RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS
HAITI
UNDERFUNDED EMERGENCY ROUND I 2014
DISEASE

RESIDENT/HUMANITARIAN COORDINATOR	**Mr. Peter de Clercq**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

The AAR was conducted in December 2014 and January-February 2015 when the Humanitarian community was drafting the Transitional Appeal 2015-2016 for Haiti. That exercise has gathered UN agencies, donors, international and national NGOs, the Red Cross Movement, and the Government.

b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report was discussed in the Humanitarian and/or UN Country Team (HCT and UNCT) 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 Movement

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: US$ 157,454,953		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	8,873,438
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	3,218,356
	OTHER (bilateral/multilateral)	143,360,889
	TOTAL	**155,452,683**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 19-Feb-14			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	14-UFE-CEF-013	Water and sanitation	1,375,103
UNICEF	14-UFE-CEF-014	Water and sanitation	2,002,614
IOM	14-UFE-IOM-006	Health	587,403
IOM	14-UFE-IOM-007	Water and sanitation	135,004
UNOPS	14-UFE-OPS-001	Health	500,129
WHO	14-UFE-WHO-008	Health	1,604,979
TOTAL			**6,205,232**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	3,014,761
Funds forwarded to NGOs for implementation	2,777,957
Funds forwarded to government partners	412,514
TOTAL	**6,205,232**

HUMANITARIAN NEEDS

In 2014, an estimated three million Haitians continued to be affected by the results of both chronic and acute needs. Mainly, they faced displacement, food insecurity, and malnutrition. Of these, an estimated 817,000 people in 35 priority communes (out of 140 in the country) remained in need of immediate humanitarian assistance. Within this context, the cholera epidemic continued to be an important concern. In spite of a significant decrease in the overall number of cholera-related deaths during 2013, Haiti still hosted half of the world's suspected cholera cases. Despite acute needs, resources to combat the epidemic have been hard to mobilize. The continuation of on-going activities was essential to preserve the gains attained so far and to further reduce the number of suspected cases of cholera.

The humanitarian community therefore focused on response to the on-going cholera epidemic and key activities to sustain efforts to curtail its transmission throughout 2014. Until 29 January 2014 Haiti reported 1,232 suspected cholera case and 14 deaths in 2014.

While overall incidence and fatality rates have been reduced, institutional fatality rates (the number of suspected cholera victims who die in cholera treatment facilities) have increased in 2013 from 0.83 per cent registered at the end of 2012 to 1.07 per cent in 2013. This reflects weaknesses with regards to the capacity of health centers to provide timely and adequate health services to cholera-affected patients. Due to the closure of many cholera treatment centers, patients also had longer journeys to get treatment which led to delays in receiving appropriate treatment.

Suspected cases of cholera were reported in all 10 departments of Haiti but four departments have been identified as systematically reporting the highest numbers since the beginning of the epidemic. These were the West, Artibonite, Centre, and North Departments.

According to Government and the Pan American Health Organization/World Health Organization (PAHO/WHO), an estimated 45,000 suspected cholera cases were expected in 2014, if the 2013 trend continued and if consolidated and nationwide efforts deployed in 2013 were sustained. The highest number of cases was expected during the rainy and hurricane seasons, from April to November. In 2014, there were 27,388 cholera cases in Haiti.

Considering needs, efforts underway and capacities, the following critical gaps were identified in the Humanitarian Action Plan 2014 with regards to cholera:

1. **Epidemiological surveillance**: This is essential to monitor and analyze the evolution of the epidemic in the country and respond swiftly to alerts. A reporting system via SMS was introduced to facilitate the reporting of data by health centers and Departmental epidemiologists to the central level. Yet, the timely collection, analysis, and reporting of data from all areas of the country remains a challenge, particularly from the community level. Rapid tests, provided with the support of the Central Emergency Response Fund (CERF) in 2013, were in place to not only differentiate the cases of cholera from those of acute diarrhea but to identify zones with high prevalence. It is therefore important to strengthen the capacity of the national laboratory to provide the clinical confirmation of patients with positive results of rapid tests. Clinical confirmation of cholera indicated the presence of vibrio bacteria, which cause cholera, and allowed adequate targeting activities to cut the transmission.
2. **The cholera alert system needed to be strengthened**: In view of feeding into the epidemiological surveillance system, an alert system at central and department level was put in place in 2010 led by the *Ministère de la Santé Publique et de la Population* (MSPP) to ensure a timely response to cholera alerts. The system was based on a network of actors in the field reporting cholera alerts via emails or phone to the MSPP, which monitored the situation and coordinated the response. With the withdrawal of many partners involved in cholera response, due to lack of funding, the timely reporting of alerts has been weakened delaying the response-time. In addition, efforts underway to improve the collaboration between the MSPP and *Direction Nationale de l'Eau Potable et de l'Assainissement* (DINEPA) at the national and departmental level needed to be strengthened.
3. **Medical care and integration of cholera into the health care system needed to be improved:** The MSPP has, for the last two years, attempted to integrate the treatment of suspected cholera patients in regular health structures attended by regular medical staff rather than in separate Cholera Treatment Centers or Units (CTC or CTU) with specific staff allocated for cholera response. Due to the withdrawal of many partners the overall number of cholera treatment facilities (CTC, CTU and Centre CTDA) has been significantly reduced. Most facilities were ran by the MSPP which has limited capacity to maintain adequate quality conditions for the treatment of suspected cholera patients, and lacks the finances to pay the necessary number of staff to ensure 24-hour shifts. As a result, treatment capacities have been significantly stretched following the increase in suspected cholera cases since April. In August 2013, six Departments had registered a higher institutional fatality rate than at the same period in the previous year, which is illustrative of the deterioration in access to and the quality of health care provided to patients. In addition, due to the closure of many CTCs, patients have to travel longer distances to treatment centers and therefore arrive with more severe dehydration which may also contribute to the increased institutional fatality rate.
4. **Availability of supplies needed to be sustained**: since the beginning of the epidemic in 2010, the *Programme de Médicaments Essentiels* (PROMESS), the national agency for the provision of medicines, has been providing medical supplies for the treatment of cholera free of charge to health centers and partners working in the cholera response. Yet, shortages of some items have been observed in health centers due to the lack of stock caused by funding shortfalls, the lack of abidance to national protocols and to

distribution problems. To supply health structures treating cholera patients, funding is needed to purchase medical supplies for the 45,000 anticipated cholera patients during 2014.

5. **Sensitization efforts needed to be pursued**: in a country where cholera was not known by the population before 2010 and inadequate hygiene behaviour of the population contributed to an average of 2,000 cases of severe diarrhea per month even before the cholera outbreak in 2010, sensitization activities were essential to cut the transmission of the disease. The MSPP introduced a new strategy for community health workers in 2013 whereby there would be 1 multipurpose community health agent per 500 to 1,000 people. This strategy would require approximately 10,500 community health workers nationally, of which about 50 per cent would be present in rural areas. At the end of 2013, only 1,700 community health workers had been trained with an average of 400 community health workers being trained each year. The training and recruitment of additional community health workers are therefore essential in particular in the most-affected areas.

6. **Water and sanitation activities needed to be stepped up**: the main cause for the persistence of cholera in Haiti was the lack of access to clean water and sanitation facilities and poor hygienic practices. Significant needs remained to reduce cholera and improve access to water and sanitation across the country. According to Government data,[1] in 2013, 64 per cent of the total population (77 per cent in urban areas, 48 per cent in rural areas), have access to safe drinking water; 26 per cent have access to improved sanitation (34 per cent in urban areas, and 17 per cent in rural areas). Basic interventions are needed – as envisioned in the National Plan for the Elimination of Cholera – to improve both health and Water, Sanitation and Hygiene (WASH) facilities across the country, and in particular, in localities at risk.

7. **Salaries needed to be paid:** At the moment of submitting the application to the CERF, most health personnel involved in cholera response had not been paid for several months, in some cases for almost a year. This had a negative impact on motivation of health professionals and on the ability of health facilities to provide health care to victims of cholera. In this context, payment of medical staff on site was a key priority as well as the identification of rosters to mobilize additional trained personnel to respond to alerts.

8. **Sanitation in Internally Displaced Persons (IDP) camps:** With regards to the sanitary conditions in IDP camps, the following problems were identified. Open defecation was reported in 118 camps out of 166 in September 2013. The average number of people per latrine stands at 114 (compared to 74 in 2012, 50 as per Sphere standards, and 100 per latrine according to DINEPA's post-earthquake strategic document defining the infrastructures and minimal services required per site)[2]. In addition, in October 2013, only 54 per cent of IDP camps (or 166 sites) had latrines, leaving more than 9,000 IDP households or 20 per cent without access to latrines[3]. As hygiene promotion activities had continued to diminish, only 49 per cent of people living in camps were able to identify three good practices to prevent cholera and had no access to basic hand washing facilities. Out of the 267 camps were monitored for WASH services through the DINEPA (including cholera response), roughly half had a cholera response mechanism (overseen by NGOs), accounting for 177 camps with cholera-related monitoring services and 128 with cholera-related sensitization[4]. Although efforts had been made to continue desludging and repairing broken latrines, resources have been insufficient to meet needs. In addition, the almost complete lack of services for solid waste management – with only 11 camps having waste management services, covering a population of 6,741 people (4 per cent of the total population) – was posing a serious health and environmental challenge.

9. Limited funding was severely hampering humanitarian capacities to pursue and scale up on-going efforts. Only US$11 million of the $38 million required for immediate life-saving needs were provided in 2013 in the appeal to respond to cholera. Less than 50 per cent of the funding necessary to implement the national two year operational plan had been mobilized at that time. Additional, predictable, sustainable and medium term funding was needed to scale up UN and GoH efforts to sustainably tackle the epidemic.

[1] Joint Monitoring Plan Update 2013
[2] DTM-IOM October 2013
[3] DTM-IOM October 2013
[4] CCCM, Shelter & Health Clusters data collection

