timely, effective response to an EVD outbreak in twelve prioritized districts in Rwanda over a six-month period".

The allocation reflected the following:

- Prioritization of those most at risk (most vulnerable) in the highest priority areas as far as possible
- Integration and Complementarity: Strategy had to be in line with national effort and build on ongoing measures and contribute to response gaps and demonstrate integration and ensure complementarity among activities.
- Proposed activities met CERF Lifesaving criteria (including CERF best practices guidance on EVD)
- Agency selection and envelope amounts were based on demonstrated capacity and comparative advantage
- The envelope was not spread too thin to maximize value for money
- Activities selected followed WHO guidelines on minimum readiness measures

Based on the above criteria, WHO and UNICEF were selected to receive US$1,4 million and $400,000 respectively. As the lead technical agency for communicable disease outbreaks, WHO is the primary focal agency for agencies and partners working closely with the Ministry of Health (MoH) and provides support for the Contingency Plan's implementation. In addition, WHO is involved in all facets of the implementation at district and national level and faced a fairly large funding gap as it has had to spread its available funding across all primary activities in the plan.

UNICEF is the lead WASH agency and Co-lead for Risks Communications working closely with the MoH and partners and used CERF funds to strengthen WASH components and community engagement and outreach.

Both agencies had complementary roles in risk communication with WHO targeting electronic media audiences while UNICEF conducting community level dialogue and campaigns reaching over 6 million people.

4. CERF RESULTS

CERF allocated 1,798,007 USD to Rwanda from its window for Rapid Respond on EVD readiness in 2019. This fund enabled WHO and UNICEF in Rwanda to reach 9,715,981 beneficiaries, including 6,715,981 beneficiaries on health activities, and more precisely 1,569,968 men, 1,785,525 women, 1,682,605 boys and 1,677,883 girls.
WHO and partners focused on enhancing surveillance for early detection, capacities for case management, infection prevention and control (IPC), building capacities for psychosocial support, safe laboratory specimen collection, packaging and referral, Point of Entry (POE) screening, ambulance services and safe dignified burials.

3,000,000 people were reached on WASH activities conducted by UNICEF & partners in order to ensure preposition of supplies for risk behaviour communication, infection prevention- control-case management in all high-risk areas and Increase knowledge of families and communities on EVD transmission, prevention and control in all high-risk areas. The beneficiaries represent 648,000 men, 792,000 women, 702,000 boys and 858,000 girls.

Project results summary WHO:
Through this CERF UFE grant, WHO scaled up priority Ebola Virus Disease (EVD) preparedness activities in 15 priority districts in Rwanda. Capacity was built of 1,230 health workers from 376 health facilities in EVD preparedness and operational readiness. A wide range of EVD related medical and non-medical logistics including 3 Thermo-scanners, laboratory supplies, and personal protective equipment (PPE) were provided. Frontline hospitals and health facilities had their Infection prevention and control (IPC) practices enhanced and isolation facilities functionalized in 3 hospitals. EVD related Standard Operating Procedures (SOPs) were reviewed and finalized and 22 hospitals conducted drills (Mini Simulations). Compassionate EVD vaccination was provided to 2,874 healthcare workers at high risk of exposure to the deadly Ebola virus and an estimated 6,000,000 individuals nationwide reached by EVD related messages through national and local media (radio and TV spots).
Overall, the project beneficiaries are estimated at 6,715,981, higher than target due, to the increase in the number priority districts from 12 to 15.

Project results summary UNICEF:
Through this CERF grant, UNICEF strengthened the preparedness, detection and response to Ebola Outbreak by providing WASH/Infection Prevention and Control (IPC) training and government endorsed supply kit for cleaning, disinfection and waste management to 24 hospitals, 259 health centers and 21 points of entry (POEs) in Rwanda's 15 high-risk districts, resulting in 429 people (46% female/54% male) trained and equipped to prevent and control the spread of EVD infection. A comprehensive, evidence-based and participatory approach to communication, employing mass and mid-media, social mobilization and community engagement leveraged existing service and community-based gathering platforms reached 131,000 people in all high-risk districts with key information on EVD signs and symptoms, modes of transmission, ways of prevention, as well as channels to refer any EVD-related concerns through door-to-door sensitization and roadshows.

Over 6.0 million people reached through live stream messaging on community radios as well as broadcasting EVD-related content on national mass media channels. In addition, LED screens installed in four strategic border locations with the DRC and Uganda broadcast EVD related messaging reaching 63,000 people on average crossing the borders daily. Six LED screens showing the EVD-related content installed in the capital City of Kigali reach 150,000 people on average daily.

5. PEOPLE REACHED

The persistence and spread of EVD in DRC closer Rwanda border and exportation of cases to Uganda, led to increase in high priority districts from 12 to 15, Points of Entry (POEs) requiring screening increased from 18 to 21. The number of hospitals, health facilities, health workers, and beneficiary population all increased.

The CERF proposal was developed in context of a National Preparedness and Contingency plan designed in August 2018. During the implantation of the CERF grant, the EVD situation evolved and the plan was revised based on prevailing risk levels. This resulted in increasing the target population from 5,319,625 to 6,715,981 regarding WHO project, as they align to the needs expressed by government. Similarly, for UNICEF project, due to the strong collaboration with government and the use of mass media, the number of people reached through various channels was much higher than planned: from 2,000,000 to 3,000,000 people reached.

The total estimated figure includes both direct beneficiaries and indirect population reached by WHO and UNICEF through media outreach, on risk communication activities.

