RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS REPUBLIC OF DJIBOUTI UNDERFUNDED EMERGENCIES ROUND I 2013

RESIDENT/HUMANITARIAN COORDINATOR	**Mr. Robert Watkins**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

No CERF-specific After Action Review has been conducted. Although, from December 2013 to January 2014, the Humanitarian partners prepared the Humanitarian Needs Overview (HNO) as part of the development of the Strategic Response Plan (SRP) for 2014-2015. It allowed the Humanitarian community to have an up-to-date common understanding of the current Humanitarian Situation in the country that takes into account all data and findings of the most recent surveys on the Humanitarian situation. In parallel, when preparing the prioritization strategy for the 2014 CERF underfunded window, a thorough analysis at Cluster level took place during the month of January on the most acute emergency needs of the different segments of the populations living in the most drought-affected regions and facing life-threatening situations. The analysis included a review of the results achieved during the 2013 implementation of CERF funded projects.

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

YES ☒ NO ☐

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

YES ☒ NO ☐

The advanced version of the report was shared for review with in-country stakeholders, notably CERF recipient agencies and sector coordinators. Its content was discussed with the implementing partners and counterparts.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: 71,670,661		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	3,312,737
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (if applicable)	0
	OTHER (bilateral/multilateral)	36,015,727
	TOTAL	**39,328,464**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 15-Feb-13			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	13-CEF-025	Water and sanitation	449,991
UNICEF	13-CEF-026	Health-Nutrition[1]	300,894
FAO	13-FAO-009	Agriculture[2]	600,823
UNFPA	13-FPA-009	Health	103,421
UNHCR	13-HCR-015	Multi-sector	325,604
IOM	13-IOM-004	Multi-sector	325,000
WFP	13-WFP-009	Food	750,275
WHO	13-WHO-009	Health	404,099
UNAIDS	13-AID-001	Health	52,630
TOTAL			**3,312,737**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	2,765,965
Funds forwarded to NGOs for implementation	516,576
Funds forwarded to government partners	30,196
TOTAL	**3,312,737**

[1] Project submitted by the "Nutrition" Cluster/Sector
[2] Project submitted by the "Food Security" Cluster/Sector

HUMANITARIAN NEEDS

What prompted the CERF request was the humanitarian crisis prevailing in Djibouti in early 2013 as the result of the persistent drought over the six previous years. The direct impacts of the drought were the high and generalized food insecurity and the unavailability of safe water. Those direct impacts were further aggravated by the increasing trend in international food prices (as the country depends on imports for over 90 per cent of its products). This context was also characterized by the influx of refugees from neighbouring countries and migrants. The overall population affected by the crisis was of 300.000 people, including 212.000 vulnerable people affected by the drought, 26.000 refugees and 65.000 migrants. In terms of food security, 132.000 people were in need of food assistance; the 2012 EFSA indicated that 42.600 people were in acute food insecurity and 24.300 in moderate food insecurity in the rural areas, while 6.500 households (around 32.500 people) were food insecure in urban areas. The 2010 IPC map for food insecurity in Djibouti indicated a level of crisis in most parts of the country, including peri-urban Djibouti-Ville, while the remaining areas remain at stressed level (such as the area of Balbala). The highest proportions of households in severe food insecurity were reported in the pastoral zone of the north-west, followed by the south-east and the centre. The drought of the last years (in 2012: 80 per cent less rains than in 2008) had as a consequence that the water sources could not refill, that surface water dried out and the salinity increased by almost 49 per cent. According to UNICEF 110.000 people in rural areas as well as 42.000 in urban areas have no access to safe drinking water. The scarce resources were often the cause of conflict between the local population and the migrants. These factors led to grave health and nutritional status of the population. Nutrition figures showed an under-five malnutrition rate of 20 per cent in Djibouti Ville and all the other regions (Tadjourah, Dikhil, Ali Sabieh, Obock, Arta), that was significantly higher than the alarm threshold (15 per cent). In 2012, high rates of respiratory diseases and diahrrea for children and adults were recorded, as well as epidemics of dengue and measles, respectively in June and January. Access to lifesaving health services remained a major challenge for the population both in rural and urban areas because of long distances, unavailability of health personal and high cost of lifesaving medicines. Women and children in drought-affected areas suffered the most from this lack of services. Maternal mortality rates was high (300/100.000 live births) and the prevalence rates of HIV/AIDS (2.7 per cent) and TB, estimated to be one of the highest in the world, were also alarming. In 2012, almost 100 patients had multi-drug-resistant TB). The above was partly the result of the fact that many TB and HIV related activities such as prevention, awareness, testing and active contact tracing for new cases could not be carried out since the funding from the Global Fund was stopped in 2009. A malaria outbreak hit the country and more specifically the capital, where most of the people had no previous encounters with malaria thus affecting many neighbourhoods but mainly being concentrated in the poorest and most underserved areas in the capital.

II. FOCUS AREAS AND PRIORITIZATION

Relevant needs assessment findings:

WASH: To ensure access to water to the rural communities and peri-urban areas; To promote hygiene/hand washing and to make available water storage material; Food Security: To implement a food voucher programme during the lean season; Nutrition: To provide emergency nutrition activities to severely malnourished under-five children and to pregnant and lactating women through both health facilities and community sites; Health: To increase access to health centres for the most vulnerable persons including women with no access to antenatal, emergency obstetrical and neonatal health care and to malnourished children with medical complications; To provide life-saving response to epidemic and transmissible diseases; To respond to the epidemic outbreaks and the needs in terms of additional medicines, rapid diagnostic tests and proper training, information and awareness to the population; Refugee/Migrants: To provide urgent WASH, health and nutrition support.

Key humanitarian data:

Key humanitarian data that justified the CERF funded projects:

212.000 vulnerable people affected by the drought,
26.000 refugees (planned estimated number)
65.000 migrants
132.000 people in need of food assistance;
42.600 people in acute food insecurity
18 per cent of households facing food insecurity in Djibouti City
70 per cent of the population in the rural areas was living with poor food consumption and a poor purchasing power;
24.300 in moderate food insecurity in the rural areas
32.500 people food insecure in urban areas.
49.1 per cent of people in rural areas without access to a protected source of drinking water
110.000 people in rural areas as well as 42.000 in urban areas have no access to safe drinking water.
Under-five malnutrition rate: 20 per cent

Maternal mortality rates: 300/100.000 live births
HIV Prevalence rate: 2.7 per cent
Number of deaths due to AIDS in 2010: 1,000 people.
10 per cent of the rural population with access to improved family latrines
GAM of 9.5 per cent (up to 12 per cent in some areas),
SAM of 5 per cent
GAM in Balbala, peri-urban area of Djibouti capital: 10 per cent
GAM in Dikhil: 13 per cent
GAM in Arta and Ali Sabieh: almost 10 per cent.
GAM in Tadjourah and Obock: over 15 per cent
Proportion of children suffering from acute malnutrition was 20 per cent with 5 per cent of severely acute malnourished.
35 per cent of the rural population lives more than one hour from the nearest health facility;
1 per cent of rural population budget is spent for health;
50 per cent of health centers in the regions have limited or no supply of water ;
50 per cent of health centers in the regions have electricity or solar power;
2 doctors in each region (Ali-Sabieh, Arta, Dikhil, Obock, Tadjourah);
In the first semester of 2012, 10,173 cases of diarrhea (6,738 children and 3,435 adults), 60,128 cases of respiratory diseases (20,717 children and 39,411 adults) as well as 456 cases of measles (314 children, 143 adults, mainly women);
3726 TB cases detected in 2010 of which 565 were children
Multi-drug-resistant TB: 100 patients
96 patients with multi-drug-resistant TB in 2010;
Livestock mortality rate: 50 per cent
Coverage of malnutrition case management : 70 per cent

Geographical coverage:

Life-saving activities were implemented in the most affected regions of the country both in rural and peri-urban areas according to the specific needs of those and to the value of key humanitarian indicators.

	Peri-Urban Area of Djibouti capital city	Ali-Sabieh	Arta	Dikhil	Obock	Tadjourah
Health	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X
Food Security	X	X		X	X	X
WASH	X	X			X	X
Multisector		X		X	X	X

The most urgent activities considering both the life-saving criteria and the greatest funding gaps were the provision of food assistance to the most vulnerable population during the lean season (people living with a handicap, orphans and women head of households); the urgent provision of safe drinking water for refugees, migrants and vulnerable rural households; urgent provision of therapeutic treatment for under-five malnourished children; provision of health assistance; protection of refugees and migrants and fighting livestock mortality.

