CERF ALLOCATION REPORT ON THE
USE OF FUNDS AND ACHIEVED RESULTS

ZAMBIA
RAPID RESPONSE
CHOLERA
2024

24-RR-ZMB-63502

Beatrice Mutali

Resident/Humanitarian Coordinator

PART I – ALLOCATION OVERVIEW

Reporting Process and Consultation Summary:

Please indicate when the After-Action Review (AAR) was conducted and who participated.	07/11/2024

An AAR was conducted on November 7. 2024 and inputs were collected from both agencies and implementing partners, including the Ministry of Health.

Some of the key lessons learned which transpired from the discussions were:

Coordination:

- The Incident Management System (IMS), led by the Ministry of Health, was central to response coordination but lacked comprehensive partner mapping to prevent duplications.
- Weekly coordination meetings enhanced information sharing but were insufficient to resolve all logistical challenges.

As recommendations, strengthening sub-national coordination and creating a actors mapping system to avoid duplications and improving collaboration with NGOs and local government actors were proposed for the immediate future.

Implementation Timeliness:

- Delayed RCCE materials hampered the initial response, underscoring the need for pre-prepared communication assets.
- Rapid response teams faced transport challenges, which delayed field deployment and case management.

Monitoring and Data Collection:

- Reliance on paper-based systems led to underreported feedback. Moving to digital platforms could streamline real-time data analysis and improve reporting.
- Stronger collaboration with government agencies in monitoring activities is needed for more accurate data collection.

Accountability to Affected Populations (AAP):

- Feedback channels were underutilized, with limited mechanisms for handling sensitive issues such as child abuse or SEA. Enhancing accessibility and confidentiality of feedback mechanisms could build trust and responsiveness.

Procurement:

- Timely procurement ensured the availability of critical items like ORS sachets and hygiene kits. However, price hikes and logistical hurdles underscored the importance of flexible procurement systems.

Establishing emergency procurement protocols and exploring joint procurement initiatives to mitigate delays, were proposed as recommendation to mitigate procurement delays.

Community Engagement:

Partnerships with faith leaders and senior citizen networks enhanced RCCE efforts. Still, deeper integration of community insights into planning stages is required.

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 ☐

The RC and heads of recipient agencies reviewed the report.

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 ☐

Yes, only to CERF recipient agencies who are also the sector co-ordinators.

1. STRATEGIC PRIORITIZATION

Statement by the Resident/Humanitarian Coordinator:

The CERF-funded response to Zambia's cholera outbreak strategically prioritized urgent, life-saving needs, focusing on multi-sectoral interventions. It enabled the rapid delivery of WASH supplies, reaching nearly 2 million people with hygiene kits and safe water treatment for over 800,000 individuals. In the health sector, 400 Oral Rehydration Corners (ORCs) were established, staffed by 650 trained Community-Based Volunteers (CBVs), providing life-saving care to over 74,000 people. Risk Communication and Community Engagement (RCCE) initiatives delivered tailored, evidence-based messaging to more than 8 million people, promoting prevention and early treatment.

The collective performance was strengthened by CERF's flexibility and timeliness, ensuring quick resource mobilization and adaptive responses to evolving needs. While the initial focus was the epicenter of the outbreak (Lusaka), other provinces, particularly Central and the Copperbelt followed, and the flexibility allowed shifting of the response to areas most in need. Strong collaboration among UN agencies, the Zambian government, and local partners enhanced coordination, maximizing impact. UNICEF and WHO have previous extensive working relationship and experience supporting government programming in prevention, detection and response to cholera outbreaks. Both within the UN system and the wider cooperating partners platform, there is division of labor, with each organization providing leadership in its respective area of strength. Within this arrangement, UNICEF provided leadership in provision of safe water, sanitation, hygiene, risk communication and community engagement, and overall interventions at community level while WHO provided leadership in surveillance, contact tracing, case management, provision of infrastructure and technical capacity building. This division of labor ensured deployment of our respective strengths and optimum synergy achieving the best outcome by addressing all possible ends of the outbreak. The integration of health, WASH, and RCCE efforts reduced mortality rates and cholera cases significantly in hotspots like Lusaka. For instance, UNICEF and WHO played a key role in supporting the coordination of the RCCE pillar and its sub pillars (Public Communication, Community Engagement and Dynamic Listening and Research), which is co-chaired by the Ministry of Health and the Zambia National Public Health Institute. Additionally, UNICEF and WHO supported the Dynamic and Listening and Research sub-pillars in evidence generation through four rounds of cholera rapid qualitative assessments. These assessments provided valuable community insights that guided the Public Communication Sub pillar with support from UNICEF and WHO to develop and disseminate targeted cholera risk communication messages and informed multi-sectoral cholera response activities.

CERF funding not only addressed immediate needs but also strengthened systems for future crises. Innovations like the transition of ORCs into surveillance sites ensured sustainability. By catalyzing additional funding from partners, CERF amplified its impact, demonstrating exceptional value in saving lives, improving resilience, and building a foundation for long-term health improvements. For instance, additional funding was obtained from ECHO for UNICEF and WHO (EUR 1 million), and from the EU and GIZ for UNICEF supported programmes (more than 4 million USD).

CERF's Added Value:

Health Sector:
CERF funding enabled the establishment of 400 Oral Rehydration Corners (ORCs) and the deployment of 650 trained Community-Based Volunteers (CBVs). These interventions ensured that 74,661 people, including 11,522 children under five, received life-saving treatment and referrals in Lusaka. The introduction of community management of Cholera in Lusaka through the ORPs/ORCs brought care closer to and within communities – an aspect that was initially missing in the response, further the use of CBVs for surveillance demonstrated the value of the community health system to emergency response and contributed to strengthening the early warning system during and after the outbreak, further strengthening the health system's resilience for future crises.

WASH Sector:
The integration of WASH services with health and risk communication measures built on the gains recorded from the reduction in cholera cases and deaths. The number of cholera cases reported per day at the end of April 2024 had reduced to 21 from the 150 cases/day in February 2024 - a reduction of 86% and by 29th June 2024, the cases per day were zero. From February to April 2024, deaths per day reduced from 3 to 0 per day, respectively. Community involvement, such as engagement with leaders and volunteers, enhanced the response's reach and sustainability.

RCCE:
Evidence-based messaging tailored to community needs, including multi-language materials and adaptations for vulnerable groups (e.g., persons with disabilities), reached over 8 million people nationwide. Partnerships with local organizations, such as ZINGO and STOP, amplified these efforts, fostering community-led prevention behaviors.

Impact Highlights:

- **Coordination and Innovation:** CERF facilitated a multi-sectoral approach, enabling agencies such as UNICEF and WHO to collaborate effectively with the government. The introduction of ORPs and targeted messaging was pivotal in rapidly controlling cholera in hotspots such as Lusaka, before reallocating resources to other provinces.
- **Sustainability:** Transitioning ORPs into ongoing surveillance mechanisms post-outbreak ensured long-term benefits, a significant improvement over similar responses in the past.

Overall, CERF's timely allocation not only addressed immediate needs but also strengthened systems for future health emergencies.

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

Yes ☒ Partially ☐ No ☐

Yes, CERF funding enabled the rapid delivery of critical supplies and services, such as WASH/hygiene kits for over 1.9 million people and the establishment of Cholera Treatment Centers (CTCs). Timely procurement and strong collaboration with local health offices ensured a steady flow of resources to affected areas, significantly reducing cholera cases and mortality rates.

Did CERF funds help respond to time-critical needs?

Yes ☒ Partially ☐ No ☐

The funds supported urgent interventions like training 650 Community-Based Volunteers (CBVs), deploying Oral Rehydration Points (ORPs), and ensuring quick referrals and treatment for cholera patients. These actions helped mitigate the outbreak's impact, with a noted decrease in mortality and cholera cases in hotspot areas like Lusaka. Nationally from 29th April 204 to 3rd June 2024, cases per day had reduced from 111 to 8 and deaths from 3 to zero, specifically for Lusaka District, cases and deaths per day had reduced by 100% in the same period.

Did CERF improve coordination amongst the humanitarian community?

Yes ☒ Partially ☐ No ☐

This CERF allocation allowed the two recipient agencies to work closely together. Between UNICEF & WHO there were ad hoc consultations particularly around coordination of field visits, complementarity. WHO, with the participation of UNICEF, hosted

cooperating partners countrywide platform (JICA, Africa CDC, US CDC, USAID) on a weekly basis to share information on the outbreak and response and to look at gaps and challenges and together generating solutions on how to support the Government. Most importantly the collective managed to allocate each other's responsibilities.

Did CERF funds help improve resource mobilization from other sources?

Yes ☒ Partially ☐ No ☐

The proposal writing and the coordination which was established during the CERF application process enabled both WHO and UNICEF to work together and develop another proposal for additional funding which was successful.

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

The CERF allocation addressed support for women and girls and programmes targeting persons with disabilities during Zambia's cholera outbreak. For women and girls, interventions included safe and dignified burials, distribution of hygiene kits critical for reproductive health, and gender-sensitive risk communication. Efforts targeting persons with disabilities included adapting information materials to ensure accessibility and inclusion in community engagement activities. These measures aimed to protect vulnerable groups disproportionately impacted by the outbreak.

CERF funding enabled timely, inclusive interventions that prioritized vulnerable groups. It strengthened the humanitarian response by integrating gender and disability considerations, ensuring access to life-saving services, and enhancing awareness through targeted communication. Through consultation with Organizations of Persons with Disabilities, inclusive 20,000 (2,000 per province) RCCE materials were cocreated and disseminated country-wide. An additional 4,900 materials are planned for development and distribution early next year, 2025. CERF also supported 650 community-based volunteers and local leaders, fostering trust and amplifying the reach of interventions. These efforts highlighted CERF's role in catalyzing broader inclusivity in emergency response.