TABLE 4: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY CATEGORY[1]		
Category	**Number of people (Planned)**	**Number of people (Reached)**
Host communities	2,000,000	3,000,000
Refugees	220,000	220,000
Returnees	0	0
Internally displaced persons	0	0
Other affected persons	5,097,625	6,495,981
Total	**7,317,625**	**9,715,981**

[1] *Best estimates of the number of people directly supported through CERF funding by category.*

TABLE 5: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SEX AND AGE[2]					
	Men (≥18)	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Planned	1,498,522	2,021,365	1,672,420	2,125,318	**7,317,625**
Reached	2,217,968	2,577,525	2,384,605	2,535,883	**9,715,981**

[2] *Best estimates of the number of people directly supported through CERF funding by sex and age (totals in tables 4 and 5 should be the same).*

TABLE 6: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PERSONS WITH DISABILITIES) [3]					
	Men (≥18)	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Planned (Out of the total targeted)	N/A	N/A	N/A	N/A	**N/A**
Reached (Out of the total reached)	N/A	N/A	N/A	N/A	**N/A**

[3] *Best estimates of the number of people with disabilities directly supported through CERF funding.*

TABLE 7a: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SECTOR (PLANNED)[4]					
By Cluster/Sector (Planned)	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Health - Health	1,066,522	1,493,365	1,204,420	1,553,318	**5,317,625**
WASH - Water, Sanitation and Hygiene	432,000	528,000	468,000	572,000	**2,000,000**

TABLE 7b: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SECTOR (REACHED)[4]					
By Cluster/Sector (Reached)	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Health - Health	1,569,968	1,785,525	1,682,605	1,677,883	**6,715,981**
WASH - Water, Sanitation and Hygiene	648,000	792,000	702,000	858,000	**3,000,000**

[4] *Best estimates of the number of people directly supported through CERF funding by sector.*

6. CERF'S ADDED VALUE

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

YES ☒ PARTIALLY ☐ NO ☐

In the development of the EVD preparedness phase I, it was anticipated that the Ebola outbreak in DRC which started in August 2018 would end by December 2018 or early 2019. Instead, the outbreak escalated with increased risk of potential spread into Rwanda, and a phase II preparedness and contingency plan was developed for the period February to July 2019. Additionally, despite the best efforts at resources mobilization, both phase I and Phase II plans were poorly funded.

With the unexpected worsening of the EVD outbreak situation in the DRC accompanied by increased risk of spread to Rwanda, the CERF funding was crucial to enable WHO and UNICEF support the government to quickly put in place some lifesaving capacities in the face of increasing risk and threat to people of Rwanda, and to ensure scaled up operations in the various areas of interventions. In particular, the funding was instrumental in scaling up surveillance activities including screening at POEs and laboratory capacities for testing and confirmation, as well as strengthen the other capabilities for operational response. Additionally, the CERF grant allowed for the prompt extension of the preparedness interventions to the additional 3 new districts.

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

YES ☒ PARTIALLY ☐ NO ☐

In the Rwanda Contingency plan Phase I, the focus and achievements were in establishing the leadership and coordination framework as well as creating awareness about the technical skills at national level. EVD specific technical capacities at both national and district were still minimal. CERF funds enabled activation and capacity building of Technical Working Groups (TWG) whose competencies up to this point were minimal, yet they are the foundation of response in case of incidence of an Ebola case in the country.

As the outbreak reached Goma, very close to Rwanda, critical technical skills had been established in some of the frontline point of entry, health facilities and districts. Until funding from other donors was realized later in the year, WHO and UNICEF depended on the CERF funding to bridge the gap and provide emergency capacity building, Indeed, CERF funding played a key role in providing the time critical EVD specific technical capacities and logistics which moved up the level of preparedness in the initial planned12 districts, and the 3 additional new districts . The vaccination of frontline healthcare workers was very urgent to ensure they are protected and have the confidence to continue offering the other healthcare services to the country.

c) Did CERF improve coordination amongst the humanitarian community?

YES ☒ PARTIALLY ☐ NO ☐

The main implementation framework was through Technical working groups (TWGs) and all partners are part of one or more TWG. The funds received through WHO was redistributed and allocated to the priority activities within the various technical working groups and enabled the functioning of the respective groups in a coordinated manner. The CERF Grant delivered by UNICEF contributed to strengthening Risk communication and community engagement activities.

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

YES ☒ PARTIALLY ☐ NO ☐

The CERF funds were instrumental in providing seed money for phase II preparedness plan to sustain the momentum for building capacities for EVD operational readiness for response as additional resources were being mobilised. Additionally, it contributed to the review for planning for the Phase 3 and preparation for more resource mobilization.

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

CERF funding was critical in responding to the unexpected especially when the risks for potential spread had increased and there was need to strengthen operational readiness capabilities in three additional districts that were not planned. More district health facilities were targeted and reached with capacity building interventions for EVD preparedness and operational readiness based on assessed needs. The funding also enabled the provision of critical logistics including EVD medical and non-medical supplies, some of which are only availed to countries only trough continuity and momentum and transition.

CERF contributed to the development of the framework for EVD readiness Provision of thermal Imaging cameras at high through put points including Kigali Airport enhanced surveillance. Infection Prevention and control (IPC) has been enhanced throughout the healthcare system. Laboratory capacity has been built both at national level for confirmatory testing as well as at hospital and health care facilities level. This has laid the foundation, upon which more capacity will be built.

7. LESSONS LEARNED

TABLE 8: OBSERVATIONS FOR THE CERF SECRETARIAT	
Lessons learned	**Suggestion for follow-up/improvement**
Mobilizing funds on EVD prepareneess has been challenging for the UN Agencies as most of the funds go to the countries working on EVD response. However prepareness is critical to avoid the propagation of the desease in the region. Therefore, funds need to be mobilized to that end.	CERF should keep providing fund on Preparness, as it is difficult to attract donors on the humanitarian aspects of EVD prepareness.Most of them focusing on the repsonse in DRC and Uganda.
CERF was critical and instrumental in strengthening operational readiness capabilities for Rwanda and ensured scale up and continuity of preparedness interventions during transition from phase I to II and from phase II to three. The funds ensured implementation of critical scale up interventions for operational readiness capabilities in all thematic areas and also allowed for expansion of planned interventions to new districts that became vulnerable with increasing risk of spread of the outbreak to areas in DRC that were closer to Rwanda. This is the first time of applying CERF funding to operational readiness capabilities for a public health event in a non-humanitarian setting and proved very useful.	This initiative was very positive and with great impact in mitigating the risk of spread of EVD to Rwanda as well as ensuring operational readiness capabilities for response in the event of an imported case. Efforts should be made to build on lessons learnt for the future in support of strengthening operational readiness capabilities for future outbreaks of EVD or other public health emergencies.
The principle of distributing the funds according to the priorities in the national plan and based on comparative advantage of the agencies involved is a good way to ensure effectiveness of the allocated resources.	This should be one of the principles for future disbursement of funds.
Preparedness is a moving target, situations change drastically resulting in need to reprioritize available funds to cater for the changing needs. In this case the funds were used to scale up operational readiness capabilities in 15 districts instead of the initial planned 12 districts.	One of the guiding principles for utilization of funds should be flexibility to accommodate changing priority needs to ensure effectiveness of the program and achieving the desired goals.

