RESIDENT/HUMANITARIAN COORDINATOR REPORT 2012 ON THE USE OF CERF FUNDS GHANA

RESIDENT/HUMANITARIAN COORDINATOR	**Ms. Ruby Sandhu-Rojon**

PART 1: COUNTRY OVERVIEW

I. SUMMARY OF FUNDING 2012

TABLE 1: COUNTRY SUMMARY OF ALLOCATIONS (US$)		
Breakdown of total response funding received by source	CERF	312,440
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	0
	OTHER (Bilateral/Multilateral)	4,553,504
	TOTAL	4,865,944
Breakdown of CERF funds received by window and emergency	**Underfunded Emergencies**	
	First Round	0
	Second Round	0
	Rapid Response	
	Cholera	312,440

II. REPORTING PROCESS AND CONSULTATION SUMMARY

a. Please confirm that the RC/HC Report was discussed in the Humanitarian and/or UN Country Team and by cluster/sector coordinators as outlined in the guidelines.

YES ☒ NO ☐

b. Was the final version of the RC/HC Report shared for review with in-country stakeholders as recommended in the guidelines (i.e. the CERF recipient agencies, cluster/sector coordinators and members and relevant government counterparts)?

YES ☒ NO ☐

The RC/HC Report was shared with the Interagency Humanitarian Working Group for inputs before submission. This group comprises of the UN Humanitarian Agencies, NGOs, and Government Counterparts.

PART 2: CERF EMERGENCY RESPONSE – CHOLERA (RAPID RESPONSE 2012)

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: 397,720		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	312,440
	OTHER (Bilateral/Multilateral)	4,553,504
	TOTAL	4,865,944

TABLE 2: CERF EMERGENCY FUNDING BY AGENCY (US$)			
Allocation 1 – Date of Official Submission: 31 July 2012			
Agency	**Project Code**	**Cluster/Sector**	**Amount**
UNICEF	12-CEF-087	Water and Sanitation	201,160
WHO	12-WHO-053	Health	111,280
Sub-total CERF Allocation			**312,440**
TOTAL			**312,440**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of Implementation Modality	**Amount**
Direct UN agencies/IOM implementation	163,335
Funds forwarded to NGOs for implementation	21,886
Funds forwarded to government partners	127,219
TOTAL	312,440

About 5,000 cases of cholera and 57 deaths were reported in Ghana in the first six months of 2012. Six out of the 10 regions have been affected with a significant increase in the number of cases in the Brong Ahafo region since week 24 of the year. Although the average Case Fatality Rate (CFR) of 1.26 per cent was relatively low *(WHO - CFS < 1per cent indicates appropriate treatment is in place)*, the figures for Brong Ahafo and Upper East were high at 6.1 per cent and 4.2 per cent, respectively. Anecdotal reports indicate that the high CFR in these regions could be due to the affected communities being poorly prepared for a cholera outbreak; with poor knowledge of the signs and symptoms of cholera; what to do about it and how to prevent it.

The infection rate had slowed in Greater Accra and other areas and, with no further deaths in Upper Eastern and Brong Ahafo Regions, the CFR had declined. However, cholera continued to spread to previously unaffected areas. With the onset of the rains and the large reservoir of infection in Greater Accra, there was a clear need to implement a coordinated and integrated response and prevention plan across the country aimed at helping communities, which were most vulnerable to cholera outbreaks, to protect them from cholera and diarrhoeal diseases.

In many instances, the pattern of spread was rather erratic, due to the general nature of the underlying environmental issues. To that end, many high density urban areas and areas with high transient populations, such as major commercial centres in rural areas, were the most at risk. Delays in reporting of the early outbreak of cholera in the regions led to high case fatality rates. The continued spread of cholera to new districts and across other borders of Burkina Faso and Côte d'Ivoire only increased the threat levels. Furthermore, the unexpectedly severe early outbreak of cholera across the West Africa sub-region in 2012 caused a level two emergency for which the Government of Ghana was unprepared. In support of Environmental Health and Sanitation Directorate (EHSD) under the Ministry of Local Government and Rural Development, in order to help halt the number of cases, UNICEF submitted a request for CERF funds to respond to supply household level water purification tablets, disinfection of shallow unprotected wells in the affected areas and provide communication materials to effectively carry out behaviour change activities.

