# NIGERIA
# RAPID RESPONSE
# CHOLERA
# 2021

# 21-RR-NGA-49477

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# PART I – ALLOCATION OVERVIEW

| Reporting Process and Consultation Summary: | |
|---|---|
| Please indicate when the After-Action Review (AAR) was conducted and who participated. | 10 August 2022 |

The After Action Review was carried out with WHO, UNICEF and UNOCHA on 10 August 2022. The WASH Sector Coordinator and the Inter-sector Coordinator were both present for the meeting.

| | | |
|---|---|---|
| Please confirm that the report on the use of CERF funds was discussed with the Humanitarian and/or UN Country Team (HCT/UNCT). | Yes ☐ | No ☒ |

Updates were shared with the HC but the final report has not yet been discussed with the HCT.

| | | |
|---|---|---|
| Please confirm that the final version of this report was shared for review with in-country stakeholders (i.e. the CERF recipient agencies and their implementing partners, clust;er/sector coordinators and members and relevant government counterparts)? | Yes ☐ | No ☒ |

Recipient agencies and related sectors were involved in the reporting process, including the review of drafts of this report and during the After Action Review. The final report, once cleared by the CERF Secretariat, will be circulated to agencies, sectors and other key stakeholders.

## 1. STRATEGIC PRIORITIZATION

### Statement by the Resident/Humanitarian Coordinator:

This CERF cholera allocation through the rapid response window provided critical funding to boost the cholera response in Nigeria. Funding for cholera was not sufficient to cover the country needs so CERF funding was critical in reducing the funding gap. Between the time of request and the receipt of funds, outbreaks continued to be reported especially across the Northwest of the country. Funds were released at the peak of the outbreak in November and the flexibility of the CERF allowed agencies to expand the coverage area as the cholera outbreak spread to other areas not initially planned for implementation.

The CERF funding allowed UN and other humanitarian partners to cover critical needs highlighted in the request which would otherwise have gone unaddressed due to limited resources. It provided an opportunity to work more closely with development partners and to key into government plans (e.g. the cholera response strategy by National Centre for Disease Control).

Given the severity of the outbreak and the expansion of the area of coverage, the case fatality ratio of 3% reflects the significant impact the intervention had, although the project target of 1% was not reached.

### CERF's Added Value:

The CERF funding added value to the humanitarian response by enabling the UN to respond to time critical needs of the population affected by the cholera outbreak in Nigeria.

The allocation improved the coordination between WHO and UNICEF and development and humanitarian actors in the states and communities of implementation. Many national and local organisations were engaged as implementing partners in the delivery of assistance in health and WASH service delivery.

The allocation strengthened the working relationship with state governments and state level response was very well coordinated. The advocacy with local community leaders also led to good working relationships and coordination with community structures.

The allocation built the residual capacity of service providers and communities in all locations of implementation due to the close collaboration with local health workers, WASH service providers and state and local government. In each location/ community of implementation, local workers were trained and 100% of cholera cases were responded to.

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

Yes ☒ Partially ☐ No ☐

This response happened concurrently with the deployment of technical resources by UNICEF and WHO and other donor's financial resources to strengthen coordination and build capacity of government partners around preparedness and response.

CERF helped initiate immediate and fast delivery of WASH supplies and humanitarian services to control the fast-growing number of reported cases and deaths in highly affected communities. partners were immediately mobilized to carry out hygiene promotion campaigns, critical desludging and environmental sanitation interventions, and deployment of chlorine supplies to disinfect water sources in affected areas.

For the health response, UNICEF and WHO already had significant presence on ground in affected states and was already working with the government on cholera and other responses (e.g COVID 19). Fast delivery was hampered by supply and procurement issues affecting the global health supply chain.

**Did CERF funds help respond to time-critical needs?**

Yes ☒ Partially ☐ No ☐

CERF funds provided immediate aid in meeting the WASH and Health needs of vulnerable people affected and at high risk of cholera in conflict-affected states of Borno and Yobe in the North-east, and underfunded states of Kaduna, Jigawa, Kano, Katsina, Sokoto, Kebbi and Zamfara states in the North-west.

CERF funds enabled UNICEF to quickly address the most urgent priorities in WASH, especially time-critical needs for disinfection and desludging of sanitation facilities in congested Internally Displaced Person (IDP) settlements and camps and rapid scale-up of chlorination of community water supply sources, hygiene promotion campaigns and distribution of water purification tablets which aided in protecting the lives of at least 180,550 people living in high-risk communities and staving off transmission of cholera in affected areas during the crisis.

Due to delays in supply and procurement process for some critical health supplies and medicines delivery was delayed. These logistical challenges were related to arrival of procurement and shipment of essential medicines, health supplies and infections prevention and control supplies. The sustained COVID-19 pandemic and its public health responses had significant disruptions to the global supply chain systems including stock-outs of essential medicines, health supplies. Additionally, as the majority of cholera infection prevention and control supplies are similar to COVID-19 response supplies, there were global shortages of supplies driven by mass procurements for COVID-19 response. These negatively affected delivery of time-critical health supplies. Insecurity in certain states of the North West also caused delays in provision of assistance although these challenges were overcome and did not have a significant impact the overall service delivery.

**Did CERF improve coordination amongst the humanitarian community?**

Yes ☒ Partially ☐ No ☐

Strong humanitarian coordination previously existed in the North-east prior to the cholera outbreak in 2021. Meanwhile, in the North-west, there was a lack of humanitarian coordination across the WASH sector. In both regions and with UNICEF and WHO as the lead, discussions around CERF funding prompted cross-agency deliberations and coordination efforts on priorities, presence, and capacities for cholera response, especially in the North-west with little humanitarian presence to identify synergies and avoid duplication of efforts. There was also good coordination between UNICEF & WHO. During the planning, they worked closely together and used the same data sources for planning.

**Did CERF funds help improve resource mobilization from other sources?**

Yes ☒ Partially ☐ No ☐

CERF contributions were leveraged to mobilize additional resources from the Rural Water and Sanitation Support Agency (RUWASSA) and donors in the North-east to implement cholera response activities, thereby expanding the reach for hygiene promotion campaigns. CERF funds also provided an opportunity for several strategic actions, while fulfilling the service delivery gaps in the North-east. Significant amongst these are:

- UNICEF supported the Cholera Technical Working Group in 2021 to strengthen the Cholera Response strategy for the North-east, in order to reinforce and redefine WASH actions.
- The project leveraged additional resources from the RUWASSA and UNICEF's existing Social Behaviour Change (SBC) network for hygiene promotion during the cholera outbreak to improve efficiencies, effectiveness and scale of the campaign.
- Mapping of water vendors and free residual chlorine monitoring in cholera hot spot locations in Borno state and development of Standard Operating Procedures (SOP) in water point chlorination.
- Community health volunteers on cholera community active case search and sensitization.
- Inauguration of Humanitarian Programme Cycle on cholera outbreak response and high-level advocacy to some affected local government areas (LGAs).

