ACTION PLAN TO ADDRESS CHOLERA / ACUTE WATERY DIARRHEA AND CHIKUNGUNYA VIRUS OUTBREAKS ON THE KENYA - ETHIOPIA - SOMALIA BORDER

AUGUST 2016 - AUGUST 2019
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EXECUTIVE SUMMARY

This report was developed by IGAD and UN agencies following the concurrent outbreaks of Chikungunya, Dengue, Cholera/AWD and Measles in Mandera, Kenya in May 2016 with similar trends reported in neighboring regions in Ethiopia and Somalia. It aims to draw attention on this highly vulnerable border region and proposes strategic interventions for the immediate, medium and longer term for sustained disease surveillance, water and sanitation and Vector control - It does not duplicate comprehensive operational requirements outlined by country level response strategies through national development plans, UNDAFs and humanitarian response plans.

While governments in the region together with humanitarian partners have been able to significantly reduce the number of cases over the past months through targeted interventions, the region remains highly vulnerable to recurrent disease outbreaks. Its population’s vulnerability is compounded by high levels of multi-dimensional poverty, low immunization levels, weak access to social services, and high levels of population movements given the nomadic nature of the border communities – who move from place to place in search of water and pasture for their animals.

Implementation of a disease preparedness and response plan could catalyze further development investments for this priority IGAD cluster for durable solutions to address chronic humanitarian needs and implement sustainable risk management practices.

This multi-agency sub-regional action plan seeks to fundraise to address the Cholera and Chikungunya virus outbreaks and their risk factors in the Mandera Triangle (Mandera Kenya, Belet Haawo Somalia and Dollo Ado Ethiopia) from August 2016 to August 2019 through immediate term, medium term and long term multi-sectoral approach. These activities will be implemented at an estimated cost of **US$21,603,738** (IGAD: 2,475,980, IOM: 3,750,950, UNICEF: 8,386,808, WHO: 6,290,000 and OCHA: 700,000) whose breakdowns by agencies are detailed in this document.

The joint action plan for responding to Cholera/AWD and Chikungunya outbreaks in the Mandera region, as well as other possible future epidemics, consists of:

- Immediate response focusing on scaling-up to effectively respond to cases and contain any further spread (3 months starting August 2016) in order to prevent additional morbidity and mortality related to the outbreak;
- Mid-term response focusing on strengthening WASH activities (12 months starting August 2016) with the objective of addressing the root causes of the cholera outbreak in the community and building the resilience of communities and systems to respond to outbreaks.
- Overall coordination focusing on leveraging existing regional coordination mechanisms where possible to strengthen cross-border information sharing, surveillance, preparedness and response with a focus on the border areas of the three countries (3 years starting August 2016).
The Mandera Triangle, comprising the borderland areas between Ethiopia, Kenya and Somalia, is chronically underdeveloped and hosts some of the most vulnerable people in the region. The poverty rate in Mandera for example is 80 per cent. According to a nutritional SMART survey conducted in June 2015 by the Government, Mandera County has a 24.7 per cent GAM rate and a 3.7 per cent SAM rate which are all above the global emergency threshold, and an immunization rate of only 27 percent. Access to basic services is low. Poor road network and transport means has contributed to the increased cost of healthcare, thus a major challenge in accessing health care services in the entire county.
Mandera County has witnessed waves of violent clan conflicts and terrorists attacks in the recent past that claimed dozens of innocent lives and has displaced hundreds of families. Mandera County also experienced several targeted terrorist attacks, killing at least 122 people since November 2014. The insecurity has prompted an exodus of teachers and health workers that adversely affects learning in schools and disrupted health services across the county. Lack of humanitarian access has also hampered surveillance and assessment activities and humanitarian deliveries, particularly in remote parts of the county. With the underlying causes of the 2014-2015 conflict unaddressed and with higher political stakes in the upcoming general elections (August 2017), a potential new cycle of violence could erupt, displacing more people.
The borderlands also constitute a dynamic trading zone that supports the livelihoods of thousands of people resulting in very high population movement. While the free movement of people is a positive element for the economy and social development of societies, it is known to be a proxy factor for the spread of diseases. It is paramount to ensure availability of services along migration routes through mobile services and not only static clinics. Therefore the approach to responding to disease outbreaks and other health emergencies should particularly be weighed on human mobility, through proper framework. For example, as leading agency on migration IOM has developed in coordination with CDC and WHO, the first comprehensive framework on human mobility for public health purposes the Health Border Migration Management (HBMM) which aims to ensure adequate and timely interventions for prevention, detection and response to diseases of public health concern, along migration routes (the mobility continuum) that is, at origin, transit, destination and return points. This framework can serve the response and preparedness of this proposal integrating innovative and effective approach.

Despite this recognized link, the health system fails to capture the mobility of people making more challenging case detection, management and follow-up. Not enough information is available on size and route of people’s movement in the area. Until this issue is properly addressed the risk of recurring outbreaks is real. In addition, the quality of health care in the area is generally poor due to chronic shortage of health care workers. Mandera County has a high health staff turnover due to seasonal insecurity, poor transport network, climatic conditions, physical and social amenities such as staff houses and poor staff motivating factors, including remuneration. The lack of equipment and essential supplies has also, from time to time,
hampered provision of quality health care across the health centers, dispensaries and the referral hospital in the county.

Mandera County has the lowest routine Immunization coverage of about 27%, far below the 80% target, as compared to other counties in the country. The County remains the worst place for a mother to give birth and for a child to be born and thrive. Maternal mortality is very high with the Mortality Ratio (MMR) of 3,795 deaths per 100,000 live births. High illiteracy, little use of contraceptives, bad traditional practices, including Female Genital Mutilation (FGM) and early marriage as well as inadequate maternal health services have led to these very poor health indicators in the county. Mandera remains among the most vulnerable Arid and Semi-Arid Lands (ASAL) counties in the country due to rampant insecurity and its poor socio-economic status.
### 1. SUB-REGIONAL CONTEXT - OUTBREAKS

Several outbreaks have occurred in the Mandera Triangle over the past year, including cholera / acute watery diarrhea (AWD), Chikungunya, dengue and others. The last three weeks have seen a spike in the number of new Cholera/AWD cases, an indication that the outbreak is still very active and becoming bigger – particularly in Belet Haawo District of Gedo region of Somalia and Dollo Ado region of Ethiopia. The uncontrolled movement of people between the three countries makes control efforts a challenge.

The cholera outbreak was most wide-spread and persistent in the area. In **Kenya**, cholera has affected 30 of its 47 counties since 26 December 2014. The Cholera outbreak in Kenya has been active since December 2014, affecting a total of 30 out of 47 counties, with a total of 16,511 cases with 254 deaths (Case Fatality Rate of 1.5%) being reported nationally by 27th June 2016. The outbreak has been declared controlled in 28 counties, including Dadaab Refugee Camps, and it is now limited to the Mandera Triangle (Mandera and Wajir Counties), and Tana River.

The Manda County reported its first outbreak of Cholera on 12 April 2016. By 30th June 2016, Mandera County had recorded a cumulative total of 1,752 cases. Of these cholera cases 46% are children under 18; of which 21% (355) are children 0-5 years, 18% (319) 6-15 years, and 7% (121) cases are 16-18 years. Therefore, more than a quarter of the reported cases were among school-age children; this is affecting regular schooling, with less than 60 per cent attendance reported in Mandera East.

Two Cholera Treatment Centers (CTCs) were established and separately run by MSF and Kenya Red Cross, with the help of the Mandera County Government and other humanitarian partners. One of the CTCs has been closed down since the outbreak has been controlled. The Cholera outbreak is largely limited to Mandera East sub-County (Mandera Town and its environs), which has an estimated population of 300,000 people.

