United Nations CERF Central Emergency Response Fund

ETHIOPIA
RAPID RESPONSE
CHOLERA
2022

22-RR-ETH-56128

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Resident/Humanitarian Coordinator

PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:

Please indicate when the After-Action Review (AAR) was conducted and who participated.	7 August 2023

On 7 August 2023, the After-Action Review (AAR) was conducted with participation from implementing partners including their project staff and field colleagues from UNICEF and WHO as well as the Health cluster coordinator at sub-national level and WASH specialist. The AAR tackled five key areas: quality of in-country consultation, appropriateness of the allocation, result and impact, CERF's added value, and complementarity with other funding mechanisms.

Quality of in-country consultations
When the first case of cholera was identified, the Heath and WASH clusters joined efforts to set up immediate action needs in consultation with the Inter-Cluster Coordination Group (ICCG) for immediate mobilization of joint efforts for the cholera response. The joint efforts by the two key clusters were critical to inform the strategic priorities in terms of activities as well as geographic areas to inform this allocation.

Appropriateness of allocation
The allocation was extremely appropriate in enabling immediate Health and WASH response to manage and contain the Cholera outbreak upon initial identification of cases in Oromia and Somalia. The CERF fund was successful in stopping Cholera cases in some of the geographic areas in Somalia though temporarily. However, population movement made it challenging to maintain that containment.

Result and Impact
The CERF fund supported the establishment of risk communication and health surveillance systems for wider support to the Cholera response, in addition to the provision of immediate care to over 438,000 people in need in high risk areas through WASH and health interventions.

CERF's added value
Partners utilized the flexibility to have an early start date for the projects which enabled an agile response on the ground. Also, worth highlighting that CERF was the first funding mechanism to provide immediate and agile funding to the Cholera response in Ethiopia in 2022. Additionally, partners re-programmed existing funding from other funding mechanisms at the time to support the Cholera response.

Complementarity
The CERF funding provided good ground to secure further resources. For instance, because CERF enabled the provision of health surveillance and capacity enhancement in addition to the provision of medical supplies, WHO was able to secure provision of vaccines.
Additionally, the CERF Cholera allocation coincided at the time with ongoing drought-response projects by UN and NGOs in Somali and Oromia which complemented well each other (considering that one of drought's associated risk factors are infectious disease outbreaks including Cholera).

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 ☐

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, cluster/sector coordinators and members and relevant government counterparts)?	Yes ☒	No ☐

1. STRATEGIC PRIORITIZATION

Statement by the Resident/Humanitarian Coordinator:

This timely CERF grant of US$ 4 million was critical in enabling humanitarian partners to provide essential health and WASH services to an estimated 438,000 people to curb the Cholera outbreak resulting in significant progress in preventing and mitigating the impact of the disease. The response was prioritized to focus on areas with high risk for Cholera in Oromia and Somali.

Notably, CERF funds allowed the humanitarian community to address the urgent needs of affected communities in the wake of the Cholera outbreak compounded by ongoing emergencies including conflict and natural hazards-related (drought and flood). The funds were a catalyst for multi-sectoral response to increasing needs and supported efforts to contain and manage the outbreak. CERF was instrumental in contributing to improvements in health surveillance and response systems, access to safe water, promote hygiene practices and strengthen the capacity of local partners. The CERF allocation has made a difference in the lives of 438,000 people in Oromia and Somali, among who most or 60 per cent were children and 98 per cent were internally displaced persons or host community members.

I commend the exemplary work done by CERF implementing partners and front-line workers, who exerted every effort to deliver under the difficult and challenging circumstances to save lives. Nevertheless, the Cholera crisis is far from over in Ethiopia. Given the continuous population movement that hindered a successful control of Cholera outbreak, among other reasons, collective efforts need to be scaled up to provide lifesaving responses to Cholera among other health crises in the country including: measles, dengue, and malaria.

CERF's Added Value:

WASH

- Provision of immediate and sustained access to safe water and proper sanitation including rehabilitation of water points and access to latrines in the targeted geographic areas.

Health

- The CERF grant was an instrument for the establishment of adequate health surveillance and responses systems in the targeted geographic areas, that enabled the mobilization of vaccines through other funding mechanisms.

Did CERF funds lead to a <u>fast delivery of assistance</u> to people in need?

Yes ☒ Partially ☐ No ☐

With an early start date option under the CERF grant, partners took immediate action on ground for the provision of assistance.

Did CERF funds help respond to <u>time-critical needs</u>?

Yes ☒ Partially ☐ No ☐

The CERF grant enabled the immediate provision of aid to curb the spread of Cholera.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

The CERF grant supported the joint cluster approach for the Cholera response as agreed at the ICCG and coordinated accordingly with implementing partners.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

WHO was able to secure vaccinations based on the health interventions supported by CERF in terms of the establishment of health surveillance as well as enhanced capacities of health facilities through the provision of medical kits and training.

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

- CERF projects were contributing to gender equality, including across age groups where aid provide considered the specific needs of different age and gender groups. Almost 50 per cent of reached beneficiaries under this allocation are women and girls.
- All CERF projects, under this grant, have solid protection mainstreaming measures, including attention to the prevention of gender-based violence (GBV) and sexual exploitation and abuse (SEA) through the capacitating of local partners as well as identification of referral pathways.
- Additionally, CERF Cash assistance support focused on empowering vulnerable groups including people with disabilities.

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	40,000,000
CERF	3,999,808
Country-based Pooled Fund (if applicable)	0
Other (bilateral/multilateral)	2,700,000
Total funding received for the humanitarian response (by source above)	**6,699,808**

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

Agency	Project Code	Sector/Cluster	Amount
UNICEF	22-RR-CEF-078	Water, Sanitation and Hygiene	2,000,000
WHO	22-RR-WHO-045	Health	1,759,831
WHO	22-RR-WHO-045	Water, Sanitation and Hygiene	239,977

[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.

