ANNUAL REPORT
ON THE USE OF CERF GRANTS
NEPAL

Country	**Nepal**
Resident/Humanitarian Coordinator	**Robert Piper**
Reporting Period	**1 January 2010 - December 2010**

I. Summary of Funding and Beneficiaries

Funding	Total amount required for the humanitarian response:		**76,816,821.00 US$**
	Total amount received for the humanitarian response:		**3,624,829.00 US$**
	Breakdown of total country funding received by source:		CERF **1,949,760.61US$**[1] CHF/HRF COUNTRY LEVEL FUNDS **706,400.00US$** OTHER (Bilateral/Multilateral) **968,669.00US$**
	Total amount of CERF funding received from the Rapid Response window:		US$
	Total amount of CERF funding received from the Underfunded window:		**1,949,760.61US$**
	Please provide the breakdown of CERF funds by type of partner:	a. Direct UN agencies/IOM implementation:	**497,707.90US$**
		b. Funds forwarded to NGOs for implementation (in Annex, please provide a list of each NGO and amount of CERF funding forwarded):	**1,014,351.28US$**
		c. Funds for Government implementation:	**415,007.18US$**
		d. **TOTAL:**	**1,927,066.36 US$**[2]
Beneficiaries	Total number of individuals affected by the crisis:		**2,025,800** individuals
	Total number of individuals reached with CERF funding:		**7,141,253** (target) total individuals
			132,287 children under 5
			314,988 females

[1] UNICEF HQs deducted 6.54 percent of recovery cost (explanation received from UNICEF Nepal)

[2] There is a difference between the total CERF funding received from the UFE Window and total funds utilized because UNFPA did not spend all the funding during the project implementation and therefore the balance amount is with UNFPA HQs. (explanation received from UNFPA Nepal)

Geographical areas of implementation:	Mugu, Achham, Bajura, Bajhang, West and Far Western districts. Seven Camps for refugees from Bhutan in Eastern Nepal (Jhapa and Morang). Bardiya, Jajarkot and Mugu districts of Mid-Western Development Region, and Achham and Kanchanpur of Far Western Development Region. See attached map (revised) .

I. Analysis

Nepal is one of the world's poorest countries. Almost 90 percent of its inhabitants live in rural areas, and about 31percent of them live below the poverty line, notably 42 percent in rural areas. Significant humanitarian needs remain in Nepal due to a combination of national and global factors. Nepal has made substantial improvement in public health indicators over the last decade. However maternal mortality ratio is still high as 281 per 100,000 live births. According to WHO estimates, reproductive ill health accounts for 33 percent of the total disease burden in women (compared to 12.3 percent for males). Only 18 percent of all deliveries are conducted by skilled birth attendants in Nepal. 80 percent of births occur at home and 56 percent of births receive no prenatal visit. More than two third of all maternal deaths occur due to preventable obstetric complications, 10 percent of Nepal women suffer from Uterine prolepses, a high morbid condition which has a huge impact on the reproductive health rights and the wellbeing of women and their families.

Three and a half million people in Nepal are still considered moderately to severely food insecure. The impact of the ongoing political instability has been dramatically exacerbated by the two acute shocks of droughts and sustained high food prices, leading to increased vulnerability to food insecurity in the country.

With official year-on-year food price inflation remaining at 18 percent, high food prices remain a significant concern as prices today are higher than (and continuing to rise from) 2008, generally known as the period of the global food price hikes. The causes of sustained domestic food price inflation include successive seasons of poor domestic food production, a prevailing trade ban on the export of staple food items by India (Nepal's major trading partner) and continued political instability.

Erratic changes in weather patterns continue to exacerbate Nepal's existing food security challenges. The areas that are the most vulnerable to the effects of climate change are generally the same areas already burdened by severe food security issues, especially in the Mid- and Far-West Hill and Mountain districts. Drought in particular poses a serious threat to vulnerable populations due to their dependence on rain-fed agriculture for domestic food production.

The population residing in the Mid/Far-West Hills and Mountains has been the worst hit by recent shocks, and by far the most food-insecure in the country, and traditionally has been exposed to more structural vulnerability factors. This area was also the initial breeding ground for the civil conflict and in the past years has witnessed renewed agitation as a direct result of severe food insecurity. Modalities centered on food assistance are urgently needed to improve the resilience of vulnerable communities to such shocks.

In 2011, WFP planned to assist 1.6 million food-insecure people under its PRRO "Assistance to vulnerable populations affected by conflict, natural disasters and high food prices in Nepal" by providing a food safety net to the most vulnerable populations. At the time of application, only 49% of the operation was funded and only 17 out of 26 districts could be reached with urgent assistance needed in the Karnali region, including the Dolpa District. The latter's food production had decreased by almost 50% in 2009 and had further been reduced in 2010.

At the time of application, WFP would have had to stop further activities in Dolpa due to under-funding of the operation. Following the confirmation of CERF funds, WFP was able not only to kick off planning of activities in the District and avoid pipeline breaks, but WFP was further enabled to raise US$ 1.2 million from EU ECHO for Dolpa and other Karnali Districts in similar urgent need of assistance.

Almost annually Nepal faces an outbreak of diarrhoea/cholera due to unsafe hygiene practices, open defecation and lack of access to safe drinking water. Additionally, poor health infrastructure, surveillance and laboratory facilities mean that highly transmissible pathogens such as vibrio cholera cannot be detected quickly at the local level, resulting in a delay in diagnosis and management, leading to high mortality and morbidity rates, especially in challenged areas such as the Mid- and Far-Western part and the Terai belt of Nepal. Based on the trends of the past five years, the Epidemiology and Disease Control Division (EDCD) of the Department of Health Services, has categorized all 75 districts into high (category A), medium (category B), and low (category C) risk groups.

The consequences of the decade-long armed conflict in Nepal have increased the vulnerability of children and pregnant and lactating women to the frequent disasters. Improving their overall nutritional status is a major challenge for Nepal, especially in view of having one of the highest stunting rates in the world. According to the 2006 Nepal Demographic and Health Survey (NDHS) , 39 per cent of the country's under-fives are underweight and 49 per cent are stunted. In some districts of the Mid- and Far-Western Development Regions, stunting rates are as high as 76 per cent and the prevalence of underweight children is 63 per cent (source: 2006 NDHS).

Similarly, the level of global acute malnutrition (GAM) indicates 13 per cent in Nepal, rising to 26.6 per cent in drought-prone mountainous areas and 20 per cent in parts of the Terai and Mid- and Far-Western hill districts. It is particularly high among the poor, landless and marginalized population. The prevalence of severe acute malnutrition (SAM) exceeds three per cent in Nepal and is as high as seven per cent in some districts of the Mid- and Far-Western Development Regions. Acute malnutrition among under-fives has developed into a 'silent emergency'. Around half of under-five mortality is associated with acute malnutrition.

The five refugee camps in eastern Nepal hosted 72,442 refugees from Bhutan (as of 31 December 2010), approximately 60 percent of which consist of refugees in economically active age (18-59 years). The large-scale resettlement to Core Group Countries (Australia, Canada, Denmark, Netherlands, New Zealand, Norway, the United Kingdom and the United States) have been smooth since October 2007, in which over 42,000 refugees have already departed, and some 56,000 individuals have submitted the declaration of interest in resettlement to UNHCR. With substantial reduction in the refugee camp population UNHCR has already started the strategic camp consolidation initiatives in concurrence with the Government of Nepal, including the administrative merger of three Beldangi camps into one in January 2011, and resulting reduction of number of the camps from seven to five. It is expected that by end of 2012, there will be only two Bhutanese refugee camps in Nepal.

To address the needs of a residual caseload in a longer-term perspective, UNHCR Nepal has developed an interagency approach to a comprehensive phase down strategy that would simultaneously address humanitarian and development needs in refugee-impacted and hosting areas. A five-year Community Based Development Programme (CBDP) has been envisioned as a joint initiative of the Government of Nepal (GoN) and the United Nations in Nepal to benefit local and refugee communities in the refugee impacted and hosting areas in Jhapa and Morang Districts. It is envisioned that the CBDP will be implemented in the leadership of GoN, with active support from UNCT, I/NGOs, and bilateral donors, and active involvement of the beneficiaries i.e. refugees and host community residents.

Refugees from Bhutan in camps mostly depend on international assistance including in the health sector. The CERF funding was instrumental to maintain life saving activities of UNHCR at the same level as in the previous years as health services play a critical role in maintaining the quality of services for those remaining in the camps through retention of key health staff. Particular area of focus was Sex and Gender Based Violence (SGBV), support for psycho-social and mental health problems, activities to address drug and alcohol abuse among adolescents and adults. In addition to camp based population, many vulnerable host community residents also accessed camp based health facilities during emergencies and especially at night facilitating coexistence among communities. The support also helped in maintaining key health staff and continuous skill up gradation of service providers in various sectors and supporting referral cases, provisioning of essential life saving drugs, supporting of accessories supplies for TPHA (Treponema Pallidum Aemagglutination Assay), RPR (Rapid Plasma Regain) and HIV test kit and

ensuring primary health services for residual refugees through adequate medical supplies. The training funded by CERF grants on HIV/AIDS, emergency obstetric care, clinical management of rape survivors to the service providers helped to build the capacity to deliver quality emergency RH and Mental health services .UNHCR Nepal 2010 HIS indicators reflect that this funding ensured maintenance of the health and nutrition services for Bhutanese Refugees to UNHCR standard . In addition the CERF funding helped to address the humanitarian health needs of refugees facing serious illnesses which were not be possible within UNHCR annual budget.

