RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS HAITI RAPID RESPONSE CHOLERA AND DROUGHT 2015

RESIDENT/HUMANITARIAN COORDINATOR	Mourad Wahba

REPORTING PROCESS AND CONSULTATION SUMMARY

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

The AAR was conducted from January to April 2016 when the Humanitarian community was discussing, drafting and launching the Humanitarian Needs Overview (HNO) and Humanitarian Response Plan(HRP) for Haiti. That exercise has gathered UN agencies, donors, international and national NGOs, the Red Cross Movement, and the Government's institutions.

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

YES ☒ NO ☐

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

YES ☒ NO ☐

The report was shared through Humanitarian Country Team (HCT) which includes UN agencies, donors, international and national NGOs, and the Red Cross Movements

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: 70,534,845		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	7,170,921
	COUNTRY-BASED POOL FUND (*if applicable*)	0
	OTHER (bilateral/multilateral)	18,796,068
	TOTAL	**25,966,989**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 23 July 2015			
Agency	**Project code**	**Cluster/Sector**	**Amount**
IOM	15-RR-IOM-022	Health	322,762
WHO	15-RR-WHO-029	Health	1,456,087
UNICEF	15-RR-CEF-079	WASH	2,366,305
Sub-total CERF allocation			
Allocation 2 – date of official submission: 24 July 2015			
UNICEF	15-RR-CEF-080	Nutrition	1,000,022
FAO	15-RR-FAO-022	Agriculture	945,422
WFP	15-RR-WFP-048	Food Aid	1,080,323
Sub-total CERF allocation			
TOTAL			**7,170,921**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN Agencies/IOM implementation	3,330,949
Funds forwarded to NGOs and Red Cross / Red Crescent for implementation	3,743,186
Funds forwarded to government partners	96,786
TOTAL	**7,170,921**

HUMANITARIAN NEEDS

The humanitarian situation in Haiti remains complex and fragile due to multiple and inter-linked risks factors, notably the persistence of cholera, the aggravation of the food insecurity and malnutrition situation due to the "El Niño", the bi-national mixed migration crisis with the Dominican Republic, the country's high vulnerability to natural disasters, as well as the remaining caseload of IDPs from the 2010 earthquake. The continued devaluation of the gourde aggravates further the living conditions of the most vulnerable.

The food insecurity affecting 3.6 million people - one third of a total population of 10 million – has been aggravated by drought and the wider effects of "El Nino" that further exposes Haiti to the risk of hurricanes and flooding in the coming months. Food insecurity and malnutrition, have affected rural areas where approximately 34 per cent of the population continues to have difficulty in meeting their basic food needs. According to the recent report of the Emergency Food Security Assessment (EFSA) published by the Haitian National Coordination for Food Security Office (CNSA), with support from the World Food Program (WFP) in February 2016, Haiti is experiencing one of the worst droughts in recent decades with 38 communes are currently in IPC Phase 3. Through the Humanitarian Needs Overview (HNO) and the Humanitarian Response Plan (HRP) launched in April 2016, humanitarian partners and the Government's institutions have estimated 1.5 million people severely food insecure and need immediate food assistance. A nutrition survey conducted by UNICEF at the end of 2015 in the 20 most drought-affected communes showed that five communes are above emergency thresholds in terms of acute malnutrition (>15 per cent GAM or >2 per cent SAM), and two more commune in alert (GAM >10 per cent) requiring immediate response. The number of children under 5 with acute malnutrition was estimated to be 130,000; approximately 56,545 children will need immediate therapeutic feeding as a lifesaving measure while 74,860 will require supplemental feeding. A census led by the government agency in charge of water and sanitation (DINEPA) and its partners in March 2016 to identify water resources affected by the drought and map the localities facing water shortages listed 44 communes in seven departments most affected by water scarcity. The reduced access to water can further deteriorate the situation of the most vulnerable families, as they may have to buy water impacting their family budget or have to fetch water in unsafe resources with the risk of catching waterborne diseases.

Cholera remains an acute emergency with more than 36,000 suspected cases and 322 deaths in 2015. Since the beginning of the epidemic, in October 2010, there have been an estimated 776,000 cholera cases and near 9,137 deaths up to April 2016. Cholera persists in Haiti largely because of a poor access to clean water and sanitation. Current estimations indicate that 25,000 people may contract the disease in 2016, while 1,125,000 people may be indirectly affected. This projection can vary greatly depending on external factors such as the political crisis, which may hinder access and the ability to quickly respond to outbreaks, or extreme natural events, including the "El Niño", or humanitarian funding in 2016. Most cases continue to be concentrated in four Departments (Artibonite, West, Centre, and North). However, localized outbreaks can spark anywhere, so partners need to cover all areas in the country to be able to provide support to the quickly overwhelmed local structures. This approach has proved successful in cutting the transmission and saving lives, and needs to be sustained.

Deportations of populations with Haitian decent from the Dominican Republic are taking place against a backdrop of increased related to drought and cholera, particularly affecting border areas. According to update from IOM, between June 2016 and 26 May 2016, 60,673 households representing 107,103 individuals have crossed the border into Haitian territory including 1,488 presumed unaccompanied minors. Based on the number of people crossing the Dominican border weekly into Haiti, the bi-national crisis is likely to affect an estimated 120,000 people in 2016.The situation of those arriving in Haiti is difficult due to insufficient reception capacity on the Haitian side of the border, with local municipalities stretched to respond and potential for tension with local residents. Another concern relates to family separation since about 40 per cent of those deported and returning are children.

Although there has been a 96 per cent decrease in the number of IDPs from the 2010 earthquake compared to the July 2010, some 62,000 people still remain displaced in 37 camps spread across Port-au-Prince's metropolitan area. Living conditions in the camps are harsh as a result of rapid decline in the access to basic services, the lack of funding, and the departure of international actors (from 512 in 2010 to 84 in early 2016). In addition, the situation in the camps raises a number of protection concerns including insecurity, gender based violence, and lack of access to social services.

IDPs are extremely vulnerable to violence and exploitation (e.g. single-headed households, elder people, women victims of GBV), have a high exposure to natural hazards, and face the risk of forced eviction. In addition, important gaps remain in terms of access to WASH, which increases the risk of cholera outbreaks. Despite no forced evictions occurred in 2015, five camps are still considered at high risk of eviction. Finally, poor housing conditions enhance exposure to disaster impacts, which is particularly acute in 16 camps.

Haiti is vulnerable to a number of recurrent climatic hazards that often surpass national coping mechanisms and require international assistance. Hazards include earthquakes, tropical cyclones and flooding aggravated by massive deforestation. These disaster risks are compounded by large-scale urbanization, poverty and internal displacement. The majority of the Haitian population is unable to recover sustainably from these periodic shocks, increasing the risk of falling back into poverty and of reaching higher levels of food insecurity, displacement and diseases. Preparedness is therefore essential to increase resilience at community and departmental levels. Almost half of the Haitian population is considered vulnerable and exposed to hydro-meteorological hazards. Of this population, 2.8 million people living in 58 communes are considered at highest risk of exposure to flooding and landslides. According to Haiti's national contingency plan for the cyclone season, 500,000 people could be affected by hydro- meteorological hazards in 2016 with 100,000 people requiring immediate humanitarian assistance.

II. FOCUS AREAS AND PRIORITIZATION

In August 2015, the humanitarian context in Haiti remained dire. Amidst a context of political instability, a persistent cholera epidemic, the probability of seasonal hurricanes and the deportation of Haitians and other populations living in the Dominican Republic, Haiti was hit for the third year in a row by lack of rain.

(i) Cholera

The health/cholera project focused on 4 priority departments with higher cholera incidence (West; Artibonite; North and Center) but provides resource for a flexible response in the other areas of the country in case of localized outbreaks. Around 82 per cent of the cholera 2015 caseload has been registered in the four priority departments. During the project implementation period (September 2015 – February 2016) the 4 departments registered 74 per cent on national caseload (17,741out of 23,784). In the last 3 months of 2015 important outbreaks have been registered in South-East, South, Grande-Anse and North West Departments. In February 2016 also the North East a usually silent department registered 208 case against the 75 registered in January, This evolution shows the pertinence of ensuring national response coverage while still focusing on the 4 priority departments.

During the first 2 months of 2016, 8,599 suspected cholera cases have been recorded against the 8,376 registered during the same period in 2015. Meanwhile, in the same period, 95 cholera related death have been recorded in 2016 against 82 in 2015. Comparing the first two months of the year while the number of cases shows a relative stability, lethality rate increases form 0.87 per cent in 2015 to 1.07 per cent in 2016. Between September 2015 and February 2016 global lethality rate is 0.97 per cent, in January and February 2016 the same rate at 1.09 per cent slightly over the WHO 1 per cent threshold. This trend reflect the following needs assessment findings: around 200 health structures (22 per cent of all health structures nationwide) received suspected cases. In many of those structures quality of institutional care remains globally low and resulted in deaths that could have been prevented. Low adherence to hygiene and operations protocols in CTDA persists and is strictly related to poor management of personnel and space, including circulation of patients and family members, and poor infrastructure. Since September 2015, the MSPP has not been able to maintain contracts of supplementary health personnel for cholera care, therefore further reducing care delivery capacity. In this context the CERF funded project was crucial to ensure life-saving cholera prevention, treatment and response activities.

The CERF projects ensured early and timely response to notified alerts and supported cholera care delivery at institutional and community level in the same areas that were indicated in the funding proposal.

- PAHO/WHO intervened in 4 priority departments (West; Artibonite; North and Centre) and supported a network of 7 health INGO (4 implementing partners directly contracted since MdM Spain, France, Belgium and Canada set up a consortium led by MdM Spain) covering the whole country. PAHO/WHO ensured epidemiological follow up, medical and non-medical items refurbishments and response monitoring countrywide.
- IOM supported the provision of life-saving cholera prevention, treatment and response to the population in the Upper Artibonite, and West department and keep an intervention capacity in the South East although in a more limited proportion. In the West department, IOM intervened in the health sector to provide life-saving assistance and cholera prevention. IOM targeted remote communes such as Croix des Bouquets, Ganthier, Fonds-Parisien, Cabaret, Arcahaie where access to health facilities are difficult, as well as remaining IDP camps/settlements with important needs and gaps, such as Corail, Mega 4, Canaan and their surrounding communities including Croix des Bouquets and Tabarre to support cholera monitoring, prevention and treatment delivery.
- In the West and Artibonite, IOM has supported the response to alerts and outbreaks and cholera management in remote communities where health facilities are either inexistent or overstretched.
- The members of the MdM Spain lead consortium intervened as follows: MdM Spain operated in the West Department (Les Palmes Region) and South Artibonite MdM Canada in the Metropolitan area of Port au Prince (West), and Northwest department, MdM Belgium in Nippes and South departments and MDM France in Grande Anse. The MdM consortium also managed a National Response Unit able to intervene in all 10 departments.
- IMC have been working mostly in the North department keeping a deployment capacity in the North-East.
- MdM Argentina has been working in the Center Department, as well as Zamni Lasanté. MdM AR Their action was concentrate in the South part of the department and CERF fund
- Zamni Lasante has deployed a significant amount of efforts to reduce cholera outbreak trends in the Plateau Central (including Center Department). ZL deployed its surge capacity amounting to up to 49 health personnel, covering up to 13 health structures.

The water, sanitation and hygiene project was proposed to strengthen the rapid cholera epidemic response mechanism in the most at-risk zones of the country. These areas were defined following outbreaks, are quick start and without control could have led to a spread over the entire territory, causing a major-scale outbreak. Thus the departments of West, Grand-Anse, Artibonite and North were targeted by this project. NGO implementing partners were CRF in the West, OXFAM in the North, Solidarites International in the West and more particularly in the metropolitan area, and ACF in the Artibonite.

By thematic sector, the project included two specific objectives:

• Output 1: Immediate WASH responses are implemented in less than 48 hours after an alert; and
• Output 2: Accurate and timely epidemiological information is available to improve effectiveness of response.

Output 1: WASH immediate responses are implemented in less than 48h after an alert	
CRF	The French Red Cross has participated in the cholera response since the beginning of the outbreak in 2010. They have been particularly involved in the West department where they have implemented numerous cholera prevention activities. They play a key role in supporting the rapid response coordination and their connection with the Haitian Red Cross is a clear added value to the project.
OXFAM	OXFAM has worked in the North and North-East for many years. They have built solid relations and partnerships with the "Directions Sanitaires" of both departments. The added value of OXFAM is also its capacity to develop long-term projects in parallel to emergency response, such as the solid waste management project they expect to undertake in the Cap Haitian neighborhood of Petite-Anse, one of the most exposed to cholera; these projects ensure a link between emergency, temporary activities and sustainable prevention interventions. OXFAM recently started to work in the Centre department where they need to be reinforced to control the current rise in cholera cases.
SOLIDARITES INTERNATIONAL (SI)	SI works in the Nippes and South-East departments. Recently, SI started to work in Port-au-Prince where it contributes to the response. SI started to work on cholera control since the beginning of the outbreak. The NGO is familiar with rapid response mechanisms such as the one covered by this project. SI works with the same approach in other countries and can rely on institutional expertise and support. In the Port-au-Prince area where UNICEF intends to support them from August onwards to increase the response capacity of the most affected metropolitan locations, SI is also implementing a long-term program of integrated housing and WASH reconstruction. SI has strong relation with DINEPA locally.
ACF	ACF works in Artibonite and North-West. ACF has worked in both departments for many years. They have a sound knowledge of WASH and cholera issues in these zones and are well integrated in the coordination mechanism. Finally, their work on the current project is satisfactory and UNICEF is confident in ACF capacities to deliver appropriate rapid responses.
UADS-MSPP	UADS is the MSPP health department in charge of the cholera response coordination. UNICEF coordinates the overall operation with UADS at the national level and finances its mobile intervention teams (EMIRA) in six departments.
Output 2: Accurate and timely epidemiological information is available to improve effectiveness of response	
DELR (MSPP)	DELR is in charge of collecting, analyzing and disseminating epidemiological information. PAHO and UNICEF support the DELR in the analysis phase. The DELR coordinates stool sample collection in the country. Samples are then analyzed at the national laboratory. UNICEF supports the laboratory in consumable chemical supplies.
Assistance Publique et Hopitaux de Marseille (APHM)	APHM provides technical support to UNICEF and the MSPP to improve promptness, completeness and analysis of epidemiological information. APHM has assisted in cholera epidemiological analysis for more than two years. The institution has an in-depth understanding of the cholera situation in the Haitian context.

