CERF ALLOCATION REPORT ON THE
USE OF FUNDS AND ACHIEVED RESULTS

UGANDA
RAPID RESPONSE
EBOLA
2022

22-RR-UGA-55796

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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.	25 January and 13-16 February 2023

After-Action Review of the UN Ebola conducted as part of Uganda's national process, as well as through a regular meeting of the UN Country Team (UNCT).

- UN Heads of Agencies participated in the After-Action Review on 13-16 February, convened jointly by Ministry of Health and WHO. The meeting was attended by line ministries, donor partners and UN Agencies, including HoAs and technical officers.
- In addition, the UNCT meeting on 25 January discussed on overall Ebola response with a focus on the UN contributions (national coordination support, coordinated UN emergency response and lessons drawn). This Head of Agencies meetings are usually attended by Deputies of Agencies as well as relevant technical staff members.

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 strategic objective of this CERF Rapid Response was two folded. Firstly, it contributed to the reduction of mortality and morbidity related to the Sudan Ebola Virus Disease (EVD) outbreak in Uganda and prevented the spread of the outbreak to other provinces of the country, as well as to neighbouring countries with minimum disruption of social and health systems. Through this CERF funding, a total of 495,998people directly benefited,. As a result of the time-effective response, on 11th January 2023, the MoH in Uganda with support from WHO officially declared the end of EVD outbreak after 42 incubation period with no new cases. It was a milestone event for Uganda having confirmed EVD eradicating it within 69 days. At the end of the outbreak, the country recorded a total of 164 cases (142 confirmed and 22 probable), 55 confirmed deaths and 87 recovered patients. No cases were reported outside the borders of Uganda.

Funding through the CERF allocation of USD 3m functioned as a catalytic funding to support the response and invoke more donors to fund, contributing the UN country team in their advocacy and resource mobilization efforts and better help position the UN Family to fulfil its mandates.On the outset of the outbreak, the UN Country Team organized its response efforts under the joint UN Response Plan supporting coherent UN narrative, requiring US $ 112 million to ensure comprehensive and quality response for a minimum of six months. As a result, 10 Agencies were able to raise over US $ 42 million, including US $ 19 million through embassies, through their own channels. The Resident Coordinator's Office (UNRCO) consistently engaged with the national government and partners, providing UNCT the required leadership on mobilizing resources and coordinated response.

In 2022, the UNRCO Office stepped up humanitarian coordination efforts by establishing Humanitarian Inter-Agency Coordination Group (HICG) and the HCT-Lite. These humanitarian coordination mechanisms were utilised also in the EVD response, as a result, joined up approach to UN programming has been advanced, with significant results. On the outset of the EVD, UNRCO designed and circulated the Joint UN Ebola Response Plan within a week's time, showcasing UN collective effort, providing UN's overall narrative on resources required, specially supported on explaining how agencies will avoid duplication. For this CERF funding, although UNHCR was not a recipient agency, under the UNRCO coordination, the three recipient agencies consulted with UNHCR assuring that their assistance will cover the refugees, resulting in reaching 119,266 refugees.

CERF's Added Value:

CERF intervention was strategic and timely, particularly in facilitating other donors to make contributions in an efficient manner. As mentioned above, additional US $ 42 M, including US $ 19M through engagement with donors at local level, was mobilised. Hence, the CERF RR allocation was catalytic. CERF added value by responding to time-critical emergency needs, while it has also created an impact on facilitating longer-term solutions such as health system capacity (disease surveillance, diagnostic, case management, contact tracing and risk communications) strengthening. WASH intervention is an example of a success: A total of 199,868 people benefited from WASH support. Through investments in WASH in health facilities, the results achieved contributed to durability for long-term prevention of infectious diseases, protection of staff and patients, and ensured the dignity of vulnerable people such as pregnant women, persons with disabilities and school children are upheld. In line with the SDGs and sector priorities, the contribution from the CERF improved access and functionality of WASH facilities in health centres and increased positive hygiene and sanitation practices among health providers and communities.

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

Yes ☒ Partially ☐ No ☐

Through this CERF grant, agencies contributed to reducing mortality and morbidity related to the EVD outbreak in Uganda and preventing the spread of the outbreak to another part of the country and neighbouring countries with minimum disruption to social and

health systems. WHO's interventions reached 495,998people, providing comprehensive interventions, including coordination, surveillance, risk communication and community engagement and case management.

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

Yes, for example, the CERF contribution for WFP was entirely allocated to direct food assistance for EVD survivors, families of the deceased, and families of contacts in institutional quarantine, reaching to a total of 4,556 people, who were in needed of urgent and critical food support.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

Coordination amongst the humanitarian community was significantly improved in 2022. With the CERF funding, including under this project, has assisted the Resident Coordinator in bringing the humanitarian community together, especially for non-refugee response under the framework of Humanitarian Country Team-Lite (HCT-L) and technical-level Humanitarian Inter-Agency Coordination Group (HICG). Despite lack of a dedicated staff for humanitarian coordination in the Resident Coordinator's Office, staff resource from within the core RCO staff (funded by the DCO) and an international UNV supported the humanitarian coordination. In general, given Uganda's profile (non-humanitarian) yet requiring hum' assistance quite often, there is room to improve coordination capacity in the RCO.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

The CERF funding has served as catalytic assistance in further mobilising required resources. The timely and efficient announcement of CERF support sent a strong signal to other donors, resulting in overall 10 Agencies including the CERF recipient agencies to raise over US$42 million through their own channels, including through the engagement with donors locally under the framework of UN Joint Response Plan prepared under the leadership of the RC.

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

Through this CERF allocation, support for women and girls, including tackling gender-based violence, reproductive health and empowerment were addressed as underfunded priority areas. Even without an outbreak or crisis, women and girls are invariably vulnerable to physical, emotional, and sexual harassment or violence. This is because of the ingrained pre-existing gender norms, practices and inequalities in families and communities. EVD outbreak can inevitably exacerbate the negative effects of these inequalities, as learnt from previous outbreaks. For example, during the 2014 – 2016 outbreak in West Africa, women and girls were disproportionately affected, leading to both an increase in sexual and domestic violence. Therefore, protection measures and attention to the needs of women and girls were crucial in this response. This CERF funding enabled collective efforts towards protecting women and girls to be more visible through requesting and ensuring evidence based reporting on measures taken in this regard, advocating and allocating additional resources for mainstream programming and to scale up protection, capacities and awareness.

Table 1: Allocation Overview (US$)

Total amount required for the humanitarian response	**0**

[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.