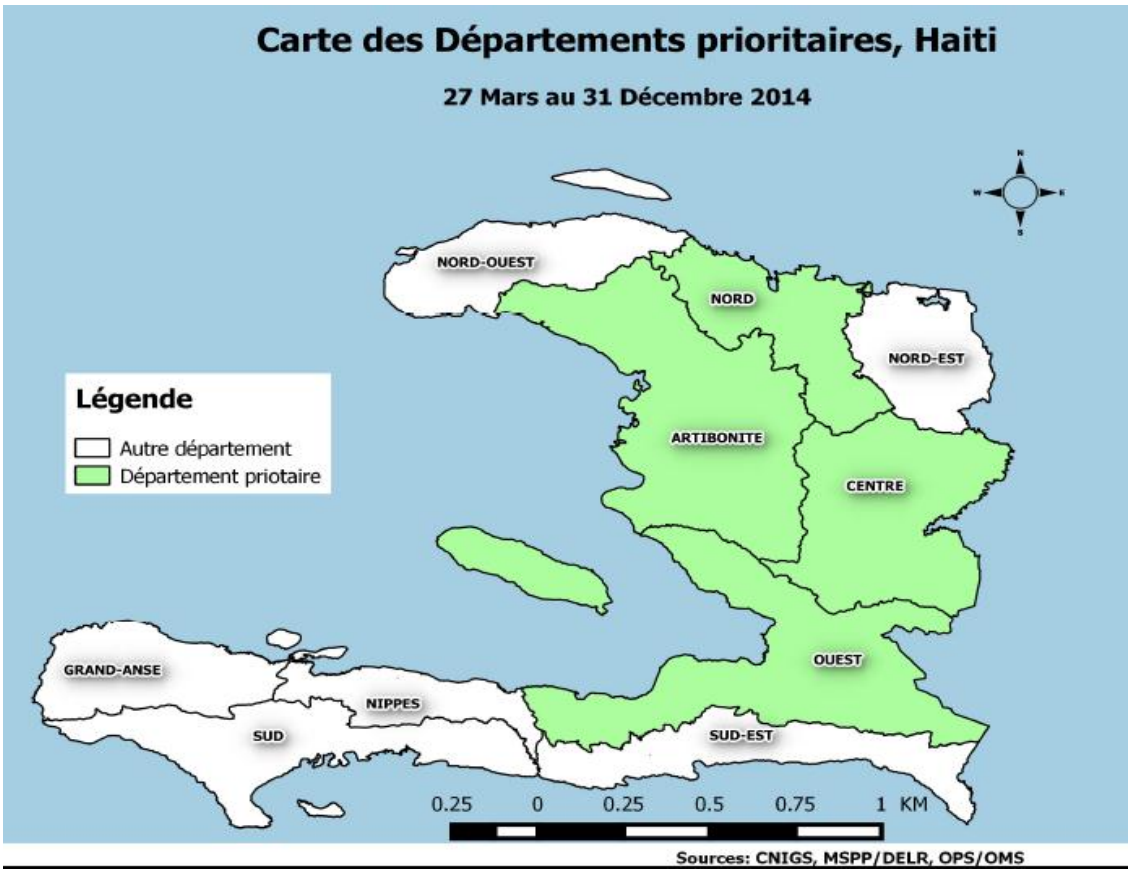
II. FOCUS AREAS AND PRIORITIZATION

The (rapid response) cholera strategy of the UN plan and the Humanitarian Action Plan (HAP) 2014 was built on the review of the strategy initiated in mid-2013 and focused on two overall objectives – prevention and control/response – with four specific sub-objectives: improving epidemiological surveillance, health promotion and sensitization, medical treatment for victims, and access to safe water and sanitation. The strategy was articulated around WASH and Health activities which needed to be implemented hand-in-hand. The strategy targeted the 45,000 potential victims of cholera and focused on areas that were facing the most difficulties in eliminating the disease.

While the humanitarian community redoubled its efforts to fight cholera epidemic the most critical gaps were registered in the most vulnerable departments mainly: North, Artibonite, Center, West, and Grande Anse. (Grande Anse was added due to the high incidence reported in 2013.)

The most critical areas were prioritized as there are existing conditions that predispose them to cholera transmission and spread:

1) Geographical: the rural areas are located hours from the health services. The walk to those centres can take 4-5 hours. This causes many cholera suspected cases to die of dehydration along the way before they reach the health facilities.
2) Lack of information or communication on cholera prevention: the level of information on cholera needed to be updated. The population was not sensitized on cholera prevention and did not know where to go if there was a cholera suspected case in the family. In those isolated areas, very few households have access to media assets (radio, television) and to electricity so they could at least listen to the spots on cholera prevention. The hygiene practices are a big challenge for the rural population who has never been informed about them.
3) Absence of water and sanitation infrastructure: the rural population has poor access to potable water. The common source of water is rivers, springs or drinking fountains. Open defecation is common practice in the rural areas because of the absence or lack of latrines and it is often prevalent near water sources.
4) The existing conditions in the IDP camps increase the vulnerability of the residents to cholera transmission and spread. The promiscuity, the absence or lack of functional latrines, potable water and good hygiene practices, access to health care services and health information on cholera prevention remain a big challenge to the control of the epidemic.



Considering the existing humanitarian context and needs to be covered, the humanitarian community, under the lead of the HC, decided to remain focused on efforts to reduce mortality and morbidity rates of cholera. The prioritisation strategy note sent to Valerie Amos, Emergency Relief Coordinator (ERC) at the time, proposed that the allocation would be used to support both emergency health and WASH prevention and response activities throughout the 10 departments of the country. Those activities implemented by actors involved in cholera response included Government structures aimed to provide rapid life-saving assistance and cholera prevention to communities. The targeted beneficiaries were the local population living in areas most at risk of cholera contamination, with a particular focus on IDP camp residents in the West Department.

III. CERF PROCESS

The above mentioned priorities and gaps were identified by the humanitarian community during the development of the Humanitarian Action Plan 2014. They were in line with critical gaps and the strategy agreed within the HCT to meet minimum cholera response requirements.

Following the announcement of the CERF allocation for underfunded emergencies to support cholera response in Haiti on 20 December 2013 by the ERC, the HC informed quickly all stakeholders. In an HCT meeting held in January 2014, the HC asked the WASH and Health cluster leads to organize meetings in order to identify the main priorities to be funded and to maximise the impact of those funds in most vulnerable communities. He also recommended cluster leads to engage all relevant stakeholders.

The clusters held their meetings separately early in January 2014 and facilitated discussions among actors. The meetings gathered UN agencies and NGOs involved in the cholera response. In order to create a synergy of action, to reinforce coordination among stakeholders and to avoid duplication, the two clusters met twice jointly on 9 and 10 January. They decided on the activities, the amount needed for response in each sector, and the targeted populations, and their approach was approved by the HCT on 22 January. Based on this, Haiti country office of the Office for the Coordination of Humanitarian Affairs (OCHA) drafted a prioritization strategy paper which was approved by the HC on 23 January 2014 and sent to Valerie Amos, then the ERC, the same day.

The utilisation of the Emergency Relief Response Fund (ERRF) Haiti was also part of discussions. The fund focused its activities on cholera response and preparedness and response to disasters. As the need of additional mobile teams was identified for North departments, the HC approved two projects (for PAHO/WHO and IMC) through ERRF to fund among others seven additional mobile teams aimed to reinforce epidemiological surveillance and response in remote areas. The ERRF allocation complemented CERF in providing coverage for the mobile teams through February 2015 and supplementing activities for the end of 2014 through the rainy season.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR

Total number of individuals affected by the crisis: 196,446 people

	Cluster/Sector	Female	Male	Total
The estimated total number of individuals directly supported through CERF funding by cluster/sector	Water and sanitation	55,352	51,094	106,446
	Health	23,400	21,600	45,000

BENEFICIARY ESTIMATION

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	**Estimated Reached**
Female	78,752	277,321
Male	72,694	213,213
Total individuals (Female and male)	151,446	490,534
Of total, children under age 5	18,623	16,088

During the first three quarters of 2014, the number of alerts and cholera cases was low. Implementing partners and agencies focused their interventions on awareness campaign and health promotion activities. They implemented local networks for early warning and response at departmental, communal and local levels. This kind of activities allowed reaching a higher number of direct beneficiaries than planned in all targeted departments.

CERF RESULTS

1. Health cluster

A joint project implemented by PAHO/ WHO, International Organization for Migration (IOM) and United Nations Office for Project Services (UNOPS) for $2,692,511 aimed to reinforce the response to cholera outbreaks in all 10 departments of Haiti.

The project allowed detecting and responding to cholera outbreaks in a timely manner within 48 hours throughout the country. Thanks to deployed mobile teams from UNOPS, Médecins du Monde Argentine (MdM-A), IOM, International Medical Corps (IMC), Médecins du Monde Belgique, Agence de Coopération Technique et de Développement (ACTED), Médecins du Monde Espagne (MdM-E), Médecins du Monde France (MdM-F) and Solidarités International (SI), 1,629 alerts were received and investigated and a response was provided within less than 48 hours during the project's implementation period (April – December 2014).

The CERF funds improved the availability and systematization of the use of rapid cholera tests by field teams and cholera facilities and allowed testing 3,699 suspected cases in April-December 2014.

Networks for early warning and response systems were established and strengthened by field partners at departmental, communal and local level. The departmental and communal health authorities had taken the lead in the alert and response system through the established network and coordinated/relayed the information to its Health/WASH partners. About 1,724 focal points were trained in the early warning system for the registration of alerts, the importance of epidemiological surveillance, communication mechanism for the management of alerts, signs and symptoms of cholera, hygiene measures including decontamination of patients' homes, use of Oral Rehydration Solutions (ORS), drinking water chlorination, etc. 3,500 identification forms were also provided to health centers to improve the registration of cholera patients and data collection at the institutional level.

The project made available a total of 21 mobile health teams equipped with medical and WASH supplies to cover all 10 departments of the country. They provided timely and adequate response to cholera outbreaks and ensured the detection of alerts, facilitated the rapid investigation of suspected cholera cases and other potential health threats, provided coordinated response to the confirmed alerts including sensitization and awareness campaigns, distribution of supplies, visited and decontaminated homes in areas where cholera cases where detected and referred patients to cholera treatment centers in some cases.

776 health staff were trained on data collection, cholera treatment protocols, corpse management and supplies, storage inventory and other essential topics to control and prevent cholera outbreaks. Cholera treatment health facilities were also supported through the continued provision of medical and non-medical supplies for cholera case management, as well as the recruitment of additional health staff to support health care delivery capacity during outbreaks.

Sensitization through education or health information on cholera preventive measures has been one of the priorities of health partners' interventions to support the reduction of cholera prevalence and mortality. All alerts responded to included sensitization and awareness campaign to promote good hygiene and sanitation practice and improve knowledge about cholera transmission risks and preventive

measures. Awareness campaign were carried out in schools, churches, public markets and neighbourhoods, either through door to door community outreach or public talks in larger groups. Sensitization activities included demonstration of the use of aquatabs and preparation of ORS, discussions, distribution of flyers, etc. These activities were accompanied by the distribution of cholera kits with soap, aquatabs and oral solutions, chlorine for proper disinfection, personal protection kits for community workers, oral rehydration solutions, etc.

Finally, the project allowed strengthening communication and coordination among cholera response actors. Meetings at local and central level were carried out with the MSPP, DINEPA and all active field partners to ensure that everyone was informed of the presence and interventions carried out by each partner.

The funds contributed to the reduction of institutional fatality rate to 1.03 per cent, while PAHO/WHO recommends a maximum of 1 per cent.

Institutional Fatality Rate from 2012-2014.

Year	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
2012	0.27	0.60	0.88	1.29	0.89	0.89	0.72	0.90	0.95	0.99	0.96	1.37
2013	1.46	0.50	1.30	0.76	0.76	1.37	0.77	0.97	0.83	1.29	1.15	1.46
2014	0.98	0.28	2.04	0.48	0.45	0.94	0.87	1.59	1.57	0.93	1.04	0.92

Globally, the project reached about 391,414 people (225,779 female and 165,635 Male) including 4,194 children under five, including through sensitization.

2. Water, Sanitation and Hygiene cluster

Two projects were funded for $3,512,721. UNICEF and IOM implemented a joint project for $1,510,107 aimed to improve sanitation and hygiene in IDP camps and another was implemented only by UNICEF for $2,002,614. It aimed to contribute to elimination of cholera epidemic by improving rapid response activities to reduce the number of suspected cholera cases and to cut its transmission.

Improvement of sanitation and hygiene in IDP camps

The joint UNICEF/International Organization for Migration (IOM) project was implemented in 116 IDP camps in Port-au-Prince. 100 per cent of these camps have benefited from desludging and disinfection by a private company well equipped and specialized in such activities which was supervised by UNICEF and DINEPA. As IDP camps were relocated, and therefore the number of camps for desludging reduced,, the number of drums to be extracted was reduced to 2,500 drums per month instead of 4,100 planned. At the end of the project, it is estimated that 30,000 drums (6,000 m^3) have been moved from 116 IDP camps (including 11 that were closed). A total of 221 latrines were rehabilitated while toilets in 11 closed camps were systematically decommissioned. CERF allocation allowed to distributing cleaning kits in 34 camps. Those distributions were accompanied by mass sensitization on the environment and waste management. About 141 mass sensitization activities on waste management reached around 9,431 people including members of camp committees.