II. FOCUS AREAS AND PRIORITIZATION

Cholera has become endemic in many parts of the country, especially due to poor basic sanitation, high rates of open defecation (latrine coverage and use is less than 10 per cent) and lack of public awareness in many areas, and children are the most vulnerable due to exposure at school and play. Over 5,000 cases of cholera and 57 deaths had been reported in the first six months of 2012 with six out of the 10 regions being affected. There was, therefore, an urgent need to address the situation before the disease spread to into the unaffected areas.

By August 2012, the water, sanitation and hygiene (WASH) Sector had convened three coordination meetings since May 2012 to review the situation and possible response actions. A joint sectoral rapid assessment was also carried out in the Greater Accra Region and the Eastern Region, which were the worst hit regions at the onset of the outbreak. There was a general lack of preparedness and capacity for effective response and lack of knowledge of the extent of the ongoing epidemic by the general population. There was also the need for advocacy to address the poor WASH environment which has been the root cause of recurrent cholera outbreaks in the country. Separate assessments were carried out in the Atebubu community, which was the epicentre of infections in the Brong Ahafo region, by the EHSD and UNICEF. Key actions identified during the assessments included the supply of household level water purification tablets, increased public education and awareness communication, and disinfection of shallow unprotected wells in the Eastern and Brong Ahafo Regions.

The main aim of UNICEF was to improve the overall risk perception and hygiene practices of communities living in cholera-prone areas through the communication for behavioural and social change activities. The approach aimed at strengthening the capacity of communities to identify their own needs even in emergency situations, to assess the options available to them, and to take action.

The overall project thus included three main components:

- Public education and awareness communication nationwide, particularly using media (radio and TV) with key focus on the Greater Accra, Eastern, Brong Ahafo and Upper East Regions.
- Disinfection of about 1,500 shallow unprotected wells, mainly in the Eastern Region and the Atebubu Area in the Brong Ahafo Region.
- Distribution of household level water purification tablets to households in key areas in the Eastern and Brong Ahafo Regions, including user education.

The original proposed geographical coverage was Greater Accra, Eastern, Brong Ahafo and Upper East Regions, however by the eighth and nineth months, the outbreak had spread to the Volta, Central and the Northern Regions. In turn, the activities covered all of these affected regions in addition to the GAR, Eastern, Brong Ahafo and the Upper East regions that were in the original proposal for the CERF funds.

There was the need for the frontline health workers to be trained in interpersonal communication (IPC) and social mobilization (SM) skills to carry out the activities to further expand awareness-raising and communication activities to reach cholera affected communities.

Soon after the training these frontline workers were deployed to the communities to carry out effective communication initiatives with enhanced skills to interact with community members which contributed to a reduction in number of cases from these affected areas.

In the case of WHO, Western (WR), Brong Ahafo (BAR) and Upper East (UER) Regions were prioritized for CERF Funding because all had higher proportions of people being affected. There were also problems of late diagnosis, reporting, little awareness and knowledge of cholera and possibly, sub-optimal treatment of people sick from cholera that needed to be improved as well as gaps in surveillance that needed to be addressed. The fatality rates in these regions – 1.2 per cent, 2.8 per cent and 3.5 per cent for Western, Brong-Ahafo

and Upper East Regions, respectively – were also unacceptably higher than WHO standards in emergency situation of 1per cent. Atebubu District in the BAR had an alarming CFR of 3.8 per cent. This assessment data was the justification for this proposal focusing on these prioritised regions, which had the potential of spreading across the international borders at Jomoro and Kasena Nankana districts of Western and Upper East Regions, respectively.