In **Ethiopia**, although the real morbidity and mortality figures from the current outbreaks, particularly Cholera/AWD are not clear, it is estimated that they could be three times higher than the currently reported cases – since deaths at community levels are not registered and reported. The first AWD case was reported from Moyale town, Oromia region on 06 November 2015, spreading to Somali region of the same town.
on 21 November 2016. The outbreak further spread to Hudet and Dollo Ado Woredas, of Liben Zone, and Dollo Bay woreda, of Afder Zone bordering parts of Kenya and Somalia countries. As of 14 August 2016, 1,099 cases and 7 deaths were reported from 3 zones and 6 Woredas of Somali region.

Critical water shortage, poor latrine coverage, and high cross border mobility (particularly migrant workers, cross border markets and visits to families living on both sides of the border) are the underlying causes of the AWD outbreak. Most people in the affected woreda use water from unprotected water sources mainly from private/commercial hand dug wells (Ella), rivers and rain water harvesting. WHO water quality tests confirmed the presence of E.coli from 41 (78.8%) of sampled hand dug well water sources. Moreover, according to the Belg/Gu multi-agency assessment in June 2016, 36 per cent of the available water schemes are non-functional. The assessment also indicated that in Afder zone, the Gu 2016 rain has performed very poorly across all the woredas with uneven distribution and early cessation. In Liban zone, the GU rain was normal in most Woredas except Dolo Ado Woreda that received only 2 days of rainfall. Water and pasture availability is relatively good in Filtu, Deka, Hudet, Mubarak and Moyale Woredas although it is anticipated that significant number of Kebeles in this Woreda will face chronic water shortage in the coming months.

In Somalia, the recent cholera epidemic is an extension of the previous outbreaks that have been reported in Kismayo in 2015. Somalia is one of the cholera endemic countries in the region characterized by recurrent AWD/ Cholera outbreaks in areas especially in the riverine regions of Juba land and Shabelle. Since 2012, a total of 44,992 cases and 1,381 deaths (CFR 3.1%) have been reported in Somalia. As of September 2016, a total of 13,598 cases of AWD/Cholera and 496 deaths (CFR 3.6%) have been reported in 25 districts. Of these 6425(47.5%) are women while 7,884 (57.9%) are children below 5 years. Over the past three years, the most affected areas for AWD cholera have been in Banadir regions, South Juba (Kismayo), Marka district in middle Shabelle, Beletweyne, Gedo and Jowar. These areas are characterized by overcrowded settlements where access to safe water and sanitation is limited. These areas also have seasonal flooding in the months of April-June and October-December.

**Chikungunya**

In Kenya, Mandera County also reported an outbreak of Chikungunya Fever, a viral disease which is spread by Aedes Aegypti mosquito that is also responsible for the spread of Yellow Fever, Dengue Fever and Zika virus. The outbreak was first reported on 1 May 2016 after laboratory tests conducted by Kenya Medical Research Institute (KEMRI) confirmed that the disease was Chikungunya fever. The outbreak affected 70 per cent of Mandera Town residents.

The outbreak of Chikungunya further placed pressure on the already overstretched health services. The exact number of people who were affected by Chikungunya Fever in Mandera County is currently unknown. However, hospitals (both private and public) were overwhelmed with admissions, case management and symptomatic treatment of the disease. According to health personnel at Mandera referral hospital, more than 70% of Mandera, Rhamu and Elwak residents were affected. At least 50 per cent of the health workers in Mandera County – particularly those at the main referral hospital were reportedly affected by the Chikungunya fever, hence the need for a substantial surge support for the health sector during the outbreak. The spread of the disease was attributed to an outbreak in the neighbouring Somalia. The presence of the virus was confirmed after samples were collected by the World Health Organization. The result indicated that there is an active circulation of Chikungunya virus in areas where the samples were obtained such as Wardhigley or Warta Nabadda and Howlwadaag districts. After Chikungunya was reported from Mandera, Kenya, the disease further spread to Dolo Ado Woreda of Ethiopia. Between 4 - 27 June 2016, a total of 864 cases were reported from Sufu Kebele/village, Dollo Ado woreda/district, Liben zone, Somali region of Ethiopia. Of the 864 cases: 356 cases (41.2%) were reported from Kebele 1; 508 cases (58.8%) from Kebele. 425 (49.2%) of the reported cases were male, and 439 (50.8%) female. The first peak of the outbreak
occurred during week 23 (283 cases, incidence rate of 20.71 per 10,000 population). The second peak occurred during week 25 when 249 cases were reported (incidence of 18.2 per 10,000 population). WHO provided support for case management and continues to provide support in surveillance for Chikungunya. No new cases have been reported since 27 June 2016.

Impact of the outbreaks
The porous border between the countries is reportedly worsening the situation – challenging surveillance and active case finding activities. Lack of a tracking system to identify the movement of people hampered elimination of the virus. The absence of an effective government health system in Belet Haawo District was also burdening the already weak health system in Mandera County – where the majority of the patients from Belet Haawo Somalia and Suftu Ethiopia seek secondary medical care.

In Mandera around 90 per cent of teachers were absent in some areas, further affecting access to education, as well as critical health and nutrition services for children and women. Dengue fever and yellow fever alerts are also ongoing. The main gaps and challenges on response to the twin outbreaks were weak health and WASH systems at county level in terms of resources allocation, technical capacity and lack of policy guidance. In addition, communication and multi-sectoral coordination between county and national level are weak, where the outbreaks are viewed as a ‘health issue’ only. Response in Mandera is also particularly challenging due to insecurity and restricted access.

The impact of these outbreaks in the regions required appropriate forms of interventions on key issues, including setting a cross-border coordination mechanism, improving systems of prevention, surveillance, control and treatment of the diseases. There are also greater needs for enhancing training and equipping of health facilities at the regional levels in the areas of communicable diseases. Currently, the health-care delivery systems in the affected areas remains weak and overstretched and unable to respond to outbreaks without support from humanitarian partners.

2. RESPONSE TO DATE

ETHIOPIA

The Ethiopian Somali and Oromia Regional Health Bureaus together with partners instituted a robust response to the outbreak and mobilized technical staff from regional and district health office level. Medical equipment and drugs from WHO, UNICEF and Save the Children were mobilized to set up CTCs. UNICEF funded Mobile Health and Nutrition Team (one MHNT) was also deployed. Technical assistance from WHO and UNICEF emergency Communication for Development (C4D) supported community engagement/social mobilization including development of appropriate print and audio materials for the response. WHO provided support in WASH/environmental health, specifically in water quality surveillance, environmental surveillance, risk identification, demonstration and distribution of household water treatment chemicals and orientation for health workers in infection prevention and control. WHO deployed WASH and health promotion officers and epidemiologists to support the response in Moyale. The Regional Health Bureau with UNICEF financial support conducted staff training at Suftu Health Centre. Through coordination and advocacy, MSF took over the CTC management and deployed medical staff and community volunteers conducting house-to-house visit in Suftu town and surroundings. In response to Chikungunya outbreak, WHO and UNICEF as member of Federal level Command Post, developed reference materials in local language for health workers on Chikungunya case definition, case management and key prevention messages.
UNICEF WASH provided 500,000 sachets of PUR to the affected areas in Somali Region. This enabled 20,833 people to have access to safe drinking water for 2 months. Adequate information was provided to all on the safe handling and use of the chemicals. In addition 25,000 brochures and leaflets on AWD were dispatched to the areas and widely distributed to raise awareness on transmission routes and how to break them. UNICEF deployed a Communication for Development consultant to technically support and work with regional health officials on how to intensify the dissemination efforts. The above mentioned concerted efforts contributed to the downward trend of AWD cases in the past weeks with efforts to be maintained.

KENYA

The County government of Mandera, in collaboration with the National Government initiated response efforts after the Cholera outbreak was confirmed in April 2016. The National Ministry of Health took the burden of providing medical supplies and personnel at the initial stage of the outbreaks to support the county government.