## Considerations of the ERC's Underfunded Priority Areas[1]:

This allocation specifically addressed priority area (1): supporting women and girls, including tackling gender-based violence, reproductive health and empowerment required most urgent funding.

The agencies adopted inclusive, localized and participatory processes that invests in the communities themselves which included all groups including women, children, persons with disabilities (PWDs) and elderly, as well as IDPs and their host communities, in planning and implementing the project. Both agencies implement a gender-responsive approach to ensure that women and girls participate in, and equitably benefit from all WASH and health initiatives.

For UNICEF, Institutional WASH initiatives improved water and sanitation services at schools, hospitals and cholera treatment centers thereby reducing gender issues such as adolescence girls' school absence because of lack of sanitation facilities to manage menstruation and high morbidities risks pregnant women face with poor WASH in hospitals. The programme specifically targeted IDP camps and settlements across all 11 states, thereby helping to reducing gender-based violence (GBV) in camps and settlements, where females experience physical hardship and physical insecurity when trying to obtain water and practice sanitation and hygiene. Women and children were empowered to equally participate (as appropriate) in the coordination of the project and the management of WASH infrastructure, including the formation of WASH committees and engagement of local area mechanics through community-based participatory mechanisms. Through their involvement, specific needs and vulnerabilities of women and girls were taken into consideration in the rehabilitation of WASH facilities to ensure facilities were suitable for children, women, PWDs and ensure minimized risks to GBV, particularly for girls and women. For example, providing screens on the entrance of women's toilets and separate rooms for the management of menstrual hygiene, toilet facilities repaired were made to be gender segregated with locks and proper lighting. Focus group discussions were gender-disaggregated so that females can be free to express their opinions. The role of women in promoting hygiene and sanitation were leveraged. During training of teachers and hygiene promotion facilitators and monitors, emphasis was made to include more of female teachers and facilitators to enable them to engage more with women during house-to-house hygiene promotion.

### Table 1: Allocation Overview (US$)

| | |
|---|---|
| **Total amount required for the humanitarian response** | **40,000,000** |
| CERF | 6,004,803 |
| Country-Based Pooled Fund (if applicable) | 0 |
| Other (bilateral/multilateral) | 0 |
| **Total funding received for the humanitarian response (by source above)** | **6,004,803** |

### Table 2: CERF Emergency Funding by Project and Sector/Cluster (US$)

| Agency | Project Code | Sector/Cluster | Amount |
|---|---|---|---|
| **UNICEF** | 21-RR-CEF-047 | Water, Sanitation and Hygiene | 2,580,000 |
| **UNICEF** | 21-RR-CEF-047 | Health | 1,720,000 |
| **WHO** | 21-RR-WHO-034 | Health | 1,704,803 |
| **Total** | | | **6,004,803** |

[1] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and HCTs/UNCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. While CERF remains needs based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the questions and answers on the ERC four priority areas here.

**Table 3: Breakdown of CERF Funds by Type of Implementation Modality (US$)**

| | |
|---|---|
| **Total funds implemented directly by UN agencies including procurement of relief goods** | **4,844,182** |
| Funds sub-granted to government partners* | 1,160,621 |
| Funds sub-granted to international NGO partners* | 0 |
| Funds sub-granted to national NGO partners* | 0 |
| Funds sub-granted to Red Cross/Red Crescent partners* | 0 |
| **Total funds transferred to implementing partners (IP)*** | **1,160,621** |
| **Total** | **6,004,803** |

* Figures reported in table 3 are based on the project reports (part II, sections 1) and should be consistent with the sub-grants overview in the annex.

## 2. OPERATIONAL PRIORITIZATION:

### Overview of the Humanitarian Situation:

As of 3 October 2021 (the date of the last NCDC SitRep), a total of 88,704 suspected cases of cholera including 3,208 deaths (3.6 per cent case fatality ratio (CFR)) were reported from 31 states and the Federal Capital Territory (FCT) (336 local government areas (LGAs)), with a notable and significant escalation in caseloads over the August – October 2021 period. These cases were considerably higher than the total numbers reported in the same period in 2020 (1,859) or 2019 (4,108). The overall national CFR estimated at 3.6 per cent in October 2021 masked sub-national variations with some LGAs having CFR's exceeding 10 per cent. The Northern states were disproportionately affected, with the eleven states accounting for more than 80 per cent of the total reported cases in the country. Inadequate access to and management of water services, high rates of open defecation, unhygienic sanitary/waste disposal systems and poor hygiene practices greatly contributed to the spread of cholera in these states. There were huge gaps in subnational government and local institutional capacities to control the outbreak, especially in services related to WASH, surveillance, risk communication, distribution of cholera supplies, case management, coordination and monitoring by partners. The situation was also compounded by the limited fiscal space of state governments and low presence of the humanitarian community in the North-west region. The sustained rainy season, inadequate access to basic health and WASH services, and continued displacements caused by insecurities and climate-related events in the North further increased the risk of spread to new LGAs and states.

### Operational Use of the CERF Allocation and Results:

In response to the crisis, CERF allocated US$6 million on 27 September 2021 from its Rapid Response window for the immediate commencement of life-saving activities in response to the cholera outbreak. This funding enabled UNICEF, WHO and their partners to provide life-saving health and WASH assistance to people, including women, men, children, and including persons with disabilities.

### People Directly Reached:

The number of cholera cases (suspected and confirmed) are generated from State Cholera Outbreak Situation Reports that track and line list all cases in the states. Line listing of cases reduces the risk of double counting and duplications in numbers reported.

Figures were calculated using disaggregated population statistics provided by the State Ministries of Water Resources and RUWASSA, as well as from IOM DTM IDP and the host population. Standards used to calculate the number of beneficiaries for each service were adapted from Nigeria's WASH in Emergency Technical Guidelines and the SPHERE standards. In the design of this project, UNICEF consulted extensively with the target communities, local government authorities, and within its sections to ensure that duplication is avoided, and complementarity of programming is ensured wherever possible. UNICEF strived to reach the same population with full complement of WASH services, thus ensuring that this population is counted once for all services. The project leveraged additional resources from the Rural Water Supply and Sanitation Agency and UNICEF's existing SBC network for hygiene promotion during the cholera outbreak to improve efficiencies, effectiveness, and scale of the campaign, reaching up to **115,587** households with key hygiene messages.

### People Indirectly Reached:

Both the WASH and Health sector state and LGA level authorities, Rapid Response Teams, health facility staff, and state and local task force members benefited from on-the-job mentorship as a result of their full engagement and involvement in the planning and implementation of the project. CERF support enabled WHO & UNICEF to complement its ongoing support to health workforce capacity building especially in the management of diseases of epidemic potential.

