CERF ALLOCATION REPORT ON THE
USE OF FUNDS AND ACHIEVED RESULTS

United Nations CERF Central Emergency Response Fund

LEBANON
RAPID RESPONSE
CHOLERA
2022

22-RR-LBN-56227

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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.		
No specific AAR was conducted for this allocation, although a broader 'Lessons Learned from Cholera Response – (Health and WASH Sectors, and RCCE Task Force)' at which all funding agencies and sub-partners were present and which informed the reporting herein.		
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:

The fast-spreading cholera outbreak was another in a line of shocks both compounded and enabled by the ever-deepening governance and economic crisis in Lebanon. In the continued absence of functioning public water and sanitation infrastructure allowing access to affordable safe water, sanitation, and hygiene to all and in view of an already overburdened and structurally weak health system, Lebanon remains fundamentally ill-equipped to deal with a potentially large scale and long-lasting outbreak. Early containment, prevention and rapid response were critical to prevent loss of life and mitigate the risks of the disease becoming endemic in the country.

CERF Rapid Response funding represented a critical and cost-effective means to allow for a) early interventions to break the chain of transmission and prevent the spread of cholera, including through emergency system-strengthening activities, and b) swift response in hotspot areas. CERF funding supported a comprehensive community-based integrated health, WASH and risk communication approach to rapid response, prevention and containment of the outbreak in highest risk areas in line with the Ministry of Public Health-led strategic plan.

The allocation was developed in complement to other funding and reprogramming efforts for cholera response, including a parallel Lebanon Humanitarian Fund (LHF) Emergency Reserve Allocation supporting NGO-led household level activities of the same integrated multi-sectoral prevention and control strategy in high-risk areas. OCHA Pooled fund mechanisms jointly allocated up to $9.6 million to kickstart time sensitive life-saving response.

CERF funding was also critical in ensuring a principled response, implemented equitably for all population groups, namely Lebanese, Syrian refugees, Palestine refugees and migrants. This importantly served to prevent a further exacerbation of inter and intra communal tensions in a context where competition for scarce services and anti-refugee rhetoric are prevalent.

CERF's Added Value:

Emergency funding under this allocation supported rapid response, prevention and containment of the outbreak and reduced mortality and morbidity through effective preparedness and response at all levels to control the disease. On 11 June, having had no reported cases since the end of February 2023, the MoPH declared the outbreak to be over. This timely containment of the outbreak was largely as a result of the successfully coordinated and timely response kickstarted with funding under CERF and Lebanon Humanitarian Fund.

915,977 people from all population groups in Lebanon were supported through UNHCR, UNICEF, WHO and partner programming through a comprehensive community-based integrated health, WASH and risk communication approach in line with the MoPH-led Cholera Integrated Prevention, Preparedness and Response Plan for Lebanon. As a result of the successful roll out the oral cholera vaccine (OCV) campaign for 915,789 people and hospitalization support for those most seriously affected the spread of the outbreak was limited. Moreover, the WASH response was able to provide clean and safe water, desludge wastewater in a secure manner and ensure that the water network was distributing treated water in areas susceptible to the spread of cholera. Water stations had the capacity for increased times of operation due to fuel provision from CERF, which meant that households were able to rely on the treated water for drinking. Information sharing and raising awareness on cholera, through workshops and trainings, further increased the knowledge of communities and empowered them to become more resilient against cholera and support limiting the impact of this and any further outbreaks.

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

Yes ☒ Partially ☐ No ☐

The allocation was successful in ensuring the very timely procurement and administration of the oral cholera vaccination to most vulnerable people in highest risk areas. Implementation of the Case Area Targeted Interventions (CATI) approach immediately upon discovery of a case and distribution of hygiene kits in such cases was immediate to the targeted populations vulnerable to infection, allowing them the means to drink safe water and maintain appropriate hygiene levels at both household and community levels.

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

CERF funds were utilized in all instances under this rapid response allocation to address time-critical needs in preventing the further spread and responding to infected cases caused by the outbreak.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

The allocation serves as an incredibly positive example of a coordinated response to crisis among government, UN and NGO partners collaborating to ensure timely response. There was strong collaboration with Health, WASH and other sectors at national and sub-national levels for more sustainable and immediate response, coaching and sensitization on Risk Communication and Community Engagement (RCCE) for sector actors and partners. The OCV vaccination campaign also set a successful model for collaboration between MoPH, UN agencies, and NGOs/INGOs for emergency response that can be built on for the future.

Did CERF funds help improve resource mobilization from other sources?

Yes ☐ Partially ☒ No ☐

Funding under CERF and LHF kickstarted response to the cholera outbreak. On WASH response, UNICEF were able to subsequently mobilize resources to develop the cholera hygiene kits which were distributed to households with new, complementary sources of funding.

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

While cholera strikes indiscriminately of sex, age and social status, those already most vulnerable are most adversely impacted. Moreover, social roles contribute to individuals' levels of vulnerability with studies showing that women and girls are more affected in cholera outbreaks. With this in mind, projects included under the allocation explicitly sought to identify and prioritize persons at heightened risk for awareness, prevention tools and treatment. This includes those who may be more severely impacted if they contract cholera due to pre-existing health conditions (malnutrition, pregnant/lactating

[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.

mothers, the elderly etc.), those less likely to have adequate access to information due to language or developmental barriers and those with greater proximity to infected water sources due to their professions or traditional gender roles.

For the provision of vaccines and hospitalization in severe cases, UNHCR ensured that persons with disabilities had equal access to vaccination and hospital care and were included through its strong community-based protection approach with several community structures and diversified communication channels with refugees. Furthermore, the vaccination was implemented through a mobile vaccination clinic going door to door to ensure access for Persons with Disabilities (PwD) limited in terms of mobility.