(ii) Drought/ Food insecurity, malnutrition and Emergency Agriculture

According to a May 2015 CNSA/FAO/WFP/FewsNet/Kore Lavi assessment in the most affected areas, the drought had led to significant deteriorations in water access as springs were drying and households needed to spend large sums of money to buy water. This led to a reduction of more than 50 per cent of agricultural production during the main agricultural season. The lack of water also affected animals. Households were forced into negative coping strategies including depleting their meagre assets. Traditional coping strategies such as migration to the Dominican Republic were not an option due to the bi-national issues of deportations and forced evictions. Not only was migration not an option, but the deportations from the Dominican Republic (close to 2,000 in the South East as of end of July 2015) were putting pressure on the food supplies close to border areas and some deportees were being hosted by vulnerable families, stretching their meagre resources even further.

Food access had become a challenge as low availability in markets led to high prices especially for local products; in some places prices were 60 per cent higher than last year. The devaluation of the Haitian Gourdes was lowering the purchasing power which when compounded with the drought and deportees led to further deterioration of the local economy. The drought affected the most vulnerable households that lost their harvest, the ones dependent on casual labour and migration for their income and those with vulnerable household members, in particular children and women. The proposed activities aimed to cover up to two of the most vulnerable areas in the country. The South-East and North-West were experiencing rain deficit for the third year in a row and were identified by the humanitarian community and donors as priority. Proposed interventions were in line with the objectives of the third pillar of the TAP to respond to severe food insecurity and fight acute malnutrition for children under two.

The impact of the drought on food security was later confirmed by an Emergency Food Security Assessment conducted in December 2015 by WFP and CNSA. The Assessment found that some 3.6 million Haitians were facing food insecurity, among them more than 1.5 million people who were severely food insecure.

Approximately 30 per cent of the population in Haiti continues to have significant challenges in meeting their basic food needs. According to the Assessment Report of the National Coordination for Food Security (CNSA, May 2015) on the agricultural situation and food security, some 200,000 rural households dependent on agriculture are severely food insecure due to the negative impact of drought on their agricultural production during the 2015 spring season. This has led to a reduction of more than 50 per cent of their agricultural production of the main agricultural season (the spring farming season produces between 50 and 60 per cent of the annual agricultural production of the country). There have been significant reductions in the availability of local food products, combined with substantial price increases and reported shortages at household level of main staple foods.

The eastern communes of the South-East Department and the southern communes of the North-West Department are the most affected. According to the CNSA report, approximately 28,500 agricultural households/family farmers of these two departments are directly affected by the prolonged drought that hit their crop production. Most of these family farmers are located in small settlements, where at least 75 per cent of households derive their livelihood from agricultural, livestock and fishery activities. Not having obtained a good harvest during the main agricultural season, they have consumed their planting material and/or have no means to purchase agricultural inputs for the next cropping seasons. It is for this reason that they are currently in need of emergency basic agricultural inputs, including seeds and planting material, to be able to resume their agricultural production during the summer and winter seasons, starting respectively in August and November 2015.

The nutrition project was proposed to support the operational implementation of prevention activities and case management of SAM, provision of therapeutic feeding inputs, medicine and a package of nutrition interventions for which UNICEF was the sector lead. The project was implemented in the targeted areas in the South-East (i.e. Thiotte, Grand Gosier, Anse a Pitre, Belle-Anse et Baie d'Orange). The Northwest and Artibonite where food insecurity was higher and there are no partners, remain sensitive departments.

UNICEF in collaboration with the MSPP and partners implemented these interventions to respond to children's needs of the by providing appropriate infant and young child feeding in emergencies and care for malnourished children.

Output 1: 7,000 severely malnourished children under five from the South-East (Anse-a-Pitre, Thiotte, Grand Gosier, Belle Anse and Baie d'Orange), North-West (Jean Rabel and Ennery), Centre (Cerca-la-Source, Belladère and Thomonde) benefitted from care and recovered.	
SHASSMEPPE	The partner works in the Northwest, West and Artibonite. Its role in communes affected by drought was to prevent the rise of the prevalence of global acute malnutrition through the management of detected cases and provision of a minimum ambulatory therapeutic program (PTA) coverage. A total of 22 PTAs were established in the North-West, Artibonite and West and four stabilisation units were reinforced. The sites were furnished with inputs and anthropometric equipment for the management of SAM cases. 10 coordination and planning meetings were conducted with health departments and nutrition focal points in targeted departments. 100 health workers were recruited and trained in community management based of acute malnutrition(CMAM) and community mobilization. Shassmeppe also supported training and refresher training of nurses on the prevention and management of malnutrition, as well as communication and infant and young child feeding (IYCF).
FONDEFH	In 2015 FONDEFH supported the MSPP in developing an intensified approach for prevention and community care involving the community in all stages of activity implementation. The NGO intervenes in parts of Centre (Belladere, Thomonde and Cerca-la-Source) and South-East (Thiotte, Anse-a-Pitre, Grand Gosier, Belle Anse and Baie d'Orange). The community health workers who are the backbone of community-based interventions were empowered to monitor the nutritional status of children in each community. Through Community mother-to-mother care groups' particular emphasis have been placed on introduction of complementary food and exclusive breastfeeding practices. They also contributed to community education, identification and screening of cases and ensured the prevention and nutritional support for any malnourished children in the community. Ready-to-use therapeutic food (RUTF) was also used in the management of SAM. However, since the withdrawal of WFP which supported the management of moderate acute malnutrition (MAM), the treatment of children is incomplete and many of them were readmitted to the PTA.

Unité de Coordination du Programme National d'Alimentation et Nutrition (UCPNANu), MSPP	The MSPP department UCPNANu in collaboration with UNICEF supervised the overall operation at the departmental level. The MSPP also played a significant role in supporting the rapid response coordination, joint supervision with focal points and, through MSPP central direction staff, data analysis.
Output 2: Number of children under five and pregnant/lactating woman reached through the promotion of appropriate infant and young child feeding practices	
FONDEFH	The project targets children 6 to 59 months regardless of sex and provides services to pregnant and lactating women who accompany their children, according to the established nutrition protocol. The project focuses on partnership and support to the MSPP to sustain the gains. Focal points and their assistants were supported so that they could continue operations. Fondefh also initiated a community initiative developed by health workers in their communities to ensure program ownership and sustainability.
Unité de Coordination du Programme National d'Alimentation et Nutrition (UCPNANu), MSPP	The MSPP department UCPNANu in collaboration with UNICEF supervised the overall operation at the departmental level. The MSPP also played a significant role in supporting the rapid response coordination, joint supervision with focal points and, through MSPP central direction staff, data analysis.
During the implementation of this project, operational capabilities and knowledge about the care and prevention of malnutrition were provided by UNICEF and partners to MSPP staff at the departmental level through a community approach. They were trained on management protocols for malnourished populations. Communities and target populations improved their knowledge and healthy food hygiene and their overall nutrition knowledge and practices. The available nutrition services in these vulnerable areas, apart from general child nutrition which targeted children regardless of sex, had a special focus on women and girls through interventions that were specifically addressed to them, as they were the more vulnerable groups at risk of anemia or micronutrient deficiencies.	

III. CERF PROCESS

On 26 June 2015, the Government of Haiti has called for support from the international community to complement its efforts in addressing the effects of the drought. The Ministry of Agriculture (MARNDR), leading the response, has requested humanitarian partners to focus their assistance on water management projects to help population to urgently access water and food. All areas targeted under the CERF proposal had been classified as in IPC Phase 3 – Crisis by the Government and its food security partners.

The proposed activities under the CERF grant request were in line with both the Transitional Appeal plan launched by the Humanitarian and Development community and the un-meet humanitarian needs appeal that was launched in August 2015 in the frame of the TAP and has identified households the most at risk of food insecurity and malnutrition due to the shocks Haiti was facing. Gaps for food security were important as few resources had been channelled through the TAP and as the bi-national issues had taken political priority. NGOs were implementing small-scale interventions in several departments by providing WASH, agriculture support and health to affected communities. Thus, in order to respond adequately to the important needs created by the drought, the Humanitarian Country Team in Haiti has advocated for access to more funding.

Following the major outbreaks recorded in late 2014 and early 2015 (25,000 new cases between November2014 and March 2015), the Ministry of Health of Haiti (MSPP) and PAHO/WHO have revised estimates of new cholera cases for the year 2015 and forecast a potential 25,000 to 30,000 people newly affected by cholera in 2015. As of 20 June, a total of 17,812 suspected cholera cases and 150 deaths had already been recorded throughout the country since 1 January 2015 (Source: DELR, Ministry of Health). In addition, in 2015, the rainy season (June – November) started with a cholera incidence much higher than last year at the same period (about 16 200 cases seen during the first 5 months of 2015 against about 5,600 cases during the first five months of 2014). This context also leaded the Humanitarian Country Team in Haiti to request access to more funding for cholera through the CERF.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR[1]

Total number of individuals affected by the crisis: 1.1 million (cholera) + 1.5 million (drought)

Cluster/Sector	Female			Male			Total		
	Girls (< 18)	Women (≥ 18)	Total	Boys (< 18)	Men (≥ 18)	Total	Children (< 18)	Adults (≥ 18)	Total
Agriculture	187,200	124,800	**312,000**	172,800	115,200	**288,000**	360,000	240,000	**600,000**
Food Aid	32,442	30,431	**62,873**	31,927	29,948	**61,875**	64,370	60,378	**124,748**
Health	109,427	149,266	**258,693**	107,690	146,896	**254,586**	217,117	296,162	**513,279**
Nutrition	159,162	55,524	**214,686**	146,920	0	**146,920**	306,082	55,524	**361,606**
Water, Sanitation and Hygiene	105,133	143,409	**248,542**	103,465	141,133	**244,598**	208,598	284,542	**493,140**

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

BENEFICIARY ESTIMATION

(i) **Cholera Response**

- **23,583:** cholera suspected cases representing the total case load calculated on a monthly base from September 2015 to February 2016. Amongst them an estimated 17.857 cases (75 per cent of total case load) have been covered by the 50.000units of RL solutions (reference medical item used to estimate the number of patients assisted) distributed by PAHO/WHO during the project implementation period. Partners and IOM reported of having supported the institutional care for globally 14,023 patients. Those beneficiaries are to be considered as included in the global case load and are not double counted
- **495408:** persons sensitized and/or benefitting of the sanitary cordons during community based response. This figure includes IOM reported global amount of beneficiaries and NGOs partners reported beneficiaries
- **598** health personnel, as globally reported by IOM and NGOs partners including doctors; nurses / auxiliary nurses and hygienists in health institutions and polyvalent health agents who received training, supervision and refreshment on the job sessions
- 4 departmental coordinators and 5 MSPP/UADS members more directly involved in response activities
- **10 MSPP/DELR technical officers supported by PAHO/WHO** only in September 2015. Due to financial constraints and end of the financial support from the CDC for salaries, DELR field technicians are no longer in place since October 2015.

The direct beneficiaries of the ***water, sanitation and hygiene project*** are people affected by or exposed to cholera regardless of gender, origin and age. Following the cholera epidemic evolution in 2014, the realistic figure for 2015 would be between 25,000 and 30,000 cases, which constitute the minimum number of direct beneficiaries. Patients' relatives were also targeted by sensitization or distribution of cholera prevention kits, which represented about 125,000 people (approximately five persons per household). The response strategy consisted of implementing a "cordon sanitaire" around the affected households for a minimum of 10 households, which corresponded to an additional 1,000,000 people. Thus, the total number of people potentially benefiting from the operation is 1,125,000 people. **Please note that this number represents the global estimation of beneficiaries reached by PAHO-/WHO- and UNICEF CERF-funded interventions.**

Cholera is indiscriminate and affects everybody, regardless of gender and age. However, most suspected cholera cases affect people above 5 years of age. The official data collected by the MSPP has not yet been disaggregated, thus no clear data on the most affected population groups is currently available. However, UNICEF's analysis shows that men were slightly more affected than women over the last six months, i.e. 55 per cent against 45 per cent.
Thus, men and particularly heads of households (both men and women) were targeted since they often decide the use and allocation of household resources. Men were sensitized on the need to purchase treated water or chlorine, soap or oral rehydration therapy to protect their families, and also on how they could themselves prevent infection and transmission of the disease.
Women were also targeted by sensitization campaigns as they were considered responsible for household sanitation and hygiene. Mothers generally made sure that all hygienic preventive measures were in place and protected the family as a whole. Collection, transport and storage of water were generally women's responsibility. Appropriate water handling and treatment, as well as food hygiene at the household level were key messages given to women.
Whatever the targeted group, UNICEF ensured that sensitization messages could not be interpreted in a way that stigmatized a specific group.
The disaggregation by age and gender comes from the Haitian statistical body (Institut Haitien de Statistique et d'Informatique or IHSI), and UNICEF applied the same age and gender ratios to the number of overall cases in each department.

(ii) Food insecurity, malnutrition and Emergency Agriculture

429,000 children, adolescents and woman were identified as beneficiaries of nutrition assistance, including 7,000 of under years children that were severely malnourished and were in need of care, 200,000 under five years and at risk to develop acute malnutrition to be addressed with preventive interventions. 100,000 adolescents and 122,000 pregnant and lactating women.
9,250 households identified in the most affected departments and that were severely food insecure due to the negative impact of drought on their agricultural production during the 2015 spring season and having significant challenges in meeting their basic food needs.
Some 200,000 households dependent on agriculture (estimates from the Assessment Report of the agricultural situation and food and nutrition security by the National Coordination of Food Security and Nutrition; May 2015) .