Within the WASH sector, through its community-driven sanitation and hygiene promotion activities, capacities of community WASH committees (WASHCOMs), volunteer hygiene promoters (VHPs), Environmental health officers (EHOs) and officers from the state environmental protection agencies (EPA), and local area mechanics at the community level were built on implementation, operations and maintenance of WASH services at the community level. UNICEF indirectly reached an additional **2.6 million people** reaching at

least **400,000 IDPs** with hygiene promotion campaigns through mass media including radio jingles and motorized announcements. Eight radio stations were engaged to reach these beneficiaries. They include Rima Radio in Sokoto, Zamfara Radio and Television Services, Vision FM in Kebbi, Kano Radio and Express Radio in Kano state, Albarka Radio in Bauchi state and ABC and Radio Gotel in Adamawa state. Due to the decreased price differences in water testing kits, the programme was able to procure almost double the planned amounts of Bacteriological H2S Field Test Kits and Chlorine/pH Pool Testers. This enabled government partners to monitor the quality and chlorine levels of additional 3,000 distinct water sources serving at least 1.5 million people for an additional three months.

**Table 4: Number of People Directly Assisted with CERF Funding by Sector/Cluster***

| | Planned | | | | | Reached | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Sector/Cluster** | **Women** | **Men** | **Girls** | **Boys** | **Total** | **Women** | **Men** | **Girls** | **Boys** | **Total** |
| Health | 37,732 | 31,170 | 50,856 | 44,294 | **164,052** | 71,373 | 61,003 | 68,893 | 59,814 | **261,083** |
| Water, Sanitation and Hygiene | 55,705 | 46,058 | 81,442 | 66,795 | **250,000** | 76,367 | 90,057 | 71,358 | 63,697 | **301,479** |

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

**Table 5: Total Number of People Directly Assisted with CERF Funding by Category***

| Category | Planned | Reached |
|---|---|---|
| **Refugees** | 8,203 | 7,816 |
| **Returnees** | 16,405 | 12,319 |
| **Internally displaced people** | 229,294 | 245,814 |
| **Host communities** | 143,745 | 186,662 |
| **Other affected people** | 16,405 | 28,600 |
| **Total** | **414,052** | **481,211** |

| **Table 6: Total Number of People Directly Assisted with CERF Funding*** | | | **Number of people with disabilities (PwD) out of the total** | |
|---|---|---|---|---|
| **Sex & Age** | **Planned** | **Reached** | **Planned** | **Reached** |
| **Women** | 93,438 | 117,640 | 5,097 | 2,409 |
| **Men** | 77,228 | 124,214 | 4,214 | 2,757 |
| **Girls** | 132,299 | 127,235 | 7,453 | 2,394 |
| **Boys** | 111,087 | 112,122 | 6,112 | 2,140 |
| **Total** | **414,052** | **481,211** | **22,876** | **9,700** |

# PART II – PROJECT OVERVIEW

## 3. PROJECT REPORTS

### 3.1 Project Report 21-RR-CEF-047

#### 1. Project Information

| | | | |
|---|---|---|---|
| **Agency:** | UNICEF | **Country:** | Nigeria |
| **Sector/cluster:** | Health<br>Water, Sanitation and Hygiene | **CERF project code:** | 21-RR-CEF-047 |
| **Project title:** | Cholera Prevention and Control through community health and WASH interventions in Northern Nigeria | | |
| **Start date:** | 26/10/2021 | **End date:** | 25/04/2022 |
| **Project revisions:** | No-cost extension ☒ Redeployment of funds ☐ | | Reprogramming ☐ |

**Funding**

| | |
|---|---|
| **Total requirement for agency's sector response to current emergency:** | **US$ 15,500,000** |
| **Total funding received for agency's sector response to current emergency:** | **US$ 1,200,000** |
| **Amount received from CERF:** | **US$ 4,300,000** |
| **Total CERF funds sub-granted to implementing partners:** | **US$** 1,160,621 |
| Government Partners | US$ 1,160,621 |
| International NGOs | US$ 0 |
| National NGOs | US$ 0 |
| Red Cross/Crescent Organisation | US$ 0 |

#### 2. Project Results Summary/Overall Performance

Through the CERF grant, UNICEF and its health partners including the National Center for Disease Control and targeted State Primary Health Care Development Agencies reached 81,353 women, children and men with lifesaving treatment and support for cholera case management through cholera treatment centers, cholera treatment units and oral rehydration points. UNICEF supported the procurement and distribution of essential medicines and health supplies and infection prevention and control supplies for the targeted states.

In 318 health care facilities, 231 schools, 1,426 communities within target states, CERF funding also enabled UNICEF and its WASH partners to provide life-saving safe water supply services to **301,479 people** as per SPHERE standards, renewed access to safe and dignified toilets/latrines and handwashing facilities to **39,460** people to curtail open defecation, reached **693,525** people with key hygiene and cholera risk awareness and prevention messages and provided essential cholera kits to **72,360** people.

The project leveraged additional resources from the Rural Water Supply and Sanitation Agency and UNICEF's existing SBC network for hygiene promotion during the cholera outbreak to improve efficiencies, effectiveness and scale of the campaign, reaching up to **115,587** households with key hygiene messages. Engaging the media to broadcast cholera jingles reached out to wider and more population on Infection, Prevention and control of cholera than would have been possible if house-to-house and community-to-community approach was adopted. Up to 2.6 million people were indirectly reached through mass media.

## 3. Changes and Amendments

The project end date was extended from 22 April 2022 to 22 July 2022 to enable completion of all planned activities that resulted from logistical challenges related to arrival of procurement and shipment of essential medicines, health supplies and infections prevention and control supplies. The sustained COVID-19 pandemic and the global public health response had significant disruption to the global supply chain systems including stock-outs of essential medicines, health supplies. Additionally, as majority of cholera infection prevention and control supplies are similar to COVID-19 response supplies, there were global shortages of supplies driven by mass procurements for COVID-19 response.

UNICEF targeted 11 states instead of 10 states as stated in the original proposal. This is as a result of the inclusion of Kaduna state during initial deliberations with CERF and the unintended omission of the state in the final project plan.

## 4. Number of People Directly Assisted with CERF Funding*

| Sector/cluster | Health | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Planned | | | | | Reached | | | | |
| Category | Women | Men | Girls | Boys | Total | Women | Men | Girls | Boys | Total |
| Refugees | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | **0** |
| Returnees | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | **0** |
| Internally displaced people | 14,410 | 9,522 | 16,896 | 13,854 | **54,682** | 17,759 | 15,839 | 7,680 | 6,720 | **47,998** |
| Host communities | 5,087 | 4,218 | 6,385 | 6,061 | **21,751** | 12,341 | 11,007 | 5,337 | 4,670 | **33,355** |
| Other affected people | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 0 |
| **Total** | **19,497** | **13,740** | **23,281** | **19,915** | **76,433** | **30,100** | **26,846** | **13,017** | **11,390** | **81,353** |
| **People with disabilities (PwD) out of the total – see WASH totals** | | | | | | | | | | |
| | 1,755 | 1,451 | 2,566 | 2,104 | **7,876** | | | | | |

| Sector/cluster | Water, Sanitation and Hygiene | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Planned | | | | | Reached | | | | |
| Category | Women | Men | Girls | Boys | Total | Women | Men | Girls | Boys | Total |
| Refugees | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 0 |
| Returnees | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 0 |
| Internally displaced people | 41,172 | 34,007 | 60,343 | 49,478 | **185,000** | 51,166 | 60,338 | 47,810 | 42,677 | **201,991** |
| Host communities | 14,534 | 12,051 | 21,099 | 17,316 | **65,000** | 25,201 | 29,719 | 23,548 | 21,020 | **99,488** |
| Other affected people | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 0 |
| **Total** | **55,706** | **46,058** | **81,442** | **66,794** | **250,000** | **76,367** | **90,057** | **71,358** | **63,697** | **301,479** |
| **People with disabilities (PwD) out of the total** | | | | | | | | | | |
| | 3,342 | 2,763 | 4,887 | 4,008 | **15,000** | **2,094** | **2,469** | **1,956** | **1,746** | **8,265** |