A total of 396 members of camp committees as well as 255 community hygiene promoters were trained and according to a final survey done by Solidarités International (SI), 72 per cent of the trained people were able to identify the routes of transmission and protection measures against feco-oral diseases, 69 per cent passed the “cholera written test” and 60 per cent passed the “protection test”. Some 67 per cent of the participants to sensitization sessions and training improved their knowledge on water borne diseases transmission prevention
IOM conducted sessions with 53 committees’ members in three other camps. They learnt basic concepts regarding hygiene and sanitation, as well as the importance of latrines in communities and the damaging effects poorly maintained latrines could have on health and the environment.

UNICEF through SI, was able to answer to 8 cholera alerts in 3 camps. (A complete WASH answer or response is composed of investigation, house disinfection, sensitization, cholera kit distribution, and when needed, water points chlorination.)

Globally, the project reached about 99,120 people (51,542 female and 47,578 male)

Improving rapid response activities to cholera cases

UNICEF implemented a wash project aimed to bring rapid response activities to cholera cases through a network of 6 NGOs active in the 10 department: French Red Cross in the West department, SI in Nippes and South East, ACTED in Grande Anse and South, ACF in Artibonite and North West, OXFAM in North and North East, Zanmi Lasante (Partners in Health) in Centre.

UNICEF has accompanied the MSPP in the investigation of cholera alerts and reinforced capacities of the Direction de l'Epidémiologie, Laboratoires et Recherches (DELR) in means of communication, supplies for clinical cholera testing and supported the operating costs of 13 technicians and two epidemiologists. 1,878 responses to alerts were given and 3,861 homes were disinfected.

Around 70 per cent of rapid response team interventions were done within 48 hours after an alert, except from October to December 2014; due to socio-politic context, only 7 per cent of the responses were done after 72 hours of an alert.

The project has supported treatment facilities by delivering 81,000 litres of ringer lactate, 5,100,000 aquatabs and 102,000 ORS doses. More than 20,000 suspected cases have been treated both by public and private cholera treatment centers.

The project allowed also to treat water and to sensitize communities. UNICEF supported the distribution of 18,418 cholera kits at the community level and 534 hygiene kits at cholera treatment center, the protection or quick fixing of 230 water points and the implementation of 527 bucket chlorination points in areas of cholera outbreak.

The fund contribute to the reduction of institutional fatality rate to 1,03 per cent, while PAHO/WHO recommends a maximum of 1 per cent.

Globally, the two WASH projects reached about 126,508 people (65,784 female, 60,724 male).

CERF's ADDED VALUE

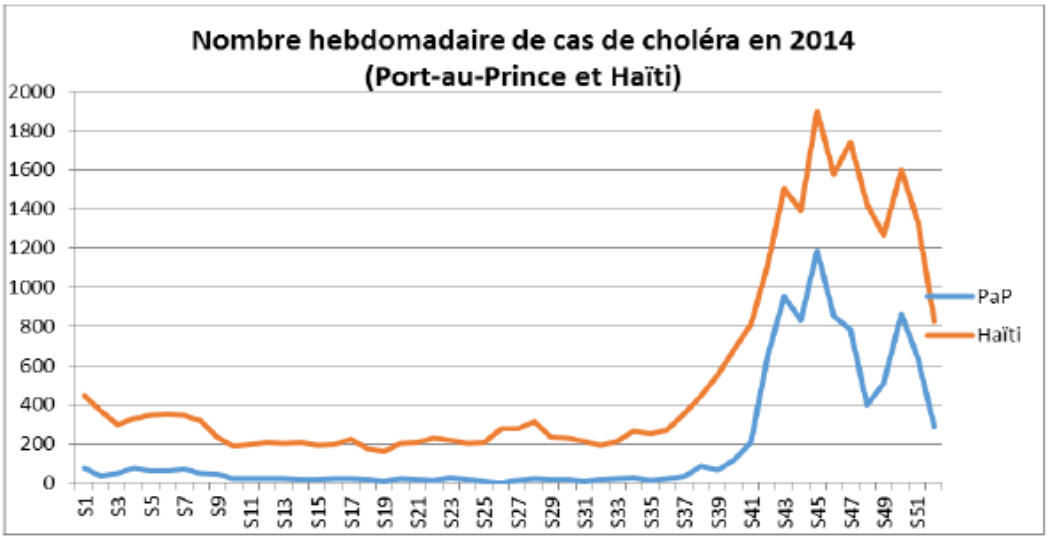
a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?
YES ☒ PARTIALLY ☐ NO ☐

The CERF funds supported the delivery of fast and high quality assistance to cholera patients and population living in areas at risk of outbreaks, with a particular focus on the IDP's still living in camps, as well as vulnerable communities living in isolated areas. This contributed to saving lives and containing the spread of cholera in the country. Beneficiary agencies deployed quickly mobile teams in the field and could respond to alerts within 48h.

b) Did CERF funds help respond to time critical needs[5]?
YES ☒ PARTIALLY ☐ NO ☐

CERF funds helped sustained timely response capacity in all departments to address cholera outbreaks. In particular, CERF funds allowed to decentralize surveillance and response capacity and to significantly expand coverage to remote and isolated areas through the massive deployment of mobile teams and the use of local networks. This contributed to the significant diminution of cholera morbidity and mortality compared to previous years, by 53 per cent between 2013 and 2014. CERF-funded activities contributed to control and reduce the impact of the severe outbreak started in October. Cholera may occur everywhere in the country as the risk remains basically the same than in 2010 when cholera started. The response funded with CERF allowed controlling outbreaks until October but then due to unpredictable external factors (water networks contamination, coordination issues, etc.), the number of cases increased again. The CERF funds became particularly instrumental in responding to the increasing cholera incidence observed in the last quarter of 2014 (September to November) to address the critical needs of cholera patients and communities.

[5] 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.).



Source : DELR, consolidé par l'APHM.

With regards to IDP camps, a huge concern existed around sanitation. CERF funds arrived at the right time and allowed to respond to very critical and priority needs in camps. Without this allocation funds, UNICEF, IOM and its partners wouldn't have been able to support sanitation and hygiene in IDPs camps throughout 2014.

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

The CERF has helped to mobilize resources. The life-saving activities as part of the CERF-funded project were implemented through a well-coordinated mechanism building on local capacities, allowing implementing partners to mobilize additional local resources (often in kind such as additional response supplies) in response to the critical needs. For example UNICEF and its partner Solidarités International received funds from ECHO to reinforce sanitation activities in IDP camps.
Furthermore, additionally, the ERRF Haiti made available funds to reinforce cholera activities in the country particularly in epidemiological surveillance, prevention and case management. The fund reinforced WHO and IMC mobile teams in the country and contributed to the implementation of the Emergency Operations Centre in MSPP aimed to coordinate emergency response including major epidemics.

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

The CERF has improved coordination amongst the humanitarian community not only to avoid duplication of efforts but also to maximize coverage of needs in the country.

First of all, following the announcement of this allocation in December 2013, the humanitarian community worked together in identification of activities and areas to be covered. OCHA and Clusters leads played a central role at this stage of the process.

Secondly, this CERF allocation significantly helped strengthen coordination of all the response actors in the field at departmental and communal level through the development of commons forms and tools for data collection, reporting, the organization of joint interventions with multi-sectoral actors, the fostering of coordination mechanisms and the systematization of good practices and tools.

Lastly, improved coordination of health and WASH actors resulted in an integrated and comprehensive approach in the areas of epidemiological surveillance (consolidation of a common database for the collection of information), prevention (awareness message and joint demonstration during the local festivities) and response (corpse management, distribution of hygiene kits and treatment of water sources during response to alerts).

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
The allocation saved lives by covering need in cholera epidemic either in IDP camps or in remote communities. The last outbreak in the Port au Prince metropolitan area also demonstrated a sufficient resources must be ensured to adequately cover this densely (i.e. high-risk) populated area with at 20 mobile teams year around.	Maintain attention on cholera epidemic in Haiti especially during April-December when rains increase the risk of outbreak.	HC/ERC
Evaluations conducted in the supported cholera centers revealed deep concerns of infrastructure deterioration, low sanitation and limited access to drinking water, shortages of medical and non-medical supplies, lack of latrines and absence of solid and medical waste management systems.	Resources must be made available to support improvement and rehabilitation works at health facility level to improve quality of health services and safe treatment conditions.	CERF secretariat / donor community

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
The funds allowed rapid response to cholera alerts and Suspected cholera cases benefitting from quality treatment	Reinforce mobilization of resources to response to alerts and reinforce this gain through all involved implementing partners.	HC/PAHO/WHO and UNICEF
During this period, the number of active cholera actors was significantly reduced. Yet the strengthened coordination between remaining organizations and the combine efforts of national and international actors were instrumental in the success of the response.	It is essential to continue to strengthen coordination, information sharing between health and WASH actors and GoH institutions, particularly mobile field teams at departmental, communal and local levels for more effective interventions on the ground. Increased national ownership and appropriation of the cholera combat is key to make interventions sustainable	UNICEF/PAHO/WHO/OCHA
The use of multisectorial mobile field teams and the multiplication of community networks help improve geographical coverage for cholera surveillance and first line response, therefore increase timeliness of response to very remote and isolated areas.	It is critical to continue supporting the decentralization of warning and surveillance systems using joint health and WASH teams and the community networks which contribute a significant portion of the alerts received and help better tailor response and prevention interventions to address areas of cholera persistence.	UNICEF/PAHO/WHO/OCHA/MSPP
Since the cholera outbreak in 2010, many cholera treatment centers were built. Unfortunately, many of those centers had either little to no maintenance. Today, there is urgent need to rehabilitate health facilities since many of them are in poor condition.	Some of the centers could benefit from rehabilitation work, however cholera treatment needs to be increasingly mainstreamed in regular health facilities	PAHO/WHO/MSPP

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF IOM	5. CERF grant period:	UNICEF 26.03.14 – 31.12.14 IOM 25.03.14 – 31.12.14
2. CERF project code:	14-UFE-CEF-013 14-UFE-IOM-007	6. Status of CERF grant:	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Water and sanitation		
4. Project title:	Improving sanitation and hygiene in IDP camps		

7.Funding				
	a. Total project budget:	US$ 1,815,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 1,510,107	▪ *NGO partners and Red Cross/Crescent:*	US$ 174,908
	c. Amount received from CERF:	US$ 1,510,107 (UNICEF US$1,375,103 IOM US$135,004)	▪ *Government Partners:*	US$ 263,995

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	55,352	51,542	Due to the progressive reduction of camps with latrines in the first quarter of 2014, the project provided services in 116 camps instead of 135. The reduction of camps is due to the relocation of 19 camps with latrines which also induced a slight reduction of the number of people assisted by the project. This explains the difference between the number of planned beneficiaries and the number of beneficiaries reached.
b. Male	51,094	47,578	
c. Total individuals (female + male):	106,446	99,120	
d. Of total, children under age 5	12,773	11,894	

9. Original project objective from approved CERF proposal

Ensure minimum standards sanitation and hygiene to reduce the risk of cholera outbreaks and other water borne and/or water related diseases in IDP camps and adjacent areas.