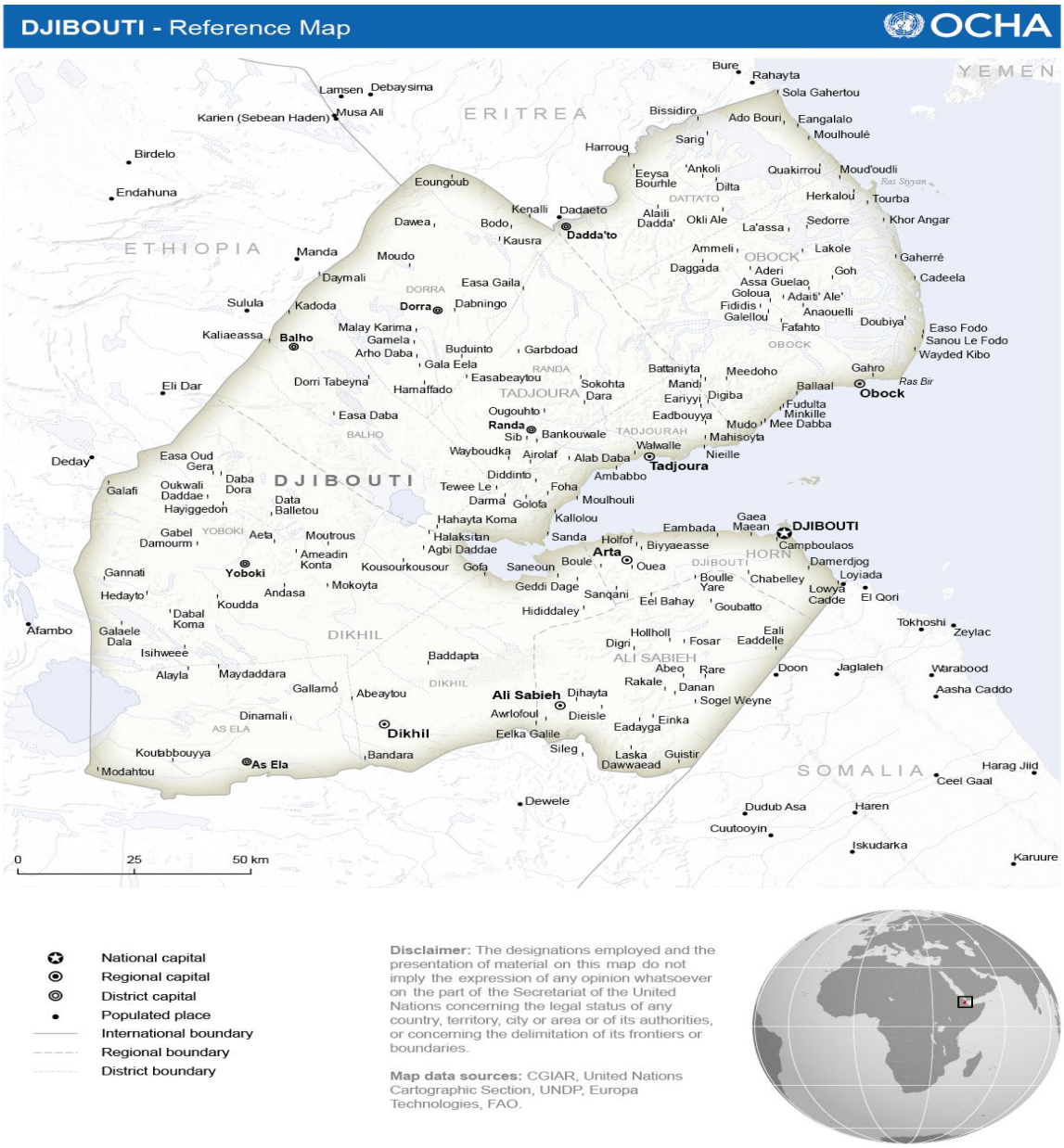

Figure 1 : Reference Map of the Republic of Djibouti

III. CERF PROCESS

During all the year 2012, six humanitarian clusters were actively following the crisis developments and they were complemented by inter-cluster meetings that served as a forum for discussing cross-cutting issues and most urgent needs including those of women and girls. In addition, most agencies organized need assessments (WFP, UNICEF, FAO) and in some cases joint assessments were conducted (UNICEF, WHO, FAO, ACF). Those assessments took into account gender aspects and specifically the situation faced by women, including pregnant and lactating women and the situation faced by girls. A system wide consultative effort involved Governmental bodies, UN Agencies and Programmes, INGOs, civil society organizations and donors to agree on the situation assessment and on a common humanitarian strategy that culminated with the launching of the 2013 CAP. Following the official announcement of the CERF allocation, briefings took place on the following steps. After the reception of the technical guidance from the CERF Secretariat, ad-hoc inter-cluster meetings were organized and concluded that the humanitarian situation portrait in the CAP 2013 did not change significantly. The inter-cluster meetings stressed that several clusters were facing important funding gaps and it recommended to the HCT, that the CERF funds had be used to meet the needs of the most vulnerable, specifically those of women and girls and to fill the funding gaps. The HCT made estimation of the funds to be allocated to each cluster based on the life-saving criteria, the evaluation gaps, the emerging needs and the underfunded clusters. The percentage of funds spent from 2012 CERF envelope was also considered for determining the prioritization

strategy. The projects contributed to gender equality and had a positive impact on the life of women, girls and children. Women and girls were not solely beneficiaries of the projects but also participated equally to men to their implementation. Furthermore, women were active members of established management committees and were taking large part in decision making processes.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR				
Total number of individuals affected by the crisis: 300,000				
The estimated total number of individuals directly supported through CERF funding by cluster/sector	**Cluster/Sector**	**Female**	**Male**	**Total**
	Water and sanitation	25,890	24,875	50,765
	Health-Nutrition[3]	21,520	12,480	34,000
	Agriculture	6,108	5,012	11,120
	Health	170,000	150,000	320,000
	Multi-sector	20,565	26,313	46,878
	Food	5,916	5,524	11,440

BENEFICIARY ESTIMATION

The total planned beneficiaries were of 217,000. That number corresponded to the highest number of beneficiaries among the clusters/sectors involved in the emergency life-saving CERF underfunded request; i.e. the health sector. Indeed, most of the planned beneficiaries were in need of a comprehensive package of emergency assistance. To estimate the total number of reached beneficiaries, the same process was used and logically the numbers of the Health sectors were taken as reference. Actually, through the CERF funded project in Health, the CERF allocation allowed reaching 30 per cent more beneficiaries than planned (320,000 against 217,000). The reason being that the activities related to outbreak monitoring and epidemic control had to cover more communities and that essential medicines had to be added with rapid diagnostic tests and anti-malarial to cover emergency and security stocks.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	**Estimated Reached**
Female	116,000	170,000
Male	101,000	150,000
Total individuals (Female and male)	217,000	320,000
Of total, children under age 5	40,000	60,000

CERF RESULTS

Overall, the CERF allocation allowed the implementation of life-saving activities for 30 per cent more beneficiaries than planned (320,000 against 217,000). The increase concerned equally the number of women and men and is mainly due to the Health cluster/sector activities. For the other cluster/sector, they were no great differences between targeted and reached beneficiaries with the exception of

[3] The Cluster/Sector is "Nutrition" in Djibouti.

the WASH cluster/sector. The reason being the delays in the liquidation of 2012 funds by partners that resulted in a significant delay in the actual start date of the Nutrition project implementation. Moreover, as some partners were unable to solve this liquidation issue on time, cooperation agreements with them had to be put temporarily on-hold. As a consequence, the project had to be partially restructured in order to revise the number of planned beneficiaries.

Key results in Water and Sanitation:

- 30,302 people in the poor neighbourhoods of Djibouti-city benefitted of improved access to safe water through the construction and rehabilitation of shallow wells (12,302 people) and the distribution of household water treatment products (18,000 people);
- 20,463 people improved their hygiene practices through awareness-raising activities (17,260 people) and the construction of latrines (3,203 people including 2,903 school children and teachers).

Key results in Nutrition

- The coverage of malnutrition case management increased from 70 per cent to 75 per cent;
- The case fatality rate of severe acute malnutrition has been reduced 3 per cent to 2 per cent;
- The recovery rate of severe acute malnutrition increased from 75 per cent to 80 per cent;
- The default rate of malnourished children treated for severe acute malnutrition decreased from 22 per cent to 19 per cent;
- 80 per cent of children under five years old out of 46,900 and 80 per cent of mothers out of 30,000 received micronutrient supplements in the different regions of the country;
- 100 per cent of mothers (24,000) using the nutrition services had access to adequate information on Young Child Feeding practices.