TABLE 9: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
In the context of the region, mobilizing funds on EVD preparedness has been challenging for the UN Agencies, as most of the funds go to the countries working on EVD response.	It is important for the UNCT, through the EVD coordination meetiing, to develop a advocating strategy for funds dedicated to preapreness and a strategic oerview of the funds planned to be available in 2020. This will benefit not only the EVD preparedness but any health emergency for which Rwanda remain at risk such as cholera.	UNCT/ RCO

PART II

8. PROJECT REPORTS

8.1. Project Report 19-RR-CEF-004 – UNICEF

1. Project Information			
1. Agency:	UNICEF	**2. Country:**	Rwanda
3. Cluster/Sector:	Water Sanitation Hygiene – including Risks Communications	**4. Project Code (CERF):**	19-RR-CEF-004
5. Project Title:	Strengthen the capacity of Rwanda, both the Government and population to prepare for and respond to a potential Ebola Virus Disease (EVD) outbreak.		
6.a Original Start Date:	01/01/2019	**6.b Original End Date:**	30/06/2019
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$ 938,400
	b. Total funding received for agency's sector response to current emergency:	US$ 500,000
	c. Amount received from CERF:	US$ 398,007
	d. Total CERF funds forwarded to implementing partners	**US$ 214,264**
	of which to:	
	Government Partners	US$ 162,537
	International NGOs	US$ 0
	National NGOs	US$ 51,727
	Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance
Through this CERF grant, UNICEF strengthened the preparedness, detection and response to Ebola Outbreak by providing WASH/Infection Prevention and Control (IPC) training and government endorsed supply kit for cleaning, disinfection and waste management to 24 hospitals, 259 health centers and 21 points of entry (POEs) in Rwanda's 15 high-risk districts, resulting in 429 people (46% female/54% male) trained and equipped to prevent and control the spread of EVD infection. A comprehensive, evidence-based and participatory approach to communication, employing mass and mid-media, social mobilization and community engagement leveraged existing service and community-based gathering platforms reached 131,000 people in all high-risk districts with key information on EVD signs and symptoms, modes of transmission, ways of prevention, as well as channels to refer any EVD-related concerns through door-to-door sensitization and roadshows. Over 6.0 million people reached through live stream messaging on community radios as well as broadcasting EVD-related content on national mass media channels. In addition, LED screens installed in four strategic border locations with the DRC and Uganda broadcast EVD related messaging reaching 63,000 people on average crossing the borders daily. Six LEDscreens showing the EVD-related content installed in the capital City of Kigali reach 150,000 people on average daily.

3. Changes and Amendments

The targets defined in the proposal were based on a total of 388 government staff to be trained at hospitals, health centers and POEs in 13 high-risk districts. During implementation, the government updated their contingency plan to 15 high risk districts, targeting 24 district hospitals, 259 health centers and 21 POEs. Government also updated their training plan for WASH/IPC, resulting in exceeding the overall number of people trained.

On WASH/IPC, however, resulting in a variation on achievement of the specific indicators set in proposal. The revised plan reflected the needs of the country better than the initial targets, set early in the preparedness efforts. Overall, 429 people were trained utilizing CERF funding, exceeding the overall target of 388 people trained and enabling the main objectives of having 1) master trainers trained and 2) adequate staff at all district hospitals, health centers and POEs in 15 high-risk districts.

Lessons learned:
Rwanda has no history of EVD, therefore the Government developed and revised the plan during the last year to adjust the strategy and add components to address some of the gaps identified during the SIMEX and Drills elements. In future, indicators should be set on training objective rather than specific staff roles or structures as they me subject to modifications. For Case Management/WASH-IPC, UNICEF and WHO will clearly define the detailed division of labour on various tasks that overlap on CM/IPC, based on learning from other high-risk countries, which will improve coordination and accountabilities.

4.a NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PLANNED)

Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	432,000	528,000	468,000	572,000	**2,000,000**
Refugees	0	0	0	0	**0**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**432,000**	**528,000**	**468,000**	**572,000**	**2,000,000**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	N/A	N/A	N/A	N/A	**N/A**

4.b NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (REACHED)

Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	648,000	792,000	702,000	858,000	**3,000,000**
Refugees	0	0	0	0	**0**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**648,000**	**792,000**	**702,000**	**858,000**	**3,000,000**

Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	**0**

In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	Due to the strong collaboration with government and the use of mass media, the number of people reached through various channels was much higher than planned.

5. CERF Result Framework

Project Objective	To strengthen the preparedness, detection and response to Ebola outbreak in line with the National Ebola Preparedness and Response Plan and UNICEF Contingency Plan.

Output 1	Ensure preposition of supplies for risk behaviour communication, infection prevention and control and case management in all high-risk areas.			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 1.1	Number of Household Kits prepositioned	5,850 Household kits prepositioned	2,250 HHs	MOH Supply unit
Indicator 1.2	Number of EHOs trained	26 EHOs are trained	25 EHOs are trained	MOH Attendance sheets
Indicator 1.3	Number of people trained on containment for 17 PoEs	102 people trained	22	MOH Attendance sheets
Indicator 1.4	Number of trained disinfection teams	26 Teams are trained (260 people)	24 district teams (163 people) In addition, 219 health centre staff. Total 382 people	MOH Attendance sheets
Explanation of output and indicators variance:	The targets defined in the CERF proposal were based on a total of 388 government staff to be trained at hospitals, health centers and POEs in 13* high-risk districts. During implementation, the Government of Rwanda updated their Contingency Plan to 15 high-risk districts, targeting 24 district hospitals, 259 health centers and 21 POEs. The Government also updated their training plan for WASH/IPC which resulted in **exceeding the overall number of people** trained on WASH/IPC, however, resulting in a variation on achievement of the specific indicators set in 2018 (proposal submission). The revised plan reflected the needs of the country better than the initial targets, set early in the preparedness efforts. Overall, 429 people were trained, exceeding the overall target of 388 people trained and enabling the main objectives of having 1) master trainers trained and 2) adequate staff at all district hospitals, health centers and POEs in 15 high-risk districts. Staff: 46% female/54% male. **The proposal stated 12 however, at the time the government was indicating a shift to 13 and the IPC TWG was using 13 high-risk districts for planning. Therefore, WASH targets in this CERF proposal were planned to use 13 districts.* Indicator 1.1: Due to the change to 15 high-risk districts as well as the cost of supplies being higher than anticipated, the TWG decided to prioritize 15 households' kits (each serving 150 families; 1 per district), rather than 39 (3/district) as planned. Therefore, the pre-positioned kits are for 2,250 families instead of 5,850 families, as reported in the interim report. Savings from this activity were used for procuring supplies for health centers and additional hospitals and POEs.			

