EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HUMANITARIAN AID
Regional Support Office for East and Southern Africa (Nairobi)

MISSION REPORT

Subject : **Reference *HIP***

Author: **Damien BLANC *(WASH Expert, West Africa Regional Office, Dakar)***

Date: **From the 18th to the 23rd of September 2017**

Actors Met:

Solidarités Internationales (SI)

Camille; Field Coordinator Maiduguri, who followed the mission on the 20th of September In Muna Corridor (Custom House and Muna Garage), email: mdg.fieldcoo@solidarites-nigeria.org, *phone: +234 (0)906 067 4012/ (0)907 828 9076, address: 8 Manasa Street, Polo, Maiduguri, Borno.*

VOURC'H Gildas; Country Director, met in a meeting in SI's office in Maiduguri on the 20th of September, email: hom@solidarites-nigeria.org, *phone: +234 (0)806 225 1295/ (0)701 364 9903, address: Plot 194, 4461 Crescent Gwarimpa Housing Estate, Abuja.*

Catholic Relief Services (CRS)

DARET Timothy; Team Lead Hygiene Promotion and Community Mobilization, who followed the mission on the 20th of September in Muna Corridor (Bakassi village), email: timothypaul.daret@crs.org, *phone: +234 (0)803 647 3467/ (0)810 111 5422, address: Plot N° 477, 41 Crescent (Off Fourth Avenue/Sa'adu Zungur Avenue), Gwarimpa, FCT, Abuja.*

NEILAN, Kyla; Emergency Coordinator, Borno State, who followed the mission in Muna Corridor (Bakassi village) and attended the meeting in SI's office on the 20th of September, email: kyla.neilan@crs.org, *phone: +234 (0)906 064 5791/ (0)810 111 5422, address: Plot N° 477, 41 Crescent (Off Fourth Avenue/Sa'adu Zungur Avenue), Gwarimpa, FCT, Abuja.*

Action Against Hunger (AAH)

SEID Abdu; Regional WASH Coordinator, met in GIZ office on the 21st of September in Maiduguri, email: washco-reg.ng@acf-inkternational.org, *phone: +234 (0)812 026 8583/ (0)813 174 2825, address: N°96 WestNorth Damboa Road GRA, Behind Indimi taHouse, Maiduguri, Borno.*

TAKUBU Danjuma; WASH Deputy Program Manager, met in GIZ office on the 21st of September in Maiduguri, email: washdpm-ma.ng@acf-international.org, *address: N°96 WestNorth Damboa Road GRA, Behind Indimi House, Maiduguri, Borno.*

ISA Adamu; Senior WASH PHP/NFI & Community Mobilization, met in GIZ office on the 21st of September in Maiduguri, email: scmo-ma.ng@acf-international.org, *phone: +234 (0)701 331 2106, address: N°96 WestNorth Damboa Road GRA, Behind Indimi House, Maiduguri, Borno.*

WHO

MARTINEZ Jorge; Health Sector/Cluster Coordinator, met in WHO/EOC offices on the 19th of September in Maiduguri, email: martinezj@who.int, *phone: +234 (0)813 173 6263/ (0)907 509 3496, address: D25 Dalori Street, New G.R.A., Bama Road, Maiduguri, Borno.*

Save the Children (StC)

MAI Gaballah; Humanitarian Team Leader, met in SI's office on 20th of September in Maiduguri, email: mai.gaballah@savethechildren.org, *phone: +234 (0)818 929 6216, address: N°8 Mohamed Kauji Street, Off Potsikum Road, Damboa Road, Maiduguri, Borno.*

AGBEMADON Yawodjin;WASH Advisor met in SI's office on 20th of September in Maiduguri, email: yawodjin.agbemadon@savethechildren.org, *address: N°8 Mohamed Kauji Street, Off Potsikum Road, Damboa Road, Maiduguri, Borno.*

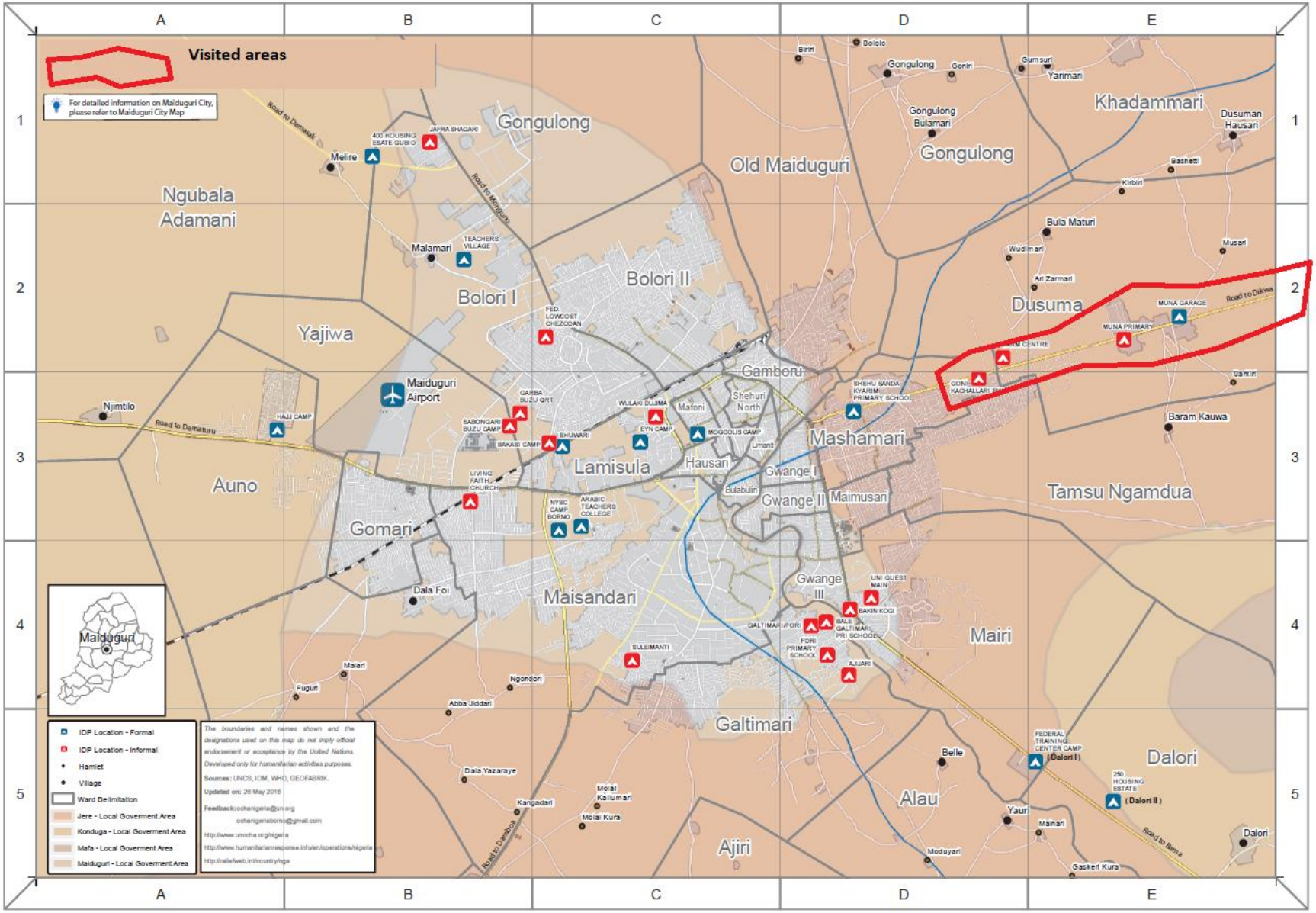
International Medical Corps (IMC)