Key results in Agriculture

- Construction of 10 Wells along key pastoralist routes in DimolehEla, Gandeli, Gorolita, Tikibleyta, FoaarHolHol, Dagahdalol, Dagawayn, DokalehGalilé, Angare and Walissa. The beneficiaries from this activity are 4800 people.
- Construction of 11 Cisterns/Water harvesting structures along key pastoralist routes in AssaelaOuraly, SankalAysouly, GagadeAlouly, GagadGegalou, MoBalanbaleh, MadhedloDikh, DalMokoronta, OngoyloDalha, GalimaAbaAss, OuylalyAssal and AdodabaGuerenleh. The beneficiaries from this activity are 1980 people.
- Distribution of 1000 Micronutrient blocks (5kg each one) in 50 key pastoralists water points. 20,000 goats benefited from this intake, owned by 2,400 people.
- Provision of Cash for Work (CfW) programme through the construction and expansion of the trench for the one-pipe aqueduct in Assagueyla (Tadjourah). The beneficiaries from this activity are 1800 people.
- Support to 21 Water point management committees. This activity was done through SOS Sahel where 14 Water committee have been restructured and trained. The direct beneficiaries from this activity are 140 people.

Key results in Health

- 11 Mobile clinics were made operational and supported in all 5 regions; there were around 1-6 outings per month per region to cover various remote areas. These varied according to the availability of the team and the doctor and also the load at the regional hospital (CMH) since the mobile clinics leaves the CMH with half of its medical team. The regularity of these visits was strengthened in 2 districts (Ali Sabieh and Dikhil), and is in process in the other regions as the terrain is more difficult. The population covered from remote areas in each region varied on each visit as the population would be informed and gather at the meeting point. Hence the reports available show that for 6 months show that for the targeted 20 per cent population in the regions living in remote areas amounting to 64,000 persons, 15816 consultations were made with 42 per cent of them for children, 7 per cent pregnant women, 47 adult population consultation hence a rate of 0.5 consultation per capita per year which is within the accepted norms.
- Emergency medicines were procured and distributed to ensure access to medicines to the 120,000 people.
- Comités de Gestion or Health committees (17) - 1 for each of the 5 CMH and 12 community health centres – reactivated. overall and 2 in the pilot project of health coupons were engaged in the training and awareness raising on the management of cases of malnutrition, diarrhoea and malaria;
- 672 households benefited from health vouchers;
- Free provision of medicines to those most at risk and to vulnerable households (2000)or the treatment of children most common illnesses documented during August to November in Djibouti capital health centers under the health coupons project;
- 250 children covered in consultations and 100 pregnant woman in Balbala II;
- 504 children visited the health centres and 155 pregnant women had prenatal consultations;
- The number of malnutrition cases weekly reported from the pots and CMH from the regions was on average varying between 20—25 cases in each facility. However in the health coupons project by increasing the information given to the population and providing them with the simple incentive of the health card and bringing them for the initial checkup, the graphs showed that comparing the 2012 and 2013 data in Arhiba for example for severe malnutrition, there were 80 cases detected in September 2013 compared to September in 2012 and for chronic malnutrition there was 49 cases detected in 2013 compared to 1 in 2012.

In Balbala 2 52 cases of severe malnutrition were detected in October 2013 compared to 20 in 2012 and 58 cases of chronic malnutrition in 2013 compared to 34 in 2012. The short time of the pilot project could definitely not be representative however the passive reporting from centers in the regions and other facilities compared to the more active search used in the pilot was corroborated with the findings of the SMART Survey conducted in December 2013. The data compiled through health facilities and community treatment sites may not reflect the real values and the access or increasing information and tracking of cases among children should be enhanced;

- Outbreak monitoring and alerts mechanism reinforced in the capital and in the regions;
- 50 per cent increase in the number of nurses and midwives who are providing HIV, VCT services to pregnant women, their husbands and malnourished children; The nurses and midwives were not giving VCT and providing HIV testing before, and if done was not quantified
- 50 per cent increase of health facilities which are providing HIV, VCT services to pregnant women, their husband and malnourished children; 5 centers out of 10 Community health centers in Djibouti capital
- 6 midwives and 6 doctors were trained on MISP (minimum initial service package – a core package of minimum reproductive health interventions in emergency settings) and on the guidelines of clinical care of cases of Gender Based Violence and the referral system;
- 6 health medical centres were provided with obstetric kits distributed as needed to the mobile teams. In addition, two (2) Vacuum Extraction for Delivery (Manual) (kits 10) and obstetric rubber pads were provided per district to ensure management of obstetric emergencies. One suture of tears (cervical and vaginal) and Vaginal Examination kit (Kit 9) was provided to the region of Ali-Sabieh to perform the suture of the diaphragm in cases of complications related to cases of GBV referred from Ali-Addeh and Holl-Holl refugee's camps. One (1) box of women condoms was also provided to the district of Ali-Sabieh;
- Other outcomes were the following: 62 women with pregnancies complications were diagnosed and transferred ; 806 ante-natal consultations were undertaken (CPN 1/CPN2/CPN3/CPN4) as well as 184 post-natal consultations; 411 women started using contraceptive methods, 3,481 condoms were distributed, 152 women and 72 men were diagnosed with STD and treated; 547 women benefited from counseling services; awareness raising and orientation sessions were provided to the members of 75 cooperatives on the detection of pregnancy complications, pre-natal consultations, family planning and nutrition of children; they benefited also from an initiation to the minimum initial service package but was not fully trained on that.

Key results in Multisector/Refugees

- At the end of 2013, 1,708 refugees were living in Holl Holl and 58 per cent of households benefited from their own family latrines: 184 family latrines were constructed.
- Access to sanitation facilities combined with hygiene promotion had a positive impact on the living conditions and health of refugees. According to the HIS (Health information System), the prevalence of the water diseases was reduced from 4.5 per cent in 2012 to 2.6 per cent in 2013. To accommodate new arrivals (572 Refugees were transferred from Ali Addeh to Holl Holl in 2013), 70 communal holes constructed were regularly cleaned and maintained on a daily basis. Six communal holes/pits were destroyed and properly filled as per the required recommendation and in the respect of the national policy. Cleanliness and waste management in the camps were ensured by the Minister of Environment as per the national policy. In the line with the Vector Control, two campaigns of outdoor residual spraying were organized in both camps (April and November) as per Djibouti epidemiological calendar. The campaigns were conducted by the National Institute of Public Health (NIPH) with respect to the national policy in partnership with CARE. It should be noted that the residual spraying campaigns were combined with disinfection/treatment of latrines (family, public and communal).This activity had a positive impact on the reduction of vector related diseases like malaria and dengue fever in the camps. Local populations surrounding the camp areas were also covered by the two campaigns. In addition, 362 family latrines were constructed in Ali Addeh. The family latrine coverage reached 82 per cent in Ali Addeh and 58 per cent in Holl-Holl. This should be considered as a great improvement because the coverage in terms of family latrine was before the project, 0 per cent in Holl-Holl and 71.6 per cent Ali Addeh in December 2012.
- Soaps were purchased and distributed during six (6) mass hygiene campaigns and door to door sensitization: 17, 524 persons in Ali Addeh and 1, 708 in Holl Holl received soap during those activities.
- In each camp, there is one functioning health centre providing the primary health services for refugees (curative and preventive care). Curative cares (acute and chronic disease) were available every day and 24 hours in both camps of Ali Addeh and Holl Holl. In 2013, 42,807 consultations in Ali Addeh and 3,599 consultations in Holl Holl were registered; the health facility utilization rate was 3.1 new visits/refugee/year in Holl Holl and 2 new visits/refugee/year in Ali Addeh. All emergencies case were timely referred (220/220). In 2013, the health centres were equipped with laboratory materials (in Holl-Holl), delivery beds (both Ali-Addeh and Holl-Holl), an oxygen Tank / Concentrator for the emergency room (Holl-Holl), and other medical materials including blood pressure monitors, stethoscopes, and thermometers for both camps. A measles vaccination targeting 629 children under-five years old was conducted during the nutrition survey in December 2013. As a result, 618 children were vaccinated. Therefore, our measles vaccination coverage has improved from 83.0 per cent in 2012 to 98.2 per cent in 2013 (while our initial target for 2013 was 85.0 per cent). In addition, a measles vaccination campaign targeting 1 to 15 years age group was carried in 2013 in collaboration with World Health Organization (WHO) and the Ministry of Health. Even though under-5 mortality rate (0.34 death/1000/month) was slightly above the initial target (0.3 deaths/1000/month), it remains within

the UNHCR acceptable standards. The mortality rate among this group was 0.3/1000/month in Ali-Addeh and 1.3/1000/month in Holl-Holl. In January 2013, an order was placed for essential drugs and medical supplies through UNHCR International Procurement System, drugs have been received in July 2013 and used in the Ali-Addeh and Holl-Holl refugees' camps health facilities.