III. CERF PROCESS

There was joint engagement between the UN and Government from the onset of the cholera outbreak, which culminated into a number of coordination meetings and joint assessments to affected areas. An initial coordination meeting of the WASH Sector Working Group, comprised of the main partners from the government, civil society organizations, non-governmental organizations and the UN in the water and sanitation sector, was convened by UNICEF in May 2012 to review the cholera situation and possible response actions. This was followed by meetings involving the UN Inter-Agency Working Group for Emergencies, who met on 22 June 2012, and a technical group, comprising of medical practitioners and experts on water and sanitation, meeting on 10 July 2012. The outcome of these meetings resulted in joint-sectoral assessment missions to the Greater Accra and Eastern Regions, which were the worst hit at the onset of the cholera outbreak. Separate assessments were also carried out in the Atebubu community, the epicentre of infections in the Brong Ahafo region, by the EHSD of the Ministry of Local Government and Rural Development, WHO and UNICEF.

Key areas for intervention identified during these assessments included: supply of household level water purification tablets, public education and awareness communication, as well as disinfection of shallow unprotected wells. In addition, gaps in cholera surveillance and case management were also identified by the health cluster as critical areas that CERF funds should be used to address.

The Environmental Health and Sanitation Directorate on behalf of the Government of Ghana subsequently requested support from the UN System for supply of household level water purification tablets and disinfection of shallow unprotected wells in the area to combat the cholera outbreak

In view of the gaps in cholera surveillance and case management, the funding support benefitted these vulnerable populations through: (i) Community-based sensitization to create immediate awareness on methods of reducing the spread of cholera while improving care seeking behaviour; (ii) Enhanced surveillance for diarrhoeal diseases; and (iii) Strengthening case management and data quality and timely sharing of data with development partners. The activities to achieve these objectives included:

- Capacity building in surveillance to enhance early case detection and reporting
- Intensifying diarrheal surveillance including improving case investigation and prompt laboratory confirmation at the peripheral operational level in the most affected areas in concerned districts
- Procurement of laboratory reagents and supplies to support early laboratory diagnosis
- Community-based sensitization through the use of IEC material and community based interventions
- Printing of updated Standards of Practices (SOPs) and Guidelines for distribution to health facilities to enhance clinical diagnosis and effective treatment and management of cases seen at health facilities in the most affected areas in concerned districts

The community sensitization posters were equally targeted at women, girls, boys and men in each of the project elements listed above at both the community and facility levels. Both male and female health workers benefitted from the training conducted for the respective project elements to enhance delivery in each of the areas at the facility and community levels.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR

Total number of individuals affected by the crisis: 452,010

The estimated total number of individuals directly supported through CERF funding by cluster/sector	**Cluster/Sector**	**Female**	**Male**	**Total**
	Water and Sanitation	29,000	28,000	57,000
	Health	24,000	16,000	40,000

Estimates of beneficiaries for the disinfection of household wells was estimated at about 20 persons (maximum), based on the fact that many of the wells are typically shared between three to five households (of five persons on the average), sometimes on a commercial basis. Communal wells, however, are estimated to cover up to 150 people, based on the guidelines provided by the Community Water and Sanitation Agency (CWSA). The relative proportion of male and female beneficiaries is based on the national population proportion of about 51 per cent female to 49 per cent male.

The estimates for the total number of beneficiaries in the communication and public awareness hinged on many informal indicators, based on the targets in the affected areas. For instance, an estimated 62 per cent of church members targeted are females and 38 per cent males; 70 per cent of women from the affected communities are in the markets and about 25 per cent are in the mosques; and about 65 per cent of males make up the lorry parks crowd. During the trainings, absolute numbers of beneficiaries reached 176 females and 144 males. For mass media activities (TV, Radio and mobile van), estimates were made using the medium's own audience reports for its health segments. About 25 per cent from approximately 825,000 affected individuals from different groups benefited from more than one channel. The difficulty in these estimates was that it was based on the groups' reports and not facts. Because communication mileage is not restrictive, it is a fact that many more people have benefited directly from these education and awareness creation than the given estimates. This includes secondary beneficiaries, who were educated through other outreach programmes in the various communities as well as jingles and spots played on various mediums. The estimated cascading effect is three.