10. Original expected outcomes from approved CERF proposal

1. Human excreta in 135 IDP camps with functioning latrines is contained and disposed of safely, preventing and reducing the transmission of excreta-related diseases, including cholera.
   - **Indicator 1:** Percentage of camps with functioning latrines in which desludging and disinfection were carried out (target 135 IDPs camps with latrines in Port-au-Prince area);
   - **Indicator 2:** Contract signed with private sector for desludging all functional latrines in 135 camps;
   - **Indicator 3 :** 4,100 drums medium volume extracted per month
   - **Indicator 4:** Percentage of camps in which WASH indicators are monitored regularly. Target: 100 per cent of IDP camps in the metropolitan area of Port-au-Prince monitored on a monthly basis;

2. 106,446 people in camps have benefited from latrines maintained and repaired properly.
   - **Indicator 1:** Number of latrines repaired in 2014 that remain functional over the course of 2014. Target: 90 per cent of repaired latrines remain functional in 90 per cent of targeted camps;
   - **Indicator 2:** Percentage of latrines which are decommissioned in camps (that close, where the structures are not handed

over to the community. Target: 100 per cent of latrines in camps that close are decommissioned;

3. Solid waste management is increased and has contributed to reduce vectors for the transmission of fecal-oral and other diseases

   - **Indicator 1:** Percentage of camps identified with severe problems of accumulated waste receiving a once -off clean up that removes accumulated waste. Target: 100 per cent of camps receive a once-off clean up that removes accumulated waste;
   - **Indicator 2:** Number of people sensitized on hygiene and waste collection.

4. Hygiene promotion is strengthened, increasing knowledge and behavior that reduce the transmission of diseases
   - **Indicator 1:** Percentage of camps in which Camp committees and DINEPA agents receive training and support from NGO partners for hygiene promotion. Target: In 100 per cent of the camps, Camp committees and/or DINEPA agents receive training and support for hygiene promotion;
   - **Indicator 2:** Percentage of IDP camps in which Cholera alerts are responded to within 48 hours: Target: cholera response provided within 48 hours within 100 per cent of IDP camps in the Port-au-Prince area (total 135 camps);
   - **Indicator 3:** Contracts of NGO partners for sensitization.

11. Actual outcomes achieved with CERF funds

1. Human excreta in 135 IDP camps with functioning latrines is contained and disposed of safely, preventing and reducing the transmission of excreta-related diseases, including cholera.

- Indicator 1: Percentage of camps with functioning latrines in which desludging and disinfection were carried out (target 135 IDPs camps with latrines in Port-au-Prince area).

The project has worked in 116 camps with latrines instead of 135 because of the relocation of 19 camps with latrines in the first quarter of 2014. 100 per cent of these camps have benefited from desludging and disinfection by JEDCO, IOM, SI or International Rescue Committee (IRC), under the coordination and follow-up of DINEPA and UNICEF. IOM specifically worked in 17 camps from March to September 2014, conducting desludging and disinfection activities.
A bi-weekly meeting with partners was held at UNICEF office to coordinate the desludging and sanitation improvement activities.

- Indicator 2: Contract signed with private sector for desludging all functional latrines in 135 camps.

UNICEF and IOM subcontracted private sector companies having the equipment required and specialized in desludging to perform these activities. Mister Clean and Clean Tech were subcontracted by IOM for the desludging of functional latrines in 17 camps. JEDCO SA was subcontracted by UNICEF for the desludging and disinfection of functional latrines in 71 camps (including 13 camps of SI). A total of 88 camps benefited from latrines desludging services with CERF funds. JEDCO SA produced a weekly follow-up table of camps latrines desludged, cross-checked by DINEPA and UNICEF officers.

- Indicator 3: 4,100 drums medium volume extracted per month.

The initial estimation, as stated in the proposal, was 4,100 drums extracted per month in 135 IDPs camps of Port-au-Prince metropolitan area. Due to the progressive reduction of camps to be desludged by our partner along the year, the number of drums to be extracted has been reduced. On average, the number of drums for the entire year is 2,500 per month (424 drums per month from March to September for IOM, the remaining by UNICEF). Latrine desludging was regularly carried out by some UNICEF's and IOM's partners, with a result by 16 December of about 30,000 drums (6,000 m^3) desludged in camps.

- Indicator 4: Percentage of camps in which WASH indicators are monitored regularly. Target: 100 per cent of IDP camps in the metropolitan area of Port-au-Prince monitored on a monthly basis.

A DINEPA survey on basic WASH conditions in camps is performed on a monthly basis (due to internal issues with their survey software, DINEPA only produced 6 WASH reports in 2014). The survey was last updated in November 2014 following a survey in the remaining 84 camps, for a population of 64,826 persons.

2. 106,446 people in camps have benefiting from latrines maintained and repaired properly.

- Indicator 1: Number of latrines repaired in 2014 that remain functional over the course of 2014. Target: 90 per cent of repaired latrines remain functional in 90 per cent of targeted camps.

According to the DINEPA survey last published in November 2014, 72 per cent of the existing latrines in the 84 camps visited are functional, with an average number of users per latrine of 86. IOM repaired 77 pits for latrines and latrines were rehabilitated in 4

camps, while Solidarités International rehabilitated 144 latrines in 7 camps.

- Indicator 2: Percentage of latrines which are decommissioned in camps (that close, where the structures are not handed over to the community. Target: 100 per cent of latrines in camps that close are decommissioned.

Apart from IOM, there are other partners involved in the decommissioning (Goal, IRC, SI, etc.). All closed camps were decommissioned (100 per cent). As part of the project, all of the camps decommissioned by IOM with CERF funds were camps that were also closed by IOM. 11 camps have been decommissioned in total with CERF. Toilets are systematically decommissioned following the closure of camps.

3. Solid waste management is increased and has contributed to reduce vectors for the transmission of fecal-oral and other diseases

Indicator 1: Percentage of camps identified with severe problems of accumulated waste receiving a once -off clean up that removes accumulated waste. Target: 100 per cent of camps receive a once-off clean up that removes accumulated waste.

Cleaning kits purchased with CERF funds were distributed in 34 camps by IRC and SI. These distributions were accompanied by mass sensitization on the environment and waste management.

In addition, in September 2014, IOM coordinating with the French Red Cross has conducted a one-off thorough clean-up of two remaining large IDP camps in the metropolitan area of Port-au-Prince: Acra Nord and Acra Sud. IOM teams conducted a thorough clean-up of solid waste surrounding latrines and cleared access for camp residents to access the latrine facilities. In June 2014, SI conducted a cleaning campaign in 1 camp benefiting to 600 people by collecting 12 m3 of solid wastes.

- Indicator 2: Number of people sensitized on hygiene and waste collection.

About 80 camps benefited from a campaign of waste collection. Partners undertook 141 mass sensitization activities on waste management throughout the year for 9,431 people including camp committees. Most of these activities have been carried out during the celebration days: United Nations Day, World Environment Day, National Child Day, and Summer camps for children and youth, Global Handwashing Day, World Toilet Day, International Children's day.

In addition, other sensitization sessions have been carried through focus groups and door-to-door visits. The population in camps is informed on the safe usage of water, the importance of Hand washing after the use of latrines and before eating, as well as safe food handling and other basic hygiene practices. IOM Hygiene Promotion teams conducted 135 mass sensitization activities throughout the year, counting with 4,785 participants, including camp committees. As such, 126 focus groups reached 2,351 persons; 624 door-to-door visits sensitized 1,642 individuals; and 157 participated and received training in a total of 4 workshops.

4. Hygiene promotion is strengthened, increasing knowledge and behavior that reduce the transmission of diseases

- Indicator 1: Percentage of camps in which Camp committees and DINEPA agents receive training and support from NGO partners for hygiene promotion. Target: In 100 per cent of the camps, Camp committees and/or DINEPA agents receive training and support for hygiene promotion.

The project conducted four workshops and 15 focus group discussions. A total of 308 people were trained (community volunteers and committee members). 396 members of camps committees with 255 community hygiene promoters were trained. According a final survey done by SI, 72 per cent of the trained people are able to identify the routes of transmission and protection measures against feco-oral diseases, 69 per cent passed the "cholera written test" and 60 per cent passed the "protection test".

SI conducted focus-group discussions with camps committees' members on specific issues (water treatment, handwashing, food hygiene, latrines use and maintenance) for 343 persons (152 women, 147 men).

IOM conducted sessions with 53 committees' members in three camps: Mega 5, Radio Commerce and Corail Sector 3. Through sessions that lasted from 09h00 until 16h00, they learnt basic concepts regarding hygiene and sanitation, as well as the importance of latrines in communities and the damaging effects poorly maintained latrines could have on health and the environment. In order to encourage the participation of camp committees and camp residents in the sensitization activities, additional leisure activities were also organized to celebrate the International Latrine Day. More information on these activities may be found in Annex 3 of this report, as well as in the following link: https://www.facebook.com/IOMHaiti/posts/743047515750790

- Indicator 2: Percentage of IDP camps in which Cholera alerts are responded to within 48 hours: Target: cholera response provided within 48 hours within 100 per cent of IDP camps in the Port-au-Prince area (total 135 camps).

100 per cent (116 camps) covered. With the complementary financial support of ECHO, SI was able to answer to all cholera alerts in the camps. With the financial support of CERF, SI worked in 3 camps (New Life Village, Santo 17, Village Eden) responding to 8 alerts in November 2014 (no previous alerts were reported).

- Indicator 3: Contracts of NGO partners for sensitization.

Sensitization sessions have been carried out by the partners involved in the project implementation: IOM, SI, Croix-Rouge Française (CRF), IRC and DINEPA.

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

Due to the progressive reduction of camps with latrines in the first quarter of 2014, the project provided services in 116 camps instead of 135. The reduction of camps is due to the relocation of 19 camps with latrines which also induced a slight reduction of the number pf people assisted by the project. This explains the difference between the number of planned direct beneficiaries and the number of beneficiaries reached.

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 or 2b): 2a. Gender equality was ensured in the recruitment of health teams and most of partners' mobile teams were comprised of 50 per cent of women.

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

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. The project was monitored throughout the year through coordination meetings, field visits, and DINEPA bi-monthly WASH indicators survey.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	IOM UNOPS WHO	5. CERF grant period:	IOM 01.04.14 – 31.12.14 UNOPS 09.04.14 – 31.12.14 WHO 02.04.14 – 31.12.14
2. CERF project code:	14-UFE-IOM-006 14-UFE-OPS-001 14-UFE-WHO-008	6. Status of CERF grant:	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Health		
4. Project title:	Reinforcement of the response to cholera outbreaks in all Departments mainly in those considered high priority and support to the national coordination for cholera response in the Ministry of Health		

7.Funding			
	a. Total project budget:	US$ 6,081,766	d. CERF funds forwarded to implementing partners:
	b. Total funding received for the project:	US$ 5,340,571	▪ *NGO partners and Red Cross/Crescent:* US$ 1,400,000
	c. Amount received from CERF:	US$ 2,692,511 (IOM US$587,403 UNOPS US$500,129 WHO US$1,604,979)	▪ *Government Partners:* US$ 0

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	23,400	225,779	The number of alerts and cholera cases was very low during the first three quarters of 2014, which allowed partners to focus more intensely on mass cholera sensitization and health promotion activities to foster behavioural change that prevent cholera transmission. Activities also centered on the development and strengthening local networks for early warning and response to support proactive cases search, timely and better tailored response and often to address the weaknesses of local staff in terms of application of treatment protocols, detection of cases, etc. These activities helped reach a much higher number of beneficiaries in all targeted departments of intervention. This was critical to support timely response capacity as the number of alerts and new cases of acute diarrheal diseases increased after September.
b. Male	21,600	165,635	
c. Total individuals (female + male):	45,000	391,414	
d. Of total, children under age 5	5,850	4,194	

9. Original project objective from approved CERF proposal

To ensure a timely and effective multisectorial response to cholera outbreaks to contribute to the reduction of the cholera-associated mortality and morbidity in all departments mainly in those considered as priorities.

10. Original expected outcomes from approved CERF proposal

Outcomes
1. Cholera outbreaks are detected and responded to in a timely manner, within 48 hours.

