RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS UNITED REPUBLIC OF TANZANIA RAPID RESPONSE CHOLERA 2015

RESIDENT/HUMANITARIAN COORDINATOR	**Mr. Alvaro Rodriguez**

REPORTING PROCESS AND CONSULTATION SUMMARY

a. Please indicate when the After Action Review (AAR) was conducted and who participated.

An AAR meeting was held on 21st June with the presence of the RCO, WHO and UNICEF.

b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (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 ☐

The report was shared with the national cholera task force

c. 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 and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?

YES ☒ NO ☐

The report was shared within the UN country team and with partners in the cholera response for comments and feedback.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: ***USD 6,000,000***		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	1,500,314
	COUNTRY-BASED POOL FUND (*if applicable*)	
	OTHER (bilateral/multilateral)	
	TOTAL	**1,500,314**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 22 October 2015			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	15-RR-CEF-126	Water, Sanitation and Hygiene	796,142
WHO	15-RR-WHO-047	Health	704,172
TOTAL			**1,500,314**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	1,242,148
Funds forwarded to NGOs and Red Cross / Red Crescent for implementation (from UNICEF)	$39,589
Funds forwarded to government partners (from UNICEF)	$218,577
TOTAL	**1,500,314**

HUMANITARIAN NEEDS

The United Republic of Tanzania has been battling a major cholera outbreak which at its peak affected twenty-eight of the country's thirty administrative regions of the country. This outbreak started in Dar es Salaam, the capital city with a population of 4.4 million, in late August 2015, and has progressively extended to almost the whole country, stretching local capacities and resources, with high risk in terms of lives and economic impact. At the time of the CERF application over 75 per cent of the cases were reported from Dar es Salaam. In Zanzibar the outbreak was first reported from mid-September 2015 and a total of 4,261 cases and 61 deaths have to date (20th June 2016) been reported. Epidemiological investigations have shown links between the outbreak in the capital city and the outbreaks in most of the other regions.

Cumulatively, 26,509 cholera cases and 413 deaths have been recorded (as of July 6th 2016). The case fatality rate of 1.55 per cent is considered high by WHO standards. Several factors may explain the high case fatality. One possible factor is underreporting of cases. Another factor is the late presentation of cases to health facilities because of inadequate health knowledge and limited public awareness about the threat of the disease.

The ongoing outbreak is unusual because of its vast geographical spread within a short period of time. The last major outbreak was in 2010 reported 1,997 cases but this was limited to Tanga and Dar es Salaam regions. The rapid spread of the outbreak fuelled fear that the situation would get substantially worse if the epidemic was not controlled before the start of the rainy season in late October. The concentration of cases in Dar es Salaam, the main commercial city of Tanzania, conjugated with a very mobile population across the country, further enhanced this risk. This outbreak can be qualified as unprecedented, it does not relate to any previous pattern of transmission, both in scale (the number of cases) and geographical spread. Poor communities living in unplanned settlements are disproportionally affected largely because of poor access to safe water and environment.

Only 59 per cent of households in Dar es Salaam have access to piped water[1]. Some illicit traders of water interfere with municipal water pipe system exposing the water to contamination with sewage. In this context, even water sources deemed "safe" were contaminated. Cholera is transmitted through ingestion of faecally contaminated water and food stuff containing the bacteria Vibrio Cholerae. Results from water quality survey reveal that the source of the outbreak was contaminated water from shallow wells, deep wells and tap water. Vibrio Cholerae was isolated from all these sources. Poor hygienic practices and lack of sanitation facilities in poorer households is also an associated factor to the outbreak.

Women and children are more vulnerable due to patterns of water collection, handling and storage practices at home. Additionally, women and adolescent girls bear a disproportionate burden of HIV largely as a consequence of gender inequalities. Dar es Salaam where the majority of cholera cases are occurring has an HIV prevalence of 9 per cent among adults. Generally, people living with HIV are at increased risk of diarrheal disease and enteric infection. Unless the response is rapidly scaled up, the outbreak will grow further and cause preventable suffering and death with disproportionate impact on these vulnerable groups. Water quality interventions and the hand washing intervention were protective against diarrhoea including in women and children affected by HIV.

The magnitude and spread of this outbreak was beyond the capacity of the Government and not enough resources was available to contain it. The aim was therefore to complement the government's response and providing much needed resources to halt the spread of disease in the country.

