RESIDENT/HUMANITARIAN COORDINATOR REPORT 2012 ON THE USE OF CERF FUNDS DJIBOUTI

RESIDENT/HUMANITARIAN COORDINATOR	Ms. Hodan Haji-Mohamud

PART 1: COUNTRY OVERVIEW

I. SUMMARY OF FUNDING 2012

TABLE 1: COUNTRY SUMMARY OF ALLOCATIONS (US$)		
Breakdown of total response funding received by source	CERF	4,019,325
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	0
	OTHER (Bilateral/Multilateral)	40,114,094
	TOTAL	44,133,419
Breakdown of CERF funds received by window and emergency	**Underfunded Emergencies**	
	First Round	4,019,325
	Second Round	0

II. REPORTING PROCESS AND CONSULTATION SUMMARY

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

YES ☒ NO ☐

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

YES ☒ NO ☐

PART 2: CERF EMERGENCY RESPONSE – DROUGHT (UNDERFUNDED ROUND I 2012)

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
***Total amount required for the humanitarian response*:**		**79,310,556**
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	4,019,325
	OTHER (Bilateral/Multilateral)	75,291,231
	TOTAL	**79,310,556**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – Date of Official Submission: 20 February 2012			
Agency	**Project Code**	**Cluster/Sector**	**Amount**
FAO	12-FAO-007	Agriculture	934,123
IOM	12-IOM-002	Multi sector	199,998
UNHCR	12-HCR-008	Multi sector	607,751
UNICEF	12-CEF-008-A	Water and Sanitation	594,011
UNICEF	12-CEF-008-B	Health-Nutrition	348,859
WFP	12-WFP-012	Food	934,001
WHO	12-WHO-009	Health	400,582
Sub-total CERF Allocation			**4,019,325**
TOTAL			**4,019,325**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of Implementation Modality	**Amount**
Direct UN agencies/IOM implementation	3,348,464.59
Funds forwarded to NGOs for implementation	569,854
Funds forwarded to government partners	101,006.41
TOTAL	**4,019,325**

The humanitarian crisis in Djibouti is the result of the persistent drought over the past six years. The direct impacts of the drought are mainly represented by high and generalized food insecurity and non-availability of safe water, which are further aggravated by the

increasing trend in international food prices (as the country depends on imports for over 90 per cent of its products). This context is also characterized by the influx of refugees from neighbouring countries (Somalia, Ethiopia and Eritrea) as well as by the transit of an enormous number of migrants directed towards the Arab peninsula. The overall population currently affected by the crisis is 300.000 people, including 212,000 vulnerable people affected by the drought, 26.000 refugees and 65.000 migrants in need of urgent life-saving assistance. It has been estimated by the Humanitarian Actors in Djibouti hat 132.000 people are in need of food assistance. The drought of the last years (in 2012: 80 per cent less rains then in 2008) had as a consequence the impossibility of refill for the water sources, as well as the drying out of the surface water with the subsequent increase in the salinity of the soil (by almost 49 per cent). According to UNICEF 110.000 people in rural areas as well as 42.000 in urban areas have no access to safe drinking water. In addition to this, the scarce resources were often the cause of conflict between the local population and the migrants.

All these factors led to a very poor health and nutritional situation for the population. Nutrition figures show an under-five malnutrition rate of 20 per cent in Djibouti Ville and all other regions (Tadjourah, Dikhil, Ali Sabieh, Obock, Arta), that is significantly higher than the alarm threshold of 15 per cent . Moreover, the health situation in Djibouti remained alarming throughout 2012. Large parts of the population were still suffering from the consequences of the drought, diminished coping mechanisms and impact of migration fluxes from Somalia and Ethiopia. Loss of livelihoods, lack of water and high food prices, as well as rural migration have led to higher levels of poverty in the rural and peri-urban areas with higher rates of malnourishment amongst children and women. These factors have added additional burden on a weakened, vulnerable and underserved population who has exhausted its dwindling coping capacities and resilience options. The health impact of the drought is reflected in deaths and suffering due to: (i) diseases causing or associated with malnutrition, (ii) diseases or epidemics linked to the lack of water or its contamination (iii) the lack of financial means to access health as remaining resources are spent on food.

This grim situation is further aggravated by the lack of access to health care facilities and services for large parts of the population who has to travel for a long distance to reach the health services, high costs, as well as the lack of equipment and life-saving medicines. The population in drought-affected areas mostly affected by the access difficulties is mainly women in child bearing age and children: they often cannot even afford the cost of transport to reach the facilities, especially for delivery and transfer of the sick. At the same time, the alert system for outbreaks and surveillance of epidemic prone diseases still faces many difficulties due to limited funding and Ministry Of Health (MOH) organizational leadership issues. A former system of obligatory declaration of diseases (13 diseases) was dismantled in 2011, its archives were lost and it is barely functional.

II. FOCUS AREAS AND PRIORITIZATION

In order to facilitate a proper prioritization process and to better define the focus areas of the intervention, a set of comprehensive need assessments has been conducted to monitor the situation in each one of the humanitarian clusters active in the Republic of Djibouti.

A Water, Sanitation and Hygiene (WASH) rapid assessment was conducted jointly by UNICEF and WHO in October 2012 in order to obtain evidence of the situation compared to 2011. In 2011 it was reported that up to 49 per cent of people in rural areas did not have access to a protected source of drinking water. At least 30 per cent of the population was using unprotected sources which were not conforming to the minimum sanitary requirements. The situation for sanitation appeared even worse as only 10 per cent of the rural population had access to improved family latrines, inducing the majority of the population to the practice of open defecation. Also, a big difference in terms of water access remains between Djibouti town and the peripheral quarters which host more than 50 per cent of the population of Djibouti City was observed in 2011 and still persisted in 2012. Poor vulnerable household are forced to buy water from informal distribution sources at up to 12 times the price of regular distribution. The results of the 2012 need assessment indicate that 110,000 people in rural areas have no access to improved water sources. These facts are directly reflected in the elevated morbidity and mortality rates of the population related to waterborne disease. In response to this, the WASH cluster decided to prioritize water provision not only in the rural areas of the country, but also in the poorest neighbourhoods of the peri-urban areas (such as Balbala and Boulaos).