2. Coordinated multisectorial response to any cholera or diarrheal disease outbreak in Haiti ensured

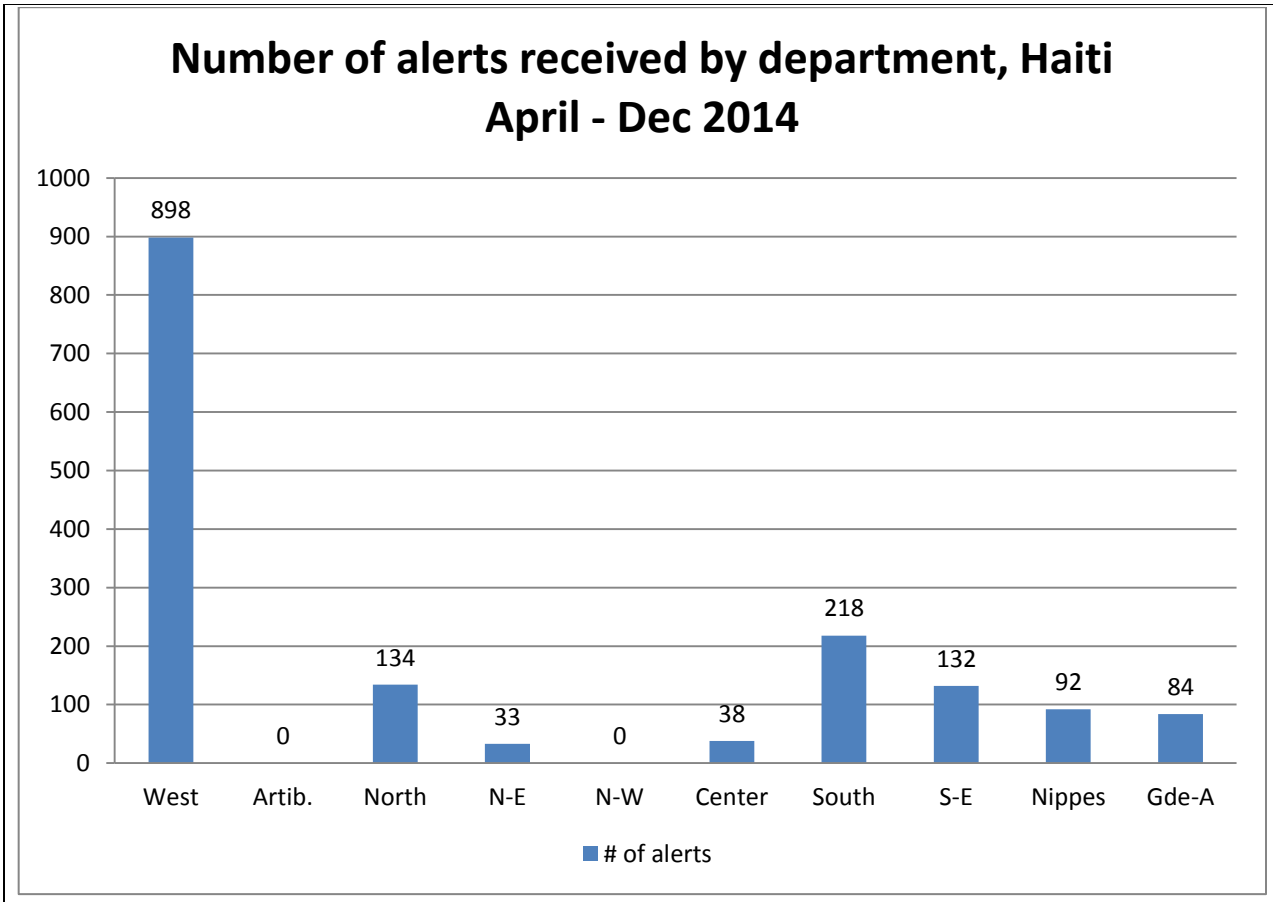
Indicators
1.1. At least 85 per cent of suspected cholera outbreaks are investigated and responded to, when needed, within 48 hours
1.2. Cases of acute diarrhoea tested when detected in the 85 per cent of the response to alerts. Data collection and transmission of information ensured
1.3. Early warning and response system created and functioning at the end of the project on each department of intervention including central level
1.4. 15 medical mobile teams equipped with medical and WASH supplies to ensure first response
1.5. 375 health staff trained on data collection, cholera treatment protocols, corpse management and supplies and stockage
1.6. 95 per cent of alerts responded include sensitisation campaigns at community level
1.7. Number of alert and response reports shared with multisectorial partners

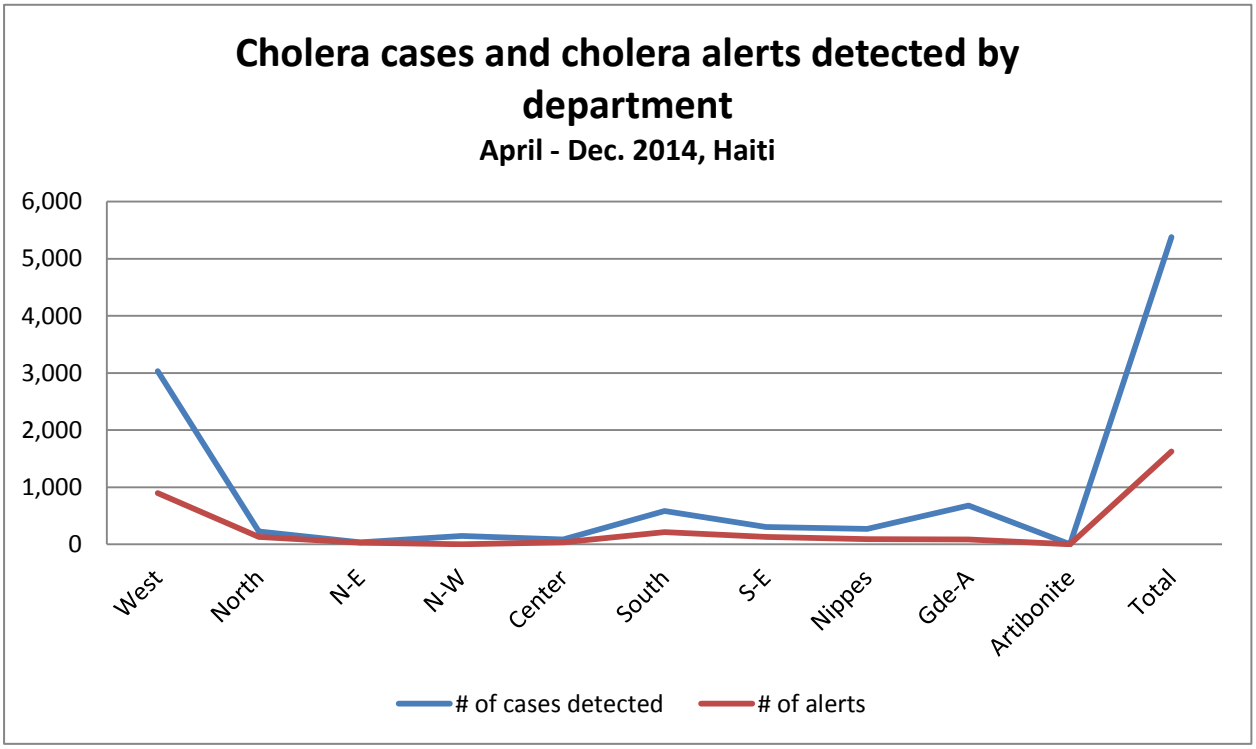
11. Actual outcomes achieved with CERF funds

Outcome 1: Cholera outbreaks are detected and responded to in a timely manner, within 48 hours.

Indicators
1.1. At least 85 per cent of suspected cholera outbreaks are investigated and responded to, when needed, within 48 hours
100 per cent of alerts of suspected cholera outbreaks were investigated and responded to within 48 hours when needed
During the implementation period of the project, a total of 1,629 alerts were received by field partners in the different targeted departments. All alerts detected were investigated by partners and health authorities and 99 per cent of alerts received a response within 48 hours of reception of the alert by the deployed mobile field teams funded by this project or other active partners in the field.

- 263 alerts were received in the West department by UNOPS,
- 38 cholera alerts in the Central Department received by MdM-A,
- 187 alerts received by IOM in the South-east and West departments. All alerts were investigated and 167 received a response by IOM (89 per cent)
- 167 alerts were received by IMC in the North and Northeast departments. All were investigated and responded to in 24 hours
- 310 alerts received by MdM-B (92 in Nippes and 218 in the South department), corresponding to a total of 857 suspected cholera cases detected during response interventions. Response was provided within 48 hours, in coordination with SI in Nippes, ACTED in the South and the respective departmental Equipe Mobile d'Intervention Rapide (EMIRA).
- 580 alerts were received by MdM-E in the Palmes region (West department). All 580 alerts were investigated and reported to health authorities. 260 (45 per cent) were responded to directly by MdM-E within less than 48 hours (including 8 joint responses with WASH partners and the MSPP's EMIRA). The rest of the alerts were responded by other partners.
- 84 alerts were received, investigated and responded to by MdM-F in the Grand' Anse department between April and December 2014.





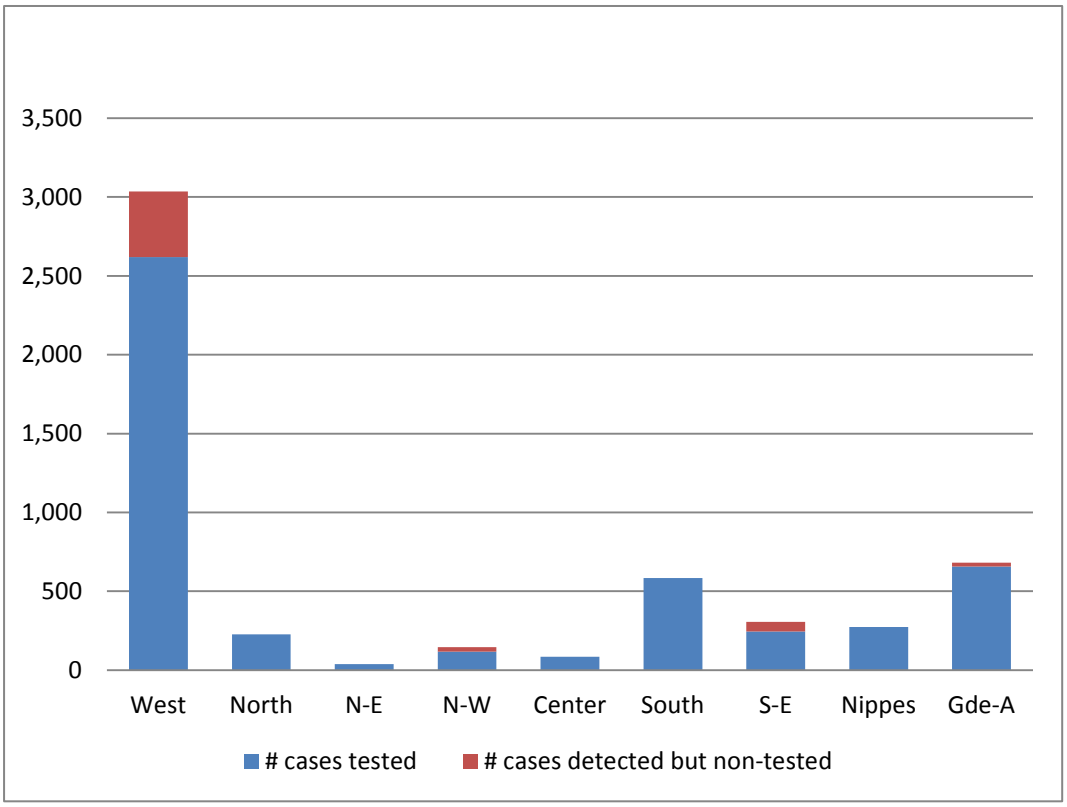
1.2. Cases of acute diarrhoea tested when detected in the 85 per cent of the response to alerts. Data collection and transmission of information ensured

90 per cent of detected cases of acute diarrhoea (suspected cholera cases) were tested.