In terms of added value, the CERF funds made an essential contribution towards building sustained institutional capacity for early warning and surveillance by training laboratory and surveillance officers in enhanced surveillance and rapid detection of cholera cases. As a result, weekly reporting has become regular with improved data presentation including mapping. In addition, CERF funding allowed to print standard operating procedures and case management protocols so they could be used by frontline health workers in the affected districts.

The CERF funding also proved useful in the case of Ghana, due to its quick availability which allowed for timely and effective assistance. Procuring commodities locally requires time. Even more time is usually needed for internationally procured commodities. Access to the CERF funds enabled timely procurement, delivery and distribution of commodities resulting in the achievement of outcomes set out for the Emergency Operations.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING

	Planned	Estimated Reached
Female	24,000	29,000
Male	16,000	28,000
Total individuals (Female and male)	40,000	57,000
Of total, children under 5	10,000	20,000

CERF Results:

- Disinfection of about 1,500 shallow, unprotected wells in the Eastern Region and in the Atebubu community (Brong Ahafo Region) and its surrounding areas.
- Distribution, including user education, of 2,600,000 water purification tablets to serve about 40,000 people in the Eastern, Brong Ahafo and Upper East, Volta, Central, Northern and Ashanti Regions.
- As many as 305 frontline health workers including Environmental Health, Community and Public Health, Health Promotion, Disease Control and Surveillance Officers, Volunteers from Ghana Red Cross Society, NADMO, Food and Drugs Board, Information Services and representatives from the District Assemblies were trained in IPC and SM skills. They were also oriented on the use of the cholera communication materials to help them effectively carry out behavior change campaigns in the seven regions as part of the response efforts. The trained and equipped frontline health workers in Eastern, Greater Accra and Northern Regions also carried out orientation sessions on cholera response and prevention techniques for 200 community volunteers and community groups. The community volunteers and trained frontline workers divided themselves into groups to provide hygiene behavior change messages targeting lorry stations, food vendors, schools, churches and mosques in selected communities reaching over 900,000 individuals.
- Awareness education were conducted through eight TV discussion programmes on four major TV stations (TV3, GTV, Metro TV and TV Africa) with nationwide coverage reaching about 60per cent of the general population using English, Twi and Ga.

- About 20 live radio broadcasts of Cholera discussions were held on four radio stations with wide regional coverage in Eastern, Central, Brong Ahafo and Volta Regions as well as about 15 community information centres. This together with the TV discussions and inter-personal communication activities in the affected districts cumulatively reached more than 5,000,000 individuals.
- A total of 700 spots of cholera jingles were played on five selected radio stations (one per region) with wide regional coverage to increase awareness on cholera infection, mode of transmission and preventive measures.
- Around 500 copies of the radio messages on Cholera in eight local languages and English were been made available to the trained frontline health workers from the seven regions, the affected MMDAs and other government agencies involved in the response. Messages were played in information vans, community information centres and public address systems across the affected metropolises, municipalities and districts to educate the general public on cholera public, reaching about 60per cent of the affected communities.
- About 500 copies of the *Story of Cholera* video documentary was made and distributed to all the trained frontline health workers and the district assemblies. These were used for group discussions, mosque and church outreaches, lorry park outreaches, shown in classrooms and displayed at community durbars to educate the community members on cholera, its causes, symptoms and treatment. The video was also played at Out Patient Departments (OPDs) and inpatient wards of the KorleBu Teaching Hospital in Accra and the Asafo Health Centre of the Eastern Region. To date, the video has been used to reach over 500,000 individuals.
- Over 3,200 school children from ten basic schools in Accra Metro of the GAR have been educated on key behaviours to protect themselves against cholera through class by class education. Of these school children, 200 have also taken part in an art competition out of which five best art works have been chosen to be printed on the school walls for continued education on cholera and other diarrheal diseases.
- 60 Community and religious leaders were sensitized and Focus Group Dialogues organized for 400 food vendors, 300 water vendors and distributors and 300 public toilet operators in Greater Accra, Eastern and Northern Regions.