For WASH programming funded under this CERF allocation, although gender targeting was not applicable, persons at heightened risk who may experience greater exposure or vulnerability – such as women and girls and children under 5 years old, were taken into account in response planning. Women and girls and children under 5 years were identified as benefiting the most from accessing safe water in high-risk areas in Lebanon. All distributed kits provided during the cholera response included female menstrual hygiene items with the cholera hygiene awareness sessions, ensuring equal access to females and consideration of their specific needs.

Moreover, Risk Communication and Community Engagement (RCCE) activities mainstreamed across all interventions retained a focus on vulnerable groups, including people with disabilities, ensuring their understanding of and access to services. UNHCR ensured the provision of gender, age and developmentally appropriate information and key messages in multiple languages and different formats (written, visual/pictorial, and audio formats) distributed through different access points (community centres, health facilities, schools) to enhance access to information as well as to reach at-risk populations such as PwD.

Table 1: Allocation Overview (US$).

Total amount required for the humanitarian response	**68,650,879**
CERF	5,000,000
Country-Based Pooled Fund (if applicable)	4,600,000
Other (bilateral/multilateral)	2,400,000
Total funding received for the humanitarian response (by source above)	**12,000,000**

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

Agency	Project Code	Sector/Cluster	Amount
UNHCR	22-RR-HCR-031	Health	1,000,000
UNICEF	22-RR-CEF-076	Water, Sanitation and Hygiene	3,000,000
WHO	22-RR-WHO-044	Health	1,000,000
Total			**5,000,000**

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

Total funds implemented directly by UN agencies including procurement of relief goods	**3,525,346**

Funds sub-granted to government partners*	
Funds sub-granted to international NGO partners*	673,573
Funds sub-granted to national NGO partners*	588,300
Funds sub-granted to Red Cross/Red Crescent partners*	212,781
Total funds transferred to implementing partners (IP)*	**1,474,654**
Total	**5,000,000**

* 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:

Following a cholera outbreak in the region, affecting Syria since 10 September 2022, the disease quickly spread, with Lebanon reporting its first case of cholera on 4 October 2022 and reaching 1225 confirmed and suspected cases by 29 October, and 16 associated deaths. The fast-spreading cholera outbreak was the latest shock both compounded and enabled by the ever-deepening governance and economic crisis in Lebanon. In the continued absence of functioning public water and sanitation infrastructure allowing access to affordable safe water, sanitation, and hygiene to all and in view of an already overburdened and structurally weak health system, Lebanon is fundamentally ill-equipped to deal with the potentially large scale and long-lasting outbreak.

The country is undergoing a multi-layered crisis, characterized by political paralysis and acute economic contraction which is compromising both institutional capacity to supply services as well as household purchasing power, driving poverty, deprivation and inhibiting availability and access to services. In August 2022, a maximum of 2 to 5 hours of electricity from the grid was received daily in much of the country, with zero hours provided in some parts of Lebanon, leading to a directly corresponding decrease in water supplied through public networks. Facing the current economic breakdown and energy crisis, the Water Establishments are not able to cover the raising operational cost and mostly run the water supply on backup generators.

Due to inadequate water supply (some areas haven't received public water for months), affected individuals in Lebanon are increasingly reliant upon unregulated, often unsafe and more expensive private water trucked to fulfil needs. Some families cannot even afford water and knowingly drink unsafe water. This has not only severe public health implications but also adds a huge burden on impoverished families since the cost of bottled water as well as water trucking services increased by six-fold compared to mid-2021. Similar to public water supply, the majority of wastewater treatment plants are no longer functioning due to electricity cuts and unaffordability of fuel to run the back-up power generators. With no solution in sight to sustainably manage these challenges, controlling a cholera outbreak becomes a near impossible task unless contained early.

Furthermore, vulnerable populations face significant barriers to accessing healthcare due to the multifaceted crises (financial, geographic, availability, and acceptability barriers from both the supply and demand sides) impacting Lebanon. An increasing number of people have been driven to seek services from the public sector, increasing the pressure and demand on a structurally weak and underinvested into public health system. This pressure only increased with the cholera outbreak.

As the cholera outbreak spread, this continued absence of functioning public water and sanitation infrastructure allowing equitable access to safe water, sanitation, and hygiene together with an overburdened health system left Lebanon fundamentally ill-equipped to deal with a potentially deadly and sustained outbreak. Early containment, prevention and rapid response were critical to prevent it becoming something large-scale and uncontrolled.

Operational Use of the CERF Allocation and Results:

Emergency funding under this allocation supported rapid response, prevention and containment of the outbreak and reduced mortality and morbidity through effective preparedness and response at all levels to control the disease. 915,977 people from all population groups in Lebanon received support through UNHCR, UNICEF, WHO and partner programming through a comprehensive community-based integrated health, WASH and risk communication approach in line with the MoPH-led Cholera Integrated Prevention, Preparedness and Response Plan for Lebanon.

In support of prevention and containment, WASH sector activities improved access to safe water, sanitation and hygiene services for 1,186,021 people in cholera high-risk areas through support to Water Establishments (WE), Wastewater Treatment Plants (WWTPs), chlorination of private water tankers, water and wastewater services complementary to the response under the CATI approach funded by the LHF Reserve Allocation, and the WASH support for cholera treatment centres and cholera treatment units.

Health sector response reinforced work to contain the disease through complementary response measures including Oral Cholera Vaccines (OCVs) for an additional 915,789 among high-risk populations, complementing the 600,000 Syrian refugees and host communities vaccinated initially in most affected informal settlements in order to interrupt the chain of transmission. The campaign finished in February 2023. In addition to the COVs procured with CERF funding, additional funding allowed WHO to procure a further 586,011 OCVs, and retains a small contingency stock with the MoPH (with expiring not until 2024) for any possible further outbreaks.

For those already infected, and to ensure equitable support for all affected populations residing in Lebanon, UNHCR ensured coverage of hospitalization costs for cholera patients with severe illness. Due to lower than expected severe cases (only 188 of the targeted 1,213 people) UNHCR reprogrammed funding to expand their coverage of people vaccinated from 307,000 to 585,940 persons. The remainder of procured vaccines by WHO were administered by NGOs.