	Indicator 1.2: 25 EHOs were trained, just 1 short of 26. Indicator 1.3: The target of 102 people was calculated before an assessment of the shifts and size of POEs was made. The TWG decided to train 1 staff on WASH-IPC per POE, resulting in a planned total of 21. That staff member will in turn train other staff on location at the POEs. Achievement is 22 people. Indicator 1.4: 26 teams/260 people were planned initially based on 2/district however, 24 teams (163 people) were trained (1/hospital) plus an additional 219 people at the 259 health centers, exceeding the overall target for people.

Activities	Description	Implemented by
Activity 1.1	Procurement of kits of supplies for districts, points of entries and communities	UNICEF
Activity 1.2	Distribution of kits of supplies to districts, points of entries and communities	Ministry of Health
Activity 1.3	Train staff in 12 districts as ToT on chlorination, disinfection, cleaning, and waste management	Ministry of Health with UNICEF technical support
Activity 1.4	Equip and train staff in 17 points of entries on decontamination	Ministry of Health with UNICEF technical support
Activity 1.5	Equip and train two district-level disinfection teams to clean/disinfect contaminated areas and manage waste	Ministry of Health with UNICEF technical support

Output 2	Increase knowledge of families and communities on EVD transmission, prevention and control in all high-risk areas			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 2.1	Number of people in high-risk districts reached with information on EVD	2,000,000	3,000,000	2018 data of Rwanda Utilities Regulatory Authority
Explanation of output and indicators variance:		A strong engagement with mass media, including leveraging community radio, helped in increasing the number of people reached with information on EVD in high-risk districts.		

Activities	Description	Implemented by
Activity 2.1	Develop communication materials on IPC for message dissemination on EVD prevention	Global Humanitarian Development Fund, Rwanda Broadcasting Agency, Rwanda Health Communication Centre, UNICEF
Activity 2.2	Train 10000 CHW and 50 implementing partners on IPC for message dissemination on EVD prevention	Global Humanitarian Development Fund, Rwanda Health Communication Centre, UNICEF
Activity 2.3	Conduct community-based awareness and interpersonal communication activities to engage the targeted high-risk communities in EVD prevention and response	Global Humanitarian Development Fund
Activity 2.4	Organize community radio programmes on five community radio stations including in car parks and markets	Rwanda Broadcasting Agency
Activity 2.5	Screen EVD prevention message on three electronic billboards fixed at the DRC and Uganda borders.	Aflink Company
Activity 2.6	Community outreach using public address systems on mobile vans in public places (markets, churches, business)	Global Humanitarian Development Fund, Rwanda Broadcasting Agency
Activity 2.7	Dissemination of EVD prevention messages by the 12 District trained RC&CE team from the district to the village level through existing community platforms (Umuganda, Umugoroba	Global Humanitarian Development Fund

	w'Ababyeyi, church services, markets days, district/sector/cells and villages authorities meeting with the community)	
Activity 2.8	House to house message dissemination by 10,000 CHW after their training on Interpersonal Communication for EVD prevention.	Global Humanitarian Development Fund

6. Accountability to Affected People

6.a IASC AAP Commitment 2 – Participation and Partnership

How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?

In all activities under Output 2, UNICEF and partners ensured participation of affected community members through pre-testing of all communication materials and calling community influencers and young people to help disseminate the EVD-related content within their communities, especially among most marginalized and hard to reach members.

Where existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?

Existing local community-based platform called -*Umuganda*, the monthly community cleanliness drive followed by community discussions, was used to strengthen EVD sensitisation by influential community members. In addition, church services were used for information sharing as Rwanda has strong religious population. Another platform-Community Radios, which are highly reliable and popular contributed to the results of the project.

6.b IASC AAP Commitment 3 – Information, Feedback and Action

How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?

UNICEF is a well-recognized UN partner that helps the Government of Rwanda to advance the country's development agenda. In the implementation of each communication/community engagement effort, UNICEF ensured that the implementing organization provided the background about the partners involved, their key missions as well as the goals of the information sharing effort around EVD.
In addition, in all community mobilization and engagement interventions the audiences were encouraged by the implementer to become active participants of the EVD information dissemination effort and share the content they received with those community members who could not be part of the intervention for various reasons, including most socially and economically marginalized.

Did you implement a complaint mechanism (e.g. complaint box, hotline, other)?
Briefly describe some of the key measures you have taken to address the complaints.

Yes ☐ No ☒

Under Output 2, UNICEF and partners established the mechanism of collecting information and addressing the concerns and questions that community members have on EVD through door-to-door, community-based interventions and interactive radio talk shows. For cases the community mobilizers were not able to resolve, community members were referred to the national free of cost hotline 114.

Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints?
Briefly describe some of the key measures you have taken to address the SEA-related complaints.

Yes ☐ No ☒

As part of UNICEF's standard operating procedures on agreements with National NGOs, SEA is a standard clause to which NGOs abide by. In addition, the key staff of the NGO were trained on SEA.

Any other comments (optional):

N/A

7.	Cash Transfer Programming

7.a Did the project include one or more Cash Transfer Programmings (CTP)?

Planned	Achieved
No	No

7.b Please specify below the parameters of the CTP modality/ies used. If more than one modality was used in the project, please complete separate rows for each modality. Please indicate the estimated **value of cash** that was transferred to people assisted through each modality (best estimate of the value of cash and/or vouchers, not including associated delivery costs). Please refer to the guidance and examples above.