CERF funding was instrumental in addressing critical needs for women and individuals with disabilities, ensuring access to tailored support and life-saving interventions. Despite the plan, the reach was low because of the lack of disability specific materials and development of such materials took time, and the limited capacity of the government to identify beneficiaries.

Table 1: Allocation Overview (US$)

[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.

GUIDANCE (delete when completed): The amount reported under "total amount required" is pre-populated with the figure from section 1 in the CERF application. For the rapid response window, this amount reflects the humanitarian requirements for the crisis that triggered the application to CERF, for a six-month period. For the underfunded emergencies window, this amount corresponds to the overall annual humanitarian requirement in the country, e.g. the HRP requirements. The amount may have remained unchanged or may need adjustments based on new findings. Other information is to be prepared by the CERF focal point based on agencies' inputs.

Total amount required for the humanitarian response	**18,974,504**
CERF	2,528,290
Country-Based Pooled Fund (if applicable)	0
Other (bilateral/multilateral)	1,718,539
Total funding received for the humanitarian response (by source above)	**4,246,829**

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

Agency	Project Code	Sector/Cluster	Amount
UNICEF	24-RR-CEF-007	Water, Sanitation and Hygiene	929,796
UNICEF	24-RR-CEF-007	Health	593,487
UNICEF	24-RR-CEF-007	Protection - Child Protection	237,395
UNICEF	24-RR-CEF-007	Nutrition	217,612
WHO	24-RR-WHO-003	Health	550,000
Total			**2,528,290**

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

GUIDANCE (delete when completed): The information is to be prepared by the **CERF focal point** based on agencies' inputs**.**

Total funds implemented directly by UN agencies including procurement of relief goods	**1,804,958**
Funds sub-granted to government partners*	406,340
Funds sub-granted to international NGO partners*	65,331
Funds sub-granted to national NGO partners*	205,420
Funds sub-granted to Red Cross/Red Crescent partners*	46,240
Total funds transferred to implementing partners (IP)*	**723,332**
Total	**2,528,290**

* 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:

Zambia is facing one of its worst cholera outbreaks in two decades. The outbreak began in October 2023, but transmission increased significantly in Lusaka in the first week of January – likely due to travel over the Christmas period. During that period, the Ministry of Health reported an increase of 71% in cases and 175% in deaths. While case numbers had stabilized in Lusaka as of early 2024, they had increased in rural districts over the first two weeks of January. Cholera is now present in all ten provinces. As of 25 January, the Zambia National Public Health Institute had recorded a total of 14,116 confirmed cases and 534 deaths. The Case Fatality Rate was nearly 4%, which is almost four times higher than the 1% emergency threshold. The Ministry of Health was reporting more than 400 cases a day. UNICEF has alerted that around 48% of all cases are children under 15. Children under five account for 32% of all cases. All schools had been closed to reduce transmission. There was a risk of a nationwide crisis due to inadequate water, sanitation and hygiene infrastructures in rural areas as well as limited response capacities.

Operational Use of the CERF Allocation and Results:

The $2.5 million Rapid Response allocation from CERF addresses the multi-sectoral needs of 1.06 million people in response to cholera in Zambia. The CERF response aims to support the affected people and communities through a multi-sectoral response targeting the Health, Nutrition, Water, Sanitation and Hygiene sectors.The assistance will be delivered by UNICEF and WHO.

People Directly Reached:

This allocation provided 2,001,997 people with life-saving assistance.

WASH

An estimated 1,925,427 women, men and children (against the target of 1,060,000 people) in cholera-affected areas were reached with improved knowledge and skills/capacity on safe drinking water handling and hand hygiene. Out of these, 715,928 people were provided with critical WASH supplies. The project over-achievement by 81% of the target is mainly attributed to expansion of the interventions to other hotspot districts in Central and Copperbelt provinces.

For the "Number of people receiving critical WASH supplies," we based the estimate on the number of supplies distributed per household, using an average household size of 5.1 members. The "Number of WASH/hygiene kits distributed" was directly counted by tracking the actual number of kits distributed. For the "Number of people receiving WASH/hygiene messaging," we tracked participation reached through dedicated Community Engagement interventions. The community engagement activities included mobilization of community and faith leaders through partnerships with Zambia Interfaith Networks and Support to Older People (STOP). These efforts involved door-to-door visits by trained community-based volunteers, reaching older adults and persons with disabilities, as well as faith leaders disseminating cholera prevention messages through religious platforms and gathering community feedback to inform response actions. Gender estimates were calculated using recent census percentages to ensure accurate gender distribution. The deviation beyond 10 percent for the indicator “Number of people receiving critical WASH supplies (e.g. WASH/hygiene kits)” is due to the extension of the interventions to other cholera hotspots in Copperbelt, which was initially started with CERF funds in Lusaka, to two additional provinces with complementary funding. Various channels were used to collect community feedback from affected populations and some of these channels included door-to-door (using paper-based forms administered by community-based volunteers from UNICEF partners Zambia Red Cross Society, STOP and ZINGO. Community feedback was also collected through community dialogue meetings (e.g churches and other existing community structures). Feedback was also collected through help desks placed across communities and Cholera Treatment Centres (e.g. in Lusaka, a helpdesk was placed at Heros stadium to collect feedback from family members inquiring about their admitted relatives). Finally, feedback was collected through call centres e.g Childline/Helpline Zambia who were engaged to collect cholera community feedback including sensitive feedback. Complaints were recorded and referred at various levels i.e health facility, district, provincial and national levels. At national levels, feedback was shared with relevant Government Ministries such as Ministry of Health, Zambia National Public Health Institute, Ministry of Community Development and Social Services (ministry in charge of protection issues) and the Police (concerning GBV related feedback). CBVs and Call Centre Agents facilitated closing the feedback loop related to community level issues.

HEALTH

At the peak of the Cholera outbreak, UNICEF set up 100 community based oral rehydration corners (ORCs) in Lusaka district’s 7 sub-districts. The ORCs reported having directly attended to 74,762 people of whom 11,522 were children under the age of five years and 63,139 were people above the age of five years. The number of people reached at the ORCs was higher than the planned figure of 9,806 because the ORCs were located in the communities close to households and hence all community members who approached the corners were attended to and either given health information and/or, if they reported being unwell, given initial treatment for Cholera i.e oral rehydration solution and linked to further care if needed.

NUTRITION

The population directly reached includes the number of children screened which was 380,288, and a total of 4,712 children were admitted on the Integrated Management of Acute Malnutrition (IMAM) program with 3,243 enrolled for MAM management and 1,469 for SAM treatment. The other directly reached beneficiaries include the 4,065 volunteers that were oriented in case identification and referral. These are the direct beneficiaries of the project and not estimated eliminating the possibility of double counting. The number of beneficiaries directly reached is above the initial planned target as the project used a community-based mother to mother peer support group called the Nutrition Support Group (NSG) to screen children within the households they deliver nutrition messages to. The use of 4,065 nutrition support group volunteers and community-based volunteers for case identification and referral enabled the screening of children done in a shorter period as more children were screened by the NSG volunteers compared if only Ministry of Health volunteers were used to screen. Especially that during the Cholera epidemic a majority of MOH volunteers were also working on other Cholera response interventions.

CHILD PROTECTION

A total of 7,465 children were reached directly with welfare and protection services and were identified through community case management. In addition, affected adult population also benefited UNICEF supported government and CSO partners to work with community volunteers known as Community Welfare Assistance Committees (CWACs) to identify vulnerable children and families, undertook needs assessment and provided welfare and protection services based on recommended care plans. The targeting of children in the refugee communities was coordinated with UNHCR thereby reducing the risk of duplication of efforts and double counting of beneficiaries. The variation of more than 10 percent is because of the active involvement of community volunteers and child helpline services that helped to easily reach identified families for assessment and services.

People Indirectly Reached:.

WASH

At least 809,000 people have been indirectly reached through the supply of water treatment chemicals to the Lusaka Water and Sanitation Company and Chibolya Water Trust. This was achieved through the provision of 630 drums of HTH chlorine for treating water at the source and point of collection, ensuring blanket coverage instead of individual household distributions.

HEALTH

As the Cholera outbreak tapered down, community-based volunteers (CBVs) were trained to visit households and deliver health education messages, information, education and communication (IEC) materials and where available distribute household Chlorine. Through this modality CBVs reached 1, 253,630 people from 5 supported provinces and distributed 9000 bottles of Chlorine specifically in Central Province's Kabwe district. The community response was further modified in-keeping with the epidemiological evolution of the Cholera outbreak, whereby, at the tail end of the outbreak, the Ministry of Health was supported to conduct community surveillance, where CBVs visited households and actively looked for cases of diarrhea in addition to providing health education messages and communication materials and through this approach, 845,775 people were reached and in the process 4,142 cases of diarrhea were identified and 1,371 cases were referred for further treatment at their nearest health facility. The numbers of people reached were obtained from the daily reports of the community-based volunteers (CBV) submitted through their health facility supervisors. Each CBV had a fixed number of households to visit per day and they reported through a standard reporting form, from which the reported data was collated by the health facility-based staff who supervised the CBVs.

NUTRITION

The indirect beneficiaries are estimated by the number of children (380,288) that were directly screened by the volunteers multiplied by the average household size which 4.5 for Lusaka (CENSUS, 2022). Bringing the total indirect beneficiaries to 1,711,296.

CHILD PROTECTION

At least 47,587 people, including 20,603 children were indirectly reached through sensitization on prevention of child protection violations including stigma and discrimination as well as information on Cholera and available social services that can be assessed. The underperformance in child protection is because of overestimation of the intial planned figures.