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

## 5. People Indirectly Targeted by the Project

Both WASH and Health sector state and LGA level authorities benefited from on-the-job mentorship as a result of their full engagement and involvement in the planning and implementation of the project. The CERF RR support enabled UNICEF to complement its ongoing support to health workforce capacity building especially in the management of diseases of epidemic potential. As such, a total of 446 health workers had their capacities built with alternative funding in compliment to the CERF RR funds.

Within the WASH sector, through its community-driven sanitation and hygiene promotion activities, capacities of community WASH committees (WASHCOMs), volunteer hygiene promoters (VHPs), Environmental health officers (EHOs) and officers from the state environmental protection agencies (EPA), and local area mechanics at the community level were built on implementation, operations and maintenance of WASH services at the community level. UNICEF indirectly reached an additional 2,000,000 million people hosting at least 400,000 IDPs with hygiene promotion campaigns through mass media including radio jingles and motorized announcements. Eight radio stations were engaged to reach these beneficiaries. They include Rima Radio in Sokoto, Zamfara Radio and Television Services, Vision FM in Kebbi, Kano Radio and Express Radio in Kano state, Albarka Radio in Bauchi state and ABC and Radio Gotel in Adamawa state. Due to the downward price differences in water testing kits, the programme was able to procure about double Bacteriological H2S Field Test Kits and Chlorine/pH Pool Testers planned. This enabled government partners monitor the quality and chlorine levels of 6,000 distinct water sources serving 1.5 million people for an additional three months.

## 6. CERF Results Framework

| | |
|---|---|
| **Project objective** | To contain the cholera outbreak, minimize rates of new infections and reduce CFR to below 1% in the short term in the 10 targeted most-affected states |
| **Output 1** | 250,000 vulnerable persons in 10 target states have improved access to clean water and sanitation services to aid in cholera prevention and control |

**Was the planned output changed through a reprogramming after the application stage?** Yes ☐ No ☐

| | |
|---|---|
| **Sector/cluster** | Health |

| **Indicators** | **Description** | **Target** | **Achieved** | **Source of verification** |
|---|---|---|---|---|
| Indicator 1.1 | WS.6 Number of people accessing a sufficient quantity of safe water as per agreed sector/cluster coordination standards and norms | 250,000 | 301,479 | UNICEF Humanitarian Situation Report, UNICEF/partner Field Monitoring Reports for the Northwest (4Ws), UNICEF, the Northeast ReportHub |
| Indicator 1.2 | WS.9b Number of people who report directly using safe and dignified toilet/latrines with functional handwashing facilities | 13,000 | 39,460 | UNICEF Humanitarian Situation Report, UNICEF/partner Field Monitoring Reports for the Northwest (4Ws), UNICEF, the Northeast ReportHub |

| | |
|---|---|
| **Explanation of output and indicators variance:** | UNICEF reached **301,479** people living in 11 states in the North-east and North-west with access to clean water and sanitation services to aid in cholera prevention and control.<br><br>This was achieved through the provision **2,799** kg drums of chlorine, **325** boxes of Aquatabs and **33,000** water testing kits used to treat and monitor the quality of water to enable people living in high risk and affected communities, health |

| | |
|---|---|
| | centers, schools and IDP settlements and camps to access clean water for drinking, cooking and practicing adequate personal hygiene.<br><br>To re-establish access to water supply for the target population, UNICEF repaired and protected 37 solar motorized systems, 330 handpump boreholes and 40 hand dug wells benefitting **301,479** people. In addition to that, structures for village-led operations and maintenance structures in communities were these systems serve were formed to aid in sustaining continuous supply of clean water to target persons, in addition to building the capacities of local area mechanics and WASH committees.<br><br>Health care facilities, cholera treatment centers (CTCs), and congested settlements and camps hosting internally displaced persons (IDPs) were targeted for repairs, sanitization, and safe desludging of **1,973** emergency latrine drop holes and their accompanying handwashing stations. This was especially important to renew access to clean sanitation facilities for **39,460** vulnerable people in order to reduce open defecation and exposure to fecal matter, especially in CTCs hosting cholera-affected persons. Within the same locations, communities were supported to institute community-led environmental sanitation campaigns for solid waste disposal, sanitization of affected household compounds and public latrines in markets, health centers and motor parks; and disinfection and cleaning up of drainages of affected communities. This was done through the engagement of community WASH committees (WASHCOMs), volunteer hygiene promoters (VHPs), Environmental Health officers (EHOs) and officers from the state Environmental Protection Agencies (EPA). |

| **Activities** | **Description** | **Implemented by** |
|---|---|---|
| Activity 1.1 | Chlorination activities – procurement, distribution and use of chlorine HTH and supplies for targeted regular water quality testing and chlorination of water sources in health centres, schools and communities | State-level RUWASSA, State Ministry of Environment, State Environmental Protection Agency |
| Activity 1.2 | Light repairs/desludging of emergency latrines (with provision of handwashing facilities) in health centres, CTCs and IDP settlement | State-level RUWASSA, State Ministry of Environment, State Environmental Protection Agency, Albarka Drainage Company (Private Firm) |
| Activity 1.3 | Cleaning and disinfection latrines and community-driven environmental sanitation | State-level RUWASSA, State Ministry of Environment, State Environmental Protection Agency |
| Activity 1.4 | Light repair and operations and maintenance (O&M) of water facilities through village-led O&M | State-level RUWASSA, State Ministry of Environment, State Environmental Protection Agency |

| | |
|---|---|
| **Output 2** | 54,000 people in 10 target states are provided with WASH commodities and are exposed to key cholera risk awareness and hygiene messages to improve hygiene behaviour, encourage health-seeking behaviour and prevent the spread of cholera |
| **Was the planned output changed through a reprogramming after the application stage?** | Yes ☐ No ☒ |
| **Sector/cluster** | Water, Sanitation and Hygiene |

| **Indicators** | **Description** | **Target** | **Achieved** | **Source of verification** |
|---|---|---|---|---|
| Indicator 2.1 | Number of vulnerable people reached with community-level cholera risk awareness, preparedness and prevention, and hygiene promotion campaigns in | 50,000 | 693,525 | UNICEF Humanitarian Situation Report, UNICEF/partner Field Monitoring Reports for the |