Total	3,999,808

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

Total funds implemented directly by UN agencies including procurement of relief goods	2,663,694
Funds sub-granted to government partners*	1,279,810
Funds sub-granted to international NGO partners*	0
Funds sub-granted to national NGO partners*	56,304
Funds sub-granted to Red Cross/Red Crescent partners*	0
Total funds transferred to implementing partners (IP)*	**1,336,114**
Total	**3,999,808**

* 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:

On 27 August 2022, the Ethiopian Public Health Institute (EPHI) announced the outbreak of cholera in Bale zone of Oromia Region. As of 16 October 2022, 25 kebeles of 3 woredas (districts) in Bale zone have reported 221 confirmed cholera cases, including five deaths with a current case fatality rate (CFR) of 2.07 per cent, according to the EPHI. In Bale zone, the currently affected localities are Harena Buluk (71), Berbere (128), and Delo Mena (22) woredas. Cholera cases were reported in Burka IDPs site of Delo Mena woreda as well. Soon after, a second cholera outbreak was reported in the bordering Somali regions, Karsadula woreda of Liban zone. As of 14 October 2022, 5 kebeles of Karsadula woreda have reported 20 confirmed cholera cases, including two deaths. Cumulative in Oromia and Somali regions, the cholera caseload reached 241 cases with 7 deaths. According to EPHI, close to 459,000 people are at risk in the four woredas. It is projected that the outbreak could spread to adjacent localities

Operational Use of the CERF Allocation and Results:

In response to the crisis, the ERC approved $4 million from CERF's Rapid Response window, as requested by the RC/HC, for the immediate commencement of life-saving activities. This funding enables UN agencies and partners to provide life-saving assistance to 205,836 people.

People Directly Reached:

A total of 438,261 people received assistance through this CERF grant, through:

- **246,615** people received WASH services including access to safe water through rehabilitation of 10 water schemes and expansion of the water systems to 13 institutions (schools and health facilities), installation and operationalizing two Emergency Water Kits (EMWAT KITs) as an immediate lifesaving intervention until the water system rehabilitation and expansion is done. In addition, 25 woreda water office staff were trained on water quality, including disinfecting water sources. During and after the training, the woreda team treated over 168 water schemes in the five cholera-affected woredas with support from regional and zonal water office staff. Moreover, **85** water bureau staff were refreshed on water quality monitoring/ testing and water purification techniques Implemented water quality monitoring, resulting in advocacy for increased access to safe and clean water sources for the target beneficiaries. In Somali, 23 contaminated water sources were disinfected. Additionally, 41 sanitation facilities constructed in both regions, as well as provision of essential WASH items/kits.
- 191,646 people received health assistance through establishment of 43 cholera treatment centres, provision of 214 emergency health kits, support to health surveillance, among other key activities.

People Indirectly Reached:

Both the health and WASH interventions funded by this CERF grant benefitted the wider communities reached in Oromia and Somali including host community, through the availability of patients receiving medical treatment, improved healthcare and WASH services, increased health awareness, and enhanced capacity for early detection and treatment of diseases.

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

Sector/Cluster	Planned					Reached				
	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Health	44,087	42,363	46,180	45,114	**177,744**	47,614	45,753	49,874	48,723	**191,646**
Water, Sanitation and Hygiene	45,407	43,101	72,690	70,365	**231,563**	48,381	45,924	77,393	74,917	**246,615**

* 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	8,607	9,297
Returnees		
Internally displaced people	167,328	178,694
Host communities	233,372	250,588
Other affected people		
Total	**409,307**	**438,579**

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	89,494	95,995	15,710	13,745
Men	85,464	91,677	14,680	13,141
Girls	118,870	127,267	21,200	17,377
Boys	115,479	123,640	20,461	16,753
Total	**409,307**	**438,579**	**72,051**	**61,016**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 22-RR-CEF-078

1. Project Information			
Agency:	UNICEF	**Country:**	Ethiopia
Sector/cluster:	Water, Sanitation and Hygiene	**CERF project code:**	22-RR-CEF-078
Project title:	Provision of lifesaving WASH services and needs to the most vulnerable cholera-affected populations of Oromia and Somali		
Start date:	01/12/2022	**End date:**	31/05/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding		
	Total requirement for agency's sector response to current emergency:	**US$ 20,000,000**
	Total funding received for agency's sector response to current emergency:	**US$ 200,000**
	Amount received from CERF:	**US$ 2,000,000**
	Total CERF funds sub-granted to implementing partners:	**US$ 1,200,114**
	Government Partners	US$ 1,143,810
	International NGOs	US$ 0
	National NGOs	US$ 56,304
	Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

"Through this CERF UFE grant, UNICEF and its partners provided nutritional screening of 2,143 children under five; referred 256 malnourished children for treatment; trained 7 staff in management of severe malnutrition; provided nutritional supplies and equipment benefiting estimated 300 children; provided education on nutrition to 634 pregnant and lactating women; and sensitized 75 community support facilitators on infant feeding practices.
The project assisted a total of 26,344 people and allowed for maintaining the malnutrition indicators within the SPHERE standards in Kakuma refugee camp in Turkana County, Kenya between March and December 2016. This was achieved during the period of increased influx of South Sudanese refugees, which exceeded the 2016 planning figures."
UNICEF, with Oromia Regional Water Resource Development Bureau and Pastoralist Concern in Somali region, provided safe and clean water to 218,828 people at 15l/per/day located. Of this total, 103,828 people were located in Bale Zone of the Oromia Region (Goro, Berbere, Guradamole, Dolo Mena and Harena Buluk woredas) and 115,000 people were located in Liban Zone of Somali Region. The water supply service was provided both to 61,272 IDPs and 157,556 members of the host communities.

In Oromia, the water supply intervention included the expansion of two water schemes in Berbere woreda (Hambela and Burkitu), rehabilitation of 10 water schemes and expansion of the water systems to 13 institutions (schools and health facilities), installation and operationalizing two EMWAT KITs[2] as an immediate lifesaving intervention until the water system rehabilitation and expansion is done. In addition, 25 woreda water office staff were trained on water quality, including disinfecting water sources. During and after the training, the woreda team treated over 168 water schemes in the five cholera-affected woredas with support from regional and zonal water office staff. In Somali, 23 contaminated water sources were disinfected.

Likewise, 24 sanitation facilities were constructed (17 in Oromia and seven in Somali regions), benefiting over 16,235 cholera-affected populations (IDPs and host communities).