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?
YES ☒ PARTIALLY ☐ NO ☐

The CERF funds supported the training of laboratory and surveillance officers in enhanced surveillance and rapid detection of cholera cases. Consequently, early warning and surveillance improved and, as a result, weekly reporting became regular with improved data presentation including mapping. The printing of cholera SOPs and case management protocols made available standardized case definition and case management tools for use by frontline health workers in the affected districts. The distribution of cholera posters also helped to educate men, women and children on and, potentially reduce the spread of the disease and number of cases.

Additionally, rapid disinfection of hand-dug wells in the Atebubu community of the Brong Ahafo Region and the other communities in the Eastern Region and the distribution of household water treatment chlorine tablets helped in the immediate breaking of the transmission chain from contaminated water. The CERF funds assisted in the rapid mobilization of the communities to educate them on the outbreak of the disease, its symptoms and the immediate actions to take if any individual experienced any of the symptoms. The funds also enabled UNICEF to stretch assistance to other parts of the country outside our focused regions. This assistance addressed the immediate response which propelled government agencies with follow up actions/ activities. For instance, IPC skills for public health workers in Greater Accra equipped them to undertake effective social mobilization and community education with the appropriate print and audio materials. Availability of IEC materials made the Metro Department release their vans for mobile announces and education in affected and high risk communities.

b) Did CERF funds help respond to time critical needs[1]?
YES ☒ PARTIALLY ☐ NO ☐

:

The availability of the CERF funds facilitated the procurement of cholera rapid diagnostic test kits, which were used by trained district level staff to rapidly diagnose cholera in minutes. Transport media were also procured to enable transport of samples from sub-district facilities to enhance accurate diagnosis.

[1] *Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns; locust* control)

Additionally, rapid disinfection of hand-dug wells in the Atebubu community of the Brong Ahafo Region and the other communities in the Eastern Region and the distribution of household water treatment chlorine tablets helped in the immediate breaking of the transmission chain from contaminated water. The CERF funds assisted in the rapid mobilization of communities to educate them on the outbreak of the disease, its symptoms and the immediate actions to take if a community member experienced any of the symptoms and this helped in the reduction of number of victims that died (reducing CFR that were very high from the onset of the outbreak).

c) Did CERF funds help improve resource mobilization from other sources?

YES ☒ PARTIALLY ☐ NO ☐

The Metropolitan, Municipal and District Assemblies (MMDAs) of the affected districts contributed in providing vehicles (fuelled) for the outreach work, information vans for playing the jingles and radio messages, chlorine powder for disinfection of the wells and volunteers who spent their time going door-to-door to create awareness and distribute chlorine tablets.

d) Did CERF improve coordination amongst the humanitarian community?

YES ☒ PARTIALLY ☐ NO ☐

The CERF has improved coordination through regular reporting of data to implementing agencies and other partners, collaboration with UNICEF, WHO, Resident Coordinator's Office (RCO) through sharing of information on progress being made and synergizing activities.