Overview of the Humanitarian Situation in Nepal and Use of CERF Underfunded Emergency Window:
CERF funds enabled WFP to maintain its essential Protracted Relief and Recovery Operation (PRRO) "Assistance to vulnerable populations affected by conflict, natural disasters and high food prices in Nepal" operating and reaching to the remaining 9 districts of the total of 26 districts in Nepal. WFP was further supported through additional funding from EU ECHO (US$ 1.2 million) for the Karnali region, including the Dolpa district which is in similar urgent need of assistance. CERF funds further enabled WFP to reach an additional 12,000 beneficiaries with the purchase of 350 MT rice.
CERF support allowed WHO to reach the vulnerable population of the remote Mid- and Far-Western regions with basic emergency health care services through provision of drugs and medical supplies and management of basic health information and health knowledge that result in reduced morbidity and mortality. CERF funding contributed to the project collaboration and discussion with the Ministry of Health counterparts as well as with health cluster partners especially the Nepal Red Cross Society and others who have presence in the field. CERF further enabled WHO to conduct a thorough health facility mapping to understand better the health situation on the ground and respond better to community needs.

The WASH cluster requested for CERF funding to implement prioritized but unfunded WASH interventions in 11 disaster-prone districts across Nepal as identified by the EDCD of the Department of Health. The WASH cluster in close collaboration with the government identified OXFAM, Save the Children, Nepal Red Cross Society, Lutheran World Foundation and IRD as the potential partners to continue life saving interventions in these identified disaster-prone districts. Rapid allocation of CERF funds allowed UNICEF to implement life-saving WASH promotion and response in eight and UNHABITAT in three diarrhoea/cholera and flood-prone districts. Interventions included social mobilization which used CERF funds to promote hygiene behaviour through orientation and distribution of hygiene supplies among the most vulnerable communities where diarrhoea and cholera were prevalent. Further, more than 2,000 Female Health Volunteers (FCHVs) and other community volunteers were trained to reach around 258,300 families of 51,660 households to demonstrate safe hygiene behaviour. CERF funding allowed the orientation of District Disaster Relief Committees (DDRC) and WASH clusters on life-saving WASH responses. Through CERF funding, partnerships were established with the Ministry of Planning and Physical Works (MPPW), the Department of Water Supply and Sewerage and WASH cluster members. The CERF funding further strengthened the WASH cluster coordination mechanisms at the district level through regular meetings and workshops. The cluster members jointly identified the most vulnerable Village Development Committees (VDCs) for the promotion of life saving WASH initiatives in the targeted areas.

UNICEF signed agreement with OXFAM, Save the Children and NRCS for the implementation of WASH lifesaving interventions in 8 disaster prone districts out of 11 (excluding Kanchapur, Kailali and Doti where CERF funds were mobilised by UN-HABITAT). Through this funding, effective partnerships were established with the Ministry of Planning and Physical Works (MPPW), Department of Water Supply and Sewerage, and WASH cluster members including I/NGOs at the national level and local government, line agencies and NGOs at the local level. These partnerships enabled WASH cluster members to provide a better response to critical WASH needs in Nepal by addressing poor sanitation and hygiene issues in the disaster prone districts of Nepal.

The priority interventions under CERF funds included strengthening the WASH Cluster coordination mechanism and capacity enhancement at the national, district and community level through regular meetings, reviews, workshops and trainings. At the community level, social mobilisation was applied as the key strategy for household outreach by strengthening the capacities of Female Community Health

Volunteers (FCHVs) and other local volunteers for effective use of hygiene supplies including ORS, Soap and water guard to build up safe hygiene behaviour.

Outcomes:
At the outcome level, as a result of WASH lifesaving interventions in 82 VDCs of 8 disaster prone districts, there has been no reports of diarrheal disease outbreaks. The sporadic incidence of diarrhoea in some programme VDCs has been dealt with by the District Disaster Relief Committee and the WASH cluster due to enhanced preparedness and response capacity. There has been a significant increase in the knowledge, attitude and practice of community people related to latrine use, hand washing, safe water and diarrhoea management as evidenced by the end line survey. The Geographical Information System (GIS) based health facility mapping collected spatial location of health facilities along with availability of health services, disaster preparedness situation, water and power supply, and health work force situation in 15 districts and the baseline information would also contribute in health sector emergency preparedness.

The following are the key programme components and the results achieved under CERF:
UNICEF is leading the WASH Cluster in Nepal as the "Provider of Last Resort". The WASH cluster co-led by the MPPW has come together after the diarrhoea outbreak in the Mid-West and Far West in 2009. Through constant advocacy in 2011, DRR and WASH in emergency was mainstreamed as a cross-cutting priority of WASH sector in the Joint Sector Review establishing a significant milestone to address the issue. There is improved coordination between sector ministries and the WASH cluster through nomination of an emergency focal point at the MPPW. WASH cluster coordination meetings have been regularly held and the National WASH contingency plans on earthquake and landslide/flood scenarios have been updated and operationalized in 2011.

The cluster has also been successful in integrating WASH components into the Nepal flagship programme on DRR led by the Consortium, thus providing opportunities for prioritising WASH issues during humanitarian crisis. At the national level, UNICEF has supported the capacity building of Government and humanitarian partners through trainings and learning visits. During 2011, a total of 11 participants from Government and CSOs gained knowledge on WASH in emergencies in national and international training programs. These organisations are now cascading their newly gained knowledge at the local level. The partners are also working in close coordination with the Environment, Sanitation and Disaster Management Section of the DWSS to finalise the technical designs for WASH facilities and training modules during humanitarian crises. Efforts are also being made to standardise emergency WASH supplies such as Hygiene kits to cater to the needs of women and children. Similarly, a training manual on "WASH promotion in Emergencies" and the guideline on 'Quick Response Team" has been finalised in collaboration with WASH Cluster for uniform application in the districts and communities. This will be endorsed by DWSS for adoption by all WASH emergency stakeholders.

At the district level, in each programme district, District Disaster Relief Committee (DDRC) and the WASH cluster has been oriented on CERF funding and life-saving WASH responses to address critical sanitation and hygiene related issues. The WASH cluster has become functional and organized meetings to discuss critical needs and provide responses in a coordinated manner. WASH training has been provided to 8 district coordinators, 80 Social Mobilizers and more than 400 DDRC and cluster members to promote improved sanitation and hygiene behavior as well as to monitor the progress. The humanitarian partners are working in close coordination with the District Disaster Relief Committee led by the Chief District Officer to build District capacity for a timely response and preparedness. All eight programme districts have developed/revised multi-cluster District Disaster Preparedness and Response Plan including WASH, and have conducted simulations of the plan to ensure preparedness and response capacity in place. District WASH clusters are active, conducting periodic meetings, progress reviews and joint monitoring of the disaster prone areas. The programme districts have also prepositioned emergency relief stocks in their local warehouses for timely response.

UNICEF and UN-HABITAT jointly organised capacity building training for the Government and non-government officials of programme districts in Nepalgunj where 42 representatives from 12 disaster prone districts (WSSDO, DHO, DEO, NRCS and NGOs) of the Mid-Western region have been trained on WASH

life-saving interventions. These initiatives have further strengthened the cluster coordination mechanism at the district and community level for timely response to tackle a humanitarian situation.

Social Mobilisation and Improved Hygiene Behaviour:
Social mobilisation for hygiene promotion has been completed in 82 VDCs in collaboration with Save the Children, NRCS and OXFAM in 8 diarrhoea prone districts. A total of 82 Social mobilisers were hired and trained on improved water, sanitation and hygiene message as well as providing practical sessions and orientation to Female Community Health Volunteers (FCHVs) and other local volunteers (Junior Red Cross Circle) on preparation of oral rehydration solution (ORS) and use of water treatment options that reduce the risk of diseases related to poor water, sanitation and hygiene. The social mobilisers have trained around 2,000 Female Community Health Volunteers (FCHVs), JRCs and other local volunteers in 8 programme districts with refresher humanitarian WASH training to allow them to act as effective hygiene and sanitation promoters also at the time of a possible diarrhoea outbreak.

The CERF funds have been used to promote hygiene behavior through orientation, IEC materials on use of latrines, fecal transmission modes, hand washing with soap and Point-of-Use (PoU). The volunteers have demonstrated and distributed hygiene supplies such as soap, chlorine and ORS among the most vulnerable communities where diarrhea epidemics and cholera were prevalent. Street dramas through mobilization of child clubs were conducted in strategic places to sensitise local communities on the risks of poor sanitation and hygiene. The FCHVs and local volunteers have been able to reach around 90,000 households in high risk VDCs with demonstration of safe hygiene behaviours including ORS and zinc use, hand washing campaigns, PoU and water disinfection through chlorination. As a result of these practical demonstrations and supply distribution, more than 504,000 people now have knowledge and skills on improved sanitation and hygiene behaviour that reduce the risks of diarrheal morbidity and mortality in the disaster prone areas benefitting more than 500,000 families. Similarly baseline and end line surveys to assess knowledge, attitudes and practices related to sanitation and hygiene have been conducted by social mobilisers in each programme VDC which show a significant increase in key sanitation and hygiene behaviours. For example: in Accham and Dailekh district, hand washing with soap after defecation increased from 17 percent to 64 percent while use of latrines has increased from 28 percent to 81percent in Jajarkot, Rukum and Bajura districts.