WASH non-food items (NFIs) were distributed to 25,000 people (women 12,750 and men 12,250). NFIs included 10,000 jerry cans, 30,000 bars of laundry soap, and 30,000 bars of body soap. The comprehensive WASH intervention has significantly contributed to the reduction of cholera cases, especially in areas where EMWAT kits were installed and eventually, three of the woredas (Harena Buluk, Dolo Mena and Berbere) were declared free of cholera immediately after the WASH services were put in place.

Social behaviour change interventions have reached over 788,189 people both in Oromia (401,139 total, 203,000 men, 198,139 women) and Somali (387,050 total, 197,396 women, 189,654 men) with key cholera prevention messages using different platforms (promotion and sensitization using AV- VAN, house to house visits by community volunteers and HEWs, a promotion at schools, etc. Community conversation and dialogue sessions engaged 294,553 people (108,113 women and 186,440 men).

Furthermore, 717 persons with disabilities received financial support (top-ups). The financial support aims at strengthening the resilience of persons with disabilities against cholera. Furthermore, an additional 500 people were reached through community discussions in Bula'd internally displaced persons (IDP) site in Hargelle, Afder Zone, Somali region. To date, the main activities conducted by social protection were:

- Training of social workers
- Establishing of grievance committees with persons with disability
- Providing disability financial support to 717 persons with disabilities
- Sensitization of the community on the disability inclusion

These activities were conducted in cooperation Somali Regional State Bureau of Lab & Social Affairs and were linked with funding from the Bill and Melinda Gates Foundation, which provided shock-responsive cash transfers to 12,033 individuals.

3. Changes and Amendments

Modifications in the Cash and Voucher Assistance (CVA)

1) <u>Modification of the Zone</u>

The decision to modify the location from Liben Zone, Somali, to Afder Zone, Somali was made to multiply the benefits of disability financial support for people with disabilities. Afder Zone was specifically chosen due to its vulnerability to a cholera outbreak, with individuals with disabilities being among the most at risk. By providing disability financial support as a top-up, individuals could invest in preventive measures such as purchasing water or arranging its delivery, addressing their additional expenses caused by disability and mitigating the threat of cholera. As a result, people with disabilities used the money to build their resilience against cholera, PDM shows that 100 per cent of beneficiaries bought food and 11 per cent drinkable water and 3,6 per cent cover health care services.

2) <u>Modification of the number of the beneficiaries</u>

[2] Emergency Water Treatment Kits.

Furthermore, the modification in the beneficiary count who receive CVA assistance from 1,000 to 717 individuals with disabilities was due to limitations in the efficiency of the Washington group's (a global standard for disability assessment) short set of questions in the humanitarian context and missing any existing data on disability prevalence in the Ethiopian context. However, this change ensured that each person with a disability received more financial support. The total amount of US$29,000, initially intended for 1,000 beneficiaries, was divided among the revised beneficiary count 717 (2,300 ETB per person = ~US$46) allowing individuals to obtain a more substantial allocation. This increase in financial support aimed to enable individuals with disabilities to meet their unique needs and invest in preventive measures, enhancing their resilience and well-being.

4. Number of People Directly Assisted with CERF Funding*

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	11,135	10,549	18,754	18,168	**58,606**	11,642	11,029	19,607	18,994	**61,272**
Host communities	27,974	26,501	47,113	45,641	**147,229**	29,936	28,360	50,418	48,842	**157,556**
Other affected people	0	0	0	0	**0**	0	0	0	**0**	**0**
Total	**39,109**	**37,050**	**65,867**	**63,809**	**205,835**	**41,578**	**39,389**	**70,025**	**67,836**	**218,828**
People with disabilities (PwD) out of the total										
	6,833	6,159	11,593	11,230	**35,815**	4,158	3,939	7,002	6,784	**21,883**

* 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

Over 10,000 people were indirectly reached through mobile van announcements. These people heard messages on cholera prevention and could practice messages they heard over mobile vans.

6. CERF Results Framework

Project objective	Improving WASH services and preventive behaviour promotion among cholera affected population in Oromia and Somali regions

Output 1	Improving safe water supply through rehabilitation of non-functioning water schemes and extension, including water piping and boreholes maintenance and water trucking to the IDP camps for cholera in Bale and Liban zones.

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

Sector/cluster	Water, Sanitation, and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	WS.15 Number of communal water points (e.g. wells, boreholes, water taps stand, systems) constructed and/or rehabilitated in communities, schools and Health centres. 24 water schemes by project end; 10 water schemes by March 14 water schemes by March 2023	24	There were 23 water sources supported (2 water systems expansion and 10) rehabilitated. 13 institutions (schools and health facilities) connected to water systems in Oromia region. 23 water sources were disinfected in Somali Region.	IP report and field monitoring report
Indicator 1.2	WS.6 Number of people accessing a sufficient quantity of safe water as per agreed sector/cluster coordination standards and norms. 205,836 people in total (118,000 in Oromia and 87,836 in Somali)102,918 people by Jan, 102,918 people by March 2023	205,839	218,828 people had access to safe water at 15l/per/day. 103,828 people in Oromia region and 115,000 people in Somali region.	IP report and field monitoring mission
Explanation of output and indicators variance:		Many water sources that were found contaminated were disinfected to protect the population using them from cholera, leading to more people being reached.		

Activities	**Description**	**Implemented by**
Activity 1.1	Detail needs and technical assessment to identify specification of necessary equipment and items for rehabilitation work.	Regional and Zonal water offices
Activity 1.2	Procurement of equipment based on the findings of technical assessment on water scheme functionality	Regional water resource development bureau
Activity 1.3	Rehabilitation work- rehabilitation of boreholes, shallow wells and water pipes	Private contractor for civil works and woreda and zonal water office own force for pipe networks

Output 2	Cholera affected population have access to gender and disability sensitive sanitation facilities; and excreta is safely managed in IDPs and institutions (schools and health facilities)

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	WS.13 Number of communal sanitation facilities (e.g., latrines) and/or communal bathing facilities constructed or rehabilitated. 28 blocks (10 blocks in Oromia and 18 blocks in Somali)14 blocks in Jan and 14 blocks in Mar 2023	28	24 sanitation facilities were constructed, 17 in Oromia and seven in Somali regions	NGO, government report and field monitoring
Indicator 2.2	WS.9a Percentage of people who report using a safe, dignified and functional sanitation facility with functional handwashing facility (with soap/cleaning agent and water). 80% (27% in Oromia and 53% in Somali)40% by Jan 2023 and 40% by Mar 2023	80	69 per cent	government report and field monitoring observation
Explanation of output and indicators variance:		Few sanitation facilities were constructed compared to the planned numbers due to price inflation of local communities in the market, resulting in less percentage using the dignified facilities.		