CTP Modality	Value of cash (US$)	a. Objective	b. Cluster/Sector	c. Conditionality	d. Restriction
None		Choose an item.	Choose an item.	Choose an item.	Choose an item.

Supplementary information (optional):
N/A

8. Evaluation: Has this project been evaluated or is an evaluation pending?	
No evaluation was planned with the little funding received, US $ 400, 000. Focus was on providing the supplies needed to key the MOH and strengthening of capacities and knowledge on EVD in the MOH and targeted communities to improve preparedness and prevention.	EVALUATION CARRIED OUT ☐ EVALUATION PENDING ☐ NO EVALUATION PLANNED ☒

8.2. Project Report 19-RR-WHO-002 - WHO

1. Project Information			
1. Agency:	WHO	**2. Country:**	Rwanda
3. Cluster/Sector:	Health - Health	**4. Project Code (CERF):**	19-RR-WHO-002
5. Project Title:	Rwanda Ebola Virus Disease Readiness Project		
6.a Original Start Date:	31/01/2019	**6.b Original End Date:**	30/07/2019
6.c No-cost Extension:	☒ No ☐ Yes	If yes, specify revised end date:	NA
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$ 6,176,085
	b. Total funding received for agency's sector response to current emergency:	US$ 3,464,147
	c. Amount received from CERF:	US$ 1,400,000
	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 UFE grant, WHO scaled up priority Ebola Virus Disease (EVD) preparedness activities in 15 priority districts in Rwanda, focusing on enhancing surveillance for early detection, capacities for case management, infection prevention and control (IPC), building capacities for psychosocial support, safe laboratory specimen collection, packaging and referral, Point of Entry (POE) screening, ambulance services and safe dignified burials. Capacity was built of 1,230 health workers from 376 health facilities in EVD preparedness and operational readiness. A wide range of EVD related medical and non-medical logistics including 3 Thermo-scanners, laboratory supplies, and personal protective equipment (PPE) were provided. Frontline hospitals and health facilities had their Infection prevention and control (IPC) practices enhanced and isolation facilities functionalized in 3 hospitals. EVD related Standard Operating Procedures (SOPs) were reviewed and finalized and 22 hospitals conducted drills (Mini Simulations). Compassionate EVD vaccination was provided to 2,874 healthcare workers at high risk of exposure to the deadly Ebola virus and an estimated 8,000,000 individuals nationwide reached by EVD related messages through national and local media (radio and TV spots). Overall, the project beneficiaries are estimated at 6,4975,981, higher than target due, to the increase in the number priority districts from 12 to 15.

3. Changes and Amendments

- The persistence and spread of EVD in DRC closer Rwanda border and exportation of cases to Uganda, led to increase in high priority districts from 12 to 15, Points of Entry (POEs) requiring screening increased from 18 to 21. The number of hospitals, health facilities, health workers, and beneficiary population all increased.
- WHO's support is aligned to needs expressed by government. The CERF proposal was developed in context of a National Preparedness and Contingency plan developed in August 2018. As the EVD situation evolved, the plan was revised based on prevailing risk levels, consequently increasing funding requirements from USD 3,500,000 to USD11,053926.

- New partners interested in specific items on the national plan emerged, therefore in a few instances, alternative needs in the same activity block were identified and implemented. For example, to support surveillance, WHO planned to procure telephone handsets for Community Health Workers to facilitate reporting. However, the government indicated they had negotiated with a mobile telephone carrier to provide handsets to all Community Health Workers (CHW) countrywide and requested WHO to procure computers for surveillance data management. This maintained the original objective to support surveillance through enhanced data availability.
- Initial national policy was to transfer all suspected EVD patients to the "Suspect Ward" at ETC. Later, it was revised to allow only confirmed cases at the ETC, necessitating setting up suitable isolation facilities at hospitals for proper management pending confirmation. Government requested WHO to support preparation of temporary isolation facilities at three hospitals in high risk districts. The objective for strengthening capacity for safe and effective EVD case management was enhanced. Similarly change in policy towards payment of incentives to government employees resulted in repurposing of funds towards enhancing operational readiness through drills and simulation exercises.
- Rwanda has a strong routine healthcare management system. The process of adapting a public health emergency management framework is in initial stages. Operating an emergency within a routine system posed multiple challenges. Government approval processes were unpredictable and often tortuous resulting in significant delays in implementation of activities for which funds had been committed or partially spent. For example, there were significant delays in starting EVD vaccination, procurement of emergency logistics, secondment of staff to support EVD the EOC/MOH, installation of thermo-scanners and preparation of Isolation units, although all activities were eventually implemented. To this end implementation of some activities overran the initial project end date.

4.a NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PLANNED)

Cluster/Sector	Health – Health				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	0	0	**0**
Refugees*	N/A	N/A	N/A	N/A	**220,000**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons*	N/A	N/A	N/A	N/A	**5,097,625**
Total	N/A	N/A	N/A	N/A	**5,317,625**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	N/A	N/A	N/A	N/A	**N/A**

4.b NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (REACHED)

Cluster/Sector	Health – Health				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	0	0	**0**
Refugees	51,542	55,837	56,805	55,816	**220,000**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	1,518,426	1,729,688	1,625,800	1,622,067	**6,495,981**
Total	**1,569,96**	**1,785,525**	**1,682,605**	**1,677,883**	**6,715,981**

Reached	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Persons with Disabilities (Out of the total number of "people reached")	N/A	N/A	N/A	N/A	N/A

In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	The CERF proposal was developed in context of a National Preparedness and Contingency plan designed in August 2018. During the implantation of the CERF grant, the EVD situation evolved and the plan was revised based on prevailing risk levels. High priority districts increased from 12 to 15. This resulted in increasing the target population from 5,317,625 to 6,715,981, as the activities implemented align to the needs expressed by government. As part of it, refugees were indirectly reached by EVD related risk communication messaging through mass media.

5. CERF Result Framework

Project Objective	Enhance operational readiness capacities for EVD detection, response and containment in Rwanda.

