RESIDENT/HUMANITARIAN CORDINATOR REPORT 2012 ON THE USE OF CERF FUNDS SIERRA LEONE

RESIDENT/HUMANITARIAN COORDINATOR	Mr. Jens A. Toyberg-Frandzen

PART 1: COUNTRY OVERVIEW

I. SUMMARY OF FUNDING 2012

<table>
<tr><th colspan="3">TABLE 1: COUNTRY SUMMARY OF ALLOCATIONS (US$)</th></tr>
<tr><td rowspan="4">Breakdown of total response funding received by source</td><td>CERF</td><td>2,461,235</td></tr>
<tr><td>COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (if applicable)</td><td>0</td></tr>
<tr><td>OTHER (Bilateral/Multilateral)</td><td>10,914,703</td></tr>
<tr><td>TOTAL</td><td>13,375,938</td></tr>
<tr><td rowspan="5">Breakdown of CERF funds received by window and emergency</td><td>Underfunded Emergencies</td><td></td></tr>
<tr><td>First Round</td><td>0</td></tr>
<tr><td>Second Round</td><td>0</td></tr>
<tr><td>Rapid Response</td><td></td></tr>
<tr><td>Cholera</td><td>2,461,235</td></tr>
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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 ☐

RC discussed with UNICEF and WHO during preparation stages of the report as well as the final reports

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:		7,010,865
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	2,461,235
	OTHER (Bilateral/Multilateral)	10,914,703
	TOTAL	13,375,938

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-090	Water and Sanitation	1,649,014
WHO	12-WHO-055	Health	812,221
Sub-total CERF Allocation			**2,461,235**
TOTAL			**2,461,235**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of Implementation Modality	**Amount**
Direct UN agencies implementation	796,758
Funds forwarded to NGOs for implementation	733,258
Funds forwarded to government partners	118,998
TOTAL	**1,649,014**

Cholera was suspected as early as November 2011. The first laboratory confirmation of cholera in Sierra Leone was on 16 February 2012 and the Government declared an outbreak on 17 February 2012. The outbreak started in the districts of Kambia and Port Loko, bordering Guinea, and later spread to all 13 districts.

The outbreak had a cross border dimension, particularly with Guinea, where the outbreak started on 6 February in Forecariah prefecture. The border between the two countries is porous and there is constant movement of local populations along and across the border, for commerce and fishing activities. Some of the communities along the border share resources, i.e. access to water.

During the earlier phase of the outbreak, the high CFR particularly noted for Kambia could have been an indication of poor case management, inadequate supplies or late reporting at health facility. Water samples from the district were found to be contaminated with Vibrio cholerae and other organisms posing a risk for continued spread and morbidity in the population of affected areas.

Kambia being on the border with Guinea, where a cholera outbreak was declared in February 2012, and Pujehun being on the border with Liberia, where cholera is endemic, raised the risk of further spread due to cross-border commercial activities. Port Loko borders the Western Area with a high population density and very mobile people. These factors were compounded by the approaching rainy season starting in May/June 2012 creating the potential for a rapid spread of cholera.

While the number of cases remained low during the first months of 2012, cholera spread rapidly in the overcrowded urban environment of Freetown (Western Area) at the onset of the rains in May 2012. Disease surveillance systems provided early warning that a large-scale outbreak was under way in late June, with the first laboratory-confirmed case in the densely populated Western Area on 16 July. This outbreak was publicly announced on 17 July 2012.

Cumulative cases registered by August stood at 6,174 cases of cholera and 115 deaths. The critical risk of cholera spreading through Freetown due to the overcrowded slum areas and limited access to safe drinking water and sanitation became apparent with cases rising exponentially. The national Case Fatality Rate (CFR) as of August 2012 stood at 1.9 per cent with 2.8 per cent in Kambia, 1.8 per cent in Pujehun, 1.3 per cent in Port Loko, 1.8 per cent Western Area, 3.64 percent in Bo and 5.1 per cent in Bombali.

Consequently, a CERF Rapid Response application process was launched in July 2012 and an appeal sent by 17 July 2012. This mechanism was led by UNICEF and WHO. At the time, the worst case scenario expected a maximum of 9,000 cases and approximately US$5 million were requested to scale up health, water, sanitation and hygiene (WASH) and social mobilization activities. In August, the number of cases increased 148 per cent during the month from 6,184 across eight districts to more than 15,000 cases across twelve districts. The number of fatalities also more than doubled from 115 on 1 August to 249 by 27 August. On 23 August, worst-case-scenario projections made by CDC on behalf of MoHS suggested as many as 33,000 cases would be reported of which 513 might die.