CERF	3,000,000
Country-Based Pooled Fund (if applicable)	0
Other (bilateral/multilateral)	112,000,000
Total funding received for the humanitarian response (by source above)	**42,000,000**

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

Agency	Project Code	Sector/Cluster	Amount
UNICEF	22-RR-CEF-072	Water, Sanitation and Hygiene	1,050,000
WFP	22-RR-WFP-062	Food Security - Food Assistance	250,000
WHO	22-RR-WHO-043	Health	1,700,000
Total			**3,000,000**

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

UNICEF, WHO and WFP all should provide detail

Total funds implemented directly by UN agencies including procurement of relief goods	**3,000,000**
Funds sub-granted to government partners*	129,574
Funds sub-granted to international NGO partners*	0
Funds sub-granted to national NGO partners*	0
Funds sub-granted to Red Cross/Red Crescent partners*	163,819
Total funds transferred to implementing partners (IP)*	**293,393**
Total	**593,393**

* 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 September 20, following one confirmed case, the Government of Uganda (GOU) announced a new Sudan EVD outbreak in Ngabano Village of Madudu sub-county, Mubende district. The outbreak spread to other eight districts of *Kassanda, Kyegegwa, Kagadi, Wakiso, Kampala, Masaka, Jinja and Bunyangabu*. The Ministry of Health (MoH) instituted measures to ensure early containment of the outbreak. An emergency National Task Force was convened, where the national Public Health Emergency Operational Center (PHEOC) was activated to coordinate the response, and an Incident Commander and pillar leads were appointed. District Task Forces in the affected and high-risk areas were activated for preparedness and response. The MOH, WHO, and other UN agencies initiated a response aiming to contribute to the reduction of mortality and morbidity related to the Sudan ebolavirus outbreak in Uganda and to prevent the spread of the outbreak to other provinces of the country, as well as to neighbouring countries with minimum disruption of social and health systems. On 11th January 2023, the MoH in Uganda with support from WHO officially declared the end of Ebola outbreak after 42 incubation period with no new cases. It was a milestone event for Uganda having confirmed Ebola virus disease eradicating it within 69 days. At the end of the outbreak, the country recorded a total of 164 cases (142 confirmed and 22 probable), 55 confirmed deaths and 87 recovered patients.

Operational Use of the CERF Allocation and Results:

On 15 October 2022 the ERC allocated $3 million from the Central Emergency Response Fund (CERF) for an urgent response to Ebola outbreak in Uganda. Funding from CERF's rapid response window enabled UN agencies and partners to immediately provide assistance in priority sectors such as, health, water, sanitation and hygiene, and Food Assistance. In total, the allocation provided response to more than 495,998of the most severely affected people, including 123,278 women, 124,325 men, 248,395 children, and 90,268 persons living with disabilities.

Utilizing this CERF grant, WFP worked with Uganda Red cross Society to support EVD survivors, families of deceased as well as families of contacts in institutional quarantine. A total of 311 metric tons of food commodities were provided as a one-off transfer to 4,556 individuals. Food assistance provision in this category of people was provided in Kassanda, Mubende, Kyegegwa and Jinja districts. Eligible households received dry rations of Cereals 60kg, Pulses 9kg, Vegetable Oil 4.5kg and Salt 0.75kg. CERF funds also contributed to providing hot meals to 47000 individuals within the Ebola treatment unit such as Mubende hospital, Madudu health centre and Jinja referral hospital.

WHO and partners contributed to reducing mortality and morbidity related to the EVD outbreak in Uganda and preventing the spread of the outbreak to other parts of the country and neighboring countries with minimum disruption to social and health systems. WHO contributed to the response through two project outputs: (1) rapidly detecting, reporting, and investigating suspected cases and contact tracing and (2) management of EVD cases in healthcare settings and communities based on standards of care and prevention of its transmission in the 05 affected districts and the Kyaka II settlement reaching 495,998persons directly. 11 WHO and 120 multi-disciplinary MOH expert teams supported the interventions in Coordination, Surveillance, Risk communication and community engagement, and Case Management. The teams deployed comprised epidemiologists, case management experts, anthropologists, psychosocial support providers, nurses, surveillance, laboratory experts, risk communication experts, and public health experts at national and subnational levels. The deployed teams engaged in the following: Uganda's eradication of Ebola in 69 days was a significant milestone in managing emergencies, and WHO appreciates the support of CERF. The MoH and WHO declared the end of the Ebola outbreak on January 11, 2023, after 42 days of incubation without new cases, recording 164 (142 confirmed and 22 probable), 55 confirmed deaths, and 87 recovered patients.

People Directly Reached:

Under the Health Sector, the targeted population was the total number of people living in the 5 districts and the refugee settlement in Kyegegwa. This was due to the surveillance component implemented in two ways:
1) At the facility level - the beneficiary who comes to seek care were supported to increase the index of suspicion of all the patients who visit the facility, this way the entire catchment population would benefit.
2) At the community - support was provided to the districts which do not have alert management in place. The alert management system where patients called in to the alert desk from the whole district and the health workers went to them and verified the alert.
When surveillance was done, it is not possible to identify who will be the one to get sick, therefore, surveillance is done to the entire population, isolating those who are suspected or confirmed and therefore, the whole district benefits.
Additionally, supporting the Village Health Teams who are responsible for community-based surveillance and contact tracing across the district is also targeting the overall population of the districts.

People Indirectly Reached:

Result 1:
Whereas for people indirectly targeted by the project, the overall population of Uganda and neighbouring countries was considered indirectly benefiting from the project as containment of the outbreak within the affected districts and ensuring it does not spread to other communities and neighbouring countries. This was done through a comprehensive response that indirectly benefited the population in these areas. The UN estimates that as of July 1, 2022, the total population of Uganda was 47,249,585; this implies that 45,016,518 girls, boys, women, and men indirectly benefited from the project. They benefited from the prevention messages that were disseminated in the country through various media, print and audio-visual, during the response via community dialogue meetings, accountability fora of RRTs, engagements with multiple stakeholders such as market vendors, boda boda riders, hospital staff, and the security forces.

Result 2:
Management of EVD cases based on standards of care and prevention of its transmission provided to all the cases reported. It is estimated that 984 people benefited indirectly (164 EVD cases with about 06 family members for each case) from the experienced healthcare providers providing the treatment and the dignified burial teams' that provided burial services. This significantly reduced the stigma and stress of caring for cases and burying EVD dead bodies.

This result supported minimum disruption of social and health systems within the families, communities, and health facilities where ETUs were set up significantly in the 09 high-risk districts.

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**
Food Security - Food Assistance	1,951	2,061	1,725	1,763	7,500	1,119	909	1,330	1,198	**4,556**
Health	384,103	390,227	720,791	737,945	2,233,066	123,278	124,325	114,278	134,117	**495,998**
Water, Sanitation and Hygiene	49,615	47,669	52,895	50,821	201,000	47,910	46,030	54,024	51,904	**199,868**

* 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	118,266	119,266
Returnees	0	0
Internally displaced people	0	0
Host communities	0	0
Other affected people	2,114,800	376,732
Total	**2,233,066**	**495,998**

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	384,103	123,278	63,377	28,550
Men	390,227	124,325	64,387	30,812
Girls	720,791	114,278	54,059	14,325
Boys	737,945	134,117	55,346	16,581
Total	**2,233,066**	**495,998**	**237,169**	**90,268**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 22-RR-CEF-072

1. Project Information

Agency:	UNICEF	**Country:**	Uganda
Sector/cluster:	Water, Sanitation and Hygiene	**CERF project code:**	22-RR-CEF-072
Project title:	Prevention of Ebola viruses' disease and mitigation of its impact through provision of WASH services, supplies, capacity building, risk communication and community engagement		
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$ 9,600,000**
Total funding received for agency's sector response to current emergency:	**US$ 1,222,000**
Amount received from CERF:	**US$ 1,050,000**
Total CERF funds sub-granted to implementing partners:	**US$ 129,574**
Government Partners	US$ 129,574
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

WASH:

With CERF funding, UNICEF implemented activities in four (4) priority districts of Mubende, Kassanda, Masaka and Kampala. Three (3) sustainable solar-powered pumped water supply systems each with 20,000 litre elevated water storage tanks were installed at Kiyuni and Butologo HCIIIs in Mubende district, and for the Kalwana ETU that was established in Kassanda district. This system supports two nearby schools. Additionally, ten (10) mobile toilets were provided to Mubende ETU (5), and Kalwana ETU (5) to improve sanitation at the site. The health facilities selected are in EVD affected areas of Mubende and Kassanda districts. Initially, UNICEF supported Water trucking on a temporary basis at Kalwana ETU site until the solar water supply system was established. With the three-water supply system operational, an estimated 2,400 (males 1,176; females 1,224)people benefitted with access to safe water, and 225 (males 110; females 115) people with access to sanitation facilities.