In general, the two CERF allocations have permitted to reach 1,156,167 children and 936,606 adults as illustrated in the following matrix.

TABLE 5: TOTAL DIRECT BENEFICIARIES REACHED THROUGH CERF FUNDING[2]			
	Children (< 18)	**Adults** (≥ 18)	**Total**
Female	593,364	593,364	**593,364**
Male	503,430	503,430	**503,430**
Total individuals (Female and male)	1,096,794	1,096,794	**1,096,794**

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

CERF RESULTS

(i) Cholera

The CERF cholera project contributed to maintain cholera related mortality under the 1 per cent. WHO threshold: between September 2015 and February 2016 global lethality rate is 0,97 per cent (224 dead cases/23583 cases) .As targeted PAHO/WHO partners and IOM implemented responses to cholera alerts and outbreaks. IOM and PAHO/WHO partners, as an average, responded to the alerts in less than 48h in 90 per cent of the cases (95 per cent for IOM) providing a complete package (investigation, sensitization, distribution, disinfection and eventual health treatment/referral) on the community responses implemented.

About 17,857 hospitalised cases (75 per cent on the national case load for the CERF implementation period) have been covered by the medical items purchased by PAHO/WHO with CERF funds and distributed to MoH and partners (estimation based on the RL solution units purchased taken as reference item). 598 health personnel including doctors; nurses / auxiliary nurses and hygienists in health institutions and polyvalent health agents received training, supervision and refreshment on the job sessions by IOM and PAHO/WHO implementing partners. These activities reinforced timeliness and quality of cholera care delivery at institutional level.

Globally PAHO/WHO partners and IOM mobilised 259 health personnel (28 deployed by IOM) including nurses, auxiliary nurses, doctors, hygienists (Global surge capacity) when the health facility’s capacity was overwhelmed and didn’t have adequate personnel during outbreaks. It is estimated that 60 health structures received this kind of support, that is to say, about 30 per cent of health facilities having acute diarrhoea treatment centres (CTDA) in the country. As forecasted the correct functionality of the Mirebalais CTDA has been Re-established by ZamniLasante (ZL).

IOM has also contracted additional 68 Community agents during the project lifetime, on a temporary basis, in order to support Cholera response at community level during an outbreak.

PAHO/WHO partners and IOM deployed a total amount of 25 mobile teams (6 by IOM) in order to ensure rapid response to outbreaks and implement, jointly with MoH rapid response teams (EMIRA) and WASH partners, the sanitary cordon strategy. According to the information provided by health and WASH partner’s through the shared PAHO/WHO and UNICEF response data base a total amount of 8220 interventions has been implemented by all Health and WASH partners and EMIRA teams countrywide. IOM team jointly with WASH partners have launched 91 Cholera responses within 48 hours in hotspots areas of the targeted Departments. The IOM response actions covered 34 zones in West Department, 35 in Artibonite and 26 in South-East Department. PAHO/WHO partners reported having provided 3134 responses globally.

The MdM National Emergency Response Unit has been deployed 10 times (9 times within 24hours) after confirmation of the need. The Unit covered 326 cholera cases providing medical care, logistic support to set up temporary cholera treatment units and conducting field investigations to identify the causes of the transmission. The Unit intervened 1 time in the Artibonite, South and North-West departments and 4 times in South-East.

. All outputs have been achieved and some indicator targets have been over reached, excepted for the output 3: “Accurate and timely epidemiological information available to better guide responses”. As described above the epidemiologic information has been regularly provided to partners by MoH departmental cholera Coordinators, PAHO/WHO in coordination with UNICEF, but it was not possible to reinforce MoH DELR investigation capacity being the 10 MSPP/DELR technical officers dismissed form their function due to financial constraints at the end of September 2015. The majority of case investigation is now done by response partners and departmental cholera coordinators directly.

Between mid - September to first week of December, the country reached the lowest cholera incidence since the beginning of the epidemic. Situation started to revert in mid-December and the year 2016 starts with a higher incidence compared with the first 2 EW of 2015. Despite in 2015, the rainy season started with a cholera incidence much higher 2014 last year at the same period, the seasonal increase in cholera incidence that often occur at the end of the year was globally better controlled and managed in 2015 when compared to 2014 thanks in part to the improved coordination and timeliness in the notification of cases and response to alerts supported by CERF funds. This enabled to better control small outbreaks and quickly and efficiently cut the transmission chain to avoid the propagation of large number of new cases. Between September 2014 and February 2015, 28,864 cholera suspected cases were recorded against the 23583 between September 2015 and February 2016.

3 months after CERF funded project epidemiologic satiation remains stable, an increase in the lethality rate is registered compared to previous year and several outbreaks continue to occur and needs to be controlled. Funds available for response are shrinking and PAHO/WHO health NGO partners are focusing their actions to the institutional case management. In this respect it has to be said that care standards at institutional level need to be constantly monitored because despite continued support for improvement, institutional care capacity varies significantly across departments and faces many limitations.

Activities 1.1 to 1.4: In 2015, with a number of suspected cholera cases equal to 36,045 (according to the MSPP), the theoretical number of direct beneficiaries was 1.98 million, counting households directly affected by cholera and the cordon sanitaire strategy already described multiplied by 10 additional households that indirectly benefitted from the response targeting the first household. From January to February 2016, 8,618 suspected cases of cholera were added by the same method of calculation, resulting in 474,000 beneficiaries. Finally, through the duration of the ***water, sanitation and hygiene project*** from September 2015 to February 2016, the MSPP noted 23,583 suspected cases of cholera at the national level, of which 64 percent or 14,348 in the four departments targeted by this project, arriving at a theoretical number of 790,000 beneficiaries.

- **In 2015,** 12,976 responses were reported by partners. Of these, 73 percent or 9,485 were in a targeted response and alert within 48 hours.
- More than 160,000 households received water treatment products at home.
- 61,973 cholera kits, 420,000 soaps, 12,000 buckets and about 585,000 packets of ORS were distributed during rapid interventions. With DINEPA, approximately 850 temporary water chlorination points were set up during outbreaks or as preventive measures to control the transmission and spread of the disease.
- During the project implementation period from September 2015 to February 2016, in the four targeted departments 5,659 responses were reported by partners following alerts. The 5,659 responses helped to target 493,140 people with the cordon sanitaire strategy, accounting for 62.5 percent of actual beneficiaries in these departments. In total almost 700,000 people were sensitized including family members of patients and members of households affected by cordons sanitaires.

Activity 2.2:

- **In 2015,** 1,941 cultures were taken at the national level, representing 5.4 percent of 36,045 suspected cases of cholera for the same year.
- For this CERF-supported project, the proportion of cultures in relation to suspected cases reached 8.9 percent.

As per the logframe, 20 percent of suspected cases received in health structures should have been administered a rapid diagnosis test (RDT): from field observations, RDTs were used by most structures under the leadership of central UADS. However, the real positive impacts of such tests were questioned. UNICEF noticed a misuse of RDTs as it often replaced clinic diagnoses based on physical symptoms of cholera. Discussions with the MSPP resulted in the decision to put an end to the use of RDTs.

It is still a priority for UNICEF to support the MSPP in increasing the percentage of cases that are currently being sent to the national laboratory (known by its French acronym LNSP) for confirmation of V. cholerae. The results are particularly important for data collection and analysis during seasons of low transmission of the epidemic to differentiate between confirmed cholera cases and other causes of severe watery diarrhoea. UNICEF had expected to reach 50 percent of positive tests that would be confirmed by cultures. However, the DELR's low capacity for analysis due to lack of human resources and low number of laboratories, led to the DELR issuing a note stating that no more than 10 percent of rapid tests should be sent for culture.

The missed target could be explained by several factors:

- ✓ The departmental coordinators were not sufficiently sensitized to the usefulness of culture results and too few Cary-Blair media orders for transporting samples were placed. Adding to logistical issues of departmental health directorates, there were many stock-outs in the whole territory.
- ✓ The establishment of the quota of 10 percent of positive RTDs to be cultured was not appropriate in relation to the dynamics of the epidemic. This percentage ignored areas or the number of suspected cholera cases. In addition, although UNICEF raised the issue of transporting samples, the number of media proved insufficient afterward. However, the total 1,941 cultures in 2015 nonetheless represented 54 percent of the MSPP indicator. The quota was established by the MSPP took into account the capacity for analysis in terms of human resources available within the LNSP.
- ✓ In order to have access to a broader set of data, UNICEF has since August 2015 been supporting a semi-private laboratory, which covers the northern part of the country. Throughout 2015 the DELR performed 1,272 cultures, while the private lab produced 669 in the space of five months**.**
- ✓ Currently the results of cultures are not diffusing the DELR to the departments. This tend to discourage the departmental coordinators of the MSPP, which in fact did not see the immediate usefulness to continue this activity.As the first solution to increasing capacity for collection and analysis, a second laboratory in the town of Saint Marc was the established in agreement with the MSPP.

- The laboratory supported by Zanmi Lasante (Partners in Health) processed 669 cultures with results in five months from August to December 2015. With LNSP, it was decided that this laboratory collect and analyze samples from the departments of North-West, North, North-East and Artibonite. In addition, by its proximity to the cities of Cabaret and Arcahaie located in the west, samples from these municipalities were analysed at this second lab. Activities will continue for the year 2016.
- Two points remain to be discussed with the MSPP: 1) with the disappearance of rapid tests, it is necessary to come up with a new definition and proportion of suspected cases on which to perform these levies; and 2) the proportion of cultures, which should be done in terms of phases of the epidemic.

(ii) Food Insecurity, malnutrition and Emergency Agriculture

WFP was able to distribute food to more than 120,000 vulnerable Haitians in areas worst affected by the drought. This comprised a two-month ration to feed a family of five and included rice, pulses, oil, sugar and salt. The beneficiaries, which consisted of families with pre and primary school age children, were targeted through the WFP school feeding network. Monitoring revealed that this general food assistance reinforced the effects of the safety net provided by school feeding, keeping most beneficiaries out of food insecurity during the drought crisis. WFP was also able to complement these immediate response efforts with Cash for Assets activities, which provided more long-term and sustainable interventions. Almost 4,000 Haitians took part in activities such as watershed management and soil conservation to improve local infrastructure for long-term development.
At the beginning of the summer season, each of the 9,000 beneficiary households received from FAO a kit of 500 sweet potato cuttings, 300 cassava cuttings and 5 kg of maize seeds (in the northwest) or sorghum seeds (south-east). During 2016 spring season, 10,500 vulnerable households, including the 9,000 beneficiaries of the summer season, received a kit/household of 500 sweet potato cuttings, 300 cassava cuttings, 5 kg of bean seeds and 5 kg of lima bean seeds or pigeon pea depending on the communal sections.

Each of the 10,500 households received 5 kg of bean seeds for the spring season.At the end of the 2015 summer season, each beneficiary household harvested about 160 kg of sweet potato, 300 kg of cassava and 250 kg of sorghum or corn. At the end of the 2016 spring season, each beneficiary family will harvest about 50 kg of beans, between 80 and 140 kg of Lima bean or pigeon peas, 250 kg of sweet potato and 300 kg of cassava. Letters of agreement were signed with four local NGOs with the purpose of targeting beneficiaries and distributing seeds and cuttings: CEHPADER and ATRAL in the Northwest department; GHV and UTRAB in the Southeast department

The targeting of beneficiaries and the distribution of seeds were carried out by NGOs in collaboration with the local technical (BAC), the CBOs and administrative authorities (CASEC). Seed's technical specifications were developed by an international expert in seed production. Seeds were technically cleared by AGPMG-FAO HQ and purchased by FAO local procurement unit in collaboration with FAO Divisional procurement unit at Headquarters (CSAP)

7725 vulnerable households (of which 66 per cent of women head's households: 5090), organized in 42 groups of vegetable producers (25 of South-east and 17 of North-west), received 330 kg of vegetable seeds and were supervised in vegetable production: 3725 households of the South-east (68 per cent of women) and 4000 households of the North-west (64 per cent of women): carrot seeds (30 kg), pepper (30 kg), cabbage (60 kg) tomato (60 kg), okra (60 kg), pepper (30 kg), spinach (30 kg) and eggplant (30 kg).

Technical Advices on vegetable crops were provided to the beneficiaries groups by FAO technical team in collaboration with the staff of the different municipal agricultural offices.

In summary, for the two cropping seasons, FAO distributed to vulnerable households a total of 14.6 tons of seeds of cereals and leguminous, 330 kg of vegetable seeds, 5.7 million cassava cuttings and 9.75 million sweet potato cuttings.125 leaders of CBOs, including 74 women (59.2 per cent) were trained in food and nutrition education by MC-EFADA a local NGO, under the supervision of a FAO nutritionist consultant, and they are applying the good nutritional education, food preparation and food hygiene practices.

Regarding Nutrition, UNICEF has worked in the communes where the food insecurity was higher in Southeast (Anse a pitre, Thiotte, Grand Gosier, Belle Anse et Baie d'orange) Northwest (Baie de Henne, Bassin bleu, Mole Saint Nicolas, Port-de-Paix, Bombardopolis) Centre (Cerca-la-Source, Belladère, Thomonde, Thomassique, Cerva Cavajal) and Artibonite(Anse Rouge, Ennery, Gonaives, Gros-Morne) and ensured availability of sufficient RUTF (Ready to use therapeutic formula) and therapeutic milk to meet the needs for treatment of severely malnourished children under five.