Activities	Description	Implemented by
Activity 2.1	Need assessment and consultation of affected communities and institutions (Health and Schools)	woreda health and water offices
Activity 2.2	Rehabilitation/construction of latrines	local contractors haired by woreda health office with technical support from the zonal health office
Activity 2.3	Decommissioning of emergency latrine	private service provider engaged by woreda health office

Output 3	Cholera affected population have access to WASH Non-food items, at host communities and IPDs sites for those displaced by drought and currently affected by 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 3.1	WS.16a Number of people receiving critical WASH supplies (e.g., WASH/hygiene kits)	25,000	25,000 people received 10,000 jerry cans, 30,000 laundry soaps, 30,000 body soaps	IP report and Post distribution monitoring (PDM)
Indicator 3.2	WS.16b Number of WASH/hygiene kits distributed	10,000	10,000	IP report and Post distribution monitoring (PDM)
Explanation of output and indicators variance:		N/A		

Activities	Description	Implemented by
Activity 3.1	Needs assessment for WASH NFI needs in target areas including institutions to mitigate the impact of cholera and improve hygiene practice	Government sector offices and stakeholders, including UNOCHA, UNICEF and WHO, have assessed multi-sector needs.
Activity 3.2	Procurement of WASH NFIs and transfer to partners	UNICEF
Activity 3.3	Distribution of NFIs to the beneficiaries	Woreda and zonal health and water offices with logistic support from WASH and Health cluster members

Activity 3.4	Post-distribution monitoring (PDM) to monitor response to the targeted population	UNICEF

Output 4	Social behavioral change (SBC) & Risk Communication and Community Engagement for WASH Coordination of RCCE interventions at regional, zonal, and Woreda levels and in IDP camps in the affected regions			
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 4.1	WS.11 Number of people demonstrating safe hygiene practices that have received hygiene promotion and/or distribution of hygiene items/materials (in vulnerable settlements and communities with a specific focus on disease transmission and prevention).	205,836	788,189 people were reached both in Oromia 401,139 (203,000 men and 198,139 women) and Somali 387,050 (women 197,396 and 189,654 men).	IP report and field monitoring
Explanation of output and indicators variance:		Hygiene promotion awareness was scaled up in many villages due to the increasing number of cholera cases during the project intervention. This ensured cholera did not affect new areas due to improved knowledge of WASH practices		

Activities	**Description**	**Implemented by**
Activity 4.1	Advocacy workshop with Government, community leaders and NGOs	[IP, regional health bureau]
Activity 4.2	Support inclusive interpersonal communication and community engagement with traditional, religious leaders and community members at household and community level	woreda health office, HEWs and community volunteers
Activity 4.3	Support knowledge generation and awareness creation for cholera prevention and control using communication (mass, traditional, social and print media)	IP with technical support from UNICEF
Activity 4.4	SBC skill building and Capacity building of pertinent actors on the key identified gaps based on the rapid assessment result	UNICEF and RHB
Activity 4.5	Monitoring and supportive supervision of the SBC-RCCE interventions at regional, zonal and Woreda level	UNICEF WASH and SBC team, RHB monitor and provide supportive supervision to woredas

Output 5	People with disabilities have a dedicated attention through this intervention, aiming at disability inclusion, assessment of the situation in the two zones, as well as distribution of financial support for these populations.			
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 5.1	Number of workshops on disability sensitization	1	One workshop was organized and 12 social workers of Bureau of Labour and Social Affairs (BoLSA) underwent a comprehensive one-	UNICEF

			day training conducted by UNICEF staff members. Two sessions were held with the community in the IDP site on disability inclusion for approximately 150 individuals. UNICEF conducted training for the grievance committee (seven individuals) on disability inclusion.	
Indicator 5.2	Cash.1a Number of people receiving multi-purpose cash (Persons with Disabilities receiving disability financial support)	1,000	In Bul'ad IDP camp, 717 persons with disabilities received disability financial support 2,300 ETB funded by CERF	Partners report
Indicator 5.3	Cash.1b Total value of multi-purpose cash distributed in USD	29,000	32,855.30	UNICEF records
Explanation of output and indicators variance:		The change in the beneficiary count from 1000 to 717 individuals with disabilities was due to limitations in the efficiency of the Washington Group's short set of questions in the humanitarian context and missing any existing data on disability prevalence in the Ethiopian context.		

Activities	Description	Implemented by
Activity 5.1	Advocacy workshop with Government, community leaders and NGOs on disability inclusion and collection of data of PWDs	UNICEF
Activity 5.2	Assessment on situation of PWDs, using Child functioning module and Washington group questions to target household with PWDs and direct distribution of disability financial support for PWDs (find and treat)	Social workers of BOLSA and UNICEF
Activity 5.3	Post distribution monitoring (PDM) to monitor impact on the targeted population	Jijiga University and Bureau Social Workers

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[3] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

[3] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. 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.

a. Accountability to Affected People (AAP)[4]:

IDPs and host communities were engaged starting from site assessment for installation of EMWAT kits, water supply and sanitation facility rehabilitation, construction and expansion. Multiple focus group discussions (FGDs) were conducted with different community groups, and their opinion were considered in making decisions regarding on-site selection. Communities were engaged to contribute in-kind for the constructions and to manage the facilities. 24 WASH committees (WASHCOMs) were established by communities to manage the schemes consisting of five members with at least two women in each group. Quality control of rehabilitation of water schemes was ensured through frequent and ongoing monitoring by UNICEF field staff and the regional water bureau.

b. AAP Feedback and Complaint Mechanisms:

WASHCOs and community volunteers were selected and oriented to provide feedback and complaint about services. Focus group discussions and meetings with community stakeholders were conducted during joint programme visits to obtain beneficiaries' feedback on the quality of the services. Results from these feedback sessions have been used to refine programme responses, e.g, selecting zones/sites for rehabilitation in the Oromia region.
As part of a comprehensive approach, delivering disability financial top-ups to shock-responsive cash transfers entailed the establishment of a grievance committee. The committee's main objective was to address grievances from the community such as not being included as a beneficiary. The selection of committee representatives encompassed persons with disability, amplifying the voices of one of the most marginalized groups in society. Collected results from the grievance committee were followed, and 91.8% of respondents said they knew how to make a complaint or provide feedback. Half of the beneficiaries (45.9%) said they submitted complaints and/or feedback, with 91.6% receiving a response, 86.6% expressing they were 'satisfied' and 13.4% were 'somewhat satisfied' with the response – no respondent was 'dissatisfied'.