OMANCHI OLOFU Emmanuel; WASH Officer, met in SI's office on 20th of September in Maiduguri, email: eomanche@internationalmedicalcorps.org, *phone: +234 (0)803 870 0770/ 815 676 3589, address: Plot 87 Damboa Road, off Circular Road, Old GRA Extension, Maiduguri, Borno.*

UNICEF

SALIHOU Lonis; WASH Specialist Maiduguri, who followed the mission on the 20th of September in Muna Garage, email: lsalihou@unicef.org, *UNICEF, UN House, D25 Dalori Street, New GRA Maiduguri, Borno, Nigeria.*

Visited Sites (in Maiduguri Urban)



Muna Garage (Host & Camp), Muna Dalti (Host & Camp), Customs House (Camp)& Bakassi Village in Muna Corridor (Incl. MSF CTC)

Executive summary.

First cases of cholera were declared on the 16th of August in Muna Garage IDPs camp in Jere LGA in urban Maiduguri on the main axis in Direction to Dikwa LGA. The epidemic spread to the other camps alongside Muna corridor and reached Dikwa and Monguno LGAs.

As of 27th of September, the total caseload of cholera cases is 4 114 affecting urban Maiduguri (Jere and MMC LGAs: 2 025cases), Dikwa (687 cases), Monguno (1 396 cases) and recently Mafa LGA (6 cases) with a case fatality under 2%.

Mission allowed monitoring Solidarités Internationales, CAFOD (CRS) and UNICEF ongoing response in Muna Corridor.

The ongoing response has been able to manage the epidemic so far although actors involved in the WASH response will not have the capacity to sustain their effort should the epidemic persists, or worse: expand.

It is as of now too early to predict its evolution: although one hand, signs of decrease are recorded in some areas (Dikwa), and on the other hand previously unaffected LGAs or wards (within urban Maiduguri and Bama) start to report cases.

It is therefore recommended to secure ECHO partners' involvement in the response for duration of one to two months and seek for opportunities of extra funding in case the epidemic should spread beyond the capacities of the WASH actors operating in the response.

Solidarités Internationales has been actively participating to the response and observations made during the mission showed excellent performance considering the security context and the limited sector coordination. A top up of their ongoing action (reference 2017/00821) of 300 000 € from the balance of the top up of the HIP 2017 is recommended to secure one to two months of activities in their areas of intervention (MMC, Jere, Monguno & Dikwa LGAs) and address newly affected one.

As for the other ECHO partners involved in the WASH response under other funds than ECHO's, it is recommended that they produce a concept note in in order to have an estimation of the amount of funds required to maintain ECHO support in case the epidemic should persist or expand.

The poor performances of UNICEF as a sector lead and an operator in the cholera response limits the added value of cholera preparedness activities for the WASH sector. Focus should be made on facilitating the transition from routine activities to epidemic related ones through the introduction of a crisis modifier result in all partners' appraisal as for 2018 HIP.

Although still weak, sector coordination has been recently strengthened with extra human resource deployed in June 2017 in Maiduguri. First signs of coordination improvement may be visible by the end of the year.

Based on their operational performances, support to UNICEF in 2018 in the WASH sector should be restricted to the sole sector coordination.