1 Basic Demographic and Socioeconomic Profile, 2014

II. FOCUS AREAS AND PRIORITIZATION

The overall goal of the CERF project was to put in place life-saving measures to curb the multiplication of outbreaks that were causing avoidable deaths amongst children and adults and to address the gaps of the cholera response plan established by the national task force. The project prioritized poor communities living in the affected regions and unplanned urban settlements. It involved social mobilization, improved access to chlorine-based disinfectants. The CERF funds were also planned to assist empowering communities and strengthening local government authorities to provide appropriate services and care for cholera prevention and management – including technical assistance, prompt cases identification from the communities, improved case management, and provision of life-saving medicines and supplies.

Given the epidemiology of the outbreak of the time of application, the interventions was planned to cover 13 regions but as the outbreak spread the whole country including Zanzibar was targeted focusing on hot spot areas and in particular focus going towards Dar es Salaam, which had over 75 per cent of the reported cases.

The planned outputs from the interventions were:

- Enhanced Cholera case management: Done through (i) a redeployment, to overburdened treatment centres, of frontline health workers oriented in case management based on WHO guidelines (ii) provision of medical supplies, laboratory reagents and testing kits for quality assured case confirmation (iii) provision of paediatric zinc supplement and oral rehydration salts and (iv) provision of lifesaving cholera kits
- Prompt identification of symptomatic cases and referral to cholera treatment centres from the affected communities through house to house/community based interventions (contact tracing, and enhanced reporting of cases and follow up disinfection). This will be achieved through the engagement of Community Owned Resource Persons (CORPs) and Community Health Workers (CHW) working in collaboration with the existing community structure (water point committees, ward executive managers, counsellors, etc.).
- An estimated 588,172 households or 2,940,858 people from the affected localities would have access to portable water. This will be achieved through provision of chlorine-based disinfectants for point of use and point of collection and including water bowsers and other water vendors. Support shall also be provided for continuous water quality monitoring and secondary chlorination at communal water points, including enforcement of bye-laws on food and water vending.

At community level, the initial response prioritized prevention with a primary focus on water source decontamination and health education. However, the national cholera taskforce advised that decontamination of wells wasn't effective hence need to change strategic direction on water point decontamination. That is how the bulky water treatment initiative was born after the Knowledge, Attitude, Perception (KAP) survey results by Center for Disease Control (CDC) in Dar Es Salaam indicated that 58 per cent of residents collect their water from vendors/kiosks. The water vendors obtain their water from various sources; deep boreholes, shallow wells and Dar es Salaam Water and Sewerage Corporation (DAWASCO) supply, which is normally never chlorinated and if chlorinated, the levels are below the recommended standards. Follow-up interventions took into account the changing situation in the city and unplanned areas. Given the scale of the crisis, the response has however shifted gear to concentrate on households and support water treatment at the point of use. Further initiatives are necessary to inform the population and raise awareness. CERF-funded interventions enabled a comprehensive approach, encompassing community sensitization (including public awareness on prevention through print and electronic media), and water treatment at point of collection by vendors or private providers and case management.

The interventions were delivered through the working mechanism of the National Cholera Task Force; which comprises of regional and municipal authorities, Ministry of Health & Social Welfare (MOHSW, WHO, UNICEF, CDC and other partners. This has been activated and holds weekly coordination meetings. The task force is led by the Government. Six technical sub-

committees have been formed at national level, these are: Water, sanitation and hygiene (WASH); Social mobilization; Surveillance; Laboratory; Curative; Logistics and administrative sub-committees. The sub-committees meet on a daily basis to update on the response and the situation in their respective areas of responsibility. The sub-committees report to the national cholera task force and closely liaise with the implementing district health and local government authorities. The cholera response coordination structures are replicated at regional and district levels. The need to support the coordination structures was identified early on in the response and other resources was allocated to support the mechanism to ensure efficient management and reporting on the outbreak. With the establishment of the new Government (following general elections in October 2015) more focus and active implementation from the Government side was noted which facilitated the impact of the response.

III. CERF PROCESS

The UN cholera response has been led by WHO which has kept the UN country team informed through situation reports and meetings. In discussion with the UN Resident Coordinator, it was agreed to develop a CERF proposal and agencies involved in the response were invited to be included. UNICEF and WHO, jointly working on the response agreed to develop a joint sectoral response.

The UN country team has been fully mobilized in ensuring a coordinated response to the cholera outbreak. It has engaged with the Government and local authorities to scale up in the on-going interventions, particularly those targeting community awareness and sensitisation. The UNCT and national authorities are engaging the larger community of development partners in Tanzania through the National Task Force, which meets on a weekly basis. The priorities for the CERF response were identified through the national task force and the cholera response plan.

Joint rapid assessments led by the Ministry of Health and Social Welfare involving the Regional and Local Government Authorities development partners was undertaken in the affected areas.