School Based Hygiene Promotion Programme:
Social Mobilizers were also mobilized in schools for WASH promotion especially hand-washing methods among children especially in Rautahat district where polio outbreak VDCs were targeted. Training on hygiene promotions were provided to the school teachers of more than 200 schools. Hygiene promotion sessions (HPS) in schools and communities were conducted more than 1000 times by FCHVs and the Social mobilisers that has enhanced students' and teachers' knowledge on diarrhea, waterborne diseases, purification of water and practical knowledge on hand washing and preparation of Oral Rehydration Solution (ORS). The school-based hygiene promotion programme has benefited more than 200,000 students and teachers with improved sanitation and hygiene behaviors.

Installation of Small Scale Mitigation Measures:
With CERF funding, more than 80 water systems damaged by floods and landslides have been repaired and reconstructed thus improving water sources in deprived and dalit communities. Similarly more than 80 hand-pumps have been elevated with raised platforms in schools, health posts and flood prone areas ensuring access to safe water in times of disaster as well. For storage of water and availability in times of need, rain water harvesting technology has been supported in more than 30 schools and public places in programme districts. Similarly 400 deprived households have been supported to build latrines and stop indiscriminate practice of open defecation thereby reducing diarrhea incidence and its recurrence. 100 percent of water sources (Hand pumps and springs) were tested for E coli. Initial tests have been made in June 2011 during the monsoon and final testing has been completed. In most of the sources the contamination level was high. People were suggested not to use the water of those sources for drinking purpose until they are further tested.

As a result of promotional efforts by the partnership with Save the Children, NRCS, and OXFAM almost 90,000 households in high risk VDCs have improved hygiene practices with proper use of life saving WASH items (e.g, 60,000 households drinking safe water from 160 small water schemes/hand pumps,

340 vulnerable households used raised latrines) to reduce the risk of a diarrhea outbreak in the targeted VDCs and Districts. CERF funding has been very instrumental in catalyzing rapid intervention and stabilize an insecure situation arising out of diarrhoea/cholera outbreaks in the disaster prone districts. The flexibility of CERF funding enabled to continue prioritized but unfunded activities planned by WASH cluster members in the disaster prone districts where poor hygiene and sanitation related issues have always been challenging.

Acute malnutrition has emerged as a 'silent emergency' in Nepal and there is an urgent need to continue support for therapeutic feeding centres and stabilization centres as life-saving interventions to prevent malnutrition-associated morbidity and mortality of under-fives, especially in the Mid- and Far-Western Development Regions. CERF funding has been utilized to support rapid emergency nutrition interventions for vulnerable children, especially children suffering from severe acute malnutrition (SAM). CERF funding has been utilized to treat 1,319 of the identified SAM children and 13 of the identified children suffering from global acute malnutrition (GAM) with medical complications, and over 10,000 children suffering from moderate acute malnutrition (MAM) have been provided with counselling services to prevent them becoming SAM. Analysis shows that the outcome was positive with a recovery rate of over 87 per cent and a death rate of below one per cent. The contribution was received at a critical juncture when the nutrition sector in Nepal was facing funding constraints and has enabled the continuation of the community-based management of acute malnutrition project (CMAM) in five districts of the Mid- and Far Western Development Regions. Purchasing of ready to use therapeutic food (RUTF) and other emergency nutrition supplies including drugs and their utilization to manage SAM cases is the main added value of CERF. Allocation of CERF funds allowed the project to avert mortality and morbidity associated with acute malnutrition. Through CERF funding, effective partnerships were established with the Child Health Division (CHD) of the Ministry of Health and Population (MOHP), two NGOs (Youth for World Nepal and Nepal Public Health and Education Group), and other nutrition cluster members. These interventions enabled for therapeutic feeding, management of medical complications in stabilization centres, and enhancement of the capacity of parents to provide adequate nutrition through promotion of infant and young child feeding (IYCF) practices.

Improving the nutritional status of children aged less than five years and of pregnant and lactating women is a major challenge for Nepal. According to the preliminary report of 2011 Nepal Demographic and Health Survey (NDHS) , 41 per cent of under-five year age children are stunted, and 29 per cent are underweight. Though this represents a slight decline since 2001, the stunting rate for Nepal in particular remains one of the highest in the world. In parts of the country, these rates are as high as 60 and 58 per cent -in Western Mountains, and Far-Western Hills, respectively (source: 2011 NDHS preliminary findings).

Similarly, the level of global acute malnutrition (GAM) is at 11 per cent in the country, which has remained stagnant over the last decade. Furthermore, these data mask wide variations across the country. GAM rises to 26.6 per cent in drought-prone mountainous areas and 20 per cent in parts of the Terai and Mid- and Far-Western Hill districts. It is particularly high among the poor, landless and marginalized population. The national prevalence of severe acute malnutrition (SAM) is 2.6 per cent, with some areas having as high as 7 per cent (e.g. some districts of the Mid-Western and Far Western Development and Terai Regions).

The Government of Nepal has made the nutritional status of children and women a high priority, and is committed to meeting the nutrition related targets of the Millennium Development Goals (MDGs) and the World Fit for Children goals. Various nutrition interventions have been introduced in the last two years, including programmes on community management of acute malnutrition (CMAM), IYCF integrated with micronutrient powders to children 6-24 months of age (IYCF/MNPs), and integration of community-based nutrition activities with other health and development programmes such as the Maternal and Newborn Health (MNH) Project, and the Community-Based Integrated Management of Childhood Illnesses (CB-IMCI) programme. While considerable progress has been made in addressing micronutrient deficiencies, substantial additional efforts are still required especially to reduce chronic child malnutrition to levels set the MDGs (see Table 1). As shown in Table 1, while child mortality has been halved already since 1995 (highlighted in yellow), improvements in poverty and especially in stunting remain slow (highlighted in orange and red, respectively).

Table 1: Indicators for the Millennium Development Goals

	1990	2000	2006	2011	2015 target
Percentage of population below the national poverty line [3]	42	38	31	25	21
Percentage of underweight children under five years of age [4]	57	53	39	29	29
Percentage of stunted children under five years of age [5]	61	53	49	41	31
Percentage of population below minimum level of dietary ene consumption [6]	49	N/A	47	N/A	25
Infant mortality/1000 live birth [7]	108	64	61	48	34
Under-five mortality/1000 live birth [8]	162	91	82	54	54

Sources: DHS 2001, 2006 and 2011 and NLSS 2011

As indicated above, acute malnutrition has remained practically unchanged over the last decade – emerging as a 'silent emergency (crisis).' There is an urgent need to continue to support CMAM as a life-saving intervention to prevent morbidity and mortality associated with severe acute malnutrition among the under-fives, especially in the Mid- and Far Western Development Regions. CERF funding has been utilized to support CMAM in the five most affected districts as part of the rapid emergency nutrition response for these most vulnerable children. The contribution was received at a critical juncture when the nutrition situation was heightened due to droughts in the Mid- and Far-Western Region and has enabled the continuation of the CMAM project in five districts in these Regions.

To respond to critical humanitarian needs, CERF funds added value by saving the lives of SAM children. CMAM has been implemented in Nepal by the MOHP, with technical and financial support from UNICEF, in three districts since 2009 and two districts since 2010. As of November 2011, a total 10,149 SAM children have been admitted at 76 Outpatient Therapeutic Programme (OTP) centres (Achham-26, Kanchanpur-17, Mugu-7, Jajarkot-11 and Bardiya-15) among them 9,187 (90.52 per cent) have already been discharged and 962 (9.48 per cent) are under treatment. Out of the 9,187 discharged children, 8,263 (89.94 per cent) have recovered, 42 (0.46 per cent) have died and 838 (9.12 per cent) have defaulted. In addition, some 258 GAM children with medical complications have been treated at six stabilization centres in five districts (Achham-180, Kanchanpur-17, Mugu-8, Jajarkot-25 and Bardiya-28). Analysis of the data shows that the recovery rate was over 89 per cent and the death rate was below one per cent; these figures are much better than the SPHERE standards of at least 75 per cent for the recovery rate and less than ten per cent for the death rate.

CERF project had an obvious added value as people in the remote districts of Mid Western and Far Western region of Nepal had very limited access to reproductive health services. In particular, rural women who are poor and socially marginalized in their communities are facing several reproductive health problems such as uterine prolapsed and other maternal morbidities. In that regard, poverty, conflict, illiteracy and poor health system are increasingly considered as socio-economic barriers to access RH services in districts. There are emerging needs of emergency reproductive health services for women in those remote districts in order to reduce the reproductive health morbidity and mortality, and hence improve the reproductive health status of people living in difficult situation.