| | | | | |
|---|---|---|---|---|
| | IDP camps, host communities and high-risk areas | | | Northwest (4Ws), UNICEF, the Northeast ReportHub |
| Indicator 2.2 | Number of people reached with cholera prevention and treatment information through mass media | 1,000,000 | 2,636,522 | UNICEF Humanitarian Situation Report, UNICEF/partner Field Monitoring Reports for the Northwest (4Ws), UNICEF, the Northeast ReportHub, Radio Reports |
| Indicator 2.3 | H.3 Number of people benefitting from cholera kits | 54,000 | 72,360 | UNICEF Humanitarian Situation Report, UNICEF/partner Field Monitoring Reports for the Northwest (4Ws), UNICEF, the Northeast ReportHub |

| | |
|---|---|
| **Explanation of output and indicators variance:** | UNICEF developed and implemented, in collaboration with its Social Behavior Change Communications (SBCC) team, integrated high impact messaging and strategy for cholera risk awareness and hygiene promotion aimed at improving hygiene behaviour, encouraging positive protective and health-seeking behavior that aid in preventing the spread of cholera. Within the 11 target states, up to **693,525** people were reached with these messages through interpersona engagement with community and religious leaders, women groups, teachers and pupils, and individual households.<br><br>UNICEF employed other social, and behaviour change interventions to ignite positive behaviours to control and prevent the spread of cholera including the use of motorized announcement vehicles to propagate awareness messages reaching about 271,762 persons; sensitization of congregations at the mosque and churches during sermons, reaching 287,709 people; and sensitizing 13,641 pupils/students in schools. Community Radio listening groups sessions and Community Dialogues/ Compound meetings were also held to increase awareness and knowledge around hygiene practices in high-risk communities. Over 12,463 people participated. A public entertainment group (Koroso Group) has been engaged in the three states to carry out hygiene enlightenment and sensitization campaigns. Together with motorized announcements, UNICEF indirectly reached an additional **2.6 million** people hosting at least 400,000 IDPs with hygiene promotion campaigns through mass media including radio jingles and motorized announcements. Eight radio stations were engaged to reach these beneficiaries. They include Rima Radio in Sokoto, Zamfara Radio and Television Services, Vision FM in Kebbi, Kano Radio and Express Radio in Kano state, Albarka Radio in Bauchi state and ABC and Radio Gotel in Adamawa state.<br><br>To compliment hygiene and cholera risk awareness messages at the household level, **12,060** affected households were provided with cholera kits containing water kits, Aquatabs and soaps that will assist households in practicing proper household water treatment, water management and personal hygiene. |

| **Activities** | **Description** | **Implemented by** |
|---|---|---|
| Activity 2.1 | Production and distribution of key messages (IEC materials) on cholera treatment and prevention | State-level RUWASSA, State Ministry of Environment, State Environmental Protection Agency |
| Activity 2.2 | Hygiene Promotion and Social mobilization, community and household engagement in affected | State-level RUWASSA, State Ministry of Environment, State Environmental Protection Agency |

| | | |
|---|---|---|
| | wards and LGAs to create awareness and initiate action to control and block transmission of cholera | |
| Activity 2.3 | Media engagement including the production and dissemination of radio jingles, TV edutainments, etc. to reinforce cholera awareness and health seeking behaviour | State-level RUWASSA, State Ministry of Environment, State Environmental Protection Agency |
| Activity 2.4 | Procurement and Distribution of lifesaving essential WASH\ Cholera Kits, including Aquatabs, antibacterial soaps, detergents, water containers to IDP settlements and vulnerable households | State-level RUWASSA, State Ministry of Environment, State Environmental Protection Agency |

| | |
|---|---|
| **Output 3** | 76,433 people reached with health interventions to identify, treat and contain cholera infections through enhanced case management and improved infection prevention and control |
| **Was the planned output changed through a reprogramming after the application stage?** | Yes ☐ No ☒ |
| **Sector/cluster** | Health |

| **Indicators** | **Description** | **Target** | **Achieved** | **Source of verification** |
|---|---|---|---|---|
| Indicator 3.1 | Number of mild, moderate and severe cholera cases treated appropriately as per WHO treatment standards | 76,433 | 81,353 | State Cholera Outbreak Situation Reports |
| Indicator 3.2 | Number of Cholera Treatment Centres and Oral Rehydration Points provided with essential Infection Prevention and Control (IPC) Supplies | 96 | 129 | State Cholera Outbreak Situation Reports |
| **Explanation of output and indicators variance:** | | CERF support enabled UNICEF to reach 81,353 individuals with appropriate treatment for mild, moderate and sever cholera cases against a targeted of 76,433. 129 cholera treatment centers, cholera treatment units and oral rehydration points were support in the targeted states. | | |

| **Activities** | **Description** | **Implemented by** |
|---|---|---|
| Activity 3.1 | Procurement and distribution of essential medicine and health supplies | [UNICEF]<br>Procurement/distribution included :<br>ORS + Zinc tablets<br>Doxycycline tablets<br>Azithromycin tablets<br>Cefixime suspension |
| Activity 3.2 | Procurement and distribution of IPC supplies | [UNICEF]<br>Procurement/distribution included:<br>Surgical and examination gloves<br>Heavy duty gloves<br>Coveralls<br>Aprons – disposable and re-usable<br>Rubber boots<br>Biohazard bags<br>Compression sprayers<br>Syringes<br>Body bags<br>Hand sanitizers |

## 7. Effective Programming

### a. Accountability to Affected People (AAP) [2]:

UNICEF engaged the crisis affected groups through participatory and community-based mechanisms. Community leaders (both traditional and religious leaders) along with WASHCOMs and VHPs were engaged actively in the campaign to control the outbreak and spread of cholera in each of the communities. Community leaders also monitored the repairs and renovation of WASH facilities in their communities, ensuring technical specifications are met. In IDP settlements and host communities, target groups received information about the project through the camp management, traditional leadership, and community mobilizers. Different population strata from the communities including girls, boys, women, and men, older people and those with disabilities, were separately consulted to ensure that different concerns of the beneficiaries on safety, dignity and preferences in the context of inclusiveness and non-discrimination were factored into the response. Affected communities were involved in the identification and assessment of WASH facilities that were repaired in their communities

Feedback from targeted communities resulted in UNICEF supporting the establishment and operationalisation of additional Oral Rehydration Points that were established closer to affected communities. These enabled easier and quicker access for affected individual and communities.