For the response, Health and WASH interventions are complementary for containment of the outbreak, which is why the proposal was for the WASH/Health cluster jointly. Based on the epidemiological data and joint assessments on the water quality, the UNCT explored what intervention that could be executed in the immediate terms in order to quickly contain the outbreak and save lives of the affected and vulnerable populations. Prioritization of activities was based on the consultations with the government, WHO, UNICEF and other partners including the national cholera task force.

CERF process led to the mobilization of WASH sector composed of the government (led by Ministry of Water) and development partners. A core group was established that supported with the development of a costed response plan for the sector on cholera. The plan includes stepping up water quality (chlorination of water points) meeting the minimum Free Chlorine Residual levels (FRC) as per the international WHO Standards with special focus on urban/peri-urban water supplies. This is geared towards building resilience for long-term cholera control/prevention.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR[1]									
Total number of individuals affected by the crisis: 4,775,314									
Cluster/Sector	**Female**			**Male**			**Total**		
	Girls (< 18)	**Women** (≥ 18)	**Total**	**Boys** (< 18)	**Men** (≥ 18)	**Total**	**Children** (< 18)	**Adults** (≥ 18)	**Total**
Health	3,233	3,103	**6,336**	3,218	3,323	**6,541**	6,451	6,426	**12,877**
Water, Sanitation and Hygiene	1,075,391	1,033,220	**2,108,611**	841,738	808,730	**1,650,468**	1,917,129	1,841,950	**3,759,079**

[1] *Best estimate of the number of individuals (girls, women, boys, and men) directly supported through CERF funding by cluster/sector.*

BENEFICIARY ESTIMATION

TABLE 5: TOTAL DIRECT BENEFICIARIES REACHED THROUGH CERF FUNDING[2]			
	Children (< 18)	**Adults** (≥ 18)	**Total**
Female	1,078,624	1,036,323	2,114,947
Male	844,956	812,053	1,657,009
Total individuals (Female and male)	**1,923,580**	**1,848,376**	**3,771,956**

[2] *Best estimate of the total number of individuals (girls, women, boys, and men) directly supported through CERF funding This should, as best possible, exclude significant overlaps and double counting between the sectors.*

CERF RESULTS

Surveillance

Community-based interventions have engaged existing community structures and are assisting the implementing agencies in tailoring interventions to their community characteristics and needs. The government grass root level structures like the Ward Health Officers, Village Health Committees, Street (Mtaa) Chair person, Village Executive Officers and village Chairpersons and volunteer network were trained and utilized in the implementation of the response at the village level with regard to disease surveillance, contact tracing, and raising awareness. The CERF funds facilitated deployments of technical assistance to the outbreak affected regions for strengthening the surveillance system. Recruitment of a local epidemiologist and public health officers helped reinforce surveillance activities and ensured timely response and reporting of cases. The epidemiologist was dedicated to the Public Health Emergency Operations Centre (PHEOC) which was established in the ministry of health with assistance from both WHO and CDC.

Cholera Case management

Training of Trainers in cholera case management was conducted in more than 10 regions, with a special focus on regions with greater burden. WHO has supported the updating, printing and dissemination of national cholera guidelines, protocols and SOPs. Training manuals on case management were reviewed and used in the conduct of training for health workers, community leaders and volunteers on contact tracing, case identification and prompt referral and treatment for symptomatic individuals from households to Cholera Treatment Centres (CTCs).

Water & Sanitation

Support was provided to MOH and other partners to conduct a multi-sectoral joint assessment of water sources, the results of which informed response to the outbreak. WHO, UNICEF and CDC supported the Ministry of Health and implementing partners to provide strategic directions to the Ministry of Water and Irrigation.

A total of 2,521,333 people - 504,267HH (2,209,382 people – 443,100 in Mainland; 311,951 people - 61,167 households from Zanzibar) have benefitted from safe drinking water through distribution of water guard for HH water treatment promotion. A total of 15,000,000 water guard tablets were distributed. The distribution targeted cholera hotspots in both Mainland (Dar Es Salaam, Morogoro, Singida, Tanga, Kigoma, Mwanza, Mara, Iringa and Kilimanjaro regions) and Zanzibar. In addition, 617,042 people benefitted from treated water supply for three months in five districts in Zanzibar through support with 1,500kg chlorine powder (HTH 65-70 per cent) to Zanzibar Water Authority (ZAWA). At community level, the initial response prioritized prevention with a primary focus on water source decontamination and health education. With the changing situation in the city and unplanned areas, the response has however shifted to concentrate on household's water treatment at the point of use.