In this context, the project successfully provided emergency life saving mobile reproductive health services in the project districts. For example, ADRA Nepal conducted mobile health camps in Mugu district and provided RH services to 1,349 individuals (Females: 1283 and Males: 66). Similarly, CARE Nepal provided RH services to 4721 individuals (Females: 4589 and Males: 132) in Acham, Bajura and Bajhang districts. Thanks to the RH camps, women in particular who used to face many reproductive health problems directly benefitted from RH services delivery. Another important feature of the CERF funding was its flexible nature that enabled to meet immediate needs as the mobile camps were planned considering the seasonal calendar of local people. Furthermore, CERF has strengthened the

[3] Millennium Development Goal Progress Report 2010
[4] NDHS 2001, 2006, 2011
[5] NDHS 2001, 2006, 2011
[6] Millennium Development Goal Progress Report 2010
[7] NDHS 2001, 2006, 2011
[8] NDHS 2001, 2006, 2011

humanitarian response at local level by responding to RH needs of rural people in ensuring the participation of district level stakeholders such as D/PHO staff, management committees of local health facilities, female community health volunteers and community groups in each of the project districts. In coordination with the Family Health Division, Regional Directorate of Health Services and District Health Offices of the project districts, the CERF funded activities were timely implemented by the partners with the technical assistance from UNFPA.

Both CARE and ADRA Nepal as UNFPA implementing partners experienced that local resources from the districts and communities were mobilized while planning and organizing the RH camps. In particular, local health service providers from District Health Offices, Female Community Health Volunteers, youths and camp support management committee members were mobilized during the project implementation. To build the local health capacity so as to respond to emergency reproductive health services specially for poor women having limited access to RH services, the project supported the government health service providers through on-site coaching onsite coaching mainly on rational use of drug, treatment of minor disorders, STI case management, counselling of women with uterine prolapsed, medical treatment and care including pelvic exercise, pessary ring insertion and screening process and referral of uterine prolapsed for surgical treatment. Moreover, the project also increased public awareness on reproductive health issues through health education and communications during the health camps. Overall, the CERF funded project significantly helped to meet the reproductive health needs of rural women in particular and also contributed to support the government's effort of reaching the unmet health needs in remote districts by providing direct RH services specially focusing on uterus prolapsed surgeries.
The CERF project equipped the MOHP's Rapid Response Teams (RRT) at the district and regional level in the Mid-Western and Far-Western Development Regions in Nepal, and the RRTs responded to outbreaks at the Village Development Committee (VDC) level. The CERF projects contributed to awareness rising at the community level on preparedness for emergencies.

In addition, the CERF project made an important contribution to the health information management in the Mid and Far West Development Regions, through the Geographical Information System (GIS) based health technology in Health Facility Mapping Survey contributed in availability of health services; disaster preparedness situation, water and power supply, and health work force situation in 15 districts and the baseline information would also assist in health sector emergency preparedness.

Following the closure of previous activities in September 2010 in Dolpa, a field level agreement was signed in November 2010 with implementing partner Winrock (already selected at the CERF grant application stage) to carry out new targeting and needs identification exercises in the district. The assessment is now complete, and WFP initiated activities with Winrock under a "Food-for-Assets" modality. Furthermore, WFP has been continuously cooperating with the Ministry of Local Development for the overall management of activities in Dolpa as well as in other districts. Despite the needs identification, Winrock could not carry out the field level activities in six VDCs of upper Dolpa due to closure of trails caused by snowfall. However, food was delivered in the lower Dolpa, where 277 mt of food was distributed to 9,700 food insecure people. The rest of the food(73 mt) were distributed to 2,300 beneficiaries located in Mugu, Humla and Jumla districts. Winrock also provided technical assistance to the District Development Committee in order to implement the projects.

As part of WFP's toolbox of food assistance to mitigate alarmingly high food insecurity levels, the planned activities in Dolpa use a "Food-for-Assets modality whereby participants receive 4kg of rice and 0.5kg of pulses per day of work contributed to community projects. The projects are designed to support each household with a maximum of 40days of work per season. This well-targeted intervention allows immediate access to food to the selected households, as provision of food is given to participating beneficiaries to compensate for works performed. Thus the activities address immediate, short-term food needs of the vulnerable populations while supporting their recovery from shocks and strengthening their resilience to future ones thanks to the productive community assets built.
WFP purchased 350mt of rice with the CERF contribution, which assisted 12,000 beneficiaries with approximately 160kg of rice per household, equivalent to 2.5 months of requirements.

III. Lessons learned

LESSONS LEARNED	SUGGESTION FOR FOLLOW-UP/IMPROVEMENT	RESPONSIBLE ENTITY
CERF fund had been catalytic in joint effort of almost all national and local stakeholders	Regular joint plan for emergency is to be strengthened in leadership of government	MPPW
CERF funds have added value by providing continuity to the WASH life-saving interventions in 11 disaster prone districts	Continue building the capacity of programme partners to effectively respond to and address critical WASH needs such as management of potential diarrhoea/cholera outbreak. Ensure better utilization of WASH protocols and training materials as part of emergency preparedness activities.	MPPW, DWSS, UNICEF and other WASH cluster members
Strengthening of district level and national level capacities in WASH is critical to ensure a quick emergency response in areas with recurrence of diarrhoea/cholera outbreaks	Conduct capacity-building activities on effective management of WASH issues in districts prone to epidemics of diarrhoeal disease. Ensure effective implementation of contingency planning for the management of WASH issues in districts prone to epidemics of diarrhoeal disease. Enhance further the capacity of WASH cluster members for management of diarrhoea/cholera.	MPPW, DWSS, UNICEF and other WASH cluster members
Adequate contingency stocks of life-saving WASH supplies are essential for effective humanitarian actions on WASH	Pre-position WASH life-saving supplies for rapid response in times of emergency. Stock management and replenishment still needs to be improved.	MPPW, DWSS, UNICEF and other WASH cluster members
Raising awareness and changing behaviour on WASH remains a challenge due to cultural and social factors	Effective media mobilization and proper communication channels needs to be identified as part of the preparedness activities.	MOHP, UNICEF and other nutrition cluster partners
CERF fund had been catalytic in joint effort of almost all national and local stakeholders	Regular joint plan for emergency is to be strengthened in leadership of government	MPPW
Inclusion of beneficiaries from Host community important to facilitate future integration of services	Inclusion of vulnerable host community and skill enhancement of local service providers is important for sustainability of the project.	UNHCR
The CERF funding allowed capacity building of health service providers as well as specific interventions for vulnerable groups which could not otherwise be funded and qualitatively improved the programme	Timely grant at the time of planning could facilitate qualitative impact of the project	UN CERF
CERF funds have added value by maintaining the CMAM project in five districts where outcomes have been highly	• Continue the process of upgrading the capacity of programme partners to sustainably respond to and address critical nutrition needs such as management of acute malnutrition.	MOHP, UNICEF and other nutrition cluster partners

encouraging	• Ensure better utilization of CMAM protocols and training materials as part of emergency preparedness activities.	
Strengthening national capacities on CMAM is critical to ensuring a rapid emergency response in areas with high levels of acute malnutrition	• Conduct capacity-building activities on effective management of acute malnutrition in highly food-insecure and flood-prone districts and districts prone to epidemics of diarrhoeal disease. • Develop contingency planning for the management of acute malnutrition in highly food-insecure and flood-prone districts and districts prone to epidemics of diarrhoeal disease.	MOHP, UNICEF and other nutrition cluster partners
Strengthening the nutrition cluster coordination mechanism for emergency preparedness and response is essential for effective humanitarian actions on nutrition	• Build the capacity of nutrition cluster members for management of severe acute malnutrition in humanitarian crisis and silent nutrition emergencies. • Pre-position ready-to-use therapeutic food (RUTF) and other emergency nutrition supplies.	MOHP, UNICEF and other nutrition cluster partners
Raising awareness on malnutrition and the need for treatment remains a challenge in a country where severe acute malnutrition is common but where children mostly have no clear visual symptoms	• Conduct communication activities providing information and raising awareness on acute malnutrition as part of preparedness activities. • Integrate IYCF with CMAM and other therapeutic and supplementary feeding programmes to address the ongoing silent nutrition crisis.	MOHP, UNICEF and other nutrition cluster partners
Quality management of SAM provides an opportunity to enhance quality of overall care provided to children aged under five in general	• Ensure integration of CMAM with community-based health and nutrition packages such as CB-IMCI, IYCF, care and WASH, and with nutrition rehabilitation units etc.	MOHP , UNICEF
CERF funds have added value by allowing continuity to the WASH life-saving interventions in 8 disaster prone districts	• Continue building the capacity of programme partners to sustainably respond to and address critical WASH needs such as management of potential diarrhoea/cholera outbreak. • Ensure better utilization of WASH protocols and training materials as part of emergency preparedness activities.	MPPW, DWSS, UNICEF and other WASH cluster members
As a result of capacity building of local WASH stakeholders, local partners are able to manage the diarrheal outbreak at the local level in Surkhet and Baitadi utilizing local resources	• Ensure effective implementation of contingency planning and its operationalization for the management of WASH issues in districts prone to epidemics of diarrhoeal disease.	MPPW, DWSS, UNICEF and other WASH cluster members
Strengthening national capacities in WASH is critical to ensuring a quick emergency response in areas with recurrence of diarrhoea/cholera outbreaks	• Conduct capacity-building activities on effective management of WASH issues in districts prone to epidemics of diarrhoeal disease.	MPPW, DWSS, UNICEF and other WASH cluster members
Strengthening the WASH cluster coordination mechanism for emergency preparedness and	• Enhance further the capacity of WASH cluster members for management of diarrhoea/cholera • Pre-position WASH life saving supplies for rapid response in times of emergency.	MPPW, DWSS, UNICEF and other WASH cluster members

response is essential for effective humanitarian actions on WASH		
Raising awareness and changing behaviour on WASH remains a challenge due to cultural and social factors	• Effective media mobilization and proper communication channels needs to be integrated as part of preparedness activities.	MOHP, UNICEF and other nutrition cluster partners