A second major area of focus for CERF funded activities is Food Security, where numerous assessments and surveys have been conducted to ensure continued mapping of the situation. The current main sources of information are the Rural Emergency Food Security Assessment (EFSA, July 2012) and the urban EFSA (November 2012), the Integrated Phase Classification in October 2012 as well as the data systematically collected by Fewsnet and other National Statistics (such as the 'Profil de la pauvreté). Overall, all the sources of information point out that the Food security conditions of rural households have deteriorated since 2011. In 2012, 42,600 people were reported as severely food insecure and 24,300 people moderately food insecure. The study on food security in urban households shows that about 6.500 (32.500 persons) living in the peri-urban areas ofBalbala and Boulaos are in conditions of severe and moderate food insecurity. The IPC map for food insecurity in Djibouti developed in 2012 indicates a level of crisis in most parts of the country, including peri-urban Djibouti-Ville, while the remaining areas remain at stressed level (such as the area of Balbala). This map takes into account the needs for food, health and nutrition, which are all priority areas for intervention in the humanitarian crisis that characterizes Djibouti. The region with elevated food insecurity include Ali Sabieh and Obock. The regions of Tadjourah, Dikhil and Arta

also have an increased number of households living with severe food insecurity conditions. Overall, the highest proportion of severe food insecure households is reported in the pastoral zone of the north-west, followed by the south-east and the centre. The Food Security cluster, combining this information with seasonality considerations and food crop specificities of the country decided to give priority to the vulnerable urban poor people living in the outskirts of Djibouti Ville, through a food voucher intervention that was designed to help them get through the three months of the lean season, from July until September 2012, when food is scarce and job opportunities are particularly limited.

In terms of nutrition, the monitoring system in place complemented by the preliminary findings of the survey on nutrition conducted by the Government partners indicate that the alarming levels of malnutrition registered in 2011 still persist. According to recent screenings, in some areas, child malnutrition and anaemia rates amongst women in childbearing age are much higher than the WHO emergency thresholds of <10 severe food for global acute malnutrition and <2 severe food for severe acute malnutrition. This situation is reported for Djibouti city and the regions Tadjourah, Dikhil, Ali Sabieh, Obock. The overall population in need is estimated to be 195,455 people, and out of these, the nutrition cluster is targeting 23,392 acute malnourished children (6-59 months), 92,129 children 6-59 months and 33,624 pregnant and lactating women. It should also be underlined that the poor nutritional status of the population often brings severe health consequences, such as increasing the incidence of watery diarrhea, pneumonia and measles, among children, and anaemia in pregnant women.

As far as health is concerned, the inventory of the health facilities carried out in October showed that in many areas, health care facilities and mobile clinics do not have the necessary equipment or human resources to treat people according to their needs and to respond to emergencies. Sixteen out of 30 health centres in the regions have limited or no access to water and only 14 out of 30 health centers have electricity or solar power (Base des données carte sanitaires, Oct 2012, SNIS). There are at best 2 doctors for regions with up to 90,000 people. Many centres have a constant shortage of life-saving medicines such as anti-malaria, antibiotics etc. The situation is particularly difficult for women: in 2011, approximately 30,000 women of childbearing age and 6,000 pregnant women were affected by the drought. With 300 cases/ 100,000 births, the maternal mortality rate in Djibouti is still very high and anaemia among pregnant women is very common. The inventory also showed that in many remote rural areas the maternal services are not functional due to lack of mid-wives and other health personnel. In Obock, only four out of seven health centres have a maternal service (midwife or other). Only a small percentage of women have access to antenatal health care and complications during pregnancy are often not recognized in time. Again in Obock, out of 1,439 births in the first six months of 2012, only 130 women (less than 10 per cent) delivered in a health facility (Rapport données sanitaires, 1st and 2nd trimester 2012). As a consequence, there is no ante-natal or post-natal health care for mother and child and around 30 per cent of the children are not vaccinated against measles and polio. Mobile clinics and ambulances exist in most districts, but do not visit remote areas on a regular basis, thus increasing the risk of complications during childbirth and the risk of maternal and neonatal mortality. Communicable diseases such as diarrhoea and respiratory diseases were the first cause of morbidity and mortality amongst children and adults in 2012. In the first semester of 2012, 10,173 cases of diarrhoea (6,738 children and 3,435 adults), 60,128 cases of respiratory diseases (20,717 children and 39,411 adults) as well as 456 cases of measles (314 children, 143 adults, mainly women) were reported (quarterly report of SNIS). Although some initial work has been done in the past year, the alert system for outbreaks and surveillance of epidemic-prone diseases, and the collection, analysis and sharing of information faces many difficulties due to limited funding and MoH organizational leadership issues. According to an evaluation of the system of community health workers done in June 2012, strengthening communities' knowledge and awareness of these potentially fatal illnesses, when no health facility is near, is also key to reduce their suffering and ensure that they are able to recognize key danger signs and request help or transfer on time to health facilities. Therefore, in 2012, the priorities of the health cluster were (i) to improve the access of the drought affected population to life-saving medicines and health services, with a focus on women and children; (ii) to strengthen the early alert and outbreak response system in the rural areas.

Concerning refugees, from March 2012 till December 2012, UNHCR and the Government of Djibouti registered 3,191 new arrivals from South Somalia, 394 from Eritrea, and 900 from Ethiopia. These refugees have received multi-sectoral assistance (Protection, Health and Nutrition, Water and Sanitation, Education, Revenue Generating Activities and protection of the environment). Also host communities benefited of some assistance, particularly those living around the camps of Ali Addeh and Holl Holl.

Also, in 2012, a number of 107,532 migrants were reported by IOM to have crossed the Gulf of Aden and reached Yemeni shores, which represent an increase of almost 50 per cent from the 53,382 crossings in 2010. Migrants face many problems including lack of information on travel conditions, desert roads, lack of water, risks of trafficking and other human rights violations, as well as risk of conflict with local resources. Main activities conducted include: awareness raising of migrants on the dangers of irregular migration and trafficking in human beings; increase of available water resources on the migration route; decontamination of water and awareness of hygiene promotion and sharing of water resources to reduce the risk of conflict.