The coordination of the response efforts was more strengthened with arrival of personnel from the Ministry of Health, WHO, UNICEF, UNOCHA, UNFPA, Kenya Red Cross, AMREF, KEMRI, NRC, Save the Children and MSF in the last week of May 2016. The team comprised of technical staff, in health, WASH, vector control, coordination, advocacy, Communication and Social Mobilization (ACSM), hygiene and sanitation as well as safe water provision.

At the peak of the outbreaks (late May 2016), an additional team of medical personnel were also deployed under Kenya Red Cross Society, MSF and Save the Children to provide services at the Mandera Referral Hospital and at the Cholera Treatment Centres (CTC) in the town. MSF was responsible for managing the main CTC at Mandera Referral Hospital which was opened on 24 May 2016 at an initial bed capacity of 80 that was later increased to 120 beds at the peak of the outbreaks in the first week of June 2016.

Kenya Red Cross Society opened a second CTC in Bulla Mpya neighborhood on 3 June 2016 to reduce the overwhelming pressure on the main MSF-managed CTC. By the end of the outbreaks in mid-August 2016, the two CTCs had line listed, treated and discharged 1,799 cholera patients. These response efforts were effective in bringing down the number of new infections and admissions at the CTCs, mainly in Mandera town, the epicenter of the outbreak.

During the twin outbreaks in Mandera, UNICEF also supported more than 345,000 women, men, girls and boys in Mandera County access WASH interventions (water treatment at source and household level, handwashing with soap and appropriate storage of drinking water).

In regards to Chikungunya fever, in partnership with Kenya Red Cross and County government, 550 households were reached with Chikungunya messages in Mandera County and 1,070 households with Cholera messages in Mandera. In addition, radio messaging on Cholera and Chikungunya reached over one million people in the counties of Mandera and Wajir.

Behavior Change Communication (BCC) materials on Chikungunya were distributed to all 184 public schools in Mandera County, reaching approximately 91,000 children and UNICEF Health supplies have supported in the treatment of more than 1,750 women, girls, boys and men suffering from Cholera in Mandera Country as well as the distribution of mosquito nets to 2,700 families affected by Chikungunya. Similarly, Save the Children carried out two levels of interventions during the outbreaks in Mandera County, including strengthening case management and Cholera prevention and control at community level (training of health workers and community health workers, cholera kits and hygiene kits supplies, logistical supports
including referrals, radio messaging on health promotion in the entire county).

Health partners in Mandera reported that Mandera County relied on a weak diagnostic laboratory, weak surveillance and case tracing capacities to respond to outbreaks of communicable diseases. The proximity of Mandera to Gedo Region of Somalia and Dollo Ado District of Ethiopia, where basic health services are reportedly also inadequate, made it a point of convergence for referrals in the region. According to Mandera County Health Ministry, more than 200 patients from Ethiopia and Somalia seek medical services daily at the public and private health centres in Mandera town and other border towns in the county.

To strengthen the coordination and information sharing mechanism in the Mandera Triangle (Mandera County, Suuftu Ethiopia and Belet Haawo Somalia), the County Commissioner of Mandera on 30 May 2016 organized a cross border meeting with representatives of the local administrations and health partners in Belet Haawo, Somalia in Mandera town. The meeting discussed the outbreaks and the level of response and capacity in Belet Haawo Somalia. The majority of the outbreaks (Cholera, Chikungunya, Dengue etc) were reportedly attributed to importation.

**SOMALIA**

Local and international NGOs (HIRDA, NCA, HDC, LLG, World Vision, Trocaire, and Relief International) took the lead to provide support to health facilities in Belet Haawo District to tackle the spread of cholera/ AWD. HIRDA and HDC (UNICEF partners) provided pharmaceutical and non-pharmaceutical supplies to the main Belet Haawo District Hospital – where the majority of the population seek treatment. NCA scaled up WASH activities and hygiene promotions in schools around the town. Life Line Gedo (LLG) with funding from Concern World Wide distributed 3,000 hygiene kits (18,000 people) in 10 villages of Belet Xaawo District to prevent further cholera/AWD outbreak. Trocaire and Relief International are distributing an additional 1800 hygiene kits in Belet Haawo town, targeting 10,800 people). World Vision also supplied medicines to Belet Haawo District Hospital for treatment of cholera. Another national partner (ASEP) is targeting 1,500 HHs (9,000 people) in Belet Amin, Bulo Jaron, Bulo Ajuran and the nearby vulnerable host communities of Belet Haawo as part of the response to chikungunya. Implemented activities are awareness raising, dissemination of information (use of fliers and brochures, road show public address, and use of local FM station) and vector control (indoor and outdoor spraying). IOM has a large health operation in Somalia and capillary geographic presence including the cross-border with Somalia with current health service delivery projects, furthermore it has capacity to mobilize rapid response team trained for cholera, and it is equipped with mobile clinics which can be made available.

**3. STRATEGY FOR RESPONSE**

The Joint Action plan for responding to cholera and Chikungunya outbreaks in the Mandera region, as well as other possible future epidemics, is comprised of a complementary response strategy:

- Immediate response focusing on scaling-up to effectively respond to cases and contain any further spread (3 months starting August 2016) to prevent additional morbidity and mortality related to the outbreak;
- Mid-term response focusing on post-response and strengthening WASH activities (12 months starting August 2016) with the objective of addressing the root causes of the cholera outbreak in the community and building the resilience of communities and systems to respond to outbreaks.
- Overall coordination focusing on leveraging existing regional coordination mechanisms where possible to strengthen cross-border information sharing, surveillance, preparedness and response with a focus on the border areas of the three countries (3 years starting August 2016).
4. PLANNED ACTIONS ACROSS THE SUB-REGION

INTER-GOVERNMENTAL AUTHORITY ON DEVELOPMENT

On 12th and 13th July, IGAD\(^1\) held its 9th Ministerial meeting for regional surveillance and response for outbreaks and epidemics including cholera, acute watery diarrhea and other outbreaks in the region. The meeting organized by IGAD with the support of UNOCHA and UNDP, was attended by IGAD health ministers member states, development and humanitarian partners - both from UN, INGOs and other affiliate organizations, including IOM, MSF and ICRC and donors (ECHO and USAID) in Nairobi, Kenya to establish IGAD regional disease surveillance and response mechanisms and robust preparedness plan to respond to all kinds of outbreaks and epidemics in IGAD region.

The outbreaks in the region require concerted efforts from affected countries, Governments, humanitarian and development partners to put in place effective surveillance and response mechanisms. This could be achieved through the provision of adequately equipped health referral centers along the common borders with the three countries to benefit the pastoralist communities in the region. As IGAD is a regional body mandated to coordinate regional efforts for the member states and further strengthen cross border collaboration, the following activities included:

**Coordination**
- Coordinate planned activities by the different stakeholders;
- Periodical review of implementation activities;
- Establish regional technical working group on integrated Diseases surveillance and response (IDSR);
- Conduct regional technical meetings;
- Conduct regional policy and development partners meetings;
- Facilitate and coordinate intercountry collaboration and joint response for outbreaks with regional perspective;
- Establish cross border coordination mechanism at local, national and region level;

**Advocacy and Resource Mobilization**
- Conduct situational analysis at the cross border district level;
- Produce evidence based document for dissemination and engaging policy makers;
- Prepare regional strategic plan based on study findings for resource mobilization;
- Establish IGAD regional basket fund and mobilize resource from development partners;
- Advocate member states for domestic resources mobilization and sustainability;

**Capacity Building**
- Provide training for Health Care providers working in the area of IDSR and M&E/HMIS at cross border Health districts and health facilities;
- Strengthen HMIS at the cross border health facilities and districts interfacing other level of ministry of Health;
- Strengthen infrastructure related to information technology to improve communication among the cross border Health facilities and Districts and other levels of MoH;
- Improve laboratory services of cross border Health facilities and establish effective referral system;

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\(^1\) The Intergovernmental Authority on Development was established in 1986. It succeeded the earlier Intergovernmental Authority on Drought and Development (IGADD), a multinational body founded in 1986 by Djibouti, Ethiopia, Somalia, Sudan, Uganda and Kenya, with a focus on development and environmental control. IGAD has been actively involved in communicable disease control and prevention in its member states.
• Establish regional forum for sharing information and good practices on IDSR.