People Directly Reached:

Reached figures presented are based on interventions under the Health Sector. Under the oral cholera vaccine roll out, 915 789 people were supported through vaccine procurement (585,940 of which were administered by UNHCR and partners with CERF funding) in addition to the additional 181 people provided with hospitalization support. The total number of people supported under the Health sector is therefore **915,977**. These people targeted under health are those living / working in high risk areas and those with outbreaks, the same benefiting from WASH services and so it was considered more accurate to consider the health target as the total to avoid double counting. While WASH interventions reported a total of 1,186,021 individuals benefiting from services, this is figure is calculated based on the populations in the catchment areas of the 28 water pumping stations and 18 wastewater treatment plants supported. As people supported directly with health services under the allocation certainly were from within these prioritised WASH locations, the number of individuals benefiting from targeted health services provides a more accurate number of reached beneficiaries.

People Indirectly Reached:

All services provided under this allocation sought to break the transmission of the outbreak and in doing so, each person who received a vaccination, or each deployment of a team to roll out the CATI approach when a case was identified prevented the further spread of the disease to others. Within the cholera outbreak, UNICEF also facilitated cholera awareness sessions in hotspot areas to improve knowledge and practices that are associated with the spreading of cholera bacteria. In total, 10,867 individuals received hygiene and Cholera awareness sessions who were able to spread the information and knowledge to their family and friends where a further 40,000 were estimated to be indirectly targeted.

As part of its response, UNHCR also conducted a large-scale awareness campaign on preventative measures and hygiene practices. These awareness campaigns involved the mobilization of partners and refugee outreach volunteers to reach communities across Lebanon. The approach ultimately had a significant effect on the reduction in the number of cholera cases and controlled the cholera outbreak in the country. The approach indirectly benefited communities in spreading prevention practices between family members as well as communities in high-risk areas.

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	290,389	314,263	149,740	161,998	916,390	290,136	314,309	149,487	162,045	**915,977**
Water, Sanitation and Hygiene	201,000	180,075	108,750	110,175	600,000	406,853	357,072	211,241	210,855	**1,186,021**

* 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	370,477	370,664
Returnees	0	0
Internally displaced people	0	0
Host communities	545,313	545,313
Other affected people	0	0
Total	**915,790**	**915,977**

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	290,389	290,136	34,811	34,811
Men	314,263	314,309	37,712	37,711
Girls	149,740	149,487	17,933	149,487
Boys	161,998	162,045	19,440	162,045
Total	**916,390**	**915,977**	**109,896**	**109,985**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 22-RR-HCR-031

1. Project Information

Agency:	UNHCR	**Country:**	Lebanon
Sector/cluster:	Health	**CERF project code:**	22-RR-HCR-031
Project title:	Life-saving hospital support and oral cholera vaccine (OCV) administration		
Start date:	01/11/2022	**End date:**	30/04/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☒	Reprogramming ☒

Funding

Total requirement for agency's sector response to current emergency:	**US$ 8,500,000**
Total funding received for agency's sector response to current emergency:	**US$ 0**
Amount received from CERF:	**US$ 1,000,000**
Total CERF funds sub-granted to implementing partners:	**US$ [826,228]**
Government Partners	US$ [0]
International NGOs	US$ [386,226]
National NGOs	US$ [227,221]
Red Cross/Crescent Organisation	US$ [212,781]

2. Project Results Summary/Overall Performance

Through the CERF Rapid Response grant, UNHCR and its partners undertook two health activities to respond to the outbreak of Cholera in Lebanon in the North, Bekaa, Akkar in Lebanon with focus on high-risk districts. During the implementation period of 6 months (Nov 2022 to April 2023), a total of 585,940 individuals - including 158,204 women, 152,344 men, and 275,392 children - were provided with the Oral Cholera Vaccine (OCVs) through the roll out of an OCV campaign in high-risk communities including in informal settlements and collective shelters through a door-to-door campaign. This included both refugees and host community members. These were delivered at the facility as well as household and community level enabling responders to target those most vulnerable and at risk for infection.

The second activity was aimed at refugees already infected and presenting severe symptoms. Through the fund, UNHCR was able to cover 100% of costs at hospitals for 188 refugee cholera patients - including 30 women, 40 men and 118 children - with severe illness. The intervention complemented the Government of Lebanon's coverage of the Lebanese population. UNHCR has an existing health care referral programme that provides coverage for hospitalization for the refugee population in Lebanon. This program was immediately leveraged to include 100% coverage of the treatment cost of cholera among refugees.

During the reporting period, the socioeconomic crisis in Lebanon coupled with the sharp increase in poverty levels and inadequate access to basic needs, including healthcare, further contributed to the dire living conditions refugees experience. Through this funding, UNHCR was able to heighten its efforts to reach vulnerable refugees with cholera treatment. The response contributed to improving the level of public health preparedness and response capacity in Lebanon. In doing so, the vaccination campaign and roll-out of vaccines interrupted the chain of transmission of infection and eases the strain on the Lebanese healthcare system. Additionally, by interrupting the transmission of cholera among the communities, the contribution supported in maintaining the country's economic and agricultural revenue and in keeping Lebanon a non-endemic cholera country.

3. Changes and Amendments

UNHCR planned to cover 100% of costs for all confirmed or suspected cholera cases among the persons of concern, including coverage of the cases admitted in the wards, the ICU and Emergency Room admissions, while the Ministry of Public Health committed to covering the same for the Lebanese population. The proposal initially envisaged that 1,213 people will receive treatment for acute watery diarrhea (incl. cholera) while 307,000 would receive Oral Cholera Vaccination (OCV) through door-to-door and mobile unit campaigns. However, due to the timely collective response to the cholera outbreak, the number of persons admitted for hospital care was lower than what the proposal had anticipated. By the end of December 2022, a total of 188 persons (including 30 women, 40 men and 118 children) out of 1,213 were admitted to hospitals for Cholera Treatment. The result can be attributed to a successful vaccination campaign where refugees across Lebanon were reached with the Oral Cholera Vaccine.