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

UNICEF conducted training of partners on PSEA to ensure accessible, safe, confidential reporting channels. PSEA messages were integrated into outreach activities (hygiene promotion) to increase communities' awareness of SEA prevention and reporting.

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

Over 50 WASHCOM members out of 120 members were women and girls; toilets were gender segregated, and distribution of WASH NFIs was done through consultation with women and girls to mitigate potential gender-based violence (GBV) risks during distribution in all the project locations.

e. People with disabilities (PwD):

WASH facilities' design considered people with disabilities, and all community dialogue and discussions included people with disabilities to get their view in programme decisions. Girls and women were given priority to receive soaps.
Social protection interventions ensured the inclusion of persons with disabilities by providing disability financial support to 717 individuals with disabilities to cover their additional costs caused by the disability. Women and children with disabilities were prioritized in the targeting process.

f. Protection:

To avoid Gender Based Violence cases associated with WASH facilities in IDPs camps, water points and latrines were constructed in a safe, accessible location to reduce the protection risk, meaning the construction took into consideration women and girls-related risks to GBV while fetching water or using latrines located remotely.

g. Education:

One primary school was targeted and over 500 pupils had access to WASH facilities.

[4] 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.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
Yes, CVA is a component of the CERF project	Yes, CVA is a component of the CERF project	717 receiving disability-inclusive financial support.

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.

Yes. Based on the assessment, each person with a disability received financial support of 2,300 Ethiopian Birr (ETB) funded by CERF. This amount covered additional expenses of persons with disabilities caused by societal barriers. The objective was to decrease the vulnerability of persons with disabilities during the cholera outbreak. This disability financial support provided persons with disabilities with an independent choice in strengthening their resilience. Households with persons with disabilities mostly used cash for the following activities: to buy food 100per cent, buy livestock 18.2 per cent, buy drinking water 11 per cent, purchase essential non-food items 7.2 per cent or cover health care costs 3.6 per cent. All respondents of the post-distribution monitoring were either very satisfied (56.7 per cent) or satisfied (43.3 per cent) with the cash transfer value.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Cash. 1a Households with PWDs will receive disability financial support/Cash and Voucher Assistance (CVA) to cover the additional challenges and costs they face in having access to services and information	717 persons with disabilities received disability financial support due to shock-responsive cash transfers	US$ 29,000	Multi-Purpose Cash	Unrestricted

9. Visibility of CERF-funded Activities

Title	Weblink
Humanitarian cash transfers changing the lives of persons with disabilities affected by emergencies	https://www.unicef.org/ethiopia/stories/humanitarian-cash-transfers-changing-lives-persons-disabilities-affected-emergencies

3.2 Project Report 22-RR-WHO-045

1. Project Information			
Agency:	WHO	**Country:**	Ethiopia
Sector/cluster:	Health Water, Sanitation and Hygiene	**CERF project code:**	22-RR-WHO-045
Project title:	Health Sector preparedness and response to the cholera outbreak in affected woredas in Somali and Oromia regions.		
Start date:	01/10/2022	**End date:**	31/03/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding		
Funding	**Total requirement for agency's sector response to current emergency:**	**US$ 10,207,720**
	Total funding received for agency's sector response to current emergency:	**US$ 2,500,000**
	Amount received from CERF:	**US$ 1,999,808**
	Total CERF funds sub-granted to implementing partners:	**US$ 136,000**
	Government Partners	US$ 136,000
	International NGOs	US$ 0.00
	National NGOs	US$ 0.00
	Red Cross/Crescent Organisation	US$ 0.00

2. Project Results Summary/Overall Performance

During the reporting period, the CERF-funded cholera project made significant progress in preventing and mitigating the impact of cholera in the Somali and Oromia regions. The project aimed to enhance cholera surveillance and response systems, improve access to clean water, promote hygiene practices, and strengthen the capacity of local healthcare providers, all of which contributed to reducing the incidence and mortality rates of cholera cases.

Key Achievements:

a) Strengthened Cholera Surveillance and Response:

- Improved early detection and reporting of cholera cases through refresher trainings for frontline healthcare workers on cholera case identification, diagnosis, and reporting.
- Strengthened laboratory capacity to ensure timely and accurate testing of suspected cholera cases by providing on site rapid diagnostic testing kits and facilitating laboratory sample transportation to the regional and national labs for confirmation of causative agents.
- Developed and implemented a robust cholera response plan, including case management protocols, referral systems, and treatment centers.

b) Enhanced Hygiene Practices:

- Conducted hygiene education and awareness sessions in schools, community centers, and households, reaching over **1.5 million** individuals.

- Distributed essential items such, water purification tablets, and hygiene promotion materials to **177,278** households, promoting proper handwashing and personal hygiene practice

c) Improved Access to Clean Water:

- **85** water bureau staff were refreshed on water quality monitoring/ testing and water purification techniques
- Implemented water quality monitoring, resulting in advocacy for increased access to safe and clean water sources for the target beneficiaries.

d) Capacity Building and Knowledge Transfer:

- Conducted refresher training workshops for **548** (395 male and 153 female) local healthcare providers on cholera prevention, treatment, and infection control measures.
- Supported the development of **85** local medical teams specializing in cholera case management and trained them in emergency response procedures.
- Facilitated knowledge exchange and learning between local healthcare providers, national authorities, and international experts through workshops and through direct supportive supervision sessions.

e) Coordination and Collaboration:

- Actively engaged with local authorities, community leaders, and relevant stakeholders to ensure a coordinated and integrated response to cholera outbreaks.
- Collaborated with other humanitarian actors and organizations in the area to share best practices, avoid duplication, and strengthen the collective impact of cholera response efforts.