Appropriate interventions were implemented to improve the situation and avoid a catastrophic deterioration in beneficiaries' already precarious health. Many malnutrition cases that were already registered were not supported due to the limited access to basic health services or political situation. The children in care were regularly monitored using national SAM protocol parameters, which allowed UNICEF to see the positive effects of the administered treatment. However, behaviour change is an outcome that can only be assessed in the long term and cannot be measured at this stage.

All planned activities were implemented globally; however, completion rates vary from one activity to another depending on the area of activity in which it was planned and unpredictable hazards. Overall, the project was a success in departments where children and pregnant women's nutritional situation was precarious.

Good outcomes and practices identified were:

- Strengthened epidemiological surveillance of malnutrition;
- More mothers were sensitized in adopting breastfeeding during the first 6 months of their babies' lives;
- Nutrition was better integrated into the daily service package project; and
- Intensified education activities in health and nutrition in institutions and communities.

CERF's ADDED VALUE

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?

YES ☒ PARTIALLY ☐ NO ☐

The CERF funds played a crucial role in ensuring rapid response to cholera outbreaks both a community level trough "cordon sanitaires" and institutional level with the surge capacity strategy and the regular refurbishment of health structures. The CERF funds were able to deliver a fast and quality assistance including to the IDP populations, vulnerable communities living in isolated areas providing life-saving medical care and containing the spread of cholera in the targeted areas

The CERF funds have contributed to rapidly improve agricultural production of beneficiary households because quality seeds and planting materials were made available for the next farming seasons and, as results, family farmers had harvested three months after the beginning of the project.

The CERF allocation was the first contribution received by WFP to respond to the severe drought that was affecting the country and pushing people deeper into the hunger. The severity of the situation was later confirmed by an Emergency Food Security Assessment (EFSA), conducted in December 2015 by WFP and the Government, which revealed that the number of people facing severe food insecurity doubled in less than 6 months. According to the study, one-third of Haiti's population was facing food insecurity; among them 1.5 million were severely food insecure. The CERF contribution enabled WFP to act quickly in the absence of other donors' contribution and to respond during this developing drought situation.

b) Did CERF funds help respond to time critical needs[1]?

YES ☒ PARTIALLY ☐ NO ☐

CERF Fund intervened during the most at risk period for cholera transmission largely contributing to control the incidence. The CERF funds were able to support the response to time critical needs through mobile rapid response teams and surge capacity mobilised within 48hrs. Additional support was provided to provide additional medical and non-medical supplies that were immediately distributed according to the needs registered in targeted departments and at the communal level.

Since September 2015, the MSPP has not been able to maintain contracts of supplementary health personnel for cholera care, therefore further reducing care delivery capacity. In this context CERF Funds added value was crucial to reinforce health structures during outbreaks

The drought had destroyed the agricultural production mechanisms of beneficiary farmers. The CERF project gave them agricultural inputs to boost agricultural production in the early seasons of summer 2015 and spring 2016.

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

YES ☒ PARTIALLY ☐ NO ☐

During CERF funded activities implementation PAHO/WHO maintained constant contact with other donors and or MoH technical/financial partners' including the World Bank, CdC and ECHO. Meeting where held with these partners and UNICEF in order to coordinate action and avoid double finding of the same activities. This helped to rationalise the use of financial resources for cholera response
The life-saving activities as part of the CERF-funded project were implemented through a well-coordinated mechanism building on local capacities, allowing IOM to mobilize local resources in response to the critical needs in South East, West and Artibonite department. It has also supported in the resource mobilization of different level of support from MSPP, humanitarian partners and local authorities.

In addition to the CERF funds, other donors funded agricultural assistance to households affected by drought: ECHO has given 523,473 USD to assist 35,000 people of the Southern Department, FAO has given 500,000 USD to assist 30,000 people of Artibonite Department, SFERA Fund gave 500,000 USD to assist 15,000 people of Artibonite Department and USAID-OFDA will possibly give 1 million USD to assist 40,000 people in the North west Department. Contacts with other donors are going on.

d) Did CERF improve coordination amongst the humanitarian community?

YES ☒ PARTIALLY ☐ NO ☐

A clear added value of the action was the significant improvement of coordination and information sharing between NGO partners and national authorities, as well as health and WaSH actors, to ensure better coverage and more comprehensive response to alerts. This translated in the standardization and streamlining of joint investigation, monitoring and reporting tools for cholera management among response actors as well as the more systematic implementation of joint health/WaSH responses integrating a full health and WASH response package. Continued efforts are needed to sustain the positive progress in that area. .All actors implementing the activities in the framework of the present action are actively involved in all cholera coordination response mechanisms at central and departmental level namely: the monthly health and WASH partner coordination meetings (central); the coordination meetings at departmental level coordinated by MoH (according to the Departments these meetings are held on a minimal monthly base, and they can be complemented by Ad-Hoc meeting in case on very acute outbreaks). PAHO participates to the national technical coordination meeting (Central level at UADS/MoH) and to the High level Task Force.

FAO worked with WFP in the implementation of the project activities and to spread complementary benefits from the joint interventions. The two United Nations agencies collaborated in targeting beneficiaries for the synergy of actions. Beneficiaries of WFP's cash for asset received technical support from FAO, particularly those who were doing activities on micro watersheds management. Those with agricultural plots also received FAO's seeds and cuttings to revive agricultural production. In addition, another FAO project funded by the Global Environment Facility (GEF) that is supporting farmers in the South-East and West

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

Departments to develop coping mechanisms to climate change has given agricultural tools and herbs cuttings to beneficiaries of cash-for-transfer to plant on the contour line for the micro watersheds management work.

The CERF project provided the opportunity to work in coordination with other actors active in the food security and nutrition sectors such as UNICEF and the WFP as well as some international NGOs. The coordination focused on the need assessment in concertation with the CNSA and the Ministry of Public Health and the response to be deployed.

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

CERF had a substantive added value to the humanitarian response as it was able to contribute to the needs and priorities in terms of responding to cholera outbreaks. Furthermore, the impacts of the CERF supported project was widespread across the regions of Haiti where cholera is persistent and was able to ensure response in specific localised complexes emergency satiation like in the SE departments ate the border with Dominican Republic where cholera touched part of the returnees population in the spontaneous camps in Anse a Pitre Municipality in November 2015.

The CERF has provided the opportunity to FAO to work with the WFP in the South-East Department on complementary actions (cash for asset and cash transfer) implemented in the same communes of intervention.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
To ensure the sustainability of actions	Actively involve the communities including voluntary committee leaders, community agents, MSPP and other local partners in responding and preventing cholera outbreaks.	IOM
Lack and poor WASH conditions	Based on the surveillance and investigations of suspected cases, we have learned from the targeted communes that the major sources of contamination/transmission remained "Fecal-oral" transmissions resulted from the lack of potable water and subsequent use of unsafe contaminated water from unprotected wells or surface water from rivers, uncollected solid waste which contained fecal matter and poor hygiene practices.	WASH Partners
Rapid Response	Rapid Response combined with communities outreach activities remained an effective approach in controlling the outbreaks in high vulnerable areas.	IOM and Coordination
There remains a significant number of rural households without agricultural inputs to resume farming in subsequent agricultural seasons	The needs for basic agricultural inputs remain high for non-assisted small farmers. Advocacy must be done to increase the financial resources so that these rural people can resume their agricultural production and food self-sufficiency.	FAO and other partners

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
The Action contributed to the development of new practical tools for cholera management that sometimes faced resistance of health authorities to endorse and disseminate them to decentralized levels and partners for application. .	Increased attention must be given to the MSPP's implementation capacity and technical support to proposed interventions. Future action should focus on continuing to support well-accepted tools and mechanisms, including the national Line Listing as well as EMIRA reporting form, MSPP investigation form etc.. Dialogue with health authorities must also continue to ensure support identify alternative approaches and resolve implementation blockages	PAHO/WHO; UNICEF; MoH
It is important to build on the priorities identified by the MSPP such as the development of community-based surveillance activities through the mobilization of community agents (ASCP).	This action supported an increased role of the ASCP in the investigation of and response to cholera alerts. The ASCP role is currently under discussion within the MSPP and PAHO/WHO provided inputs for the possible revision of the ToR of ASCP, who must remain a polyvalent agent. Communuty based surveillance has to be considered a for future actions including through the mobilisation of whider community based neterworks (DPC volunteers; HRC volunteers etc..)	PAHO/WHO; UNICEF ; MoH and implementing partners
Continued support of health NGOs and PAHO/WHO is instrumental to improve capacity and quality of care. However, no sustainable impact can be obtained without the active collaboration of health authorities and health structures managers to ensure continued guidance and monitoring of health personnel in the proper application of protocols for cholera care	A more in depth analysis of institutional lethality rate, with cross-checking of CTDA evaluation results, must be conducted to support the MSPP in developing a plan of action to improve institutional cholera care.	PAHO/WHO; MoH Health partners

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	IOM WHO	**5. CERF grant period:**	26/08/2015 – 25/02/2016 (IOM) 27/08/2015 – 31/03/2016 (WHO)
2. CERF project code:	15-RR-IOM-022 15-RR-WHO-029	**6. Status of CERF grant:**	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Health		
4. Project title:	Ensure adequate and rapid response to cholera alerts and outbreaks by the Health sector in Haiti		

7.Funding				
a. Total funding requirements[2]:	US$ 16,317,399	d. CERF funds forwarded to implementing partners:		
b. Total funding received[3]:	US$ $2,087,428.60	▪ *NGO partners and Red Cross/Crescent:*	US$ 922,954.26	
c. Amount received from CERF:	US$ 1,778,849	▪ *Government Partners:*		

Beneficiaries						
8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).						
Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	280,800	259,200	540,000	74,710	101,910	176,620
Adults (≥ 18)	304,200	280,800	585,000	73,524	100,292	173,816
Total	**585,000**	**540,000**	**1,125,000**	**148,234**	**202,202**	**350,436**

8b. Beneficiary Profile		
Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs		
Host population		
Other affected people	1,125,000	350,436
Total (same as in 8a)	**1,125,000**	**350,436**

[2] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.
[3] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	Please note that the number of people planned represents the global estimation of the beneficiaries reached both by PAHO/WHO and UNICEF CERF funded interventions jointly. This estimation is based on 12 months (year 2015) estimation at national level. Please consider to cumulate the number of people reached indicated in this table with the same amount reported by UNICEF to obtain the total nr of beneficiaries reached by heath and WASH response.

CERF Result Framework			
9. Project objective	To contribute to the reduction of mortality and morbidity rates associated with cholera in Haiti		
10. Outcome statement	The global lethality rate related to cholera is maintained under 1 per cent during 2015		
11. Outputs			
Output 1	Health emergency community responses to alerts are implemented in less than 48h cutting the transmission of the infection within communities and local population		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Percentage of appropriate responses at community level conducted within 48 hours after a confirmed alert	90%	90% (includes IOM indicator
Indicator 1.2	Percentage of response at community level with complete package (investigation, sensitization, distribution, disinfection and eventual health treatment/referral)	90%	95% (includes IOM indicator:)
Indicator 1.3	Percentages of emergency responses activated by MdM National Emergency Response Unit within 24hours after confirmation of the need.	90%	90%
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Timely detection and reporting of every suspected cholera cases received in Cholera treatment centres or detected in the communities	PAHO/WHO field teams(as co-leading actor with MSPP, in Center; West; North and Artibonite), Health structures personnel in charge (on a routine base), IOM (Focus on West; Upper Artibonite; residual South East) MdM AR ((Center) MdM Consortium: (Focus: West; Lower Artibonite; plus 4 other departments) IMC: Focus North; residual North East ZL: Center	As planned: PAHO/WHO field teams(as co-leading actor with MSPP, in Center; West; North and Artibonite), Health structures personnel in charge (on a routine base), IOM (Focus on West; Upper Artibonite; residual South East) MdM AR ((Center) MdM Consortium: (Focus: West; Lower Artibonite; plus 4 other departments: Grande Anse; Nippes; Sud; North-West) IMC: Focus in the North; residual North East ZL: Center

Activity 1.2	Investigation of cholera potential causes in affected localities and active search for new suspect cases.	PAHO/WHO field teams(as co-leading actor with MSPP, in Center; West; North and Artibonite) , IOM (Focus on West; Upper Artibonite; residual South East) MdM AR (Center) MdM Consortium: (Focus: West; Lower Artibonite; plus 4 other departments) IMC: Focus North; residual North East	PAHO/WHO field teams(as co-leading actor with MSPP, in Center; West; North and Artibonite) , IOM (Focus on West; Upper Artibonite; residual South East) MdM AR (Center) MdM Consortium: (Focus: West; Lower Artibonite; plus Grande Anse; Nippes; Sud; North-West) IMC: Focus North; residual North East:
Activity 1.3	Immediate health responses launched within 48h in areas where suspected cases have been reported/confirmed in coordination with EMIRA and WASH partner when available.	PAHO/WHO field teams (as co-leading actor with MSPP, in Center; West; North and Artibonite) IOM (Focus on West; Upper Artibonite; residual South East) MdM AR: Center MdM , Consortium: (Focus: West; Lower Artibonite; plus 4 other departments) IMC: Focus North; residual North East	As Planned PAHO/WHO field teams(as co-leading actor with MSPP, in Center; West; North and Artibonite) , IOM (Focus on West; Upper Artibonite; residual South East) MdM AR (Center) MdM Consortium: (Focus: West; Lower Artibonite; plus Grande Anse; Nippes; Sud; North-West) IMC: Focus North; residual North East::
Activity 1.4	Mobilize MdM Emergency Response Unit according to established activation criteria	MdM Spain lead consortium (punctual country wide intervention capacity)	As Planned: MdM Spain lead consortium (punctual country wide intervention capacity)
Activity 1.5	Support of operational/management capacity of the MSPP ; elaborating planning tools; Ensure alert/response mechanism monitoring and regular joint analysis of the response performance including the implementation of regular or had hoc meeting at departmental and national level.	MSPP, PAHO/WHO in coordination with UNICEF, and partners	As Planned: MSPP, PAHO/WHO in coordination with UNICEF, and partners
Output 2	Timely and quality of cholera care delivery ensured at institutional level		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Minimum nr of cholera cases taken care at institutional level with medical items supplied	More 8000	More 17857 (includes IOM indicator: 2217 cases)
Indicator 2.2	Number of health personnel receiving supervision and on-site refresher trainings on application of care protocols	500	598 (including IOM indicator::202 health personnel)