- The annual nutrition survey was conducted in December 2013. It revealed that the anaemia prevalence among women of reproductive age is 26.8 per cent (26.7 per cent in Ali-Addeh and 25.2 per cent in Holl-Holl). The results of 2013 nutrition survey noted that the prevalence of GAM was 12.6 per cent (9.7-16.2) and 11.9 per cent in Ali Addeh and Holl-Holl respectively. The SAM was 3.0 per cent (1.7-5.1) and 2.1 per cent for Ali Addeh and Holl-Holl camps. There is a significant increase in the GAM in Ali Addeh and although MAM cases remained similar to 2012, the SAM cases have increased by sixfold. The discontinuation of nutri-butter (due to budget constraints) which was given as a blanket supplementation feeding in March 2013 might have had some impact on the malnutrition levels. A total of 335 births were reported: 330 were assisted by qualified medical personnel (291 Ali Addeh and 39 in Holl-Holl) giving a rate of 98.5 per cent of cases assisted in Ali-Addeh and Holl-Holl. Two cases of rape were reported. The victims (both females) were identified and they received necessary assistance (including the PEP Kit within 48 hours). As a result, 100 per cent of identified rape survivors received PEP within the recommended 72 hours after the incident.
- Voluntary counselling and testing services (VCT) were available in Ali Addeh and Holl-Holl camps. The laboratory technicians and VCT staff were trained and received authorization of the ministry of health to practice at the camp level accordingly. A total of 522 persons accepted counselling and HIV testing (494 women and 28 men) of which 5 cases were positive (2 men and 3 women). The total number of persons living with HIV in both camps is of 35 (34 in Ali Addeh and 1 in Holl-Holl). Among them, 28 are under ARV treatment supported by the Ministry of Health national HIV treatment centre Djibouti capital. The remaining 7 cases are not yet eligible according to the national protocol. In addition, all of them received support (additional food items, medical and psychosocial). With the advocacy of the UN joint team fight against HIV, the new national HIV strategic plan has planned a decentralization of ARV program.

Key results in Multisector/Migrants

- The provision and distribution of essential drugs, infusions, Oral Rehydration Salt (ORS) for case management and prophylaxis provided operational relief to the current strain on functional primary health care facilities to 15,461 beneficiaries.
- 23,068 individuals were reached for improved Acquired Watery Diarrheal (AWD)-awareness including 3,600 migrants. 150,000 Chlorine tablets and ORS were disseminated in villages for local communities and migrants. Additionally, 2,500 individuals were referred to the health centres.
- 15,000 flyers in local language disseminated to potentially affected populations.
- 1,000 vulnerable cases with severe medical conditions were identified and referred to nearby hospitals. Initial assistance was provided to them before referring them to appropriate services at the hospitals in Obock and Tadjourah. 6,568 were directly assisted with improved health awareness, safe hygiene practices and provided access to early diagnosis, referral and timely medical treatment. 2,500 migrants were provided with access to health care services and received treatment for various illnesses including diarrheal diseases, tuberculosis and malaria among others.
- Increased awareness on AWD and hygiene of various health partners and communities was achieved through outreach activities and coordination meetings. The coordination also involved the Health authorities. The number of people (local community and migrants) reached, the control of the cases of AWD within the communities, the fact that no conflict on the use of resources was reported in areas reached are good signs that the objective of the hygiene awareness was reached.
- 244 vulnerable migrants directly provided with emergency evacuation assistance to their country of origin.

Food

- Household food consumption score of the assisted beneficiaries was improved. After the project, 96.8 per cent of the assisted households (HH) had an Acceptable Consumption Score versus 88.7 per cent at mid-term review exercise;
- WFP ensured the start of the voucher programme and therefore the timely assistance provided to 6,500 urban poor household during a period where they see their purchasing power increasingly weakened as food and non-food expenses increase.
- The food ration distributed through vouchers covered only the daily caloric gap (1,300 kcal) the urban poor households face during the warm season, hence didn't cover the full 2,100 kcal required caloric intake requirement because they had access to other limited caloric intake.
- The food consumption profile of the targeted households also showed a deficient consumption of particular macro and micronutrient rich foods, that entails higher risk of important micronutrient deficiencies such as Vitamin A and iron for women and young children. The food basket provided by the voucher programme helped providing some of these vitamins to reduce the risks of anaemia and other micronutrient deficiencies among the poor urban households and particularly the women and the young children.

CERF's ADDED VALUE

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

The UNAIDS led component of the Health joint project excepted (ref. Project Results section), CERF funds led to a fast delivery of assistance to the beneficiaries; for instance, the timely provision of supplies for the malnutrition case management, the timely improved access to WASH services in suburban areas, the timely order of medicine for the refugees etc. However, despite the rapid availability of CERF funds, the delivery of assistance in WASH took a bit longer to effectively materialize in rural areas. Moreover, it is worth to mention that the rapid availability of CERF funds allowed in certain cases the provision of emergency assistance prior the availability of other funds (e.g. migrants).

b) Did CERF funds help respond to time critical needs[4]?
YES ☒ PARTIALLY ☐ NO ☐

The UNAIDS led component of the Health joint project excepted (ref. Project Results section), CERF funds helped to respond timely to critical needs. In Nutrition for instance, CERF funding enabled prompt/early action to respond to life-saving needs and time critical requirements in helping for the rapid provision of therapeutic milk and essential drugs for the treatment of severe malnourished children. In the WASH, CERF funding enabled response to time critical needs by improving access to safe water for 30,302 people in the poor neighbourhoods of Djibouti-city through the construction and rehabilitation of shallow wells (12,302 people) and the distribution of household water treatment products (18,000 people) (ref. Key Results section above). Furthermore, CERF 2013 funding was timely helpful to meet the high humanitarian needs among vulnerable migrants and affected host communities. IOM supported an unprecedented high number of stranded migrants along the corridor of migration in Djibouti. As agreed upon funds were reallocated from rehabilitation of 5 water points previously planned because priority was given to unexpected emergency evacuation to 244 vulnerable migrants. Thanks to the CERF funding, 244 vulnerable migrants were evacuated to their country of origin and been reunified with their families members. The project provided water decontamination tabs; rehydration salts, and drugs supplies to cope with humanitarian needs faced by migrants and host communities. CERF allocation was helpful especially when UNHCR was facing the budget constraints effect to cover some needs of hygienic sector in the camps. This funding permitted to provide soaps to refugees at a crucial period of spreading of hygiene disease.

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

It is partially that CERF funds improved resource mobilization from other sources of funds. In some cases, CERF funded projects were developed as part of the whole humanitarian response. Therefore, other projects were developed to mobilize funds from other partners mainly throughout bilateral and multilateral cooperation (e.g. in WASH, Nutrition, Refugees). CERF funding supported the urgent implementation of life-saving activities, other mobilized resources covered additional component of the overall Humanitarian Response.

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

CERF improved coordination amongst the humanitarian community. In addition to that, CERF improved complementarity and information-sharing among the humanitarian community. The above mentioned was reached under the leadership of the concerned ministries. For instance, to deal with the nutritional emergency, the Ministry of Health set up a National Coordination Team at the central and regional levels. The Nutrition cluster with representatives from technical department of the Ministry of Health, other sectors and UN Agencies contributed to the coordination of nutrition-related interventions. The WASH cluster was also re-activated in September after few months of relative inactivity due to turnover of personnel. It made a positive contribution to improved coordination of WASH interventions and to the HNO/SRP preparation process. The Ministry of Agriculture was fully on board and playing an active leadership role. Overall CERF helped to bringing humanitarian actors together to determine priorities, to support the highest priority projects, to support joint monitoring activities and to share experience and good practices and to develop complementarities among humanitarian actors. In addition, through the improved coordination, the CERF allowed the mitigation of tensions between refugees and local populations in the camps and surroundings villages.

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

[4] 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.).

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Response capacities	Life-saving criteria and CAP/SRP underfunded projects should be maintained as a core of all allocations however, capacities of delivery could also be further taken into consideration.	CERF

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Intersectoral collaboration for nutrition interventions	The organization and management mechanism set up by MoH for the response with the cooperation of other partners was successful and enabled partners to provide the much needed support to malnourished children. This will need to be further continued and sustained	All Sectors
Community-based approach for nutrition interventions	The community-based approach for severe acute malnutrition management is found to be the better way for a good coverage of malnourished children.	Nutrition Sector
Maintenance of water installation	Limited capacities for the maintenance of water installation could be a threat to the continuous provision of sufficient and quality supply of water to populations particularly in rural areas. Capacity building of water management committees at community level will allow to mitigate the risk; a regulatory framework for these committees is being developed.	WASH Sector

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	27.02.2013-31.12.2013
2. CERF project code:	13-CEF-025	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Water and sanitation		☒ Concluded
4. Project title:	WASH Response in vulnerable areas victim of drought		

7.Funding				
	a. Total project budget:	US$2,500,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 851,535	▪ *NGO partners and Red Cross/Crescent:*	US$ 300,763
	c. Amount received from CERF:	US$ 449,991	▪ *Government Partners:*	US$ 5,392

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	84,350	25,890	Delays in liquidation of 2012 funds by partners (resulted in a significant delay in the actual start date of project implementation which also reflected on the actual cost of some activities. Moreover, as some partners were unable to solve this liquidation issue on time, cooperation agreements with them had to be put temporarily on-hold which resulted in some activities not taking place and their expected beneficiaries not being reached –at this stage at least -; the project had to be partially restructured in order to revise the number of planned beneficiaries and to partially compensate this "loss" of beneficiaries. Despite this effort, the discrepancy between the number of beneficiaries planned and reached remained.
b. Male	67,650	24,875	
c. Total individuals (female + male):	152,000	50,765	
d. Of total, children under age 5	19,760	6,599	

9. Original project objective from approved CERF proposal

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

The specific objectives are:

- Improve equal access to safe and appropriate water for women, girls, boys and men and preserve health by making at least minimum quantities of clean water available for drinking and household use for 67,000 drought-affected people;
- Improving access to adequate sanitation for the poor of neighbourhoods of Djibouti;
- Improve sanitation and hygiene practices for 85,000 people (women, girls, boys and men) at community level and those poorest peri-urban areas in Djibouti City (themes of water conservation, environmental hygiene, diarrheal diseases, maintenance latrines, hand washing….).