II. Results

Sector/ Cluster	CERF project number and title (If applicable, please provide CAP/Flash Project Code)	Amount disbursed from CERF (US$)	Total Project Budget (US$)	Number of Beneficiaries targeted with CERF funding	Expected Results/ Outcomes	Results and improvements for the target beneficiaries	CERF's added value to the project	Monitoring and Evaluation Mechanisms	Gender Equity
Food Security	**10-WFP-071** Assistance to Vulnerable Populations Affected by Conflict, Natural Disasters and High Food Prices in Nepal	520,978	66,784,609	12,000 beneficiaries in Dolpa district, including 5,604 women and 1,620 children under five	▪ Food consumption score to exceed threshold for 80% of targeted households. ▪ Coping Strategy Index: reliance on major negative coping mechanisms decreased for 80% of targeted communities. ▪ Gender score: 80% of women in leadership to report active involvement in key decisions.	▪ Activities are ongoing. Results to be confirmed in next report.	▪ Allocation of CERF funds allowed the project to begin immediate planning after the needs were identified. ▪ Allocation of CERF funds contributed to WFP receiving additional funds from EU ECHO for the Karnali region, including Dolpa district. ▪ Allocation of CERF funds enabled WFP to reach an additional 12,000 beneficiaries.	The CERF component of the project will be monitored under the overall project monitoring and evaluation of the WFP NEPAL PRRO.	▪ Family members of the food insecure households benefitted from the project. The benefit was equally distributed among the family members.

Health	**10-WHO-067** Enhancing Access to Basic Emergency Health Care Services of Two Remote Regions	221,556	550,000	Total beneficiaries 6,174,175 (933,489 under five population and 3,095,725 female and 3,078,450 male population)	▪ Increased access to essential health services in the two developmental regions ▪ Rapid Response Teams (RRT) equipped for disaster and outbreak response at district and regional level in the Mid and Far West Development Regions ▪ Awareness on preparedness for emergencies in the health aspects raised at the community level ▪ Health information on available health resources in the Mid and Far West Development Regions mapped using GIS application and made available to all partners	▪ WHO continued propositioning of essential medicine, response equipment, inter-agency emergency health kits (IEHK), diarrheal disease kits (DDK) to support the MOHP. ▪ RRTs are equipped with the RRT personal deployment kits in 10 districts in Nepal from CERF support; and WHO provided orientation trainings to RRTs including the utilization of kits during emergencies and outbreak in the region in two regions. ▪ Village Development Committee (VDC) level contingency planning (CP) activity with hygiene promotion campaign, health behaviour survey, street drama, different rallies organised and provided knowledge on health emergencies, and health messaging to the communities for emergency response ▪ Health facility information mapped out in 15 districts in two regions which included access and the technical areas of each facility covers through Geographical Positioning System (GPS) coordinates collected and merged the same in the nation-wide Health Facility Mapping database using Geographical Information System (GIS) technology.	▪ Rapid allocation of CERF funds supported to timely completion of the ongoing life-saving interventions particularly on health sector needs that were identified including development of a VDC level health sector CP which is first of its kind in Nepal. ▪ The GIS based health facility mapping collected spatial location of health facilities along with availability of health services, disaster preparedness situation, water and power supply, and health work force situation in 15 districts and it would contribute in health sector emergency preparedness	WHO with implementing partners regularly monitored the progress through regular meetings, field visits from the central to region, district and VDC level In the monthly IASC Health Cluster meeting the IPs updated the progress made including he MOHP partners.	• RRT includes women's participation • Special attention to women particularly to house-wife, children were given while organized the drama and street programme with female participation. In addition, the community based health behavioural survey was conducted with active female participation as well. • The GIS based health facility mapping survey a female computer assistant in GIS Survey Team

Water and Sanitation	**10-CEF-056-B** Preventing Deaths of Vulnerable Population (Children and Women) Through Life-Saving WASH Promotion and Response	333,234	1.2 million	900,000 vulnerable population from 11 disaster-prone districts including 460,000 female, 440,000 males and 137,000 children under 5 years	▪ Reduction in outbreak of disease related to water, hygiene and sanitation in the targeted districts from the baseline; Baseline and end-line survey were carried out before the start of the project and following the completion of the intervention. ▪ Improved KAP in targeted areas through hygiene awareness practices; ▪ Reduced workload of dalit and voiceless people through installation/repair of water systems and helping to increase care and support to their children and promote their livelihood	▪ Capacity building of 11 national and district WASH cluster members including 82 social mobilisers, 2000 FCHVs and local volunteers has been conducted to ensure preparedness and response capacity at all levels. ▪ No incidence of diarrhoea/cholera reported from programme districts as a result of life saving interventions. ▪ Baseline and end line survey to assess knowledge, attitude and practice of community people on water, sanitation and hygiene has been conducted in 82 programme VDCs. FCHVs have reached to 90,000 hhs covering 504,000 people and 200,000 school children and teachers. Significant improvement in key hygiene behaviour (use of latrine, hand washing with soap and use of water disinfectants) reported against the baseline. ▪ Small scale WASH mitigation works like alleviated latrines and hand pumps, demonstration water harvesting schemes etc has been installed benefitting around 60,0000 households and 225,000 females. The programme areas have reported reduced workload of women due to installation of water points near their communities.	Rapid allocation of CERF funds allowed the implementation of prioritized but unfunded WASH interventions in 8 diarrhoea/ cholera and flood-prone districts of Nepal	▪ UNICEF and its implementing partners in collaboration with district WASH cluster have identified the vulnerable VDCs and population and mobilised local level female community health volunteers and other volunteers for social mobilisation and hygiene supplies (ORS and Zinc, water guard and soap) distribution. Similarly baseline survey on KAP has been ongoing in the programme districts/VDCs. ▪ Technical monitoring of construction works by district engineers was done and joint programme monitoring by WASH cluster (national and district level) was undertaken for progress monitoring ▪ Standard assessment checklist developed by WASH cluster was used for assessing the baseline/end line survey. ▪ Endline Survey to assess the work load of women and dalit community	▪ Special attention has been paid to the hygiene needs of adolescent girls and young women to ensure equitable use of hygiene supplies ▪ Equal participation of women has been ensured in all aspects of programme implementation and special attention has been paid to the hygiene needs of adolescent girls and young women to ensure equitable use of hygiene supplies

Nutrition	**10-CEF-056-A** Community-based Management of Acute Malnutrition	**384,786**	388,165 (The CERF allocation is not the total budget for the project. This is only a part of the total project budget.)	4,500 SAM children 21,000 MAM children 1,080 GAM children with medical complications	• Identified all SAM children through community-based screening mechanisms conducted by FCHVs and community health workers and treated with RUTF at OTP centres • Provided on time treatment for GAM children with medical complications at stabilization centres in existing facilities in eight hospitals of five CMAM districts • Supplied and utilized adequate therapeutic foods (F75, F100, RUTF), ReSoMal, antibiotics and other essential drugs for stabilization centres for facility-based management of GAM children with medical complications	• As of November 2011, 10,149 SAM children have been identified and treated in five • So far, 258 GAM children with medical complications have been identified and treated in six stabilization centres in five districts • RUTF (2,500 cartons), F100 (42 cartons), F75 (93 cartons), ReSoMal (30 cartons), antibiotics, Salter scales and height boards have been purchased with CERF funds; RUTF, ReSoMal, therapeutic milk (F100, F75) have been supplied and made available for malnourished children in all OTP centres and stabilization centres for facility-based management of SAM children and GAM children with medical complications • Community-based awareness-raising activities have been initiated through IYCF integration with CMAM services in five districts • Through CMAM, more focus has been given to high-risk communities such as HIV-concentrated communities, female-headed households, Dalit settlements, etc.	CERF has supported the maintenance/ continuation of life-saving interventions through the CMAM project in five districts of Nepal Purchasing of RUTF and other emergency nutrition supplies including drugs and their utilization to manage SAM cases is the main added value of CERF Allocation of CERF funds allowed the project to respond to identified needs, averting mortality and morbidity associated with acute malnutrition	• Monitoring and supportive supervision has been conducted through regular field visits by MOHP officials, UNICEF staff and NGO people to project districts, and by DHO/DPHO staff and CMAM monitors to OTP centres, stabilization centres and FCHVs, assessing whether RUTF and essential nutrition supplies are reaching beneficiaries on time and being used appropriately • Monitoring and supportive supervision has been undertaken to upgrade the capacity of health workers and volunteers for better response/service delivery	• The CMAM project places attention on the importance of creating an enabling environment for families to feed and take care of sons and daughters for the prevention and treatment of malnutrition • Community awareness is raised on the importance of involving fathers and other family members in the feeding and care of young boys and girls • Necessary support has been provided within the family and community for mothers to take proper care of young daughters and sons.