A total of 974,692 people (of which 225,312 are pupils in 231 schools) have benefitted from the bulky water chlorination initiative in Dar Es Salaam (Ilala, Temeke, Kinondoni), Morogoro and Zanzibar. During a cholera outbreak, access to safe drinking water is critical and chlorine is an effective tool to disinfect and protect water supplies from recontamination. The bulky chlorination initiative was born following a KAP survey by CDC and MOHCDGEC in January in Dar es Salaam indicating that 58 per cent of the residents access their water from water vendors whose water sources were generally never chlorinated and if chlorinated at collection points, were found to have low or nil FRC at point of use. Hence CDC, MOHCDGEC and collaborated to use 8.68gm Sodium dichloroisocyanurate (NaDCC) tablets to treat large volumes of drinking water supplies to improve chlorination during this outbreak. A three month supply of chlorine tablets was distributed to water vendors and water trucks in cholera affected areas of Dar es Salaam and Morogoro. The bulk chlorination program includes 1) identification of bulk water providers, (2) training of vendors on proper dosing techniques (3) distribution of chlorine tablets, and (4) monitoring of the vendors to determine if the tablets are used and if the chlorine residual is within the recommended range. Identification of water vendors, distribution of chlorine tablets and monitoring visits is currently being conducted by the ward health officers located in each of the targeted wards. Each vendor received a supply of chlorine to treat their water for three months. Afterwards, social marketing campaigns were initated whereby vendors were able to purchase chlorine tablets, which is a similar to how water purification tablets are sold for household level water treatment. A total of 1,341 water vendors were identified through a mapping exercise in the target cholera hotspot wards from the respective regions. Through monitoring by Ward health Officers, it reveals that 95 per cent of the mapped water vendors are participating. The table below indicates summary of water vendors reached with bulky water chlorination initiative. Two Ward Health Officers from each of the targeted hotspot ward were trained on the concept behind bulk chlorination initiative, the dosing protocols and monitoring of Free Residual Chlorine (FRC) levels. Each Ward Health Officers was further provided with a Pooltester and reagents for regular monitoring. FRC monitoring indicates that 88% of vendors' are now supplying water with chlorine levels of between 0.5-1mg/litre – which is within the recommended range. The 8.86mg aquatabs are being used for the bulky chlorination exercise, 299,520 tablets have been [procured. Based on the current mapped

water vendors and schools included in the initiative, the target population will continue receiving chlorinated water for five months with the current stock of Aquatabs.

Location	No Wards/ Shehias	No Vendors	No schools	Beneficiaries		FRC Levels	
				People	Pupils	Before	After
Ilala	5	152	4	146,780	5,600	0mg/l	0.5-1mg/l (96%)
Temeke	5	128	None	114,588	0	0mg/l	0.5-1mg/l (80%)
Kinondoni	5	412	12	140,780	16,212	0mg/l	0.5-1mg/l (85%)
Morogoro	8	138	15	138,450	13,500	0mg/l	0.5-1mg/l (90%)
Zanzibar	115	511	200	208,782	190,000	0mg/l	N/A- just commenced
Total/Average	**138**	**1,341**	**231**	**749,380**	**225,312**	0mg/l	**0.5-1mg/l 88%**

An evaluation is currently in the planning stage and the results of this evaluation will help guide future programmatic action.

Social Mobilization

Activities implemented range from IEC material development, community engagement, training of volunteers, supervisors, orientation of key people, media orientation and social mobilisation assessment in hot spot regions/district. Key messages on cholera including signs and symptoms of cholera, what to do when you get infected, how to prevent infection and how to use water guard, were disseminated. In addition, monitoring and reporting tools for community based activities were developed and used in Dar es Salaam region.

A total of 3,759,079 persons have been reached with cholera sensitization messages through a network of 400 volunteers from Tanzania Red Cross Society (TRCS), Pemba Island Relief Organization (PIRO) and Zanzibar Association of People Living with HIV/AIDS (ZAPH). This has been achieved through house to house visits, schools, community/religious meetings, TV and Radio channels in target regions. Monitoring has indicated that 83 per cent of the target beneficiaries can recall two transmission routes and two prevention measures for cholera. UNICEF and MOHCDGEC have developed/adapted two Information, Education and Communication (IEC) tools to support grass root community sensitization and mobilization on cholera control/prevention. The tools are the flip charts (Bango Kitita) and The Story of Cholera (TSOC). DVD/CD. The TSOC has been developed by the Global Health Media Project and is available for free in a number of languages including Swahili. TSOC video was translated into Tanzanian Swahili, re-voiced and adopted by the MOHCDGEC and MOH in Zanzibar. The Flip chart is a tool used by community and facility level health workers in creating awareness through interpersonal communications and for stimulating discussions on health issues and finding solutions that suit the local context.