Through investments in WASH in health facilities, the results achieved contributed to durability for long-term prevention of infectious diseases, protection of staff and patients, and ensured the dignity of vulnerable people such as pregnant women, persons with disabilities and school children are upheld. The selection of health facilities for support was influenced by the volume of out- and inpatients seeking

medical services at peak times, and the SPHERE standards with respect to per capita access to the services provided. In line with the SDGs and sector priorities, the contribution from the CERF improved access and functionality of WASH facilities in health centres and increased positive hygiene and sanitation practices among health providers and communities.

With CERF funding, UNICEF furtrher supported Mubende and Kassanda districts to train 465 health workers (males 183; female 282) on IPC-WASH standards between December 2022 and January 2023. The training was facilitated by the Ministry of Health (MoH), WHO and other partners to ensure adherence to Standard Operating Procedures in health facilities.

Additionally, UNICEF procured, and distributed IPC-WASH supplies to 96 health facilities (74,400 patients reached) (males 36,456; females 37,944) and 250 schools (125,000 pupils reached) (boys 61,250; girls 63,750) in Kampala, Kassanda and Mubende districts. Overall, 199,865 people (males 97,933; females 101,932) reached with critical supplies and trainings. The distribution of IPC-WASH supplies was done to improve hygiene standards to reduce the risk of EVD transmission in the targeted institutions, and to ensure safe re-opening of schools in February 2023. UNICEF also provided replenishment of consumable supplies to all the 96 health facilities and 250 schools supported with IPC-WASH supplies under CERF, to avoid stock running short and compromising the quality of care. Furthermore, UNICEF hired a plumber who was engaged in the repair of all non-functional handwashing facilities in health facilities and schools across Mubende district in December 2022. In total 47 handwashing facilities were repaired through this contract.

Overall, the project achieved 100% of its intended objectives within the agreed timeframe. There is no ask from RC/HC and HCT/UNCT action for either a no-cost extension or re-programming.

3. Changes and Amendments

N/A

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	0	0	**0**	0	**0**	0	0	**0**	0	**0**
Host communities	0	0	**0**	0	**0**	0	0	**0**	0	**0**
Other affected people	**47,940**	**46,060**	**54,060**	**51,940**	**200,000**	47,910	46,030	54,024	51,904	**199,868**
Total	**47,940**	**46,060**	**54,060**	**51,940**	**200,000**	**47,910**	**46,030**	**54,024**	**51,904**	**199,868**
People with disabilities (PwD) out of the total										
	959	921	1,082	1,038	**4000**	**958**	**920**	**1,081**	**1,037**	**3,996**

* 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

WASH:
In total, an estimated 12,000 additional people have benefited from the water supply systems established in Mubende (2) and Kassanda. Each system has been extended to provide additional stand taps outside the target institutions to enable members of the nearby communities to access water that has been provided.

6. CERF Results Framework

Project objective	To contribute to Government of Uganda efforts to prevent EVD transmission and reduce related morbidity and mortality in affected districts
Output 1	Strengthen capacity for EVD infection prevention and control through WASH services, supplies and RCCE interventions in outbreak and high-risk districts

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	WS.6 Number of people accessing sufficient and safe water for drinking, cooking and/or personal hygiene use as per agreed sector standard	2,400	2,400	District Report
Indicator 1.2	Number of people accessing appropriate sanitation facilities in targeted ETUs	225	225	District Report
Indicator 1.3	WS.16a Number of people receiving critical WASH supplies at health facilities	74,400	74,400	District Report
Indicator 1.4	WS.16a Number of people receiving critical WASH supplies (e.g. WASH/hygiene kits) in schools	125,000	125,000	District Report
Indicator 1.5	Number of healthcare providers receiving refresher training on the minimum emergency response package for IPC	465	465	District Report
Indicator 1.6	AP.1b Percentage of affected people who state that they are aware of their rights and entitlements (4,263,600)	60%	75%	Ipsos – UNICEF EVD Post assessment report on Public Views on Ebola (June 2023)
Indicator 1.7	AP.2b Percentage of affected people who state that they are aware of feedback and complaints mechanisms established for their use - (1,705,440)	40%	73%	Field activity reports (Dreamline, Uganda Red Cross Society, and Lutheran World Foundation) as reflected on the SBC 2023 EVD Dashboard

Indicator 1.8	AP.3b Percentage of affected people who state that they were consulted on the humanitarian response -(852,720)	10%	50%	Field activity reports as reflected on SBC 2023 EVD Dashboard& UNICEF After Action Review Assessment exercise.

Explanation of output and indicators variance:	WASH: Research has shown that improving WASH conditions in health facilities can help to establish trust in health services and encourage better health seeking behaviour (WHO/UNICEF 2015). Provision of WASH in health care facilities/ETUs prevented infections at health facility transmitted infections and reduced spread of disease (nosocomial infections), protected staff and patients, as well as upheld the dignity of vulnerable groups such as pregnant women and persons with disabilities. In the recent EVD outbreak in Mubende district, an estimated 14% of infections occur within the health facility (MoH EVD 2022 Sitreps #9 and #10). Infection prevention and control through WASH has been identified as a key enabler in overall IPC for case management of infectious diseases such as EVD. IPC remains the single most important aspect of EVD preparedness that continues to have major gaps due to weak IPC infrastructure, especially at the primary healthcare facilities. With funds from CERF, UNICEF installed a total of 10 mobile toilet units at the Mubende and Kassanda ETUs established as part of the EVD response. The targeted ETUs lacked adequate sanitation facilities thus posing increased risks for infection transmission. High-volume ETUs that routinely service patients from communities were targeted with the support. The installed sanitation facilities are gender, child, and disability friendly toilets, thus contributed to improved infection and control beyond EVD. The water system at the targeted health care facilities were also improved and solar booster pumps installed. Additional activities supported by CERF included the orientation of respective district local government focal persons on the Operation and Maintenance (O&M) of WASH facilities and on positive hygiene and sanitation practices. The strengthened district capacities contributed to better quality of supervision, monitoring and mentorship, fostering ownership of the facilities for the long-term. There was no variations against the planned results. .. However, for indicators 1.6,1.7 and 1.8 more people were reached than planned as the estimated population was lower than the actual number of people reached. The initial scope for direct beneficiaries was 9 districts and this was the basis for calculating the target populations. However, during the response, the risk communication and community engagement interventions covered a broader geographical scope, for example, mass media was countrywide, and the eventual lockdown of two districts became a nation-wide issue and preventive messages were disseminated on multiple media platforms. Other interpersonal communication interventions included community dialogue meetings, monthly accountability fora with members of the village taskforce, and engagement with key influencers and stakeholders such as market vendors, boda-boda riders, hospital staff, and the security forces.