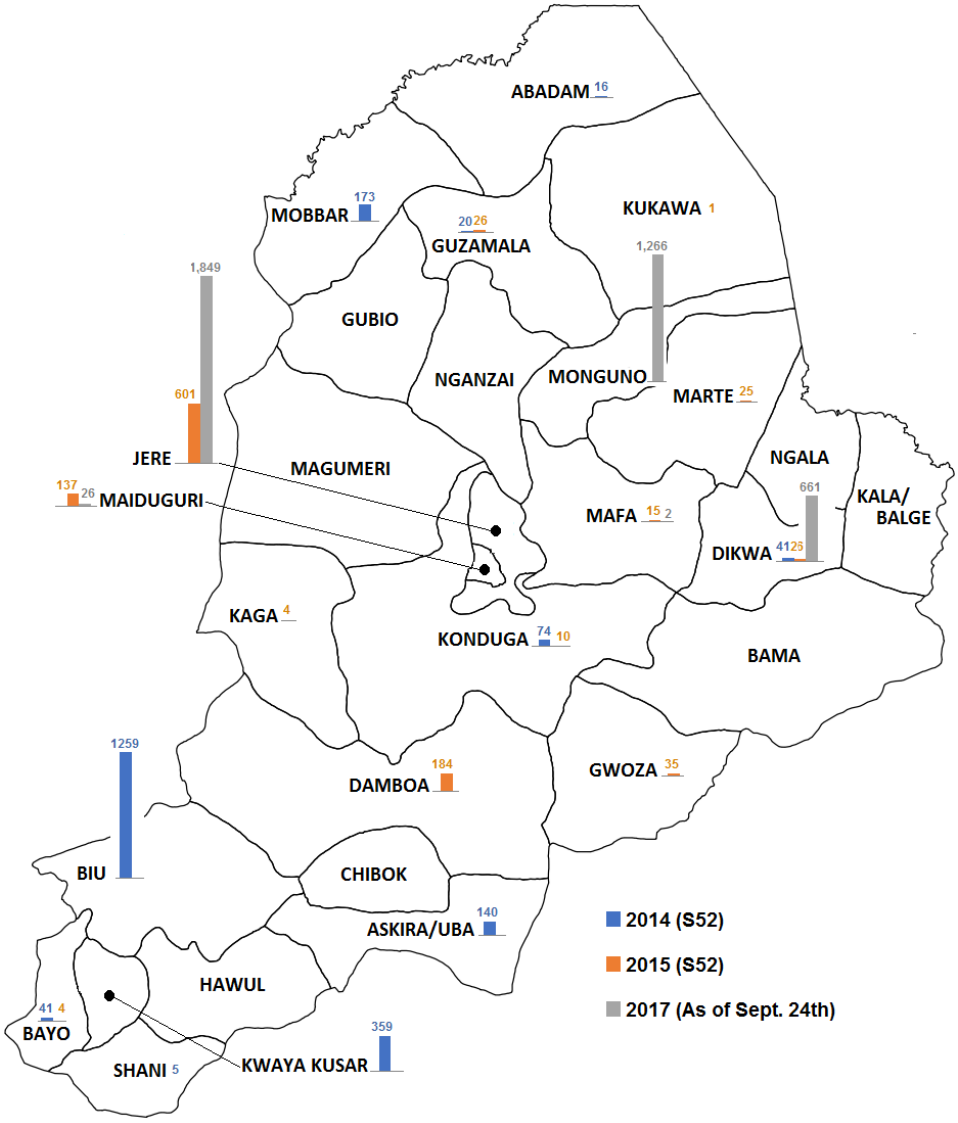
CONTENT TABLE

1 Context 1
1.1 Cholera in Borno State 1
1.2 2017 Epidemic trends 1
1.2.1 Urban Maiduguri (Jere & MMC LGAs) 1
1.2.2 Outreach LGAs 2
1.3 2017 epidemic WASH Response 3
1.3.1 Urban Maiduguri (Jere & MMC LGAs) 4
1.3.2 Outreach LGAs 4
1.3.3 Cholera Vaccination 4
2 Observation & Comments 5
2.1 Partners capacity 5
2.1.1 WASH Cluster Coordination 5
2.1.2 Partners response capacity 5
2.1.3 ECHO partners involved in the Cholera Response 6
2.1.4 Vaccination campaign 8
2.2 Epidemic trends on the current set up. 8
3 Expert recommendations 8
3.1 2017 Programming 8
3.2 Operational recommendations 9
3.3 2018 WASH Strategy in terms of cholera response and preparedness 10
3.3.1 Preparedness: 10
3.3.1 Response: 10
4 Sector policy compliance 11

1 Context

1.1 Cholera in Borno State

Cholera epidemics affect Borno state on a rather frequent basis, latest ones being 2014 and 2015 affecting respectively 2,128 and 1,068 people). 2014 epidemic affected mainly LGAS near the border with Cameroun whereas most of the cholera cases in 2015 were reported in Jere and Maiduguri[1] LGAs in IDPs camps with a similar pattern as 2017's. So far the biggest caseload was in 2010 with 41,787 cases from 18 States, most affected states being Borno, Bauchi and Katsina[2]. 2017 epidemic is still contained to Borno state so far although it could expand to others states or bordering countries if not contained.



Epidemics in Borno state from 2014 to 2017 [Source: UNICEF]

1.2 2017 Epidemic trends

1.2.1 Urban Maiduguri (Jere & MMC LGAs)

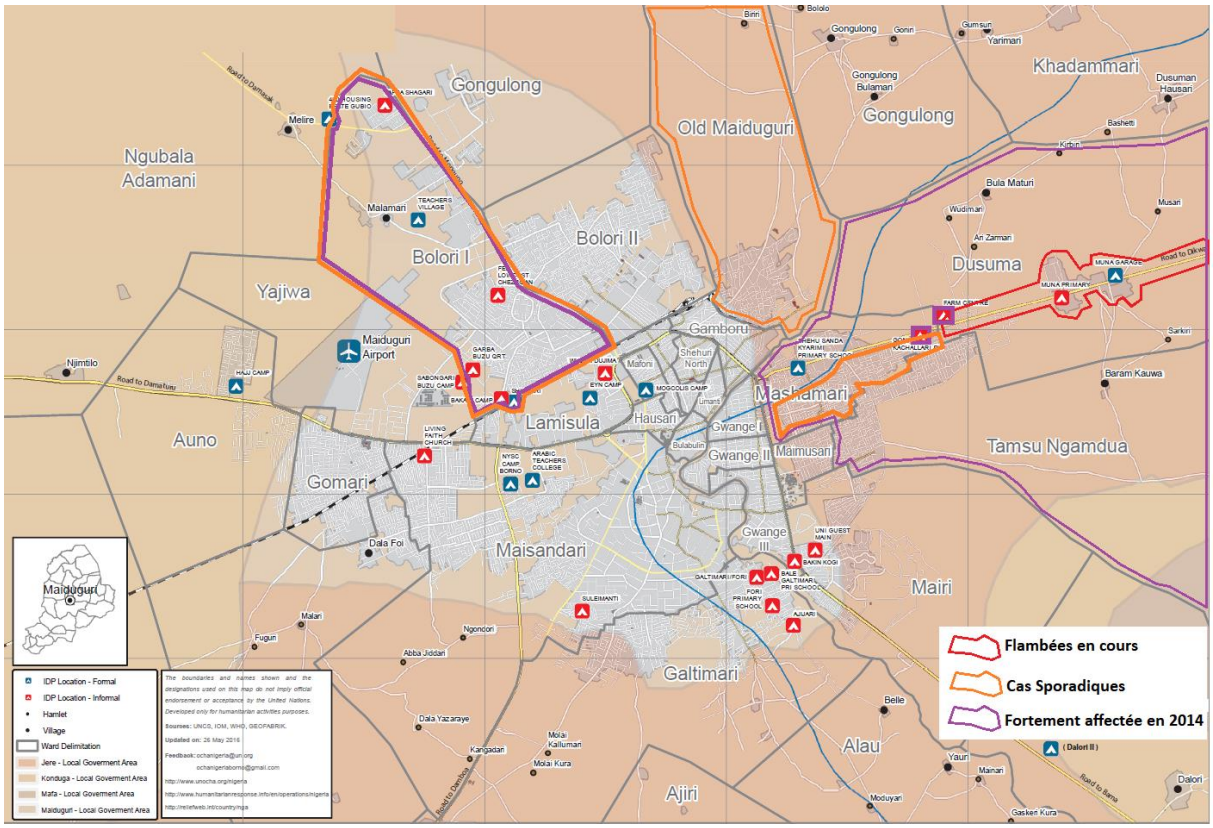
On 16th of August, 1st cholera cases was reported in Muna Garage IDPs camp, Dusuma Ward in Jere LGA, located north east of Maiduguri urban area (including Jere & MMC LGAs). The epidemic then extended along the main road axis called Muna Corridor reaching 133 cumulated cases as end of August to expand rapidely to 2 025 cumulated cases (as of 27th of September). In Urban areas mainly affected areas remain Muna Garage, Muna Dalti and

[1] Maiduguri Municipal County (MMC).