The CERF project helped improve the availability and systematization of the use of rapid cholera tests by field teams and cholera

facilities:

- In the Central department, rapid cholera tests were applied to all suspected cases of cholera by MdM Argentina.
- In the West department, Rapid Diagnostic Tests (RDT) were used on 80 per cent of the 2,018 cases of acute diarrhoea detected during the 89 per cent of alerts that were responded to by IOM. Data collection and transmission of information was 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.
- In the North and Northeast department, all suspected cholera cases were tested by IMC mobile teams in the field, or at institutional level (CTC/CTU) using the rapid cholera tests procured by IMC. During the implementation of the project, 266 cases of acute diarrhoea were detected and tested during response to alerts by IMC mobile teams (38 in the northeast and 228 in the North department), out of which 250 tested positive and received treatment and 16 tested negative.
- In the Nippes and South departments, MdM-B organised training sessions with MSPP for the 38 health providers of cholera services in Nippes and 85 providers in the South. At this occasion, departmental laboratory technicians conducted a theoretical and practical session on the use of RDT. They were distributed to health infrastructures in both departments to support their systematic use.
- In the region of Les Palmes in the West department, MdM-E provided support and training at institutional level in 11 health centers to systematize the use and analysis of rapid cholera tests. Over 98 per cent of the cases of acute diarrheal diseases received were tested (1,004 out of the 1,017 cases attended were tested, out of which 838 tested positive).
- In the Grand' Anse department, MdM-F supported health authorities and treatment centers in the availability and use of RDT to facilitate the early detection of cholera cases and support timely response while waiting for laboratory confirmation. 31 health professional in 25 health centers were trained in the use of the RDT. 681 cases of acute diarrhea were detected between April and December 2014, out of 657were tested with RDT (96 per cent) and 625 were positives.
- In the Northwest department, 117 of the 146 detected cases of acute diarrhea were tested (80 per cent).



Department	# of cases detected	# cases tested
West	3,035	2,619
North	228	228
N-E	38	38

N-W	146	117
Center	86	86
South	584	584
S-E	306	245
Nippes	273	273
Gde-A	681	657
Artibonite	N/A	N/A
Total	**5,377**	**4,847**
		90.14 per cent

1.3. Early warning and response system created and functioning at the end of the project on each department of intervention including central level

Networks of early warning and response systems were established and strengthened by field partners at departmental, communal and local level.

- In the Central Department, MdM-A established and supported eight (8) community networks of 184 health agents which were trained in the early warning system for the registration of alerts in preparedness for the rainy and hurricane seasons to support the rapid detection and communication of suspected cases of cholera and other post-heavy rains diseases.
- IOM trained 359 focal points included 164 focal points in IDP camps and border areas of the West department, 195 community health focal points in the South east department and 142 brigadiers/focal points in Artibonite to support detection and reporting of suspected cholera cases and other public health threats. This approach has been an instrumental element in early warning and response systems given that most of the cholera cases occurred in isolated areas, both within communities and vulnerable IDP camps. Through this established network, the focal points were able to provide IOM with timely information of alerts in the community and IDP camps and enabled the deployment of mobile rapid response teams within 48 hours. By the middle of the project implementation, the departmental and communal health authorities had taken the lead in the alert and response system through the established network and coordinated/relayed the information to its Health/WASH partners. IOM, in collaboration with WASH partners, supported the departmental authorities by transmitting alerts received from the communal and local level to departmental authorities.
- In Nippes and the South department, MdM-B strengthened early warning community networks to support epidemiological surveillance and increase coverage. The 262 members of the 32 sub-networks in the department of Nippes and 304 members of the 34 sub-networks in the South department were trained in epidemiological detection and WASH and health practices for cholera response. They were provided with supplies and equipment for the decontamination health promotion activities in areas where outbreaks were detected (sprayers, buckets, personal protection equipment, soaps, ORS and stretchers to transport the weakest patients to cholera treatment facilities), as well as SIM cards to communicate with health structures and transfer alerts and epidemiological data.
- In the region of Les Palmes, in the West department, MdM-E has established two community networks (Léogane and Petit Gôave) of a total of 161 community volunteers which were trained in data collection and information sharing to support surveillance and early warning capacity at community level. Topics focused on the importance of epidemiological surveillance, communication mechanism for the management of alerts, signs and symptoms of cholera, hygiene measures including decontamination of patients' homes, use of ORS, drinking water chlorination etc. Supervision visits and training were also provided in all 11 health structures to strengthen data management and reporting and support the early warning and response system.
- MdM-F, in partnership with other cholera response actors, established a common epidemiological database for the collect and data management of cholera cases. The collected data was analysed weekly with health authorities to identify areas of persistence and tailor field response interventions. 3,500 identification forms were also provided to health centers to improve the registration of cholera patients and data collection at institutional level.
- 406 volunteers of the Direction de la Protection Civile (DPC) and the departmental epidemiological surveillance network in Grand' Anse were trained in the importance of epidemiological surveillance, communication mechanism for the management of alerts, signs and symptoms of cholera, hygiene measures including decontamination of patients' homes, use of ORS, drinking water chlorination to support real-time information and timely response. The community early warning networks were provided with basic supplies and equipment to support first response to the detected alerts such as chlorine, ORS, etc. In addition, five sentinel sites were established at commune level (Anse Macon, Doco, Annette, Linton, and Lacombe) by MdM-F and the Direction Sanitaire de la Grande Anse (DSGA) to support first response to new cases in these areas and sensitization activities.
- 48 community volunteers of 5 communes of the Northwest department were identified and trained by MdM-C to form part of community cholera response networks. Volunteers were trained on cholera detection and data collection, chlorination,

good hygiene practices and sensitization.

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1.4. 15 medical mobile teams equipped with medical and WASH supplies to ensure first response

21 medical mobile teams equipped with medical and WASH supplies were mobilized to ensure first response
A total of 21 mobile health teams equipped with medical and WASH supplies were deployed to cover all 10 departments of the country to provide timely and adequate response to cholera outbreaks. Mobile teams ensured the detection of alerts, facilitated the rapid investigation of suspected cholera cases and other potential health threats, and provided coordinated response to the confirmed alerts including sensitization and awareness campaigns, distribution of supplies, visits and decontamination of homes in areas where cholera cases where detected (1,074 houses in the West department –UNOPS, 214 houses in the Central plateau – MdM-A,), referral of patients and even transportation of patients in some cases.

- 3 mobile health teams were deployed in the West department by UNOPS
- 2 mobile health teams comprised of one doctor, one nurse, one health promotion expert and one logistician were deployed in the Central department by MdM-A. These teams organized 86 health care delivery days targeting the provision of basic health care services and health promotion activities, which benefited a total of 495 families living in communities where cholera cases where detected.
- 7 mobile teams were deployed by IOM to support rapid response in three (3) departments: two teams in the South East department, three teams in the West department (including one joint team with Direction Sanitaire de l'Ouest (DSO) /EMIRA and UNOPS and two temporary teams in Artibonite to support response to new outbreaks in St Michel de l'Attalaye and Ennery, in collaboration with WASH partners. Teams were comprised of one or two nurses equipped with medical and non-medical items and brigadiers to conduct investigation/ verification of case management, assessment of CTC/CTU, decontamination of affected households, sensitizations and mass awareness, distribution of cholera related items such as aquatabs, soaps and Information, Education, Communication (IEC) materials (flyers, "Chimen lakay" magazines with key messages on cholera prevention and medical items (Ringer lactate, Perfusion set, I.V catheter, Doxicycline, Zinc, Glucose DW 50 per cent,Azitromicyn, HTH). In certain cases, teams established ORP+ in affected areas with difficult access to other treatment options. Furthermore, when there was a need for additional medical staff within the local health care facility (CTC/UTC and CDTA), IOM rapid response nurses are made available to support the existing staff with reception of new patients, case management and organizing the health care facility.
- 2 mobile teams – one based in Cap Haitien in the North department and one based in Fort Liberté in the Northeast department – were deployed daily by IMC to support active search of diarrheal cases, and investigation and rapid response to detected alerts. Each team was comprised of one doctor, one nurse, one health promotion agent and one driver. Two additional nurses were recruited in August 2014 to provide support to the CTU of Plaisance to attend cholera patients at night and on weekends.
- 2 mobile teams in Nippes and the South department mobilized by MdM-B.
- 2 mobile teams each comprised of two nurses and one health agent were deployed by MdM-E in the region of Les Palmes to support the DSO in the rapid response to alerts and cholera outbreaks. The two teams were also supported by one doctor, one coordinator and a logistician to facilitate the application of treatment protocols, trainings and support procurement of health and medical supplies to health centers.
- 2 mobile teams each comprised of two nurses and one health agent were deployed by MdM-F to support rapid response to received alerts in the department of Grand' Anse.
- 1 mobile team comprised of two nurses and 1 logistical administrator was mobilized in Port-de-Paix in the Northwest department by MdM-Canada to support cholera response operation of the Direction Sanitaire du Nord-Ouest (DSNO) and other partners.

1.5. 375 health staff trained on data collection, cholera treatment protocols, corpse management and supplies and stockage

776 health staff were trained on data collection, cholera treatment protocols, corpse management and supplies, storage inventory and other essential topics to control and prevent cholera outbreaks. Cholera treatment health facilities were also supported through the continued provision of medical and non-medical supplies for cholera case management, as well as the recruitment of additional health staff to support health care delivery capacity during outbreaks.

- 419 health personnel were trained by IOM in the West and South-east departments, including 359 health focal points, 22 brigadiers, 30 nurses/auxiliary nurses and 8 hygienists. The training activities targeted two categories of professionals: medical personal in the CTC/CTU/CTDA and community health workers (brigadiers, hygienists, nurses and auxiliary nurses). The training aimed to build or reinforce local capacities in the areas of adequate use of cholera rapid tests, proper application of standard guidelines and treatment protocols, safe management of collected samples (specimen) and rapid testing of suspected cholera cases. Oral Rehydration Point (ORP+) staff were trained on cholera modules (clinical signs and symptoms, mode of transmission, decontamination and key prevention messages focusing on water treatment, hand washing, hygiene practices).
- 123 health care professionals were trained in Nippes (38) and the South (85) on cholera treatment management and the use of rapid tests.

- 39 health professionals and hygienists in the region of Les Palmes (West) were trained or re-trained by MdM-E in management of cholera, stock management, waste management, organization of a CTC / UTC and epidemiological monitoring tools.
- 111 health centers personnel were trained in cholera care delivery, data collection, waste and stock management, organization of a CTC / CTU and epidemiological monitoring tools by MdM-F in the Grand' Anse department. In addition, MdM-F organized 18 simulation exercises at community level for the installation of tents and temporary cholera treatment structures and trained 36 community leaders in the management of contingency stocks.
- 148 health personnel and community workers were trained on cholera treatment protocols and case management in the Northwest department by MdM-C, including 52 nurses and nursing assistants in the communes of Port-de-Paix, Anse-à-Foleur, St. Louis North, Mole St. Nicolas, Jean Rabel and Turtle Island; 84 brigadiers in the communes of Port-de-Paix, Jean Rabel and Mole St Nicolas and 10 members of the departmental EMIRA and 2 nurses of MdM-C.