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	2,768	2,583	3,339	3,116	11,806	30,462	29,267	7,615	7,418	**74,762**
Nutrition	1,490	1,660	10,278	11,134	24,562	0	0	705	764	**1,469**
Protection - Child Protection	0	0	1,040	960	2,000	0	0	4,466	4,807	**9,273**
Water, Sanitation and Hygiene	258,858	239,611	291,793	269,738	1,060,000	470,200	435,239	530,025	489,963	**1,925,427**

* 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	229	1,808
Returnees	0	0
Internally displaced people	0	0
Host communities	26,068	74,762
Other affected people	1,060,000	1,925,427
Total	**1,086,297**	**2,001,997**

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	261,024	500,662	25,889	26,580
Men	242,205	464,506	23,961	18,604
Girls	302,136	538,364	29,179	6,808
Boys	280,932	498,465	26,974	4,522
Total	**1,086,297**	**2,001,997**	**106,003**	**56,514**

PART II – PROJECT OVERVIEW

3. PROJECT REPORTS

3.1 Project Report 24-RR-CEF-007

1. Project Information

Agency:	UNICEF	**Country:**	Zambia
Sector/cluster:	Water, Sanitation and Hygiene Health Protection - Child Protection Nutrition	**CERF project code:**	24-RR-CEF-007
Project title:	Multi-sectoral integrated intervention in cholera affected communities		
Start date:	18/01/2024	**End date:**	17/07/2024
Project revisions:	No-cost extension ☐ Redeployment of funds ☐		Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency:	**US$ 6,487,000**
Total funding received for agency's sector response to current emergency:	**US$ 490,000**
Amount received from CERF:	**US$ 1,978,290**
Total CERF funds sub-granted to implementing partners:	**US$ 676,521**
Government Partners	US$ 359,530
International NGOs	US$ 65,331
National NGOs	US$ 205,420
Red Cross/Crescent Organisation	US$ 46,240

2. Project Results Summary/Overall Performance

WASH

CERF provided an integrated package of cholera control interventions including distribution of water treatment chemicals, hygiene promotion and distribution of soap and buckets. The interventions also included water quality monitoring and sanitation promotion both in institutions and communities. During the implementation period, the WASH project successfully reached an estimated 1,925,427 women, men and children (against the target of 1,060,000 people) in cholera-affected areas with improved knowledge and skills/capacity on safe drinking water handling and hand hygiene. The project's over-achievement by 81% of the target is mainly attributed to expansion of the interventions to other hotspot districts in Central and Copperbelt provinces. Beneficiaries were directly reached by CBVs and religious leaders through door-to-door sensitizations, church sensitizations as well as community engagement meetings. Direct beneficiaries' contact details were captured through paper-based registers/forms and consolidated into excel sheets by UNICEF partners (STOP and ZINGO). Out of these 715,928 people with critical WASH supplies, exceeding the target of 700,000. An additional 809,000 people were also supported with access to clean water through provision of chlorine by UNICEF to commercial utilities and Water Trusts

for treatment of water at source and point of collection. Additionally, after approval to extend the intervention beyond Lusaka, the distribution was expanded to the Copperbelt province, which was the epicenter of the cholera outbreak where 140,513 WASH/hygiene kits were distributed, surpassing the target of 125,000 households. The project was implemented in Lusaka, Central, Southern, and Copperbelt provinces. As a result, the project improved access to clean water for affected communities and raised awareness about the importance of treating water for safe use. This contributed to enhanced hygiene practices and reduced the risk of cholera transmission. To promote hygiene practices for a safe and protective return to school, WASH school Kits[2] were procured and distributed to 135 schools: A total of 278,304 students were reached, with 205,469 students in 92 schools in Kitwe and 72,835 students in 43 schools in Ndola benefiting from these interventions. To enhance Community Engagement a total of 3,360 faith leaders and CBVs were engaged in community action in Lusaka through Zambia Interfaith Networks (ZINGO). These leaders included: 312 Faith Leaders who further mobilizing 10 pre mapped platform leaders (choir leaders, Sunday school, youth group, women and men group pastoral group and small cell groups etc.) bringing a total 3120 leaders engaging with large congregation disseminating prevention messages as well as small group dialogue. Additionally, 240 CBVs and older person champions from Support To Older People (STOP) were trained and engaged in community action contributing to engaging of vulnerable communities in Lusaka. The combined effort of the partners reached nearly 2 million people in Lusaka through house-to-house promotion and community mobilization events.

Working across the response sectors, evidence-based Risk Communication and Community Engagement (RCCE) activities were enhanced in collaboration with government and partners. UNICEF together with MOH, University of Zambia and partners conducted Rapid Qualitative Assessments (RQAs) which highlighted key barriers in prevention practice and early care seeking. Based on the insights, UNICEF and MOH led the refocus on priority behaviors to halt the outbreak through clear messaging on 3 Cs (Clean and safe water, clean hands, and early Care). TV and radio 3Cs message disseminated in the 7 main local languages (Kaonde, Luvale, Lunda, Tonga, Lozi, Bemba and Nyanja) through 44 national and community radio stations reached approximately 5.48 million people. Additionally, various IEC materials were printed and disseminated including 3 Cs posters, child friendly posters, and CBV tools. The IEC materials were further adapted to Braille print and Sign Language, working jointly with MOH and organizations and networks of persons with disabilities such as Zambia Agency for Persons with Disabilities, Zambia Federation of Disability Organizations, Federation of Sign Language Interpreters and Translators and Deaf Society. Over 600,000 multi-language IEC materials and mobilizer tools were distributed in communities including refugees and asylum seekers in Lusaka, and 166 schools in Lusaka reaching over 450,000 learners promoting safe school reopening.

At the outset of the outbreak, UNICEF had mobilized its regular funding to support Zambia Red Cross (ZRCS) to train and deploy CBVs to support community engagement. Through the technical support of the RCCE Collective Service, a community feedback mechanism dashboard was established to systematize the insights gathered using 5 themes (rumors, observations and beliefs, Questions, Suggestions). The system further strengthened the capacity to generate feedback by partners supported by CERF including ZINGO and STOP, and call centre agents (Childline Call Centre). The feedback highlighted key concerns to enhance responsive messaging and closing the feedback loop to communities. Furthermore, leveraging on existing Childline Zambia referral mechanisms, sensitive feedback was referred to relevant line ministries and authorities (e.g. the police, GBV Units, MoH, etc.). An ongoing effort to sustain the application of the community feedback system to multiple emergency response through roll out of capacity building and development of Standard Operating Procedure (SOP) is underway under the leadership of MOH and ZNPHI. The application of RQA insights and systematic community feedback to inform/adjust rapid action enhanced the value of evidence-based, people-centered RCCE approaches as a standard step in humanitarian responses.

HEALTH

The health project initially focused on improving community case management as well as facilitating referral of affected people from the community to the nearest treatment point, this was in response to the high number of community deaths recorded during the Cholera outbreak especially in Lusaka district. UNICEF supported the Ministry of Health to set-up 100 Oral Rehydration Corners (ORCs) in 7 sub districts of Lusaka. The ORCs were manned by trained community-based-volunteers, a total of 400 were trained and supported with equipment to use in reconstituting and safely dispensing oral rehydration solution (ORS). A team of 42 heath workers who supervised the CBVs were also trained over a period of 48 hours. To ease operational challenges, Lusaka Health Office was supported with 8 hired vehicles for supervision and monitoring. In addition, talk time was provided to ensure communication between the CBVs and their supervisors. The Lusaka district was also supported to repair their Ambulance fleet, a total of 7 vehicles were repaired with the aim of contributing to improved patient movement through the referral chain. The 100 ORCs reached 74,661 people, among whom were 11,522 children under the age of five years. The number of people reached at the ORCs is much higher than the planned figure of 9,806 because the ORCs were located in the communities and close to households and hence all community members who approached the corners

[2] "Stop Cholera Kits" containing 6x1.5L bleach, 20x500g bars of soap, 12x250ml household chlorine bottles, buckets for handwashing and drinking, 3 C's brochures (A4), and 3 C's posters (A1) featuring cholera prevention messages.

were easily attended to (and within reach) and either given health information and/or, if they reported being unwell, given initial treatment for Cholera and depending on severity, Oral rehydration solution was provided or they were linked to further care if needed. As the Cholera outbreak tapered down, community-based volunteers were orientated and/or trained to visit households and deliver health education messages and materials such as brochures on Cholera prevention and they reached 1,253,630 people in selected districts of the Central and Copperbelt province. The community response was further modified in-keeping with the epidemiological evolution of the outbreak, whereby, at the tail end of the outbreak, the Ministry of Health was supported to conduct community surveillance, whereby, in addition to providing health education messages and materials to households, CBVs actively looked for diarrhea cases. This was conducted in Eastern, Central, Copperbelt and Lusaka provinces in 16 district and through this approach, 845,775 people were reached among which 4,142 cases of diarrhea were identified, and 1,371 cases were referred for further treatment at their nearest health facility. Among the identified cases of acute watery diarrhea, 34 of the cases met the case definition of Cholera and were tested with rapid diagnostic tests (RDTs). The RDTs used in the community surveillance, were from the Ministry of Health, under a consignment that GAVI the Vaccine Alliance had procured. The support for community-based surveillance conducted in 19 districts of Central, Eastern, Copperbelt and Lusaka provinces, trained 1157 CBVs and 468 health workers (who supervised the CBVs). The community surveillance approach has contributed a wealth of information on status of water and sanitation in the areas where the CBVs worked, the Ministry of Health has used the information to contribute to the on-going national mapping of priority areas for multisectoral intervention (PAMI) as part of national preparedness for Cholera in Zambia.

NUTRITION

Through this project UNICEF supported the ministry of health orienting 4,065 Nutrition Support Group Volunteers and Community Based Volunteers. Furthermore, UNICEF supported screening of a total of 380,288 children during the project lifespan depicting a 95% coverage. From February to July 1,469 children were enrolled for Severe wasting or Sever Acute Malnutrition (SAM) treatment while 3,243 were enrolled for moderate Wasting management or Moderate Acute Malnutrition. During the screening of children, a total of 1,140,864 people were reached indirectly with awareness campaigns on the **3 Cs** for Cholera prevention – Clean and Safe water, Ealy Care and Clean Hands. UNICEF further procured and distributed 2016 cartons of RUTF,40 cartons of F-75, 17 cartons of F-100 and 600 packs, 2 cartons of Resomal were procured and distributed to Lusaka District for treatment of children with severe wasting with or without medical complications.