Output 2 Activities	Description	Implemented by (Planned)	Implemented by (Actual)
Activity 2.1	Deployment of supplementary nurses/auxiliaries and hygienists in hospitals and health centers when the health facility is overwhelmed and doesn't have adequate personnel during peaks	- IOM (Focus: West; Upper Artibonite. Plus South East) - MdM Consortium (Focus: West; Lower Artibonite; plus 4 other departments) - IMC:IMC: Focus North; residual North East - ZL (Center)	IOM (Focus: West; Upper Artibonite. Plus South East) - MdM Consortium (Focus: West; Lower Artibonite; plus 4 other departments) - IMC:IMC: Focus North; residual North East - ZL (Center)
Activity 2.2	Carry out regular supervisions and onsite refreshment trainings of estimated 500 medical staff including polyvalent agents, nurses, auxiliary nurse, doctors on cholera care and cholera related topics(to keep adequate quality of care these activities are done on a regular base by rotating in the concerned health structures)	- PAHO/WHO field teams (as co-leading actor with MSPP, in Center; West; North and Artibonite) - IOM:Focus: West; Upper Artibonite. Plus South East - MdM Consortium: Focus: West; Lower Artibonite; plus 4 other departments - IMC : Focus North; residual North East - ZamniLasante: Center	PAHO/WHO field teams(as co-leading actor with MSPP, in Center; West; North and Artibonite) , IOM (Focus on West; Upper Artibonite; residual South East) MdM AR (Center) MdM Consortium: (Focus: West; Lower Artibonite; plus Grande Anse; Nippes; Sud; North-West) IMC: Focus North; residual North East
Activity 2.3	Supply of medical items to support health structures on a regular basis and during outbreaks (8000 cases covered by PAHO/WHO).	- ZL: Center - PAHO/WHO field team in Center (only back up capacity) - PAHO/WHO filed teams and PAHO/WHO central storage for West; Artibonite; North; and rest of the country. - IMC: Focus North; residual North East	ZL: Center; PAHO/WHO field team in Center (only back up capacity) -PAHO/WHO filed teams and PAHO/WHO central storage for West; Artibonite; North; and rest of the country. -IMC: Focus North; residual North East
Activity 2.4	Distribution of non-medical supplies to NGO partner and health care facilities on a regular basis and during outbreaks	- PAHO/WHO: focus on Center; West; North and Artibonite and remaining needs rest of the country - IOM:residual needs	PAHO/WHO: focus on Center; West; North and Artibonite and remaining needs rest of the country IOM:residual needs in West; Upper Artibonite and South East

		in West; Upper Artibonite and South East	
Activity 2.5	Re-locate the cholera treatment services and install a rehabilitated acute diarrheal treatment Center within the structure of the nearby health facility (CDI) in Mireballais	Zamni Lasante	Zamni Lasante
Output 3	Accurate and timely epidemiological information available to better guide responses		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	Percentage of suspected cases fully investigated by MSPP/ DELR field technicians	60%	Not measurable
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Reproduce case investigation and mortality investigation templates	PAHO/WHO	PAHO/WHO
Activity 3.2	Organize joint field monitoring visit and investigations with MSPP/ DELR central and field technicians.	PAHO/WHO and MSPP/DELR	PAHO/WHO
Activity 3.3	Support stools sample collection, transport and laboratory analysis	PAHO/WHO and MSPP/DELR	PAHO/WHO and NGO partners
Activity 3.4	Support DELR daily reporting on cholera epidemiological trends	PAHO/WHO and MSPP/DELR	PAHO/WHO and MSPP/DELR

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

Output 1:

Throughout this Action, PAHO/WHO, through its emergency management team based in the EOC at central level, and the 4 filed teams in the priority departments provided continued support to the health authorities to monitor alerts and coordinate investigation and response. Daily communications between PAHO/WHO's Alert Monitoring Officer, all 10 departmental cholera Coordinators and PAHO field teams ensured timely registration of new alerts and regular collect of information on the evolution of cholera outbreaks and possible case resurgence as well as real-time information on response capacity in the field.

PAHO/WHO partners provided a total amount of 3134 responses each one as follows: MdM Spain (415); MdM BE (229); MdM CA (845); MdM France (589); MdM Argentine (487); IMC (569). The MdM Consortium led by MdM Spain deployed 14 mobile teams while MdM Argentine and IMC deployed respectively 2 and 3 mobile teams

IOM has received a total of 95 Cholera alerts distributed as following: West Department (34), Artibonite (35) and South-East Department (26). IOM in coordination with WASH partners and EMIRA were able to respond to 91 alerts (95 per cent). IOM has deployed a total of six (6) rapid response teams (2 medical staff and 1 log. assistant) in the targeted Departments to respond to Cholera alerts in collaboration with WASH partners and the respective departmental authorities (Department Sanitaire de l'Ouest -DSO and Department Sanitaire de Sud Est (DSSE) as well as EMIRA, upon receiving an alert within 48 hrs. IOM has contracted additional 68 Community agents during the project lifetime, on a temporary basis, in order to support Cholera response at community levels during an outbreak. During the project execution. At community level, IOM Cholera Response has supported Cholera Structure with the deployment of 68 communities' agents (brigadiers/ASCP), for communities outreach activities and Sanitary Cordon. These activities reached out 364,753 people through 2,860 awareness campaign (mass and door to door). Moreover, community agents conducted 22,158 home visits and 7,902 households' decontamination during sanitary cordons

The joint mobile team (MSPP/EMIRA, IOM-WASH partners) was deployed to the area where the alert was reported to conduct response activities such as: investigation/verification of the reported cholera alert, case management, assessment of the capacity of the health care facility, sensitization and mass awareness sessions on cholera prevention, distribution of cholera-related items such as Aquatabs, soaps and IEC materials (flyers, "Chimen lakay" magazines with key messages on cholera prevention), and distribution of medical items such as lactated ringers, IV catheters, medicines, cholera beds, and so forth.

PAHO/WHO liaised with MdM for the mobilisation of Emergency Response Unit for each of the 10 deployments that have been organised and this in order to ensure that established activation criteria where met and that the Unit was intervening in coordination with other actors present of the field and with local health authorities

Regular and ad-hoc coordination meetings were held monthly or more frequently countrywide including the 4 priority departments. All 4 priority departments were able to share with response partners critical information presented and discussed in coordination meetings in a timely manner (usually within 2 business days PAHO/WHO's close coordination with health authorities helped facilitate the validation process and improve timeliness of information sharing.

Output 2:

The MdM consortium mobilised 166 health personnel (Surge Capacity) to reinforce cholera institutional care during outbreaks.

IMC mobilised 15 health personnel and Zanmi Lasante 30. IOM has contracted additional 24 nurses during the project lifetime, on a temporary basis, in order to support Cholera response at institutional (CTC/CDTA) level during an outbreak.

IMC trained/refreshed and supervised 56 health personnel, Zanmi Lasante 40 and the whole MdM Consortium 300. IOM trained/refreshed and supervised globally 202 health personnel.

The most efficient solution to ensure that the cholera treatment services in Mirebalais are provided according to the standards was to renovate the existing structure in order to ensure a better integration with the nearby health facility (CDI) in Mireballais which is at the same time the external clinic of the Mirebalais University Hospitals (MUH). After several assessments MoH, ZL and PAHO/WHO concluded that a relocation of the service was not possible because of the unavailability of spaces. Case management condition sensibly improved in this structure a rotation of personnel is effective with the CDI and MUH.

PAHO/WHO field teams visited on a monthly basis for rapid assessment all cholera treatment structures in the 4 priority Departments (58). Moreover during the implementation period structures have been fully evaluated thorough assessments of the entire health structure, looking at infrastructure set-up and operations, water and sanitation systems, human resources levels and skills, protocol applications, etc. using extensive checklists established by the MSPP. These evaluations aimed to identify in details all the needs (supplies & material, trainings, human resources, etc.) and interventions that must be taken to improve healthcare delivery. These monitoring visits have been conducted jointly with MoH and NGOs partners.

IOM has established new Cholera Facilities (ORP plus, CTDA)) for life-saving operations in remote areas during outbreak. During the reporting period a total of 7 ORP plus were established in the West department (2), Artibonite (3) and South East Department (2). Moreover, IOM has provided support with medical and non-medical materials, and for the running operation of the Cholera structures including repair of electrical system (night), provision of fuel for the generator, delivery of water.

PAHO/WHO provides medical items based on a list of 10 "most vital drugs". These items were continuously present and available in all 10 departments, either at CDAI level, PROMESS or in the PAHO field teams' stocks. A few field partners also maintained these items in stock and supported regular distribution of supplies to health facilities to ensure proper healthcare delivery capacity. Furthermore PAHO/WHO provided 7 most essential WASH items, to partners, CDAIs and health structures. No prolonged shortages of essential WASH items (more than 7 days) were recorded during the overall implementation period.

Output 3

The epidemiological surveillance and investigation capacity of the MSPP, through the DELR, has severely reduced in 2015 with the removal of DELR departmental field technicians since October 2015 due to financial constraints. This situation didn't permit the implementation of the case investigation by those technicians, neither the joint DELR PAHO/WHO filed investigation monitoring activities. The majority of case investigation is now done by response partners and departmental cholera coordinators directly. A standardized national LL template was only introduced in November 2015 by the DELR.

With the assistance of the PAHO statistician and database manager, daily information on cholera cases was compiled, analysed and reported through bulletins presentations and situation reports to inform partners and health authorities of the evolution of the epidemic and support rapid decision-making to adapt the response. PAHO/WHO field teams ensured logistics for collection and transportation of

laboratory samples for culture analysis.

IOM rapid response team has provided direct support to local health care facility (CTC/UTC and CDTA) in triage, case management, surveillance reporting and laboratory samples for culture analysis. Furthermore, The alerts reported a total of 1,811 cholera suspected cases, and five (5) deaths. Data collection and transmission of information ensured to the respective departmental health authorities and partners for immediate response actions in the community to further prevent spread of cholera, such as decontamination, sensitization, contact tracing.

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

The project has been designed taking into account the needs jointly assessed by PAHO/WHO and its implementing partners trough permanent exchanges with MoH at national and departmental/local level. All the implementing partners have a sound knowledge of the needs in their respective area on intervention and solid relations built with local leaders and the population.

PAHO/WHO implementing partners constantly worked jointly with health authorities and in the framework of the established coordination mechanisms at departmental level. The partners constantly informed health authorities about the scope of their support and response capacity. The same dialog has been maintained with community leaders (including the actors f traditional medicine, religious leaders and community agents) who were directly involved in the projects activities implementation. Monitoring activates of cholera treatment centres have been dealt by PAHO/WHO jointly with MoH and implementing partners. These ones always solicited departmental health authorities to conduct joint cholera alerts investigations and field monitoring.

Over the course of the project, IOM worked closely with MSPP in implementing the activities at the institutional and commune level, involving the voluntary community leaders and provided trainings to medical staff and community agents. The IOM Health Team established coordination networks between the community agents, local authorities and MSPP. Consequently, through this integrated approach, affected populations were properly taken into account and continuations of activities related to cholera response in the targeted communes will be sustained beyond the project implementation period.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
If evaluation has been carried out, please describe relevant key findings here and attach evaluation reports or provide URL. If evaluation is pending, please inform when evaluation is expected finalized and make sure to submit the report or URL once ready. If no evaluation is carried out or pending, please describe reason for not evaluating project.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	UNICEF	**5. CERF grant period:**	24/08/2015 – 23/02/2016
2. CERF project code:	15-RR-CEF-079	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Water, Sanitation and Hygiene		☒ Concluded
4. Project title:	Support to nationwide cholera prevention and response activities		

7.Funding			
a. Total funding requirements[4]:	US$ 20,204,320	d. CERF funds forwarded to implementing partners:	
b. Total funding received[5]:	US$ 5,763,877	▪ *NGO partners and Red Cross/Crescent:*	US$ 2,222,217
c. Amount received from CERF:	US$ 2,366,305	▪ *Government Partners:*	US$ 55,000

Beneficiaries

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

Direct Beneficiaries	*Planned*			*Reached*		
	Female	*Male*	*Total*	*Female*	*Male*	*Total*
Children (< 18)	280,800	259,200	540,000	105,133	103,465	208,598
Adults (≥ 18)	304,200	280,800	585,000	143,409	141,133	284,542
Total	**585,000**	**540,000**	**1,125,000**	**248,542**	**244,598**	**493,140**

8b. Beneficiary Profile

Category	*Number of people (Planned)*	*Number of people (Reached)*
Refugees		
IDPs		
Host population		
Other affected people	1,125,000	493,140
Total (same as in 8a)	**1,125,000**	**493,140**

[4] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.
[5] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	This difference may be due to the following reasons: - The 1,125,000 beneficiaries described in the original proposal pertained to the entire country and the year 2015; The CERF project targeted exclusively the departments of the North, Centre, Artibonite and West, from September 2015 to February 2016. As described above, the actual number of beneficiaries during the project duration of 790,000 people for 14,438 suspected cases of cholera. Thus compared to the initial target, nearly 44 percent of targeted benefited from a response related to the cholera epidemic, but compared to the real target, 62 percent of people benefited from a suitable response. - The difference is also explained by the ability of teams to respond to cases. UNICEF believes that a team can respond to about five cases per day in urban areas, but down to two cases per day in rural areas where houses are more dispersed. - In addition, as described above at the end of year 2015 until February 2016, most cases of the epidemic were located in the northern department with as starting point the municipalities of Pilate and Plaisance. The continued political wrangling and disagreement on local election results, consequently led to a deterioration of the security situation prohibiting for several days or weeks adequate responses from partners and mobile teams of the DSN (EMIRA).