					• Provided counselling services to MAM children and encouraged their parents to prevent them from becoming SAM • Monitored all project performance conducted under the CMAM project • Capacitated all health workers, FCHVs and NGOs on nutrition rehabilitation treatment, screening and early identification of SAM and MAM children, IYCF and care and WASH counselling services • Reduced the prevalence of SAM and MAM children, particularly among high-risk groups including female-headed households, Dalits, and other vulnerable groups	• During screening of under-five children in communities by FCHVs and in health facilities by health workers, more than 15,000 MAM children have been provided with counselling services to prevent them from becoming SAM • The CMAM project has been monitored in five districts by CHD, UNICEF, concerned District Health Offices (DHOs) and health workers • Capacity of 8,612 health workers and health volunteers has been upgraded through training, refresher training, review meetings and monitoring visits, enabling health workers and volunteers to provide effective CMAM services in five districts • IYCF has been integrated in all CMAM districts and IYCF counselling has been provided to all parents of SAM and MAM children		• Field visits emphasize monitoring of process indicators to detect problems during the pilot • Existing monitoring modalities in the MOHP health system are being utilized to monitor the performance of interventions at the health-facility level and coverage of screening outreach	• Messages are reinforced in individual counselling sessions for caretakers seeking health and nutrition services, especially targeting young girls, boys and mothers • Boys and girls aged less than five years suffering from acute malnutrition are benefitting equally from this intervention • Programme data suggest greater admission rates for girls: across all five districts, admission rates average 57 per cent for girls and 43 per cent for boys

Reproductive Health	**10-FPA-043** Emergency Life Saving Mobile Reproductive Health Services in the Remotest and Conflict Affected Districts of Nepal	235,871	475,000	Female: 5,000 Male: 2,000 Children: 1,000 75 women screened would undergo surgical correction, 4000 women would receive medications, advices and referrals for various types of RH problems and 10000 women would get health education, information on MOHP's policy provisions and available service provisions from various levels of Health Facilities.	▪ Increased access to life-saving RH services in project districts ▪ Critical RH morbidity among women detected through mobile RH camps ▪ Women with advanced uterine prolapsed provided surgical service ▪ # of persons registered by camps –5000 (500/Camp) ▪ # of persons receiving general health services ▪ # of persons provided with essential RH services ▪ # of women screened for SGBV receiving counselling and referral services ▪ # of persons provided with ▪ diagnostic services by kind of investigations ▪ # of women inserted with ring pessary and trained for self insertion of ring pessary ▪ # of women by age group and detailed address and contact points listed for surgery for uterine prolapse ▪ Increased utilisation of screening, counselling and referral services by victims of sexual and gender based violence; ▪ Increased utilisation of voluntary counselling and testing services for HIV/AIDS ▪ To Increase availability of life-saving and essential health services, particularly reproductive health services;	▪ Up to the end of the reporting period, all preparatory work for the camps has been successfully completed. Coordination meeting with central, regional and district level stakeholders completed and sites identified for medical camps in consultation with community members. These sites have also been endorsed by the district reproductive health coordination committee. The medical camps in Achham, Bajhang and Bajura commenced in the 4th week of Jan 2011. Camps in Mugu commenced in the 1st week of March in Mugu district due to snow fall in Jan 2011. ▪ Advocacy through FM., Radio as well as FCHVs and mother's group have commenced as part of pre camp activities. ▪ 6070 RH camp beneficiaries (198 males and 5394 Females ▪ 4721 persons registered males 132, females 4589 by CARE ▪ 1349 persons registered by camps – males 66, females 1283 by ADRA ▪ Among 5592 patients who have received OPD services, 3599 had reproductive health issues and 2471 had general health problems. ▪ 409 women screened for SGBV receiving counselling and referral services ▪ 364 patients received treatment for STI through syndromic approach.	The targets districts are four of the worst conflict hit districts and also have a very low HDI. The sites chosen for the camps are some of the remotest of locations and some of the locals have never seen a doctor in their locality. The district and community stakeholders have expressed extreme happiness on the prospect of the camps. These camps would not have been possible without support from CERF. Apart from meeting humanitarian needs, the project aimed to show Government and donors on the need to invest more in these remote locations from an equity perspective. Rapid allocation of CERF funds allowed the project implement in need basis, allowed collaborative efforts from government, local stakes and the implementing partners, local ownership and capacity building. Further, added support in coordination and logistics support. The project was successful to provide services including check ups, laboratory investigation, medical treatment, health education and onsite coaching to the GON service providers	•	▪ At the planning stage, discussions were held with boys, girls, women and men from marginalized communities to agree on the best location for camps. It was planned to involve local volunteers for logistic support during the camps. ▪ Special attention was paid to RH needs of women giving special attention to uterine prolapse as most of the women keep it secret. However, counselling was carried out for both men and women. ▪ RH needs and issues of adolescent girls and boys were addressed too.

						▪ 1647 persons provided with basic laboratory diagnostic services ▪ 282 women with uterine prolapse inserted with ring pessary and trained for self care ▪ 116 women with uterine prolapse identified for surgical service were referred for surgery and 72 of them got operated. ▪ 327 people received HIV/AIDS test and counselling/referral services. ▪ 69 health service providers received on site coaching on RH skills including UP management ▪ Direct beneficiaries of IEC/BCC activities were 5168 while more than 11 000 approx. received various kinds of health education and information on RH via IEC materials distribution.			

Health	**10-HCR-041** NPL-10 MS-26262 Protection and Assistance to Refugees from Bhutan in Camps	93,680	106,196.00	*79,220* Bhutanese Refugee 26,483 Children 6,863 Children (below 5) 38,876 Women 40,344 Male	▪ Maintained basic health indicators within UNHCR standard ▪ Provided medical referral to most vulnerable refugees ▪ Supported at least ten refugee patients with life threatening conditions needing emergency interventions such as kidney dialysis, chemotherapy etc. prior to resettlement for stabilization during their resettlement process. ▪ Provided HIV/AIDS training and conduct VCT counselling and testing. ▪ Organized three events of HIV/AIDS training to targeted high risk groups ▪ Voluntary counselling and testing (VCT) services were provided at seven centres (six in camps and one at host community). ▪ Approximately 5,000 clients (refugees and host community residents) utilize the VCT services	▪ Public health indicators were maintained within UNHCR standards as following: ○ Crude Mortality Rate:-0.4 deaths/1,000/month ○ Under 5 Mortality Rate:-0.5 deaths /1,000/month ○ Infant Mortality Rate:-28.1 deaths/1,000 live birth ○ Neonatal Mortality Rate:-10.8 deaths /1,000 live birth ○ Coverage of Complete antenatal care : 97 per cent ▪ Maternal Mortality Rate: ○ 72,170 refugee populations were provided the support of emergency drug supplies ○ 13 refugee patients with life threatening conditions were provided the required emergency interventions, out of which costs for ten were covered through the CERF funding. ○ A week long refresher training on safe delivery was provided to 27 MCH staff in a specialized maternity hospital. ○ 3,406 individuals used VCT services. ○ All pregnant women attending the ANC services counselled on PMTCT and more than 87 per cent accepted the testing. ○ Syphilis screening coverage among ANC mothers were 99 per cent. ○ Care and support to PLWHA including treatment for opportunistic infections and antiretroviral treatment provided. A total of 5 PLWHA received referral for above mentioned services. ○ 21 PHCs MCH staff including 3 doctors was trained on clinical management of SGBV cases. ○ IEC Materials on HIV/AIDS, SGBV etc printed and distributed.	Allocation of CERF fund allowed to meet Basic health needs of Bhutanese Refugees from Bhutan in Nepal Adding resources for addressing the life-threatening conditions of the refugees Adequate care, treatment and support ensured to the SGBV survivors and the people living with HIV/AIDS. Enhanced capacity of health care providers Preventive messages widely disseminated among the refugee and host community residences. Continued with some critical health care human resources to maintain the quality of service delivery Ensured uninterrupted supply of essential drugs and consumable items to camp PHCs for the refugees through out the year Supported to maintain the life saving initiatives for refugees from Bhutan in Camps Prevented unwanted maternal death and pregnancy related complications Risk of HIV/AIDs reduced and quantity of response improved	▪ CERF funded activities were closely monitored by UNHCR through regular field visit ▪ Structured supervision check list and other monitoring tools used to review the periodic progress of the activities ▪ Weekly and monthly Health Information System	▪ Emphasis was given to build the capacity of female service provider which helped to address the need of female beneficiaries.