CHILD PROTECTION

With 40 percent of deaths due to the cholera outbreak being children aged five years and below, UNICEF supported the Ministry of Community Development and Social Services (MCDSS) to activate a protection response targeting the most vulnerable children and families. Through UNICEF technical support and funding from CERF, a total of 48,738 persons directly and indirectly affected by cholera were reached with protection services. A total of 21,120 (7,990 boys/13,130 girls) were reached by community volunteers and MCDSS social workers, who through case management process; identified, assessed and facilitated the provision of required social services including welfare, health, MHPSS among others and in line with identified needs. Key among protection interventions were family tracing and reunification for separated children, responding to gender-based violence among others. Working with the Child Helpline center, trained counselors provided support MHPSS and referral services to a total of 47,587 people, including 20,603 children. These persons were also sensitized on cholera and available linked services to a safe and accessible channel to report sexual exploitation as means of preventing double vulnerability from cholera outbreak and when accessing services. Additionally, a total of 8,002 people including 3,688 children (1,545 boys; 2,143 girls) children at risk of gender-based violence were identified and provided with information to prevent gender-based violence including available services they can access and in close proximity to their communities. Also, 1,969 children (1,094 boys; 875 girls) children were assisted to reunite with their families. In many of the hotspots in Lusaka where cholera was high, are also large numbers of refugee settlements especially in the Makeni refugee transit center. A total of 1,808 (1,084 males, 724 females) people, out of which 687 children (412 boys; 275 girls) children benefited from referrals to enable them access protection and psychosocial support services. In addition, 1,285 households; including 423 refugee households were assessed and benefited from in-kind support services through the Government Public Welfare Assistance Scheme (PWAS).

3. Changes and Amendments

WASH

During the project implementation, several challenges were encountered that required deviations from the original proposal. One significant issue was the inadequate in-country production capacity for some supplies, particularly household chlorine, which impacted the timely distribution of household kits. To mitigate this, bulk chlorine was distributed while liquid chlorine procurement was in progress, ensuring continuous treatment of water supplies. Additionally, at the onset of the response, there was no shared understanding among stakeholders on the process for testing free residual chlorine. Different processes were being applied, which prompted the engagement

and training of interns to support the Ministry of Health and the Lusaka Water and Sanitation Company in standardizing and conducting chlorine monitoring.
With CERF's approval, a modification to the original plan was made to expand the distribution of household "Stop Cholera Kits" beyond Lusaka to the Copperbelt province, which became the new epicenter of the cholera outbreak. This led to the procurement of 140,000 kits, exceeding the initial target of 125,000 households, ensuring access to safe drinking water and promoting handwashing in affected areas.

HEALTH
As the Cholera outbreak tapered down, community-based volunteers initially trained to manage Oral Rehydration Corners (ORCs) were re-orientated and/or re-trained to conduct household visits and deliver health education messages and distribute information materials and where available household Chlorine, this covered the initial extension of support to the Central and Copperbelt provinces. The community response was further modified in-keeping with the epidemiological evolution of the outbreak, whereby, at the tail end of the outbreak, the CBVs were trained to conduct community surveillance thus actively search for cases of diarrhoea as well as collect environmental health information that has fed into the on-going nationwide mapping of priority areas for multisectoral response for Cholera, as part of the national preparedness for the 2024/25 Cholera season and is a contribution towards the elimination of cholera in Zambia.

NUTRITION
The estimated number of children aged 6 – 59 months in the Lusaka district is about 400,000, with a total 380,288 children screened during the project lifespan depicting a 95% coverage. The Cholera Epidemic coincided with the declaration of a drought emergency affecting 84 districts in the country including Lusaka. This further exacerbated the vulnerability of children 6-59 months to malnutrition.
This is evidenced by the steady increase in the number of children enrolled for severe wasting in the district as the year progressed. From February to July 1,469 children were enrolled for Severe wasting or Sever Acute Malnutrition (SAM) treatment while 3,243 were enrolled for moderate Wasting management or Moderate Acute Malnutrition. The steady rise in the number of children with moderate wasting necessitated the need to extend procured treatment commodities to the management of children with moderate wasting to prevent children from deteriorating into severe wasting.
A SMART survey was conducted in May 2024 and showed very low prevalence of wasting in Lusaka district at 3.8 per cent for Global Acute Malnutrition (GAM) with Severe wasting prevalence being less than 1% per cent.
Despite the overestimation of the district prevalence of severe wasting the effects of the drought led to a steady rise in the number of children with severe wasting due to food insecurity caused by the drought.

CHILD PROTECTION
The spread of Cholera from Lusaka to other parts of the country, specifically Copperbelt necessitated the Ministry of Community Development and Social Services to activate community case management to protect children from violence and abuse. Using the lessons learned in Lusaka District, UINICEF supported the MCDSS to support community-based case management in Ndola, Kitwe and Chililabombwe districts, Copperbelt Province.

4. Number of People Directly Assisted with CERF Funding*

Sector/cluster	Health									
	Planned					Reached				
Category	Women	Men	Girls	Boys	Total	Women	Men	Girls	Boys	Total
Refugees	0	0	0	0	**0**	0	0	0	0	**0**
Returnees	0	0	0	0	**0**	0	0	0	0	**0**
Internally displaced people	0	0	0	0	**0**	0	0	0	0	**0**
Host communities	2,112	2,544	2,100	3,050	**9,806**	30,462	29,267	7,615	7,418	**74,762**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**2,112**	**2,544**	**2,100**	**3,050**	**9,806**	**30,462**	**29,267**	**7,615**	**7,418**	**74,762**
People with disabilities (PwD) out of the total										
	250	215	260	255	**980**	**13,006**	**9,073**	**3,343**	**2,212**	**27,634**

Sector/cluster	Nutrition									
	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	1,490	1,660	10,278	11,134	**24,562**	0	0	705	764	**1,469**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**1,490**	**1,660**	**10,278**	**11,134**	**24,562**	**0**	**0**	**705**	**764**	**1,469**
People with disabilities (PwD) out of the total										

* 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.

	364	541	470	554	**1,929**	**0**	**0**	**0**	**0**	**0**

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	258,858	239,611	291,793	269,738	**1,060,000**	470,200	435,239	530,025	489,963	**1,925,427**
Total	**258,858**	**239,611**	**291,793**	**269,738**	**1,060,000**	**470,200**	**435,239**	**530,025**	**489,963**	**1,925,427**
People with disabilities (PwD) out of the total										
	25,889	23,961	29,179	26,974	**106,003**	**13,574**	**9,531**	**3,465**	**2,310**	**28,880**

Sector/cluster	Protection - Child Protection									
	Planned					**Reached**				
Category	**Women**	**Men**	**Girls**	**Boys**	**Total**	**Women**	**Men**	**Girls**	**Boys**	**Total**
Refugees	0	0	0	0	**0**	0	0	724	1,084	**1,808**
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	1,040	960	**2,000**	0	0	3,742	3,723	**7,465**
Other affected people	0	0	0	0	**0**	0	0	0	0	**0**
Total	**0**	**0**	**1,040**	**960**	**2,000**	**0**	**0**	**4,466**	**4,807**	**9,273**
People with disabilities (PwD) out of the total										

* 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.

	0	0	104	96	**200**	**0**	**0**	**69**	**103**	**172**

* 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

At least 809,000 people have been reached through the supply of water treatment chemicals to the Lusaka Water and Sanitation Company and Chibolya Water Trust, surpassing as they received support of a total of 630 drums HTH chlorine, for treatment of water at source and point of collection which provided blanket coverage rather than individual household distributions.

HEALTH

As the Cholera outbreak tapered down, community-based volunteers were trained to visit households and deliver health education messages and they reached 1, 253,630 people. Further through community surveillance activities 845,775 people were reached among which 4,142 cases of diarrhea were identified, and 1371 cases were referred for further treatment at their nearest health facility.

Health and WASH interventions were complemented with risk communication and community engagement (RCCE) actions such as adaptation and dissemination of a series of cholera prevention messages in the 7 national local languages (Kaonde, Luvale, Lunda, Tonga, Lozi, Bemba and Nyanja), reaching diverse communities across Zambia. The messages on cholera prevention and control were broadcast through national local radio stations. Between April 2024 to July 2024, a total of 44 radio stations were mobilized to disseminate key cholera messages, ensuring comprehensive media coverage across all 10 provinces of the country. Out of the 44 stations, 13 were national broadcasters, while the remaining 31 were community-based radio stations (among which included faith-based radio stations), which played a crucial role in reaching even the hardest to reach populations. The nationwide radio campaign successfully reached approximately 5.48 million people across the 10 provinces with vital messages.

NUTRITION

A total of 4,065 Nutrition Support Group Volunteers and community-based volunteers screened 380,288 children between the ages of 6-59 months for Wasting (Malnutrition). During the screening of children, a total of 1,711,296 people were reached indirectly with awareness campaigns on the 3 Cs for Cholera prevention (Clean and Safe water, Ealy Care and Clean Hands).

CHILD PROTECTION

At least 47,587 people, including 20,603 children were indirectly reached through sensitization on prevention of child protection violations including stigma and discrimination. Information on Cholera and available social services including where they can be assessed was disseminated working with community volunteers and Child Helpline and Lifeline platforms.

6. CERF Results Framework

GUIDANCE (delete when completed):

- The "Achieved" column should contain data only and use the same unit of measurement used for the "Target" value.
- Provide brief explanations for any variance (timeliness, under- or over-achievement) between "Target" and "Achieved" in the relevant field ("Explanation of output and indicators variance"). Specifically note where key targets were not met or were met but not within intended timeframe. More detailed explanation for deviations between planned and achieved outputs should be included in section 3 "Changes and Amendments".
- Please indicate the source of verification for each indicator in the column "Source of verification".
- The "Implemented by" column should indicate who (recipient agency, government partner, NGO etc.) actually implemented the activity (as opposed to who was planned to implement). Any change between planned and actual IPs should be explained in 3 "Changes and Amendments").