The CERF Proposal was submitted with an initial 7 INGO (ACF, Save the Children, CONCERN, GOAL, OXFAM, Sierra Leone Red Cross); However, UNICEF commenced the response with NNGO that were already based in the hotspot locations that had regular programming taking place; this NNGO constituted Search for Common Ground, CTF and CAWEC. Hence additional amount of US$ 68,653 was utilized in hygiene promotion campaigns, safe water supply and monitoring.

II. FOCUS AREAS AND PRIORITIZATION

Through ongoing surveillance data reported weekly, it was noted that an increasing number of diarrhoea and vomiting (D&V) cases were being reported in Sierra Leone from 2 November 2011. By the first week of January 2012, Kambia, Moyamba, Port Loko and Pujehun, as well as Freetown in Western Area, reported a high number of D and V cases.

Missions were undertaken to the affected districts to assess the situation on the ground from 24 to 25 January and from 6 to 11 February 2012. The assessment was undertaken by national officers of MoHS, laboratory personnel, partners (including WHO and UNICEF) and members of the district health directorates. The team reviewed documents in the districts, health facility register and patient records and they collected stool and water samples for laboratory analysis. Vibrio cholerae was confirmed in the samples from Kambia and Port Loko districts.

Following these assessment missions to Kambia and Port Loko, and with the confirmation of cholera in stool and water samples, MoHS subsequently declared an outbreak of cholera in these districts.

In view of the reported increase in the number of D&V cases in other districts and given the mobility of the population, the risk of cholera spreading to other districts of the country was high, particularly to those contiguous to the affected districts, such as the Western Area, where the capital Freetown is. This called for a concerted effort to address the epidemic and prevent its spread through effective coordination, surveillance, good case management and prevention, hygiene promotion, communication and social mobilization activities, as well as access to safe water.

Cholera was confirmed in a stool sample from an adult female index case who died at Yeliboya – an island community situated in the Atlantic Ocean in Kambia. The water supply to this community is reported to be brought in from contaminated water points outside the island. Poor toilet facilities also pose a risk for contaminating water bodies. More than 20 other primary health care units (PHU) and several villages in the Chiefdoms in Kambia also reported cases of diarrhoea. The assessment in Kambia showed that as of 19 February 2012, a total of 385 cases with 13 deaths had been reported and that the CFR was 3.3 per cent. By 6 March the number of affected people had reached 490.

Of those affected, about 70 per cent were above five years and just over half (52 per cent) were females. Yeliboya alone accounted for about one third (34 per cent) of the cases from Kambia. In Port Loko, as at 6 February 2012, 311 cases were recorded with profuse watery diarrhoea and severe dehydration and two had died, which represented a CFR of 0.64 per cent. By 6 March 2012, the respective figures in Port Loko were 1168 cases, eight deaths and a CFR of 0.7 per cent. Cases were also reported from more than 12 chiefdoms. The first vibrio cholera confirmed case was in a stool specimen of an adult male at Menika PHU.

Due to the rapid spread of the outbreak to other parts of the country, the geographical intervention coverage expanded from the original 6 (Western Area, Kambia, Pujehun, Port Loko, Bombali and Bo) to 12 districts, the additional six districts being Kenema, Bonthe, Moyamba, Tonkolili, Koinadugu and Kono.

III. CERF PROCESS

Given the scenario, an assessment in these districts indicated a cholera outbreak with an urgent need for a rapid coordinated response to strengthen surveillance to monitor the trends and identify newly affected areas for interventions, treat and reduce spread from contaminated water sources, stockpile supplies and logistics and improve case management to decrease the CFR. There was also a need to intensify community sensitization through health education on safe water, good hygiene and environmental sanitation practices. While addressing these issues in the affected districts, it was also prudent to scale up preparedness in the other districts that had not yet reported cases to detect a possible outbreak as early as possible.