The activities, funded by CERF, enabled the convening of WASH Sector Emergency Coordination Meetings, bringing together all the actors and government agencies in the WASH sector. These actors included UNICEF Ghana Office (WASH and Communication for Development), WHO, EHSD, Water Directorate, Community Water and Sanitation Agency (CWSA), representatives from National Disaster Mangement Organization (NADMO), Environmental Health and Sanitation Directorate of the Ministry of Local Government and Rural Development (MLGRD), the Water Directorate of the Ministry of Water Resources, Works and Housing (MWRWH), Water Aid Ghana, Ghana Urban Water, Health Promotion Department (HPD) of Ghana Health Service (GHS), and School Health Education Program (SHEP) of the Ghana Education Service (GES). Another similar meeting that was organized was the Cholera Communication Sub-Committee that also brought together communication experts from the School Health Education Programme (SHEP), UNICEF, Media, National Disaster Mangement Organization (NADMO), and Health Promotion Department (HPD)/GHS to review the cholera response and communication plan that had been developed by UNICEF with CERF Funds. The implementation of the communication plan also brought all the actors in the humanitarian community together (for instance, radio and TV discussions, organized by NADMO, brought together experts and resource persons from GHS, EHSD, HPD and other places).

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT

Lessons Learned	Suggestion For Follow-Up/Improvement	Responsible Entity

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS

Lessons Learned	Suggestion For Follow-Up/Improvement	Responsible Entity
The erratic pattern of spread of the cholera outbreak suggests that the entire country is at risk. Crowded urban areas which frequently host major events, such as markets and funerals seem to be the most at risk.	There is need for an urgent drive to address the issues of open-defecation (unsafe excreta disposal) and to promote hand washing with soap and household water treatment and safe storage across the country, especially in the crowded, urban areas.	MLGRD
Rapid response is very critical to curbing the spread of cholera and saving lives.	Agencies should always have some funds on hand to start the response process while sourcing for funds from donor.	UN agencies

An objective may appear feasible at the proposal development stage, but may prove difficult to achieve within the allotted implementation time and may call for adjustment. One of the objectives was to ensure effective community-based BCC for sensitizing and soliciting the community for participatory cholera containment campaign using Red Cross as implementing partner	Periodic evaluation of implementation of activities will inform the need for adjustment to be able to achieve set targets.	UN system

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF Project Information			
1. Agency:	**UNICEF**	5. CERF Grant Period:	01-07-2012 – 31-03-2013
2. CERF project code:	**12-CEF-087**	6. Status of CERF grant:	☐ On-going[2]
3. Cluster/Sector:	Water and Sanitation		☒ Concluded
4. Project Title:	Cholera response to children's needs: Public awareness and support to safe drinking water in four regions affected by the cholera outbreak		
7.Funding	*a. Total project budget:*	US$ 253,000	
	b. Total funding received for the project:	US$ 253,000	
	c. Amount received from CERF:	US$ 201,160	

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	24,000	29,000	The well disinfection exercise in the Eastern Region covered some communal wells, which typically serve up to 150 persons, as compared to the household wells, which may serve up to 20 persons. Furthermore the exercise covered a total of 170 wells, instead of the 60 originally planned. The planned figures for the communication aspect were for affected districts in five regions; however, by the time the funds were received, more districts had been affected. As a result, instead of district trainings, there were regional trainings which enabled the trainees to reach more people than originally planned. Additionally, in order to be able to bring the situation under control swiftly, more mass media (Radio, TV, Mobile Van and PA system) was used, and this expanded the reach of individuals.
b. Male	16,000	28,000	
c. Total individuals (female + male):	40,000	57,000	
d. Of total, children under 5	10,000	20,000	

9. Original project objective from approved CERF proposal

- Enhancing access to safe water to 40,000 people in the Eastern, Brong Ahafo and Upper East Regions.
- Promote positive health and hygiene behavior in selected districts, with focus on eliminating the practice of open defecation and strengthening hygiene practices, such as hand washing with soap, at critical times and household water treatment in order to limit the outbreak of diseases, such as diarrhoea and cholera

10. Original expected outcomes from approved CERF proposal

[2] UNICEF was granted a no cost extension from the CERF Secretariat.