UNHCR's approach to communicating with communities and awareness campaigns on Cholera, including the mobilization of refugee outreach volunteers - a network of dedicated community members who support UNHCR in disseminating information on services and campaigns - to reach greater refugee populations increased awareness and ultimately minimized the spread of Cholera. Other approaches such as promoting hygiene practices and supporting surveillance in high-risk locations played a major role in the overall response. This consequently facilitated a decrease in the number of cases requiring hospital admission for acute cholera treatment.

UNHCR submitted a redeployment of funds request, and following its approval resulted in the redeployment of USD 261,967 from hospitalization to OCV. This led to a new budget of USD 138,000 for Hospitalization and USD 800,967 for OCV, hence expanding the reach to persons in need. With the revised budget, UNHCR targeted a total of 585,940 persons with OCVs, up from the 307,000 originally planned, allowing for an effective response to the outbreak on the ground and reaching vulnerable populations. This redeployment of funds has also helped increase the overall number of persons targeted by this project, from 308,200 to a final total of 586,128.

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	58,237	63,916	41,857	41,857	**205,867**	104,448	100,579	89,090	92,727	**386,844**
Returnees	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Internally displaced people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Host communities	28,969	31,808	20,778	20,778	**102,333**	53,807	51,814	45,895	47,768	**199,284**
Other affected people	0	0	0	0	**0**	[Fill in]	[Fill in]	[Fill in]	[Fill in]	**[Fill in]**
Total	**87,206**	**95,724**	**62,635**	**62,635**	**308,200**	**158,255**	**152,393**	**134,985**	**140,495**	**586,128**
People with disabilities (PwD) out of the total										
	4,623	4,623	4,623	4,623	**18,492**	**9,495**	**9,144**	**8,099**	**8,430**	**35,168**

* 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

As part of its response, UNHCR conducted a large-scale awareness campaign on preventative measures and hygiene practices. These awareness campaigns involved the mobilization of partners and refugee outreach volunteers to reach refugee communities across Lebanon. The approach ultimately had a significant effect to the reduction in the number of cholera cases and controlled the cholera outbreak in the country. The approach indirectly benefited both refugees and the local community in spreading prevention practices between family members as well as communities in high-risk areas.

6. CERF Results Framework

Project objective	Enhance cholera prevention, response and surveillance and ensure treatment and timely life-saving support for cholera/acute watery diarrhoea patients.
Output 1	Oral Cholera Vaccination

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.4 Number of people vaccinated	307,000	585,940	UNHCR/partners
Indicator 1.2	% of coverage of targeted population	At least 80% of coverage	At least 80% of coverage	UNHCR/partners
Explanation of output and indicators variance:		Redeployment of funds/reprogramming approved by CERF		

Activities	**Description**	**Implemented by**
Activity 1.1	Administration of the Oral Cholera Vaccine to residents of hotspot areas through door-to-door and mobile unit campaigns	Implementing partners (MEDAIR, AMEL, LRC)

Output 2	Hospital admission for Cholera Treatment

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.11 Number of people receiving treatment for acute watery diarrhoea (incl. cholera)	1,213	188	UNHCR/partners
Explanation of output and indicators variance:		Redeployment of funds/reprogramming approved by CERF		

Activities	**Description**	**Implemented by**
Activity 2.1	Coverage of 100% of the treatment cost of cholera for refugee patients with acute watery diarrhoea	UNHCR through TPA

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[2] 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)[3]:

UNHCR seeks to ensure that all persons of concern can access quality health services. Special measures to ensure inclusiveness and accessibility for specific groups of concern, among which women, adolescent girls and boys, the elderly, the young, people with disabilities will continue.

Both the AGD approach and Commitment to Gender Equality are key to ensuring Accountability to Affected People (AAP). UNHCR Lebanon is therefore continuously strengthening its AAP to ensure that refugees and others of concern, including communities affected by displacement, are at the centre of all that we do, have equal access to services and participate equally in the making of decisions that affect their lives, families and communities. Participation entails that refugees and others play a critical role, as partners, in assessing their needs, and in designing, implementing, monitoring and evaluating the solutions to address them, including through their own involvement. Through such meaningful participation, UNHCR ensures that protection and assistance programmes are effective and accountable to persons of concern, all in partnership with the government, civil society and affected communities.

b. AAP Feedback and Complaint Mechanisms:

UNHCR ensures that Accountability to Affected People continues to be central in the cholera response. In specific, the feedback, complaints and views of refugees are gathered through the following diverse channels:

- UNHCR National Call Centre
- Partner hotlines
- Community volunteers who share community risks, concerns, priorities and suggestions as they implement awareness and sensitisation sessions
- Protection monitoring activities
- Focus group discussions
- Complaint boxes at UNHCR and partners
- Exit interviews with randomly selected patients
- Field visits
- Observations

The information, analyzed by age, gender and diversity, informed and guided cholera prevention and response activities.

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

[2] 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.

[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.

UNHCR's system for the Prevention of Sexual Exploitation and Abuse (PSEA) entails the dissemination of information to refugees on UNHCR's zero-tolerance policy and how to file complaints, internal SOPs and regular trainings for staff and partners. Numerous confidential reporting mechanisms are in place, including a strong retaliation policy for those who come forward in reporting allegations, with all cases being reported to the Inspector General's Office (IGO) for independent oversight. When it comes to identification, referral, and services to survivors of SEA, UNHCR provides access to services through the existing GBV referral pathways and service delivery mechanisms, including access to Safe Shelters, legal support, immediate medical support and coverage of treatment, psychological support through specialized partners, and access to learning opportunities.