Activities	**Description**	**Implemented by**

Activity 1.1	Provision of water through the upgrading of exiting/new systems in three HCFs and ETUs supporting a total of 2,400 beneficiaries in targeted HCFs]	Private contractor, with supervision & monitoring by the District Water Office (DWO)
Activity 1.2	Provision of sanitation facilities to three HCFs/ETUs supporting a total of 225 beneficiaries in targeted HCFs	Private contractor, supervised by the District Health Office (DHO)
Activity 1.3	Provision of critical WASH/IPC supplies to 96 HCFs/ETUs across the five target districts (Kyegegwa, Kassanda, Kagadi & Bunyangabu with HCFs in Mubende already support through other funds), for a period of three months reaching a total of 74,400 people	Distributed by UNICEF supply section and supervised by MoH & WHO
Activity 1.4	Provision of critical WASH/IPC supplies to 250 of the most vulnerable/at-risk schools in the five target districts for a period of three months reaching a total of 125,000 people (students/teachers)	Distributed by UNICEF supply section and supervised by District Education Officers (DEOs) & WHO
Activity 1.5	Training of health care providers on IPC	Implemented by MoH & WHO
Activity 1.6	Provision and dissemination of lifesaving information through trusted channels including mass and social media	UNICEF supported/commissioned 47 radio stations at national and district levels to disseminate key messages and hosting of radio-talk shows. UNICEF commissioned 7 TV stations. UNICEF supported and worked closely with the Ministry of Health – Health Promotion Department for the regular refinement and dissemination of messages through online platforms like Twitter, LinkedIn, social media, Hotlines, and SMS. It is estimated that the mass media channels reached at least 6,523,592 people across the country, which was 99% of the planned target. UNICEF also utilized CERF funds to print IEC materials for Jinja district: 4,000 posters in Lusoga language for Jinja district; 2,000 posters in English; 1,000 Fact sheets with Questions and Answers on Ebola for trained mobilizers; distributed 100 PVC banners for display in towns and trading centres; 1,000 flipcharts and 500 Job-aides for VHTs for use during community meetings and house to house visits.
Activity 1.7	Support extensive and targeted mobilization and deployment of key influencers and potential allies and equipping them with relevant communication tools to become allies that address fears, rumours, and misinformation	A service contract was signed with Ipsos for Social Listening to capture online public views on the outbreak and related response services.
Activity 1.8	Build the capacity for effective community engagement by enabling local actors and communities to become partners in corrective action through participatory regular assessment and analysis of risks, community feedback, and the utilization of social data for responsive programming	UNICEF recruited and deployed 10 Social and Behaviour Change staff on temporary appointments (TAs), some were supported through CERF funding for salary and each staff was equipped with a hired vehicle, the latter, reinforced mobilisations/movements with the districts. Service contract was signed with Dreamline Products Limited for intensified sensitization in Kampala City; 381,773 (males 187,069; females 194,704) people were reached through interventions with Dreamline.

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]:

WASH:

To ensure accountability to affected communities, UNICEF interventions incorporated a community engagement in the affected areas; Madudu, Butologo Kiyuni in Mubende district and Kalwana in Kassanda district and supported them with development of feedback mechanisms to allow responsive programming and ownership. Additionally, key community actors such as Local Council leaders, Water User Committees (WUCs), Village Health Teams (VHT), religious leaders and politicians were oriented and involved in all stages of planning, implementation, and monitoring. The UNICEF WASH team worked closely with UNICEF's Field Operations & Emergency section to conduct U-reports in Kassanda, Kampala and Mubende districts to gather feedback from beneficiaries on the appropriateness and quality of WASH services provided to them. The feedback will be used to guide and adjust programming where necessary for future WASH interventions in similar Public Health emergency responses.

RCCE:

A total of 854,769 community dialogue meetings were held during the response process, this included orientation, consultative, and post-response meetings in the 9 districts that had proven EVD cases. In each district, Village Taskforce Committees were established, to work with the VHTs and other members of the response teams, such as the burial teams, involved in daily surveillance/contact tracing and as mobilizers to manage and dispel common myths and rumours, as well as provide regular updates to the affected populations. Over 465,017 households were visited by the trained VHTs. Project exit meetings were held in each of the supported districts with local leaders at different levels (from village to district) to ensure proper closure, continuity, and action plans by the affected groups.

The trained and deployed mobilizers conducted targeted mobilization by reaching out to specified groups of special interest such as refugees, women, children, and adolescents. For example, in Kampala city 281,507 children and adolescents aged between 10 to 18 years were oriented and given opportunities to share their views on the SVD outbreak and the response.

Example of views from the people

- *'Continue giving us messages on Ebola because some people are not aware of its existence'*
- *'Ebola is real, and my sister succumbed to it' – female respondent Kampala Central*
- *'You need to go deep in the slums as well since most people do not know about Ebola and how to protect themselves from it'– Male respondent Wakiso*

The real-time interaction with the affected populations created opportunities for discussion on PSEA to allay fears and misconceptions and discover incidences of discrimination and stigma, and instances where follow-up visits and additional services such as psychosocial support were required.

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[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.

b. AAP Feedback and Complaint Mechanisms:

RCCE:
Overall, 3,870,819 people shared their concerns and asked questions through the established feedback mechanisms. The latter included, village level meetings conducted by the Village taskforce; stop-over meetings with trained mobilizers during the community drives (hired cars with sound-systems or trained boda-boda drivers that were equipped with recorded messages on megaphones and illustrated-job-aides and posters). Trained VHTs were equipped with daily reporting tools that would capture views and concerns from the people and the VHT Coordinators with Smarts phone-created WhatsApp numbers and groups to enable real-time reporting.

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

UNICEF Uganda is committed to providing an environment that is safe for anyone where UNICEF has contact, including staff, volunteers, and beneficiaries. UNICEF has established internal reporting mechanism in all its programme sites, as part of the inter-agency PSEA network in Uganda. UNICEF work on recording and handling SEA related complaints is guided by UNICEF's strategy to prevent and respond to sexual exploitation and abuse and the UN protocol on provision of assistance to victims of sexual exploitation and abuse which ensures assistance is provided in a victim centred rights based, age, disability and gender sensitive, non-discriminatory and culturally appropriate manner. However, no cases of SEA reported because government had restricted all activities during the Ebla outbreak including community gatherings, schools and markets so that chances for incidents of SEA was reduced.

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

The WASH projects are informed by a gender analysis of national and international frameworks related to Gender Based Violence (GBV) and whether they provide protection to women, girls, and boys, which informs programme design to address the identified gender needs. Therefore, WASH project is designed in a way that provides safe and reliable WASH services close to health facilities, with the aim of reducing the burden of walking long distances to fetch water and lower the risk of GBV encountered at point of water collection, working closely with child protection section to ensure water collection points are safe for women and girls. In the water management committee, women are expected to make-up at least 50% of the members, as this is one of the key decision-making bodies within the communities. 23 units of sex-disaggregated sanitation facilities were also constructed in HCF/ETUs to support privacy that enables proper menstrual hygiene management for adolescent girls, and women, and reduces risk of GBV occurring at these facilities.

e. People with disabilities (PwD):

UNICEF works closely with key stakeholders particularly agencies programming on people with disability in the community to identify disabilities linked to prevention and control of transmission of EVD. UNICEF programme design considers inclusion of people with disabilities in provision of sanitation facilities.

f. Protection:

UNICEF ensured programme design considered having separate facilities for male, females and people with disabilities clearly labelled to avoid protection issues. UNICEF designs take into consideration how latrines, bathrooms and water points are located and built to limit protection risks in consultation with district community services. Training was conducted for 36 WASH committees, 10 local leaders, district authorities on identification of Protection, SEA and GBV risks and referral mechanisms to social action and other protection services.

g. Education:

UNICEF intervention ensure that, all the schools in the high-risk districts are provided with IPC-WASH supplies including menstrual hygiene pads to reduce the risk of Ebola transmission within the school environment.

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.