III. CERF PROCESS

All the projects implemented under the 2012 CERF funding are harmonized with the needs and priorities presented in the Djibouti CAP 2012. The Humanitarian Country Team held meetings in January and February 2012 in order to develop the strategic priorities based on the latest information available. The final decision concerning the CERF allocation was taken during the UNCT meeting convened on 14th February 2012. Also, several consultations with UN OCHA regional office in Nairobi took place, as well as discussions with representatives of the CERF secretariat throughout the whole preparation of the proposals process. The prioritization of the projects was based on the information provided by the various agencies, including those from the needs assessments carried out. Inputs from INGOs and governmental counterparts were collected during the respective cluster meetings by the cluster leads and later on reported by the UN agencies, particularly for the WASH, Nutrition and Food Security clusters. The strategic priorities defined for 2012 were WASH and food security, complemented by health.

During the rest of the year 2012, six humanitarian clusters were activated: Food Security and Rural Development, Nutrition, WASH, Health, Early Recovery and Multi-cluster (refugees and migrants). In addition to these, periodically Inter-Cluster meetings were also held, in order to enable discussion of cross-cutting issues and try also to promote joint assessments and other initiatives. The Humanitarian Actors in Djibouti, basing on the evidence from the needs assessments and other documented data made available by surveys and reports, decided to engage in another Consolidated Appeal Process also for the year 2013, and for this reason a wide consultative process with all partners was accomplished (including INGOs, local NGOs, Government and Donors). The joint effort for the preparation of the 2012 CERF Report started in January 2013 with the announcement of the reporting process and main deadlines at the HCT Meeting and, subsequently, to the Inter-Cluster meeting that followed. A special Inter-Cluster meeting was held to explain the templates, the guidelines and to agree on internal deadlines for the various agencies to share inputs with the CERF focal point in Djibouti that consolidated them with a final revision by OCHA regional office in Nairobi. Special attention was devoted in applying the gender marker in order to have gender disaggregated data and to ensure the gender mainstreaming of all the actions realized under the 2012 CERF funding.

III. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR

Total number of individuals affected by the crisis: **387,029**

	Cluster/Sector	Female	Male	Total
The estimated total number of individuals directly supported through CERF funding by cluster/sector	Agriculture	6,468	4,312	10,780
	Food	7,090	4,533	11,623
	Health	106,000	100,000	206,000
	Health-Nutrition	15,683	6,817	22,500
	Multisector	27,192	30,434	57,626
	Water and Sanitation	46,500	32,000	78,500

The lead UN Agency for each cluster provided the beneficiaries figures that were estimated according to internal organizational monitoring systems, as well as combining information from partners (NGOs, Government and other UN agencies). Internal consistency of the figures was assured through cluster discussions. As the CERF funding was often used in combination with other sources of funding for the implementation of a greater budget project, in these cases pro rata figures were applied, as per guidelines provided by the CERF secretariat. Efforts to try avoid double counting of the beneficiaries while computing the overall total were also exerted, and this area remains one of most challenging aspects as some people may have benefited from various projects in different clusters. Also, all data was disaggregated by sex and age group, and the needs of refugees and migrants were also separately analysed.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	**Estimated Reached**
Female	207,602	208,933
Male	191,895	178,096
Total individuals (Female and male)	408,502	387,029
Of total, children under 5	107,409	119,275

CERF Results

On the basis of the estimations made by each UN Agency responsible for its specific humanitarian cluster, and following the procedures explained above, a total of 387,029 direct beneficiaries were reached through CERF funding in 2012 in the Republic of Djibouti. This figure, compared to the 408,502 that were initially planned indicates a difference of 21,473 people. This discrepancy can be considered of small dimension and reasonable on the basis of the estimating methodologies and techniques. It should also be noted that all the targeted under-five children were reached and expectations were even exceeded.

The CERF funds allowed the MoH to improve the access of the drought affected population to life-saving health services and medicines. Diseases that are inherent in a drought situation such as diarrhoea and respiratory infections could be addressed. Also, a measles epidemic in the beginning of the year and a Dengue outbreak in June were responded to. In order to strengthen the protection against outbreak diseases, an ad-hoc measles campaign was carried out to target schoolchildren that had not been vaccinated. In addition, during 2012, the MoH gradually mobilized new mobile clinics in the regions to improve the access to health care in remote areas. However, issues related to the clinics maintenance remain and the MoH is currently investigating durable solutions. The Government has is no emergency response budget , but since November last year, the MoH in collaboration with the Ministry of Defence has been operating a boat to transport severe cases from Tadjourah to the capital which shortens the length of the trajectory from 3-4 hours to 45 minutes.

Thanks to CERF funds, the alert system for outbreaks and surveillance of epidemic-prone diseases became functional again. The two structures under the MoH that are responsible for surveillance and outbreak response ((SNIS (Service National d'Information Sanitaire) and INSPD (Institut National de Santé Publique de Djibouti)) were supported and through rural telephony, the alert in case of an outbreak could quickly be transferred to the central level. The elaboration of a list of monitored diseases (15) and their definitions helped the health staff on the ground to transmit clearer messages to the responsible structures. The analysis of the collected data proved to be more difficult and due to organizational leadership issues between the two structures that consider themselves as the reference for epidemiological information, there are still problems in the process of sharing the information and responding in a timely manner to such alerts. With CERF funds, people living in drought affected areas in most impoverished areas in the capital could access medicines. Staff in health centres received training on Tuberculosis, HIV, surveillance and outbreak response. Community based approaches were reviewed and the profile for community health activities were strengthened.

CERF Added Value

The CERF has added value to the humanitarian response in Djibouti in five distinct, but linked ways:

- Rapid response to a worsening situation: Agencies highlighted the speed of the CERF allocation that had allowed them to ensure timely responses to the emergency. For example through CERF funding UNICEF was able to provide potable water through emergency water trucking, and WHO was able to procure emergency health kits (IEHK) and laboratory reagents and supplies .