CERF Result Framework			
9. Project objective	Provide timely and adequate WASH rapid response to all cholera alerts in West, Artibonite, Centre and North Department		
10. Outcome statement	The annual incidence of cholera in Haiti is maintained below 0.3 per cent in 2015		
11. Outputs			
Output 1	WASH immediate responses are implemented in less than 48h after an alert		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Percentage of appropriate responses conducted within 48 hours after a confirmed alert	90%	88%
Indicator 1.2	Percentage of response with complete package (investigation, sensitization, distribution, disinfection)	90%	98%
Indicator 1.3	Number of people assisted with a complete cholera kit (average per month)	NA (depends on incidence level)	4,780 (on the project time and targets departments), 13,348 (2015 and for the whole country)
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Early detection (through cholera treatment centres daily monitoring and community health workers network trained to inform NGOs of each alert) and communication of every suspected cholera cases received in cholera treatment	NGOs partners (see description of each partner in part. II)	NGOs partners

	centres or detected in the communities		
Activity 1.2	Investigation of potential causes of cholera in affected localities and active search for new suspect cases.	NGOs partners	NGOs partners
Activity 1.3	Undertake immediate WASH responses within 48h in areas where suspected cases have been reported/confirmed.	NGOs partners	NGOs partners
Activity 1.4	Implement (with DINEPA and NGOs) emergency water systems protection and repairing to control ongoing outbreaks	DINEPA and NGOs partners	DINEPA and NGOs partners
Output 2	Accurate and timely epidemiological information is available to improve effectiveness of response		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of epidemiological reports provided by APHM from August to December 2015	2	2
Indicator 2.2	Percentage of suspected cases whose stool sample is sent for confirmation to the National Laboratory or private laboratories	20%	8,9% (on the project time) and 5,4% for year 2015
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Provide timely and accurate epidemiological information to partners to better adapt the response	APHM, UNICEF and PAHO	APHM, UNICEF
Activity 2.2	Confirmation of suspected cases through Laboratory tests	DELR, UNICEF	DELR, UNICEF

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

Indicator 2.2:

- We had expected to reach 20 per cent of positive test that would be confirmed by cultures. However, and to their low capacity analysis by lack of human resources and the number of laboratories, the LNSP / DELR has forwarded a note that only 10 per cent of rapid test should be sent for culture.
- Unicef with the MSPP of august 2015, then supports the establishment of a second enteric laboratory in order to document and clarify the epidemic on the northern part of the country. In 2015, the LNSP has performed 1,272 cultures and lab Saint Marc 669 in the space of five months of operation on the year 2015. Finally, it was in 1,941 cultures were performed 5.4 per cent more total cases.
- Two points remain to be discussed here with the MSPP:
  - ➢ With the disappearance of rapid tests, it is necessary to define a new definition and proportion of suspected cases on which to perform these levies,
  - ➢ The proportion of cultures, should be done in terms of phases of the epidemic,

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

Monitoring of partners' activities

Partners were asked to report their activities on a dedicated Google drive that UNICEF managed. Each NGO had its own username and password and could not access other NGOs' pages. Actions undertaken during the previous month were analyzed by UNICEF specialists and discussed at the monthly meetings with partners.

UNICEF organized a monthly strategic meeting with all NGO partners (health NGOs and PAHO participated in these meetings) to continuously adapt the strategy to the evolving situation. In addition, UNICEF emergency team members undertook regular field visits to monitor partners' activities.

UNICEF was assisted by APHM in the scientific approach and quality control.

NGOs partners were also required to undertake regular post-distribution monitoring to assess the impact of distributed items and level of satisfaction of the recipients.

Financial control

With the implementation of UNICEF Harmonized Approach to Cash Transfer (HACT), financial spot-checks were done two to three times per year by UNICEF staff and once by an external audit firm depending on the partner's level of financial risk assessed by an external firm.

Evaluation

An external evaluation of the UNICEF operation started in June 2013 took place in September 2015. The results will be used to update and improve the UNICEF strategy in the framework of the National Cholera Elimination Plan.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☒
This CERF-funded project supported the MSPP and DINEPA's integrated national strategy for the elimination of cholera in the short term (2013-2015). UNICEF and PAHO were executing partners. From October 2015 to February 2016, the HYDROCONSEIL company performed an external evaluation of the strategy of the fight against cholera as applied by UNICEF.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☐

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	UNICEF	**5. CERF grant period:**	19/08/2015 – 18/02/2016
2. CERF project code:	15-RR-CEF-080	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Nutrition		☒ Concluded
4. Project title:	Response to the nutritional emergency Haiti through the management and prevention of malnutrition among vulnerable groups		

7.Funding				
	a. Total funding requirements[6]:	US$ 4,000,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received[7]:	US$ 1,225,022	▪ *NGO partners and Red Cross/Crescent:*	US$ 353,527
	c. Amount received from CERF:	US$ 1,000,022	▪ *Government Partners:*	US$ 21,595

Beneficiaries

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

Direct Beneficiaries	*Planned*			*Reached*		
	Female	*Male*	*Total*	*Female*	*Male*	*Total*
Children (< 18)	107,640	99,360	207,000	159,162	149,920	306,082
Adults (≥ 18)	122,000		122,000	55,524		55,524
Total	**229,640**	**99,360**	**329,000**	**214,686**	**149,920**	**361,606**

8b. Beneficiary Profile

Category	*Number of people (Planned)*	*Number of people (Reached)*
Refugees		
IDPs		
Host population	329,000	361,606
Other affected people		
Total (same as in 8a)	**329,000**	**361,606**

[6] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.
[7] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	The number of pregnant and lactating women planned in the original proposal was not reached because: - Implementing partners encountered difficulties in performing the community aspect because of a lack of available health agents in serving institutions; - Nurses in charge also had many other responsibilities within the institutions, and lack of staff nutrition services delivery in some health centers were major challenges faced by implementing partners; and - The election period was also an important negative aspect in the implementation of activities.

CERF Result Framework			
9. Project objective	Deliver coordinated and integrated lifesaving assistance to people affected by emergencies.		
10. Outcome statement	1. Management of Acute Malnutrition for under-5 children in Stabilization Centers (USN), and OTPs Program according to national and international protocol; 2. Prevention of the deterioration of the nutrition status of most vulnerable children and women through food and micronutrient supplementation social mobilization, C4D and technical support		
11. Outputs			
Output 1	7,000 severely malnourished children under 5 years from Southeast (Anse a pitre, Thiotte, Grand Gosier, Belle Anse et Baie d 'orange) Northwest (Jean Rabel, Ennery); Centre (Cerca-la-Source, Belladère, Thomonde) are benefitted from care and recovered		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of children screened for severe acute malnutrition	200,000	205,106
Indicator 1.2	Number of children admitted into the treatment program in management of severe acute malnutrition	7,000	5,730
Indicator 1.3	Percentage of children cured of severely acute malnutrition	85%	75.25%
Indicator 1.4	percentage of children who have left the program(defaulters)	10%	22.4%
Indicator 1.5	percentage of children who died in the program	5%	1.77%
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Treatment of children suffering from SAM through local strengthened institutions.	UNICEF and implementing partners (Fondefh and Shassmeppe)	MSPP,FONDEFH and SHASSMEPPE
Activity 1.2	Procurement of nutritional supplies, including Micronutrient powder, ready to use therapeutic food, therapeutic milks, anthropometric equipment and essential drugs for systematic treatment of medical complications from acute malnutrition	UNICEF and implementing partners (Fondefh and Shassmeppe)	MSPP,FONDEFH and SHASSMEPPE

Activity 1.3	Supporting active and passive screening activities at community and institutional level.	UNICEF and implementing partners (Fondefh and Shassmeppe)	MSPP,FONDEFH and SHASSMEPPE
Output 2	Number of children under 5 years and pregnant/lactating woman reached with Promotion of appropriate infant and young child feeding		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	No of staffs trained in IYCF (Health workers and mothers)	2,400	89 staffs trained in PCMA
Indicator 2.2	No of supervision realized	48	63 institutions supervised. 30 supervision by UNICEF and 20 by MSPP
Indicator 2.3	No of children received micronutrient Powder or supplemented,	21,000	11,642 + 4,592 (received Zinc and Iron) = 16,234
Indicator 2.4	No of children received vitamin A	200,000	68,341
Indicator 2.5	Number of field visit of supervision performed	48	63 institutions supervised. 30 supervision by UNICEF and 20 by MSPP)
Indicator 2.6	Number of pregnant and lactating woman attending IYCF education session	80,000	8,143
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Ensure appropriate and timely counselling to mothers on infant feeding and prevention of malnutrition	UNICEF and implementing partners (Fondefh and Shassmeppe)	MSPP,FONDEFH and SHASSMEPPE
Activity 2.2	Improve the quality of complementary foods through home fortification with essential micronutrients (vitamins and minerals) for children.	UNICEF and implementing partners (Fondefh and Shassmeppe)	MSPP,FONDEFH and SHASSMEPPE
Activity 2.3	Supplementation of children from 6 to 59 months with vitamin A	UNICEF and implementing partners (Fondefh and Shassmeppe)	MSPP,FONDEFH and SHASSMEPPE
Activity 2.4	Support supervision of health providers and implementing partners	UNICE, and implementing partners (Fondefh and Shassmeppe)	MSPP,UNICEF

Activity 2.5	Promote infant and young child feeding practices	UNICEF and implementing partners (Fondefh and Shassmeppe)	MSPP,FONDEFH and SHASSMEPPE

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

The total number of beneficiaries of less than 18 years was achieved globally; this represented the number of children screened for SAM, number of children treated for SAM and number of supplemented children. However, the number of pregnant and lactating women and training in IYCF were below target because of the difficulties in the implementation of the community component:

- Lack of medical staff and health workers in the MSPP system;
- Lack of community groups;

The continued political instability affected considerably the implementation of the project at the first stage, and disagreement on local election results had a negative impact on the visits of pregnant women to health structures and reduced the movement of too few health agents.

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

For the execution of this project, partners in collaboration with the MSPP conducted joint supervision to monitor and adjust when needed partners' activities. On a monthly basis, the partners reported their activities and data to the MSPP, copying UNICEF for analysis and dissemination to the central level.

The MSPP organized a monthly nutrition meeting (CTN) with all NGO partners to constantly adjust the response. The partners presented their data, challenges and bottlenecks. Additionally, the UNICEF nutrition team performed regular field visits to monitor partners' activities. A programmatic meeting in mid-term and final project were conducted with responsible partners.

During the implementation of this project UNICEF undertook five programmatic visits.

With the implementation of UNICEF Harmonized Approach to Cash Transfer (HACT), one financial spot-check was done for each partner by UNICEF staff (nutrition and finance).

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
If evaluation has been carried out, please describe relevant key findings here and attach evaluation reports or provide URL. If evaluation is pending, please inform when evaluation is expected finalized and make sure to submit the report or URL once ready. If no evaluation is carried out or pending, please describe reason for not evaluating project.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

<table>
<tr><th colspan="4">TABLE 8: PROJECT RESULTS</th></tr>
<tr><td colspan="4">CERF project information</td></tr>
<tr><td>1. Agency:</td><td>FAO</td><td>5. CERF grant period:</td><td>24/08/2015 – 30/04/2016</td></tr>
<tr><td>2. CERF project code:</td><td>15-RR-FAO-022</td><td rowspan="2">6. Status of CERF grant:</td><td>☐ Ongoing</td></tr>
<tr><td>3. Cluster/Sector:</td><td>Agriculture</td><td>☒ Concluded</td></tr>
<tr><td>4. Project title:</td><td colspan="3">Emergency agricultural assistance to family farmers affected by drought in the South-East and North-West Departments</td></tr>
</table>

<table>
<tr><td rowspan="3">7.Funding</td><td>a. Total funding requirements[8]:</td><td>US$ 7,920,000</td><td colspan="2">d. CERF funds forwarded to implementing partners:</td></tr>
<tr><td>b. Total funding received[9]:</td><td>US$ 2,468,895</td><td>▪ NGO partners and Red Cross/Crescent:</td><td>US$ 106,731</td></tr>
<tr><td>c. Amount received from CERF:</td><td>US$ 945,422</td><td>▪ Government Partners:</td><td>US$ 0</td></tr>
</table>

Beneficiaries

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

Direct Beneficiaries	*Planned*			*Reached*		
	Female	*Male*	*Total*	*Female*	*Male*	*Total*
Children (< 18)	16,317	10,878	27,195	16,317	10,878	27,195
Adults (≥ 18)	15,183	10,112	25,305	15,183	10,112	25,305
Total	31,500	20,990	52,490	31,500	20,990	52,490

8b. Beneficiary Profile

Category	*Number of people (Planned)*	*Number of people (Reached)*
Refugees		Fill in
IDPs		Fill in
Host population		Fill in
Other affected people	45,000	52,490
Total (same as in 8a)	**45,000**	**52,490**

[8] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.
[9] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	Given that some prices of seeds and planting material were lower than expected, the project purchased more agricultural inputs and provided relief assistance to more beneficiaries than expected (52,490 instead of 45,000).