- About 40,000 people in the Eastern, Brong Ahafo and Upper East Regions have improved access to safe drinking water to avert further cholera infections
  About 2 million people nationwide on the cholera outbreak, including school children have enhanced awareness and practice safe sanitation and hygiene behaviours to halt the further spread of the disease

11. Actual outcomes achieved with CERF funds

Main response has been based on UNICEF support, through the disinfection of 1,500 shallow, unprotected household wells at Atebubu (BAR), which was reinforced through the distribution of Aquatabs (2,260,000 tablets – 30,000 people for about 65 days.

An additional 170 wells have been disinfected in the Birim Central, New Juaben and Suhum Kraboa Coaltar Districts of the Eastern Region, enhancing access to safe water for about 57,000 people. Again, as a result of the communication activities, the targeted population have enhanced awareness and have started practicing safe sanitation and hygiene behaviours to halt cholera outbreaks and the spread of the disease.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

UNICEF had initially envisaged that Ghana Health Service (GHS) would implement the entire C4D part of the proposed activities, but after GHS raised concerns, UNICEF had to re-negotiate, which took considerable time. Eventually, UNICEF had to divide up the response activities over three implementing partners namely GHS, National Disaster Management Organization (NADMO) and Environmental Health and Sanitation Directorate. This realignment of the programme led to a negotiation by UNICEF for a three-month no-cost extension from the CERF Secretariat.

This arrangement enabled UNICEF to successfully complete a training programme for 160 frontline health workers as well as other stakeholders in health on Interpersonal communication skills (IPC) and community mobilization. The stakeholders were also oriented on the use of the cholera communication materials to help them effectively carry out behavior change campaigns.

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☐ NO ☒

If 'YES', what is the code (0, 1, 2a, 2b): If 'NO' (or if GM score is 1 or 0): In the programme implementation, it was ensured that both men and women participate in the all activities. In distributing the Aquatabs, for e.g. we ensured that women in the households receive them as well as training the women in its usage.

14. M&E: Has this project been evaluated?	YES ☐ NO ☒

If yes, please describe relevant key findings here and attach evaluation report or provide URL:

TABLE 8: PROJECT RESULTS

CERF Project Information

1. Agency:	**WHO**	5. CERF Grant Period:	28 August 2012 – 27 February 2013
2. CERF project code:	**12-WHO-053**	6. Status of CERF grant:	☐ On-going
3. Cluster/Sector:	**HEALTH**		☒ Concluded
4. Project Title:	**ENHANCING CHOLERA DETECTION, REPORTING, CASE & DATA MANAGEMENT IN 5 REGIONS WITH CHOLERA OUTBREAK IN GHANA**		

7.Funding		
	a. Total project budget:	US$ 144,720
	b. Total funding received for the project:	US$ 111,280
	c. Amount received from CERF:	US$ 111,280

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	24,000	24,000	
b. Male	16,000	16,000	
c. Total individuals (female + male):	40,000	40,000	
d. Of total, children under 5	10,000	10,000	

9. Original project objective from approved CERF proposal

1. To enhance early detection for early case management
2. To improve case management outcome with no death due to cholera infection
3. To strengthen early warning systems through capacity building in data management and reporting
4. To ensure effective community-based BCC for sensitizing and soliciting the community for participatory cholera containment campaign

10. Original expected outcomes from approved CERF proposal

1. Reduction in weekly reported cases and deaths with eventual no death due to cholera
2. Improved case fatality rates due to early treatment seeking behaviour
3. Early detection of cases
4. Improved community based reporting of cases
5. Final containment with no cholera case