- Gap filling while mobilizing other resources: For some UN agencies, CERF provided an important rapid stop-gap fund while discussions took place with other donors about funding. The relatively rapid process and ability to engage in technical discussions with UN colleagues to make the case for funding was highlighted as significant.

- Establishing humanitarian response capacity: As all agencies are small in Djibouti in terms of human resources available, for most of them the CERF funding has been an important contribution to maintain a necessary emergency capacity.

- Leveraging other funds: Agencies specifically used the CERF funding to demonstrate results and make the case for further funding from other donors, as well as in advocating the importance of the activities undertaken with governmental counterparts.

- Donations in a resource scarce environment: In providing $4,019,325 (9.1 per cent of the total funding received for the Djibouti 2012 CAP), the CERF acted also as a donor of last resort, in the scarcity of other donors. In the absence of the CERF contribution, the gap between requirements and funds received would have been significantly larger and the CAP would only have been funded at 50.7 percent of the funds appealed for.

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

CERF funding enabled all UN Agencies and partners to deliver quick assistance to the targeted beneficiaries. For example, a timely response to measles and dengue outbreaks was made possible thanks to the emergency health kits (IEHK) that were procured through CERF funding. Similarly, a measles vaccination campaign for school children was carried out targeting children from 6-14 years. Also, with the availability of CERF funds, IOM reported that it was able to start assistance to migrants before other funding become available for support.

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

Djibouti is a country under constant threat of measles, polio, malaria and dengue epidemics because of its geographical location. The influx of refugees and migrants from Somalia and Ethiopia increases this risk. CERF funds helped to set up an alert system for outbreaks through rural telephony and by strengthening the two structures under the MoH responsible for surveillance and outbreak response. Thanks to a quick passing of the information and a subsequent reaction of the humanitarian community and the Ministry, measles as well as a Dengue outbreak could be identified and contained in time. The CERF funding was timely as it was the first funding available to support stranded migrants. The funding came on time when anti-migrant sentiments within the host community were growing, due to reasons such as the use of water points by migrants. Prior to funding availability, several deaths of migrants were registered due to dehydration. The funding helped increase water coverage and improve the community's and migrants' knowledge of best practices regarding the use of water resources. The project provided water decontamination tablets and rehydration salts for families for cases of acute watery diarrhea (AWD).

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

CERF funds were instrumental in leveraging additional funds from different sources. UN agencies and partners inform that they could use the CERF funding to demonstrate results and make the case for further funding from other donors, as well as advocate the importance of the activities undertaken with Governmental counterparties.

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

CERF helped improve coordination amongst the humanitarian community in many ways. First, it provided an opportunity for joint discussion and prioritization of the most urgent humanitarian and life-saving actions; this was the trigger for a consultative process with various partners (NGOs, Government, Donors, and Research Institutes) which represented a good forum for discussing humanitarian issues. This was true from the moment of the project proposals, through the monitoring of the activities, until the reporting and consolidation stage. In addition, the CERF funding enabled all agencies to maintain a humanitarian response capacity.

[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)

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons Learned	**Suggestion For Follow-Up/Improvement**	**Responsible Entity**
Early stage involvement of focal point for reporting on CERF funding of the previous year.	All the valuable support provided by the CERF Secretariat for the reporting on the use of the CERF funds for the previous year has been highly appreciated, as well as the opportunity of clarifications and openness to discussion also through teleconference. However, it is suggested to alert the focal point responsible for the coordination of the reporting exercise on the CERF funding possibly more in advance. There were a lot of information on the reporting process, deadlines and necessary actions that came in on a short notice and a better planning of the necessary steps could have been undertaken at country local level if this information could be shared a bit more in advance.	CERF Secretariat

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons Learned	**Suggestion For Follow-Up/Improvement**	**Responsible Entity**
The cluster coordination was improved, however a closer follow-up of the cluster is needed in order to achieve the desired result	Cluster coordination helps to improve the response and should be further strengthened in Djibouti.	All cluster leaders

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF Project Information			
1. Agency:	WFP	5. CERF Grant Period:	23-03-2012 - 31-12-2012
2. CERF Project Code:	12-WFP-012	6. Status of CERF Grant:	☐ Ongoing
3. Cluster/Sector:	Food Security		☒ Concluded
4. Project Title:	Food/Voucher Assistance to vulnerable people in Djibouti city		
7. Funding	*a. Total project budget:*		US$ 2,232,669
	b. Total funding received for the project:		US$ 1,212,707
	c. Amount received from CERF:		US$ 934,001

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	5,353	7,090	
b. Male	3,397	4,533	
c. Total individuals (female + male):	8,750	11,623	
d. Of total, children under 5	1,580	1,279	

9. Original project objective from approved CERF proposal

The objective of the proposed activity is to provide emergency assistance through an income transfer to 10,330 food insecure people living in peri-urban areas of Djibouti city to meet their minimum (basic) food needs during a 3 month period at the peak of the lean season (July - September 2012). Without such assistance, targeted population would not be able to meet their minimum food needs, especially children and their mothers.

10. Original expected outcomes from approved CERF proposal

Improved food consumption over assistance period for target households.

11. Actual outcomes achieved with CERF funds

The project improved the household food consumption score of the targeted households. At the end of the project 97.4% of the assisted population had reached an acceptable food consumption score. 15,090 food insecure people received assistance through CERF funded income transfers (3,018 households).

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

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2a

The selection criteria are based on women headed family and orphans among others. Identification of beneficiary is done by the local women associations based on their close knowledge of the situation in their neighbourhoods. Vouchers are given to women within the household, who are managing the food consumption.

M&E structures were designed to include indicators related to gender and age among others. Source of information is based on both food distribution monitoring at shop level and Post Distribution Monitoring (PDM). The latter is based on home visits to women and focus group discussions which include women, as well as other categories in the community

14. M&E: Has this project been evaluated?	YES ☒ NO ☐

The project was monitored during the course of the activities, through regular PDM visits and also market visits and monitoring of food commodities prices. In addition to that, a baseline study was conducted on 10% of the beneficiaries that also were assessed at the end of the project. This evaluation measured the impact of the project on the food consumption score of the assisted households. The monitoring of the project was done jointly with the government counterpart, the State Secretary for National Solidarity.