Output 1	Enhance capacity for prevention, early detection and response to EVD outbreak.			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 1.1	Number (proportion) of Priority District with functional Epidemic management committees	12 (100%)	0 (0%)	KPI Monitoring July 2019
Indicator 1.2	Number and proportion of Health facilities in priority districts with staff trained on surveillance	376 (100%)	376 (100%)	Training Reports Available
Indicator 1.3	Number /proportion) of health facilities reporting EVD cases weekly and timely (alert, suspected and confirmed cases)	376 (100%)	376 (100%)	Weekly Surveillance Reports, eIDSR, EOC EVD Weekly Reports
Indicator 1.4	Number of community health workers trained	20,000	20,000 (100%)	Training Reports available (obtainable from Director Surveillance at RBC or Director Community Health at the respective District Hospital)
Indicator 1.5	Number of community health workers equipped with phones for reporting of alerts	2500 (12.5%)	N/A	N/A
Indicator 1.6	Proportion of villages in which Community Health Workers have a phone for EVD reporting	40%	N/A	N/A
Indicator 1.7	Number (proportion) of villages with trained community volunteers	6000 (98%)	NA	N/A
Indicator 1.8	Number of healthcare providers trained on EVD detection and diagnosis;	377	1230 (326%)	DI training Reports (WCO)
Indicator 1.9	Number of laboratory staff trained on sample collection, packaging and lab diagnosis	56	160 (286%)	DI training Reports (WCO)

Indicator 1.10	Number of POE staff trained on screening at POE and reporting /referral pathways	204	1230 (603%)	DI training Reports (WCO)
Indicator 1.11	Proportion of Points of Entry with trained staff for EVD Screening	100%	22 (124%)	Weekly EOC Reports
Indicator 1.12	Numbers (proportion) of Districts with trained and functional RRTs (1 at national and 1/district for all 12 priority districts	12 (100%)	15 (125%)	Training Reports/Refresher Training reports, attendance lists Available

Explanation of output and indicators variance:

1.1. All Priority District were oriented and some constituted Epidemic Management Committees, however none was yet fully functional by July 30th, 2019, because they have not yet started holding the weekly meetings.

1.5. The government informed WHO another partner was to provide phone handsets to all Community Health Workers (CHW) nationwide. All community workers have Phones and report routinely. However, the phones were not procured from this grant. WHO Funds were repurposed for procurement of computers for surveillance data management.

1.6. Same as 1.5 above

1.7. MOH and Local governments carried out TOT and cascade training using funding from other sources. Hence funds were repurposed for another activity for training more Healthcare Workers and conducting drills in hospitals in the additional 3 priority districts.

1.8. More health workers than initially proposed have been trained on EVD detection and diagnosis because the mode of training was changed from "Technical pillar based" (surveillance only) to an integrated approach covering surveillance, IPC, Case management, laboratory, and ambulance staff. The result was more that more health workers acquired the knowledge and skills even if surveillance is not may not be their routine responsibility.

1.9. Number of laboratory staff trained on sample collection, packaging and lab diagnosis increased due to an increase due to change in priority districts.

1.10. Number of POEs increased from 17 to 21 during the period of implementation. POE screening is manned by Health workers from resident districts who are deployed on weekly rotations. POE screening was thus part of the integrated EVD detection and diagnosis Health workers.

1.11. As 1.10

1.12. Priority districts increased from 12 to 15 due to the change in risk linked to Ebola spread to Goma and Bukavu in DRC as well as exportation of cases to Uganda.

Activities	Description	Implemented by
Activity 1.1	District Epidemic Management Team established, oriented and functional in all 12 priority districts	MoH and WHO
Activity 1.2	Conduct training Surveillance focal persons in all HFs in the 12 priority districts on enhanced EVD surveillance	MoH and WHO
Activity 1.3	All health facilities in the priority districts implementing weekly EVD reporting	MoH/RBC/Health Facility Managers
Activity 1.4	All 6000 villages in the 12 priority districts are trained on EVD community surveillance and alerting mechanisms and are implementing community surveillance system for early detection of EVD at community level	MoH/RBC/Health Facility Managers

Activity 1.5	Community health workers conduct active case search and report	District Local Government / MoH
Activity 1.6	Conduct training for Community Health Workers	District Local Government / MoH
Activity 1.7	Procurement and distribution of phones	MoH
Activity 1.8	Training /refresher training of Health workers	MoH and WHO
Activity 1.9	Screening for EVD conducted in all priority POEs	District Local Government, MoH and WHO
Activity 1.10	Laboratory staff trained on sample collection, packaging and testing	MoH/RBC/NRL and WHO
Activity 1.11	Training of POE on screening and referral pathways	MoH and WHO
Activity 1.12	Hold regular meetings of District Epidemic Management Team	Mayor/Director General District Hospital/MoH

Output 2	Enhanced capacities for safe and effective EVD Case Management			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 2.1	Number (proportion) of Health Workers trained on case management and IPC	572 (100%)	1,230 (215%)	Health Care Worker Integrated Training and Integrated Drill Reports
Indicator 2.2	Proportion of health facilities with functional Minimum IPC measures (checklist of minimum IPC practices)	185 (100%)	32 (17%)	Report of IPC assessment in hospitals conducted in May 2019 & Minimum IPC Assessment reports for Health facilities Rubavu
Indicator 2.3	Number of ETU staff offered specialized training on ETU and case management (30 staff per shift, for 4 shifts, and 1 stand-team)	150	124 (83%)	ETU Staff Training Report
Indicator 2.4	Number (proportion) of health workers trained on MHPSS	340 (100%)	206 (61%)	Mental Health and Psychosocial Support (MPSS) Training Report/Integrated Training Reports (WCO)
Indicator 2.5	Number (proportion) of community Health workers and volunteers trained on PSS,	390 (100%)	N/A	
Indicator 2.6	Number (proportion) of district hospitals with established temporary isolation facilities	18 (100%)	16 (89%)	Assessment Reports
Indicator 2.7	Number (proportion) of Districts with trained ambulance teams (8 members per team, and one team/per district for the 3 highest priority districts)	3 (100%)	3 [100%)	Training Reports
Explanation of output and indicators variance:		2.1. The variance in number of Health Workers trained on case management and IPC is to increase in number of priority districts as well as adoption of integrated approach to training. 2.2. Assessment was limited to the 24 hospitals and 8 health facilities in Rubavu. This figure constitutes the baseline. The findings are being used to develop a national IPC self-assessment and monitoring system, before assessing the rest. A post intervention assessment at end of project has not yet been done.		