8. Visibility of CERF-funded Activities

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

3.2 Project Report 22-RR-WFP-062

1. Project Information

Agency:	WFP	**Country:**	Uganda
Sector/cluster:	Food Security - Food Assistance	**CERF project code:**	22-RR-WFP-062
Project title:	Supporting Ebola virus disease containment efforts in Uganda through food assistance		
Start date:	10/11/2022	**End date:**	09/05/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 6,233,012**
Total funding received for agency's sector response to current emergency:	**US$ 989,011**
Amount received from CERF:	**US$ 250,000**
Total CERF funds sub-granted to implementing partners:	**US$ 0**
Government Partners	US$ 0
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 163,819

2. Project Results Summary/Overall Performance

Through this CERF grant, WFP worked with Uganda Red cross Society to support EVD survivors, families of deceased as well as families of contacts in institutional quarantine. A total of 311 metric tons of food commodities were provided as a one-off transfer to 4,556 individuals. Food assistance provision in this category of people was provided in Kassanda, Mubende, Kyegegwa and Jinja districts. Eligible households received dry rations of Cereals 60kg, Pulses 9kg, Vegetable Oil 4.5kg and Salt 0.75kg. CERF funds also contributed to providing hot meals to 47000 individuals within the Ebola treatment unit such as Mubende hospital, Madudu health centre and Jinja referral hospital.

Enrolment of eligible households was conducted in coordination with the District Health Office, the District Incident Commander, the Surveillance Pillar lead, and the respective Ebola Treatment Units. Eligible lists were received and validated by the district authorities before distribution planning. Additionally, households' information was strictly anonymized and only accessible to delegated persons to respect confidentiality and prevent stigmatization.

Food distribution was conducted in accordance with Infection Prevention and Control protocols which includes pre-packaging the food commodities to avoid sharing as well as home drop-off to eligible households. Sensitization and messaging on EVD were also conducted at the point of food collection by the households.

One of the challenges experienced was with the last mile distribution of food to individual households. This slowed down the speed of distributions while increasing operational burden. However, this was important to ensure EVD spread through group distributions was effectively mitigated, as well as reducing stigmatization especially dealing with affected households

3. Changes and Amendments

There was a change in the geographical coverage due to effective containment measures that had a positive implication in ensuring no further spread of EVD in Kagadi and Bunyangabu districts. Therefore, there was no provision of food assistance in these locations. Though the outbreak expanded to Jinja district and WFP extended the food assistance to this location.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Food Security - Food Assistance									
	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	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Host communities	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Other affected people	1,951	2,061	1,725	1,763	**7,500**	1,119	909	1,330	1,198	4,556
Total	**1,951**	**2,061**	**1,725**	**1,763**	**7,500**	**1,119**	**909**	**1,330**	**1,198**	**4,556**
People with disabilities (PwD) out of the total										
	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**

* 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

This CERF contribution was entirely allocated to direct food assistance for EVD survivors, families of the deceased, and families of contacts in institutional quarantine.

6. CERF Results Framework

Project objective	Food Security - Food Assistance
Output 1	Provision of lifesaving food commodities to 7,500 people in category 1 districts

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

Sector/cluster	Food Security - Food Assistance			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	FS.5a Percentage of households with an acceptable food consumption score	80	N/A	N/A
Indicator 1.2	FS.5c Percentage of households with a poor food consumption score	10	N/A	N/A
Indicator 1.3	FS.1d Percentage of households relying on emergency livelihoods coping strategies	10	N/A	N/A
Indicator 1.4	FN.1a Number of people receiving in-kind food assistance	7,500	4556	Partner reports
Indicator 1.5	FN.1b Quantity of food assistance distributed in MT	365	3111	COMET
Indicator 1.6	AP.3b Percentage of affected people who state that they were consulted on the humanitarian response	100%	N/A	N/A
Indicator 1.7	AP.4b Percentage of affected people who state that the assistance, services and/or protection provided correspond with their needs	>96%	N/A	N/A
Explanation of output and indicators variance:		The food security indicators were not assessed due to the specific emergency context of Ebola. The target was not achieved because at planning phase, the case load was 7500, however, the funds provided could only reach at total of 4556 individuals with food rations.		

Activities	**Description**	**Implemented by**
Activity 1.1	Provision of food commodities for wet feeding of patients, caretakers and health workers.	Ministry of Health, Service provider
Activity 1.2	Provision of one -off take home ration for survivors, and suspected contacts and households in home-based isolation.	WFP in partnership with Uganda Red cross Society

Activity 1.3	Community engagements and sharing sensitization messages	Ministry of Health

The food security indicators were not assessed due to the specific emergency context of Ebola.

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]:

The response adhered to the core principles of AAP through consulting beneficiaries and other stakeholders in identifying the most vulnerable for targeting purposes. This was done in consultation with the district officials to provide beneficiary lists. Additionally, the beneficiaries were informed about distribution dates in time through phone calls and clearly informed that the food was provided as a one-off for cushioning against them effects of Ebola Virus Disease. Food was also pre-packaged to facilitate easy carrying of food from distribution point to their homes, while ensuring IPC measures are maintained such as avoiding contact with other beneficiaries.

b. AAP Feedback and Complaint Mechanisms:

Complaints and feedback from beneficiaries were registered at the complaint desk at every food distribution point. The complaints were captured in a tool to ease tracking. The main complaint was beneficiaries' credentials. Fortunately, 100 percent of the registered complaints were resolved during the period of the response.

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

WFP has a network of field focal persons at the Field Office, Area Office, and national levels who receive and document reports of sexual exploitation and abuse, direct survivors to multi-sectoral actors for survivor support services, and report cases to Senior Management. The Country Representative escalates cases to the OIGI for further investigation and management. WFP also provides the contact information for OIGI, which allows affected populations to report SEA cases immediately. The Cooperating Partner and contractors were required to have a PSEA policy and reporting mechanism. In partner and vendor Field Level Agreements (FLAs) and contracts, a PSEA prohibition clause is incorporated, and they were required to report any SEA to WFP. WFP also continued to operate a toll-free helpline staffed by operators who are fluent in the languages spoken by the affected populations.

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

Women participated in the distribution process. Additionally, the lists generated by the district stakeholders ensured inclusion of women and girls as beneficiaries of the food assistance. At the distribution point, key messages were shared, including messages against gender-based violence. However, no cases were reported regarding gender-based violence during the implementation period.

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.

Information was disseminated through various channels to cater for the specific information access challenges encountered by PwDs. During project implementation, the project ensured that distribution facilities are easily accessible to people with disabilities (PWDs) and that PWDs receive priority service. As PwDs arrange for transportation for their rations, assistance was offered for carrying large goods at distribution points.

f. Protection:

Working with stakeholders, the most at-risk populations were identified and targeted as primary beneficiaries for the project and the targeting criteria was explained to avoid misunderstandings and promote social cohesion. The protection risk assessment was part of the multifunctional risk assessment to identify protection risks and mitigation measures to be implemented during project delivery. Caution was also taken in organizing the timing and location of activities given the security situation in the region to avoid exposing beneficiaries to possible harm.

g. Education:

No aspects of education were catered for under this grant.

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.

Given the intensity of care required by EVD patients & contacts, and the isolation protocols that were put in place, it was decided collectively by the three agencies that in-kind assistance was the best intervention modality for this response.

Parameters of the used CVA modality:

Specified CVA activity (incl. activity # from results framework above)	**Number of people receiving CVA**	**Value of cash** (US$)	**Sector/cluster**	**Restriction**
Non	0	US$ 0	Choose an item.	Choose an item.