The Story of Cholera Video was broadcasted in seven major TV stations (ITV, TBC, Azam, Star, Channel 10, Abood and Tumain TV) nationally in December 2015 and January 2016. 100 TSOC CDs were distributed to 29 radio stations in the country. Two TV and three Radio Spots on hand washing, HH water treatment with water guard and latrine use were also developed, distributed and aired by the above TV and Radio stations. In addition, the video is also circulating on electronic messaging via *Whatsapp* and on UNICEF facebook page. These materials have also been shared through socio media (Full Shangwe, Dewji Blog, Habari za Jamii, You tube and Facebook. UNICEF and MOHCDGEC also collaborated with *PushMobile* to promote cholera information access through toll free short code 15774. Over 125,000 mobile users accessed cholera information through this short code. The video has proved very powerful in triggering discussions on cholera (causes, transition, and control/ prevention) and role of the individuals/HHs and community in taking action to prevent the disease. Where it has been shown, it has triggered communities to take action to emulate the example of the 'boy' - the change agent in the video.

The result of this has been the halting of transmission in Dar es Salaam and Tanga regions, which accounted for more than 70 per cent of cholera cases at the onset of the outbreak. Partners have fully engaged with the Government and local authorities to scale up on-going interventions, particularly those targeting community awareness and sensitization. Key advocacy messages focus on hygiene practices, food safety, prompt identification of cases and referral. Advocacy campaigns have been employed to complement life-saving interventions related to case management and reduction in mortality.

Further, 12,000 Flip charts and 4,500 TSOC DVDs have been printed and distributed to 55 districts in 16 regions. Twenty-five thousand leaflets on cholera for schools were also printed and distributed to 500 schools both in mainland and Zanzibar. In addition, 600,000 cholera leaflets were produced and distributed to same number of person in Zanzibar. A total of 11,757 households (58,785 people) have been reached from 194 (58 per cent) Shehias in Zanzibar by volunteer peer educators from

Red Cross, ZAPH, Environmental Engineering and pollution control organization (EEPCO) and Pemba Island Relief Organization (PIRO). Three hundred volunteer peer educators were trained on community sensitisation for cholera control in between January and February 2016. This was an innovative collaboration with MOH Zanzibar and UNICEF in engaging NGOs that have established networks of community based volunteers on HIV/AIDS and other sectors to add mobilization against cholera on to their day to day activities. In addition, TRCS trained 407 volunteers in mainland who have been instrumental in water guard distribution coupled with community mobilization and sensitization towards cholera control/prevention. Four hundred water/food vendors and 400 community/religious leaders were also trained on cholera prevention and control. A total of 112,736 pupils from 211 schools comprising of primary schools, madrassas and few secondary schools in Zanzibar have been sensitized by Red Cross, PIRO and ZAPHA and school health teachers using cholera Bango Kitita and cholera leaflets.

A team of 31 people composed of Regional, District and WardHealth Officers from 5 cholera hotspot Regions (Mwanza, Mara, Geita, Arusha and Simiyu) have participated in Training of Trainers (ToTs) on socio mobilization for cholera at the grassroots level. In Mwanza, the TOTs have already cascaded the training to 20 ward health officers from 2 hot spot districts in the region. The participants developed District/Ward level socio mobilization action plans which have been shared with the National Cholera Task Force level to advocate for resource allocation.

Fifty-three journalists from local media from five Regions (Manyara, Arusha, Mwanza, Mara and Mbeya) received half day orientation on cholera and how they can support in disseminating messages to raise awareness among the general population.

Nine hundred people (555 CHW, 253 Religious and local leaders, 36 Ward health Officers and 65 R/CHMT) received half day induction on socio mobilization at the grass root level in five regions (Mbeya, Arusha, Manyara, Mwanza and Mara)

Fifty-six Regional/District health officers were trained on WASH preparedness and response targeting five cholera hotspot Regions (Mbeya, Rukwa, Katavi, Njombe and Iringa)

Laboratory

Initial trainings were conducted on laboratory diagnosis, and laboratory supplies and their quantifications. The country has 30 regional laboratories. Now 18 laboratories have capacity of confirming cholera as they were also provided with the needed supplies, equipment and technical expertise. All four zonal reference laboratories (KCMC, Bugando, Mbeya Referral and Muhimbili) have capacity of confirming cholera outbreak serotyping and antimicrobial susceptibility testing. The National reference Laboratory NHL QATC has capacity of confirming the outbreak, validates method, provide technical trainings and mentorship, and Quality Control of other laboratory in the country through quality checks. WHO, USAID, CDC, Population Services International (PSI) and Tanzania Red Cross Society has supported the MOHSW with laboratory agents; medical supplies; equipment, water treatment chemicals and laboratory diagnostics.