### b. AAP Feedback and Complaint Mechanisms:

Vulnerable and marginalized groups were involved in the design and implementation of the project through voluntary engagement, FGD feedback while observing COVID-19 protocols, and random key informant interviews using the facilities to get feedback from users. Separate meetings for IDPs, host communities, youths, girls and disadvantaged groups, such as people with disabilities, in order to ensure documentation of their points of view, suggestions and potential claims. The project ensured that women are effectively represented in all platforms/committees. "Safe spaces" were created for women and girls to address their specific concerns and the project ensured security and protection analysis was done to ensure no risk to women at meeting sites. Community and government participation was sustained at all stages of the project to ensure transparency and allow for adjustments based on feedback throughout the project period to ensure value for money, the needs of key beneficiaries are adequately met, and vulnerable groups are not marginalized. Work plans and implementation agreements were reviewed with Government partners to contribute to mutual accountability between UNICEF and Government partners.

### c. Prevention of Sexual Exploitation and Abuse (PSEA):

PSEA is fully integrated in all UNICEF partneship agreements, supply chain contracts and capacity building activities for the staff, consultants, volunteers, vendors, and implementing partners. All partners have a low-risk rating following a PSEA assessment and have designated PSEA focal persons to eunsre compliance to all core standards.

Within the WASH sector implementation,

- RUWASA staff were made aware of UNICEF Zero Tolerance for SEA policy and agreed to comply with the guidelines and to report any incidence when/if they occur.
- Female mobilizers and volunteers were deployed to work in households engaging women and girls during hygiene promotion awareness campaign so as to reduce possible incidence of sexual abuse.
- All personnel working directly or indirectly on this project were sensitized and adhere to Child Safeguarding policy and Protection from Sexual Exploitation and Abuse policies.
- The project ensured that women are effectively represented in all platforms/committees. Focus group discussions will be gender disaggregated so that females can be free to express their opinions. "Safe Spaces" were created for women and girls to address

[2] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

their specific concerns and the project ensured security and protection analysis was done to ensure no risk to women at meeting sites.

- Through adequate involvement of women and girls, their specific needs and vulnerabilities were taken into consideration in the rehabilitation of WASH facilities to ensure facilities were suitable for children, women, PLWDs and ensure minimized risks to SGBV, particularly for girls and women. For example, providing screens on the entrance of women's toilets and separate rooms for the management of menstrual hygiene, toilet facilities repaired were made to be gender segregated with locks and proper lighting.

**d. Focus on women, girls and sexual and gender minorities, including gender-based violence:**

UNICEF implements a highly gender responsive approach to ensure that women and girls participate in, and equitably benefit from all WASH and health initiatives. Institutional initiatives improved water and sanitation services at schools, hospitals and cholera treatment centers thereby reducing gender issues such as adolescence girls' school absence because of lack of sanitation facilities to manage menstruation. Improved WASH and health services specifically targeted IDP camps and settlements across all 11 states, thereby helping to reducing gender-based violence in camps and settlements, where females experience physical hardship and physical insecurity when trying to obtain water and practice sanitation and hygiene.

Women and children were enabled to equally participate (as appropriate) in the coordination of the project and the management of WASH infrastructure, including the formation of WASH committees and engagement of local area mechanics through community-based participatory mechanisms. The project ensured that women are effectively represented in all platforms/committees. Focus group discussions will be gender disaggregated so that females can be free to express their opinions. "Safe spaces" were created for women and girls to address their specific concerns and the project ensured security and protection analysis was done to ensure no risk to women at meeting sites.

Through their involvement, specific needs and vulnerabilities of women and girls were taken into consideration in the rehabilitation of WASH facilities to ensure facilities were suitable for children, women, PWDs and ensure minimized risks to SGBV, particularly for girls and women. For instance, providing screens on the entrance of women's toilets and separate rooms for the management of menstrual hygiene, toilet facilities repaired were made to be gender segregated with locks and proper lighting. Focus group discussions will be gender disaggregated so that females can be free to express their opinions.

The role of women in promoting hygiene and sanitation were leveraged. For example, During training of teachers and hygiene promotion facilitators and monitors, emphasis was made to include more of female teachers and facilitators to enable them to engage more with women during house-to-house hygiene promotion.

**e. People with disabilities (PwD):**

The CERF project was built with the aim of improving equitable access to cholera treatment and prevention services for the most vulnerable and marginalised persons including with disabilities. UNICEF adopted inclusive, localized and participatory processes that invests in the communities themselves which included all groups including women, children, persons living with disabilities (PWDs) and elderly, as well as IDPs and their host communities, in planning and implementing the project. Households with PWDs were specifically targeted and 11,790 PWDs benefitted with water supply and sanitation interventions in their communities and were provided with hygiene supplies. Latrines were made accessible for PWDs during light repairs by including such facilities as ramps and handrails.

**f. Protection:**

In programme implementation, UNICEF ensured protection of affected and at-risk persons by enforcing the following measures in accordance with its social safeguard policy and requirements which focuses on prevention of child labour and exploitation; prevention of gender-based violence and promotion of wellbeing, dignity and safety of women, adolescents and children; and prevention of sexual exploitation and abuse by employees and personnel:

- Use of children for labour force to work on light repairs of WASH facilities was prohibited and observed complied by the vendors at all the locations.
- Implementations were fast tracked at each site to avoid delays that will put children at risk in search of alternative sources while repairs were ongoing
- UNICEF carried out security and protection analysis at project inception with women to women group discussions to ensure no risk to women at meeting sites and gender-disaggregated "safe spaces" were created for women and girls to address their specific WASH needs
- UNICEF adopted inclusive, localized and participatory processes that invests in the communities themselves which included all groups including women, children, persons living with disabilities and elderly, as well as IDPs and their host communities, in planning and implementing the project
- All contractors and facilitators were oriented on gender and sexual based violence and committed to observing the highest standards of preventing it and reporting it if observed.

**g. Education:**

The cholera oubreak did not have significant disruption to education including access to safe learning enviroments, but the number of school aged children affected was significant and therefore the design of the project was geared towards the restoration of and imprvoed access to essential education services and learning continuity in affected communities.

Up to 229 schools were targeted with WASH response reaching an average of 654 pupils per school. Therefore about 150,000 pupils were reached with hygiene promotion interventions and benefit from improved community water supply and sanitation services, thereby reducing their risks of cholera and diarrheal infection and contributing to safe, inclusive and effective learning environments, healthy pupils and students who perform well in school, and positively influencing hygiene practices in the wider community.