**WHO**

WHO as global health cluster lead, will continue to provide technical guidance for outbreak response including country level surge support/deployment, support for surveillance, case management and risk communication as well as gap filling during public health emergencies, as provider of last resort. WHO works in collaboration with Federal/National Ministries of Health (and lower level counterparts) and partners to ensure that response is timely and in line with its standards.

**WHO actions will include:**

• Surveillance and Laboratory strengthening: orientation of laboratory personnel, procurement of laboratory reagents, transport media and support for confirmatory testing as needed; strengthening of EWARS; strengthening of data collection, collation, analysis and use for public health action; and timely detection, verification and initiation of response.

• Capacity building for rapid response teams in outbreak preparedness and response from national to district levels—this will include development of standard RRT training materials (as per IDSR), equipping and maintenance of a roster of trained RRTs by region to keep track of available expertise.

• Support for strengthening coordination of AWD/cholera response with partners and FMoH from national to district levels including contingency planning, capacity building, joint assessments and operationalization of emergency operations centers for public event management.

• Support for risk communication including development, dissemination, monitoring and assessment of standard messaging.

• Support for water quality surveillance/monitoring including procurement of water testing kits and consumables, orientation of staff from FMoH, regions and districts; capacity building in environmental surveillance and infection prevention and control

• Support capacity building of rapid response teams, trainers (ToT) at national level on Cholera preparedness, response, prevention, case management and control, focusing on essential linkages between disease’s epidemiology and WASH;

• Provide technical advice and deploy staff to support visits to affected areas/countries to provide advice and surge capacity to catalyse timely and effective Cholera outbreak declaration and response design efforts.

**UNICEF**

UNICEF has an extensive network of partners in the sub-region. Planned actions will focus on leveraging existing regional coordination mechanisms at organization and inter-agency levels to strengthen cross-border information sharing, surveillance, preparedness and response, with a focus on the border areas of the three countries.

**Actions by UNICEF ESARO will include:**

**Capacity Building: Technical support provided to countries to build capacity for Cholera preparedness, prevention and response**

• Support capacity building of rapid response teams, trainers (ToT) at national level on cholera preparedness, response, prevention, case management and control, focusing on essential linkages between the disease’s epidemiology and WASH

• Develop a cholera risk matrix and available resources including supplies and funding at country level

• Conduct joint technical support visits to cholera affected countries to provide advice and surge capacity to catalyse timely and effective cholera outbreak declaration and response design efforts
• Ongoing quality assurance and technical support for social and behavior change interventions across the three countries

**Information management: Improved functional information systems in place across targeted countries in the region.**

• Contribute to strengthening of Integrated Disease Surveillance and Response (IDSR) systems at national level and regularly collect, analyse, interpret and disseminate cholera epidemiological data Regular production and dissemination of Cholera information, situation reports and bulletin to partners within the sub-region;

• Initiate, and support analytical epidemiological studies on risk factors, transmissions pathways and trends of recent Cholera outbreaks in the sub-region;

• Develop appropriate research tools and methods for conducting research on social and behavioural change communication and barriers to effective outbreak management;

• Conduct cross sectional surveys to assess compliance with and acceptability of WASH and other Cholera preventive interventions to control Cholera epidemic outbreaks and information for policy and decision making at national and sub-regional levels;

• Regular production and dissemination of Cholera information, situation reports and bulletin to partners within the sub-region;

• Initiate, and support analytical epidemiological studies on risk factors, transmissions pathways and trends of recent Cholera outbreaks in the sub-region;

• Develop appropriate research tools and methods for conducting research on social and behavioural change communication and barriers to effective outbreak management;

• Conduct cross sectional surveys to assess compliance with and acceptability of WASH and other Cholera preventive interventions to control Cholera epidemic outbreaks.

**Coordination / Advocacy: Multi-sectoral outbreak advocacy and coordination strengthened at the sub-regional level**

• Provide evidence based advocacy material strengthening the intimate link between Cholera occurrence and the lack of access to water and sanitation;

• Conduct Cholera advocacy and sensitization meetings with Resident Coordinators (RCs) of Cholera high risk countries with a view to encouraging them to advocate for medium to long-term Cholera control and prevention measures to their respective governments;

• Establish regular liaison with and conduct joint advocacy visits to and with important stakeholders such as IGAD within the region and to countries experiencing outbreaks;

• Support adherence to the International Health Regulations;

• Conduct at least one sub-regional consultation (Kenya, Somalia and Ethiopia) per year to share knowledge, lessons and strengthen coordination and cross border collaboration.

**Knowledge Management: Knowledge and dissemination of best practices for outbreak mitigation strengthened at national level**

• Initiate the development and field testing of evidence-based specific hygiene promotion messages, modes of communication and interventions to improve Cholera mitigation knowledge at national and community level;

• Support country specific adaptation, production and dissemination of Health and WASH and Communication for Behaviour and Social Change best practices for Cholera mitigation and vector control;

• Continue to explore the use of oral cholera vaccine in outbreak context.

• Support documentation of effective, and promising WASH social and behaviour change communication approaches.
OCHA

OCHA has a global humanitarian coordination mandate and will continue to provide coordination role for this sub-regional disease outbreaks in close collaboration with the County Government of Mandera and the local administrations on the Somalia and Ethiopia sides. Besides the coordination activities, OCHA will provide technical support to the agencies/NGOs involved and the County Government of Mandera in the response efforts in Mandera Triangle. OCHA activities will include:

- Support the Mandera Triangle (Mandera Kenya, Suftu Ethiopia and Belet Haawo, Somalia) with in-country and Cross-border coordination efforts
- Support in information sharing and information flow between the various humanitarian actors and government entities during the response efforts of the current outbreaks
- Support the information management needs, including developing of maps and graphs (visuals) during the response phase of the outbreak
- Organize and lead humanitarian in-country and cross-border missions (assessments and monitoring) before, during and after the response efforts

IOM

The first half of 2016, IOM has implemented health emergency response programming in 28 countries, with a budget of over US$50 million. In East and Horn Africa both regional and country-level IOM has a large presence and skilled staff capacity on emergency response and preparedness, including laboratory diagnosis and health mobile unit. IOM counts on its consolidated collaboration with both migration and health competent authorities to address disease of public health concerns with human mobility angles. IOM will make available the IOM’s Population Mobility Mapping for Public Health Emergency Response framework as innovative tool and it will focus on capacity building, response and information management. IOM will also contribute in knowledge sharing platform and advocacy. Country presence at cross-border including rapid response team will be made available for this interventions.

Capacity Building: Technical support provided to countries to build capacity for Cholera preparedness, prevention and response.

- Development training programs, including simulation exercises, and a learning platform (including long-distance learning) on i. Emergency health operations, including Incident Management Systems (IMS) and Emergency Operations Centre (EOC); ii. Rapid assessment methods and tools, including (in conjunction with WHO) the standard WHO Public Health Risk Assessment in Emergencies; iii. Infection Prevention and Control (IPC); iv. Environmental health, v. Mental health and psychosocial services (MHPSS) in emergency.
- Roll-out trainings on the subject above mentioned for governments officials, IP and relevant stakeholders and academia). This will include the roll-out of HBMM framework for the assessment on mobility patterns and health high risk to direct mobile units interventions and public health strategy.
- Coordinate and strengthen/Establish mobile primary healthcare units for vulnerable and affected cross border Migrant and Mobile Populations (MMPs) in selected high-risk area for active finding
- Information Management: Improved functional information systems in place across targeted countries in the sub-region.
- Produce and disseminate mobility mapping infographic for public health concerns
- Integrate UNICEF component with Mainstreaming of population mobility information into Integrated Disease surveillance and Response (IDSR)
- Integrate UNICEF component with community mobility mapping exercise as tools and methods for the research on social and behavioral change communication and barriers to effective outbreak management.
• Hire one local Epidemiologists, one emergence coordinator and environmental health technicians/experts for three months
• Create the emergency roster of health personnel through partnerships with NGOs, CSOs, universities and training institutions, as well as the private sector as well as finalize agreement for fast-track recruitment process
• Coordination/Advocacy: Multi-sectoral outbreak advocacy and coordination strengthened at the sub-regional level
• Engagement of humanitarian and development agencies to mobilize funds committed to emergency interventions
• Facilitate weekly meetings during emergency, at least monthly cross-border consultation in the selected areas during the post-emergency
• Knowledge Management: Knowledge and dissemination of best practices for outbreak mitigation strengthened at national level
• Integrating mobility information within outbreaks report, strategic documents
• Assuring integration with existing IOM relevant programme such as integrated border Management and regional platform on migrations.