In addition to that, WFP performed an external evaluation to the project, the overall findings of the evaluation are:

Relevance: The project is relevant. It addresses the needs of the urban poor when they experience a seasonal shock which threatens their livelihoods further. The evaluation has further recommended that this kind of program should become one element of the national safety net which is planned to provide targeted support to the poor.

Effectiveness: Based on the food security assessment of a sample of the beneficiaries, the evaluation concluded that the project improved the household food consumption score of the targeted households. Indeed, at the end of the project 97.4% of the assisted population had an acceptable food consumption score. Therefore the project was evaluated to be effective.

Efficiency: The evaluation concluded that if only measured in cost efficient terms, the ration cost exceeded by 23.5% the usual WFP monthly ration cost, delivered in bulk. However, non-monetary considerations should also be taken into account (no selling and/or theft of rations, security, and maintenance of dignity of the beneficiaries). Therefore, the project could be considered as efficient and WFP should consider reviewing the cost for its future voucher transfer programmes.

TABLE 8: PROJECT RESULTS			
CERF Project Information			
1. Agency:	**WHO**	5. CERF Grant Period:	16 April 2012 – 31 December 2012
2. CERF Project Code:	**12-WHO-09**	6. Status of CERF Grant:	☐ Ongoing
3. Cluster/Sector:	**Health**		☒ Concluded
4. Project Title:	Ensuring life-saving interventions to vulnerable people affected by the drought		
7. Funding	*a. Total project budget:*		US$ 2,981,910
	b. Total funding received for the project:		US$ 626,301
	c. Amount received from CERF:		US$ 400,582

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	106,000	95,000	
b. Male	100,000	85,000	
c. Total individuals (female + male):	206,000	180,000	
d. Of total, children under 5	80,000	80,000	

9. Original project objective from approved CERF proposal

Ensuring lifesaving interventions to vulnerable populations affected by the drought

10. Original expected outcomes from approved CERF proposal

1. Complete weekly reports on selected indicators monitoring outbreak disease (cholera and measles) from all rural facilities; target is 85%.

2. Response to outbreaks as per need within 72 hours.

3. Develop and implement a TB screening and treatment program for migrants is in Ali Sabieh and Obock

4. Strengthen case management of malnourished children with complications.

5. Procure and distribute emergency medicines, vaccines and reagents for outbreak confirmation of measles and cholera.

11. Actual outcomes achieved with CERF funds

Outcome 1 and 2: There are two different statistical bodies that collect the data on epidemic prone diseases from the different health facilities in rural and urban areas. While SNIS (système national d'information sanitaire) receives and analyses data from rural telephony and from the routine data from health facilities in the rural areas (5 hospitals (CMH) and 30 health centres) as well as from the 11 community health centres in Djibouti-town on a monthly basis, data from 10 health facilities in Djibouti-town are

analyzed weekly by INSPD (Institut National de Santé publique de Djibouti).

The two bodies were not following the same procedures, not collecting the same data and not using the same list of diseases. This and the fact that reports are often late made it more difficult to analyse the data and to react in time in case of an outbreak alert.

The CERF project helped to put in place a system of rural telephony in all regions that now ensures a timely alert for outbreak diseases possible. Outcome 3. TB screening and treatment program for migrants is developed and implemented in Ali Sabieh and Obock.

TB screening continued in all regions. In addition, a leaflet was developed and distributed in all health centres and to health personnel and community health workers to raise awareness of TB and TB treatments.

Outcome 4. Trainings on diarrhoea management were carried out for the health staff of several districts and on the central level. Trainings on IMCI, malnutrition and childhood complications were also provided.

Outcome 5. Five IEHKs were ordered to provide lifesaving emergency treatment to over 100,000 people for 6 months. The order was delayed because of lack of storage capacity. The IEHKs were available and started to be distributed at the end of the year.

In addition, cholera diagnostic kits and outbreak kits were procured and distributed. One ad-hoc vaccination campaign took place that helped to increase the coverage of schoolchildren from 6 to 15 years that had not been vaccinated earlier and therefore were unprotected against measles and polio. To strengthen the immunization of the children, a Vitamin A dose was distributed to the vaccinated children as well. The campaign was carried out through the Vaccination Program (Programme élargit de vaccination). The Djibouti Red Crescent Society should have been involved in the campaign but due to organizational difficulties it did not participate.

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

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 0 The formulation of the project was based on a more generic approach, and less focusing on specific gender groups as the scope was equally distributed across both gender whether we were talking about outbreaks or overall population access to health services

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated?	YES ☐ NO ☒

TABLE 8: PROJECT RESULTS: WASH

CERF Project Information

1. Agency:	UNICEF	5. CERF Grant Period:	2/04/2012- 31/12/2012
2. CERF Project Code:	12-CEF-008-A	6. Status of CERF Grant:	☐ Ongoing
3. Cluster/Sector:	*Water sanitation and Hygiene(WASH)*		☒ Concluded
4. Project Title:	*WASH response in vulnerable areas*		

7. Funding	*a. Total project budget:*	US$ 4,801,980
	b. Total funding received for the project:	US$ 2,798,050
	c. Amount received from CERF:	US$ 594,011

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	46,500	46,500	There is no significant discrepancy between planned and reached beneficiaries
b. Male	32,000	32,000	
c. Total individuals (female + male):	78,500	78,500	
d. Of total, children under 5	12,500	12,500	

9. Original project objective from approved CERF proposal

The objective of the proposal is to contribute to ensuring that all children and women are protected from the adverse consequences of drought, with priority placed on the most vulnerable.
The specific objectives are to:

- Improve equal access to safe and appropriate water for women, girls, boys and men and preserve health by making at least minimum quantities of clean water available for drinking and household use for 35,500 drought-affected people;
- Improve access to adequate sanitation for the poor the poor neighbourhoods of Djibouti;
- Improve sanitation and hygiene practices for 43,000 people (women, girls, boys and men) at community level and those poorest peri-urban areas in Djibouti City.