CERF's ADDED VALUE

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

The CERF allocation was approved and disbursed in October 2015 and within one and a half month the outbreak in Dar es Salaam, which was the main hotspot at the time, was getting under control due to the intensified activities made possible with the CERF allocation.

b) Did CERF funds help respond to time critical needs[2]?
YES ☒ PARTIALLY ☐ NO ☐

Yes, the allocation came at a crucial time where political commitment was missing and other funding sources were not available.

c) Did CERF funds help improve resource mobilization from other sources?
YES ☐ PARTIALLY ☒ NO ☐

Further financial contributions from humanitarian partners have not been forthcoming while technical assistance has been provided. As the government did not declare an emergency, partners have been reluctant to provide financial support. Due to this challenge, UNICEF mobilized $569,541 from own regular resources to support in the cholera response in the country

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ PARTIALLY ☐ NO ☐

Yes it helped to come together to jointly prioritize interventions and to discuss comparative advantages among agencies. It further improved the collaboration and coordination with other partners such as PSI and Tanzanian Red Cross Society.

e) If applicable, please highlight other ways in which CERF has added value to the humanitarian response

Through the new collaboration established with PSI social marketing for sustainable distribution of chlorine tablets was introduced whereas support provided with free tablets was connected with continued availability for local purchase from PSI outlets. The social marketing effectively created sustained demand for chlorine tablets from existing outlets and creating potential for new outlets thus contributing to an expanded and sustainable supply chain.

[2] 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, etc.).

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Guidance and templates for application is well developed and support quick applications	Continue to ensure that guidance is well prepared to support speedy development of applications at country level.	CERF secretariat
Duplications in information provided in Chapeau and Project applications	For applications with few sectors and projects involved there are some duplications for the information required in the chapeau and the project description, there should be a consideration of having a more streamlined application for smaller projects.	CERF secretariat
Importance of CERF funds in low-level emergency countries	To highlight the importance of CERF in low-level emergency countries like Tanzania where humanitarian resource mobilization is difficult due to low presence of humanitarian partners.	CERF secretariat

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Need for follow-up on agreed deliverables during implementation period	A more continuous follow-up on status of implementation of the project during the implementation period would support agencies in being reminded on agreed deliverables and track progress.	UNCT
Partnership between various organizations including government ministries, NGOs, UN agencies and leading stakeholders worked well.	Involvement and support of partnership in interventions in emergency response should continue to support a multisector approach to response	
CERF interventions have mainly addressed life-saving interventions but have also laid ground work in attracting attention of water sector programmes to build resilience by addressing underlying causes mainly around poor water and sanitaion infrustructure	Follow up on funding on the costed water sector plan for cholera response	Water sector development programme

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	UNICEF WHO	**5. CERF grant period:**	01/10/2015 – 31/03/2016
2. CERF project code:	15-RR-CEF-126 15-RR-WHO-047	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Water, Sanitation and Hygiene (UNICEF) Health (WHO)		☒ Concluded
4. Project title:	Lifesaving Health & WASH Interventions in Response to the Cholera Outbreaks in Tanzania		

7.Funding				
	a. Total funding requirements[3]:	US$ 4,000,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received[4]:	US$ 2,349,999	▪ *NGO partners and Red Cross/Crescent:*	US$ 39,589
	c. Amount received from CERF:	US$ 1,500,314	▪ *Government Partners:*	US$ 218,577

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	755,839	717,531	1,473,370	1,078,624	1,036,323	2,114,947
Adults (≥ 18)	752,821	714,667	1,467,488	844,956	812,053	1,657,009
Total	**1,508,660**	**1,432,198**	**2,940,858**	**1,923,580**	**1,848,376**	**3,771,956**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs		
Host population		
Other affected people	2,940,858	3,759,079
Total (same as in 8a)	**2,940,858**	**3,759,079**

[3] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[4] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	The total beneficiaries have increased from 2,940,858 target planned to 3,759,079 predominantly due to the addition of the bulk water chlorination initiative. In addition, the high number of schools reached also helped boost the beneficiaries. There are more children reached than in the plan as more schools were reached than planned.