5. ADVOCACY AND FUNDING REQUIREMENTS

In collaboration with IGAD and with regional Resident Coordinators supported by OCHA will reinforce resources mobilization and advocate for cross-borders activities in term of communicable diseases outbreak prevention, rapid response and management for $21,603,738.
<table>
<thead>
<tr>
<th>Delivery Area</th>
<th>Activities</th>
<th>Time Frame</th>
<th>Budget (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coordination</strong></td>
<td>Conduct joint planning meeting by the different stakeholders</td>
<td>Once in 2 years</td>
<td>120,000</td>
</tr>
<tr>
<td></td>
<td>Periodical review meetings for the implementation of activities</td>
<td>Once a year (2 times)</td>
<td>300,000</td>
</tr>
<tr>
<td></td>
<td>Conduct quarterly supervision missions</td>
<td>Quarterly (8 times)</td>
<td>80,000</td>
</tr>
<tr>
<td></td>
<td>Establish regional technical working group on integrated Diseases surveillance and response (IDSR)</td>
<td>Twice a year (4 times)</td>
<td>200,000</td>
</tr>
<tr>
<td></td>
<td>Facilitate and coordinate intercountry collaboration at cross border and joint response for outbreaks</td>
<td>Quarterly (8 times)</td>
<td>120,000</td>
</tr>
<tr>
<td></td>
<td>Establish cross border coordination mechanism at regional level</td>
<td>Once a year for 2 years</td>
<td>100,000</td>
</tr>
<tr>
<td></td>
<td><strong>Sub-total</strong></td>
<td></td>
<td><strong>920,000</strong></td>
</tr>
<tr>
<td><strong>Advocacy and Resource mobilization</strong></td>
<td>Conduct situational analysis at the cross border district level and validation workshop</td>
<td>Once (in 2 years)</td>
<td>130,000</td>
</tr>
<tr>
<td></td>
<td>Produce evidence based document for dissemination and engaging policy makers</td>
<td>Once (in 2 years)</td>
<td>54,000</td>
</tr>
<tr>
<td></td>
<td>Prepare regional strategic plan based on study findings for resource mobilization, including validation and printing</td>
<td>Once</td>
<td>220,000</td>
</tr>
<tr>
<td></td>
<td>Establish IGAD regional basket fund and mobilize resources from development partners</td>
<td>Once</td>
<td>80,000</td>
</tr>
<tr>
<td></td>
<td>Advocate member states for domestic resource mobilization and sustainability</td>
<td>Once in 2 years</td>
<td>60,000</td>
</tr>
<tr>
<td></td>
<td><strong>Sub-total</strong></td>
<td></td>
<td><strong>544,000</strong></td>
</tr>
</tbody>
</table>
### Capacity building and M&E for cross border

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Frequency</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide training for health care providers working in the area of IDSR and M&amp;E / HMIS at cross border health districts and health facilities</td>
<td>Once a year (2 times)</td>
<td>140,000</td>
</tr>
<tr>
<td>Strengthen HMIS at the cross border health facilities and districts interfacing other level of MoH</td>
<td>Once</td>
<td>100,000</td>
</tr>
<tr>
<td>Strengthen infrastructure related to information technology to improve communication among the cross border health facilities and districts and other levels of MoH</td>
<td>Once</td>
<td>150,000</td>
</tr>
<tr>
<td>Improve laboratory services of cross border health facilities and establish effective referral system</td>
<td>Once</td>
<td>320,000</td>
</tr>
<tr>
<td>Establish regional forum for sharing information and good practices on IDSR</td>
<td>Once</td>
<td>140,000</td>
</tr>
</tbody>
</table>

**Sub-total**: 850,000

**Total programmes**: 2,314,000

**Administration and logistics**: 161,980

**Grand Total**: 2,475,980

### WHO

<table>
<thead>
<tr>
<th>Response Period</th>
<th>Kenya</th>
<th>Somalia</th>
<th>Ethiopia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate response to outbreaks (3 months starting August 2016)</td>
<td>950,000</td>
<td>870,000</td>
<td>670,000</td>
<td>2,490,000</td>
</tr>
<tr>
<td>Mid-term post response phase (12 months starting August 2016)</td>
<td>1,350,000</td>
<td>980,000</td>
<td>750,000</td>
<td>3,080,000</td>
</tr>
</tbody>
</table>
### Coordination mechanisms (2 years starting August 2016)

<table>
<thead>
<tr>
<th></th>
<th>Kenya</th>
<th>Somalia</th>
<th>Ethiopia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>270,000</td>
<td>250,000</td>
<td>200,000</td>
<td>720,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,570,000</strong></td>
<td><strong>2,100,000</strong></td>
<td><strong>1,620,000</strong></td>
<td><strong>6,290,000</strong></td>
</tr>
</tbody>
</table>

*WHO Kenya in partnership with MoH, Kenya Red Cross, Save the Children, MSF and Mentor Initiative

### UNICEF

<table>
<thead>
<tr>
<th>Phase</th>
<th>ESARO</th>
<th>Kenya</th>
<th>Somalia</th>
<th>Ethiopia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate response to outbreaks (3 months starting July 2016)</td>
<td></td>
<td>1,704,000</td>
<td>1,800,000</td>
<td>429,502</td>
<td>3,933,502</td>
</tr>
<tr>
<td>Mid-term post response phase (12 months starting July 2016)</td>
<td></td>
<td>800,000</td>
<td>1,925,000</td>
<td>662,306</td>
<td>3,387,306</td>
</tr>
<tr>
<td>Coordination mechanisms</td>
<td>500,000</td>
<td>50,000</td>
<td>516,000</td>
<td></td>
<td>1,066,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500,000</strong></td>
<td><strong>2,554,000</strong></td>
<td><strong>4,241,000</strong></td>
<td><strong>1,091,808</strong></td>
<td><strong>8,386,808</strong></td>
</tr>
</tbody>
</table>

*Differences in funding requirements reflect the different situations on the ground in the three countries (both volume of activities and costs of implementation*

*UNICEF Kenya in partnership with the MoH headquarters, County Government of Mandera Department of including, preventative, promotive and WASH, County Government of Mandera Department of Education (School health), County Government of Mandera Department of Disaster Management and Kenya Red Cross

### IOM

<table>
<thead>
<tr>
<th>Region</th>
<th>Kenya</th>
<th>Somalia</th>
<th>Ethiopia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate response to outbreaks (3 months starting in August 2016)</td>
<td>50,000</td>
<td>350,000</td>
<td>650,000</td>
<td>400,000</td>
</tr>
</tbody>
</table>
Mid-term post response phase (12 months starting August 2016) | 300,000 | 600,000 | 1,200,000 | 600,000 | 1,800,900
---|---|---|---|---|---
Coordination mechanisms | 200,000 | 50,000 | 200,000 | 100,000 | 550,000
Total | 500,000 | 1,000,000 | 2,050,000 | 1,100,000 | 3,750,950