Additionally, UNHCR has conducted a comprehensive PSEA capacity review for all its implementing partners to ensure that partners have the requisite capacity with respect to protection against sexual exploitation and abuse (PSEA). A common standardized UN Implementing Partner PSEA Capacity Assessment tool was developed affecting the requirements of the United Nations Protocol on Allegations of Sexual Exploitation and Abuse Involving Implementing Partners (the UN Protocol).

Finally, UNHCR is a member of the interagency PSEA network, including of its core group.

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

UNHCR ensures that refugees of all ages and backgrounds have access to quality services as part of its Age, Gender and Diversity (AGD) approach in the overall cholera response.

UNHCR ensures that the existing community volunteers, the majority of whom are women, reach women, girls, boys, older persons and other at risk with the essential information to prevent and respond to cholera. The response, including community volunteers, will explicitly identify and prioritise persons at heightened risk for awareness, prevention tools and treatment. This includes those who may be more severely impacted if they contract Cholera due to pre-existing health conditions (malnutrition, pregnant/lactating mothers, AIDS), those less likely to have adequate access to information due to language or developmental barriers and those with greater proximity to infected water sources due to their professions or traditional gender roles.

Response activities under this request ensures that the needs of all affected groups are considered and cholera data are disaggregated into gender, age, nationality and other critical variables to develop targeted interventions for each vulnerable group. RCCE activities retain a focus on vulnerable groups, including people with disabilities, ensuring their understanding of and access to services. While cholera strikes indiscriminately of sex, age, and social status, those already most vulnerable are most adversely impacted. Moreover, social roles contribute to individuals' levels of vulnerability with studies showing that women and girls are more affected by cholera outbreaks. Cholera is transmitted principally through contaminated water and food. Women and girls have a heightened risk of coming into contact with a high infectious dose of cholera through their domestic roles, including taking care of sick family members, cleaning latrines, fetching and handling water, and preparing contaminated raw food. This is reinforced by gender data from the early stage of the Lebanon response. It has moreover been identified that the number one cause of death in cholera is the late seeking of medical care with people most at risk of dehydration (including pregnant and lactating women, children, disabled and elderly) likely having to seek medical attention the soonest.

Although gender targeting will not be applicable for the type of activities under this CERF allocation, persons at heightened risk who experience greater exposure or vulnerability – such as women and girls and children under 5 years old, were taken into account in response planning.

e. People with disabilities (PwD):

Through this project UNHCR ensured that persons with disabilities have equal access to vaccination and hospital care and are included through its strong community-based protection approach with several community structures and diversified communication channels with refugees. These include reception centres, info desks, call centres and hotlines, complaints boxes, social networks, household visits, protection monitoring, community centres, community groups, volunteers, and solidarity initiatives to help support people exposed to extreme poverty, rising unemployment and desperation that are creating harmful coping mechanisms and protection risks including persons with specific needs such as older persons and persons with disabilities.

In addition, UNHCR ensured the provision of gender, age and developmentally appropriate information and key messages in multiple languages and different formats (written, visual/pictorial, and audio formats) distributed through different access points (community centres, health facilities, schools) to enhance access to information as well as to reach at-risk populations such as PwD.

Furthermore, the vaccination was implemented through a mobile vaccination going door to door to ensure access for PwD who are limited in terms of mobility.

f. Protection:

Protection, Gender and Gender-Based violence including MHPSS and Risk Communication and Community Engagement are key cross-cutting components to be mainstreamed into the response.

During the Cholera outbreak, a number of protection risks were taken into account that impacted the safety, mental health and psychosocial wellbeing of individuals and communities, including: reduced access to essential protective spaces and services, disruption of care for children and other dependents (older persons, persons with disabilities) due to absence (while in treatment) or loss of caregivers, disruption or loss of livelihoods during treatment or following death impacting the family or support network, heightened anxiety, mistrust and isolation due to fear of the disease, negative attitudes and behaviours (violence, exclusion, stigma, discrimination) toward disease survivors, families of patients and those who could transmit the disease (i.e., frontline responders), long term physical and health impacts and wide-spread loss and grief.

As a result, UNHCR's protection partners worked closely with health and WASH counterparts to reduce the risk of exposure to the disease and to prevent and respond to violence and other protection concerns that may have arised as a result of the outbreak.

g. Education:

Protection sector partners provided awareness sessions (prevention messages & measures) to children, educators, community facilitators and caregivers involved in CP. In addition to working with the reproductive health sector health providers including mid-wives as an entry to point to pregnant/lactating women to raise awareness on Cholera & practical steps to prevent it.

UNHCR ensured the provision of gender, age and developmentally appropriate information and key messages in multiple languages and different formats (written, visual / pictorial, and audio formats) distributed through different access points (community centers, health facilities, schools) to enhance accessibility to information.

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	Choose an item.	[Fill in]

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.

[Fill in]

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	**Weblink**
CERF, "a fund by all, for all," a lifesaving cholera response in Lebanon	***https://www.unhcr.org/lb/17053-cerf-a-fund-by-all-for-all-a-lifesaving-cholera-response-in-lebanon.html***
[Insert]	[Insert]
[Insert]	[Insert]

3.2 Project Report 22-RR-CEF-076

1. Project Information

Agency:	UNICEF	**Country:**	Lebanon
Sector/cluster:	Water, Sanitation and Hygiene	**CERF project code:**	22-RR-CEF-076
Project title:	WASH response to Cholera in Lebanon		
Start date:	25/10/2022	**End date:**	24/04/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 38,600,000**
Total funding received for agency's sector response to current emergency:	**US$ 700,000**
Amount received from CERF:	**US$ 3,000,000**
Total CERF funds sub-granted to implementing partners:	**US$ 648,426**
Government Partners	US$ 0
International NGOs	US$ 287,346.93
National NGOs	US$ 361,079
Red Cross/Crescent Organisation	US$0

2. Project Results Summary/Overall Performance

Since the start of the cholera outbreak and with the generous contribution of CERF, UNICEF has supplied **1,364,050 litres of fuel** to water and wastewater stations which ensured that stations are operational for a minimum of 4 hours per day in hotspot areas. A total of **1,174,934 individuals** were reached through this intervention. Additionally, the Bekaa Water Establishment and Beirut and Mount Lebanon Water Establishment were supplied with a total of **8 tons of chlorine powder** to treat water in areas susceptible to Cholera outbreaks. Notably, UNICEF has implemented Cholera interventions in **four governmental hospitals**: Halba Governmental Hospital was provided with temporary latrines for Cholera inpatients to ensure wastewater flow; while Tripoli, Bebnine and Arsal Hospitals and public healthcare centres have received UNICEF support in designing an improved wastewater process for Cholera patients.