11. Actual outcomes achieved with CERF funds

The number of cholera cases steadily declined nationwide over the fourth quarter of 2012 from a high of 700 cases in week 37 to 6 cases in week 52 and 0% case fatality of. In the first 3 weeks of 2013, there were no confirmed cases of cholera reported. In the targeted districts of Kasena Nankana (UER), Atebubu (BAR) and Jomoro (WR), the number of cases declined and eventually reached zero by week 40. In each of these districts, CFR declined from a maximum of 10%, 3.8% and 2.3%, respectively to 0% in the last weeks of the outbreak in each district, signifying early reporting and improved case management. The three districts benefitted from supervisory monitoring visits that included on-the-job coaching on surveillance and reporting. The CERF funds

contribution to the outcomes was in the form of:

- training 40 health officers in enhanced surveillance, reporting and data quality management to improve early warning and timely detection of cases
- building the capacity of 45 laboratory and disease control officers in the rapid diagnosis of cholera and data management
- procurement of laboratory supplies to support timely cholera diagnosis, including 41 Kits Cholera Smart Rapid Diagnostic kits with each containing 25 tests, 4 boxes of Mac Cartney Autoclave tubes that contained 288 bottles per carton and 4 bottles/packets Cary Blair Medium 500g (used for transporting samples for laboratory testing)
- printing of 3,000 Cholera Standard Operating Procedures, which also includes guidelines and treatment protocols to facilitate prompt management according to standard guidelines
- printing of 42,000 cholera posters for distribution to targeted districts to raise awareness on the disease

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

The actual outcomes were achieved.

13. Are CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☐ NO ☒

If 'YES', what is the code (0, 1, 2a, 2b):

If 'NO' (or if GM score is 1 or 0): The community sensitization posters were equally targeted at women, girls, boys and men in each of the project elements listed above in both the community and facility levels. Both male and female health workers benefitted from the training conducted for the respective project elements to enhance delivery in each of the areas at the facility and community levels.

14. M&E: Has this project been evaluated?	YES ☐ NO ☒

If yes, please describe relevant key findings here and attach evaluation report or provide URL**:**

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/ Sector	Agency	Partner Name	Partner Type	Total CERF Funds Transferred To Partner US$	Date First Installment Transferred	Start Date Of CERF Funded Activities By Partner	Comments/ Remarks
12-CEF-087	WASH	UNICEF	RWDP CoC	NGO	21,886.24	24.09.2012	24.09.2012	
12=CEF-087	WASH	UNICEF	EHSD/MLGRD/GHS	Government	109,216	24.09.2012	24.09.2012	The main reason for the increase in allocations for the government partners was due to increased capacity of the government counterparts to respond to the emergency. The fact that UNCIEF was able to work with the Emergency team coordinated by the National Agency for Disaster Management helped expand the partnership with Government.
12- WHO-053	Health	WHO	GHS/MoH	Government	18,000	15.08.2012	28.08.2012	WHO directly procured the laboratory reagents as well as printed the guidelines and treatment protocols for management of cholera instead of MOH. The reason for the direct procurement was to avoid delays that usually occur during MOH procurement processes. With the on-going cholera epidemic, making the reagents and document available was a time bound activity. WHO therefore decided to limit the delays given that the CERF disbursement and implementation needed to

								take place a certain time frame. Also, the Red Cross failed to implement the behavioural activities on hygiene messages as planned due to inadequate internal arrangements

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

BAR	Brong Ahafo
BCC	Behaviour Change Communication
C4D	Communication for Development
CFR	Case Fatality Rate
CWSA	Community Water and Sanitation Agency
EHSD	Environmental Health and Sanitation Directorate
GES	Ghana Education Service
GHS	Ghana Health Service
HPD	Health Promotion Department
IPC	Interpersonal Communication
MLGRD	Ministry of Local Government and Rural Development
MoH	Ministry of Health
MMDA	Metropolitan, Municipal and District Assemblies
MWRWH	Ministry of Water Resources, Works and Housing
NADMO	National Disaster Mangement Organization
RWDP CoC	Rural Water Development Programme of the Church of Christ
SHEP	School Health Education Programme
SM	Social mobilization
SOP	Standard of Practice
UER	Upper East Region
WASH	Water, sanitation and hygiene
WR	Western Region