Project objective	Provide a multi-sectoral integrated intervention in cholera affected communities in Lusaka District
Output 1	An estimated 1,060,000 women, men and children in cholera-affected areas in Lusaka have improved knowledge and skills/capacity on safe drinking water handling and hand hygiene.

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.16a Number of people receiving critical WASH supplies (e.g. WASH/hygiene kits)	700,000	715,928	Distribution Report
Indicator 1.2	WS.17 Number of people receiving WASH/hygiene messaging	1,060,000	1,925,427	RCCE Narrative Report
Indicator 1.3	WS.16b Number of WASH/hygiene kits distributed	125,000	140,513	Distribution Report
Indicator 1.4	Number of people participating in engagement action	4,040	3,160	RCCE Narrative Report
Indicator 1.5	People sharing their concerns and asking questions/clarifications for available support services to address their needs through established feedback mechanisms	6,200	74,943	RCCE Narrative Report
Explanation of output and indicators variance:		With the approval to extend beyond Lusaka province, the distribution of household kits has been expanded to Copperbelt, now the new epicenter of the cholera outbreak. As a result, 140,000 "Stop Cholera Kits" have been procured, surpassing the target of 125,000 households. Indicator 1.2 has a significant variance from what was initially targeted as our partners (STOP and ZINGO) where able to reach more community members with cholera hygiene information by leveraging on already existing community structures and religious networks to reach additional people with cholera RCCE activities. Similarly, STOP and ZINGO staff, in particular M&E and program officers/coordinators were trained in community feedback mechanism. Following the training, UNICEF, with support from IFRC/Collective service provided the partners with Community Feedback Mechanism paper-based forms as well as online forms which CBVs and religious leaders used to collect community feedback. Most of this feedback, however, was largely collected by STOP CBVs during their door-to-door sensitization activities.		

Activities	**Description**	**Implemented by**
Activity 1.1	Improve access to safe drinking water, through water quality monitoring, chlorination, and coordination	MOH
Activity 1.2	Distribute WASH items together with WASH/hygiene messages	MOH
Activity 1.3	Support WASH and IPC activities in schools, CTCs, ORPs, and/or health facilities in Lusaka District's hot spots	MOH
Activity 1.4	Support partners to conduct rapid assessment to generate insights to inform messages and approaches	Direct Cash Transfer to University of Zambia
Activity 1.5	Produce and disseminate mass-media messages on national TV and community radio stations	Direct contract with production LTA
Activity 1.6	Reprint and distribute hygiene-promotion/cholera prevention IEC materials and child friendly messages for teachers, learners, mobilizers, and specific vulnerable groups including networks of persons with disability, refugees, and asylum seekers	Direct contract with production LTA
Activity 1.7	Mobilization and community action planning with community/faith leaders	Partnership with Zambia Interfaith and key influencers (ZINGO and STOP)

Output 2	Support the government efforts to reduce morbidity (cases) and mortality (death) due to cholera, by enhancing community-based activities through multisectoral approaches
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	Number of ORS sachets delivered to healthcare facilities	1,300,000	1,300,000	UNICEF Reports
Indicator 2.2	H.7 Number of functional health facilities (ORCs) supported	50	100	MOH Reports
Indicator 2.3	H.11 Number of people receiving treatment for acute watery diarrhea (incl. cholera)	9,806	74,661	MOH Reports

Explanation of output and indicators variance:	The number of people reached at the ORCs is much higher than the planned figure of 9,806 because the ORCs were located right at the household level in the communities. I.e ORCs located in the communities and close to households and easily accessible hence all community members who approached the corners were easily attended to and either given health information and/or, if they reported being unwell, given initial treatment for Cholera and depending on severity, Oral rehydration solution was provided, or they were linked to further care if needed. On the 100 ORCs achieved vs the 50-target set was necessitated by the high number of cholera cases from the communities, within the 7 sub-districts of Lusaka, majority of which were inaccessible owing to the flooded and impassible roads. More OCRs meant more community members could easily access the first point of care before making it to the final bigger facility of cholera treatment centre if necessary.

Activities	**Description**	**Implemented by**
Activity 2.1	Procurement and pre-position ORS for high burden subdistricts	UNICEF
Activity 2.2	Support community-based health workers with refresher orientation on community-based care and equip (CBVs 600 + PHN 60)	MOH and Zambia National Public Health Institute
Activity 2.3	Support the establishment, equipping and operationalization of 150 ORCs/ORPs in selected locations within 6 high burden subdistricts of Lusaka.	MOH and Zambia National Public Health Institute
Activity 2.4	Support the establishment of referral systems and linkages of ORC/Ps and CBVs to designated health facilities (3 vehicles for each subdistrict and 3 at the DHO)	MOH and Zambia National Public Health Institute
Activity 2.5	Support the integration of community-based surveillance, case management (ORC/Ps), RCCE and WASH to improve contact tracing, early treatment seeking and referral for children, pregnant women, elderly and other severe cases	MOH and Zambia National Public Health Institute

Output 3	Children in cholera-affected communities who have severe wasting access timely treatment to preserve lives
Was the planned output changed through a reprogramming after the application stage?	Yes ☐ No ☒

Sector/cluster	Protection - Child Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	N.3a Number of people admitted to SAM treatment programme (therapeutic feeding)	2,000	1,469	DHIS 2, from February 2024-July 2024
Explanation of output and indicators variance:		The estimated number of children aged 6 – 59 months in the Lusaka district is about 400,000. A total of 380,288 children were screened for severe wasting during project life span in the district is depicting a 95% coverage. Of the number screened between February to July 1,469 children were enrolled for Severe wasting or Sever Acute Malnutrition (SAM) treatment and 3,243 were enrolled for moderate Wasting management or Moderate Acute Malnutrition. The target number of children with wasting to be treated was based on ministry of health prevalence data from as far as far back as 2018. Recently a SMART survey was conducted and showed very low prevalence of wasting in Lusaka district at 3.8 per cent for Global Acute Malnutrition (GAM) with Severe wasting prevalence being less than 1% per cent.		

Activities	**Description**	**Implemented by**
Activity 3.1	Procurement and prepositioning of supplies for treatment of severe wasting	UNICEF
Activity 3.2	Orientation of community-based volunteers and health workers (outside CTCs) on identification and treatment of severe wasting.	MOH and Plan International

Output 4	Children, parents and caregivers in host community, refugee and migrant children and families that are most affected by the cholera outbreak and are vulnerable or at risk of violence and abuse, receive timely case management support that enables them to access community based Mental Health and Psychosocial Support and counselling services.

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

Sector/cluster	Nutrition			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 4.1	CP.3 Number of children affected with cholera receiving protection support (e.g., family tracing, reunification, reintegration, case management services, etc.)	21,412	21,120	UNICEF program monitoring reports UNICEF implementing partner reports
Indicator 4.2	PP.1b Number of people accessing protection referral mechanisms and/or pathways.	24,562	11,759	UNICEF program monitoring reports UNICEF implementing partner reports
Explanation of output and indicators variance:		The indicator 4.2 is specifically looking at people who out of identified cases through community case management assessment and Child Helplines were referred to specialized protection services provided by social, Health and other mapped service providers. The 11K is a subset of case management data		

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

Activity 4.1	Support community welfare assistants and volunteers to conduct awareness raising activities on Child protection violations including stigma prevention.	Ministry of Community Development and Social Services
Activity 4.2	Children, parents, and caregivers, including refugee and migrant communities, most affected by the cholera outbreak are supported through community case management to access social services MHPSS, counselling, family reunification.	Ministry of Community Development and Social Services Access to Health Child Helpline / Child Lifeline Zambia
Activity 4.3	Facilitate continued care and protection for children separated from families or primary caregivers due to cholera related absence (indisposition or deceased), ensuring children remain in family-based care.	Ministry of Community Development and Social Services

7. Effective Programming

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

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

WASH

WASH activities were implemented directly through the Ministry of Health's district and sub-district structures. Distributions were carried out in collaboration with local community leadership, who played a key role in identifying the most vulnerable households to receive the kits. The identification process was inclusive, involving community meetings and consultations to ensure that no vulnerable group was overlooked. Over 30 engagement meetings with community members were held in existing community structures (schools, Nutrition Support Groups, Churches etc). The selection criteria for the distribution of WASH kits included households of women who had a child under 2 years, pregnant women, breastfeeding women and persons with disabilities. The distribution was conducted by CBVs in collaboration with local authorities who shared their distribution plan with UNICEF WASH focal point persons. Additionally, district health offices held consultative meetings with local leaders to identify hotspot communities where the WASH kits would be distributed. This comprehensive targeting process ensured that all households, including those most at risk, received cholera kits in the affected areas.

HEALTH

Health activities were conducted at the community level through the Ministry of Health's established community health system structures. Community based volunteers (CBVs), who are selected by peers from their neighborhoods were trained to support community case management, health education and active case finding. The CBVs report back to their communities through their neighborhood health committees (NHCs), and on a day-to-day basis CBVs were supervised by health care workers from the nearest health facility.

[3] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

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

NUTRITION

Nutrition activities were implemented using the Nutrition Support Group Model, which is a peer-to-peer mother support group at community level within health facility catchment areas. The Nutrition support group of volunteers each have a group of 10 households they visit to deliver multi-sectoral lessons on different nutrition specific and nutrition sensitive topics to households with pregnant and breastfeeding women monthly. With the passion and commitment, the NSG volunteers have for the community work they do of delivering multisectoral lessons to Households they appreciated the call for continued sensitization of communities on Cholera prevention messages as well as screening children for severe wasting amidst the cholera epidemic in Lusaka District. The Nutrition support group volunteers report to Nutrition promoters who are supervised by government staff who are focal point persons for nutrition at the health facility. This ensures continued feedback to both the community and district level structure.