					▪	▪ Street dramas targeting to high risk were conducted both in camps and local community. ▪ Salary of six MCH staff for six months, 18 Emergency In-charges and seven VCT counsellors for four months provided from CERF fund.		▪	▪
WASH	**10-HAB-008**	146,760	146,760	27,940 (Direct) 385,000 (reached)	▪ To prevent and reduce incidences of death of the most vulnerable people who have access only to contaminated water, poor sanitation and hygiene in 4 flood high risk Terai districts (Rautahat, Sarlahi, Kailai and Kanchanpur) and 7 diarrhoea epidemic prone hill districts (Jajarkot, Rukum, Achham, Dailekh, Bajura, Baitadi and Doti) reaching approximately 150,000 households with over 900,000 people by the end of project period.	▪ Reduction in outbreak of disease related to water, hygiene and sanitation in the targeted districts ▪ Improved KAP in targeted areas through hygiene awareness practices; ▪ Reduced workload of dalit and voiceless people through installation/repair of water systems and helping to increase care and support to their children and promote their livelihood;	Local resource pooling and planning for emergency	▪ Utilised its strong field presence for field monitoring activities and ensuring quality assurance of the planned interventions. In this process, a joint monitoring team formed under the WASH cluster in which both government (WASH, Health and DDRC) and NGO representatives will participate. The findings of the field trips shared in the DDRC, WASH cluster for further improvement. ▪ Procured project supplies from its system by ensuring standard quality and delivery to the respected partners in the districts. Standard monitoring tools developed to document utilisation of supplies in the targeted districts and information collected from partner NGOs regularly to Utilised its strong field presence for field monitoring activities and ensuring quality assurance of the planned interventions. In this process, a joint monitoring team formed under the WASH cluster in which both government (WASH, Health and DDRC) and NGO representatives will participate. The findings of the field trips shared in the DDRC, WASH cluster for further improvement.	

								▪ Procured project supplies from its system by ensuring standard quality and delivery to the respected partners in the districts. Standard monitoring tools developed to document utilisation of supplies in the targeted districts and information collected from partner NGOs regularly to ensure the correct use of hygiene supplies. ▪ Carried out baseline and end-line surveys as agreed by the WASH cluster. In addition, partners submitted quarterly progress reports which further discussed during the cluster meetings. Following the completion of the project, a final report submitted as per the CERF guidelines.	

Annex 1: NGOS and CERF Funds Forwarded to Each Implementing NGO Partner

NGO Partner	Sector	Project Number	Amount Forwarded (US$)	Date Funds Forwarded
Save the Children	WASH	10-CEF-056-B	40,094.00	31/12/2010
NRCS	WASH	10-CEF-056-B	44,714.00	01/12/2010
OXFAM	WASH	10-CEF-056-B	9,261.00	21/12/2010
Youth for World Nepal (YWN)	Nutrition	10-CEF-056-A	30,928.00	07/12/2010
Nepal Public Health and Education Group (NEPHEG)	Nutrition	10-CEF-056-A	27,244.05	07/12/2010
IRD Nepal	WASH	UN-HABITAT CERF – 10 /11 - A	31,458	03/03/11
LWF Nepal	WASH	UN-HABITAT CERF – 10 /11 - B	10,848	18/02/11
Association of Medical Doctors for Asia (AMDA)-Nepal	Health of the Population improves or remains stable RISK of HIV/AIDS reduced and quality of response improved	0000000071	106,196	
CARE Nepal	Health	10-FPA-043	22,759	1/11/2010
ADRA Nepal	Health	10-FPA-043	1,177	1/11/2010
ADRA	HEALTH	10-FPA-043	1,100	17-Dec-10
ADRA	HEALTH	10-FPA-043	25,916	1-Feb-11
ADRA	HEALTH	10-FPA-043	18,079	13-May-11
CARE	HEALTH	10-FPA-043	20,699	17-Dec-10
CARE	HEALTH	10-FPA-043	64,859	25 Jan 2011
CARE	HEALTH	10-FPA-043	37,715	8-Jun-11
International Relief and Development (IRD)	WASH	10 HAB 008	62,915	03/03/2011
The Lutheran World Federation (LWF)	WASH	10 HAB 008	27,121	18/02/2011
Association of Medical Doctors for Asia(AMDA)-Nepal	Health of the Population improves or remains stable RISK of HIV/AIDS reduced and quality of response improved	0000000071	106,196.00	
Youth for World Nepal (YWN)	Nutrition	10-CEF-056-A	US$ 30,928.00 US$ 17,753.00	April 2011
Nepal Public Health and Education Group (NEPHEG)	Nutrition	10-CEF-056-A	US$ 27,244.05 US$ 15,643.05	April 2011
Save the Children Total	WASH	10-CEF-056-B	US$ 38,631.93	30/11/2010
			US$ 28,784.51	31/03/2011

			67,416.44	
NRCS Total	WASH	10-CEF-056-B	43,083.28	01/12/2010
			37,278.17	31/03/2011
			80,361.45	
OXFAM	WASH	10-CEF-056-B	73,000.00	31/03/2011
Nepal Red Cross Society (NRCS)	Health	10-WHO-067	14,962.68	16June 2011

Annex 2: UNFPA 043 Project

The following section include the achievements made by each respective implementing partners CARE Nepal and ADRA Nepal with the support from CERF funded project:

CARE Nepal

The project supported by CERF funds remarkably contributed to address women's immediate RH problems especially in terms of uterine prolapse in remote districts namely Achham, Bajhang and Bajura through the outreach RH medical camps. During RH camps, different types of sexual and reproductive health services were provided including family planning and general health services.

I. RH Camps

A total of 9 RH camps (3 days each) were conducted in the project districts. Camp sites were finalized through consultation with District Reproductive Health Coordination Committee (DRHCC) and other district stakeholders including non government organizations as well. In the planning and implementation process, there was coordination at different levels – mainly central level between the Family Health Division and UNFPA and at regional level between the Regional Directorate of Health Services and UNFPA Regional Support Offices.

II. Direct beneficiaries

The total direct beneficiaries received various RH services during the entire mobile camps were 4721 (females: 4589 and males: 132). Actually, 4721 beneficiaries includes both who entered OPD and had clinical checkups and those who received health education sessions. Of the total 4243 clients in the OPD, 1281 were Dalits, 13 Janajatis, 2946 Brahmin and Chhetri and 3 were from other ethnicity.

The number of individuals benefitted with the RH services is summarized below:

Table 1: RH services provided in 3 districts

S.N	Services	Bajhang	Achham	Bajura	Total
1	Total beneficiaries (Direct)	1923	1197	1601	4,721
2	Lab services (Total)	419	334	580	1,333
2.1	HIV test	75	60	50	185
2.2	VDRL test	137	61	89	287
3	VCT counselling	75	60	50	185

In addition to this, more than 10 000 people received information on RH through information stalls and existing networks (FCHV and educational institutions) and groups (e.g. mothers groups).

III. UP Cases

Altogether, 250 women were inserted with ring pessary and trained for self care. 90 cases were referred from the screening camps to Team Hospital in Dadeldhura to receive surgical treatment. 72 received surgical treatment. The age group of those that went through surgery were between 23 yrs to 65 years old. 18 referred cases, unfit for surgery were referred to higher level hospital for surgical operation.
Unfit patients in this context mean those who were rejected by anaesthetists on the basis of their clinical history. As some had high or low blood pressure and nausea problems they had to be kept under observation and treatment. Those that couldn't recover did not attend surgery. Some patients had renal problems or infected by hepatitis B and few had cardiac and respiratory problems. These patients could not be admitted as the surgical facility in the camp was not sufficiently equipped in case of any complications arising. Consequently, these patients were well counselled and were referred to Kathmandu Model Hospital. However, during follow up, most of the clients did not go because of the expenses induced in staying in Kathmandu. Actually, only one case of those referred went to surgical hysterectomy in Kathmandu Model Hospital.

The UP services provided in three project districts are summarized in the table below:

Table 2: UP services in the project districts

S.N	UP Services	Bajhang	Achham	Bajura	Total
1	UP First degree	60	8	46	114
2	UP Second degree	72	68	91	231
3	UP Second degree (pessary)	65	66	80	211
4	UP Third degree	59	30	37	126
5	UP III rd degree (pessary)	12	15	12	39
6	UP referral	42	17	31	90
7	Health Education (Direct)	1923	1197	1601	4721

IV. Family Planning Services

The RH camps were successful to provide to 662 women family planning counselling. Among them, 210 and 38 had implant insertion and IUCD services respectively.

Table 3: Family Planning and GBV services

S.N	FP Services	Bajhang	Achham	Bajura	Total
1	IUCD insertion	20	5	13	38
2	Implant insertion	72	72	66	210
3	Family planning counselling	257	208	197	662
4	Psychosocial counselling	140	62	190	392

Of the total patients visiting OPD, 392 patients received counselling on Sexual and Gender Based Violence. The approach adopted was on individual counselling, family counselling and group counselling.

V. Capacity building of local health staff

The project further enhanced the capacity of health workers through on site coaching during the screening camps. A total of 65 health service providers received on site coaching on RH skills including UP management. Local level health workers especially nursing staffs (ANM, MCHW, Staff nurse) were assigned with the Medical Officers for developing their skills regarding FP – IUCD, Implant insertion and

ring pessary insertion. Moreover, local health staffs were trained on counselling techniques and developing health education techniques and skills.