[2] This outbreak affected three other neighbouring countries of the "Lake Basin" area: Niger, Chad and Cameroon.

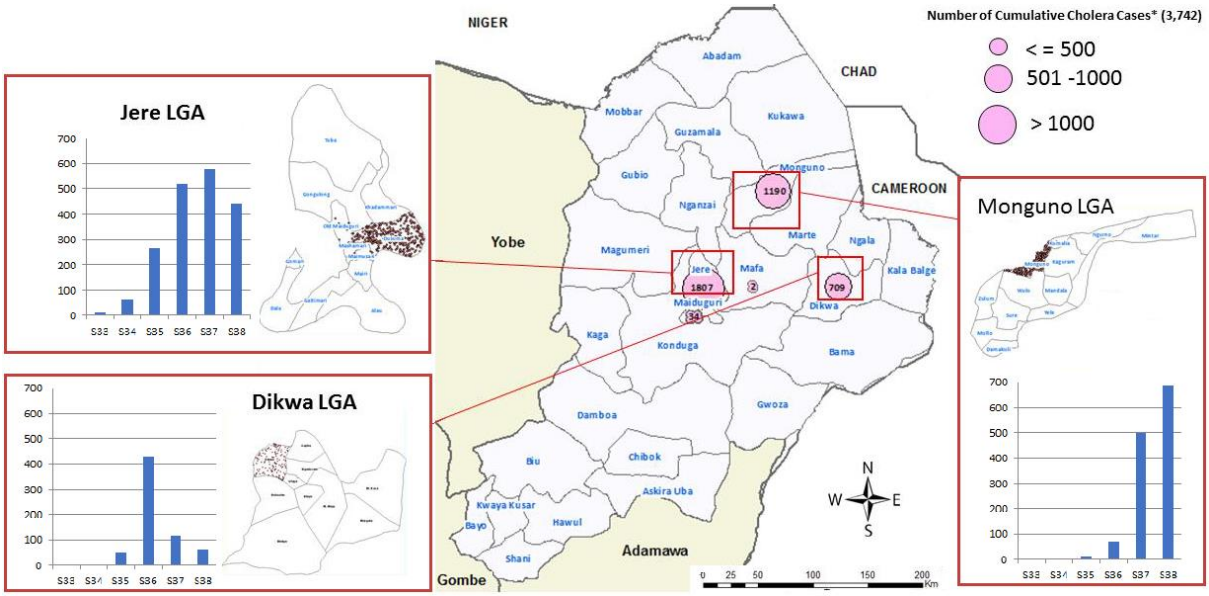
Customs House IDPs camps with flares within the neighbouring communities. Those areas were one of the most affected during last cholera out break in 2015[3].

Several cases were reported in Old Maiduguri, Mashamari (North East Maiduguri Urban) and Bolori 1 (North West of Maiduguri Urban) in September. The number of cases emerging in those areas either previously affected (in 2014 for Bolori 1 and Mashamari) or with dificulties of access (Old Maiduguri) might be the initial signs of the extension of the epidemic within the town. Should the epidemic extend in town, cholera response may be hampered by security constraints (in South East Maiduguri in particular).



Localization of ongoing outbreak and existing flares compared to 2014 affected areas in urban Maiduguri (Jere & MMC LGAs) [Source: UNICEF].