CERF Result Framework			
9. Project objective	Improving of food security of 9,000 vulnerable households affected by drought in the South-east and North-west departments through their access to seeds and planting material for the revival of agricultural activities during the next two cropping seasons.		
10. Outcome statement	Vulnerable households have access to seeds and planting material to boost their agricultural production for the next cropping season		
11. Outputs			
Output 1	9,000 vulnerable households have access to seeds and planting material		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of vulnerable households who receive a kit per household of 8 kg of Lima bean or cowpea seeds (5000 households), 300 cassava cuttings and 500 sweet potato cuttings (9000) and 5 kg of maize seeds or sorghum seeds (5000).	9,000 households	At the beginning of the summer season, each of the 9000 beneficiary households received a kit of 500 sweet potato cuttings, 300 cassava cuttings and 5 kg of maize seeds (in the northwest) or sorghum seeds (south-east). During 2016 spring season, 10,500 vulnerable households, including the 9000 beneficiaries of the summer season, received a kit/household of 500 sweet potato cuttings, 300 cassava cuttings, 5 kg of bean seeds and 5 kg of lima bean seeds or pigeon pea depending on the communal sections.
Indicator 1.2	Number of vulnerable households who receive 8 kg of bean seeds per household	5,000 households	Each of the 10,500 households received 5 kg of bean seeds for the spring season.
Indicator 1.3	Three to four (for cassava) months after sowing/planting of seeds/cuttings, these seeds/cuttings will allow each beneficiary to have a harvest of about 80 kg of Lima bean or bean, 300 kg of Cereals and 300 kg tubers		At the end of the 2015 summer season, each beneficiary household harvested about 160 kg of sweet potato, 300 kg of cassava and 250 kg of sorghum or corn. At the end of the 2016 spring season, each beneficiary family will harvest about 50 kg of beans, between 80 and 140 kg of Lima bean or pigeon peas, 250 kg of sweet potato and 300 kg of cassava.
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Tender and letter of agreements with Local NGOs	FAO has already launched the Call for tenders for the selection of Local NGOs partners	Letters of agreement were signed with four local NGOs with the purpose of targeting beneficiaries and distributing seeds and cuttings: CEHPADER and ATRAL in the Northwest department;

			GHV and UTRAB in the Southeast department
Activity 1.2	Selection of the most affected households	Local NGO ,FAO, BAC, CBO and local authorities	It was carried out by NGOs in collaboration with the local technical (BAC) and administrative authorities (CASEC)
Activity 1.3	Development of technical specifications , purchase and procurement of seeds and planting material	The technical specifications of seeds and the tender for the purchase of seeds and planting material have being prepared by FAO	Seed's technical specifications were developed by an international expert in seed production. Seeds were technically cleared by AGPMG-FAO HQ and purchased by FAO local procurement unit in collaboration with FAO Divisional procurement unit at Headquarters (CSAP)
Activity 1.4	Distribution of seeds and planting material to the beneficiaries and technical advice	Local NGO , FAO, BAC	It was done by NGOs in collaboration with the local technical and administrative authorities
Output 2	8,000 vulnerable households with access to the irrigation or watering receive vegetable seeds		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of vulnerable households who receive 40 grams of seeds of different vegetable species. Often these households are grouped into associations of vegetable producers.	8,000 households (at least 60 per cent of women)	7725 vulnerable households (of which 66 per cent of women head's households: 5090), organized in 42 groups of vegetable producers (25 of South-east and 17 of North-west), received 320 kg of vegetable seeds and were supervised in vegetable production: 3725 households of the South-east (68 per cent of women) and 4000 households of the North-west (64 per cent of women).
Indicator 2.2	These seeds allow to each beneficiary household to harvest about 300 kg of vegetables	8,000 households (at least 60 per cent of women)	With the seeds received, each beneficiary household had a production of about 700 kg of vegetables produced during 2 growing seasons.
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Selection of vulnerable beneficiaries of vegetable seeds.	FAO, BAC, CBO and local authorities	The selection of beneficiaries of vegetable seeds was done by the FAO team in collaboration with the local technical and administrative authorities (BAC, CASEC).
Activity 2.2	Development of technical specifications , purchase and procurement of seeds	The technical specifications of seeds and the tender for the purchase of seeds	Seed's technical specifications were developed by the FAO international seed's expert. Seeds were technically cleared by AGPMG-FAO HQ and purchased by the local procurement unit

		and planting material have being prepared by FAO	of FAO in collaboration with the Division of procurement at FAO Headquarters (CSAP)
Activity 2.3	Distribution of seeds and planting material to the beneficiaries and technical advice	FAO, BAC	330 kg of vegetable seeds were purchased and distributed to beneficiaries: carrot seeds (30 kg), pepper (30 kg), cabbage (60 kg) tomato (60 kg), okra (60 kg), pepper (30 kg), spinach (30 kg) and eggplant (30 kg). Technical Advices on vegetable crops were provided to the beneficiaries groups by FAO technical team in collaboration with the staff of the different municipal agricultural offices.
Output 3	The capacity of CBOs leaders and vulnerable households in nutrition and food hygiene education is strengthened.		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	The trained CBO leaders (including 60 per cent women) of the South-east Department apply good nutritional, food preparation and food hygiene practices	120 leaders (at least 72 women)	125 leaders of CBOs, including 74 women (59.2 per cent), were trained in food and nutrition education by MC-EFADA a local NGO and they are applying the good nutritional, food preparation and food hygiene practices.
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Tender and letter of agreement with Local NGO	FAO and local NGO	Mothers Clubs-Espwa Fanmi Dayiti (MC-EFADA) is the NGO that has been selected as the partner of FAO to carry out the training in nutrition education
Activity 3.2	Selection of CBOs leaders to be trained	FAO, Local NGO partners, BAC and local authorities	The selection of CBOs leaders was done by the FAO team in collaboration with the local technical and administrative authorities (BAC, CASEC and nutrition committees)
Activity 3.3	Training of CBOs leaders on nutrition and food hygiene education with practice session of food preparation.	Local NGO and FAO	A total of 125 leaders of CBOs, including 74 women (59 per cent), were trained on good nutritional practices. It was a roll-out training which began with training of leaders who replicated the training received for 1250 people (64 per cent of women) selected from the seed's project beneficiaries.
Activity 3.4	Monitoring and supervision of the implementation of the acquired knowledge	FAO, BAC and DDA	MC-EFADA staff and the FAO consultant on nutrition monitored and supervised this knowledge-sharing gained by the leaders of CBOs to vulnerable households of their localities.
Output 4 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**

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

1. Two Months of Non Cost Extension of the project were requested by FAO

FAO has requested a special authorization for a Non Cost Extension of the project because the project depended on the onset of growing seasons and availability of good quality seeds and crop cuttings as well as drought tolerant varieties. Since seed producers were not used to producing large quantities of seeds of these varieties, it was impossible to have all the necessary quantities of seed in one growing season. Moreover, the purchase of vegetable seeds was done from foreign suppliers. Finally, the extension of the project period has allowed beneficiaries to receive seed assistance at the beginning of the spring season, the main growing season that yields more than 50 per cent of national agricultural production and covers all agricultural agro-ecological areas of the Northwest and Southeast departments.

2. Increase in the number of vulnerable households beneficiaries

Because of the rapid devaluation of the gourde against the dollar, seeds and cuttings prices were lower than the expected prices in the project. For this reason, the amount of seeds and cuttings purchased substantially increased. This permitted the project to increase the number of beneficiary households during the spring season from 9,000 to 10,500: the 1,500 additional households are located in the Northwest. In addition, 9,000 beneficiary households received seeds and cuttings during 2 growing seasons (summer 2015 and spring 2016) instead of a single growing season (see attached tables). The table below shows the quantities of purchased seeds and cuttings. Significant increase in their agricultural production is expected, as the current spring season looks good with regular rainfall. Thus, it can be concluded that the project has doubled the expected production per beneficiary household.

Type of seeds and cuttings	Unit	Expected quantities	Purchased and distributed quantities
Vegetable seeds	kg	300	330
Cassava cuttings	cutting	2,700,000	5,700,000
Sweet potato cuttings	cutting	4,500,000	9,750,000
Lima bean seeds (pois de souche) and/or cowpea seeds (pois inconnu)	Tons	40	55.5
Bean seeds	Tons	40	52.5
Cereals seeds (maize or sorghum)	Tons	25	38.5

3. Number of beneficiary households of vegetable seeds

The number of beneficiary households of vegetable seeds is slightly lower than the number specified in the project: 7,725 instead of 8,000. In fact, the drought has so affected the 3 communes of the Southeast department that most water sources have dried up. Many members of groups of vegetable producers did not agree to produce vegetable crops in their plots without any secure access to water supply . In addition to vegetable seeds, the project gave agricultural tools to groups of vegetable producers (1000 hoes, watering cans 1000, 1000 watering buckets and 1000 machetes).

4. Synergy with WFP activities in the Southeast

In the Southeast, FAO worked with WFP in the implementation of the project activities and to spread complementary benefits from the joint interventions. The two United Nations agencies collaborated in targeting beneficiaries for the synergy of actions. Beneficiaries of WFP's cash for asset received technical support from FAO, particularly those who were doing activities on micro watersheds management. Those with agricultural plots also received FAO's seeds and cuttings to revive agricultural production. In addition, another FAO project funded by the Global Environment Facility (GEF) that is supporting farmers in the South-East and West Departments to develop coping mechanisms to climate change has given agricultural tools and herbs cuttings to beneficiaries of cash-for-transfer to plant on the contour line for the micro watersheds management work.

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

implementation and monitoring:
Before the project formulation, an emergency food security assessment was conducted jointly by the CNSA in collaboration with FAO, WFP and some NGOs to assess urgent needs of rural households affected by drought. The agricultural assistance of this project is a contribution to the needs of vulnerable households raised by the evaluation mission. During the execution of the project activities, FAO worked with local technical and administrative authorities. A team of agronomists were installed in the offices of the Departmental Directorate of Agriculture (DDA) of the Northwest and Departmental Directorate of Environment (DDE) of the Southeast for synergy with local authorities in the supervision and coordination of project activities. The selection of beneficiaries of all project components was made in collaboration with local administrative and technical authorities and Community based organizations (CBOs) in respect of gender balance. In each commune beneficiary targeting committees were set up by FAO, partner NGOs, municipal agricultural offices and CBOs. At the end of the selection, each committee submitted a preliminary list of beneficiaries to the leaders of CBOs and local communities for public validation supervised by local authorities, FAO teams and partner NGOs. At the beginning of each growing season, the same local authorities and CBOs were always consulted to select the type of seeds and cuttings to be distributed according to growing seasons and agricultural potential of different communal sections. The choice of participants in the nutrition training was also made by FAO staff in direct collaboration with MC-EFADA, basic nutrition committees of each commune and CBOs prioritizing vulnerable women with children under 5 years and families with elderly.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☒
During the implementation of activities, FAO field agronomists regularly monitored field activities and collected information that was shared with the FAO Monitoring and Evaluation Unit: quantity of seed and cuttings received by households, constraints encountered in the implementation of activities, average production obtained by the beneficiaries of seeds, number of persons trained, etc. To assess and confirm the compliance/coherence of outcomes with project objectives, on-site inspections are being carried out by the international seed expert. The Letters of Agreement (LoA) between FAO and NGO partners required them to provide detailed progress and final reports including detailed on impact analysis (see partners' reports for the 2015 summer season in annex). The information contained in these reports is being cross-checked through field visits carried out on a regular basis by FAO Monitoring and Evaluation team.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☐

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	WFP	**5. CERF grant period:**	26/08/2015 – 26/02/2016
2. CERF project code:	15-RR-WFP-048	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Food Aid		☒ Concluded
4. Project title:	Emergency assistance to vulnerable households affected by drought in the South-East department		

7.Funding			
a. Total funding requirements[10]:	US$ 24,500,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[11]:	US$ 3,349,844	▪ *NGO partners and Red Cross/Crescent:*	US$ 137,757
c. Amount received from CERF:	US$ 1,080,323	▪ *Government Partners:*	US$ 20,191

Beneficiaries

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

Direct Beneficiaries	*Planned*			*Reached*		
	Female	*Male*	*Total*	*Female*	*Male*	*Total*
Children (< 18)	32,542	32,025	64,567	32,442	31,927	64,370
Adults (≥ 18)	30,525	30,039	60,562	30,431	29,948	60,378
Total	**63,065**	**62,064**	**125,129**	**62,873**	**61,875**	**124,748**

8b. Beneficiary Profile

Category	*Number of people (Planned)*	*Number of people (Reached)*
Refugees		
IDPs		
Host population		
Other affected people	125,129	124,748
Total (same as in 8a)	**125,129**	124,748

[10] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.
[11] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	No significant discrepancy

CERF Result Framework			
9. Project objective	WFP's Strategic Objective 1 - Save lives and protect livelihoods in emergencies		
10. Outcome statement	Meet urgent food and nutrition needs of vulnerable people and communities and reduce under nutrition to below emergency levels		
11. Outputs			
Output 1	Food/Cash distributed in sufficient quantity, quality and in a timely manner to targeted households.		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of beneficiaries receiving assistance as per cent of planned (disaggregated by activity; by women, men, girls, boys)	125,129	124,748
Indicator 1.2	Quantity of food assistance distributed, as per cent of planned distribution (disaggregated by type)	100%	102%
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	General Food or distributions	WFP and partners (ASEBED, SIKSE, ODRG, FONDEFH)	WFP
Activity 1.2	Food or cash distributions for creation of assets	WFP and partners (AJAD, CODES/DDAS, FOSAC)	WFP and partners (ODN)
Output 2	Stabilized or improved food consumption over assistance period for target households		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Food Consumption score	100 per cent of targeted households have at least borderline consumption	95%
Indicator 2.2	Daily Average dietary diversity	100 per cent of targeted households consume at least 3 food groups on average per day	Not available
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**

Activity 2.1	Food or cash distributions for creation of assets	WFP and partners	WFP and partners (ODN)
Output 3	Established or rebuilt livelihoods in fragile settings and following emergencies		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	Improved access to assets and basic services including community and market infrastructure - Community Asset Score	CAS increased in at least 75 per cent of targeted communities	13%
Indicator 3.2	Number of community assets restored or maintained by targeted communities and individuals , by type and unit of measure	Project specific[12]	36,000 meters of grass strips realized 373 kg of seeds distributed 210,000 fruit seedlings planted 42,711 meters of dry wall built 13,975m3 of thresholds dry stone erected 100,000 plant cutting planted
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Food or cash distributions for creation of assets	WFP and partners (DINEPA, MARNDR)	WFP and partners (ODN)

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

For General Food Distributions, the beneficiaries, which consisted of families with pre and primary school age, were targeted through the WFP school feeding network. Monitoring revealed that the general food assistance reinforced the effects of the safety net provided by school feeding, which avoided the deterioration of their food security level.