**OCHA**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time frame</th>
<th>Budget (USD)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination meetings, capacity building for local authorities, equipment</td>
<td>12 months</td>
<td>250,000</td>
<td>In country and cross-border coordination (joint Kenya, Somalia and Ethiopia). Capacity building for local authorities, equipment, special flight hire for high profile meetings involving VIPs</td>
</tr>
<tr>
<td>Administration, logistics and equipment</td>
<td>12 months</td>
<td>450,000</td>
<td>Transport, venues, equipment and allowances</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>700,000</td>
<td></td>
</tr>
</tbody>
</table>

**6. MONITORING AND EVALUATION**

Under coordination of IGAD, OCHA, WHO, UNICEF and IOM the county health department and the respective Ministry of Health are responsible for the overall monitoring, evaluation and reporting of the project. Health coordination forums exist at all levels that meet to review planning, implementation and monitoring. Monthly joint coordination meetings will also be led by the county health teams with the implementing partners at county level.
ANNEX I: PLANNED ACTIONS ACROSS THE COUNTRIES

ETHIOPIA

Short-term response

WHO

WHO, through its emergency health technical officers and subnational cluster coordinators, will provide **coordination** support to strengthening outbreak response at RHB level. They will support the RHB to conduct planning, providing the required technical guidance to ensure that the response is in line with the national standard, and is both timely and responsive. They will conduct real time monitoring of the outbreak response to inform refining of further actions.

WHO will deploy **surveillance officers/epidemiologists** to outbreak sites to provide support in proper data collection, collation, analysis and use for public health action. This will include the proper use of line lists, detailed case investigations, risk assessments (in conjunction with environmental health/WASH officers)

WHO will continue to support CTC **case management** and oversight ensuring adherence to standards for management of AWD in order to prevent deaths within CTCs and will procure international diarrhoeal disease kits, international emergency health kits. In addition, WHO will support infection prevention focusing on provision of personal protective equipment for HWs in CTCs, the procurement and appropriate use of disinfectants (chlorine) in treatment centres for decontamination, assessment of CTCs siting and flow to prevent cross contamination within the CTC as well as the surrounding community, advocacy for provision of food in CTCs to prevent caregivers from contracting the disease.

In the CTC mainly on hand washing, appropriate latrine/shower facility. At community level, UNICEF will also **strengthen the capacity of government** in the inspection of food vendors in the high risk locations (semi-urban and urban). UNICEF will support also environmental cleaning campaigns targeting IDPs, refugees and migrant workers.

UNICEF

In the WASH sector, **provision of clean drinking water** is the main intervention in the short term through procurement and distribution of household water treatment chemicals (with orientation on how to use) for communities using contaminated water. In addition, the **protection and treatment of water at source** in the AWD affected locations with disinfection of jericans will have to be done. This will be supplemented by distribution of water storage containers to the most needy (based on identified gaps). Regular testing and monitoring bacteriological water quality should also be ensured by providing water testing equipment’s. For areas where there is no adequate water supply schemes, the installation of emergency water treatment plants and, as a last resort, water trucking may be planned for communities and CTC.

WHO will work closely with FMoH and RHB to **develop appropriate communications plans** for outbreak response, working closely with surveillance and case management teams for **identification of high risk groups** in order to target messages appropriately; identify further risk factors through knowledge actions and practices surveys in the community and provide feedback for further public health action.

In the **social mobilization** section, strengthening capacity of the local emergency Command Post through Establishing/revitalizing a social mobilization subgroup and providing technical support for communication planning and action are key priorities. Reporting to the government led emergency Command Post,
the subgroup will be best positioned to lead the planning, coordination and monitoring communication interventions with the engagement of key community groups. With the leadership of the social mobilization group, ongoing rapid assessments will be employed to identify behavioral and communication barriers, mapping of partners/social mobilizers on the ground, and understand shifts in knowledge and awareness. Sensitization of key influencers will be undertaken to ensure buy in and engagement of key leaders (religious and community/clan leaders, traditional healers, local administrators and CBOs) who are instrumental in engaging with and mobilizing their respective communities. Capacity building on Inter Personal Communication (IPC) will focus on community mobilizers and key communication actors; including health extension workers and local mobilization teams. Besides, IEC materials development and dissemination will be supported by procurement of megaphones to support live mobilization.

During the emergency phase, UNICEF will develop operational research themes, as part of the coordination mechanisms, by identifying risks and agree on measures to maximize the response (health, Wash C4D, Education, nutrition) at country/federal, region, district levels.

Mid-term response

WHO

WHO shall procure water quality test kits and consumables for the RHB and provide orientation in water quality analysis and environmental surveillance for RHB staff; provide orientation on and procure materials for infection prevention and control in case treatment centres (chlorine, personal protective equipment); provide guidance on food safety and enforcing the public health act; vector control and other measures for control of Chikungunya.

WHO will work with FMoH and RHB to standardize messages on epidemic prone diseases and disseminate these messages, coordinating with partners to ensure that they use them in development of IECs. WHO shall also work with FMoH/RHB to field test and then monitor the messages. The messages will focus on hand hygiene, food safety, general hygiene, recognition of symptoms and early treatment seeking, prevention, funeral management (for AWD/ cholera) and others.

WHO, through its emergency health technical officers and subnational cluster coordinators, will provide coordination support to strengthening outbreak response at RHB level. They will support the RHB to conduct planning, providing the required technical guidance to ensure that the response is in line with the national standard, and is both timely and responsive. They will conduct real time monitoring of the outbreak response to inform refining of further actions.

Coordination mechanisms are in place at Federal, Regional and District levels with the establishment of Technical Committees, Command Posts and specific AWD Task Forces. Overall, the coordination should be further strengthened at all levels and further developed on the cross border aspect. The issue of preparedness actions to be taken in the highly vulnerable refugee camps (Dolo Odo woreda). WHO shall support the RHB and other coordination structures to coordinate outbreak response activities as expected. Coordination shall be multi-sectoral, and organized along thematic response working groups. Every effort will be made to organize inter woreda/region/country interactions to share experiences and plan joint interventions wherever possible.

WHO will support the Regional PHEM and RHB offices to collect, analyze and report on these outbreaks as expected and, on a weekly basis. Agreement will be reached on the modalities of data sharing and reporting with FMoH/RHB.
WHO will deploy surveillance technical officers to Somali and Oromia regions to support strengthening of daily and weekly reporting during outbreaks; analysis of data for public health action and monitoring of the epidemiological situation.

UNICEF

For the prevention of Chikungunya outbreak, focus will be put on vector control through the strengthening the regular mosquito control- clean up (community based search and destroy) of stagnant breeding sites for the larvae by the community. As part of prevention activities, “search and destroy” strategy will be implemented and linkage with the Government Productive Safety Net Program PSNP should be part of the advocacy activities.

According to the recent Belg/Gu multi agency need assessment (June), over 36% of boreholes are not functioning in Somali region, the water supply coverage of woreda like Dollo Ado is very low. Therefore as mid-term response the following interventions are recommended to ensure water safety and sanitation: rehabilitation of the broken pipelines at risk of contamination, expansion of water schemes from existing sources, emergency drilling of shallow wells where possible (to increase access to water), strengthening the Woreda Water Office capacity in water management, advocate for the construction of communal latrines in the context of migrant labours and displaced communities and high risk market places, and regular testing and monitoring of bacteriological water quality.

UNICEF will conduct and sustain social mobilization and awareness raising activities through different channels including community dialogue and sensitization (trained community mobilizers and health workers), IPC activities through sensitized community leaders, school based promotion, local radio stations is planned. Besides, capacity building on Inter Personal Communication (IPC) focusing on local edutainment groups, and media content development and reporting to radio stations will continue to be undertaken. Sustaining the ongoing development, distribution and monitoring of use of multi-media IEC materials is also planned.

In order to strengthen surveillance, UNICEF ECO will recruit two WASH / C4D monitors to be deployed in Liben zone of Somali Region. They are expected to monitor the ongoing situation, preparedness and response at zonal and cross border level.