The National Cholera Task Force convened on weekly basis by the MoHS; participants include UNICEF, WHO, MSF Belgium, Urban WASH Consortium members (ACF, Oxfam, Concern, GOAL and Save the Children) and local WASH partners (Sierra Leone Red Cross), worked jointly with the Ministry of Health and Sanitation, the Ministry of Water and Energy Resources to evaluate the situation and identify trends and gaps. As the outbreak continued to spread, the UNCT on 17 July 2012 formally tasked WHO and UNICEF to continue their efforts to engage with the MoHS and other stakeholders including NGOs, such as MSF and ACF, and to launch a CERF Rapid Response appeal to seek urgent funding for the above mentioned lifesaving interventions. The response was based on affected population without gender focus. WHO and UNICEF created a technical working group, which developed the technical aspects of the CERF application, alongside the overall coordination by the Office of the Resident Coordinator. This technical working group met at least weekly from mid-July until it merged with the Cholera Control and Command Centre (C4) (see section IV-d below) when it was established on 27 August 2012.

IV. CERF RESULTS AND ADDED VALUE

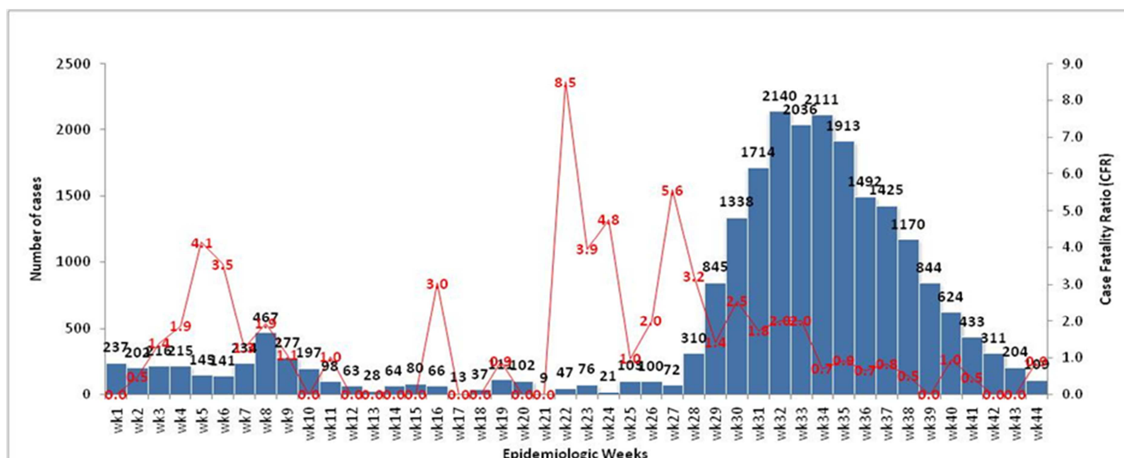
TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR				
Total number of individuals affected by the crisis: **3,459,453**				
The estimated total number of individuals directly supported through CERF funding by cluster/sector	**Cluster/Sector**	**Female**	**Male**	**Total**
	Water and Sanitation	1,721,781	1,737,672	3,459,453
	Health	1,721,781	1,737,672	3,459,453

At the time of the CERF application, six districts, namely the Western Area, Port Loko, Kambia, Pujehun, Bo and Bombali had been affected by cholera. In view of the fact that cholera is highly infectious, the total district populations were considered as target populations. An estimated 2,571,989 persons in the remaining seven districts in Sierra Leone were considered as potentially indirect beneficiaries due to cholera transmission dynamics.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	**Estimated Reached**
Female	1,737,672	1,737,672
Male	1,721,781	1,721,781
Total individuals (Female and male)	3,459,453	3,459,453
Of total, children under 5	615,782	615,782

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

The activation of the CERF process coincided with a surge in the number of cases by week 29 of the cholera epidemic after which it continued to rise for several weeks, as shown in the graph below:



The CERF funds led to fast delivery of assistance to beneficiaries as the Ministry of Health and Sanitation managed to mobilise a critical number of health workers to participate in the key intervention areas (surveillance, laboratory confirmation, case management and infection control, WASH, social mobilisation, case investigations and follow ups) of the response. These were deployed to the affected communities where treatment centres were established thus improving access to care in line with WHO guidelines. Through CERF funding the health workers were trained in case management, infection risk mitigation and control which resulted in the efficient management of cases. Health promotion messages were disseminated at treatment centres as well as in the communities resulting in the implementation of preventive measures by communities and early care seeking that resulted in the reduction of complications and deaths.