CHILD PROTECTION

UNICEF facilitated the mobilization and orientation of 120 Community Welfare Assistant Committee (CWAC) members across the cholera affected districts as the frontline focal points in reaching affected communities and those at risk. This ensured that the protection messages related to the cholera outbreak were delivered by members of the affected community, in their language, thereby further enhancing outreach and effectiveness of communication and understanding of interventions that were being implemented with CERF funding.

b. AAP Feedback and Complaint Mechanisms:

UNICEF with support from the Collective Service (a partnership between UNICEF, WHO and IFRC), supported the establishment of a Community Feedback Mechanism Dashboard. Working with IFRC, UNICEF partners Ministry of Health (at sub national levels), Zambia Red Cross, Support to Older People (STOP), Zambia Interfaith Networking Group (ZINGO) and Childline/Lifeline Zambia were trained in Community Feedback Mechanisms, including how to document and refer sensitive feedback. As a result of these trainings, 3058 community feedback was collected (mainly through paper -based forms by Zambia Red Cross Volunteers) analysed and shared with relevant partners to inform cholera response activities. Through CBVs and Call Centre Agents- referral mechanisms were established and where possible feedback on their complaints was given to community members, closing the feedback loop. Additionally, some of the feedback collected was triangulated with the 4 rounds of Cholera Rapid Qualitative Assessments (RQA) findings and shared with relevant stakeholders to inform response. Additionally, through STOP, Additionally, 74 943 feedback collected from 324,971 community members, including 64,872 older people aged 60 years and above and their families, as well as 5493 persons with disabilities engaged by STOP CBVs was used to inform STOP's RCCE cholera emergency response activities. Risk communication activities undertaken included: tailored IEC materials (3 Cs (Clean Hands, Clean and Safe drinking water, Early Care) Cholera poster, OCV poster, CBV OCV and ORP job aids). Other activities included door-to-door sensitization by CBVs, community sensitization activities in schools, markets and churches, Cholera radio jingles (both adult and child friendly), TV PSAs and Child Friendly 3Cs posters Link Community Engagement activities included community dialogue meetings, engagement meetings with community gate keepers, phone-in radio programs and collection of community feedback.

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

There was no SEA incidence reported during the implementation period. Nonetheless, community members were sensitized on the risks of PSEA in humanitarian response and the available reporting pathways including child helpline and lifeline numbers 116 and 933 respectively. Similarly, UNICEF ensured that frontline workers that were in contact with the affected communities were sensitized on PSEA and were aware of UNICEF zero tolerance policy to SEA. Trained front line workers are also mandated to report SEA cases. All iNGO and NGO engaged in the implementation of the interventions were assessed on PSEA before agreements were signed off. With the drought emergency currently ongoing, UNICEF and other protection agencies are improving the processes and have defined and agreed on a reporting mechanism that is used to report SEA. Also help desk in food distribution centers have also been put in place to improve the processes.

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

In development and humanitarian nexus, Child Protection response mirror protection programming for vulnerable populations to prevent and address violence, abuse, neglection and exploitation. This focuses on delivering case management services, preventing, and

addressing gender-based violence and prevention of sexual exploitation and abuse, and provision of Mental Health and Psychosocial Services. Using a protection mainstreaming; child rights, age, diversity and gender mainstreaming approach was critical to prevent exclusion or discrimination, where children, women and /or child-headed, women headed households, the chronically ill, persons with disability and the elderly were prioritised in humanitarian response in the manner and ways in which protection services and assistance were delivered. Thus, capacities of community structures were strengthened to identify, assess the different needs of boys and girls; men and women; the minority such as persons with disabilities, migrant and refugee communities; and referred them to appropriate gender sensitive and responsive protection and assistance services.

e. People with disabilities (PwD):

UNICEF ensured PwDs were reached with saving cholera messages by adapting and translating Cholera IEC materials (3 Cs poster, OCV poster, CBV Job aids) into braille print and sign language. Working jointly with Ministry of Health and organizations and networks of persons with disabilities e.g. Zambia Agency for Persons with Disabilities, Zambia Federation of Disability Organizations, Federation of Sign Language Interpreters and Translators and Deaf Society of Zambia, cholera messages were tailored and contextualized. The translated materials were distributed to disability centres across the 10 provinces of Zambia. Additionally, through STOP, 5,493 persons with disabilities were directly reached with cholera RCCE activities in Lusaka district.

f. Protection:

Child Protection messages were mainstreamed in outreach messages across sectors. This included PSEA and Gender-Based Violence. Additionally, coordination among community volunteers in the affected communities was enhanced to support efficient referral to social services including cholera treatment centers and other service delivery pathways.

g. Education:

WASH

In response to the presence of schools in the targeted intervention areas, activities were designed to ensure that school-going children have access to WASH services and hygiene promotion. Specifically, schools in affected and at-risk communities were prioritized for the distribution of soap and handwashing buckets to prevent cholera outbreaks and minimize learning disruptions. To promote safe and protective back-to-school hygiene practices, 141 schools received "Stop Cholera Kits," which included 6x1.5L bleach, 20x500g bars of soap, 12x250ml household chlorine bottles, handwashing, and drinking buckets, along with 3 C's brochures (A4) and posters (A1) featuring cholera prevention messages. This comprehensive approach aimed to safeguard students and prevented the spread of cholera within the schools. Additionally, 1170 posters and 262,160 flyers were distributed in 166 schools in Lusaka reaching over 450,000 learners, promoting safe school reopening. Furthermore, 20,000 child-friendly 3 Cs posters were distributed to all 10 provinces of Zambia.

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.

It was not included because the focus was on monitoring protection risk, mitigation and prevention of GBV, SEA.

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

Guidance (to be deleted): Please list weblinks to publicly available social media posts (Twitter, Facebook, Instagram, etc.), videos and/or success stories, evaluations or other kind of reports on the agency's websites covering CERF-funded activities under this project.

Title	**Weblink**
Safe water treatment using chlorine comparator	https://youtu.be/i_Mj2Di-wog
Schools reopening support	https://youtu.be/i_z999XLUIc?list=TLGGar1RcrLCszIyNDA0MjAyNA
[Insert]	[Insert]

3.2 Project Report 24-RR-WHO-003

1. Project Information

Agency:	WHO	**Country:**	Zambia
Sector/cluster:	Health	**CERF project code:**	24-RR-WHO-003
Project title:	Rapid Emergency response to minimize the incidence and mortality associated with cholera in the Lusaka districts by halting the spread of the disease and preventing its extension to unaffected areas		
Start date:	08/02/2024	**End date:**	07/08/2024
Project revisions:	No-cost extension ☐	Redeployment of funds ☐	Reprogramming ☐

Funding

Total requirement for agency's sector response to current emergency: **GUIDANCE**: Figure prepopulated from application document.	**US$ 4,664,174**
Total funding received for agency's sector response to current emergency: **GUIDANCE**: Indicate the total amount received to date against the total indicated above. Should be identical to what is recorded on the Financial Tracking Service (FTS). This should include funding from all donors, including CERF.	**US$ 150,000**
Amount received from CERF:	**US$ 550,000**
Total CERF funds sub-granted to implementing partners: **GUIDANCE**: Please make sure that the figures reported here are consistent with the ones reported in the annex.	**US$ 46,810**
Government Partners	US$ 46,810
International NGOs	US$ 0
National NGOs	US$ 0
Red Cross/Crescent Organisation	US$ 0

2. Project Results Summary/Overall Performance

Through the contribution of the CERF funding, WHO and its partners in the health sector reached 1,115,000 people out of which 23,381 directly benefited from quality treatment. Twenty-eight technical surge personnel were recruited by WHO both from within (one) and outside (twenty-seven) the country to support response. These, together with 521 volunteer health workers and Community based Volunteers (CBVs) that were recruited and oriented ensured compliance with WHO and national cholera outbreak control guidelines.

The funding was used to procure 18 tents with a capacity to hold 234 cholera patients at a time, and 14 tons of standard WHO/UNICEF cholera kits for water quality monitoring, water treatment, case management, personal protection and laboratory diagnostics.

The capacity for case detection and management in affected subdistricts in Lusaka, and districts in Southern, Central and the Copperbelt provinces was enhanced through dissemination and use of cholera consolidated guidelines and frequent field visits with on-job training and mentorship. A multi-sectoral Intra-Action Review of the cholera response conducted in April 2024 identified best practices for sustainability as well as gaps leading to development of recommendations for improving response within this outbreak and for subsequent outbreaks.

WHO supported the orientation of both health care workers and community-based volunteers in all areas of the response operations. The sessions that span over 2 -3 days included in-patient operations, patient transport, integrated community package, safe and dignified burials, surveillance, laboratory testing strategy and specimen collection and transport. In total, about 700 health care workers were

oriented in the above areas, while more than 400 community-based volunteers received short training to enhance community-based surveillance for early detection and referral to Cholera Treatment Centers (CTC) to reduce mortalities.

WHO supported the cholera response in all the districts that had an outbreak. A total of 10 CTCs were sited and erected to ensure the quality of care to all the patients. Infection prevention and control (IPC), case management, and surveillance/laboratory guidelines were developed and disseminated to all the CTCs. WHO supported the procurement and distribution of water treatment and quality monitoring kits to cover all 10 CTCs and surrounding communities. In addition to the 9 kits, 345 kg of chlorine, 10,000 puri tabs were procured to support the provision of safe water supply and compliance with IPC standards.

Through these interventions, cholera cases started to decline in Lusaka district in January and February 2024. The case fatality also started to decline, with an initial fatality rate as high as 3.7% declining to 1.6% in succeeding months of the outbreak from March 2024. Even when the epidemiological situation changed with Southern, Central and Copperbelt provinces taking up an increasing share of cases, WHO's support to interventions in the affected districts resulted in a quick decline in cases largely due to the integrated community case management strategy.