10. Original expected outcomes from approved CERF proposal

The project is expected to provide safe water to 67,000 people including 5,000 through water trucking in the poor neighbourhoods of Djibouti. It will also prevent outbreaks of water borne diseases through increased knowledge in good hygiene practices and

behavioural change for 85,000 people (women, girls, boys and men).

11. Actual outcomes achieved with CERF funds

- 30,302 people in the poor neighbourhoods of Djibouti-city benefitted of improved access to safe water through the construction and rehabilitation of shallow wells (12,302 people) and the distribution of household water treatment products (18,000 people);
- 20,463 people improved their hygiene practices through awareness-raising activities (17,260 people) and the construction of latrines (3,203 people including 2,903 school children and teachers).

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

As explained in section 8 above, project implementation suffered important delays in part related to the difficulties faced by a number of partners to liquidate transfers of funds made to them by UNICEF in 2012 and which resulted in the need to postpone the renewal of cooperation agreements with them until November 2013; this significantly reduced the time available for project implementation and the resulting increase in cost and cancelling of some activities (e.g. rehabilitation of pumping stations and water trucking). The collaboration with the Djiboutian Red Cross had to be cancelled as the funds liquidation from 2012 was unduly delayed and not completely settled.

These constraints led UNICEF to restructure the project, review some of its modalities and to revise planning figures. After evaluating the implementation capacity of partners, UNICEF agreed with them on the activities to keep as per plan, those to be cancelled and those to be further strengthened in quality terms or expanded in coverage.

Despite these changes and adaptation efforts, it was not possible to fully meet the expected outcomes. The project was able to provide safe water to 30,302 people in the poor neighbourhoods of Djibouti-city, against the 67,000 planned. However, instead of water trucking (which was expected to benefit 5,000 people), UNICEF and partners decided to invest in more sustainable alternatives, such as shallow wells (12,302 beneficiaries). Household water treatment products were distributed to 18,000 people. In terms of hygiene promotion, the number of beneficiaries reached 20,463 people, against the expected 85,000. At this level, the priority was given to the construction of latrines. As a result, the number of beneficiaries of access to improved latrines increased from the 600 initially planned (through construction of 100 latrines) to 3,203 (including 2,903 school children and teachers).

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

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

Although no full-fledged external project evaluation has been undertaken, joint monitoring visits were conducted by UNICEF and the implementing partners (ACF, ADIM, Care and the Ministry of Agriculture and Water Resources). The information gathered in the field was used to evaluate the capacity of the implementing partners, assess gaps and identify which components of the project could be strengthened in order to increase the number of their beneficiaries so as to partially compensate the decrease having resulted from the reorientation or cancelling of few activities.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	15.02.2013-31.12.2013
2. CERF project code:	13-CEF-026	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health-Nutrition		☒ Concluded
4. Project title:	Nutrition Emergency Management in Djibouti		

7.Funding				
	a. Total project budget:	US$ 3,210,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 1,181,138	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$ 300,894	▪ *Government Partners:*	US$ 24,804

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	21,520	21,520	NA
b. Male	12,480	12,480	
c. Total individuals (female + male):	34,000	34,000	
d. Of total, children under age 5	24,000	24,000	

9. Original project objective from approved CERF proposal

The overall objective of the project is to ensure that the nutrition status of boys and girls, and pregnant and lactating women is protected from the effects of drought in Djibouti.

The specific objectives are:

- Ensure that all acutely malnourished children are treated according to international norms;
- Ensure that the micronutrient status of all children under five years old, and pregnant and lactating women are taken into account;
- Ensure that mothers and children have access to proper information on nutrition and infant and young child feeding practices.

10. Original expected outcomes from approved CERF proposal

- Increase the coverage of malnutrition case management from 70 per cent to 80 per cent;
- Reduce the case fatality rate of severe acute malnutrition below 5 per cent;
- Increase the recovery rate of malnourished children over 75 per cent;
- Reduce the default rate below 10 per cent;
- Provide at least 80 per cent of under five children and mothers with micronutrient supplements;
- All mothers using the nutrition services have access to adequate information on Young Child Feeding practices.

11. Actual outcomes achieved with CERF funds

- The coverage of malnutrition case management increased from 70 per cent to 75 per cent;
- The case fatality rate of severe acute malnutrition has been reduced 3 per cent to 2 per cent;
- The recovery rate of severe acute malnutrition increased from 75 per cent to 80 per cent;
- The default rate of malnourished children treated for severe acute malnutrition decreased from 22 per cent to 19 per cent;

- 80 per cent of children under five years old out of 46,900 and 80 per cent of mothers out of 30,000 received micronutrient supplements in all regions of the country;
- 100 per cent of mothers (24,000) using the nutrition services had access to adequate information on Young Child Feeding practices.

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

The fact that the coverage of malnutrition case management increased but still remained below the expected 80 per cent seems to be related to capacity gaps at the level of the governmental partner, as the National Nutrition Programme lacks qualified personnel for implementing some of the activities particularly in some underserved areas insufficiently covered by the programme due to absence of health facilities and/or of community health workers.

The discrepancy in terms of default rate (above the recommended cut-off-point of 15 per cent and the target of 10 per cent) is explained by the fact that some children have abandoned the treatment. Overwhelmed with multiple household responsibilities, with several children under their care and sometimes needing to walk long distances in order to bring their children to the community sites or health centres, many mothers were unable to regularly bring their children in order to complete the treatment.

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

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

Although no full-fledged external project evaluation has been undertaken, monitoring and supervision activities have been conducted by UNICEF and the team of the National Nutrition Programme on a quarterly basis, in order to collect statistics from health facilities and community sites (internal evaluation). The actual outcomes are compared to the reference indicators provided by the World Health Organization.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	FAO	5. CERF grant period:	19.03.2013-24.12.2013
2. CERF project code:	13-FAO-009	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Agriculture		☒ Concluded
4. Project title:	Coping with water scarcity: Increasing water access for pastoralist and agro pastoral		

7.Funding				
	a. Total project budget:	US$ 1,500,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 600,823	▪ *NGO partners and Red Cross/Crescent:*	US$ 36,734
	c. Amount received from CERF:	US$ 600,823	▪ *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	5,148	6,108	This discrepancy is due to the fact that we had more beneficiaries in two activities (creation of 14 water point management committees and the distribution of the micronutrient blocks).
b. Male	3,432	5,012	
c. Total individuals (female + male):	8,580	11,120	
d. Of total, children under age 5	5,720	7,407	

9. Original project objective from approved CERF proposal

- Urgently increase water access for drought-affected pastoralist and agro pastoral communities
- Provide urgent and basic support to animal health through the provision of animal nutrient supplements at key pastoral water points.

10. Original expected outcomes from approved CERF proposal

- 21 pastoralist communities will have sufficient access to water. 21 communities have been supported through the construction of 21 water points.
- A minimum of 20 000 goats will have access to micronutrients and improved animal health

11. Actual outcomes achieved with CERF funds

- Construction of 10 Wells along key pastoralist routes in Obock region: DimolehEla, Gandeli, Gorolita, Tikibleyta, Angare and Walissa and in Ali Sabieh region : FoaarHolHol, Dagahdalol, Dagawayn, DokalehGalilé. The beneficiaries from this activity are 4800 people.
- Construction of 11 Cisterns/Water harvesting structures along key pastoralist routes in Dikhil region: AssaelaOuraly, SankalAysouly, GagadeAlouly, GagadGegalou, MoBalanbaleh, MadhedloDikh and in Tadjourah region: DalMokoronta, OngoyloDalha, GalimaAbaAss, OuylalyAssal and AdodabaGuerenleh. The beneficiaries from this activity are 1980 people
- Distribution of 1000 Micronutrient blocks (5kg each one) in 50 key pastoralists water points in the 5 regions of Djibouti. 20,000 goats benefited from this intake, owned by 2,400 people.
- Provision of Cash for Work (CfW) programme through the construction and expansion of the trench for the one-pipe aqueduct in Assagueyla (Tadjourah). The beneficiaries from this activity are 1800 people.
- Support to 16 Water point management committees. This activity was done through SoS Sahel which supported the restructuration and training 14 Water committees in Tadjourah region. Out of 16 water committees originally planned, at the stage of implementation the population of 2 communities preferred to merge into 1, and in 2 other cases the transhumant

communities had left the site to come back the successive season. The direct beneficiaries from this activity are 140 people.