Rapid response teams were trained and established. They conducted investigation and identified risk factors which were communicated to implementing partners. The teams comprised one District Medical Officer, one District Health Sister, two District Surveillance Officers, one District Social Mobilisation Officer, one District Laboratory Technician, one District Health Superintendent, one District Environmental Health Officer, and one District Monitoring and Evaluation Officer.

Surveillance mechanisms including laboratory confirmation were put in place for monitoring hot spots as well as trends of acute diarrhoeal in the all the districts. This facilitated reprioritisation of response activities.

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

The CERF funds helped respond to a critical need in a timely manner for which there were insufficient resources available in-country. By the time of placing the CERF request, only ACF, MSF and UNICEF could partially mobilized some financial resources. All other organizations responded to the epidemic rapidly upon receipt of CERF funds and later mobilization of funds from other donors took effect.

Laboratory surveillance is critical in cholera epidemic control as this provides critical evidence in the progression of the epidemic. When the cholera epidemic commenced in Sierra Leone, the laboratories in the country did not have the capacity to confirm. Samples were shipped outside the country for confirmation and it would take up to two weeks to get results. The CERF funds facilitated provision of reagents and supplies for the confirmation of cholera. This was also made possible through training of laboratory scientist at CPHRL. Training of laboratory staff and clinicians in sample collection and analysis was conducted through international staff mobilised through WHO support. Laboratory confirmation was critical in guiding interventions and also helped to confirm epidemics in new areas as well as monitoring of transmission at the tail end epidemic. CERF funds covered expenses related to redeployment of staff by the MoH even to remote hard-to-reach areas (riverine communities, areas without a road network, and mountainous areas) thus allowing timely management of suspected cases in these areas which contributed to curb the transmission curve as well as the CFR in these areas.

[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)

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

YES ☒ PARTIALLY ☐ NO ☐

Initially it was difficult to mobilize resources without a declaration of cholera outbreak by the Government. However, following the arrival of the CERF Rapid Response funds, donors, i.e. DFID, OFDA Irish Aid and later the AfDB, commenced resource mobilization. In addition to funding, the demand for additional international support from other WHO offices became apparent while the proposal only accommodated two consultants. Epidemiologists, clinicians, laboratory scientists, logisticians, environmental health and social mobilisation experts were engaged. This necessitated additional resources to be mobilised to cater for the human resources and to enhance cholera control activities in other districts that were not part of the CERF proposal. Early positive results in districts covered by the CERF funds encouraged other donors to provide additional support for the extension of cholera control interventions to other districts.

d) Did CERF improve coordination amongst the humanitarian community?

YES ☒ PARTIALLY ☐ NO ☐

Coordination through the cholera task force had commenced prior to receipt of CERF funds. Coordination further improved following the joint launching of the appeal and the joint planning of the response. The coordination was effectively carried out among 1) cholera task force members (Ministry of Health and Sanitation (MoHS) NGOs, UNICEF, WHO and Red Cross) and 2) UNICEF and WHO.

Upon receipt, the WASH Social Mobilization became more active with improved coordination. A cholera coordination mechanism was established at the President's Office, and a Command and Control Centre was established at WHO.

The CERF funding helped to improve coordination among the partners who participated in the response to the epidemic. The response to the cholera epidemic was coordinated through the Ministry of Health and Sanitation supported by the United Nations, international organizations and NGOs at various levels of operation. WHO supported MoHS to establish the Cholera Control and Command Centre (C4) at national level which provided strong health sector leadership and technical coordination for the cholera epidemic response. The C4 standardized reporting of cases to understand their distribution, to guide treatment priorities and to inform prevention messages. The C4 was composed of five thematic technical working groups: case management, surveillance and laboratory, WASH, social mobilization and logistics. A representative of the multi-sectorial national cholera taskforce constituted the C4 core group.

WHO supported the establishment of district level coordination structures which facilitated coordination of NGOs and other partners at that level.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons Learned	**Suggestion For Follow-Up/Improvement**	**Responsible Entity**
WHO mandate is mainly technical support. During the epidemic, support was solicited from WHO HQ, AFRO and IST/WA which required more funds for personnel. Funds allocation for personnel was grossly inadequate	There is need to revisit the proportion of funds allocated for personnel.	CERF secretariat
Response to epidemic is dependent on the capacity of the country to manage epidemics prior to emergency. The country was not well prepared to respond to the epidemic. The funds were stretched beyond the emergency.	There is need to consider funding for preparedness and response activities outside the epidemic period.	CERF secretariat