1.2.2 Outreach LGAs

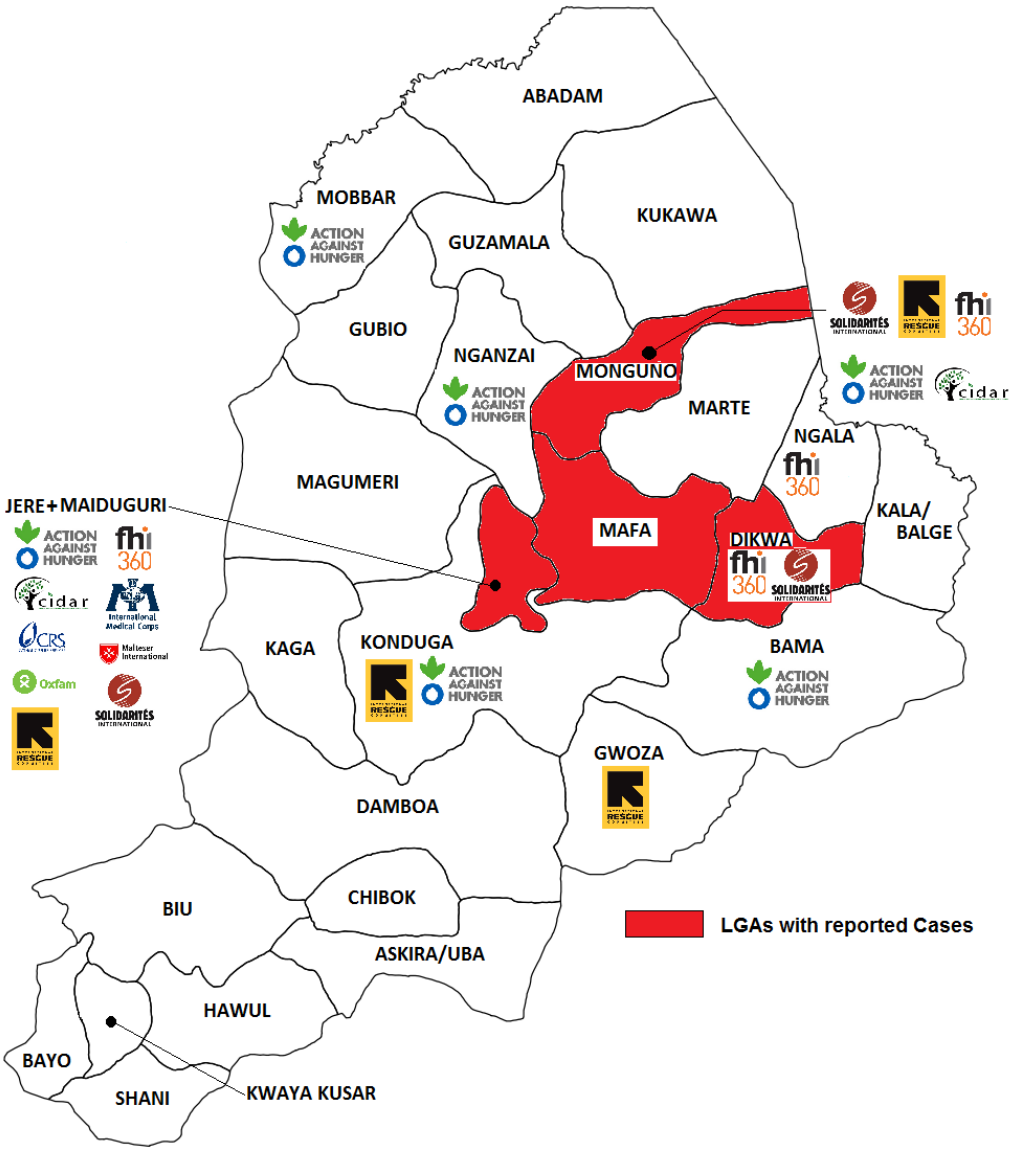


Weekly epidemic trends in Most affected LGAs (Jere LGA included MMC cases) [Source OCHA & WHO]

[3] Total number of cholera cases in 2015 was 1,039.

Beside Jere and MMC LGAs, cases of cholera were reported in Dikwa and Monguno LGAs as of 2nd and 3rd of Spetember. The epidemic spread in both LGAs following two different trends: if Dikwa seems to show a decreasing number of cases over the last two week (for a total of 687 cases as of September 27th), epidemic in Monguno seems to maintain a rather high incidence rate over the past two weeks (with 1 396 cumulated cases as of September 27th).

1.3 2017 epidemic WASH Response



Location of operational WASH actors in Borno State as of 11th of September [Source: Cluster WASH]

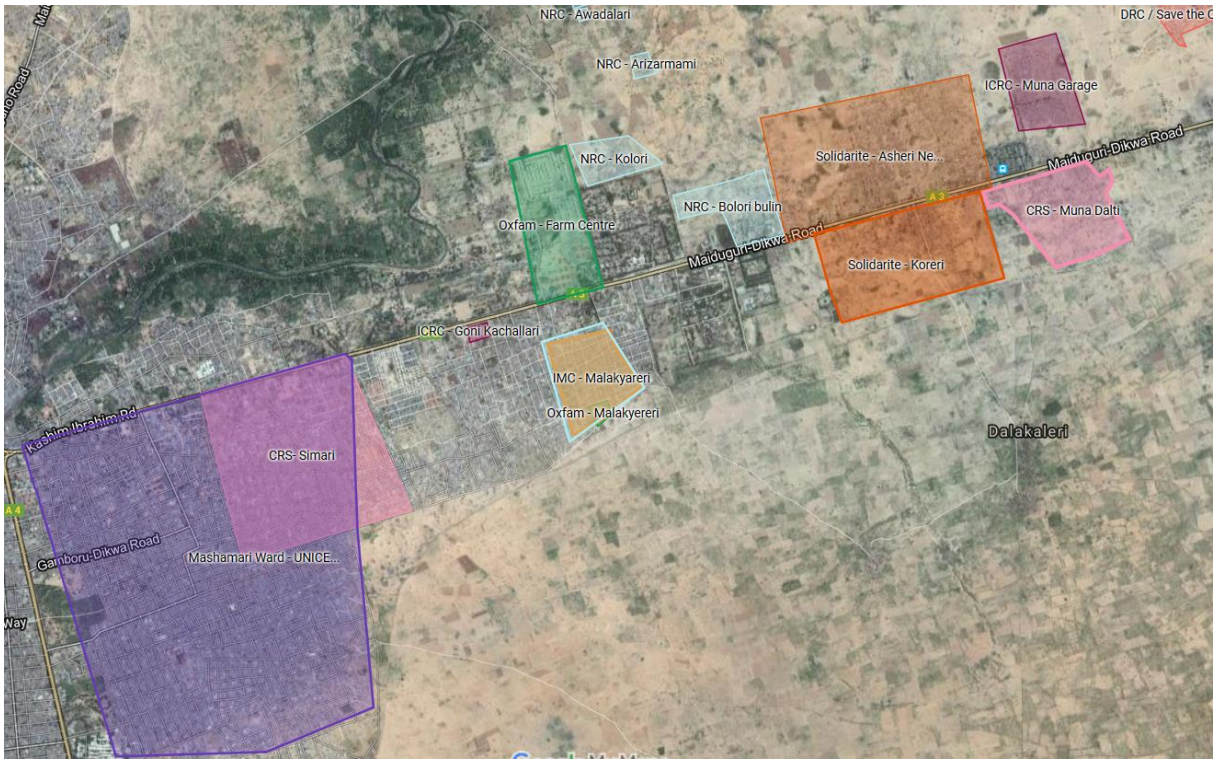
Sector coordination reports that 17 agencies are involved in the WASH sector as of 20th of September[4] in Borno State affected LGAs (Dikwa, MMC+Jere & Monguno).

Joint Coordination (WASH + Health) are held in Maiduguri urban (lead UNICEF & Ministry of Health).

Additional resources from the UNICEF Regional Cholera Platform is to deployed by the 26th of September to strengthen the WASH response.

[4] INGOs: AAH, CRS, DRC, FHI360, IMC, IRC, MSF, OXFAM, Save the Children, SI, and Malteser International; Local NGO: CIdar; International Organization: ICRC; UN Agencies: UNICEF & IOM & Governmental Agencies: RUWASSA & BOSSEPA

1.3.1 Urban Maiduguri (Jere & MMC LGAs)



Areas of responsibilities per NGOs involved in the cholera WASH response in Muna Corridor [Source: WASH sector]

The WASH response reacted quite swiftly as the first cases were detected in Muna Garage mid-August. A coordination meeting was held at local level in order to identify the areas of responsibilities in Muna Corridor. The area has been divided in 9 zones which fall under the monitoring of either Solidarités Internationales (SI)I, CRS, CIDAR, Oxfam, DRC and IRC. SI insured the coordination until it was taken over by UNICEF on September the 6th.

In terms of response, three NGOs (ACF, SI & Oxfam) cover partially the areas. They can operate beyond the one reported in the table aside pending on the availability of their resources.

Main gaps identified as of 20th of September are Gwange I-II-III, Galtimari, Bolori I & Gomari airport areas.