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

- As per the project document, the project intended to support 21 Water point management committees in all the regions. However only 16 Water point management committees (which then became 14 due to some merges) have been practically identified at the phase of implementation and trained.
- Regarding the provision of the CfW, the work initially planned for the beneficiaries to do was to build protection or surroundings around the water points from floods. Since no flood happened and it was an essential work to do it was agreed with the Ministry of Agriculture as well as the local authorities to use the CfW for the construction and expansion of the trench for the one-pipe aqueduct in Assagueyla instead.

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): 1
If 'NO' (or if GM score is 1 or 0): The project contributed to gender equality. Specifically the Outcomes number 1, 2 and 5 indicated in this report have positively affected mostly the life of women, girls and children, being traditionally responsible for collecting water for cooking, cleaning, health and hygiene and bringing the animals to the water points. Usually in rural areas women and children walk long distances to fetch water, so increasing the number of water points have drastically reduced these burdens. Regarding outcome number 5, gender equality have been considered including women and men balanced participation for the creation and the training of water management committees, as well as the assignment of responsibilities.

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

In compliance with FAO policy on evaluation and in consideration of its budget size, no separate evaluation of the project is anticipated. However, the project will contribute to the OED-managed Evaluation Trust Fund and will potentially be evaluated through a cluster approach, along with other projects that share one or more of the following characteristics: theme and/or approach, geographical area of intervention, resource partner. If during project implementation the parties deem a separate evaluation necessary, this will be organised under OED's responsibility and fully funded through the project budget.

Main findings:

1. In targeted areas the distances and the time necessary to access water have been reduced (for example in Tadjoura Region in some cases the distance have been reduced from 30km to 2km, In Dikhil region from 5km to 700m).
2. In areas where the geomorphologic characteristics doesn't offer any source of water to local population, and the accessibility is extremely difficult to vehicles, the project allowed the creation of rain water harvesting systems (underground cisterns) to collect and store water.
3. The project had a certain impact on the community water management, in particular on the aspects of access to water for humans and livestock. However it has emerged that more emphasis and recurrent training should be possibly supported through additional activities or projects in the future.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNFPA	5. CERF grant period:	March-December 2013
2. CERF project code:	13-FPA-009	6. Status of CERF grant:	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Health		
4. Project title:	Reduce and mitigate the immediate health consequences of the drought on the vulnerable population affected by the drought		

7.Funding				
	a. Total project budget:	US$ 945,211	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 1,048,632	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$ 103,421	▪ *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	950	2,052	
b. Male	200	150	
c. Total individuals (female + male):	1,150	2,202	
d. Of total, children under age 5	0	0	

9. Original project objective from approved CERF proposal

- Ensure access of the population affected by the drought to lifesaving health services
- Respond to outbreaks and epidemics through establishing a functioning local response, early warning health and nutrition alert system and monitoring

10. Original expected outcomes from approved CERF proposal

Access

- 25 per cent increase in the number of pregnant women with access to emergency obstetric care in 75 sites
- at least 15 per cent of girls have access to quality health
- health care providers and the management committees of 75 mutual health workers are trained on the mechanism of response to sexual violence
- Minimum Initial Service Package-MISP: MISP implemented in communities, in 11 mobile clinics, the health centre of the refugee camp and hospital areas:
    - 5 doctors and 5 midwives trained regions
    - 2 doctors and 2 midwives trained refugee camp
    - 1 doctor and nurses trained IOM
    - 750 people in 75 locations mutual's formed
    - 400 boys and girls trained in reproductive health including HIV

11. Actual outcomes achieved with CERF funds

A capacity development training of medical staff in the targeted areas was organized. 6 midwives and 6 doctors participated in the training. It focused on the MISP training (minimum initial service package – a core package of minimum reproductive health interventions in emergency settings) and on the guidelines of clinical care of cases of Gender Based Violence and the referral system. The training raised the understanding of the complexity of managing cases of GBV victims and the need to ensure proper

coordination among the stakeholders at central, local and community levels. To guarantee an efficient response, the reinforcement of the technical and coordination skills of the stakeholders was recommended. It would ensure the early management of reproductive health cases with complications and the involvement of the mobile medical team's doctors in all planning phases, the implementation and monitoring.

The six health medical centres were provided with kits distributed to the mobile teams. In addition, 2 kits 10 obstetric rubber pads were provided per district to ensure management of obstetric emergencies. 1 kit 9 was provided to the region of Ali-Sabieh to perform the suture of the diaphragm in cases of complications related to cases of GBV referred from Ali-Addeh and Holl-Holl refugee's camps. One (1) box of women condoms was also provided to the district of Ali-Sabieh. 34 per cent increase in the number of pregnant women with access to emergency obstetric care in 75 sites.

Other outcomes were the following: 62 women with pregnancy complications were diagnosed and transferred ; 806 antenatal consultations were undertaken in four prenatal centres as well as 184 post-natal consultations; 411 women started contraceptive methods, 3,481 condoms were distributed, 152 women and 72 men were diagnosed with STD and treated; 547 women benefited from counselling services; awareness raising and orientation sessions were provided to the members of 75 cooperatives on the detection of pregnancy complications, pre-natal consultations, family planning and nutrition of children; they benefited also from an initiation to the minimum initial service package but was not fully trained on that.

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

Only 100 youth were reached out of the 400 planned as the number of young people in the communities where the interventions took place was lesser than expected.

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
If 'NO' (or if GM score is 1 or 0): Please describe how gender equality is mainstreamed in project design and implementation

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

Activity monitoring took place and a community needs-assessment is scheduled in 2014

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNHCR	5. CERF grant period:	11.03.2013-31.12.2013
2. CERF project code:	13-HCR-015	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Multi-sector		☒ Concluded
4. Project title:	Protection and multi-sectoral assistance for refugees, asylum seekers and mixed migrants in Djibouti		

7.Funding				
	a. Total project budget:	US$ 26,094,487	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 4,230,177	▪ *NGO partners and Red Cross/Crescent:*	US$ 168,867
	c. Amount received from CERF:	US$ 325,604	▪ *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	10,705	11,199	NA
b. Male	11,774	12,611	
c. Total individuals (female + male):	22,479	23,810	
d. Of total, children under age 5	2,523	2,603	

9. Original project objective from approved CERF proposal

The main objective is to provide Protection and multi sectoral assistance to the refugees and asylum seekers in Djibouti by:

- Ensure satisfactory sanitation facilities in Holl-Holl camp.
- Ensure primary health care to refugees Ali Adeh and HolHol camps.

10. Original expected outcomes from approved CERF proposal

- 100 per cent of Holl-Holl camp based refugees will have suitable sanitation facilities.
- 83 per cent of Ali-Addeh camps based refugees have access to their own family latrines.
- Both health facilities will be functioning and appropriately staffed and equipped and 100 per cent of refugee population have access to appropriate drugs.

11. Actual outcomes achieved with CERF funds

- At the end of 2013, 1,708 refugees were living in Holl Holl and 58 per cent of households benefited from their own family latrines: 184 family latrines were constructed.
- Access to sanitation facilities combined with hygiene promotion had a positive impact on the living conditions and health of refugees. According to the HIS (Health information System), the prevalence of the water diseases was reduced from 4.5 per cent in 2012 to 2.6 per cent in 2013. To accommodate new arrivals (572 Refugees were transferred from Ali Addeh to Holl Holl in 2013), 70 communal holes constructed were regularly cleaned and maintained on a daily basis. Six communal holes/pits were destroyed and properly filled as per the required recommendation and in the respect of the national policy. Cleanliness and waste management in the camps were ensured by the Minister of Environment as per the national policy. In the line with the Vector Control, two campaigns of outdoor residual spraying were organized in both camps (April and November) as per Djibouti epidemiological calendar. The campaigns were conducted by the National Institute of Public Health (NIPH) with respect to the national policy in partnership with CARE. It should be noted that the residual spraying campaigns were combined with disinfection/treatment of latrines (family, public and communal).This activity had a positive impact on the

reduction of vector related diseases like malaria and dengue fever in the camps. Local populations surrounding the camp areas were also covered by the two campaigns. In addition, 362 family latrines were constructed in Ali Addeh. The family latrine coverage reached 82 per cent in Ali Addeh and 58 per cent in Holl-Holl. This should be considered as a great improvement because the coverage in terms of family latrine was before the project, 0 per cent in Holl-Holl and 71.6 per cent Ali Addeh in December 2012.