10. Original expected outcomes from approved CERF proposal

The project is expected to provide safe water to 35,500 people including 10,000 through water trucking in the poor neighbourhoods of Djibouti. It will also benefit for 43,000 people through the promotion of basic and personal hygiene promotion and will prevent outbreaks of water borne diseases through increased knowledge in good hygiene practices and behavioural change.

11. Actual outcomes achieved with CERF funds

CERF funds enabled 35,000 people to access safe drinking water. In addition, a total of 43,000 people were reached through Hygiene Promotion campaigning, through the joint work of UNICEF and its partners (ACF and Paix et Lait 23,000 people, CARE 11,000 people and ADIM 9,000 people). An overall improved coordination during emergency preparedness and response was also ensured by regular meetings of the wash cluster.

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

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐
If 'YES', what is the code (0, 1, 2a, 2b): 2a **If 'NO' (or if GM score is 1 or 0):**	
14. M&E: Has this project been evaluated?	YES ☒ NO ☐

TABLE 8: PROJECT RESULTS: NUTRITION

CERF Project Information

1. Agency:	UNICEF	5. CERF Grant Period:	3/04/2012- 31/12/2012
2. CERF Project Code:	12-CEF-008-B	6. Status of CERF Grant:	☐ Ongoing
3. Cluster/Sector:	Nutrition		☒ Concluded
4. Project Title:	Acute malnutrition case management		

7. Funding		
	a. Total project budget:	US$ 4,500,000
	b. Total funding received for the project:	US$ 1,372,918
	c. Amount received from CERF:	US$ 348,859

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	17,425	15,683	
b. Male	7,575	6,817	
c. Total individuals (female + male):	25,000	22,500	
d. Of total, children under 5	15,000	13,500	

9. Original project objective from approved CERF proposal

- Screen acute malnourished children within the highly vulnerable areas mainly at the community level;
- Undertake the screening of malnutrition among pregnant and lactating women;
- Manage severe and moderate acute malnourished children within health facilities and at the community level with collaboration of community associations and community health workers;
- Provide pregnant and lactating women with nutritional care; and
- Promote nutritional best practices such as exclusive breastfeeding up to six months and timely and adequate complementary feeding.

10. Original expected outcomes from approved CERF proposal

- Increase malnutrition case management coverage to over 80%;
- Keep the case fatality rate of severe acute malnutrition on less than 5%;
- Increase the recovery rate of malnourished children to over 70%;
- Decrease the default rate to below 10%;
- Provide at least 80% of under five children and mothers with micronutrient supplements;
- Raise awareness of all mothers using nutrition services on good nutrition.

11. Actual outcomes achieved with CERF funds

- Coverage of malnutrition case management: 80%;
- Case fatality rate of severe acute malnutrition: 1,3%;
- Recovery rate of severe acute malnutrition: 80%;
- Default rate: 13%;
- Proportion of children and mothers receiving micronutrient supplements: 90%;
- Proportion of mothers reached for the improvement of nutrition practices: 90%.

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

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2b

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated?	YES ☐ NO ☒

The project has been evaluated with the technical support of OCHA. Also, monitoring and supervision of activities have been conducted by the national team with the support from UNICEF and OCHA.

TABLE 8: PROJECT RESULTS

CERF Project Information

1. Agency:	FAO	5. CERF Grant Period:	18-April-2013- [31-Dec-2012]
2. CERF Project Code:	12-FAO-007	6. Status of CERF Grant:	☐ Ongoing
3. Cluster/Sector:	Food Security		☒ Concluded
4. Project Title:	Strengthening rural food security through urgent access to water for nomadic and agro pastoral communities to promote food security and safeguard livelihood asset in response to the drought crisis		

7. Funding		
	a. Total project budget:	US$ 2, 050,000
	b. Total funding received for the project:	US$ 934,123
	c. Amount received from CERF:	US$ 934,123

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	6,828	6,468	Due to the fact that the quantity of Solar Pumps has been reduced to 15 units, consequently only 1,700 beneficiaries targeted have been reached. The provision of 400 camels has been reduced to 270, hence affecting planned beneficiaries (2,400 people). Only 1900 people will benefit from this activity.
b. Male	4,552	4,312	
c. Total individuals (female + male):	11,380	10,780	
d. Of total, children under 5	7,586	7,007	

9. Original project objective from approved CERF proposal

To increase access to water for 9,580 vulnerable, food insecure pastoralist and agro-pastoralist beneficiaries affected by the prolonged drought in rural areas of Djibouti. To increase food security through cash for work and support to small irrigation of vegetable and fodder plots for 1 800 beneficiaries

10. Original expected outcomes from approved CERF proposal

- 777 food insecure households have access to water within their communities;
- 300 food insecure households have increased access to food through cash for work activities;
- 420 rural households have improved capacity for diversification of livelihoods and improved income generation activities through the provision of solar pumps and drip irrigation kits;
- 400 rural households have increased access to distant water supplies during the current dry spell until water sources are replenished through provision of camels**.**

11. Actual outcomes achieved with CERF funds

- Construction of 7 underground cisterns of 100m³ in Bouboukto, Gagadeh, Hadley, Maguido, Dawrero, Cheikeitto. The beneficiaries from this activity are 1680 people.
- Rehabilitation of 10 key wells in Obock (Maraaelo, Adoyla-Ela, Gehere, Galato-af, Hamamdou, Bala'a, Doubya and Massakinatou). The beneficiaries from this activity are 2500 people.
- Provision of Cash for Work through the construction of one pipe-aqueduct in Assagueyla (Tadjourah) targeting 1800 beneficiaries
- Construction of 11 km pipe-aqueduct in Assagueyla to link isolated communities to a water source. The beneficiaries from this activity are estimated to 1200 people.