Area	NGO
Old Maiduguri : Faria, Shuwari Lambu, Madinatu, El miskin, Shuwari Galkri	ACF
Dala Area	ACF
Bolori II	SI
Muna Corridor (Farm Center and Malakyareri)	Oxfam
Muna Corridor : from Mashamari to Custom house	SI

Cholera related WASH response capacity in Maiduguri Urban as of 20th of September

1.3.2 Outreach LGAs

In Dikwa LGA, WASH coordination is led by FHI 360 and in Moguno LGA by MSF & SI.

Some actors, although not yet operational intends to implement WASH activities in outreach LGas: IMC in Damboa and Dikwa and Terre des Hommes in Jere & Mafa.

1.3.3 Cholera Vaccination

A 5 days vaccination campaign started on 18th of September. The vaccination included a single dose vaccination (instead of usually two).

Vaccination targeted camps of MMC, Jere, Dikwa, Monguno and Konduga with an expected coverage of 96%. Vaccination in Jere LGA includes, some host communities as well (total of 18 785 vaccination for a total population of 19 568).

LGAs	Total population	Targeted population	% Coverage
Jere	131 264	126 013	0.96
MMC	352 954	338 836	0.96
Monguno	111 938	107 460	0.96
Dikwa	277 056	265 974	0.96
Konduga	45 347	43 533	0.96

Vaccination campaign objectives in IDPs camps (incl. Host Communities in Jere LGAs)

2 Observation & Comments

2.1 Partners capacity

2.1.1 WASH Cluster Coordination

So far, the coordination mechanism consists mainly in the aggregation of data without any analysis or search for consistency:

- The piling up of partners' activities does not allow a proper analysis on whether the partners 'responses are indeed coping with the caseload to address. So far the report does not answer to the question "is it enough?" although the recently issued (May 2017) "*WASH strategic framework for cholera risk reduction and response during the rainy season in North East Nigeria*" paved the road for proper cholera response monitoring.

  Such shortfall highlights the limited added value of institutional support (here UNICEF) in preparedness when involved staff do not have the capacity and/or will to embed the expected outcomes;
- The absence of analysis does not allow any projection in terms of response. Questions such as the duration the partners will be able to continue their support, their capacity to cover newly affected areas remain unaddressed;
- In Urban Maiduguri, it is neither possible to see clearly if reported activities are part of a classic "Sword & Shield" WASH response to cholera epidemic, or the strengthening of WASH services in areas not yet affected by cholera cases;
- The limited data compiling is in itself inconsistent with the different levels of details provided by the partners (site location). The coordination does not seek to harmonize the data they collect;
- The time keeping between the reporting of cholera cases and the response (household disinfection) is a key indicator to ascertain the effectiveness of the WASH response. The coordination has not yet provided any guidance (not to mention records) for the maximum delays the partners should respects in their response; and
- Although initiated at the beginning of the response and later abandoned, the georeferencing of the cholera cases (GPS coordinates of affected households) is not effective anymore. Such data collection is necessary in order to capitalize on the epidemic trends to enable the production of evidence-based structural solution to address the issue in the long term.

2.1.2 Partners response capacity

2.1.2.1 MAIN CHALLENGES

The WASH response to cholera outbreaks is a two sided approach including 1) the eradication of source of contamination (the "sword") and 2) limiting the contamination through interaction ("the shield") notably throughout securing public places with hygiene & sanitation outputs (in market for instance).

Partners are operating in highly volatile context under suicide bombers threat which does not allow working in crowded public places with limited if any control of the movements of people. It tends to limit the capacity of the partners to deploy the proper "Shield" component of the WASH response.

The partners' presence mapping in outreach LGAs is misleading as it tends to suggest that partners in those LGAs have the capacity to deploy themselves in the entire area. Partners' deployment capacity is restricted to the capital city of each LGA they work in. Beyond those isolated spots, little if any is known about the health status of the population and the progress of the cholera outbreak (if any). WHO is resuming sets of mobile clinic which are able to go beyond the capital cities of LGAs but the frequency of their rotation (one month) is too long to detect (and contain) any cholera outbreak.

2.1.3 ECHO partners involved in the Cholera Response

2.1.3.1 PARTNERS WITH A WASH COMPONENT IN THEIR ONGOING GRANTS

Solidarités Internationales (project reference 2017/00821)

SI implements WASH activities in Monguno, Dikwa and urban Maiduguri and showed the greatest involvement in the cholera response. The setting ("sword component") observed in the field during the mission is of excellent quality. With the available funds they have with their ongoing action, they have the capacity to continue their support to the response for approximately a month.

ACF-ES (reference 2017/00827)

ACF implements WASH activities in urban Maiduguri. The INGOs is with Solidarités and Oxfam involved in the containment of cholera cases ("Sword component") with the capacity to continue their support to the response for a month at best. Due to agenda constraint, the mission did not include onsite visits.

IRC-UK (reference 2016/01358)

IRC implements WASH activities in Bakassi and NYSC camps in Maiduguri. Due to agenda constraint, the mission did not include on site visit although activity reports shows a strengthening of their initially scheduled activities (reservoirs chlorination) rather than participation to the cholera response itself.

UNICEF/Borno (reference 2016/01342)

UNICEF has several grants ongoing with ECHO including WASH component such as WASH in Health (reference 2016/01342) and support from the Cholera Platform (reference 2016/01342) at regional level.

As for UNICEF in Borno, the agency is still working with its institutional partner (RUWASA and BOSEPA) although those are not directly involved in the cholera response. Their main activity consists in the strengthening of WASH services. Until June 2017, there was limited expertise within UNICEF in Borno state. Previous mission reports highlight the main flaws in the setting of water supply facilities which were never addressed. It would have contributed to the reduction of the risk of cholera outbreak expansion (with the introduction of water chlorination system in water piped networks for instance).

Stagnant water around the water stand supervised by RUWASA (UNICEF implementing partner) in cholera affected Custom House IDPs camp A creating a contamination hazard

Recently "rehabilitated" latrines under UNICEF supervision in Custom House IDPs camp B with presence of open defecation creating a contamination hazard

UNICEF is also involved in the cholera response with implementing partners as CIDAR in Maiduguri and Monguno.

The performance of its implementing partner remains unclear. Observations made in the field revealed limited expertise and absence of follow up from UNICEF's part. There is still limited capacity (and will, considering the repeated recommendations addressed to the agency on

that issue) to properly monitor the performances of their implementing partners.

The recent strengthening of the coordination may address the issue next year but it will still be pending for the ongoing cholera outbreak.

- *UNICEF/Cholera Platform (reference 2016_01275)*

The Cholera Platform is an ECHO supported project which includes operational support in case of cholera outbreak:

- Human resource deployment in order to support the response; and
- Supply of NFI to address 5 000 cholera affected people and sensitize 30 000 in cholera affected area.