1.6. 95 per cent of alerts responded include sensitisation campaigns at community level

99 per cent of alerts responded to (1,609 alerts in total out of 1,629 total) included or were followed-up by sensitisation and health promotion activities at community level

One of the key pillars of the National Cholera Elimination Plan of the MSPP is cholera promotion and prevention. Sensitization through education or health information on cholera preventive measures has been one of the priorities of health partners' interventions to support the reduction of cholera prevalence and mortality.

All alerts responded to included sensitization and awareness campaign to promote good hygiene and sanitation practice and improve knowledge about cholera transmission risks and preventive measures. Awareness campaign were carried out in schools, churches, public markets and neighbourhoods, either through door to door community outreach or public talks in larger groups. Sensitization activities included demonstration of the use of aquatabs and preparation of ORS, discussions, distribution of flyers, etc. These activities were accompanied by the distribution of cholera kits with soap, aquatabs and oral solutions, chlorine for proper disinfection, personal protection kits for community workers, oral rehydration solutions, etc.

- In the West department, UNOPS conducted sensitization and health promotion activities in 71 schools, 7 cholera treatment centers, 6 local associations and 4 governmental institutions, reaching a total of 160,020 people. UNOPS mobile teams also trained 36 people from local organizations in cholera prevention practices and procured cholera kits to 13,655 individuals located in areas where cholera outbreaks were detected
- In the Centre department, MdM-A, through its networks of community health agents, conducted hygiene promotion and cholera prevention activities at community level along with the healthcare days organized by the mobile teams. Agents distributed prevention and promotion materials, organized public talks with the local population and procured hygiene and sanitation items.
- In the West and South-east department, to encourage the targeted beneficiaries in IDP camps and in vulnerable communities to adopt good hygiene practices, IOM conducted health promotion activities that included 8,824 door-to-door home visits and 351 sensitizations sessions in market places, inside the IDP camps, churches, schools and inside the vulnerable communities that reached 13,136 beneficiaries. Beneficiaries included children, youth, and pregnant women, persons with limited mobility, elderly and adults. Following the sessions, flyers with the key messages on cholera prevention and some items such as aquatabs or soaps are distributed to the participants.
- In the North and Northeast departments, IMC field teams reached a total of 63,085 people, including 27,974 men and 35,111 women, through sensitization and health promotion activities during preventive community visits and response to alerts in 27 communes. The teams also distributed supplies including 13,478 bags of ORS, 164,990 tabs of aquatabs, soap, 1,792 pamphlets. Teams also performed disinfections of 293 latrines and 184 homes and supported the field teams of the MSPP to strengthen prevention and sensitization efforts during Carnival and other community festivities.
- In the South and Nippes departments, MdM-B conducted 20 mass sensitization sessions for cholera prevention during local festivals and response to alerts, which included the installation of sensitization and health promotion banners in public places, the distribution of aquatabs, ORS, soap, community demonstration of good practices and use of the procured supplies, installation of hand-washing stations, distribution of flyers and T-shirts with hygiene messages, organization of focus groups to discuss good hygiene practices as well as radio spots broadcasted on local radio channels. These interventions reached out to a total of 35,918 individuals.
- In the West department, in the region of Les Palmes, MdM-E implemented a sensitization, prevention and decontamination strategy at community level which resulted in 12,050 individuals sensitized about cholera risks and preventive practices through door-to-door visits and public talks (including 5,157 men and 6,893 women), 43,695 aquatabs, 1,931 soaps and 2,221 hygiene kits distributed and 1,001 homes and 408 latrines decontaminated. These interventions were complemented by mass sensitization campaigns through two local radio stations and a TV channel for the daily broadcasting of prevention messages (5 times a day), the organization of cholera sensitization shows. Mass sensitization activities carried out by MdM-E reached a total of 52,047 people (27,078 women and 24,969 men).
- MdM-F conducted sensitization sessions at community level through the project, using mass sensitization strategies, public gathering and home visits. 270 community sensitization activities were carried out for a total number of beneficiaries of 64,624 people. Door-to-door visits help further support prevention efforts. Each home was systematically

visited at least three times to ensure sustainable behaviour change. Mass sensitization campaigns were organized with five radio stations to broadcast messages on cholera transmission modes, prevention measures and management of dead bodies (on average five time a day) as well as special shows on cholera prevention during the global hand-washing week.

Outcome 2: Coordinated multisectorial response to any cholera or diarrheal disease outbreak in Haiti ensured

1.7. Number of alert and response reports shared with multisectorial partners

All reports produced by partners on alert and response activities were shared with multisectorial partners
Since the beginning of the project, communication and coordination with all cholera response actors was strengthened. Meetings at local and central level were carried out with the MSPP, DINEPA and all active field partners to ensure that everyone was informed of the presence and interventions carried out by each partner.

- MdM-A carried out meetings with local health centers and departmental health authorities to improve coordination between field teams and fixed health infrastructures, developed a communication network with 4 cholera treatment facilities and established a local operational office in Lascahobas and a network of 32 community oral rehydration points to support cholera response and information management. Bi-weekly meetings were organized with the MSPP cholera coordinator of the department of the Center and shared all 38 reports on cholera detected alerts and referred cases to CTC. Despite much improvement, epidemiological information sharing and operational coordination with the departmental cholera coordinator of the MSPP remains a challenge.
- UNOPS shared 100 per cent of its weekly activity reports with multisectorial partners to improve information sharing and reduce duplication of activities. 15 joint and coordinated interventions between UNOPS, the CRF, IOM, UNICEF and the MSPP were also carried out.
- On a daily or weekly basis, IOM shared reports on the alerts received (new cases, deaths) and response provided with key partners including the DSO/Direction Sanitaire du Sud-Est (DSSE) and WASH actors in order to ensure effective coordination of the interventions and timely response to the alerts. IOM, together with WASH partners, responded to 89 per cent of the alerts received in both targeted departments (167/187) and a report of the response provided was issued following each alert and shared with the departmental sanitary directions and partners.
- In the North and North-east department, IMC participated regularly in the sectoral tables and coordination meetings with stakeholders and the different actors involved in the fight against cholera in order to avoid duplication in the responses. A weekly deployment plan containing details information about the mobile teams' areas of intervention for response to alerts, early case detection and prevention, was prepared and communicated to the Direction Sanitaire du Nord (DSN), Département Sanitaire du Nord-Est (DSNE), the EMIRA and others partners including PAHO / WHO teams. Regular coordination with heads of health infrastructures, community leaders was ensured via phone calls and meetings, as well as daily visits to treatment facilities to gather information on the geographical sources of cholera contamination. A daily report on new cases at CTC / CTU level was shared through e-mail and SMS with the departmental infectious diseases coordinators and other entities involved in the response.
- In the South and Nippes department, MdM-B developed common case management and reporting tools with other WASH and health actors in the field to facilitate coordination and information sharing with other key stakeholders. Regular sectorial tables were organized to facilitate a coordinated health response and a multisectorial operational framework with all WASH and health local response actors were established (common protocols and reporting tools developed, information sharing through interventions reports, joint deployment of health and WASH teams in 100 per cent of responses to alerts…). 100 per cent of field interventions were followed by the production of a joint WASH / health report which was shared with the departmental health directorates to provide real-time information to health authorities.
- In the West department, MdM-E shared 100 per cent of its reports on alert investigation and response with health authorities (DSO) and multi-sectorial response partners (WASH actors, EMIRA, etc.).
- In the department of Grande Anse, weekly meetings were held between MdM-F, ACTED and the DSGA to share information on epidemiological surveillance and alerts and bi-weekly meetings were organized with health and WASH actors to coordinate field cholera response.
- An investigation and response report was prepared jointly by MdM-F and WASH partners following each alert received in the Grand' Anse department. All reports were then systematically shared with departmental health authorities.

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

During the first three trimesters of 2014, cholera alerts were low and there were even weeks during which there were no reported cholera cases. During the dry season and these times of low incidence, partners' rapid response teams focused on the identification and training of community focal points to strengthen local capacity and address knowledge and capacity weaknesses through trainings, meetings, sensitization sessions and as well as assessments of health care facilities. During the final three (3) months of the project, cholera alerts started to increase, even quite significantly in certain areas, triggering the mobilization of the rapid

response team and trained local personnel to attend all the alerts received at commune-level.	
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 or 2b): 2a. Cholera epidemic affects both men and women they are treated as beneficiaries without gender considerations. However as women are responsible for safe water and hygiene in their families, sensitization activities reached more women than men. **If NO' (or if GM score is 1 or 0):**	
14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
This project has not been evaluated as a whole. However, most partners conducted individual evaluation of their intervention strategies, achieved results and challenges. Achievements reached thanks to CERF funds were also reviewed in the end-of-the-year assessment of the 2014 HAP and the identification of strategies for the 2015 transitional action plan for Haiti. Partners' self-assessment demonstrated that the activities carried out under this project were globally positive and successful. Interventions helped improve coordination with multisectorial response actors and facilitated the decentralization of the detection and response capacity through the establishment of community networks for epidemiological surveillance and first response. Activities directly targeting the local population were welcomed and well-received and help address some persistent myths about cholera transmission and promote preventive measures to a wider audience. However, important structural weaknesses remain which are significantly affecting progress and the capacity of response actors to control cholera outbreaks. In particular, the lack of access to water and sanitation infrastructures in many health centers and communes, combine with the demotivation of health staff and the isolation of rural communities, are many barriers to the potential elimination of cholera.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	26.03.14 – 31.12.14
2. CERF project code:	14-UFE-CEF-014	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Water and sanitation		☒ Concluded
4. Project title:	Support the national contingency plan to eliminate cholera by improving rapid response activities to reduce the number of suspected cholera cases and to cut the transmission		

7.Funding				
	a. Total project budget:	US$ 26,809,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 12,700,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 1,203,079
	c. Amount received from CERF:	US$ 2,002,614	▪ *Government Partners:*	US$ 148,519

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	23,400	14,242	MSPP and PAHO/WHO had targeted the number of potential patients to 45,000 for the year 2014. However, the interventions of the different actors involved in this project have reached 27,388 direct beneficiaries. In addition, 809,186 people (420,777 female and 388,409 male) were sensitized on hygiene promotion and have benefited cholera kits, hygiene kits, water treatment product, soaps, repairing water points, decontamination of homes etc.
b. Male	21,600	13,146	
c. Total individuals (female + male):	45,000	27,388	
d. Of total, children under age 5	5,830	3,560	

9. Original project objective from approved CERF proposal

Provide timely and adequate WASH and medical cholera response activities in the affected areas and where alerts are detected to reduce cholera-associated mortality and morbidity. Provide intense sensitization campaigns to change hygiene behavior and therefore contribute to cutting the transmission.