3. Changes and Amendments

The project did not undergo any amendments. It was implemented as approved.
However, while Lusaka district was reporting most of the cholera cases when the project proposal was submitted, the country witnessed a significant epidemiological shift starting late January 2024, with districts outside Lusaka gaining prominence. Through most of February and March, Southern, Central and Copperbelt provinces started reporting an increasing number of cases. This necessitated a shift in the location of response to the districts outside Lusaka. This still did not alter the focus of the project and approved activities.

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	54	50	65	60	**229**	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	2,768	2,583	3,339	3,116	**11,806**	6,276	8,427	4,173	4,505	**23,381**
Total	**2,822**	**2,633**	**3,404**	**3,176**	**12,035**	**6,276**	**8,427**	**4,173**	**4,505**	**23,381**
People with disabilities (PwD) out of the total										
	277	258	334	312	**1,181**	**164**	**116**	**42**	**28**	**350**

* 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

RCCE reached an estimated 1,000,000+ people across the ten provinces of Zambia. As a core intervention for cholera control, WHO worked with UNICEF and partners to develop messages for community risk communication and engagement. The messages were hosted on print platforms, community radio stations and televisual equipment that included television sets. These messages reached more than the cholera cases, and therefore had an effect beyond the population affected. The intention was to empower the community to manage cholera risk better. The estimate of this number reached is made from media houses engaged during the RCCE campaign.

6. CERF Results Framework

Project objective	Reduce morbidity and mortality among the affected population by improving equitable access to quality healthcare services in the supported CTC, CTU and ORPs.
Output 1	High-quality healthcare services are provided by effectively deploying a team of experts, including local and international professionals, along with community-based volunteers.

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.11 Number of people receiving treatment for acute watery diarrhea (incl. cholera)	11,806	23,381	National SitRep
Indicator 1.2	% of healthcare facilities with less than 3 days of stockout of medicines and medical-supplies through the project implementation	100	100	Stock Movement Report
Indicator 1.3	Number of health care workers provided with orientation of utilization of medical protocol and supplied for management of - 300 nurses and 30 midwives, 10 nutritionists, 30 doctors on Cholera Clinical Management in 8 CTC/Us cholera patients	378	521	Cholera response report WHO Zambia action tracker
Indicator 1.4	Number of functional health facilities supported- 7 cholera treatment units1 cholera treatment center	8	10	WHO internal cholera SitRep WHO Zambia action tracker

Explanation of output and indicators variance:	While it was estimated that 11,806 people would directly benefit from the project, this number significantly increased with the direct beneficiaries doubling. As the outbreak ended up being larger than forecasted, the number of direct beneficiaries significantly increased. Likewise, due to the massive spread of the outbreak, there was need to train more personnel in satellite areas outside Lusaka which significantly increased the number of Health Care Workers oriented and trained. Extra CTCs were established in initially un-planned places like Chirundu and Siavonga districts in Southern province.

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

Activity 1.1	Deployment of national and international case management experts to support provision of health services in cholera treatment centres and Cholera Treatment Units. Deployment of 30 midwives and 10 nutritionists to the CTUs/CTCS.	WHO and MoH: WHO deployed 27 international and one local surge staff to support affected communities through the provision of quality healthcare. The local surge person was a Health Logistics Officer using.
Activity 1.2	Support to the existing oral rehydration points (ORP) in catchment area (4 Community based volunteers per ORP x 10 ORP points x 3.7 dollars per days x 30 days for 6 months). The support to the existing ORP will reach 6,017 people.	WHO and MoH: WHO trained and deployed >400 CBVs to support the cholera community-based response initiative in Lusaka district and Southern, Copperbelt and Central provinces.

Output 2	Efficient deployment of rapid response teams, enhancing community case detection and optimizing the referral process to specialized care facilities.

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	Number of people referred to higher level and/or specialized health services (referred from ORPs to CTUs and subsequently to CTCs)	100	4,713	Community referral forms. While the number of referrals may be higher than this figure, we report on referrals into Heroes Stadium as this information is the one available.
Indicator 2.2	The average time taken for a patient to be referred from an ORP to a CTU and then to a CTC when needed, measured in hours or days	< 1 hour	< 1 hour	ORP register, cholera register
Indicator 2.3	Percentage of public health alerts generated through community-based and/or health-facility-basedsurveillance or alert systems investigated within 24 hours	100	100	Call centre logs, district and health facility rumour logbooks
Explanation of output and indicators variance:		The number of people referred to higher level health facilities during the outbreak was higher than planned due to the magnitude of the outbreak. Secondly, In Lusaka district, the bulk of the cases were occurring in slums with poor road infrastructure, inadequate health facility coverage, and late presentation with severe illness necessitating referral to higher better-established facilities.		

Activities	**Description**	**Implemented by**
Activity 2.1	Support the referral of patients from ORPs to the designated CTUs and further to the CTC when needed.	WHO and MoH: WHO hired standard vehicles and also provided office transport that were used to support referral of patients from ORPs to the designated CTUs and CTCs.
Activity 2.2	WHO will collaborate closely with the Ministry of Health (MoH) to establish a robust supervision system for healthcare personnel in Cholera Treatment Units (CTUs) and Cholera Treatment Centers (CTCs). This system will	WHO and MoH: WHO supported the enhancement of detection, documentation and reporting of Cholera cases through Community and Event-based Cholera Surveillance Streams in the district reporting confirmed

	include weekly and daily supervision of nurses, resident doctors, nutritionists, midwives, and all clinical staff working in CTUs/CTCs. The aim is to ensure the consistent provision of high-quality care to patients admitted within these facilities. Supervision will encompass regular monitoring of staff performance, adherence to clinical protocols, and adherence to infection control measures. Any issues or challenges identified during supervision will be promptly addressed through training, support, or other appropriate interventions to maintain and enhance the quality of care provided	cholera outbreaks. WHO also provided technical and financial support to CTCs and CTUs. WHO technical personnel held sevarl missions weekly to Lusaka district to monitor and provide technical support to response interventions. Similar missions were held to Southern, Copperbelt and Central provinces with assessments and response planning support.

Output 3	Enhanced capacity of Lusaka district health facilities through the distribution of emergency medical and cholera-specific kits, accompanied by on-the-job training for health workers on kit utilization

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

Sector/cluster	Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of verification**
Indicator 3.1	H.1a Number of emergency health kits delivered to healthcare facilities-8 cholera kits1 Emergency IEHK Kit2 Nutrition KitLocal Cholera nutrition therapeutic feeds procured	11	15	Stock movement report
Indicator 3.2	% of patients with cholera and severe malnourished under-five years patients admitted to CTU and CTC units who receive nutrition therapeutic feeds as a proportion of the total eligible patients.	100	0	This activity was overseen by the co-implementors (UNICEF)
Explanation of output and indicators variance:		WHO procured the kits through the WHO supplies network which resulted in cost-cutting and efficiency of procurement. The supplies were pre-station in the regional hubs in either Nairobi, Dubai or Accra. There was also a need to increase the items procured as the outbreak was larger than initially forecasted.		

Activities	**Description**	**Implemented by**
Activity 3.1	WHO will be responsible for procuring cholera kits, which will include supplementary Oral Rehydration Solution (ORS) and intravenous (IV) fluids modules specifically designed for Cholera Treatment Centers/Units (CTC/CTUs), including low osmolarity ORS. Additionally, emergency kits, tents, and other essential medical supplies will be procured and supplied by WHO.In addition to procurement, WHO will provide operational support to ensure that the kits and other supplies are effectively delivered to the target health facilities. This support will involve coordinating logistics and transportation to ensure timely and efficient delivery.Furthermore, WHO will oversee the raising of tents at designated sites to establish temporary Cholera	WHO and MoH: WHO coordinated the procurement, storage and distribution of cholera kits. The procured kits included standard WHO/UNICEF kits for case management, water quality monitoring, water treatment, laboratory testing, and tents. WHO assessed, sited, set up, commissioned, maintained, and decommissioned tents for use as temporary CTCs/CTUs in line with IPC standards. International and local costs for shipping the procured supplies was also supported by this funding.

	Treatment Centers/Units where needed. These tents will serve as crucial infrastructure for providing care to cholera patients during outbreaks and will be strategically positioned to maximize their effectiveness in responding to the outbreak.	Data visualisation equipment which included screens and wall mounts were procured and installed in the incident management room. In summary the following kits were procured: . 18 tent shelters with capacity to accommodate 234 patients at the same time . Cholera case management supplies capable of treating about 33,000 cholera patients . Infection prevention and control supplies for over 2,500 health workers Standard cholera kits including laboratory supplies for 5,100 cases
Activity 3.2	WHO will ensure the procurement and supply of nutritional kits specifically tailored for cholera patients admitted to Cholera Treatment Units (CTUs) and Cholera Treatment Centers (CTCs) who also present with malnutrition. These kits will address the nutritional needs of patients with cholera and malnutrition concurrently, providing comprehensive care to address both conditions effectively.In addition to procuring and supplying nutritional kits, WHO will focus on addressing complications related to malnutrition among cholera patients in CTUs and CTCs. This approach complements the work of UNICEF, particularly in addressing moderate malnutrition cases. By adopting this focused strategy, WHO aims to ensure comprehensive care for severe cholera cases within the overall cholera control strategy.Furthermore, WHO will provide orientation and on job supervision to Ministry of Health workers on the management of cholera and malnutrition. This will equip healthcare workers with the necessary knowledge and skills to effectively manage and treat patients presenting with both cholera and malnutrition, contributing to improved patient outcomes and overall cholera control efforts.	In recognition of the co-implementors comparative advantage, procurement of therapeutic feeds was ceded to UNICEF.
Activity 3.3	Conduct targeted on-the-job orientation sessions for health workers within the district, focusing on the proper utilization of the emergency kits and cholera-specific resources	WHO and MoH: WHO technical personnel (logistics, case management, IPC, and laboratory specialists) travelled to districts to provide onsite orientation of health workers on the proper utilisation of the emergency kits and cholera-specific resources. The logistician conducted field missions to provide support in the proper use of shelters, logistics management, forecasting needs, and decommissioning of the shelters.