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons Learned	**Suggestion For Follow-Up/Improvement**	**Responsible Entity**
The epidemic facilitated collaboration at all levels between government and partners	Establish and maintain emergency management committee with a minimum of quarterly coordination meetings	MoHS, ONS
Multi-sectorial and multi-year preparedness and response plans are critical for guiding line ministries, NGOs, UN Agencies and international organisations to prepare and respond to epidemics	Develop, distribute and implement multi sectorial and multi-year cholera preparedness and response plans	MoHS, line ministries, UN Agencies, international organisations, NGOs, civil societies/organisations
There was no specific budget line for preparedness and response activities and prepositioning of strategic stocks	Allocate funds for preparedness and response, purchase and prepositioning of strategic stocks	Ministry of Finance/MoHS/, line ministries and partners
Risk factors persist in the environment and there is potential for future epidemics.	There is need to improve provision of safe water supply and ensure improved sanitation	MoHS, line ministries and partners
National reference laboratory did not have capacity to confirm outbreaks. This capacity has been built but is still fragile.	There is need to support continuous functionality and sustainability including quality control of CPHRL. In addition there is need to expand to regional and district laboratories	MoHS

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF Project Information			
1. Agency:	**UNICEF**	5. CERF Grant Period:	17 July 2012 – 16 Jan 2013
2. CERF project code:	**12-CEF-090**	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	WASH		☒ Concluded
4. Project Title:	Emergency rapid response to cholera outbreak in Sierra Leone		

7. Funding		
	a. Total project budget:	US$ 4,889,893
	b. Total funding received for the project:	US$ 3,149,014
	c. Amount received from CERF:	US$ 1,649,014

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	1,737,672	1,203,881	69 per cent of the total beneficiaries were reached in the intervention. The originally planned figure was based on the projected attack rate, however, the cholera cases started to drop at week 35, i.e. five weeks after receipt of CERF funds.
b. Male	1,721,781	1,192,872	
c. Total individuals (female + male):	3,459,453	2,396,753	
d. Of total, children under 5	615,782	426,621	

9. Original project objective from approved CERF proposal:

The main objective is to reduce morbidity and mortality rates caused by the cholera outbreak in Sierra Leone.

Specific objectives are to:

- Strengthen multi-sectorial (WASH, social mobilization and health) and interagency response and coordination activities (the Government, local authorities and municipalities, UN Agencies and NGOs).
- Improve quality case management in health facilities through the supply of essential drugs, medical equipment. Refresher training of health workers is also provided.
- Reduce cholera transmission through the provision of safe water sources in Freetown and Western Area.
- Reduce cholera transmission through the improvement of community sensitization and behavioural change practices of the population at risk. Effective disease surveillance for early case detection and treatment to control the further spread of the epidemic.
- Improve the quality of cholera case management in health facilities in coordination with other partners.

10. Original expected outcomes from approved CERF proposal:

- CFR in the cholera treatment centres /units < 1 per cent (WHO standard).
- General CFR at the national level (including deaths at the community level) < 3 per cent.
- All cholera treatment and unit centres are supplied with essential drugs and WASH equipment with 0 shortage notified.
- Mass media sensitization is effective at the national level through 100 per cent radio coverage.
- Intra household transmission of cholera is reduced through a 100 per cent chlorine pulverization of households of patients referred to a CTC.
- Communities at risk are aware of preventive measures and procedures to follow in case of contamination
- Improved timeliness and completeness of daily reporting.

11. Actual outcomes achieved with CERF funds:

- Access to safe water at community and household level was greatly improved.