- Soaps were purchased and distributed during six (6) mass hygiene campaigns and door to door sensitization: 17, 524 persons in Ali Addeh and 1, 708 in Holl Holl received soap during those activities.
- In each camp, there is one functioning health centre providing the primary health services for refugees (curative and preventive care). Curative cares (acute and chronic disease) were available every day and 24 hours in both camps of Ali Addeh and Holl Holl. In 2013, 42,807 consultations in Ali Addeh and 3,599 consultations in Holl Holl were registered; the health facility utilization rate was 3.1 new visits/refugee/year in Holl Holl and 2 new visits/refugee/year in Ali Addeh. All emergencies case were timely referred (220/220). In 2013, the health centres were equipped with laboratory materials (in Holl-Holl), delivery beds (both Ali-Addeh and Holl-Holl), an oxygen Tank / Concentrator for the emergency room (Holl-Holl), and other medical materials including blood pressure monitors, stethoscopes, and thermometers for both camps. A measles vaccination targeting 629 children under-five years old was conducted during the nutrition survey in December 2013. As a result, 618 children were vaccinated. Therefore, our measles vaccination coverage has improved from 83.0 per cent in 2012 to 98.2 per cent in 2013 (while our initial target for 2013 was 85.0 per cent). In addition, a measles vaccination campaign targeting 1 to 15 years age group was carried in 2013 in collaboration with World Health Organization (WHO) and the Ministry of Health. Even though under-5 mortality rate (0.34 death/1000/month) was slightly above the initial target (0.3 deaths/1000/month), it remains within the UNHCR acceptable standards. The mortality rate among this group was 0.3/1000/month in Ali-Addeh and 1.3/1000/month in Holl-Holl. In January 2013, an order was placed for essential drugs and medical supplies through UNHCR International Procurement System, drugs have been received in July 2013 and used in the Ali-Addeh and Holl-Holl refugees' camps health facilities.
- The annual nutrition survey was conducted in December 2013. It revealed that the anaemia prevalence among women of reproductive age is 26.8 per cent (26.7 per cent in Ali-Addeh and 25.2 per cent in Holl-Holl). The results of 2013 nutrition survey noted that the prevalence of GAM was 12.6 per cent (9.7-16.2) and 11.9 per cent in Ali Addeh and Holl-Holl respectively. The SAM was 3.0 per cent (1.7-5.1) and 2.1 per cent for Ali Addeh and Holl-Holl camps. There is a significant increase in the GAM in Ali Addeh and although MAM cases remained similar to 2012, the SAM cases have increased by sixfold. The discontinuation of nutri-butter (due to budget constraints) which was given as a blanket supplementation feeding in March 2013 might have had some impact on the malnutrition levels. A total of 335 births were reported: 330 were assisted by qualified medical personnel (291 Ali Addeh and 39 in Holl-Holl) giving a rate of 98.5 per cent of cases assisted in Ali-Addeh and Holl-Holl. Two cases of rape were reported. The victims (both females) were identified and they received necessary assistance (including the PEP Kit within 48 hours). As a result, 100 per cent of identified rape survivors received PEP within the recommended 72 hours after the incident.
- Voluntary counselling and testing services (VCT) were available in Ali Addeh and Holl-Holl camps. The laboratory technicians and VCT staff were trained and received authorization of the ministry of health to practice at the camp level accordingly. A total of 522 persons accepted counselling and HIV testing (494 women and 28 men) of which 5 cases were positive (2 men and 3 women). The total number of persons living with HIV in both camps is of 35 (34 in Ali Addeh and 1 in Holl-Holl). Among them, 28 are under ARV treatment supported by the Ministry of Health national HIV treatment centre Djibouti capital. The remaining 7 cases are not yet eligible according to the national protocol. In addition, all of them received support (additional food items, medical and psychosocial). With the advocacy of the UN joint team fight against HIV, the new national HIV strategic plan has planned a decentralization of ARV program.

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

The initial proposal was the construction of 1,000 family latrines in Holl Holl. At of the end of the project, a total of 546 family latrines were constructed in both camps (362 at Ali Addeh and 184 at Holl-Holl) in 2013 to mitigate the impact of unfunded construction of latrines. In addition, UNHCR could not provide soap with its regular budget. Considering that this situation could have negatively impacted on hygiene conditions in the camps, UNHCR proceeded with CERF funds to the purchase and distribution of soap, activity having the same sanitation and hygienic objective.

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
If 'NO' (or if GM score is 1 or 0): Please describe how gender equality is mainstreamed in project design and implementation

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

The project evaluation was conducted in June and December 2013. The indicators analysis shows that the targets were reached although with some disparities between the two refugee camps. It has been recommended to set up a monthly meeting to check provision taken by the Health implementing partner “CARE International” in order to improve access to refugees in Health centre. UNHCR procured Basic Essentials Drugs, however medical prescriptions of some patients with chronic diseases are not provided regularly. It has been recommended to CARE to procure such drugs after the review and approval of the medical committee established at the camp level. Referred medical cases require attention, and CARE must recruit a nurse in Djibouti to support patients in hospitals. CARE should be regular monitor chronic patients living in Ali-Addeh and Holl-Holl refugees camps. The evaluation of project implementation in health, nutrition and WASH enabled UNHCR and its partners to interact with beneficiaries and interpret/analyse the results together in preparation for the year 2014. Conclusion: CERF funding enabled prompt response to life-saving activities to refugee’s population and fill gaps in a very crucial sectors like Health, Nutrition et WASH.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	IOM	5. CERF grant period:	March-December 2013
2. CERF project code:	13-IOM-004	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Multi-sector		☒ Concluded
4. Project title:	Improving lifesaving capacities, health care access and protection of vulnerable migrants in Djibouti		

7.Funding				
	a. Total project budget:	US$ 5,831,500	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 325,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$ 325,000	▪ *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	1,393	9,366	In the proposal the total number of individuals (3,623) targeted with CERF funding (breakdown by sex and age) in the table does not include the host communities. However the number of beneficiaries from the host communities was mentioned in the proposal (15,000). Overall the project aimed to reach 18,623 beneficiaries (migrants and host communities). Due to the high demand IOM excided the target and reached 23,068 beneficiaries (including 6,568 migrants and 16,500 host community members).
b. Male	2,230	13,702	
c. Total individuals (female + male):	3,623	23,068	
d. Of total, children under age 5	725	2,306	

9. Original project objective from approved CERF proposal

General Objective: Urgently provide lifesaving humanitarian assistance to migrants and populations in Djibouti through emergency evacuation, health, WASH, and protection-related assistance to meet their basic needs, with particular consideration for vulnerable individuals, namely women, children, elderly, and people with health concerns.

10. Original expected outcomes from approved CERF proposal

- Operational relief to the current strain on functional primary health care facilities through distribution of essential drugs, for case management, and prophylaxis for close contacts provided to health authorities;
- Up to 150,000 chlorine tablets and up to 3,600 migrants reached for improved health awareness, hygiene, treatment of cases for diseases inclusive of diarrheal illness, in case of outbreak. All migrants among the 3,600 in need of health support will be referred to health centres.
- Up to 15,000 flyers in appropriate language disseminated to potentially affected populations;
- Facilitated referral services provided to vulnerable population, including women heads of households, lactating mothers and women with children under 5 as well as elderly and those with special needs;
- Increased awareness on communicable diseases and hygiene of various health partners and communities achieved, and coordination within this multi-sectorial response to disease outbreak is improved.
- Up to five water points rehabilitated and/or established along the migratory corridor in collaboration with partners
- 35 vulnerable migrants directly provided with emergency evacuation assistance to their country of origin.

11. Actual outcomes achieved with CERF funds

a. The provision and distribution of essential drugs, infusions, Oral Rehydration Salt (ORS) for case management and prophylaxis provided operational relief to the current strain on functional primary health care facilities to 15,461 beneficiaries. The essential drugs were procured and delivered directly to the Hospitals of Obock, Tadjourah and Dikhil in coordination with the Minister of Health. A deed of donation has been signed by the MoH and each of the hospitals mentioned above. The drugs were used to fill the gaps created with the influx of migrants.

b. 23,068 individuals were reached for improved Acquired Watery Diarrheal (AWD)-awareness including 3,600 migrants. 150,000 Chlorine tablets and ORS were disseminated in villages for local communities and migrants. Additionally, 2,500 individuals were referred to the health centres.

c. 15,000 flyers in appropriate language disseminated to potentially affected populations.

d. 1,000 vulnerable cases with severe medical conditions were identified and referred to nearby hospital. Initial assistance was provided to them before referring them to appropriate services within the hospital in Obock and Tadjourah. 6,568 were directly assisted with improved health awareness, safe hygiene practices and provided access to early diagnosis, referral and timely medical treatment. 2,500 migrants were provided with access to health care services and received treatment for various illnesses including diarrheal diseases, tuberculosis and malaria among others.

e. Increased awareness on AWD and hygiene of various health partners and communities was achieved through outreach activities and coordination meetings. The coordination also involved the Health authorities. The number of people (local community and migrants) reached, the control of the cases of AWD within the communities, the fact that no conflict on the use of resources was reported in areas reached are good signs that the objective of the hygiene awareness was reached.

f. As agreed upon with OCHA Djibouti, 15 per cent of the total direct project costs were reallocated from the rehabilitation of 5 water points to unexpected emergency evacuation activities.

g. 244 vulnerable migrants directly provided with emergency evacuation assistance to their country of origin.