7. Effective Programming

CERF expects partners to integrate and give due consideration to cross-cutting issues such as Accountability to Affected People (AAP), Protection from Sexual Exploitation and Abuse (PSEA), People with disabilities (PwD), Centrality of Protection as well as Gender and

Age. In addition, the Emergency Relief Coordinator (ERC) has identified four underfunded priority areas[5] often lacking appropriate consideration and visibility: women and girls, people with disabilities, education and protection. **The following sections demonstrate how cross-cutting issues and the ERC's four underfunded priority areas have been addressed through project activities and should highlight the achieved impact wherever possible.**

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

During the development of this project, MoH as well as Lusaka district health leadership were consulted and their input considered. However, owing to the urgent need to complete the project concept and avail support to the affected people, it was not possible to fully involve community members in the affected areas. However, as health responders had adequately interacted with the community members in the community, at ORPs and in CTCs/CTUs, knowledge gained was useful in the development of the project. Also, WHO convened and hosted all partners in response in weekly meetings. These included CSOs that has adequate presence in the communities and could provide an accurate view of community beneficiaries needs.

In April 2024, a cholera Intra-Action Review (IAR) was conducted to ascertain what was working well and less well during response and information used for course correction. Community members and civil society organizations were invited to the IAR.

b. AAP Feedback and Complaint Mechanisms:

In close collaboration with UNICEF, WHO developed and mainstreamed RCCE principles and strategies for strengthening community – centered and community – led outbreak preparedness and response within technical pillars. UNICEF, WHO, the Ministry of Health runs a call center for addressing community concerns and providing information to the public frequently. In addition to heath emergencies and other disease outbreaks, the call center also addresses routine evolving public health concerns from communities. During the action WHO working closely with the Ministry of Health strengthened existing systematic mechanisms for preparing, collecting, analyzing, sharing and action on community data for outbreak readiness and response to outbreaks and health in emergencies. WHO support to Ministry of Health developed indicators to integrate community based- facility management (CFM) indicators into the District Health system, activated platforms for data sharing, integrated tools for community data collection and provided technical and financial support for strengthening CFM system.

The Call Centre remained an integral part of the response and functioned effectively. The center received calls from the public seeking information and included logs to rumors and misconceptions whose information was analyzed to inform risk communication messaging. Support was provided to develop standard operating procedures and tools for CFMs. The public were fully informed about what cholera, the level of risk, the prevention measures, maintaining credibility and public trust by providing accurate, science-based information. Avoid speculation, dispel rumors, misinformation, and misperceptions as quickly as possible.

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

The UN Zambia PSEA Network is the coordinating body with the objective to strengthen the prevention and response to sexual exploitation and abuse (SEA) throughout Zambia. It works to facilitate multi-sectoral, inter-agency actions aimed at preventing SEA, and ensure the provision of accessible, timely, and survivor-centered SEA responses services by using the existing GBV structures/ systems/ response service. A complaint or report can be made regarding the alleged misconduct of a humanitarian or development worker related to sexual exploitation or abuse of a beneficiary, directly by the survivor or by anyone who has a suspicion or a concern. In this regard, complaints may be received from various complaint and feedback mechanisms (CFMs), such as Focal Points, community committees, call centers, online platforms, women centers, child friendly spaces (school-based systems), help desks, and GBV and VAC referral mechanisms (It is

[5] These areas include: support for women and girls, including tackling gender-based violence, sexual and reproductive health and empowerment; programmes targeting people with disabilities; education in protracted crises; and other aspects of protection. The ERC recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. While CERF remains needs-based, the ERC will be looking for country teams to prioritize projects and mainstreamed activities that systematically and effectively address to these four historically underfunded areas. Please see the Questions and Answers on the ERC four priority areas here.

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

important to note that SEA reporting is anonymous). A victim/survivor of SEA has the right to assistance and support and must be able to access the GBV and/or VAC services (as appropriate). These services can include immediate assistance such as urgent medical care (for example, clinical management of rape); safety and protection; basic material assistance such as food, clothing, and transportation to access services; psychosocial support, legal services, and support for children born as a result of sexual exploitation and abuse. Longer-term assistance can include comprehensive health care, ongoing psychosocial support, including mental health, legal assistance, livelihood support, skills training and education.

The WHO PSEA focal person developed a PSEA plan for the outbreak as is standard practice. The country also hosted the WHO global PSEA focal person who came to check on the appropriateness of focusing of PSEA activities. As part of the PSEA plan, the WHO PSEA focal person worked with the UN PSEA team to implement the PSEA sensitization and monitoring activities.

No PSEA case was reported during the outbreak.

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

A gender responsive approach was used to ensure that the perspectives of women and girls, men are integrated into all aspects of the response. The response took account of the different needs, and recognized the potential barriers that people may face and third ensure that women and men could access health services equally. Gender analysis was conducted to know how the outbreak was affecting women and men especially those from vulnerable or marginalized groups. Women were also part of the decision-making and implementation process at all levels including at community levels. Women participated as health volunteers trained by WHO and as Community based volunteers. The delivery of services was responsive to men, women and girls and provided minimum service Packages so that women and men and adolescent girls and boys had access to priority sexual and reproductive health services in weeks of the emergency and comprehensive sexual and reproductive health services, including GBV-related services. Developed and implemented communication strategies to highlight the specific health risks affecting women and men, as well as targeting adolescent girls and boys. Collected and reported data by sex and age and applied a gender analysis to inform intervention.

During the outbreak, WHO deliberately analysed data of cases and deaths by gender. In January 2024, it was realised that more males were dying than females, mainly at home. A rapid assessment was conducted in Lusaka province that determined the likely causal factors. This informed subsequent response interventions that targeted alcohol consumption among other responsible factors. Working with UNICEF, it was also discovered that children were more affected, contributing to almost 50% of the morbidities. Together with the realization that closure of schools was affecting learners who are predominantly children, advocacy was conducted to escalate interventions targeting children and on re-opening of schools.

e. People with disabilities (PwD):

For the Zambians who have disabilities, emergencies, such as disease outbreaks present a real challenge. Sensory, physical, psychosocial, intellectual or other impairments interact with various barriers to, can prevent them from participating in, or having access to services or protection.

Acknowledging that protection is not routinely WHO's area of focus during humanitarian crises, we worked with UNICEF to explore appropriate messaging modalities that would target risk communication and management of people who have specific disabilities. A human rights-based approach to disability was used to place persons with disabilities at the centre and reduced barriers and risks that they face. The response structures recognized the capacity of persons with disabilities to contribute to the response. Disability inclusion was achieved as persons with disabilities meaningfully participated in all their diversity, their rights were promoted, and disability-related concerns were addressed. Sign language was used at Heroes and Matero Level 1 hospital and on the National Broadcaster ZNBC TV to facilitate communication with people with hearing disabilities. Disability organizations were also included in the Risk Communication and Community Engagement Pillar activities.

f. Protection:

We acknowledge that the sector division of labor places protection outside WHO's responsibility. Protection during this outbreak was addressed mainly by UNICEF and IOM interventions.

However, WHO ensured the rights of patients were safeguarded in the CTCs through adequate anonymity and privacy during data handling and information-sharing. The risk communication and community engagement interventions were geared towards informing the public, contributing to adequate awareness, and protecting them from infection.

g. Education:

N/A

8. Cash and Voucher Assistance (CVA)

GUIDANCE (delete when completed): Cash and Voucher Assistance (CVA) refers to all programs where cash or vouchers for goods or services are directly provided to affected people. In the context of humanitarian assistance, the term is used to refer to the provision of cash or vouchers given to individuals, household or community recipients; not to governments or other state actors. CVA covers all modalities of cash-based assistance, including vouchers.

If more than one modality was used in the project, please complete separate rows for each activity. Please indicate the estimated **value of cash** that was transferred to people assisted through each modality (best estimate of the value of cash and/or vouchers, not including associated delivery costs).

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.

WHO supports national health security needs mainly through direct engagement with the government Ministries, Departments and Agencies that implement and oversee interventions addressing the needs. WHO does not usually use downstream partners nor provide cash directly to beneficiaries in the community. The health needs that are supported by WHO can only be addressed through provision of goods and services to the community.
Lastly, the cholera outbreak did not experience humanitarian situations within which CVAs are the most desirable modality of meeting people's needs.

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
End cholera!	https://www.facebook.com/share/p/dwe3iQV8tqR1D2Hn/
Capacity building of CBVs in Chililabombwe	https://www.facebook.com/share/v/kNDmJVpFkqJYFcvQ/

CBVs and the Cholera Community Integrated Response	https://www.facebook.com/share/p/VETVcmggpFmBDiXm/

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS I

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
24-RR-CEF-007	Health	UNICEF	GOV	$13,617
24-RR-CEF-007	Health	UNICEF	GOV	$41,739
24-RR-CEF-007	Health	UNICEF	GOV	$42,776
24-RR-CEF-007	Health	UNICEF	GOV	$7,535
24-RR-CEF-007	Nutrition	UNICEF	INGO	$65,331
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$3,891
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$7,385
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$11,691
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$35,250
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$5,416
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$8,292

ANNEX: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS II

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$20,586
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$83,507
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$3,397
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	GOV	$5,200
24-RR-CEF-007	Water, Sanitation and Hygiene	UNICEF	RedC	$46,240
24-RR-CEF-007	Child Protection	UNICEF	NNGO	$101,101
24-RR-CEF-007	Child Protection	UNICEF	NNGO	$24,231
24-RR-CEF-007	Child Protection	UNICEF	GOV	$69,248
24-RR-CEF-007	Multi-Sector	UNICEF	NNGO	$35,174
24-RR-CEF-007	Multi-Sector	UNICEF	NNGO	$44,915
24-RR-WHO-003	Health	WHO	GOV	$46,810