9. Visibility of CERF-funded Activities

Title	Weblink
[Insert]	[Insert]

3.3 Project Report 22-RR-WHO-043

1. Project Information

Agency:	WHO	**Country:**	Uganda
Sector/cluster:	Health	**CERF project code:**	22-RR-WHO-043
Project title:	Response to Sudan Ebolavirus Outbreak in Uganda		
Start date:	01/10/2022	**End date:**	31/03/2023
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 67,998,366**
Total funding received for agency's sector response to current emergency:	**US$ 9,608,690**
Amount received from CERF:	**US$ 1,700,000**
Total CERF funds sub-granted to implementing partners:	**US$ 0.0**
Government Partners	US$ 0.0
International NGOs	US$ 0.0
National NGOs	US$ 0.0
Red Cross/Crescent Organisation	US$ 0.0

2. Project Results Summary/Overall Performance

Through this CERF grant, WHO and its partners contributed to reducing mortality and morbidity related to the EVD outbreak in Uganda and preventing the spread of the outbreak to another part of the country and neighboring countries with minimum disruption to social and health systems.
The CERF funding supported the two project outputs of (1) rapidly detecting, reporting, and investigating suspected cases and contact tracing; and (2) management of EVD cases in healthcare settings and communities based on standards of care and prevention of its transmission in the 09 affected districts and the Kyaka II settlement reaching 495,998 persons directly.

The interventions reached 495,998of the most severely affected people, including 123,278 women, 124,325 men, 248,395 children, and 90,268 persons living with disabilities.in the target area during the project period October 1, 2022-March 2023.
11 WHO and 120 multi-disciplinary MOH expert teams supported the EVD response in the 09 affected districts and other areas of need. The teams deployed comprised epidemiologists, case management experts, anthropologists, psychosocial support providers, nurses, surveillance, laboratory experts, risk communication experts, and public health experts at national and subnational levels. The deployed teams engaged in the following:

- Setting up 05 Ebola treatment units (ETUs)at the Mubende Regional Referral Hospital (02 units), Madudu, Mulago Hospital, and Entebbe
- Setting up 02 holding centers in Jinja and Masaka.
- Conducting 15 trainings in the project target area for 329 healthcare workers in clinical care, IPC, and safe and dignified burial.
- Operationalization of the Rapid Response Teams (RRTs) at different response levels for easy alert management and contact tracing.
- 959 Village Health Teams in the 5 project target districts and other affected areas were oriented in contact tracing, evidence-based surveillance, community active case finding for Ebola, regular monitoring, and coaching to enhance contact tracing and event-based surveillance work.

Uganda's control of Ebola in 69 days was a significant milestone in managing emergencies, and WHO appreciates the support of CERF. The MoH and WHO declared the end of the Ebola outbreak on January 11, 2023, after 42 days of incubation without new cases, recording 164 (142 confirmed and 22 probable), 55 confirmed deaths, and 87 recovered patients.

3. Changes and Amendments

During the implementation period, no changes and amendments were made..

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	25,908	23,045	34,687	34,626	**118,266**	37,997	41,114	18,819	21,336	**119,266**
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	0	0	0	0	**0**	0	0	0	0	**0**
Other affected people	358,195	367,182	686,105	703,319	**2,114,801**	85,281	83,211	95,459	112,781	**376,732**
Total	**384,103**	**390,227**	**720,792**	**737,945**	**2,233,067**	**123,278**	**124,325**	**114,278**	**134,117**	**495,998**
People with disabilities (PwD) out of the total										
	63,377	64,387	54,059	55,346	**237,169**	27,592	29,892	13,244	15,544	**86,272**

* 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

Result 1:
Whereas for people indirectly targeted by the project, the overall population of Uganda and neighbouring countries was considered indirectly benefiting from the project as containment of the outbreak within the affected districts and ensuring it does not spread to other communities and neighbouring countries. This was done through a comprehensive response that indirectly benefited the population in these areas. The UN estimates that as of July 1, 2022, the total population of Uganda was 47,249,585; this implies that 45,016,518 girls, boys, women, and men indirectly benefited from the project. They benefited from the prevention messages that were disseminated in the country through various media, print and audio-visual, during the response via community dialogue meetings, accountability fora of RRTs, engagements with multiple stakeholders such as market vendors, boda boda riders, hospital staff, and the security forces.

Result 2:
Management of EVD cases based on standards of care and prevention of its transmission provided to all the cases reported. It is estimated that 984 people benefited indirectly (164 EVD cases with about 06 family members for each case) from the experienced healthcare providers providing the treatment and the dignified burial teams' that provided burial services. This significantly reduced the stigma and stress of caring for cases and burying EVD dead bodies.

This result supported minimum disruption of social and health systems within the families, communities, and health facilities where ETUs were set up significantly in the 09 high-risk districts.

6. CERF Results Framework

Project objective	To contribute to the reduction of mortality and morbidity related to the current Sudan Ebola Virus Disease (EVD) outbreak in Uganda and to prevent the spread of the outbreak to other provinces of the country, as well as to neighbouring countries with minimum disruption of social and health systems.
Output 1	5 affected districts and the Kyaka II settlement are rapidly detecting, reporting, investigating suspected cases, and contact tracing.

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

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 1.1	Proportion of alerts verified within 24 hours of alert notification	100%.	98%	Alert call center reports, Go data, and eIDSR.
Indicator 1.2	Percentage of new confirmed cases previously listed on contact lists	100%.	86%	Go data and end of outbreak report.

Explanation of output and indicators variance:	98% of the alerts received across the call centers were verified and investigated with the support of the 02 deployed epidemiologists and other health workers facilitated; WHO did not achieve the proposed target of 100% due to poor road networks and phone connectivity. Over the response period, percentage of confirmed cases previously listed on the contact list improved from 56% to 86% at mid point and 92% by end of outbreak

Activities	**Description**	**Implemented by**
Activity 1.1	WHO deployed 02 Epidemiologists for 06 months to support Mubende and Kyegegwa/Kyaka II in alert management, case investigation, and contact tracing.	WHO

Activity 1.2	**959** VHTs were oriented in contact tracing, event-based surveillance, and community active case finding for Ebola in the 05 affected districts, including the Kyaka II settlement.	WHO
Activity 1.3	**164** (119 Health assistants and 45 epidemiologists) trained and facilitated to support active case search in health facilities. 7,382 alerts met the case definitions and 6,681 were sampled and investigated, and 142 tested positive for Ebola.	WHO & MOH
Activity 1.4	**80** MOH officers were facilitated to support the alerts and call dispatch centers for 04 months.	WHO & MOH
Activity 1.5	**120** multi-disciplinary/multi-sectoral Rapid Response Teams (RRTs) were deployed across the 05 affected districts, including the Kyaka II settlement, for 04 months. WHO facilitated the RRTs with per diem, risk allowance, airtime, and transport fees.	WHO & MOH

Output 2	Cases of Sudan Ebola Virus disease in healthcare settings and communities of the 05 affected districts and the Kyaka II settlement are managed based on standards of care and prevention of its transmission.

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

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 2.1	Case fatality ratio for all confirmed cases admitted into Ebola Treatment Units	< 39%. Absolute figures cannot be provided at this stage due to the nature of the response.	38.7%	National line list and situation reports.
Indicator 2.2	Number of trainings held on 1) clinical care, 2) IPC, and 3) safe and dignified burial	15 trainings (3 trainings/district in 5 affected districts, including the Kyaka II settlement)	15	Training reports.
Indicator 2.3	CC.1 Number of implementing partner staff receiving training to support programme implementation	300	329	Training reports
Explanation of output and indicators variance:		The estimated case fatality rate of the Sudan Ebola virus disease was 55% from the previous outbreaks. 38.7% was achieved due to the quality of clinical care, referral systems, partnerships with MOH and implementing partners, and established surveillance systems during the outbreak.		