Challenges and Lessons Learned:

Some of the challenges encountered included:

- Limited access to affected areas: In some instances, reaching remote or conflict-affected areas posed challenges due to limited infrastructure, poor road conditions, or security concerns. This hindered the timely delivery of supplies, equipment, and medical personnel to the affected communities.
- Inadequate sanitation and water infrastructure: Insufficient or poorly maintained water and sanitation infrastructure in the target areas presented a challenge. This resulted in limited access to clean water sources and inadequate sanitation facilities, which increased the risk of cholera transmission and hindered efforts to promote proper hygiene practices.
- Community resistance and cultural barriers: Overcoming community resistance and addressing cultural barriers to change hygiene behaviors proved challenging. Some communities had deep-rooted practices or beliefs that were difficult to shift, making it crucial to engage community leaders and conduct extensive community sensitization to promote behavior change.
- Limited resources and funding constraints: Insufficient financial resources and funding constraints posed challenges to project implementation. This affected the ability to scale up interventions, adequately train healthcare workers, and ensure the availability of necessary supplies and equipment for cholera prevention and treatment.
- Weak healthcare system and infrastructure: In some cases, the project faced challenges associated with weak healthcare systems, including limited capacity in healthcare facilities to effectively manage and treat cholera cases. Inadequate laboratory facilities for timely and accurate diagnosis of cholera also posed challenges.
- Seasonal and environmental factors: Cholera outbreaks are often influenced by seasonal and environmental factors such as heavy rainfall, flooding, and inadequate waste management systems. These factors often exacerbated the spread of cholera and presented challenges in implementing preventive measures.

Lessons Learned and Mitigation Strategies:

To address these challenges, the project team implemented the following mitigation strategies and learned valuable lessons:

- Strengthened coordination and partnerships: Enhanced coordination and collaboration with local authorities, community leaders, and other stakeholders helped overcome logistical challenges and ensured a more integrated and effective response.
- Adapted to the local context: Tailoring interventions to the local context and engaging with communities through culturally sensitive approaches played a crucial role in gaining community acceptance and promoting behavior change.
- Capacity building and training: Prioritizing capacity building of local healthcare workers, including training on cholera case management, infection prevention and control, and surveillance, helped strengthen the healthcare system's response capacity.
- Robust monitoring and evaluation: Regular monitoring and evaluation activities provided valuable insights into the effectiveness of interventions, enabling the project team to make necessary adjustments and improvements.

- Advocacy for increased funding: Advocacy efforts were undertaken to secure additional funding and resources to address the identified challenges and ensure the sustainability of cholera prevention and control interventions.

3. Changes and Amendment

No changes or amendments were requested for this project.

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	1,882	1,872	1,890	1,887	**7,531**	2,033	2,022	2,041	2,038	**8,134**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	23,250	22,276	25,335	24,272	**95,133**	25,110	24,059	27,362	26,214	**102,745**
Host communities	18,955	18,215	18,955	18,955	**75,080**	20,471	19,672	20,471	20,471	**81,085**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**44,087**	**42,363**	**46,180**	**45,114**	**177,744**	**47,614**	**45,753**	**49,874**	**48,723**	**191,964**
People with disabilities (PwD) out of the total										
	7,767	7,456	8,406	8,077	**31,706**	**8,388**	**8,052**	**9,078**	**8,723**	**34,241**

Sector/cluster	Water, Sanitation and Hygiene									
	Planned					Reached				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	269	267	270	270	**1,076**	291	288	292	292	**1,163**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	3,321	3,182	3,619	3,467	**13,589**	3,587	3,437	3,909	3,744	**14,677**
Host communities	2,708	2,602	2,934	2,819	**11,063**	2,925	2,810	3,167	3,045	**11,947**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**6,298**	**6,051**	**6,823**	**6,556**	**25,728**	**6,803**	**6,535**	**7,368**	**7,081**	**27,787**
People with disabilities (PwD) out of the total										
	1,110	1,065	1,201	1,154	**4,530**	**1,199**	**1,150**	**1,297**	**1,246**	**4,892**

* 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

Beyond the primary beneficiaries of the project that included patients receiving medical treatment, improved healthcare services, increased health awareness, and enhanced capacity for early detection and treatment of diseases, this CERF project also indirectly benefited several groups of people, contributing to the broader impact on community health and well-being:

i. Families and communities of direct beneficiaries: The improved health outcomes of individuals who receive medical treatment or access health services positively impact their families and communities. By reducing illness and increasing overall health, the project indirectly enhanced the well-being and resilience of these communities.

ii. Health workers and staff: The project's capacity-building activities and provision of essential medical supplies and equipment improve the working conditions and capabilities of healthcare workers indirectly benefited the entire healthcare workforce by enhancing their ability to deliver quality healthcare services.

iii. Other healthcare facilities: The project's interventions, such as refresher training programs, infrastructure upgrades, and knowledge sharing, contributed to strengthening the overall health system in the target region. This indirectly benefits other healthcare facilities and providers, improving the quality and accessibility of healthcare services beyond the project's immediate scope.

iv. Vulnerable and at-risk populations: Through health awareness campaigns, the project indirectly reached vulnerable and at-risk populations who were not direct beneficiaries. By disseminating crucial health information and promoting preventive measures, the project enhances the health literacy and resilience of these communities.

v. Host communities: In cases where the project serves refugees or displaced populations, the health interventions indirectly benefited the host communities. By improving health infrastructure and services in the area, the project enhances the overall health and well-being of both the displaced populations and the host communities.