The supply of NFI is dedicated to address the very first onset of a cholera outbreak in affected areas where resources and presence of actors are limited. A review of WASH actors present in Borno state and a mapping of the WASH resource which could be deployed in case of cholera outbreak led the platform to decide not to mobilize those NFI as they would be of limited added value considering the resource available in situ.

If the decision of the Platform makes sense for Maiduguri urban and to some extent Monguno and Dikwa where WASH actors are present, it may not be that relevant in LGAs with limited presence of actors should they be affected by the epidemic.

As for the mobilization of human resource, the only person available was not in capacity to be deployed at the beginning of the outbreak (health related issues). With the absence of a permanent head of project[5], the platform has been able to deploy resource in situ on the 26th of September only, 41 days after the first cholera cases were reported.

2.1.3.2 PARTNERS WITH ONGOING ECHO GRANTS NOT INCLUDING A WASH COMPONENT

- *CRS/CAFOD-UK (reference: 2017/00818)*

CRS is conducting an ECHO supported project which includes mainly food assistance, although they implements WASH activities in Maiduguri with other sources of funding (OFDA). Their response seems similar to IRC with a strengthening of their ongoing activities rather than a real involvement in the response. From what has been observed in the field, they are able to reach quite good standards in terms of facility setting (latrines) but limited expertise in the WASH sector and limited follow up (observed network during the mission was not chlorinated enough).

- *DRC (reference 2016/01327)*

DRC has ongoing grants under ECHO funds dedicated to protection and shelter as part of the rapid response mechanism in Borno State. The shelter component of the project includes the distribution of kits which includes WASH items. They took an active part at the beginning of the crisis and remain a supplier of WASH NFI if needed. They are not participating to the response as such (in the “sword” component of the response).

- *IMC-UK (reference 2016/01362)*

IMC has ongoing grants under ECHO funds although not WASH related (in MMC, Konduga and Jere LGAs). They intend to conduct WASH activities in Damboa and Dikwa.

- *Save the Children-UK (reference 2016/01360)*

Save the Children also has a grant with ECHO mainly on protection, food assistance and nutrition in Damboa and Mafa LGAs. They are also active in Maiduguri although previous WASH missions revealed extremely poor level of performance in the sector.

- *Plan International-IR (reference 2017/00825)*

Plan International is working in Mafa and Gwoza LGAs implementing protection and EiE

[5] The person leading the platform left during the first quarterly of 2017; the targeted replacement defaulted in June 2017 after an almost completed recruitment process.

activities with ECHO funds. They are recorded as WASH partners at coordination forum although their involvement in the cholera response remains unclear.

2.1.3.1 PARTNERS WITHOUT ONGOING ECHO GRANTS

Oxfam and Malteser Hiilsfdienst, are WASH partners present in urban Maiduguri although not supported by ECHO at the moment.

Terre des Hommes is aiming at implementing WASH related activities in Mafa and Jere LGAs although they are not yet operational (as of 11th of September).

2.1.4 Vaccination campaign

With the campaign on going at the time of the visit, it was still too early to assess whether they have been able to cover the targeted population. Based on the protocol adopted, some issues can be raised:

- The protection of the Shancol Cholera vaccine is of 66% if administrated in two doses in a 14 days interval[6]. Protocol adopted in Maiduguri consisted in a single dose. Recent studies on efficiency of single dose vaccine against cholera showed that the protection effect was of 40% in general, but with variation according to the age (up to 63% for children from 5 to 14 years but only 16% for children from 1 to four years[7]). Conclusion of the study is that single dose vaccination was suitable only for people older than 5 years. No specific follow up was made in the campaign for children between 1 and 5 years of age; and
- The coverage was mainly limited to the camps (a part from Jere where 18 785 people from host communities received vaccines as well). The risk is that if the outbreak should expand to the communities, the barrier provided by the vaccine may not be effective anymore.

2.2 Epidemic trends on the current set up.

Should the epidemic start to decrease, it can be hoped that the current set up will last until the end of the crisis. Although epidemic trends in Dikwa showed an important decrease since the last two week it cannot be considered already as contained in this LGAs. With sustained trends in Maiduguri urban and high incidence in Monguno, this scenario cannot be considered as the most likely ones.

Two other scenarios are possible:

1) A rather sustained incidence of cases in the two coming months contained in the areas already covered by the WASH actors. In that configuration, active WASH actors will have to secure funds to pursue their efforts;
2) An expansion of the epidemic in urban Maiduguri, newly affected outreach LGAs or in Moguno, Dikwa and now Mafa. The existing response capacity will not be able to address this situation and advocacy will be needed to secure more funds and attract more actors;

This second scenario includes the possible extension of cholera cases to bordering countries such as Chad, Niger and Cameroun in areas where already structurally limited alert systems are even more weakened by the presence of Boko Haram groups.

3 Expert recommendations

3.1 2017 Programming

It is not yet possible to foresee if, where and when the epidemic will expand and to what magnitude. The vaccination campaign may have a containment effect although the epidemic has the potential to break through the net the campaign set up since it did not cover the host communities the affected populations interact with, nor does it have the same efficiency as a double dose vaccination campaign would.

[6] See WHO position paper on cholea vaccine in 2010 at http://www.who.int/immunization/cholera_PP_slides_20_Mar_2010.pdf.

[7] See "Efficacy of a Single-Dose, Inactivated Oral Cholera Vaccine in Bangladesh", May 2016 at http://www.nejm.org/doi/pdf/10.1056/NEJMoa1510330

In terms of scenario It is therefore wiser to consider that the persistence of the epidemic over the two coming months as the most likely scenario. In that perspective, the capacities of the operating partners may be stretched to the extent they may not have the resources to cope with.

It is therefore recommended to secure funds to the most efficient partners involved in the cholera response and to seek opportunities for additional funds in case the epidemic would continue to expand in the two coming months:

- Solidarités' costs for an extra two months in the most affected areas (Maiduguri and Monguno) and extra provision to secure one month of intervention in new area and to those with lesser number of cases (Dikwa LGA) are 461 544 €, 400 000 € of which needs can be allocated from the existence balance of HIP 2017 recent top up[8];
- With CRS in the process of producing a modification request, it is recommended to introduce a crisis modifier result which would allow them to secure their response if extra funds are made available;
- It is recommended to advocate to ECHO WASH partners involved in the response (ACF, Oxfam) to produce a concept note in order to fast-track the funds allocations if/once those are made available at ECHO's level; and
- The availability of extra funding capacity from ECHO should be envisaged either through a top up of the HIP 2017 or through the epidemic decision. This latter may provide more flexibility as it does not imply a consultation as wide as for a HIP 2017 top up.