KENYA

Short-term response

WHO

WHO will deploy an Emergency officer and an epidemiologist to support overall outbreak coordination with the health and wider health sector partners for the control of outbreaks and for the response. The Organization will also ensure linkages with National and regional laboratories in Nairobi. The organization will also establish joint projects monitoring and reporting mechanisms. WHO will also support the Ministry of Health to deploy teams to conduct indoor residual spraying and other key environmental control activities to prevent breeding of mosquitoes.

WHO will lead rapid assessment and risk analysis of the situation to inform policy and decision makers. WHO will also support capacity for real time information management and dissemination through the production of situational reports as well as bulletins and press releases. WHO will also support development
of resource mobilization and response plans. **Outbreak reporting tools and guidelines** will also be procured and sent to the Mandera triangle.

WHO will work closely with Ministry of health develop appropriate **communications plans** for outbreak response, working closely with surveillance and case management teams for **identification of high risk groups** in order to target messages appropriately. Community health care workers will be mobilized public health preventive services to the community especially in the hard to reach areas. The teams will provide Risk communication, preventive services and offer immunization services.

WHO will facilitate the establishment of the minimum **laboratory diagnostic capacity** in the affected areas. WHO will procure laboratory reagents and basic equipment to improve communicable diseases diagnosis at the PGH. WHO plans to **strengthen the capacity for disease outbreak and rumour investigation** and reporting through the deployment of surveillance officers/epidemiologists to outbreak sites to provide support in proper data collection, collation, analysis and use for public health action. This will include the proper use of line lists, detailed case investigations, and risk assessments (in conjunction with environmental health/WASH offi cers). WHO will also support training of health care workers in **integrated disease surveillance and outbreak investigation and control**.

WHO will ensure **case management** are up to global standards at the CTCs. **Essential drugs and supplies**, as well as hazard specific kits such as cholera kits and IHEK kits, will be procured to boost the county stock piles to avoid stock outs. WHO will ensure optimal safety of health workers through enhanced infection prevention and control and provision of personal protective equipment for Health Workers in Cholera Treatment Centers (CTCs). In addition the organization will procure appropriate disinfectants (chlorine) in treatment centers for decontamination, assessment of CTCs siting and flow to prevent cross contamination within the CTC as well as the surrounding community, advocacy for provision of food in CTCs to prevent caregivers from contracting the disease.

**Mid-term response**

**WHO**

WHO will support the Ministry of Health develop **recovery and resilience building health plans** using the post-Sendai disaster risk management global frameworks and standards. Outlined activities will ensure communities are better prepared to respond to disease outbreaks and disasters.

As the health sector lead WHO will ensure **coordination** forums within the health sector are conducted on a regular basis at national and county levels ensuring all actors are brought on board and actions are synergized. Other sectors will also be involved as need be.

**UNICEF**

UNICEF will support **management of Cholera at community level** using ORS and Zinc sulphate for cases presenting with mild and moderate dehydration. In addition, UNICEF will support the mapping of Community Health Services to identify coverage in Mandera County due to current low coverage of community health services in the county (less than 5%).

The management of Cholera Treatment Centres (CTCs) will be strengthened through **sensitization of health workers, and community health volunteers** to manage cholera cases as per CTC guidelines to reduce possible infection transmission at CTCs. In addition, Mandera County health teams will be supported in offering periodic quality assurance including mentorship to CTC teams during implementation of cholera and chikungunya response.
UNICEF will **procure, preposition and distribute the required supplies** (Health, WASH, C4D and Education), including logistical requirements required to ensure timely delivery and distribution. Community Health Volunteers and CHEWs will be supported in conducting assurance activities to **monitor household/community based cholera and Chikungunya interventions** (using community based health information systems tools).

UNICEF will also **target schools with prevention activities** such as the provision of water tanks/latrines and capacity enhancement of school health clubs and Boards of Management. A comprehensive and systematic **public awareness campaign** around prevention and management of Cholera and Chikungunya will be implemented. UNICEF will also provide technical support and capacity development to national MOH for **disease Outbreak communication** to support county-level response. At the community level, UNICEF will support the identification and selection of CHVs to implement community level preventive and promotive cholera and Chikungunya key care practices.

UNICEF will support conducting of a **Cholera epidemiological study** by Kenya Medical Research Institute. UNICEF will **Support the establishment of community-based surveillance and referral systems** for Cholera and Chikungunya, incorporated into routine surveillance systems during early recovery. In addition UNICEF will support the **development of county-level emergency preparedness and response plans** and support capacity development on medium term strategies for preparedness and response at county level. Throughout this response, UNICEF will also analyze and document the key root causes and support the development of plans for addressing long-term needs.

UNICEF will conduct a **comprehensive KAPB Assessment** to identify the risk behaviors, gaps in knowledge, practice, skills, capacity, resources, opportunities and stakeholders. In addition, UNICEF will promote enhanced information sharing among stakeholders across counties (including cross-border information, best practices exchange initiatives and close inter-county emergency networks and linkages). This will allow the implementation of multi-sectoral After Action Reviews (AAR) – lessons learnt, documentation and evidence-based development advocacy messaging (legislation, planning, budgeting information management and practice standards).

UNICEF will facilitate **school based cholera sensitization / trainings and behavior change communication interventions** (for teachers, BoMs and children) and establish school based health clubs that will engage in awareness and preventive activities amongst their peers and their communities. Appropriate supplies will also be provided to ensure that vulnerable schools / children are supported to either prevent or respond to cholera.

UNICEF will strengthen the capacity of sectoral and multi-sectoral **coordination** structures under the leadership of the county Government. This will be facilitated by the recruitment of a senior-level Cholera Coordinator (focusing on inter-ministerial and strengthening cross-sectoral national coordination, including strengthening linkages between national and county level).

**SOMALIA**

*Short-term response*

**WHO**

WHO will **enhance surveillance system and laboratory capacities** at different levels to reduce the escalation of the outbreaks. Support national public central laboratory to collect samples for confirmation
and ensure the timely delivery laboratory essential supplies. Strengthen effective case identification & reporting, data quality check, distribution of medical supplies, carry out outbreak investigation including risk assessments in areas reporting alerts of cholera or chikungunya outbreaks. Engagement with the sectors for multi-sectoral responses in places deemed fit.

**UNICEF**

In response to the outbreaks, UNICEF will support the Ministry of Health (MoH) by providing case management supplies to be provided to partners in affected areas. These included diarrheal diseases kits with infusion modules and additional intravenous fluids to treat severe cases, essential drugs and commodities. UNICEF will **procure essential drugs and commodities** from SD Copenhagen; the provision of these lifesaving medicine and commodities to target health facilities will contribute to improving access to essential lifesaving health services (quality primary and secondary health care) for crisis-affected populations aimed at reducing avoidable morbidity and mortality.; UNICEF has a regional warehouse in Mogadishu; the emergency transportation of the supplies to the facilities is done by airlifting. UNICEF support to the CTC aims at maintaining the CFR within the accepted rates and SPHERE standard. WASH cluster will use its regional supply hub network to deliver supplies in as close proximity to affected areas as possible and rapidly deploy supplies within 72 hours when access opens up.

At the time of discharge for the fully recovered patients, a **discharge package** consisting of WASH hygiene kit will be handed over to the discharging patient. Items in the discharge package should sufficient to cover the needs of an entire family of six for period of three months. These include – 20 liter plastic bucket with cover, 20 liter jerry cans, 200 chlorine tablets and 5 bars of soap. While admitted at the CTC, the patient will be provided with soap for cleaning and washing. In order to minimize transmission at the CTC the WASH cluster will avail chlorine powered (HTH -65%) for regular disinfection including handwashing station for visitors.

There is also need to **provide safe water supply, hygiene and sanitation services** at the health facilities/ Cholera Treatment Centres (CTCs) and protect water sources for infection control. UNICEF interventions’ strategies are proven to be effective within this context, which include ensuring access to WASH commodities, early case detection and referral as well as effective case management. Proper treatment of cases that are referred early enough reduces number of deaths and stops further transmission.