6. CERF Results Framework

Project objective	Keep morbidity and mortality levels in cholera-affected populations and communities affected to below emergency thresholds.			
Output 1	Prepare for, detect and respond to cholera and other epidemic prone disease outbreaks in drought-affected populations, internally displaced populations (IDPs) and host communities			
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	Number of mobile and static health facilities and RRTs in the affected areas have received the necessary surveillance tools and basic refresher training. 85 (RRTs: 60 – Local Health facilities staff: 25)	85	85 (100%)	Field reports.
Indicator 1.2	H.5 Percentage of public health alerts generated through community-based and/or health-facility-based surveillance or alert systems investigated within 24 hours	100%	100%	Weekly PHEM reports

Indicator 1.3	H.6 Proportion of functional health facilities sharing timely report	90%	90%	Weekly PHEM reports
Explanation of output and indicators variance:		Output has been achieved with no major variance. Average reporting was slightly high due to sustain field presence of WHO and NGO staff during outbreak response.		
Activities	**Description**	**Implemented by**		
Activity 1.1	Provide orientation for health facility staff in affected areas to identify, treat, and report cases of epidemic-prone infectious diseases (cholera, measles, COVID)	Ethiopian Public Health Institute (EPHI) Regional Emergency Operational Centre EOCs/WHO/Health Cluster partners		
Activity 1.2	Provide health facility staff in affected areas with reporting formats for the submission of weekly surveillance reports	Ethiopian Public Health Institute (EPHI) Regional Emergency Operational Centre EOCs/WHO/Health Cluster partners		
Activity 1.3	Provide technical and logistic support for active case search and contact tracing and follow up for potential outbreaks of infectious diseases through RRTs and community health workers.	Ethiopian Public Health Institute (EPHI) Regional Emergency Operational Centre EOCs/WHO/Health Cluster partners		
Activity 1.4	Support to the development of detailed woreda OCV micro-plans, and deployment of vaccination team for targeted woredas	Ethiopian Public Health Institute (EPHI) Regional Emergency Operational Centre EOCs/WHO/Health Cluster partners		
Activity 1.5	Distribute cholera field and laboratory investigation kits to the frontline and regional laboratories.	Ethiopian Public Health Institute (EPHI) Regional Emergency Operational Centre EOCs/WHO/Health Cluster partners		
Activity 1.6	Logistical support for biological sample transportation from the frontline to the regional/national laboratories.	WHO, Ethiopian Public Health Institute (EPHI)		

Output 2	Provide essential curative and preventive health care services, including referrals, for affected populations including IDPs.			
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	H.8 Number of primary healthcare consultations provided	205,836	206,745	Outpatient records from health facilities and MHNTs.
Indicator 2.2	H.1a Number of emergency health kits delivered to healthcare facilities	118	214	WHO dispatch documents
Indicator 2.3	Number of health facility and woreda staff receiving basic case management and IPC refresher training for cholera and other infectious diseases.	400	548	Training reports
Indicator 2.4	H.11 Number of people receiving treatment for acute watery diarrhoea (incl. cholera	1768	2,245	Health Facility and MHNT reports
Explanation of output and indicators variance:		Output has been achieved with some indicators overshot due to overall improved WHO and partner presence on the frontline.		
Activities	**Description**	**Implemented by**		

Activity 2.1	Distribute/ preposition essential medical kits, including SAM kits, to frontline partners, MHNTs and health facilities.	Regional Health Bureaus, Health Cluster partners and WHO.
Activity 2.2	Support RHBs to provide ambulances for referral patients for further care and transporting stool sample for lab testing	WHO and Health clusters partners
Activity 2.3	Support refresher training of health facility and project staff in case management and IPC training for cholera and other infectious diseases prevention and response.	WHO and Health clusters partners

Output 3	Provide case management for cholera cases			
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 cholera treatment centres established in Oromia and Somali regions [number may increase if other regions are affected depending on case load at the sites]	34	43	Field reports
Indicator 3.2	Case fatality ratio for cholera across all Cholera Treatment Centres (CTCs) supported	<1%	1.6%	CTC data and cholera sitreps
Explanation of output and indicators variance:		A CFR of <1% was not achieved due to delays seeking medical attention due to various reasons such as lack of access to healthcare facilities, lack of awareness about the disease, social stigma, or fear of being quarantined. Delays in seeking treatment resulted in a higher risk of complications and deaths.		
Activities	**Description**	**Implemented by**		
Activity 3.1	Support establishment of cholera treatment centers and Oral Rehydration Points (ORPs) in Oromia and Somali (number may increase if outbreak spread other regions)	Regional Health Bureaus, WHO and Health clusters partners		
Activity 3.2	Provide clinical surge support and supportive supervision to improve treatment outcomes and quality of care for cholera patients.	Regional Health Bureaus, WHO and Health clusters partners		
Activity 3.3	Printing and dissemination of cholera treatment guidelines	Regional Health Bureaus, WHO and Health clusters partners		

Output 4	Strengthen RCCE and WASH to reduce cholera transmission in affected and high-risk woredas in Oromia and Somali regions			
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 4.1	Number of advocacy and sensitization meetings for key	17	39	WHO and health cluster partner reports

	groups in cholera affected and high risk woredas in Oromia and Somali			
Indicator 4.2	Number of cholera IEC materials printed and distributed	17,000	27,000	WHO distribution reports
Indicator 4.3	Number of water bureau staff refreshed on water quality monitoring/ testing and water purification techniques (5 per woreda).	85	85	WHO training records
Explanation of output and indicators variance:		The team utilized all the available resources effectively, thereby increasing the productivity and efficiency of indicators 4.1 and 4.2. On the other hand, the team quickly adapted to changes that occurred during project execution and immediately came up with suitable solutions that helped to extend the available resources as the outbreak spread.		

Activities	Description	Implemented by
Activity 4.1	Conduct advocacy and sensitization meetings for key groups including local media, education bureau heads, and community leaders, etc., on cholera in affected and high risk woredas in Oromia and Somali	WHO and Health clusters partners
Activity 4.2	Print and distribute of cholera IEC materials 1000 @ woreda	WHO and Health clusters partners
Activity 4.3	Support assessment of the functionality of water facilities and implementation of water quality monitoring in cholera affected and at risk woredas.	WHO and Health clusters partners
Activity 4.4	Procure and distribute water quality monitoring kits to RHBs and Health Cluster partners	WHO and Health clusters partners

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[5] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

a. Accountability to Affected People (AAP)[6]:

We ensured that the project was designed, implemented, and monitored in a way that respects the rights, dignity, and needs of the affected populations. Here are some key elements of AAP in the context of this cholera project:

[5] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. 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.