CERF Result Framework			
9. Project objective	Avert mortality and morbidity in the cholera affected regions of Tanzania through lifesaving health and WASH interventions		
10. Outcome statement	Lives saved and quality of lives improved in the affected regions		
11. Outputs			
Output 1	Enhanced cholera case management for 65,250 symptomatic individuals		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Cholera case fatality rate reduced	<1.0%	1.6%
Indicator 1.2	Number of regional laboratories with quality assured capacity to confirm cholera cases including culture/drug susceptibility testing	12	18
Indicator 1.3	Number of clinicians and community health workers redeployed to overburdened cholera treatment centres	200	220
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Conduct half-a-day emergency orientation for frontline health workers on clinical case management in accordance with WHO guidelines	MOHSW	WHO/MOHSW
Activity 1.2	Procure (laboratory reagents) cholera testing and drug susceptibility kits	WHO	WHO
Activity 1.3	Redeploy 200 clinicians and community health workers to high burden cholera treatment centres (and provide subsistence allowances for redeployed health workers)	MOHSW	WHO/MOHSW
Activity 1.4	Procure & provide paediatric core package of oral rehydration salts with zinc	WHO	WHO/MOHSW
Activity 1.5	Procure 7 cholera kits	WHO	WHO
Output 2	Prompt identification and referral of case from 588,172 households to Cholera Treatment Centres		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number (and percentage) of affected households disinfected	588,172 (100%)	625,117
Indicator 2.2	Proportion of districts outbreak reports	100%	80%

	submitted complete and timely		
Indicator 2.3	Clinicians, Community Health Workers, Public Health Officers and Community Owned Resource Persons (CORPs) oriented on case finding and prompt referral	360	360
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Household and latrine disinfection: Procure chlorine and supponated cresol for disinfection in households where cases have been identified	WHO	WHO/MOHSW
Activity 2.2	Recruit one epidemiologists at NOC grade for 6 months (WHO staff)	WHO	WHO
Activity 2.3	Recruit three public health officers at NOB grade for 6 months (WHO staff)	WHO	WHO
Activity 2.4	Facilitate a half-a-day emergency orientation for 200 Clinicians and Community Health Workers, 100 Community Owned Resource Persons (CORPs), and 60 Public Health Officers.	WHO/MOHSW	WHO/MOHSW
Output 3	588,172 households from the affected localities have access to portable water		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	Residual Free chlorine (FRC) level of 0.3-0.5mg/litre for drinking water at HH level	>70%	88%
Indicator 3.2	Percentage of water points (deep wells, boreholes, piped sources) with zero coliforms	100%	88%
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Urgent provision of water treatment tablets and disinfectants at the household level to ensure the treatment of water at the point of use;	UNICEF	TRCS MOHCDGEC MOH Zanzibar
Activity 3.2	Disinfection of infected water sources (deep wells, pipe water)	UNICEF/TRCS	MOH Zanzibar MOE Zanzibar Kinondoni MC
Activity 3.3	Monitoring of the acceptance and use of the HH level water treatment agents	UNICEF	TRCS/MOHCDGEC
Activity 3.4	Water quality monitoring at collection and point of use (FRC and Bacteriological)	UNICEF	UNICEF/Kinondoni, Ilala and Temeke MC MOH Zanzibar
Activity 3.5	Emergency orientation on water quality monitoring	UNICEF/TRCS	TRCS/MOHCDGEC/ UNICEF
Activity 3.6	Hire a WASH specialist based in UNICEF Dar es Salaam	UNICEF	UNICEF

Output 4	588,172 households and communities are empowered for better health seeking behaviour; more aware of safe behaviour related to personal hygiene, sanitation and food safety		
Output 4 Indicators	**Description**	**Target**	**Reached**
Indicator 4.1	80% of the beneficiaries are able to recall at least 2 transmission routes and 2 prevention measures for cholera.	80%	83%
Indicator 4.2	Community volunteers oriented on health seeking behaviour on personal hygiene, sanitation and food safety	400	400
Indicator 4.3	Number of schools sensitized on cholera prevention and control	450	500
Output 4 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 4.1	Information, Communication and Education on hygiene/sanitation through radio, TV, house to house visit and community meetings	UNICEF/TRCS	UNICEF/TRCS/MOHCDGEC/ MOH Zanzibar
Activity 4.2	Printing and distribution of cholera IEC materials to regions and LGAs	UNICEF/TRCS	UNICEF/TRCS/MOHCDGEC/ MOH Zanzibar
Activity 4.3	Rapid induction of 300 food handlers and water vendors on improved hygiene practices	UNICEF/TRCS	UNICEF/TRCS
Activity 4.4	Rapid sensitization in 450 schools most at risk (about 300 in Dar es Salaam and 150 in other regions) on cholera prevention and control	UNICEF/TRCS	UNICEF/ MOH/MOE Zanzibar/ZAPH/PIRO/TRCS
Activity 4.5	Rapid induction of the community/faith-based leaders	UNICEF/TRCS	UNICEF/TRCS/ZAPH/PIRO/TRCS
Activity 4.6	Facilitate a half-a-day emergency orientation for 400 community volunteers on health seeking behaviour on personal hygiene, sanitation and food safety	UNICEF/TRCS	UNICEF/TRCS/PIRO/ZAPH