In informal settlements, with the support of partners, UNICEF has delivered at least **35 litres/day** of clean drinking water in all areas of intervention. UNICEF also cleaned and disinfected water tanks; latrines were replaced where needed. UNICEF's Cholera response is centered on the Case Area Targeted Intervention (CATI) approach, which targets households that fall within a 150-meter radius from a suspected case. Households residing in this catchment area were supplied with chlorine family hygiene kits and disinfection kits with interventions provided through water trucking, desludging, cleaning, and the disinfection of water tanks and pits.

Since the start of the outbreak, through CERF funding, UNICEF has reached the following results across all governorates in 2,725 informal settlements between October 2022 and February 2023:

- 28 water pumping stations in operation
- 18 wastewater treatment plants in operation
- 879 municipalities managing chlorination operation
- 4 CTCs/CTUs with functioning water and wastewater facilities
- 1,109 critical family hygiene kits distributed to 6,657 individuals in hotspot areas

- 25,448 m3 of water trucking to 2,725 informal settlements
- 7,614 m3 of desludging to 365 informal settlements
- 9 sprayers procured to clean water tanks in 9 informal settlements
- 10,867 individuals received hygiene and Cholera awareness sessions
- 220 frontline workers received Cholera disinfection kits
- 948 disinfection kits supplied to 5,685 individuals in hotspot areas.

Through CERF funding, UNICEF has reached a total of **1,186,021 individuals** (245,853 Syrian refugees and 940,168 Lebanese) and provided essential services to reduce the risk of Cholera spread amongst the most vulnerable population in Lebanon. The project activities contributed to improving the overall operation and access to safe drinking water, providing emergency water and sanitation services to the most vulnerable in cholera hotspot areas and limited the risk of cholera spread in public health centers through tailored interventions.

3. Changes and Amendments

Not applicable

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	78,150	74,375	47,500	49,975	**250,000**	76,854	73,141	46,712	49,146	**245,853**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	122,850	105,700	61,250	60,200	**350,000**	329,999	283,931	164,529	161,709	**940,168**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**201,000**	**180,075**	**108,750**	**110,175**	**600,000**	**406,853**	**357,072**	**211,241**	**210,855**	**1,186,021**
People with disabilities (PwD) out of the total										
	6,030	5,402	2,663	3,305	**17,400**	**10,408**	**8,954**	**5,189**	**5,100**	**29,651**

* 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

Within the cholera outbreak, UNICEF facilitated cholera awareness sessions in hotspot areas to improve knowledge and practices that are associated with the spreading of cholera bacteria. In total, 10,867 individuals received hygiene and Cholera awareness sessions who were able to spread the information and knowledge to their family and friends where a further 40,000 were estimated to be indirectly targeted.

6. CERF Results Framework

Project objective	Ensure timely and appropriate WASH prevention and response measures to control the spread of Cholera, with special attention to the populations in high-risk areas.
Output 1	Functioning water pumping stations and wastewater treatment plants in key high-risk areas

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 1.1	Number of priority water pumping stations in operation	6	28	Internal Monitoring
Indicator 1.2	Number of priority wastewater treatment plants in operation	2	18	Internal Monitoring
Explanation of output and indicators variance:		As cholera spread, it was important to expand and provide fuel to the wastewater plants which were in hotspot areas to prevent the further spread of cholera. This has led to an over-achievement in the number of wastewater treatment plants in operation.		

Activities	**Description**	**Implemented by**
Activity 1.1	Provision of diesel fuel to priority water pumping stations	UNICEF
Activity 1.2	Provision of diesel fuel to priority wastewater treatment plants	UNICEF

Output 2	Water tankers in municipalities are supplying chlorinated water

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 municipalities managing chlorination operation	T.B.D. based on areas with confirmed or suspected cases	879	Activity Info
Explanation of output and indicators variance:				

Activities	**Description**	**Implemented by**
Activity 2.1	Provision of chlorine powder to municipalities through Lebanese Red Cross	UNICEF

Activity 2.2	Training of municipality staff in chlorination of water tankers	Lebanese Red Cross

Output 3	Water and wastewater facilities ensured in designated CTCs/CTUs			
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	Number of CTCs/CTUs with functioning water & wastewater facilities	12	4	Internal Monitoring
Explanation of output and indicators variance:		Due to the decline in cholera cases, the need for CTCs and the number of CTUs decreased, which led to an underachievement in the number of CTCs/CTUs with functioning water and wastewater facilities		

Activities	**Description**	**Implemented by**
Activity 3.1	Assessment of condition of water and wastewater facilities in CTC/CTUs	UNICEF
Activity 3.2	Construction/rehabilitation of facilities	UNICEF

Output 4	Rapid WASH response through Case-area targeted interventions (CATI) approach			
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 people receiving critical WASH supplies (e.g. WASH/hygiene kits)	250,000	245,853	Activity Info
Explanation of output and indicators variance:		Due to the decrease in cases, the CATI approach was no longer needed as the Ministry of Health officially declared the outbreak to be over, which led to an underachievement in the number of people receiving critical WASH supplies.		