	2.4 The total number of people trained in MHPSS was 153 health workers for delivery of interventions in the community and, 53 to be able to work inside the ETC and isolation units. The duration of training increased from 3 days to 4 days to cater for additional IPC skills for all Health workers. 2.5 There was no funding to train Community Health Workers on Psychosocial Support. 2.6 Temporary rooms for isolation of suspected cases were identified at the respective hospitals. However, some of these need to be remodelled to be fit for purpose, and work is still ongoing g to this effect.

Activities	Description	Implemented by
Activity 2.1	Conduct training of health care workers in health facilities in priority districts on EVD case management and IPC practices (target is at least 3 HCWs per health facility in the priority districts)	MoH and WHO
Activity 2.2	Conduct assessments of the IPC practices in all Health facilities in the 12 priority districts using the WHO checklist of minimum IPC standards	MoH and WHO
Activity 2.3	Establish a roster of staff trained on ETU management and operations, ready to be deployed in the ETU when required	MoH/RBC
Activity 2.4	Manage a roster of staff trained on ETU management and operations, ready to be deployed in the ETU when required	MoH/RBC
Activity 2.5	Establishment of a pool of staff properly trained on MHPSS, who can be deployed if and when required.	MoH and WHO
Activity 2.6	Establish a pool of CHWs that are trained on PSS, and ready to be deployed when required.	MoH and WHO
Activity 2.7	Establish functional temporary isolation units in all the 18 district hospitals in the 12 priority districts for temporary isolation of an EVD suspect case	District Local Government/MoH and Partners
Activity 2.8	Train and establish at least 3 Burial Teams (one per district) in the 3 highest at risk districts	MoH and WHO
Activity 2.9	Train and establish ambulance teams in the 3 highest at risk districts (one /district).	MoH and WHO

Output 3	Support vaccination/protection of health care and frontline workers			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 3.1	Number of vaccination teams trained on good clinical management and on the vaccination SOP	5 teams (100%)	5 (100%)	Training Report
Indicator 3.2	Number (proportion) of districts having at-risk health care and frontline workers vaccinated	12 (100%)	6 (50%)	Vaccination Report
Indicator 3.3	Number (proportion) of districts that received at least one supervisory visits during the vaccination period.	12 (100%)	6 (50%)	Vaccination Report
Explanation of output and indicators variance:		3.2. The vaccine doses (3,000) received were inadequate to cover all eligible Healthcare workers, which could only cover 6 districts.		

	3.3. All the districts where vaccination took place received a visit. However, we were unable to cover the planned 12 districts because of limitations in vaccine doses.

Activities	Description	Implemented by
Activity 3.1	Training of 5 vaccination teams on good clinical management and on the EVD vaccination SOP	MoH and WHO
Activity 3.2	To conduct at least one supervisory visit per district during the vaccination process	MoH and WHO
Activity 3.3	Deploy staff to supervise vaccination at district level	MoH and WHO

Output 4	Equipment and medical supplies availed and made accessible			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 4.1	Number of Thermo-scanners procured and installed at 2 of the most busy and high risk POEs	2 (100%)	3 (150%)	Receipts, Delivery notes, installation and verification reports
Indicator 4.2	Number of heavy-duty Xerox colour printer procured and installed	1 (100%)	1 (100%)	WHO Inventory/asset record/procurement records
Indicator 4.3	Number (and proportion) of the priority POEs equipped with thermos-flash thermometers for screening	17 POEs (100%)	21 124%)	POE Weekly reports
Indicator 4.4	Percentage days of stock out of EVD diagnostic kit	0%	0%	NRL Stock Ledger
Indicator 4.5	Numbers (Percentage) of health facilities in the 12 priority districts reporting no-stock out of basic IPC materials for standard precautions	100%	100%	Delivery schedules, Laboratory stock ledger and Laboratory Information management systems
Indicator 4.6	Number of copies of SOPs booklet printed	5200	5000 (96%)	Supplier invoices, Delivery notes, procurement records
Explanation of output and indicators variance:		4.1. Number of Thermo-scanners was increased to three because of the great need to install an additional 2 cameras for screening at Kigali International Airport. 4.3. No of POE increased to 22 due to revised risk levels		

Activities	Description	Implemented by
Activity 4.1	Procure 2 thermo-scanners; 300 thermoFlash thermometers; screening supplies and commodities for 185 HFs and for 17 POEs; PPE and materials for basic standard precautions; 2500 cell phones for alerting EVD cases from the community; laboratory kits and supplies; 1 heavy duty Xerox color printer	MoH and WHO
Activity 4.2	Install 2 new thermo-scanners at 2 of the most busy and high risk POEs	MoH/Directorate of Immigration & Emigration and WHO
Activity 4.3	Distribute thermosFlash thermometers for screening to all POEs and HFs	MoH and WHO
Activity 4.4	Distribute and avail laboratory supplies and reagents for EVD diagnostic testing	MoH/NRL and WHO

Activity 4.5	Distribute PPE and supplies of basic supplies for standard precaution to all health facilities in all the 12 priority districts	MoH and Partners
Activity 4.6	Distribute EVD Diagnostic kits to district hospitals	MoH/Director General of District Hospitals and WHO

Output 5	Sustain Radio and TV spots for Community awareness on EVD prevention and control			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 5.1	Number of radio spots on EVD messages over 3 months	180	180	Weekly reports by Rwanda Health Communication Centre to EOC
Indicator 5.2	Number of TV spots on EVD messages over 3 months	90	90	Weekly reports by Rwanda Health Communication Centre to EOC
Explanation of output and indicators variance:		5.1. Rwanda Health Communication Centre is the national agency mandated to implement and monitor media activity. The radio listenership in Rwanda through this period was estimated at 8,000,00 individuals.		

Activities	**Description**	**Implemented by**
Activity 5.1	Pay for contract with media houses	WHO
Activity 5.2	Carry out EVD related talk show	MOH (Rwanda Health Communication Centre)
Activity 5.3	Awareness	WHO/ MOH (Rwanda Health Communication Centre)

Output 6	Support EVD Drills and simulation Exercises			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 6.1	Proportion of High-Risk Districts that have conducted at least one drill or simulation exercise during the 6-month period of project implementation	4 (100%)	15 (375%)	Drill Reports
Indicator 6.2	Proportion of high-risk districts that have developed improvement plans following drills and simulation exercises during the 6 months period of project implementation	4 (100%)	15 (375%)	Drill reports
Explanation of output and indicators variance:		The national implementation strategy recommended drills to focus on hospital level drills in place of national simulation exercises to better improve skills of the health workers, before conducting another national level full scale SIMEX. A total of 22 hospitals in 15 priority districts conducted integrated drills.		