- Provision of 15 solar pumps and 100 drip irrigation kits to drought-affected small gardens for increased vegetable and fodder production. The provision of solar pumps and drip irrigation helped to reach 1700 people.
- Distribution of 270 camels (54 per region) to vulnerable communities for improved water access (through assistance to water transportation). The restocking of this activity has allowed reaching 1900 people of which 50% of women.

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

- Construction of an 8 km pipe-aqueduct in Assagueyla was planned. Instead an 11 km pipe-aqueduct has been constructed. The Topography expert recommended extending the pipeline approximately 3 km away from the wadi (Location to avoid).
- Regarding the procurement of 20 solar pumps; only 15 have been purchased. The price increased compared to last year's planning figures. Consequently, planned quantity has been reduced to 15 solar pumps.
- As per the project document, the project intended to distribute 400 camels to vulnerable communities. Once again, the actual price increased compared to last year and so the project only distributed 270 camels.

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2a

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated?	YES ☒ NO ☐

Only two activities were monitored and evaluated. Others activities are still ongoing.

TABLE 8: PROJECT RESULTS

CERF Project Information

1. Agency:	IOM	5. CERF Grant Period:	19 March 2012 to 31 December 2012
2. CERF Project Code:	12-IOM-02	6. Status of CERF Grant:	☐ Ongoing
3. Cluster/Sector:	Multi sector		☒ Concluded
4. Project Title:	Improving lifesaving health care access and protection of vulnerable migrants in Djibouti		

7. Funding		
	a. Total project budget:	US$ 2,500,000
	b. Total funding received for the project:	US$ 954,627
	c. Amount received from CERF:	US$ 199,998

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	5,500	16,600	More than double of the targeted beneficiaries were reached. Local communities have shown a lot of interest in the sensitization messages. The sensitization on best practices, coupled with distribution of chlorine tabs and ORS and the rehabilitation of wells is believed to have contributed to a better control of AWD and reduced the risks of conflicts around water resources.
b. Male	9,500	18,792	
c. Total individuals (female + male):	15,000	35,392	
d. Of total, children under 5	2,000	2,477	

9. Original project objective from approved CERF proposal

Enhance the response capacities of the Djiboutian Government in providing life-saving humanitarian assistance, to promote public health and prevention measures in order to reduce avoidable mortality and morbidity amongst migrants and host communities.

10. Original expected outcomes from approved CERF proposal

- Provide essential diarrheal diseases (AWD) commodities to local MOH (Obock Hospital and health posts) for case management and early detection and surveillance addressing the specific needs of vulnerable migrants, the majority of which are male, recognizing the special vulnerability of female migrants who face higher protection and health risks.
- In collaboration with community leaders, local authorities and migrant communities, provide health education to communities for fostering improved hygiene and treatment seeking behavior of men, women, boys and girls, elderly within migrant and host communities paying attention to the special needs of each group to ensure sustainable change in behavior; and provide chlorine for water treatment and oral rehydrating solution (ORS) to heads of households; assist in treatment and referrals of suspected cases, as applicable.
- Reproduce and disseminate IEC materials providing basic information on hygiene practices in appropriate language/pictures.
- Strengthen and facilitate the referral system for vulnerable populations.
- Actively participate in and promote district and national level coordination on diarrheal diseases, including AWD response

for men, women, boys and girls within migrant and host communities paying attention to the special needs of each group to ensure sustainable response.

- Rehabilitate up to eight existing water points along the migratory corridor and Obock area in order to increase access to safe drinking water, hygiene and sanitation and reduce morbidity and mortality.

11. Actual outcomes achieved with CERF funds

- The provision and distribution of essential drugs, infusions, ORS for case management, and prophylaxis is expected to have provided operational relief to the current strain on functional primary health care facilities.
- 35,392 individuals were reached for improved AWD-awareness including 12,753 migrants. Chlorine tablets and ORS were disseminated in villages for local communities and migrants. 724 cases treated for diarrheal diseases (all causes), but no outbreak and no cholera cases detected.
- 18,220 AWD flyers in appropriate language disseminated in the communities and also among migrants populations.
- 339 vulnerable cases were identified. Initial assistance was provided to them before referring them to appropriate services within the hospital in Obock and Tadjourah.
- Increased awareness on AWD and hygiene of various health partners and communities was achieved through outreach activities and coordination meetings. The coordination also involved the Health authorities. The number of people (local community and migrants) reached, the control of the cases of AWD within the communities, the fact that no conflict on the use of resources were reported in areas reached are good signs that the objective of the hygiene awareness were reached.
- Ten water points were rehabilitated along the migratory corridor in Obock and Tadjourah area (rehabilitation of eight water points was initially planned but available funds allowed for the rehabilitation of two more). This activity was coordinated with FAO. These wells came to increase the water coverage for communities and migrants.

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

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 1

Given that women and children contribute a lot in collecting water in communities, they benefited more directly in the sensitization messages. Women are more vulnerable on the migration route. Special attention was given to them during sensitization and referral process. In the MRC where migrants are received before being referred to health centres, there is a clear separation between men and women used facilities.

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated?	YES ☒ NO ☐

The project was regularly monitored. OCHA conducted a midterm evaluation of the project. The report concluded with satisfaction on sensitization messages delivered. It is based on this satisfaction that more areas are targeted for sensitization in 2013.

TABLE 8: PROJECT RESULTS

CERF Project Information

1. Agency:	UNHCR	5. CERF Grant Period:	2-04-2012/31-12-2012
2. CERF Project Code:	12-HCR-008	6. Status of CERF Grant:	☐ Ongoing
3. Cluster/Sector:	Multi-Sector		☒ Concluded
4. Project Title:	Protection and multi-sectoral assistance for refugees, asylum seekers and mixed migrants in Djibouti		

7. Funding		
	a. Total project budget:	US$ 26,683,669
	b. Total funding received for the project:	US$ 5,431,685
	c. Amount received from CERF:	US$ 607,751

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	9,141	10,592	
b. Male	10,351	11,642	
c. Total individuals (female + male):	19,492	22,234	
d. Of total, children under 5	1,580	2,512	

9. Original project objective from approved CERF proposal

- Improve and secure quality and quantity of water sources to refugees in Ali-Addeh and Holl-Holl refugee camps avoiding and controlling watery diarrhoea and other water related diseases.
- Ensure satisfactory sanitation facilities in the new camp.
- Ensure primary health care to refugees Ali-Addeh and Holl-Holl camps.