## 8. Cash and Voucher Assistance (CVA)

**Use of Cash and Voucher Assistance (CVA)?**

| Planned | Achieved | Total number of people receiving cash assistance: |
|---|---|---|
| No | No | 0 |

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Not applicable

## 9. Visibility of CERF-funded Activities

| Title | Weblink |
|---|---|
| Renovated solar borehole at Kara Primary School in Yobeserves the children's various needs. | *https://twitter.com/UNICEF_Nigeria/status/1524327447038148608* |
| #ForEveryChild, protection from cholera & other water-related diseases. | *https://twitter.com/UNICEF_Nigeria/status/1509607596537303043* |

## 3.2 Project Report 21-RR-WHO-034

### 1. Project Information

| | | | |
|---|---|---|---|
| **Agency:** | WHO | **Country:** | Nigeria |
| **Sector/cluster:** | Health | **CERF project code:** | 21-RR-WHO-034 |
| **Project title:** | Support in transmission containment and reduction of related mortality of Cholera disease in 147 LGAs across 10 states in Nigeria. | | |
| **Start date:** | 27/10/2021 | **End date:** | 26/04/2022 |
| **Project revisions:** | No-cost extension ☒ | Redeployment of funds ☐ | Reprogramming ☒ |

**Funding**

| | |
|---|---|
| **Total requirement for agency's sector response to current emergency:** | **US$ 5,000,000** |
| **Total funding received for agency's sector response to current emergency:** | **US$ 750,000** |
| **Amount received from CERF:** | **US$ 1,704,803** |
| **Total CERF funds sub-granted to implementing partners:** | **US$ 0** |
| Government Partners | US$ 0 |
| International NGOs | US$ 0 |
| National NGOs | US$ 0 |
| Red Cross/Crescent Organisation | US$ 0 |

### 2. Project Results Summary/Overall Performance

- 6,245 frontline workers were trained in surveillance and case management for cholera
- Deployed national Rapid Response Teams (RRTs) of 54 Nigeria Centre for Disease Control (NCDC) personnel to the 10 States to investigate and respond to cholera outbreaks
- Established 424 Oral Rehydration Points (ORPs) and 155 Cholera Treatment Centres (CTCs) in the country
- Investigated 95% of public health alerts from the communities and health facilities within 24 - 48 hours of reporting suspected cholera cases
- 96% of health facilities shared timely weekly reports for public health intelligence and analysis
- Capacity built for 470 Rapid Response Teams in the areas of surveillance, case management and risk communication
- Sensitized 4,074 community stakeholders (LGA Chairpersons, Traditional and Religious leaders) and community gatekeepers for cholera alert reporting and provision of public health information to community members

### 3. Changes and Amendments

The project was initially planned to be implemented in 147 LGAs in 10 states. During project implementation, the risk analysis revealed that cholera outbreak would occur in the states that had not been previously included. Therefore, a modification request was submitted and approved on 20th April 2022 to expand coverage across the 37 states. A no cost extension of the project from April to June was equally granted.

## 4. Number of People Directly Assisted with CERF Funding*

| Sector/cluster | Health | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Planned | | | | | Reached | | | | |
| Category | Women | Men | Girls | Boys | Total | Women | Men | Girls | Boys | Total |
| Refugees | 1,887 | 1,558 | 2,543 | 2,215 | **8,203** | 1,720 | 1,490 | 2,582 | 2,024 | **7,816** |
| Returnees | 3,773 | 3,117 | 5,086 | 4,429 | **16,405** | 2,833 | 2,340 | 3,819 | 3,327 | **12,319** |
| Internally displaced people | 10,188 | 8,416 | 13,731 | 11,959 | **44,294** | 10,099 | 8,323 | 13,560 | 11,841 | **43,823** |
| Host communities | 18,111 | 14,962 | 24,411 | 21,261 | **78,745** | 20,060 | 16,553 | 27,054 | 23,507 | **87,174** |
| Other affected people | 3,773 | 3,117 | 5,086 | 4,429 | **16,405** | 6,561 | 5,451 | 8,862 | 7,726 | **28,600** |
| **Total** | **37,732** | **31,170** | **50,857** | **44,293** | **164,052** | **41,273** | **34,157** | **55,877** | **48,425** | **179,732** |
| **People with disabilities (PwD) out of the total** | | | | | | | | | | |
| | 415 | 343 | 559 | 487 | **1,804** | **315** | **288** | **438** | **394** | **1,435** |

* Figures represent best estimates of people directly supported through CERF funding. Disaggregation by sex and age represents women and men ≥18, girls and boys <18.

## 5. People Indirectly Targeted by the Project

Through integrated health risk messaging, 680,000 vulnerable populations, 451 hard to reach and security compromised communities in 11 states

## 6. CERF Results Framework

| | |
|---|---|
| **Project objective** | To contain the transmission of cholera outbreak at community level through the deployment of surveillance and rapid response teams (RRTs); |
| **Output 1** | Enhanced and timely detection, investigation and response to cholera disease alerts in the 147 affect LGAs |

**Was the planned output changed through a reprogramming after the application stage?** Yes ☐ No ☐

| **Sector/cluster** | Health | | | |
|---|---|---|---|---|
| **Indicators** | **Description** | **Target** | **Achieved** | **Source of verification** |
| Indicator 1.1 | H.5 Percentage of public health alerts generated through community-based or health-facility-based surveillance or alert systems investigated within 24 hours | 90 | 95% | Weekly state reports |
| Indicator 1.2 | H.6 Proportion of functional health facilities sharing timely reports95% (140) | 95 | 96% | Weekly state reports |
| Indicator 1.3 | CC.1 Number of frontline aid workers (e.g. partner personnel) who received short refresher training to support programme implementation (case managers at ORPs and CTCs trained on case management and IPC) | 147 | 6,245 | Training reports |
| Indicator 1.4 | CC.1 Number of frontline aid workers (e.g. partner personnel) who received short refresher training to support programme implementation (RRT members) | 588 | 470 RRTs (each RRT with 7-9 members) | Training reports |
| **Explanation of output and indicators variance:** | | The project was initially targeted for 10 states, but the implementation was later expanded to 37 states | | |

| **Activities** | **Description** | **Implemented by** |
|---|---|---|
| Activity 1.1 | Conduct epidemiological investigations to identify transmission sources and map affected population clusters; | WHO and State Ministry of Health and Nigeria Centre for Disease Control |
| Activity 1.2 | Conduct environment surveillance, sampling various possible infection sources of infection; | WHO and State Ministry of Health |

| | | |
|---|---|---|
| Activity 1.3 | Conduct case surveillance, testing suspect cases with RDTs and sending samples of RDT positive suspect cases for lab testing; | WHO, State Ministry of Health and Nigeria Centre for Disease Control |
| Activity 1.4 | Conduct active cases finding in health facilities; | WHO and State Ministry of Health |
| Activity 1.5 | Deploy multisectoral LGA RRTs for case investigation, surveillance, identification of transmission containment measures and identification of sites for ORPs & CTCs; | WHO and State Ministry of Health |
| Activity 1.6 | Strengthen the lab diagnostic network for timely processing of environmental and case surveillance samples | WHO, State Ministry of Health and Nigeria Centre for Disease Control |
| Activity 1.7 | Monitor the implementation of surveillance, lab interventions | WHO, State Ministry of Health and Nigeria Centre for Disease Control |

| | |
|---|---|
| **Output 2** | Reduce and maintain case fatality ratio (CFR) of less than 1% through prompt and improved case management; |