Activities	**Description**	**Implemented by**
Activity 4.1	Provision of supplementary water supply and wastewater disposal services in outbreak locations	LOST, WVI, LebRelief and SCI
Activity 4.2	Provision of chlorination and disinfection supplies	LOST, WVI, LebRelief and SCI

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[4] 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)[5]:

Using the CATI method as described above, households which were in the immediate vicinity of a suspected/confirmed cholera case were deemed to be most vulnerable and were provided with the appropriate response. The response did not discriminate towards a particular population; all were included in the UNICEF cholera response whether Syrian refugees, Lebanese host community or other.

b. AAP Feedback and Complaint Mechanisms:

As part of the humanitarian response in informal settlements, UNICEF operates a complaint and beneficiary support call centre which is in place to receive feedback and improve accountability of UNICEF programmes. This system is available for all population types and maintains confidentiality of beneficiaries. On a monthly basis, UNICEF reviews the complaints and feedback and shares back this information with implementing partners.

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

UNICEF developed a PSEAH strategy closely aligned and articulated around PSEA global priority outcomes[6]. Following the endorsement of the UN protocol on SEA allegations involving Implementing Partners (IPs), UNICEF started rolling out a mandatory capacity building process for more than 60 local IPs to ensure full compliance with SEA minimum standards. Thus, the majority of beneficiaries of UNICEF's funded programmes had access to safe, accessible reporting channels. SEA victims receive victim-centred, age, gender sensitive, and culturally appropriate services. As per the contractual obligations, UNICEF's partners have to promptly report SE allegations in a timely manner to UNICEF. All SEA allegations related to UNICEF personnel or IPs are reported directly to the Office of Internal Audit and Investigations (OIAI) and included in UN-wide database Secretary General's Reporting Mechanism**.** All beneficiaries of assistance can report SEA allegations to UNICEF through the provided UNICEF hotline.

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

All distributed kits provided during the cholera response included female menstrual hygiene items with the cholera hygiene awareness sessions, ensuring equal access to females and consideration of their specific needs.

e. People with disabilities (PwD):

[4] 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.

[5] 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.

[6] The three priority outcomes are (i) safe and accessible reporting mechanisms, (ii) quality, victim-centred support, and (iii) accountability for every child and adult victim in all humanitarian responses.

As noted previously, distributions and cholera awareness were accessible to all. It was important to include all because of the nature of the public health outbreak that left all vulnerable.

f. Protection:

The CATI approach ensured that the potentially affected persons would receive the response immediately. If a suspected case was reported, all the population in the vicinity would receive the cholera response because they were most at risk. This was put in place to protect those most at risk but also to reduce the risk of cholera spreading and increasing the number of affected persons.
In addition, the AAP feedback and complaints mechanism as well as PSEA reporting mechanism also allowed for the integration and mainstreaming of Protection under this project.

g. Education:

Not applicable

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	Choose an item.	[Fill in]

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.

[Fill in]

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
[Insert]	[Insert]
[Insert]	[Insert]

[Insert]

[Insert]

3.3 Project Report 22-RR-WHO-044

1. Project Information

Agency:	WHO	**Country:**	Lebanon
Sector/cluster:	Health	**CERF project code:**	22-RR-WHO-044
Project title:	Oral Cholera Vaccination to high-risk settings in Lebanon		
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$ 10,220,022**
Total funding received for agency's sector response to current emergency:	**US$ 1,700,000**
Amount received from CERF:	**US$ 1,000,000**
Total CERF funds sub-granted to implementing partners:	**US$ [NA]**
Government Partners	US$ [Fill in]
International NGOs	US$ [Fill in]
National NGOs	US$ [Fill in]
Red Cross/Crescent Organisation	US$ [Fill in]

2. Project Results Summary/Overall Performance

- Through this CERF UFE grant, WHO has procured 915,790 doses of OCV vaccines for targeted population saving interventions within hospitals to ensure that 90% of the population most at risk (a total of 1,017,428 people) living in the 8 districts identified as hot spots are vaccinated with a single-dose campaign of oral cholera vaccine (OCV). Procured doses have been delivered to the MoPH central drug warehouse where they were distributed to NGOs as per the OCV taskforce recommendation and implementation plan. OCV were delivered both at facility as well as household and community levels enabling responders to target those most vulnerable and at risk for infection. A Door-to-Door strategy was the main mechanism for vaccination delivery.
- As soon as Lebanon's ICG application was approved, a cholera vaccination committee was formed on the 26th of October 2022 with main objective to quickly devise an implementation plan prioritizing most at-risk individuals. Based on WHO and GTFCC recommendations, a community-based door-to-door approach was agreed upon. WHO and UNICEF supported with the development of relevant targeting criteria, microplanning, training material for vaccinating teams, and IEC material for social mobilization. In parallel, UNHCR supported with the operationalization of the campaign through four implementing partners: MEDAIR, MSF, the Lebanese Red Cross, and Amel Association International. Within ICG-approved districts, the MoPH targeted areas down to cadasters (administrative level 3) using 3 principles: cadastres categorized as most at risk using the hotspot map, cadastres with active cases detected and reported, and cadastres that ensured geographic continuity for teams on the field. This included: Akkar, Baalbek, Zahle, Minieh-Donnieh, Zgharta, Saida, Tripoli, Keserwan, Aley, Baabda, Beirut, Jbeil, Koura, Meten and Sour.
- On Wednesday, 14 December 2022, over 915,789 doses of cholera vaccines arrived at Lebanon with the support of the World Health Organization (WHO) and International Coordination Group and funded by the United Nations Central Emergency Response Fund (CERF).
- Additionally, this CERF UFE grant granted support for 3 staff members at country office for 6 months to support the implementation of this project including technical and operations support:
  - 1 Environmental Health Officer (NOA)

- 1 Senior Procurement Assistant (G6)
- 1 Operations Associate (UNV)

3. Changes and Amendments

[NA]

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	117,367	127,148	60,462	65,500	**370,477**	**117,367**	**127,147**	**60,462**	**65,500**	**370,477**
Returnees	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Internally displaced people	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Host communities	172,722	187,115	88,978	96,498	**545,313**	**172,722**	**187,115**	**88,978**	**95,498**	**545,313**
Other affected people	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total	**290,089**	**314,263**	**149,440**	**161,998**	**915,790**	**290,089**	**314,262**	**149,440**	**161,998**	**915,789**
People with disabilities (PwD) out of the total										
	34,811	37,712	17,933	19,440	**109,896**	**34,811**	**37,711**	**17,933**	**19,440**	**109,896**

* 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

The OCV campaign formed a key component on stopping the further spread of cholera. This role in containment of the disease can be cosidered to have idirectly supported the families and broader communities of those vaccinated.