Activities	**Description**	**Implemented by**
Activity 6.1	Conduct drills to test district level operational readiness in at least 4 priority districts	MoH/District hospitals and partners
Activity 6.2	Support at least 4 districts to develop improvement plans following simulation exercise to test district level operational readiness.	MoH and partners
Activity 6.3	Conduct full scale simulation exercises to test various aspects of the preparedness plan	MoH and WHO

Output 7	Strengthen WHO Technical Capacity

Indicators	Description	Target	Achieved	Source of Verification
Indicator 7.1	Number of planned international positions filled	3	N/A	N/A
Indicator 7.2	Number of planned national positions filled	3	3	Contracts
Indicator 7.3	Number of drivers recruited	2	2	Contracts
Explanation of output and indicators variance:		7.1. The approved proposal did not include international positions		

Activities	Description	Implemented by
Activity 7.1	Recruitment of International and national staff	WHO

6. Accountability to Affected People

6.a IASC AAP Commitment 2 – Participation and Partnership

How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?

The project was designed to touch lives of every individual in the priority Districts. The community members were informed through social mobilization that they can report symptoms of Ebola to the Community Health Workers and that the Health Workers will get to know about their sickness and mobilize timely public health intervention by reporting to the public health authorities while observing measures for IPC self-protection. All interventions were adapted to the socio-cultural context in Rwanda, including language of communication. Interventions were continuously adjusted as lessons were learnt.

Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalized groups, what alternative mechanisms have you used to reach these?

This grant was to support EVD preparedness, undertaken by national and local governments with support from WHO and other partners. Hence participation of the vulnerable and marginalized was assured by working through the government structures, which in Rwanda go right up the grassroots. Community level interventions were done through government structures that have a high level of consultation and community involvement. WHO did not directly implement interventions at community level.

6.b IASC AAP Commitment 3 – Information, Feedback and Action

How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?

This was ensured by working through existing government structures. The affected people were informed through their normal channels routinely utilized by government.

Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints. Yes ☐ No ☒

Complaints raised during training were addressed immediately and recorded for reporting and action. Complaints at community level were channeled and addressed through government's normal channels.

Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints. Yes ☐ No ☒

Although no specific system was set up, this was ensured by government involvement and utilization of the community-based approach and feedback channels.

Any other comments (optional):
N/A

7. Cash Transfer Programming					
7.a Did the project include one or more Cash Transfer Programming (CTP)?					
Planned			**Achieved**		
No			No		
7.b	**Please specify below the parameters of the CTP modality/ies used**. If more than one modality was used in the project, please complete separate rows for each modality. Please indicate the estimated **value of cash** that was transferred to people assisted through each modality (best estimate of the value of cash and/or vouchers, not including associated delivery costs). Please refer to the guidance and examples above.				
CTP Modality	**Value of cash (US$)**	**a. Objective**	**b. Cluster/Sector**	**c. Conditionality**	**d. Restriction**
None	US$ [insert amount]	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Supplementary information (optional): N/A					

8. Evaluation: Has this project been evaluated or is an evaluation pending?	
There was no evaluation planned. The monitoring framework was included in the project design in form of the Gant chart and project results framework. Indicators for monitoring implementation of this plan have been provided in the results framework. Measures of monitoring indicators were generated through routine activity reports, which included lessons to inform further adaptation and implementation of the project. The strategic leadership and coordination system was in place to ensure proper command and control system. The Technical Working Groups (TWGs) were responsible for directing implementation, coordination and reporting on the planned activities, as well as guide and support resources utilization. The TWG also supported rolling out the implementation of planned activities to the priority districts, tracking progress, and reporting nationally within the technical coordination mechanism, and to the overall Emergency Operation Centre (EOC) at Ministry of Health on a weekly basis. The EOC, together with the technical arm, were responsible for updating and reporting to the sectoral and inter-ministerial coordination mechanism that reports directly to the Head of State. Periodic evaluation of outcomes has been carried out through assessments, drills, monitoring community behaviour and awareness of EVD prevention and control.	EVALUATION CARRIED OUT ☐ EVALUATION PENDING ☐ 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$
19-RR-CEF-004	Water, Sanitation and Hygiene	UNICEF	NNGO	$51,727
19-RR-CEF-004	Water, Sanitation and Hygiene	UNICEF	GOV	$86,000
19-RR-CEF-004	Water, Sanitation and Hygiene	UNICEF	GOV	$60,411
19-RR-CEF-004	Water, Sanitation and Hygiene	UNICEF	GOV	$16,126

ANNEX 2: Success Stories

The integrated drills in all hospitals in the 15 districts for the first time brought together all members of the rapid response teams to work together as a team and to test the operational readiness of all components of the preparedness at district level. This enhanced the capacity of primary healthcare workers to adequately protect themselves from getting infected, facilitated early detection and isolation of patients suspected of having EVD. Gaps identified lead the hospitals to come up with improvement plans to bridge those gaps that can be monitored in the future on a table top exercise in the future. It promoted teamwork, corporation, refreshed skills and allowed them to work in the different thematic areas of the response.

For the first time Rwanda can test sample for EVD in the country. The grant enabled the acquisition of this capacity to test both using GeneXpert and RT-PCR, the two confirmatory tests required to declare a sample definitively positive or negative.

ANNEX 3: ACRONYMS AND ABBREVIATIONS (Alphabetical)

CHW	Communiy Health Workers
DRC	Democratic Republic of the Congo
EVD	Ebola Virus Disease
EHOs	Environmental Health Officers
GHDF	Global Humanitarain Development Fund
IPC	Infection Prevention and Control
MOH	Ministry of Health
PoE	Points of Entry
RBC	Rwanda Biomedical Centre
RHCC	Rwanda Health Communication Centre
RC&CE	Risk Communicaiton and Community Engagement
TWG	Technical Working Group
WASH	Water, Sanitation and Hygiene