10. Original expected outcomes from approved CERF proposal

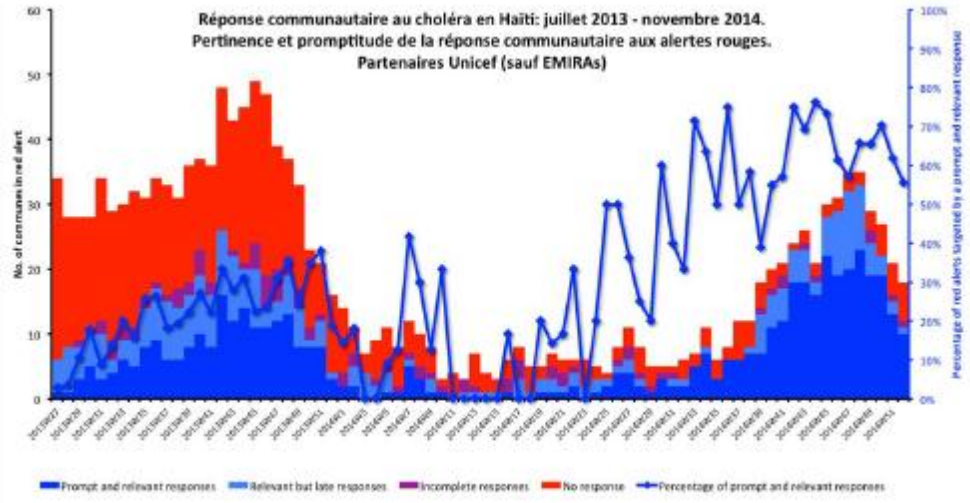
- Number of rapid response to cholera alerts coming from the MSPP and other communal sources are responded to; number of people sensitized
- Number of contacts between the health departments and the DELR transferring cholera data; number of stool samples tested at the National Laboratory
- Number of suspected cholera cases benefitting from quality treatment

11. Actual outcomes achieved with CERF funds

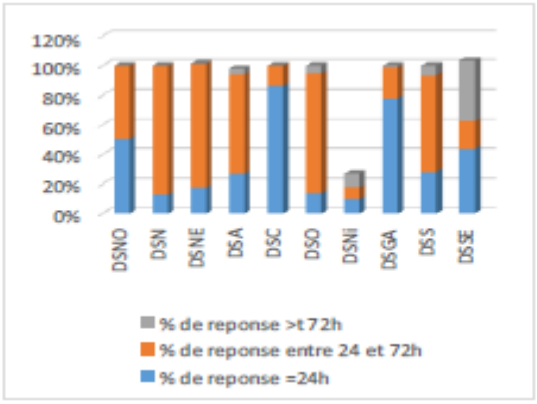
- Number of rapid response to cholera alerts coming from the MSPP and other communal sources are responded to; number of people sensitized

Through our 6 NGOs partners in the field and the EMIRA of MSPP, 1,878 responses to alerts were given and 3,861 homes were disinfected. UNICEF also supported the nationwide distribution of 18,418 cholera kits at the community level and 534 hygiene kits at cholera treatment center, the protection or quick fixing of 230 water points and the implementation of 527 bucket chlorination points in areas of cholera outbreak.

The graph below shows the relevance and promptness of the WASH responses between July 2013 and November 2014. It particularly shows a huge improvement in the partners' response between 2013 (beginning of the operation) and the second part of 2014, with most of the red alerts covered with relevant and/or prompt response (red bars means no response to a reported alert, while light blue stands for relevant but late (>48h) response, and dark blue is for prompt and relevant responses. When responses are noted relevant it means that the complete WASH package has been provided: quick epidemiological investigation, disinfection, hygiene sensitization, cholera kits distribution, and chlorination of water points when needed. The cholera kit is composed of: 12 soaps, 200 Aquatabs, 5 ORS, one optional bucket with tap.



As shown in the graph below, approximately 70 per cent of rapid response team interventions were done within 48 hours after an alert over the year. Between October to December 2014, only 7 per cent of the responses were done after 72 hours of an alert (source: UNICEF online monitoring tool).



Graph showing the WASH response promptness by department.

- Number of contacts between the health departments and the DELR transferring cholera data; number of stool samples tested at the National Laboratory

UNICEF performed the close monitoring of cholera outbreaks and accompanied the MSPP in the investigation of cholera alerts. UNICEF provided to the DELR means of communication; supplies for clinical cholera testing at the National laboratory and supported the operating costs of 13 technicians and two epidemiologists. UNICEF has subcontracted the University of Marseille to strengthen the epidemiological surveillance system, including data analysis.

Daily data on cholera were regularly sent by the departments to DELR which produced a weekly national bulletin regularly until October 2014. With the spreading of the disease between November and December, DELR capacity has been exceeded and bulletin became less regular. However, to overcome this constraint UNICEF and its partners coordinated directly with the departmental level to be informed of the daily cases and carry out appropriate responses.

Cholera rapid diagnostic tests were carried for about 60 per cent of all cases. Laboratory confirmation took place but faced some constraints. So far, the transportation process of stool samples to the National Laboratory is not effective in all departments because of a lack of transportation means and clear process from MSPP. However, about 6,000 confirmation tests by the national laboratory have been made in 2014, representing 22 per cent of the total number of suspected cases reported.

- Number of suspected cholera cases benefitting from quality treatment

20,392 suspected cases have been treated by either MSPP or private cholera treatment centers. UNICEF supported treatment facilities by delivering 81,000 litres of Ringer lactate, 5,100, 000 Aquatabs pils and 102,000 ORS, especially in support of EMIRA teams.

The institutional fatality rate is slightly less than in 2013 with 1.03 per cent, while WHO recommends a maximum of 1 per cent. (Cholera mortality is considered under controlled when it is at a maximum of 1 per cent.)

Indicator	2013	2014
Cholera incidence rate*	0.49 per cent	0.24 per cent
Cholera global fatality rate	1.2 per cent **	1.14 per cent *
Cholera institutional fatality rate***	1.07 per cent	1.03 per cent

*Source: Haiti 2014 Final Periodic Moniitoring Report

**Source: Cholera in Haiti. End in Sight. Decmber 2013

***Source: MSPP DELR National Surveillance Monitoring Report Week 51

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

MSPP and PAHO/WHO had targeted the number of potential patients to 45,000 for the year 2014. However, the interventions of the different actors involved in the fight against cholera have reduced this number to 27,388. Thereby, the project has reached 27,388 direct beneficiaries. In addition, people were sensitized on hygiene promotion (about 92,000 people through rapid response and an additional 467,000 people through preventive mass sensitization in schools, markets, churches, door to door etc.) and have benefited 18,418 cholera or hygiene kits, water treatment product, soaps, repairing water points, decontamination of homes etc.

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 or 2b): 2a. As cholera affects men and women equally, rapid response and prevention activities and surveillance are not ruled by gender considerations. Nevertheless, as women are responsible for safe water and hygiene practices in households, a special focus was given to them when conducting sensitization campaigns.

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

14. Evaluation: Has this project been evaluated or is an evaluation pending?

The project is part of the strategy developed by UNICEF in June 2013 to support the short-term component of the government's plan to eliminate cholera in Haiti. It is monitored regularly by the field missions organized by the UNICEF Cholera Specialists and University of Marseille subcontracted by UNICEF to support the implementation of the strategy. It will be evaluated after two years, i.e. by July 2015.

EVALUATION CARRIED OUT ☐

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Implementing Partner Name	Sub-grant made under pre-existing partnership agreement	Partner Type	Total CERF Funds Transferred to Partner US$	Date First Installment Transferred	Start Date of CERF Funded Activities By Partner*	Comments/Remarks
14-UFE-CEF-014	Water, Sanitation and Hygiene	UNICEF	MSPP/DELR	Yes	GOV	$148,519	13-Aug-14	21-Mar-14	This partner had cash advances to justify in the UNICEF financial system before receiving the amounts provided under the CERF.
14-UFE-CEF-014	Water, Sanitation and Hygiene	UNICEF	Solidarites International	Yes	INGO	$228,954	26-Nov-14	21-Mar-14	This partner had cash advances to justify in the UNICEF financial system before receiving the amounts provided under the CERF.
14-UFE-CEF-014	Water, Sanitation and Hygiene	UNICEF	Croix Rouge Francaise	Yes	INGO	$310,220	13-Dec-14	21-Mar-14	This partner had cash advances to justify in the UNICEF financial system before receiving the amounts provided under the CERF.
14-UFE-CEF-014	Water, Sanitation and Hygiene	UNICEF	ACF	Yes	INGO	$587,619	17-Dec-14	21-Mar-14	This partner had cash advances to justify in the UNICEF financial system before receiving the amounts provided under the CERF.
14-UFE-CEF-014	Water, Sanitation and Hygiene	UNICEF	Oxfam GB	Yes	INGO	$76,256	17-Dec-14	21-Mar-14	This partner had cash advances to justify in the UNICEF financial system before receiving the amounts provided under the CERF.
14-UFE-CEF-013	Water, Sanitation and Hygiene	UNICEF	DINEPA	Yes	GOV	$263,995	10-Jun-14	26-Mar-14	The partner could not receive new UNICEF funds in march 2014 due to the delay in the justification of the funds received in 2013.
14-UFE-CEF-013	Water, Sanitation and Hygiene	UNICEF	Solidarites International	Yes	INGO	$174,908	17-Jun-14	26-Mar-14	The partner could not receive new UNICEF funds in march 2014 due to the delay in the justification of the funds received in 2013.
14-UFE-WHO-008	Health	WHO	IMC	No	INGO	$250,000	5-May-14	21-Apr-14	IP has pre-financed the starting of its activities
14-UFE-WHO-008	Health	WHO	MdM-France	No	INGO	$250,000	5-May-14	21-Apr-14	IP has pre-financed the starting of its activities
14-UFE-WHO-008	Health	WHO	MdM-Canada	No	INGO	$250,000	5-May-14	21-Apr-14	IP has pre-financed the starting of its activities
14-UFE-WHO-008	Health	WHO	MdM-Belgium	No	INGO	$250,000	5-May-14	21-Apr-14	IP has pre-financed the starting of its

									activities
14-UFE-WHO-008	Health	WHO	MdM-Spain	No	INGO	$250,000	16-May-14	21-Apr-14	IP has pre-financed the starting of its activities
14-UFE-WHO-008	Health	WHO	MdM-Argentina	No	INGO	$150,000	5-May-14	21-Apr-14	IP has pre-financed the starting of its activities

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

Acronym	
ACTED	Agence de Coopération Technique et de Développement
CERF	Central Emergency Response Fund
CRF	Croix-Rouge Française
CTC	Cholera Treatment Center
CTDA	Centre de Traitement des Diarrhées Aigues
CTU	Cholera Treatment Unit
DELR	Direction de l'Epidémiologie, de Laboratoire et de la Recherche
DINEPA	Direction Nationale de l'Eau Potable et d'Assainissement
DSGA	Direction Sanitaire de la Grande Anse
DSN	Direction Sanitaire du Nord
DSNE	Direction Sanitaire du Nord-Est
DSNO	Direction Sanitaire du Nord-Ouest
DSO	Direction Sanitaire de l'Ouest
DSSE	Direction Sanitaire du Sud-Est
DPC	Direction de la Protection Civile
DTM	Displacement Tracking Matrix
ECHO	European Commission- Humanitarian Aid and Civil Protection
EMIRA	Equipe Mobile d'Intervention Rapide
ERC	Emergency Relief Coordinator
ERRF	Emergency Relief Response Fund
GOAL	Global Addiction Recovery Partners
GoH	Government of Haiti
HAP	Humanitarian Action Plan
HCT	Humanitarian Country Team
IDP	Internally Displaced Person
IEC	Information, Education, Communication
IMC	International Medical Corps
IOM	Internation Organization for Migration
IRC	International Rescue Committee
MdM-A	Médecin du Monde Argentine
MdM-B	Médecin du Monde Belgique
MdM-C	Médecin du Monde Canada
MdM-E	Médecin du Monde Espagne
MdM-F	Médecin du Monde France
MSPP	Ministère de la Santé Publique et de la Population
NGO	Non Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
ORS	Oral Rehydration Solution
ORP	Oral Rehydration Point
PAHO/WHO	Pan American Health Organization/World Health Organization
PROMESS	Programme de Médicaments Essentiels
RC/HC	Resident Coordinator/Humanitarian Coordinator
RDT	Rapid Diagnostic Tests
SI	Solidarites International
UN	United Nations

UNCT	United Nations Country Team
UNOPS	United Nations Office of Project Services
USD	United States Dollar
WASH	Water, Sanitation and Hygiene