VI. Overall achievements and contribution

Overall, the project through close coordination with all stakeholders had direct positive impacts on RH services to the affected women. These interventions contributed to Nepal government's effort in addressing the most common and pertinent RH problems of women living in remote areas. This project also demonstrated a unified response by the humanitarian community. As a result, this joint relief efforts was implemented smoothly with no duplication. The government bodies at district and other stakeholders have commended positively on CARE's efforts. Furthermore, local level ownership enabled the project to achieve its goals.

4.2 ADRA Nepal

I. RH Camps:

ADRA Nepal conducted 3 reproductive health mobile outreach camps in Mugu district. The project aimed at addressing the existing needs of reproductive health services in remote villages of Mugu district. Mobile camps mainly provided gynaecological services, general health check-ups, SGBV counselling, STI and VCT counselling and laboratory services.

A total of **1,349 clients** (Females: 1283, Males: 66) benefitted with a wide range of RH services. Among the clients 21.8 percent were Dalit, 4.2 percent were Janjati and 73.9 were others which includes Brahmin, Chhetri, Thakuri. Out of the 1 283 females, 1,095 (85.3%) received gynaecological services. The details of services provided are summarized in the table below:

Table 4: RH services provided in Mugu district

A	Service Delivery	Target in total	Achievements		
			Male	Female	Total
1	Number of direct beneficiaries in receipt of RH services	1350	66	1283	1349
2	Number of gynaecological service recipients *(Male clients attended with their spouse for counselling on STI and infertility)*	NA	30	1095	1125
3	Number of STI/RTI syndrome case management recipients	135	11	24	35
5	Number of emergency obstetric first aid recipients	NA	0	3	3
6	Number of mobile camp counselling service recipients	20	41	250	291
7	Number of general health services recipients	NA	34	190	224
8	Number of basic laboratory service recipients	675	40	274	314
9	Number of GBV cases identified and counselled	7	0	17	17
10	Number of health service providers received on site coaching on RH skill	15	1	3	4
11	Number of BCC events and activities *(Group discussion: 10 times, Health education:13 times)*	NA			23 (events)
12	Number of IEC/BCC materials distributed/disseminated	900			**1305**
B	Ethnicity of Patients				
	Dalit		19	276	295
	Janajati		3	54	57
	Others		44	953	997
	Total		66	1283	1349

II. Uterine Prolapse

Altogether 134 women with different degree of uterine prolapsed attended the mobile camps. As the uterus prolapsed has been a major problem in hilly region of Nepal, the project attempted to solve this problem by screening third degree, inserting ring for second degree and taught the perennial exercise to first degree. The status of uterus prolapsed is summarized below:

Table: 3 Uterine Prolapse Status

UP	Identified number	Ring Pessary Inserted	Referred for surgery
First degree	55	47	
Second degree	47	32	
Third degree	32	0	26
Total	**134**	**79**	**26**

The 26 cases requiring UP surgery list were referred to the DHO of Mugu because there was no financial provision for UP surgery in ADRA side.

III. On-site coaching

In order to build the capacity of local health facilities, the project provided on-site coaching to 4 service providers (Females: 3 and Male: 1) during mobile camps. On-site coaching areas were mainly about counselling and methods of insertion and removal of pessary rings as well as aseptic techniques and management of simple general health disorders in low resource settings.

IV. Information, Education and Communication

This project also addressed preventive measures by educating the communities on health issues through distribution of IEC/BCC materials. These materials included brochures, flip charst and posters. In total, 1305 brochures were distributed during the camps.

Annex 4: Fund utilisation – UNICEF WASH

Requisition Reference	Issue Date	Description	Amount
NEPA/2010/00003719-1	01-12-10	NRCS- DCT as per new agreement 2010 - Nepal Red Cross Society- Humanitarian capacity building for WASH disaster preparedness	43,083.28
NEPA/2010/00003720-0	30-11-10	1st DCT - SCF - WASH program	38,631.93
		Cash Sub-total	81,715.21
NEPA/2010/00000174-1	11-10-10	ORS - emergency supplies for WASH	19,780.12
NEPA/2010/00000194-1	12-10-10	W Guard and Soap: WASH emergency sup. replenishment	49,157.96
NEPA/2010/00000226-1	22-11-10	PoU/HW & Sanitation IEC printing	16,713.06
		Supply Sub-total	85,651.14
NEPA/2011/00002963-0	27-06-11	@CASH/NEPS2011999999	-2,024.56
		Cash Sub-total	-2,024.56
NEPA/2011/00003191-0	25-05-11	@CASH/NEPA2011999999	-3.00
		Cash Sub-total	-3.00
NEPA/2011/00000962-1	31-03-11	1st DCT - 2011 - OXFAM - WASH Humanitarian Capacity building..	73,000.00
NEPA/2011/00000963-1	31-03-11	Transportation cost of emergency contingency materials (water guards/FCHV kits) to districts	6,973.73
NEPA/2011/00000975-1	31-03-11	2nd DCT - 2011 - Nepal Red Cross Society - WASH Humanitarian and life skill development program for emergency	37,278.17
NEPA/2011/00000976-1	31-03-11	2nd DCT 2011 - Save the Children- Life saving WASH promotion and response in Mid/Far West Nepal	28,784.51
NEPA/2011/00001575-0	03-06-11	Travel costs - (airfare) - Resource persons for humanitarian wash capacity building training in Surkhet	360.22
NEPA/2011/00001643-0	10-06-11	Transportation costs of Piyus/ORS, and other emergency items - from NCO warehouse to districts	1,304.99
		Cash Sub-total	147,701.62
NEPA/2011/00000149-1	27-05-11	WASH EMERGENCY preparedness - Supply of Plastic Buckets	10,533.61
		Supply Sub-total	10,533.61
NEPA/2011/00000155-1	07-01-11	To support CERF orientation to district Chapters of NRCS in Dhangadhi	238.87
NEPA/2011/00000285-0	05-04-11	To attend the UNICEF and SAVE The Children's partnership meeting at Park Village Resort, 20-21 Jan. 2011	28.08
NEPA/2011/00001518-1	27-05-11	To attend CERF training on WASH in emergencies in Nepalgunj To accompany joint field mission to Rautahat, Siraha and Saptari	527.46
		Travel Sub-total	794.41
		Grand Total of Funds Committed	**324,368.43**
		Total Funds Still Available	**5,865.94**

Annex 4: Acronyms and Abbreviations

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immuno-Deficiency Syndrome
AMDA	Association of Medical Doctors of Asia
ANM	Auxiliary Nurse Mid-Wife
ARV	Anti Retro Viral
BR	Bhutanese Refugee
CABA	Children affected by HIV and AIDS
CARE	Cooperative for American Relief Everywhere
CB-IMCI	Community Based –Integrated Management of Childhood illness
CB-NCP	Community–Based Newborn Care package
CERF	Central Emergency Relief Fund
CERF	Central Emergency Response Funds
CHD	Child Health Division
CMAM	Community-based management of acute malnutrition
CMC	Camp Management Committee
CSOs	Civil Society Organisations
DACC	District AIDS Coordination Committee
DAG	Disadvantaged Group
DDRC	District Disaster Relief Committee
DHO	District Health Office
DHO	District Health Office
DOTs	Directly Observed Therapy
DPHO	District Public Health Office
DWSS	Department of Water Supply and Sewerage
EPI	Expended Programme on Immunization
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FP	Family Planning
GAM	Global Acute Malnutrition
GBV	Gender Based Violence
GoN	Government of Nepal
HF	Health Facilities
HIS	Health Information System
HIV	Human-Immuno-Deficiency Virus
HWWS	Hand Washing With Soap
IEC	Information Education and Communication
INGO	International Non Government Organization
IP	Implementing Partner
IRD	International Relief and Development Nepal
IUCD	Intra Uterine Contraceptive Device
IYCF	Infant and Young Child Feeding
JRC	Junior Red Cross Circle
KAP	Knowledge, Attitude and Practice
LWF	Lutheran World Federation
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Assistant
MCHs	Maternal and Child Health Supervisor
MCHW	Mother and Child Health Workers
MDG	Millennium Development Goal
MLD	Ministry of Local Development
MNP	Micronutrient Powder
MOHP	Ministry of Health and Population
MPPW	Ministry of Physical Planning and Works
NDHS	Nepal Demographic and Health Survey
NGO	Non Government Organization
NRCS	Nepal Red Cross Society
ODF	Open Defecation Free

OPD	Out Patient Department
ORE	Out Reach Educator
OTP	Outpatient Therapeutic Programme
PHC	Primary Health Centre
PHCP	Primary Health Care Centre Project
POU	Point-of-Use
ReSoMal	Ready to Use Therapeutic Milks
RH	Reproductive Health
RHCC	Reproductive Health Coordination Committee
RHD	Regional Health Director
RPR	Rapid Plasma Regain
RRT	Rapid Response Team
RTI	Reproductive Track Infection
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SGBV	Sexual Gender Based Violence
SM	Social Mobilisers
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UP	Uterine Prolapse
VCT	Voluntary Counselling and Testing
VDC	Village Development Committee
VDRL	Venereal Disease Research Laboratory
WASH	Water, Sanitation and Hygiene