Activities	**Description**	**Implemented by**
Activity 2.1	**05** Ebola treatment units (ETUs) set up at the Mubende Regional Referral Hospital (02 units), Madudu, Mulago Hospital, Entebbe, and 02 holding centers in Jinja and Masaka were set up with WHO support. The technical guidance for setting up the treatment and isolation centers provided by WHO facilitated the effective management of EVD cases. Other facilities supported include (Mulago, Madudu, Jinja, and Masaka) and provision of tents (5 tents to Masaka, 03 tents to KMA (Kiruddu and Kiswa), 03 tents to Jinja RRH and Buwenge. WHO also supported reorganizing and setting up the National treatment center in Entebbe by deploying a case management expert who provides mentorship and conducts drills for the team of health workers. WHO deployed 12 VHF kits to support the response in the field (5 to Mubende, 2 to Fort Portal, 1 to Jinja, 1 to Masaka, 1 to Mulago ETU, and 2 to Entebbe ETU) in addition to the PPE provided. The well-equipped and managed ETUs resulted in a 38.7 % Case fatality ratio for all confirmed cases admitted into Ebola Treatment Units.	WHO
Activity 2.2	**06** technical experts in caring for patients, including 02 Case Management, 02 Psychosocial Support, and 02 Infection Prevention and Control, were recruited by WHO to support the program implementation. The experts included international and national consultants/staff and UN volunteers with different specialties.	WHO

	These technical experts trained the 329-partner staff of different health cadres to manage EVD cases in the 09 highly affected districts.	
Activity 2.3	**80** MOH Ebola response experts were facilitated by per diem, and a risk fee to support case management and paid**.** These also helped manage cases in Mubende ETU, conducted IPC mentorship in health facilities, provided psychosocial support, and provided care, bedside mentorship, and training as the outbreak spread to other districts.	WHO
Activity 2.4	WHO supported training of 328 HCWs from partners in case management in Entebbe, Masaka, Jinja, Mubende, and at the refugee settlement on clinical care, IPC, and safe and dignified burial and provided PPEs during the training.	WHO
Activity 2.5	WHO strengthened patient care and monitoring in the ETUs in Fort Portal Mubende, Madudu, Mulago (2 ETUs), Entebbe, Jinja, and Masaka through the procurement and distribution of 13 oxygen concentrators, 07 glucometers, 350 Glucose test strips, 27 hand-held and finger-tip pulse oximeters, 13 beds complete with mattresses, 600 doses of iv piperacillin/ tazobactam, 500 tablets of amoxiclav tablets, 600 tablets of azithromycin tablets and 150 doses of iv dexamethasone. In addition, assorted supplies, and consumables (drugs, supplies for [point of care diagnostic equipment, consumables for treatment administration) of 87 items have been procured and partly distributed to the treatment centers.	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[6] 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)[7]:

WHO supported operationalizing the district and sub-county task forces, which constituted different members from religious, cultural, and political leaders, village health teams, and refugee representatives, making a core team of the affected population. For purposes of AAP, stakeholder engagement meetings were held in EVD-affected districts as a process of and commitment to supporting communities to speak out, listen to and act on community needs and feedback.
These community members were involved in the response interventions through capacity building in surveillance, risk communication, and safe and dignified burials. All these made the communities accept the guidance on the prevention of EVD by MOH and WHO.

An anthropologist was deployed to build confidence by closely engaging locals to collect data for informing subsequent response measures. The involvement of the various categories of persons in the response paved the way for a meaningful engagement, working with communities and actively seeking and putting forward the voices of the most vulnerable.

b. AAP Feedback and Complaint Mechanisms:

WHO ensured a streamlined and transparent feedback and complaint mechanism from all stakeholders involved in the response.

[6] 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.

[7] 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.

- At the district level, partners nominated two (2) people, and their contacts shared throughout the neighbourhood during community involvement sessions and on local radio stations.
- The National Task Force, District Task Forces, and the Multi-stakeholders were trained and encouraged to report cases or allegations of Sexual Exploitation, Abuse, and Harassment (SEAH).
- WHO facilitated the country office's Preventing Response to Sexual Exploitation, Abuse, and Harassment (PRSEAH) committee professionally handling the allegations.
- Information materials on PRSEAH with guidance on the reporting were printed and distributed.
- WHO popularized the toll-free contact number of the SAUTI (116), originally developed and supported by UNICEF for feedback and complaint reporting.

These gave different ways to provide feedback and report problems during the EVD response. Only one gender-based violence case was recorded against a service provider and referred to the Uganda Police Force.

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

WHO included SEAH in all of its efforts, beginning with the orientation of new employees recruited to support the response and continuing with orientations and training throughout any activity. For instance, it was included in all activities' training and meeting agenda.

WHO used already established mechanisms for feedback and reporting of SEAH at different levels, such as;

1. District and community: In each District, WHO established SEAH committees and focal points, and district, sub-county, and village task forces were trained on SEAH reporting.
2. Response teams: 668 responders were trained (including WHO, partners, and the district leadership) and WHO shared toll-free lines for reporting any SEAH case.
3. The SAUTI feedback and reporting platform was popularized in collaboration with UNICEF.
4. SEAH Information materials were also printed and distributed to all the EVD-affected districts.

All the complaints received were 100% investigated, and the necessary actions were taken.

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

The male EVD survivors and their spouses were offered counselling, and follow-up visits were conducted by the mental health and psychosocial experts to address issues of GBV arising, given that the Ebola virus remains in some body fluids for over 06 months and can sexually be transmitted.

e. People with disabilities (PwD):

The response ensured the inclusion of PWD during the selection of multi-stakeholders to train as trainers of SEAH; persons with disabilities, especially women counsellors, were targeted for training. These were required to cascade the training to other PWD. In addition, during community engagement and social mobilization, WHO made a deliberate effort to reach out to the PWD with information on EVD, the risks, modes of transmission, and prevention measures.

All the associates/ WHO staff were trained in handling communities. WHO deployed an Anthropologist under the community engagement pillar to ensure close interaction with the communities and with much focus on the PWDs.

f. Protection:

668 (369 males, 299 females) district multi-stakeholders received training on the World Health Organization's Policy on PRSEAH and the Code of Conduct for WHO workers and associates to protect the vulnerable. Because of their role as primary caregivers for the sick and aged, women and girls were given extra protection from the disease by WHO. In-depth counselling of EVD survivors also maintained the safety of vulnerable groups and those exposed to the virus. WHO knew that male survivors would pressure their partners into unprotected sex because the Ebola virus stays in sperm for more than 06 months. Consequently, survivors and their families received extensive counselling and participated in rehabilitation and follow-up programs.

g. Education:

WHO, UNICEF, MOH, and its partners implemented school-based surveillance in 120 schools reaching 96,022 learners and 2,790 teachers with Ebola preventive messages. In addition, the WHO distributed IPC supplies to schools in the affected districts, primarily in the disease hotspots, to prevent the disease's spread.
564,000 copies of Ebola IEC materials were produced and distributed to universities, hospitals, and communities in English and local languages.