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

Government Counterparts were not included in the group of partners that will support in the implementation of activities in the proposal. However, during the course of implementation it was deemed necessary to include them in order to increase reach/coverage in the hotspot areas. They included MOHCDGEC, MOH Zanzibar, and Municipal Councils in Dar Es Salaam as opposed to only working with TRCS in the initial plan.

Five hundred instead of 450 schools in the plan have been reached. This resulted from engaging the MOE and NGOs – ZAPH and PIRO in addition to TRCS in Zanzibar.

On the indicator "100 per cent deep wells, pipe water have zero coliforms": 88% per cent was achieved due to different level of uptake/acceptance by the water point owners/ water vendors in target areas. However, the 88 per cent result is encouraging and the team continues to build on that towards the 100 per cent target.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

The beneficiaries were sensitised on how to use the water guard before the distribution was undertaken by the volunteers. The same information was disseminated through TV and radio stations. The beneficiaries were also informed of their entitlements and referred to nearest water guard outlet (where applicable) promoted by PSI where they could obtain continued supply at a fee. PSI is running socio marketing for water guard to ensure that stocks are locally available through trade for easy access by households. This is a part of efforts to build resilience against future outbreaks. Other resilience building strategies include updating of the National Cholera Preparedness Plan in line with the experience and lessons learnt from current outbreaks; and advocacy to government to enforce bye-laws on household ownership of latrines. Capacity building for teachers, Regional and District local government was promoted to strengthen capacity for emergency cholera response.

As part of the process to build resilience in the country, the CERF process led to the mobilization of WASH sector composed of the government (led by Ministry of Water) and development partners. A core group was established that supported with the development of a costed response plan for the sector on cholera. The plan includes stepping up water quality (chlorination of water points) meeting the minimum Free Chlorine Residual levels (FRC) as per the international WHO Standards with special focus on urban/peri-urban water supplies. This is geared towards building resilience for long-term cholera control/prevention.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No evaluation was planned or conducted related to the response to the cholera outbreak. UNICEF used regular monitoring mechanisms as a means to collect info and data on outputs/results. The monitoring methods included field monitoring visits, spot checks and through rapid Response Teams led by the MOHCDGEC.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
15-RR-CEF-126	Water, Sanitation and Hygiene	UNICEF	RedC	$39,589
15-RR-CEF-126	Water, Sanitation and Hygiene	UNICEF	GOV	$118,006
15-RR-CEF-126	Water, Sanitation and Hygiene	UNICEF	GOV	$82,021
15-RR-CEF-126	Water, Sanitation and Hygiene	UNICEF	GOV	$1,536
15-RR-CEF-126	Water, Sanitation and Hygiene	UNICEF	GOV	$5,354
15-RR-CEF-126	Water, Sanitation and Hygiene	UNICEF	GOV	$11,660

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

CDC	Center for Disease Control
CHW	Community Health Workers
CORPs	Community Owned Resource Persons
CTC	Cholera Treatment Centres
DAWASCO	Dar es Salaam Water and Sewerage Corporation
EEPCO	Environmental Engineering and pollution control organization
FRC	Free Residual Chlorine
IEC	Information, Education and Communication
MC	Municipal Councip
MOE	Ministry of Education (Zanzibar)
MOH	Ministry of Health – Zanzibar
MOHCDGEC	Ministry of Health, Community development, Gender, Elderly and Children
MOHSW	Ministry of Health & Social Welfare
NHL	National reference Laboratory
PHEOC	Public Health Emergency Operations Centre
PIRO	Pemba Island Relief Organization
PSI	Population Services International
RAS	Regional Administrative Secretary
TRCS	Tanzania Red Cross Society
TSOC	The Story of Cholera DVD
WASH	Water, Sanitation and hygiene
WHO	Ward Health Officers
ZAPH	Zanzibar Association of People Living with HIV/AIDS
ZAWA	Zanzibar Water Authority