6. CERF Results Framework

Project objective	Ensure that 915,790 people living in the 8 districts identified as hotspots are vaccinated with a single dose campaign of OCV in order to reduce morbidity and mortality and stop further transmission of the outbreak
Output 1	Procure 915,790 doses of OCV vaccines for targeted population

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	# of doses procured and delivered to Lebanon	915,790	[915,789]	[PO, delivery notes]
Indicator 1.2	# of OCV doses distributed	915,790	[915,789]	[delivery notes]
Explanation of output and indicators variance:		[NA]		

Activities	**Description**	**Implemented by**
Activity 1.1	Initiate international procurement of OCV vaccines	[WHO]
Activity 1.2	Reception of 915,790 doses of OCV vaccines in batches	[WHO]
Activity 1.3	Monitoring the distribution of 915,790 doses of OCV vaccines	[WHO]

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[7] 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.**

[7] 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)[8]:

The Cholera Response Plan was the basis of this project and was developed in close consultation with local and international NGOs, Ministry of Health counterparts, and UN agencies.

The targeted population was the most vulnerable groups living in areas and cadastres with suboptimal access to health care as well as safe water and sanitation.

This CERF project is accountable towards this most vulnerable population in terms of accessing prevention through the oral Cholera vaccines. It will also help in slowing the spread of the outbreak, allowing more time for other outbreak control measures such as Chlorination at community level, raising awareness and operationalizing of cholera Treatment Units and Centres to offer more adequate and safe care.

b. AAP Feedback and Complaint Mechanisms:

As this CERF application included only the procurement of 915,789 doses of OCV vaccines, no complaint mechanism was envisioned for this specific activity, nevertheless the distribution of the procured doses was monitored through the Logistics management System (LMS) together with monthly reporting.

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

WHO Lebanon team conducted four sessions for partners and one session for staff members on "Prevention of Sexual Exploitation, Abuse and Harassment (PSEAH)" over February and March 2023. The training was delivered at a peripheral level in Beirut, North, Bekaa and South governates. It aimed to ensure that health responders and WHO personnel have the minimum standard knowledge to prevent sexual exploitation, abuse and harassment. The training was designed to equip staff and partners with knowledge to define sexual misconduct and recognize their role and responsibilities. The dedicated focal point for Gender and Protection prepared and delivered these training sessions in alignment with WHO materials.

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

This project was aligned with WHO gender policy incorporating non-discriminatory practices, ensuring equal access to resources and opportunities, and establishing mechanisms for reporting and addressing any incidents of discrimination or violence as well as taking into consideration the different and unique needs and experiences of women, girls and sexual and gender minorities.

e. People with disabilities (PwD):

[8] 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.

The project ensured to meet the essential needs and accessibility and inclusion for people with disabilities through an inclusive planning that consider the need and rights of people with disabilities.

f. Protection:

Access to Oral Cholera Vaccination was inclusive of all populations according to a pre-defined vulnerability and risk areas.

g. Education:

As the project involved only procurement of the OCV vaccine, no work was done in support of education

8. Cash and Voucher Assistance (CVA)

Use of Cash and Voucher Assistance (CVA)?

Planned	Achieved	Total number of people receiving cash assistance:
No	Choose an item.	[Fill in]

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.

[Fill in]

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.
[Fill in]	[Fill in]	US$ [insert amount]	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink

An additional 900 000 doses of cholera vaccines arrive in Lebanon	***FB: https://www.facebook.com/wholeb/posts/pfbid02LdLsVLJFgoDpTuKPCBhdqy3fjrsV7agQ97C1nYPk3BQgKSdWrBeZmzs6p3o29p2Ml***
Launching of the #cholera vaccine at the community level by the Minister of Public Health accompanied by WHO team and other partners, targeting the most vulnerable population in Akkar	***FB: https://www.facebook.com/wholeb/posts/pfbid0p6B1jENFYwJCsR3amcmo5x2XP85CNyhQiNnje6pELYWoM9WXkrAWCzvRZ2HNjGgcl*** ***Twitter: https://twitter.com/WHOLebanon/status/1591473621381570562*** ***Instagram: https://www.instagram.com/p/Ck3jH8lrJ7R/?utm_source=ig_web_copy_link&igshid=MzRlODBiNWFlZA==***
The first cholera vaccine targeting healthcare workers was given today at the Halba Abdallah Rassi Governmental Hospital in the presence of WHO representative in Lebanon Dr. Abdinasir Abubakar, Minister of	

Public Health Dr. Firass Abiad, and heads of sister agencies and other partners.

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
22-RR-CEF-076	Water, Sanitation and Hygiene	UNICEF	NNGO	$237,479
22-RR-CEF-076	Water, Sanitation and Hygiene	UNICEF	INGO	$123,000
22-RR-CEF-076	Water, Sanitation and Hygiene	UNICEF	NNGO	$123,600
22-RR-CEF-076	Water, Sanitation and Hygiene	UNICEF	INGO	$164,347
22-RR-HCR-031	Health	UNHCR	RedC	$212,781
22-RR-HCR-031	Health	UNHCR	INGO	$386,226
22-RR-HCR-031	Health	UNHCR	NNGO	$227,221