**Prevention and control activities** will include: **Rapid KAP assessment** to inform communication interventions; quick **mapping of partners/social mobilizers** on the ground and refresher training on IPC for cholera prevention; **information dissemination** through relevant communication channels; IEC materials development and dissemination; conduct community dialogue/IPC activities, etc.

In order to contain and control the spread existing communication and C4D / IEC materials will be updated. This will include all the materials on the WASH cluster website. Update the WASH hygiene promotion tools and guidance for partners including the “Stamp-Out Cholera” page for donor/media briefing and or information. Maintain and disseminate updated **communications plan** for AWD Prevention and Response – linking to overarching responsibilities matrix in the Somalia WASH cluster response plan. Radio talk shows and TV spots including awareness raising messages using the SMS will be activated in a timely manner. All C4D / IEC materials will be translated into Somali.

There will be a need to **training of media practitioners** on how to report on AWD/cholera prevention and response interventions to ensure proper containment and prevention.

Control of the outbreak is further compounded by the **limited awareness of safe hygiene practices and**
inadequate sanitation facilities. Poor hygiene practices include poor handling of water during collection, transportation or storage resulting in contamination; and lack of handwashing with soap at critical times. The resulting poor disposal of infectious human waste highly increases the risk of further contamination of water and subsequent increase in new cases, control challenges and new deaths. Shallow wells and river channels which are regular sources of drinking water tend to be contaminated both biologically and chemically. In congested urban/semi-urban communities, the proximity of shallow wells to latrines contributes to drinking water contamination due to subsurface seepage, while in the rural areas the poor sanitary conditions around the wells lead to the inflow of pathogens from surface faecal content.

Funds will help reach affected persons and their families with hygiene promotion messages through radio spots, information, education and communication (IEC) materials, household visits by hygiene promoters, and temporary access to safe water through distribution of water disinfection tablets.

Awareness raising campaigns should be intensified in market places and schools with particular focus on kiosks or restaurants where prepared foods are sold. During these campaigns the key hygiene messages will be disseminated include handwashing, household water treatment and safe storage and the use of toilets. During the sensitization campaign, community and opinion leaders including imams and sheiks or clan leaders will be engaged. School health clubs will be reactivated as well as health talk at health facilities before the start of the day’s work. Posters will be printed and displayed at all public places including radio and TV shows hosting opinion leaders, respected senior citizens.

UNICEF emergency response is implemented jointly with recipient’s communities, health authorities, NGOs implementing partners and stakeholders directly in the affected geographical locations and populations. Communities include the local leaders, religious leaders and entities. Partners include community based organizations, national agencies and international partners. Targeting has been done in consultation with stakeholders in the affected areas are involved in actual response (implementation and monitoring). Response design has ensured the involvement of women and the most vulnerable households to ensure their unique needs and circumstance have been factored.

Monitoring of activities: Distribution of kits, household chlorination, usage of latrine etc. Ensure positive free chlorine residual at household and water source, to ensure effective chlorination. Monitor AWD rates at local health posts / CTCs, and from WHO AWD tracking matrix, to assess impact of WASH intervention. Adjust intervention as required. The WASH Cluster will track progress against indicators set in planning phase. It will be important to review trend of the new infection rates with report against WASH interventions to understand impact, and review with the intention of improving AWD response plan accordingly. A sanitation risk survey to ascertain the number of houses with latrines and proximity of the household latrine to the shallow well at the household will provide a background information into the efficacy of the shallow chlorination or household chlorination.

Distribution of ORS and Zinc tablet at HH level, for early use and prevention of dehydration. Ensuring a protective environment has been considered in the selection of sites and design of WASH facilities. Multiple interventions will be used including fixed case management sites (health facilities) and community based Oral Rehydration Treatment and referral centres, to ensure those far from referral facilities get early treatment. During initial stages of the disease, as many as 80 per cent of patients can be treated with oral rehydration salts (ORS) as outpatients at designated ORS corners. For early use and prevention of dehydration, the distribution of ORS and Zinc tablet will be done at household level by the network of Community health workers and through the WASH RSH.

Cholera mild cases will be referred to the Oral Rehydration Treatment points which will be located in
the communities, which are expected to treat as many as 80 per cent of the cases. The severely ill will be referred to the cholera treatment centres at the hospitals and CTC/CTUs at nearest health facilities. Line lists and health facility based record will be maintained by trained health workers on ground and availed for weekly and periodic monitoring. Stocks of supplies will also be monitored using two methods: report based and periodic stock counts as feasible. All data will be aggregated and shared with partners weekly including, recommendations and lessons learnt, to ensure better implementation of all response components for better results.

Mid-term response

UNICEF
In terms of **vector control and personal protection**, spot checks will be carried out to ascertain residual chlorine at household levels and restaurants. As such community hygiene promoters engaged for home visits will be equipped with tools and devices for measuring the residual during the home visits. Since most communities in Somalia depend on Berkads (underground storage for collecting surface run- offs, these berkads in most cases become breeding spots for mosquitoes. The same is true for small rainwater harvesting cisterns at household level. It is advisable to continuously chlorinate these reservoirs or containers because of the mosquito larva.

A **sanitation risk survey** to ascertain the number of houses with latrines and proximity of the household latrine to the shallow well at the household will provide a background information into the efficacy of the shallow chlorination or household chlorination.

Undertake **enhanced community engagement** to encourage their participation and in this regard the need to conduct awareness raising activities through refresher trainings and workshop targeting Imam’s, youth and women leaders, Local Authority, implementing partner agencies in the area, teachers, school children and other opinion leaders. During the sensitization workshops or campaign demonstration exercises will be carried out on the use of the chlorine tablets or chloro-fluc as well as handwashing.

UNICEF will continue to support activities to reach affected persons and their families **with hygiene promotion messages** through radio spots, information, education and communication (IEC) materials. In addition, continued financial and technical support to the NGOs IP to providing case management in health facilities in affected areas.

The **WASH Cluster** has a network of regional / district focal points that meet on monthly basis. The frequency of the meetings will be determined by the severity of the cases. Alongside the regional coordination mechanisms in the ten state of SC Somalia are the Regional Supply Hubs. In Gedo region there are two regional supply hubs – Elwaq and Luuq. For most agencies that operate from Nairobi, WASH cluster coordination meetings are held on monthly basis and efforts will be made as far as possible to ensure that they are multi-sectoral in nature.

The Health and WASH cluster have an **information management system** in place to detect and report on all AWD cases in Somalia, in support of the MoH. Efforts to increase coordination of Education cluster information management will enhanced so that cases that affect children at school level can be properly traced and handled before they escalate.
ANNEX II: 3W OPERATIONAL PRESENCE

- ACTED, CONCERN, COOPI, DRC, IOM, LIFELINE GEDO, NCA, NRC, SADO, SHRA, SRDA, UNICEF, WDC
- ARC, ARD, CEDA, HDC, DCDO, HIRDA, GF, IOM, MERCY USA, OFDA, TROCAIRE, UNICEF
- ADRA, CERID, HIRDA, MFA, NCA, IMC, NFY, NOFYL, NRC, SEDHURO, SVA, SWCEDA, SYDF, TSS

THE BOUNDARIES SHOWN ON THIS MAP DO NOT IMPLY OFFICIAL ENDORSEMENT BY THE UNITED NATIONS.

Creation date: 23 Aug 2016

Kenya

Ethiopia

Somalia

Mandera Triangle (Mandera Kenya, Gedo Somalia and Dolo Ado Ethiopia)

Number of implementing partners per district:

- 15 - 20
- 10 - 14
- 5 - 9
- 1 - 4

MANDERA COUNTY

GEDO REGION

SOMALI REGION

Some information may be incorrect as not all organizations have conveyed their activities and presence to the coordinating agency.