8. Cash and Voucher Assistance (CVA) (NOT APPLICABLE TO WHO)

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]

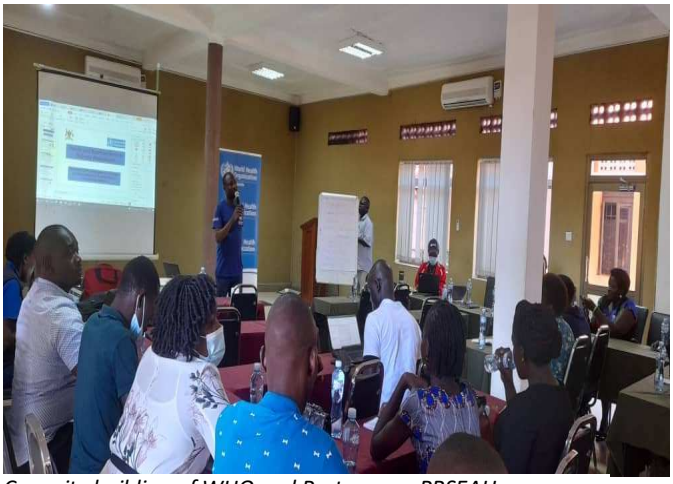
Parameters of the used CVA modality:

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.

9. Visibility of CERF-funded Activities

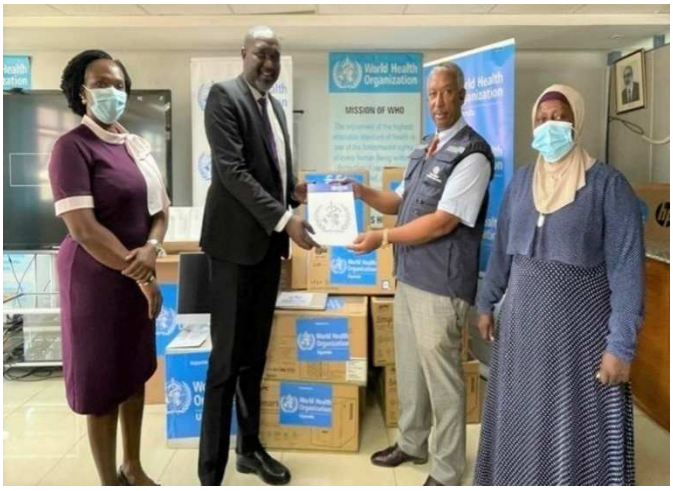
Title	Weblink
A special Thank you to the partners	https://twitter.com/tegegny/status/1613172313494589440
Keeping up the vigilance on Ebola in Uganda's capital	https://www.afro.who.int/photo-story/keeping-vigilance-ebola-ugandas-capital
Orienting Health workers in Kyegegwa	https://twitter.com/WHOUganda/status/1575798488331218944
Uganda's capital races to Curb the spread of Ebola	https://www.afro.who.int/photo-story/ugandas-capital-races-curb-spread-ebola
Ebola National Review meeting	https://twitter.com/WHOUganda/status/1625066418000494593
Deploying more vehicles in Kampala	https://twitter.com/WHOUganda/status/1585528224158728194
Monitoring Ebola survivors	https://twitter.com/WHOUganda/status/1617825846085189632

Ebola Accountability Forum	https://twitter.com/WHOUganda/status/1612765771146616833
Regional Ebola After Action Review	https://twitter.com/WHOUganda/status/1623624310630895616
Launch of the Ebola post-recovery plan	https://twitter.com/WHOUganda/status/1623250649134600193

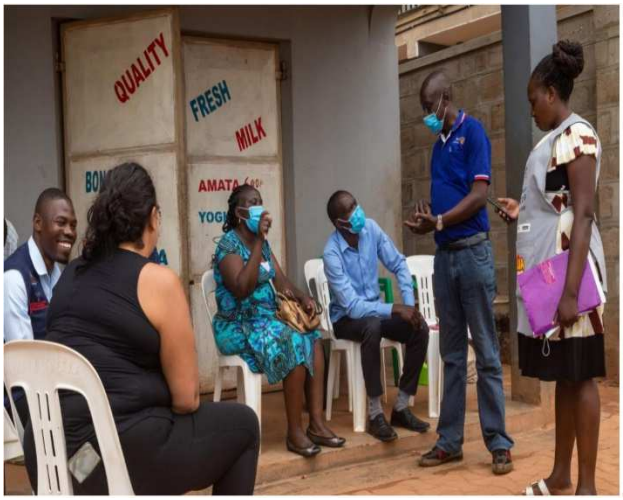


Capacity building of WHO and Partners on PRSEAH

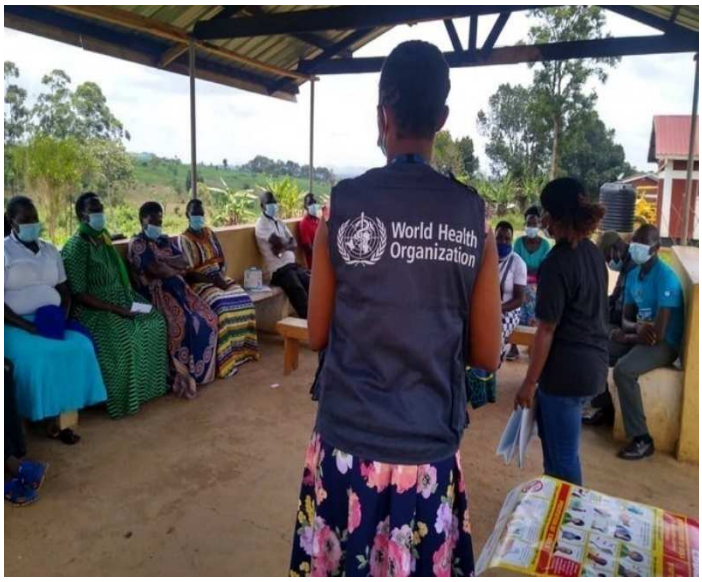
Health workers flashing the SEAH sign after orientation by WHO



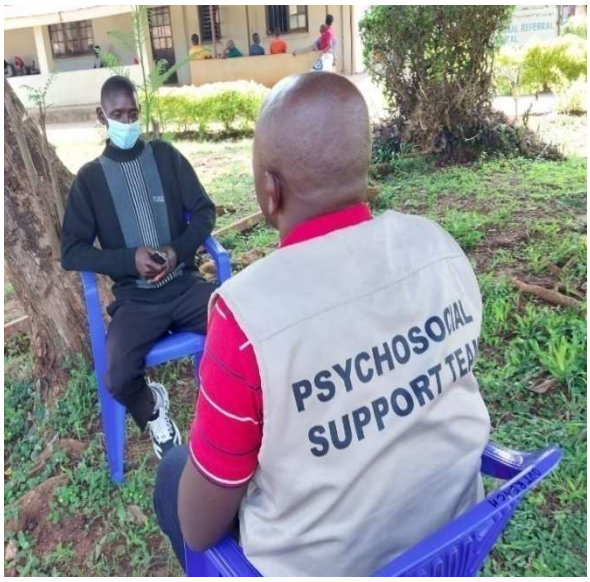
WHO donating assorted supplies to KCCA to improve management of Ebola alerts & evacuation of cases.



A meeting of a WHO-supported contact tracing team in Rubaga division



VHT training Kyaka II Host Community in Kyegegwa district on infection prevention & control.



Providing Psychosocial support to an Ebola Survivor

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-072	Health	UNICEF	GOV	$10,023
22-RR-CEF-072	Health	UNICEF	GOV	$41,176
22-RR-CEF-072	Health	UNICEF	GOV	$23,638
22-RR-CEF-072	Health	UNICEF	GOV	$18,517
22-RR-CEF-072	Health	UNICEF	GOV	$19,769
22-RR-CEF-072	Health	UNICEF	GOV	$15,074
22-RR-CEF-072	Health	UNICEF	GOV	$1,377
22-RR-WFP-062	Food Assistance	WFP	NNGO	$163,819