[6] 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.

- Participation and Engagement: The project actively engaged with affected communities, seeking their input, feedback, and participation throughout the project cycle. This was achieved through regular community consultations, feedback mechanisms, and meaningful engagement with community leaders and representatives.
- Information Sharing: Transparent and timely communication was essential. The project provided affected communities with accurate and relevant information about the cholera outbreak, prevention measures, available services, and response efforts. Information was communicated in a manner that is culturally appropriate, easily understandable, and accessible to all, including marginalized groups.
- Monitoring and Evaluation: The project incorporated mechanisms to monitor and evaluate its AAP efforts. Regular assessments were conducted to measure the project's adherence to AAP principles and to identify areas for improvement, mainly through participatory methods.
- Learning and Accountability: The project promoted a culture of learning and accountability by regularly reviewing and reflecting on AAP practices. Lessons learned and best practices were documented and shared with the relevant stakeholders to improve future interventions and promote accountability across the humanitarian sector.

b. AAP Feedback and Complaint Mechanisms:

Feedback Mechanisms: The project established effective feedback mechanisms that allowed affected communities to voice their concerns, provide feedback, and make suggestions. These mechanisms included a hotline, suggestion boxes, community meetings, or dedicated project personnel who received and responded to feedback.

Complaints and Response Mechanisms: The project establishes a clear and accessible complaints and response mechanism. This enables affected individuals to report any grievances, violations of rights, or concerns related to the project. The mechanism ensures that complaints are taken seriously, investigated promptly, and addressed appropriately.

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

WHO has a consolidated internal PSEA mechanism. As per WHO's procedures, all implementing partners are required to sign a code of conduct which includes the adherence to PSEA principles. During the CERF project implementation, PSEA pocket cards were developed and distributed to the affected population to increase awareness and enhance uptake of the PSEA reporting mechanism. These included inter-agency channels for reporting and the referral pathway. All service providers and humanitarian aid actors were sensitized on the utilization of the reporting mechanisms to ensure service provision as well as enactment of disciplinary measures for UN staff according to internal procedures. All WHO staff are required to complete a course on the Prevention of Sexual Exploitation and Abuse (PSEA), and the project's implementing partners were trained in WHO's policies. Beneficiaries were informed on the existence of the whistle-blower system through which acts of SEA can be reported without retaliation. Under the same token, WHO engaged closely with UNFPA who had an establish SGBV program in the project sites.

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

Women and girls are the most affected when emergencies hit. WHO supported to inform women and girls about sexually transmitted infections and their consequences and supported health workers and health extension workers and peer educators to provide awareness session in their neighborhoods health training, where I was taken care of for free and I feel good now,
Specific risk communication messaging addressing the special needs of women and girls were designed, including information on how women as the caregivers shuld protect themselves from COVID-19 and other communicable diseases. Women leaders were identified as agents of change (positive deviants were identified and recognised among community members).

The project also supported health workers to provide psychosocial, and medical support to survivors of sexual violence, including legal referrals where applicable. This has contributed to gradual increase in the reporting of rape.
Many HIV positive women and girls of going to the hospital to get their antiretroviral therapy refill and access general health services out of fear of COVID-19. WHO has worked with partners to rebuild confidence in the health facilities through enhanced community engagement and maintenance of essential health services. COVID19 programming has now become integrated into other health service delivery.

e. People with disabilities (PwD):

Approximately, seventeen (17.6) percent of the entire population consisted of people living with disabilities (PLWD) in the target zones. The crisis disproportionately affected these individuals, putting them at risk of increased morbidity and mortality, underscoring the urgent need improved provision of health care for this group and maintain the global health commitment to achieving Universal Health Coverage (UHC).

PLWD, including physical, mental, intellectual, or sensory disabilities, were less likely to access health services, and more likely to experience greater health needs, worse outcomes, and discriminatory laws and stigma. Crisis mitigation strategies such as (https://www.who.int/hac/techguidance/preparedness/disability/en/) had been designed to be inclusive of PLWD to ensure they maintain respect for "dignity, human rights and fundamental freedoms, and reduce existing disparities.

f. Protection:

WHO and partners supported the development of self- protection capacities and assist people to claim their rights to health and nutrition services through creating demands for services, assess the utilization of services through project activities, seek the feedback and appraisal of target population on services provided to them, among others.
Affordable (free-of-charge) treatment especially for the people who had lost their livelihood and were displaced prevented them from resorting to disastrous coping strategies which would arise from out-of-pocket expenditures due to health care further preventing their abuse and exploitation.

g. Education:

This project does not directly address education activities.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	No	N/A

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.

The government of Ethiopia along with its partners have endeavoured to ensure that emergency health services are availed free- of-charge to vulnerable communities, which is why cash Transfer programming (CTP) was not an appropriate modality for assistance in this sector, and for this population. Although financial incentives such as transport reimbursements appear to provide motivation to beneficiaries, they are unsustainable, and it is also difficult to determine the poorest of the poor who need it most. Finally, CTPs are not necessarily sufficient to overcome entrenched poor health seeking behaviors and other health care access issues. The greatest motivation in this context remains therefore the improved quality of life and averted suffering and deaths that result from enhanced access to quality health services.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
N/A				

9. Visibility of CERF-funded Activities

Title	**Weblink**
Delivering health services to Ethiopia's drought-affected populations	• https://www.afro.who.int/photo-story/delivering-health-services-ethiopias-drought-affected-pulations?country=30&name=Ethiopia • https://twitter.com/WHOEthiopia/status/1627968173847769090?s=20
WASH/CHOLERA response	• https://twitter.com/WHOEthiopia/status/1643591844020846592?s=20

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Sector	Agency	Implementing partner type	Funds transferred in USD
22-RR-CEF-078	Water, Sanitation and Hygiene	UNICEF	GOV	$ 487,278
22-RR-CEF-078	Water, Sanitation and Hygiene	UNICEF	GOV	$ 461,751
22-RR-CEF-078	Water, Sanitation and Hygiene	UNICEF	GOV	$ 194,781
22-RR-CEF-078	Water, Sanitation and Hygiene	UNICEF	NNGO	$ 56,304
22-RR-WHO-045	Health	WHO	GOV	$ 136,000