- The campaign of social mobilization was highly effective, with the majority of the population reached with clear, coherent and consistent messaging about how to prevent and treat cholera from home and when to seek medical care.
- Government commitment, especially from MoHS, became high once an emergency was declared
- Beneficiaries and communities were included in programme design and implementation, and feedback mechanisms were established, including provision of a hotline.
- Monitoring and supervision of interventions increased overall performance.
- Blue Flag Volunteers (BFV) were identified, trained and deployed to disseminate key hygiene messages through house to house visits, focus group discussions and community drama and song events in all affected city areas.
- WASH committees were established and trained to carry out bucket chlorination and distribution of aqua tabs in all affected communities. Aqua tab distribution has proven more effective in rural chiefdoms where people currently utilize rain-water for domestic purposes.
- NFI kits (ORS, Aqua tabs, soap, and IEC materials) were distributed to people in hard to reach areas of affected rural communities.
- Food vendor kits - consists of a hand washing station (1x 35 litre bucket with tap and lid, 1 x 10 litre bucket, 18 cakes of soap) and 2 gallons of bleach (for washing dishes and pots) were distributed in 21 popular markets. Due to regular spikes in reported cases, it was apparent that one of the main transmission routes was in market places and fishing wharfs and particularly through food vendors.
- Lobbying through the Government regulatory body for icemakers, water bottling and sachet packing companies to chlorinate their water before processing within Freetown.
- Training and supporting Freetown prison to chlorinate their water prior to consumption by 1,590 inmates and staff.
- Truck-loads of cholera liquid waste were safely deposited at dump sites and soak away pits from CTUs.
- Carried out social mobilization activities including drama activities in two schools. Street vendors, religious leaders and some schools were targeted in each of the city sections as well as beneficiaries at household level with Health promotion messages. IEC materials were reproduced for distribution in communities, schools, markets, and PHUs. In addition, the Story of Cholera film was regularly played in public markets, schools, and at village level. The movie generated a very strong positive response
- 103 hand washing buckets were distributed in 43 schools. Conducted hygiene promotion with school children through key messaging, question and answer sessions, games and where logistically possible showed 'The story of Cholera Movie' on big screen.
- The CERF Proposal was submitted with an initial 7 INGO (ACF, Save the Children, CONCERN, GOAL, OXFAM, Sierra Leone Red Cross); However, UNICEF commenced the response with NNGO that were already based in the hotspot locations that had regular programming taking place; this NNGO constituted Search for Common Ground, CTF and CAWEC. Hence additional amount of US$ 68,653 was utilized in hygiene promotion campaigns, safe water supply and monitoring.

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

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 response was based on the affected populations without gender focus. Women and children's access to life interventions were monitored through the duration of implementation**.**

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-055**	6. Status of CERF grant:	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Health (WHO)		
4. Project Title:	Emergency rapid response to cholera outbreak in Sierra Leone		

7. Funding		
	a. Total project budget:	US$ 2,960,438
	b. Total funding received for the project:	US$ 976,469
	c. Amount received from CERF:	US$ 812,221

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	810	810	This project consisted in training health workers on case management and infection control and also providing free telephone lines for close user groups for reporting. The direct beneficiaries of this project therefore differs significantly from the indirect beneficiaries i.e. the populations affected by cholera.
b. Male	16	16	
c. Total individuals (female + male):	826	826	
d. Of total, children under 5	0	0	

9. Original project objective from approved CERF proposal:

The main objective is to reduce morbidity and mortality rates caused by the cholera outbreak in Sierra Leone.

Specific objectives are to:

- Provide effective disease surveillance for early case detection and treatment to control the further spread of the epidemic
- Improve quality of cholera case management in health facilities in coordination with other partners.

10. Original expected outcomes from approved CERF proposal:

- CFR in the cholera treatment centres and units < 1 per cent (WHO standard).
- General CFR at the national level (including deaths at the community level) < 3 per cent.
- All cholera treatment and unit centres are supplied with essential drugs with 0 shortage notified.
- Improved timeliness and completeness of daily reporting.

11. Actual outcomes achieved with CERF funds:

Weekly CFRs at cholera treatment centres and units dropped to one per cent at the end of August (week 34) and have remained at or below this threshold ever since.

District CFR

Name of District	Highest CFR (%) before CERF	CFR beginning of CERF (Week 32)	CFR < 1%
Western Area	4.4% week 27	1.3%	0% week 39
Port Loko	11.8% week 27	2.2%	0% week 38
Kambia	16.7% week 26	2.7%	0% week 39

Pujehun	11.8% week 30	2.7%	0% week 38
Bo	6.7% week 29	2.4%	0% week 51
Bombali	7.4% week 30	2.7%	0% week 36