10. Original expected outcomes from approved CERF proposal

- 100% of Ali-Addeh refugees have access to quality water provided by UNHCR controlled water system.
- 100% of Holl-Holl refugees have access to quality water provided by UNHCR controlled water system.
- The Camp Health centres have continuous quality water supply.
- 100% of refugees in Ali-Addeh and Holl-Holl camps have equal access to water points with special stress to most vulnerable categories (women, children and handicapped).
- 100% of new arrivals in Holl-Holl camp have suitable sanitation facilities.
- Two health facilities will be functioning and appropriately staffed and equipped and 100% of refugee population have access to appropriate drugs.

11. Actual outcomes achieved with CERF funds

- The construction of 3km of pipeline between Nakhal and Ali Addeh has improved the provision of safe drinking water in Ali Addeh. PHD90 pipes were used to connect the newly constructed big diameter hand dig well located in Nakhal wadi to Ali Addeh existing water supply network. In addition annexes infrastructures were also constructed to make the system functional: pumping system with solar panels and submersible; guardian house; pumps house and other hydraulic structures like pressure regulators and glances. Through this project the provision of safe drinking water has increased from 80m^3/day to 200m^3/day. This project has secured 100% access to safe drinking water to all refugees. The amount of water provided is equally distributed around the different sections of the camp.
- A new water supply network pipe was constructed at Holl Holl's new refugee camp comprising: 2 concrete reinforced tanks of 100m^3 each; 10 tap stands of 6 taps each)**.** The implementation of this has enabled the transfer of 250 families from Ali Addeh to Holl Holl where 100% of the refugees have equal access to safe drinking water. Till date the provision of safe drinking water in this new camp stands at 30 litters/person/day> UNHCR minimum standards.
- To accommodate families transferred from Ali Addeh to Holl Holl new refugees camp, 12 blocks of communal latrines with 4 pits each were constructed in temporally material and equitably distributed between sections of the camp. Among the 12 blocks constructed 6 were dedicated to men and 6 to women. In addition 8 blocks of public toilets were also made available for families and equally distributed between males and females. The implementation of this has contributed to maintain the good sanitation and hygiene condition of refugees in this new area.
- In addition two blocks of communal latrines with 8 pits each (8 pits for men and 8 pits for women) and two blocks of public toilets with 8 boxes each (one block for men and one block for women) were also constructed at Ali Addeh transit centre to accommodate the flux of new arrival from Somalia received along the year.

The combined water supply and sanitation activities delivered in both camps by UNHCR and implementing partners has a positive impact on the refugees' living conditions. For example no death and no outbreak due to the insufficient or lack of water or sanitation services was register in any of the camps in 2012.

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

13. Are the CERF-funded activities part of a CAP project that applied an IASC Gender Marker code? YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a, 2b): 2a

UNHCR conducts participatory assessments on a continuing basis and holds a planning exercise in March for the following year. It culminates in a careful assessment of needs of the populations concerned, based on UNHCR's observations as well as consultations with NGOs and other implementing partners, donors, government officials, and the beneficiaries themselves. In March 2012, the UNHCR Country operation Plan for 2013 workshop was held with all partners in Djibouti. In November 2012, Age Gender and Diversity Mainstreaming (AGDM) exercises were held with refugees in Djibouti (Camps based refugees and urban cases). The exercises were led by UNHCR following a participatory methodology involving all partners of UNHCR in the country. In addition, daily monitoring activities are arranged by UNHCR and partners in the camps.

If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated? YES ☐ NO ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/ Sector	Agency	Partner Name	Partner Type	Total CERF Funds Transferred To Partner US$	Date First Instalment Transferred	Start Date Of CERF Funded Activities By Partner	Comments/ Remarks
12-WFP-012	Food Security	WFP	UNFD	NNGO	9,820	01/05/2012	01/05/2012	During the CERF funding period, WFP managed to reach the planned beneficiaries figures using the food voucher modality, which appeared to be an effective transfer modality to the food insecure beneficiaries in the City of Djibouti. The CERF allowed WFP to start the implementation of the project on time which was in line with the objectives of the project. As a follow up of this activity and taking into consideration the recommendations of the external evaluation, WFP is intended to implement the same activity in 2013 and hopes that it can continue to rely upon the CERF for critical financial support.
12-WFP-012	Food Security	WFP	Paix et Lait	NNGO	2,918	01/05/2012	01/05/2012	
12-CEF-008-B	Nutrition	UNICEF	Ministry of Health	Government	101,006.41	01/05/2012	15/05/2012	The implementation of the project has been completed on 31/12/2012 as planned.
12-CEF-008-A	WASH	UNICEF	CARE INTERNATIONAL	INGO	120,000	01/04/2012	15/04/2012	The implementation of the project has been completed on 31/12/2012 as planned.
12-CEF-008-A	WASH	UNICEF	ACF	INGO	150,000	01/04/2012	15/04/2012	
12-CEF-008-A	WASH	UNICEF	ADIM	NNGO	80,000	01/04/2012	15/04/2012	
12-HCR-008	Multi-Sector	UNHCR	CARE INTERNATIONAL	INGO	186,000	01/04/2012	01/04/2012	The implementation of the project has been completed on 31/12/2012 as planned.

12-FAO-007	Agriculture	FAO	ADLD	NNGO	21,116	19/03/2012	19/03/2012	The implementation of the project has been completed on 31/12/2012 as planned.

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

CMH	Centre Médical Hospitalier
INSPD	Institut National de Santé publique de Djibouti, Ministry of Health
IOM	International Organization for Migration
MOH	Ministry of Health
PDM	Post Distribution Monitoring
SNIS	Système National d'information Sanitaire, Ministry of Health
UNFD	Union Nationale des Femmes Djiboutiennes