3.2 Operational recommendations

Coordination mechanism should be strengthened including:

- A clear separation of the WASH related activities distinguishing:
  - Routine strengthening of WASH services in areas not yet affected by cholera cases; and
  - Proper WASH interventions participating to the cholera response guided by the occurrence of cholera cases ("Sword & Shield" approach). The related activities should be based on the "sword and shield"[9] approach which includes:
    - Cases tracking (GPS coordinates records);
    - Household disinfections which goes beyond the simple spraying around the household premises and includes proper management and use of 0.2% and 2% chlorine solutions;
    - Secure hygiene & water storage at affected households level (distribution of NFI kits including, Jerrycans, bucket with lids, water disinfection tabs and soap);
    - Affected households' water & sanitation facilities disinfection (including bucket chlorination, drainage and pit emptying if conducted with proper protection equipment);
    - Strengthening of access to safe water during at 5 consecutive days without cholera reports among the users;
    - Cholera awareness messaging (symptoms description, action to take in case of suspicious case, ways to prevent contamination) in the neighborhood;
    - Securing WASH services in public places (if security allows) with entrance and exit, food stands/restaurant equipped with hand washing devices supplying 0.05% chlorinated water and restriction of unhygienic cold food sales; and
    - Supervision of all activities in order to ascertain that minimum standards are achieved.
  - Cholera response coordination should include:

[8] The balance being available within the project funds as some initially scheduled activities (non-cholera related) will be supported through another grant.

[9] More tools and guidance are available at http://www.plateformecholera.info.

- Response delays tracking in order to insure that the response is on site in less than 24 to 48 hours once the case is reported at health facility level;
- Homogenization of the data compiled including a more coherent localization of the interventions and their duration on site (for water chlorination in particular); and
- Data analysis in order to highlights the gaps in the cholera response in terms of delay and coverage and to seek for better synergies and/or extra resources.

- A review of the cross border (and cross state for Nigeria) alert mechanisms including update of the contact lists, routine communication of cholera cases in wards and LGAs bordering other countries/states; and
- A review and update of the alerts system and contingency plans in bordering countries (Extrême Nord Region in Cameroun, Lac in Chad and Diffa in Niger);

3.3 2018 WASH Strategy in terms of cholera response and preparedness

3.3.1 Preparedness:

The first actors to respond to the reporting of cholera cases were INGOs operating in the affected areas. The sector coordination was absent of the coordination mechanism as it appeared to be unable to provide the guidance and synergies required to address the issue.

Although they had set a cholera response plan one month and half before, it took more than 3 weeks to the coordination to take over the lead with still some important gaps in terms of operational added value (see upper comments).

Such a low level of performance highlights that investing in cholera preparedness with the current institutional actors is of little added value, and may result in counterproductive effects[10].

3.3.1 Response:

Since the INGOs and among them ECHO partners, were the most responsive actors at the onset of the crisis, it is recommended to facilitate the reorientation of activities through the systematic introduction of crisis modifier in all ECHO supported appraisal working in North East Nigeria (and to some extend to all partners working in the Lac Tchad basin).

As for UNICEF in Borno, they have proven repeatedly to be unable to upgrade their standards to requirements in a cholera prone area such as Borno requires despite the repeated recommendations and technical orientations to do so over more than three years. It is therefore not recommended to continue to support the agency in the processing of WASH related outputs.

On the other hand, they have recently strengthened their cluster coordination capacity. Although too late to have an effective added value on the current cholera crisis, it is recommended to envisage the support the sector coordination for 2018 in order to sustain its presence in Maiduguri.

As now everywhere in most crisis affected countries, and either for agencies or INGOs, the quality of the response does not depend anymore on the institutions but on the capacity of the capacity of the people they deploy in situ. With most of them affected for a period of one year or less, it is rather difficult to identify in December 2017 which partner will be the most qualified to implement WASH related cholera response in the second half of 2018.

As for the cholera platform, ECHO' support ends in September 2018 although a no cost extension may be foreseen considering the expected underspending due to the absence of head of project for nine months now. It is therefore likely to cover 2018 cholera prone season. Lessons learnt exercise must be made and action taken to address their incapacity to deploy the required human resources in time for the ongoing cholera crisis in Nigeria when it is their core operational added value.

[10] Expected result in preparedness activities may not turn into effective operational capacities when required, resulting in unexpected delays in the scheduled interventions and further extension of the epidemic in the meantime.

4 Sector policy compliance

All above mentioned supported action are sector policy compliant.

The issue in the humanitarian sector is not the compliance to WASH ECHO policy since its content are quite general and focus on quality standards in the setting of strategies, targeting of populations, and programming of activities for which the skills of a generalist of the organization of the partners is enough to secure.

The shortfall is that ECHO WASH policy does not have quality standards in terms of performances of the expected services and the requirements it involves in terms of supervision (while setting the service) and monitoring (once set).

It is therefore extremely difficult to hold ECHO partners accountable for the quality of services the beneficiaries have, at the end of the line, access to.

Such expertise used to be embedded within most partners until the year 2000 when most of the international staff started to build their experience with onsite direct implementation work, with close if not direct participation to the implementation of activities for which a technical added value was expected.

Since the year 2000 and the professionalization of the humanitarian environment, newly recruited staffs start their career directly at management level with a master degree which allows them to fit quickly in the humanitarian architecture but with little if any skill in the technical requirement to achieve and monitor the services they are expected to provide to the beneficiaries. Those skills usually rely on the capacities of local counterparts who usually do not have the skills to process and monitor the outputs under the international standards ECHO partners claim to achieve.

As long as the DG-ECHO will not institutionalize technical quality standards, there will be little margin to challenge the partner when sector experts highlights flaws based on their personal expertise. It is particularly accurate for the WASH and S&S sector where no UN agencies are standards keepers as WHO is for the health sector.

As long as experts' statements will not be backed up by technical reference imbedded in ECHO, they have no legal basis and cannot be sustained against the partners on a contractual basis. The main issues which can be opposed to partners is either the absence of service or its delivery out of the needed timeframe. Its quality remained mostly unaccounted.

Results is services delivered to the beneficiaries of poorer and poorer quality which not only challenge the legitimacy of the humanitarian actors towards the populations they are meant to support, and eventually, their security, but the role of ECHO as a reference donor in the WASH sector.

Feed-back Request Box

None