- Overall, the national level of crude CFR reduced from 1.6 per cent in August to 1.3 per cent by the end of December 2012.
- Daily reporting at national and district levels through supporting toll-free lines Closed User Group network maintained. This resulted in improved reporting ranging from an average of 73 per cent to 95 per cent. Generated daily cholera updates which guided response.
- Functional Central Public Health Reference Laboratory bacteriology unit to confirm cholera in-country.
- Provision of laboratory reagents and Personal Protective Equipment.
- 826 health workers trained on cholera diagnosis and case management.
- Case definitions, case management guidelines and handbook produced and distributed to health facilities.
- Establishment and maintenance of the Cholera Command and Control Centre for MoHS.
- Outbreak investigation, field assessments and supervision conducted.
- Mobilisation of international staff (epidemiologists, laboratory experts, data management, Social Mobilisation and Public Health consultants) to support the response.
- General CFR at National Level was reduced to 1.3 per cent.
- All District Medical Stores were supplied with essential drugs. However, there were reports of stock out at facility level. The drugs procured by CERF ensured that there were no national stock outs during the period where other resources (drugs and medical supplies) were being mobilized from other sources.
- Establishment of weekly meetings of the National Cholera Task Force, and a dedicated ‘Cholera Command and Control Centre’ (C4) improved the response coordination.
- Early warning and disease surveillance, including use of Rapid Diagnostic Tests (RDTs) allowed epidemiological trends to be picked up relatively quickly.
- Collaboration when responding to the outbreak, preparing for transition and engaging in preparedness planning was good among implementing agencies and with government-led coordination mechanisms.
- Daily cholera reporting and identification of hotspots enabled timely intervention.
- A functional bacteriology laboratory was established.

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

N/A

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 response was based on the affected populations without gender focus. Women and children’s access to life interventions were monitored through the duration of implementation**.**

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[2]	Agency	Partner Name	Partner Type	Total CERF Funds Transferred To Partner US$	Date First Instalment Transferred	Start Date Of CERF Funded Activities By Partner	Comments/ Remarks
12-CEF-090	Water and Sanitation	UNICEF	SLRC	NGO	43,127	27/08/12	27/08/12	
12-CEF-090	Water and Sanitation	UNICEF	Search for common ground	NGO	19,683	29/08/12	29/08/12	
12-CEF-090	Water and Sanitation	UNICEF	SCF	NGO	142,869	30/08/12	30/08/12	
12-CEF-090	Water and Sanitation	UNICEF	ACF	NGO	188,733	31/08/12	31/08/12	
12-CEF-090	Water and Sanitation	UNICEF	GOAL	NGO	27,672	31/08/12	31/08/12	
12-CEF-090	Water and Sanitation	UNICEF	OXFAM	NGO	218,618	31/08/12	31/08/12	
12-CEF-090	Water and Sanitation	UNICEF	CONCERN	NGO	43,886	31/08/12	31/08/12	
12-CEF-090	Water and Sanitation	UNICEF	MOHS	Government	58,998	18/09/12	18/09/12	
12-CEF-090	Water and Sanitation	UNICEF	MOWR	Government	60,000	20/09/12	20/09/12	
12-CEF-090	Water and Sanitation	UNICEF	CAWEC	NGO	31,786	21/11/12	21/11/12	Due to the familiarity of terrain in Kambia, the NNGO CAWEC was sub granted to commenced WASH intervention in specific villages in Kambia district that were still persistently reporting high cases especially for under 5 years
12-CEF-090	Water and Sanitation	UNICEF	CTF	NGO	16,884	11/12/12	11/12/12	The NNGO CTF was sub granted to monitor the WASH coverage and to identify any pockets of the outbreak and report back

[2] Water and Sanitation includes social mobilization

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

ACF	Action Contre La Faim (International NGO)
AFRO	WHO African Regional Office
BEmONC	Basic Emergency Maternal Obstetric and Neonatal Care
BRAC	International NGO
C4	Cholera Control and Command Centre
CARE	Cooperative for Assistance and Relief Everywhere (International NGO)
CFR	Case Fatality Rate
CPHRL	Central Public Health Reference Laboratory
CRS	Catholic Relief Services (International NGO)
DPC	Directorate of Disease Prevention and Control
EHD	Environmental Health Division (Ministry of Health and Sanitation)
EmONC	Emergency Maternal Obstetric and Neonatal Care
GOSL	Government of Sierra Leone
IST/WA	Inter Country Support Team West Africa
LWI	Living Waters International (International NGO)
MOHS	Ministry of Health and Sanitation
MoHS	Ministry of Health and Sanitation
MOWR	Ministry of Water Resources
NGO	Non-Governmental Organisation
ONS	Office of National Security
PHU	Peripheral Health Unit
RRTs	Rapid Response Teams
SCF	Save the Children International (International NGO)
SLRC	Sierra Leone Red Cross
UN	United Nations
WASH	Water Sanitation and Hygiene
WHO	World Health Organization