**Was the planned output changed through a reprogramming after the application stage?** Yes ☐ No ☐

| **Sector/cluster** | Health | | | |
|---|---|---|---|---|
| **Indicators** | **Description** | **Target** | **Achieved** | **Source of verification** |
| Indicator 2.1 | H.7 Number of functional health facilities supported | 140 | 219 | Weekly state reports |
| Indicator 2.2 | H.8 Number of primary healthcare consultations provided | 3,500 | 4634 | Line lists |
| **Explanation of output and indicators variance:** | | There were several cholera outbreaks reported and responded to in 12 states | | |

| **Activities** | **Description** | **Implemented by** |
|---|---|---|
| Activity 2.1 | Establish ORPs and CTCs in sites assessed and designated by the RRT. Training site staff and provide case management job aids, documentation tools, IPC amenities and case management supplies; | WHO, State Ministry of Health and Nigeria Centre for Disease Control |
| Activity 2.2 | Engage and train health workers in case management and IPC in ORPs/CTCs to correctly manage AWD cases; | WHO, Federal Ministry of Health, State Ministry of Health State Primary Health Care Development Agency/Board and Nigeria Centre for Disease Control |
| Activity 2.3 | Support ORP and CTC site running costs; | WHO, State Ministry of Health Nigeria Centre for Disease Control |
| Activity 2.4 | Procure and pre-position initial consignment of diagnostic, treatment and IPC supplies for AWD case management; | WHO, State Ministry of Health and Nigeria Centre for Disease Control |
| Activity 2.5 | Monitor CERF funded laboratory, case management and IPC interventions through national EOC, state EOC and LGA teams; | WHO and Nigeria Centre for Disease Control |

## 7. Effective Programming

**a. Accountability to Affected People (AAP) [3]:**

Needs assessments were carried out in all the initial 10 states which clearly identified and quantified specific needs. Stakeholder mapping, engagements and community feedback were held in the five states of Bauchi, Gombe, Kano, Borno, Taraba and Jigawa and this guided and streamlined the implementation strategy in all the states. Community members were involved in the planning, implementation and evaluation phases of the intervention using human centred design approach.

**b. AAP Feedback and Complaint Mechanisms:**

Community feedback, tracking and social listening served as mechanisms for feedback and provided further insights for course corrective measures and informed decision making. Identified champions and influencers in every state that were involved in the instituted complaint system.

**c. Prevention of Sexual Exploitation and Abuse (PSEA):**

All the field personnel involved in the response efforts including staff and surge personnel undertook the PSEA mandatory training. Furthermore, a reporting PSEA mechanism was established, closely monitored by a WHO PSEA personnel. Community based complaint mechanism was established including recipient state governments. PSEA mainstreaming that involved the orientation of the rapid response teams and conducted education sessions to the recipient communities on what PSEA is and channels of reporting.

**d. Focus on women, girls and sexual and gender minorities, including gender-based violence:**

Core response activities especially Oral Cholera Vaccine campaigns were designed to promote gender equity and economic empowerment through mainstreaming gender in HR recruitments and engagements. Community engagements and messaging were targeted at the vulnerable population such as women, girls and boys. In areas with cultural sensitivity which restricted access to clients and services by male personnel, care were taken to ensure implementation by female personnel.

**e. People with disabilities (PwD):**

Risk Communication, Community engagements and messaging were targeted at the PwD, and were prioritized during services and commodities deliveries in communities.

**f. Protection:**

NA

**g. Education:**

NA

## 8. Cash and Voucher Assistance (CVA)

**Use of Cash and Voucher Assistance (CVA)?**

| Planned | Achieved | Total number of people receiving cash assistance: |
|---|---|---|
| No | No | NA |

[3] AAP and PSEA are part and parcel of IASC commitments, and therefore mandatory for compliance for all UN agencies and partners. Agencies do not necessarily need to establish new AAP and PSEA mechanisms for CERF projects if functioning ones are already in place. For more information please refer to the IASC AAP commitments.

If **no**, please describe why CVA was not considered. Where feasible, CVA should be considered as a default response option, and multi-purpose cash (MPC) should be utilised wherever possible.

If **yes**, briefly note how CVA is being used, highlighting the use of MPC, and if any linkages to existing social protection systems have been explored.

Not applicable

## 9. Visibility of CERF-funded Activities

| Title | Weblink |
|---|---|
| WHO conducts training on cholera prevention | https://www.afro.who.int/countries/nigeria/news/who-conducts-training-integration-oral-cholera-vaccine-emergency-and-preventive-situations |
| WHO facilitates training for health workers on cholera preparedness | https://www.afro.who.int/countries/nigeria/news/who-facilitates-training-health-workers-oral-cholera-vaccines-preparedness-against-cholera-outbreaks |
| Community Health Champions target over 20000 households with prevention messages | https://www.afro.who.int/countries/nigeria/news/community-health-champions-target-over-20000-households-risk-disease-prevention-messages-yobe-state |
| WHO supports Delta State | https://www.afro.who.int/news/who-supports-delta-state-fight-against-cholera-outbreak |
| WHO support Benue State to curb Cholera outbreak | https://www.afro.who.int/news/who-supports-benue-state-curb-cholera-outbreak-among-vulnerable-populations |
| WHO supports Bauchi State to vaccinate over 700,000 people | https://www.afro.who.int/news/who-supports-bauchi-state-vaccinate-over-700000-persons-oral-cholera-vaccines-during-reactive |
| Health workers in FCT raise awareness on prevention measures | https://www.afro.who.int/news/health-workers-fct-raise-awareness-protective-measures-contain-spread-infectious-diseases |
| WHO support s Jigawa State to fight Cholera outbreak | https://www.afro.who.int/news/jigawa-state-who-fight-outbreak-oral-cholera-vaccine |
| Update on Cholera situation | https://twitter.com/WHONigeria/status/1575043853102419968?s=20&t=sWiaCZZ156LqYKGHjK0D0Q |
| Same as above | https://twitter.com/WHONigeria/status/1493583879319527426?s=20&t=sWiaCZZ156LqYKGHjK0D0Q |
| Same as above | https://twitter.com/WHONigeria/status/1518631549574471680?s=20&t=sWiaCZZ156LqYKGHjK0D0Q |
| Same as above | https://twitter.com/WHONigeria/status/1369643329328209922?s=20&t=sWiaCZZ156LqYKGHjK0D0Q |
| Same as above | https://twitter.com/WHONigeria/status/1518631560651681792?s=20&t=sWiaCZZ156LqYKGHjK0D0Q |
| Same as above | https://twitter.com/WHONigeria/status/1390629566360739840?s=20&t=sWiaCZZ156LqYKGHjK0D0Q |

## ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

| CERF Project Code | Cluster/Sector | Agency | Implementing Partner Name | | Sub-grant made under pre-existing partnership agreement | Partner Type | Total CERF Funds Transferred to Partner US$ | Date of First Payment to Implementing Partner | Start Date of CERF Funded Activities By Implementing Partner* |
|---|---|---|---|---|---|---|---|---|---|
| | | | Extended Name | Acronym | | | | | |
| 21-RR-CEF-047 | Water, Sanitation and Hygiene | UNICEF | Rural Water Supply and Sanitation Agency | RUWASSA | Yes | GOV | 1,160,621 | 1-Dec-21 | 22-Oct-21 |