Cash For Assets interventions aimed at decreasing the degradation of natural resources and protecting the livelihoods of the affected communities. To alleviate security and financial constraints, the country office undertook a pilot phone baseline survey combined with a field survey. The baseline showed that 33 percent of households were food insecure and were using negative coping mechanisms. WFP Community Assets Score surveys conducted in 18 communities showed that only 13 percent of them have made progress, far from the targeted 80 percent. Although assets created or reinforced by WFP were tied to government priorities (Ministry of Agriculture), they did not always correspond to the basic needs of the most vulnerable population. In 2016, WFP will reinforce communication with grass-roots communities from the project design stage to final evaluation.

[12] 15 sites expected.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:
For CFA, WFP worked with its partners to ensure that the community participates at all levels of the project: design (proposed activities are validated by the community as priorities), implementation (asking the community to contribute resources to the budget in order to safeguard the sustainability of the project), and monitoring (complaint mechanisms and the participation of the communities in post-distribution monitoring surveys). For General Food Distributions, WFP or its partners systematically conducted Food Basket Monitoring in the course of each and every field monitoring and encouraged beneficiaries to consistently verify the quality and quantity of their rations. WFP monitoring identified a lack of knowledge of recipients and communities concerning the targeting criteria. In response, WFP and partners involved in the drought response in 2016 will increase awareness sessions and the visibility of criteria prior and during distributions. Indicators collected through post-distribution monitoring (PDM) and frequent field visits show that no beneficiaries experienced safety problems while traveling to or during distributions.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
A decentralize evaluation of WFP Haiti Protracted Relief and Recovery Operation 200618, under which this project was implemented, is currently being conducted by TANGO (Technical Assistance to NGOs). The Final Evaluation Report is due to WFP on July 12th.	EVALUATION PENDING ☒
	NO EVALUATION PLANNED ☐

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
15-RR-CEF-079	Water, Sanitation and Hygiene	UNICEF	GOV	$55,000
15-RR-CEF-079	Water, Sanitation and Hygiene	UNICEF	INGO	$783,247
15-RR-CEF-079	Water, Sanitation and Hygiene	UNICEF	INGO	$250,002
15-RR-CEF-079	Water, Sanitation and Hygiene	UNICEF	INGO	$295,477
15-RR-CEF-079	Water, Sanitation and Hygiene	UNICEF	INGO	$499,763
15-RR-CEF-079	Water, Sanitation and Hygiene	UNICEF	INGO	$393,729
15-RR-CEF-080	Nutrition	UNICEF	GOV	$21,595
15-RR-CEF-080	Nutrition	UNICEF	NNGO	$160,000
15-RR-CEF-080	Nutrition	UNICEF	NNGO	$141,461
15-RR-CEF-080	Nutrition	UNICEF	NNGO	$52,066
15-RR-WHO-029	Health	WHO	INGO	$300,000
15-RR-WHO-029	Health	WHO	INGO	$223,577
15-RR-WHO-029	Health	WHO	INGO	$299,577
15-RR-WHO-029	Health	WHO	NNGO	$99,800
15-RR-FAO-022	Agriculture	FAO	NNGO	$26,237
15-RR-FAO-022	Agriculture	FAO	NNGO	$40,874
15-RR-FAO-022	Agriculture	FAO	NNGO	$18,082
15-RR-FAO-022	Agriculture	FAO	NNGO	$19,867
15-RR-FAO-022	Agriculture	FAO	NNGO	$1,672
15-RR-WFP-048	Food Assistance	WFP	GOV	$20,191
15-RR-WFP-048	Food Assistance	WFP	NNGO	$18,809
15-RR-WFP-048	Food Assistance	WFP	NNGO	$66,910
15-RR-WFP-048	Food Assistance	WFP	NNGO	$30,489
15-RR-WFP-048	Food Assistance	WFP	NNGO	$21,549

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

ACF	Action Contre la Faim
AP-HM	Assistance Publique Hopitaux de Marseille
ASEBED	Agence de Secours et de Bienfaisance aux Enfants Défavorisés
ATRAL	L'Association des Travailleurs Agricoles de Paulin Lacorne
BAC	Bureau Agricole Communal
CASEC	Conseil d'Administration de la Section Communale
CBO	Community Based Organization
CEHPADER	Centre Haïtien de Promotion et d'Appui au Développement Rural
CFA	Cash for Assets
CNSA	Coordination National de la Sécurité Alimentaire et Nutritionnelle
CNSA	National Coordination for Food Security
CRF	Croix Rouge Francaise
CTC	Cholera Treatment Center
CTDA	Centre de Traitement de Diarrhee Aigue
CTU	Cholera Treatment Unit
DDA	Direction Départementale de l'Agriculture
DDE	Direction Départementale de l'Environnement
DELR	Direction Epidemiologique et Laboratoire de Recherche
DINEPA	Direction Nationale de l'Eau Potable et de l'Assainissement
DSA	Direction Sanitaire de l'Artibonite
DSO	Direction Sanitaire de l'Ouest
DSSE	Direction Sanitaire de l'Artibonite
EFSA	Emergency Food Security Assessment
EMIRA	Equipe Mobile Intervention Rapide
FAO	Food and Agriculture Organisation
FONDEFH	Fondation pour le Développement et l'Encadrement de la Famille Haïtienne
GFD	General Food Distributions
GHV	Groupe Horizon Vert
IHSI	Institut Haitien de Statistiques etr d'Infomatique
IOM	International Organization for Migration
IPC	Integrated Food Security Phase Classification
LNSP	Laboratoire National de Sante Publique
MARNDR	Ministry of Agriculture
MC-EFADA	Mother's Club- Espwa Fanmi Dayiti
MSPP	Ministere de la Sante Publique et de la Population
NGO	Non-Profit Organization
ODN	Organisme de Développement du Nord
ODRG	Organisation de Développement du Nord
PDM	post-distribution monitoring
RdT	Rapid Test
SI	Solidarites Internationals
SIKSE	Société d'Information en Communication Sociale et Economique
TAP	Transitional Appeal plan
UADS	Unite d'Appui et de Decentralisation Sanitaire
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO/PAHO	World Health Orgainzation/Pana American Health Organizaiton.

ANNEX 3: Quantity of distributed seeds and estimated production for the summer season 2015

						Quantity of seeds (kg) and number of cuttings				Estimated production (tons)			
Departments	**Communes**	**Communal sections**	**Number of beneficiaries**			**Sweet potato**	**Cassava**	**Sorghum**	**Maize**	**Sweet potato**	**Cassava**	**Sorghum**	**Maize**
			Men	**Women**	**Total**								
South-east	Anse à Pitre	1ère section Boucan Guillaume	203	447	750	375000	225000	3750		125,0	225	375	
		2ème section Bois d'Orme	314	436	650	325000	195000	3250		108,0	195	325	
		Sous-total 1	**517**	**883**	**1400**	**700000**	**420000**	**7000**		**233,0**	**420**	**700**	
	Belle Anse	1ère section Baie d'orange	289	111	400	200000	120000	2000		67,0	120	200	
		2ème section Mabriole	264	336	600	300000	180000	3000		100,0	180	300	
		4ème section Corail Lamothe	269	131	400	200000	120000	2000		67,0	120	200	
		5ème section Bel Air	405	195	600	300000	180000	3000		100,0	180	300	
		6ème section Pichon	317	183	500	250000	150000	2500		83,0	150	250	
		7ème section Mapou	224	276	500	250000	150000	2500		83,0	150	250	
		Sous-total 2	**1768**	**1232**	**3000**	**1500000**	**900000**	**15000**		**500,0**	**900**	**1500**	
	Grand Gosier	1ère section Colline des chênes	319	281	600	300000	180000	3000		100,0	180	300	
		Sous total-3	**319**	**281**	**600**	**300000**	**180000**	**3000**		**100,0**	**180**	**300**	
	Total Sud-est		**2604**	**2396**	**5000**	**2500000**	**1500000**	**25000**		**833,0**	**1500**	**2500**	
North-west	Bombardopolis	1ère section Plate forme	315	485	800	400000	240000		4000	133,0	240		192
		2ème section Forges	316	484	800	400000	240000		4000	133,0	240		192
		3ème section Plaine d'Orange	156	244	400	200000	120000		2000	67,0	120		96
		Sous total 1	**787**	**1213**	**2000**	**1000000**	**600000**	**0**	**6000**	**333,0**	**600**		**480**
	Mole Saint Nicolas	1ère section de Côte de Fer	271	229	500	250000	150000		2500	83,0	150		120
		2ème section Mare-Rouge	206	294	500	250000	150000		2500	83,0	150		120
		Sous Total 2	**477**	**523**	**1000**	**500000**	**300000**	**0**	**2500**	**166,0**	**300**		**240**
	Baie de Henne	3ème section Réserve ou Ti Paradis	350	450	800	400000	240000		4000	133,0	240		192
		4ème section l'Estère Déré	116	84	200	100000	60000		1000	33,0	60		48
		Sous total 3	**466**	**534**	**1000**	**500000**	**300000**	**0**	**5000**	**166,0**	**300**		**240**
	Total Northwest		**1730**	**2270**	**4000**	**2000000**	**1200000**		**13500**	**667,0**	**1200**		**960**
Grand total			**4334**	**4666**	**9000**	**4500000**	**2700000**	**25000**	**13500**	**1500,0**	**2700**	**2500**	**960**

ANNEX 4: Quantity of distributed seeds and estimated production for the spring season 2016

Department	Communes	Communal sections	Number of beneficiaries			Quantity of seeds (kg) and number of cuttings distributed							Estimated production (in tons)				
			Men	*Women*	*Total*	*Bean*			*Lima bean*	*Pigeon pea*	*Sweet potato*	*Cassava*	*Bean*	*Lima bean*	*Pigeon pea*	*Sweet potato*	*Cassava*
						DPC40	*Buena vista*	*Xrav*	*Béséba*	*Grain maron*	*Mizé maléré*	*CMC40*					
North-west	Baie-de-Henne	Dos d'Ane	202	298	500	2500			2500		250000	0	25	40		125	0
		Citerne Remy	354	346	700		3500		3500		350000	210000	35	56		175	210
		Reserve	350	450	800		4000		4000		400000	240000	40	64		200	240
		L'Estere-Dere	116	84	200	1000			1000		100000	60000	10	16		50	60
		Sous-total 1	**1022**	**1178**	**2200**	**3500**	**7500**	**0**	**11000**		**1100000**	**510000**	**110**	**176**	**0**	**550**	**510**
	Mole-Saint-Nicolas	Mare-Rouge	271	229	500	2500			2500		250000	150000	25	40		125	150
		Cote-de-Fer	330	470	800		4000		0	4000	400000	240000	40	0	107	200	240
		Sous-total 2	**601**	**699**	**1300**	**2500**	**4000**	**0**	**2500**	**4000**	**650000**	**390000**	**65**	**40**	**107**	**325**	**390**
	Bombardopolis	Desforges	316	484	800	4000				4000	400000	240000	40	0	107	200	240
		Plateforme	315	485	800	4000				4000	400000	240000	40	0	107	200	240
		Plaine d'Orange	156	244	400	2000				2000	200000	120000	20	0	53	100	120
		Sous-total 3	**787**	**1213**	**2000**	**10000**				**10000**	**1000000**	**600000**	**100**	**0**	**267**	**500**	**600**
	Total Nord-ouest		**2410**	**3090**	**5500**	**16000**	**11500**	**0**	**13500**	**14000**	**2750000**	**1500000**	**275**	**216**	**373**	**1375**	**1500**
South-east	Anse-à-Pitres	1ère section Boucan Guillaume	203	447	650	3250			3000	3250	325000	195000	32,5	48	87	162,5	195
		2ème section Bois d'Orme	314	436	750	3750			0	3750	375000	225000	37,5	0	100	187,5	225
		Sous-total 3	**517**	**883**	**1400**	**7000**	**0**	**0**	**3000**	**7000**	**700000**	**420000**	**70**	**48**	**187**	**350**	**420**
	Belle-Anse	1ère section Baie d'orange	289	111	400	2000			0	2000	200000	120000	20	0	53	100	120
		2ème section Mabriole	264	336	600			3000	3000		300000	180000	30	48		150	180
		4ème section Corail Lamothe	269	131	400			2000	2000		200000	120000	20	32		100	120
		5ème section Bel Air	405	195	600		3000		3000		300000	180000	30	48		150	180
		6ème section Pichon	317	183	500			2500	0	2500	250000	150000	25	0	67	125	150
		7ème section Mapou	224	276	500			2500	2500		250000	150000	25	40		125	150
		Sous-total 4	**1768**	**1232**	**3000**	**2000**	**3000**	**10000**	**10500**	**4500**	**1500000**	**900000**	**150**	**168**	**120**	**750**	**900**
	Grand Gosier	1ère section Colline des chênes	319	281	600	3000			3000		300000	180000	30	48		150	180
		Sous-total 5	**319**	**281**	**600**	**3000**			**3000**		**300000**	**180000**	**30**	**48**	**0**	**150**	**180**
	Total Sud-est		**2604**	**2396**	**5000**	**12000**	**3000**	**10000**	**16500**	**11500**	**2500000**	**1500000**	**250**	**264**	**307**	**1250**	**1500**
Grand Total			**5014**	**5486**	**10500**	**28000**	**14500**	**10000**	**30000**	**25500**	**5250000**	**3000000**	**525**	**480**	**680**	**2625**	**3000**