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

For this project, the discrepancy between planned and actual outcomes was due to the fact that an unexpected number of vulnerable migrants were assisted for emergency evacuation to country of origin. As a result of this high demands, 244 migrants were assisted while only 35 were planned.

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): 1
If 'NO' (or if GM score is 1 or 0): Please describe how gender equality is mainstreamed in project design and implementation

Young women adults were recruited and sensitized young migrant girls and women on the risks related to illegal migration. A psychological support team comprised women and men and provided psychological support and counselling respectively to girls/women, boys/men victims of boat accidents and suffering of post-traumatic stress.

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

A final evaluation will be done at the end of the CERF 2013 round II, which will end in June 2014. Although, the project has not yet been evaluated, regular field monitoring visits were conducted. During the project period, the MRC assisted the highest number of emergency evacuation ever registered in Djibouti since the opening of the MRC in 2011, hence the sensitization sessions seems to have had effect. The monitoring also noticed a drastic reduction of the number of diarrheal cases and other diseases related to contaminated water.

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	WFP	5. CERF grant period:	04.03.2014 – 31.12.2014
2. CERF project code:	13-WFP-009	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Food		☒ Concluded
4. Project title:	Food Voucher Assistance to vulnerable people in Djibouti city		
7.Funding	a. Total project budget: US$ 1,093,933	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project: US$ 1,020,649	▪ *NGO partners and Red Cross/Crescent:*	US$ 10,212
	c. Amount received from CERF: US$ 750,275	▪ *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	5,916	5,916	NA
b. Male	5,524	5,524	
c. Total individuals (female + male):	11,440	11,440	
d. Of total, children under age 5	2,307	2,307	

9. Original project objective from approved CERF proposal

The overall objective of the project is to support the poorest and most food insecure populations by improving food access for the urban poor during the lean season (July - September 2013) through the provision of food vouchers to a total of 11,440 food insecure people living in peri-urban areas of Djibouti. Without such assistance, targeted population would not be able to meet their minimum food needs, especially 2,307 children under five among the beneficiaries.

10. Original expected outcomes from approved CERF proposal

Strategic Objective 1: Save lives and protect livelihoods in emergencies Goals: To save lives in emergencies and reduce acute malnutrition caused by shocks to below emergency levels			Impact: Contribution to MDGs 1 and 4
Outcome	**Indicator**	**Corporate target and performance measure**	**Project target and data source**
Outcome 1.1: Improved food consumption over assistance period for target households	1.1.1 Household food consumption score	Score exceeded the threshold for 80 per cent of targeted beneficiaries.	Target: Food consumption score exceeded 28 for target households Source: monitoring data
Output	**Indicator**		
Output 1.1: Vouchers distributed in sufficient quantity to target groups of women, men, girls and boys under secure conditions.	1.1.1 Number of women, men, girls and boys receiving voucher food by category and as per cent of planned. 1.1.2 Total amount of voucher transferred to beneficiaries, as per cent of planned.		

11. Actual outcomes achieved with CERF funds

100 per cent of the targeted beneficiaries received food voucher:
Female: Planned 5,916 – Reached 5,916
Male: Planned 5,524 – Reached : 5,524
Girls: Planned 2,242 – Reached: 2,242
Boys: Planned 2,254 – Reached: 2,254
Total Individuals: Planned 11,440 – Reached: 11,440
100 per cent of the total amount of voucher was transferred to beneficiaries.

Household food consumption score of the assisted beneficiaries was improved. After the project, 96.8 per cent of the assisted HH had an Acceptable Consumption Score versus 88.7 per cent at mid-term review exercise. The project filled the calories gap faced by the urban poor during the warm season by ensuring a caloric intake of 1,300 Kcal/per/day. The ration didn't cover the full 2,100 kcal required caloric intake requirement because the urban poor had access to other limited caloric intake. The aim of the ration was to compensate for the gap. The food basket provided by the voucher programme also helped provide vitamins and micronutrients to reduce the risks of anaemia and other micronutrient deficiencies among the poor urban households and particularly the women and the young children.

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

NA

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
If 'NO' (or if GM score is 1 or 0): Please describe how gender equality is mainstreamed in project design and implementation

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

The project was evaluated at midterm and at the end (Final evaluation), Major findings of the final evaluation are:

- FCS was improved (see 11.)
- 54 per cent of beneficiaries appreciated the quantity of food included in the ration and distributed
- 95.3 per cent of beneficiaries appreciated the quality of the food distributed in the ration.

- 94 per cent of beneficiaries appreciated the composition of the food basket
- 71 per cent of beneficiaries consider that project was implemented during a difficult period of the year. When majority of the families facing difficulties to access the markets due to lack of resources.

Also, beneficiaries requested an improvement like the increasing of quantities of some energetic commodities for children under five like vegetable oil and sugar, and also adding fish, dates fruits, milk etc. WFP will look into those suggestions during the formulation of the next round of the voucher assistance.

In addition to that, the final evaluation reported that the beneficiaries have others priorities that should be addressed during the same period:

- Education fees support (schools furniture, bags, etc.) in September
- Health fees support (drugs, consultation, etc.) to integrate with Voucher distribution
- Dressing fees support in September with the new academic year starting

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	WHO	5. CERF grant period:	March – December 2013
2. CERF project code:	13-WHO-009	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Reduce and mitigate the immediate health consequences of the drought on the vulnerable population affected by the drought		

7.Funding				
	a. Total project budget:	US$ 2,469,301	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 404,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$ 404,000	▪ *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	116,000	170,000	Outbreak monitoring and control had to cover more communities in view of the malaria outbreak , and medicines targeting the needs in essential medicines had to be added with rapid diagnostic tests and anti-malarials to cover emergency and security stocks .
b. Male	101,000	150,000	
c. Total individuals (female + male):	217,000	320,000	
d. Of total, children under age 5	40,000	60,000	

9. Original project objective from approved CERF proposal

- Ensure access of the population affected by the drought to lifesaving health services
- Respond to outbreaks and epidemics through establishing a functioning local response, early warning health and nutrition alert system and monitoring

10. Original expected outcomes from approved CERF proposal

Access

- Mobile clinics respond to emergencies in a timely manner within 24 hours of locally raised alerts
- 85 per cent of the health staff in rural areas (health facilities and mobile clinics) is able to recognize and to respond to life threatening conditions (malaria, dengue, measles, cholera, complicated pregnancies, malnutrition) and to outbreak
- Emergency medicines, vaccines and reagents for outbreak confirmation of measles, cholera are procured and distributed to mobile teams and health centres disposing of a functional storage facility
- The cold chain for the transport of life-saving medicines is functional in at least 10 health centres that had no or a broken cold chain (fridges)
- 25 per cent increase in the number of pregnant women with access to emergency obstetric care in 75 sites
- at least 15 per cent per cent of girls have access to quality health
- health care providers and the management committees of 75 mutual health workers are trained on the mechanism of response to sexual violence
- Minimum Initial Service Package-MISP: MISP implemented in communities, in 11 mobile clinics, the health centre of the refugee camp and hospital areas:
- 5 doctors and 5 midwives trained regions
- 2 doctors and 2 midwives trained refugee camp
- 1 doctor and nurses trained IOM

- 750 people in 75 locations mutual's formed
- 400 boys and girls trained in reproductive health including HIV
- 25 doctors and 50 nurses are trained on Case management of malnourished children with medical complications and their malnourished/anemic pregnant mothers
- 25 rural communities and 2 urban ones in Balbala implement a community based self-service approach to identify serious health danger threats and manage them
- A medical voucher system offering essential Health preventive and curative services to 2 of the poorest urban communities is implemented in linkage to a food voucher system in 2 pilot community health centres in Djibouti city during the hunger gap period from June to September (lean period)
- Outbreaks and epidemical diseases
- In rural areas, mobile clinics respond to an alert of transmissible disease in 72h and in urban areas the response takes 48h. The protocol for the disease is known and respected in all health facilities.
- Guidelines, simple brochures, posters on life threatening conditions (HIV, TB, Dengue, Cholera/ Diarrhea, Malaria) are developed and used by community health workers and community health volunteers
- Outbreak investigation kits (for mobile clinics and health facilities in rural areas) are provided
- Weekly reports on selected indicators monitoring epidemic prone diseases (cholera, measles, dengue, diarrhea, respiratory diseases, HIV, TB) from 85 per cent of the health centres.
- Data on the outbreak diseases is collected through rural telephony in the remote regions and compiled into reports.
- Monthly bulletin issued with analysis of reports by SNIS and coordination of the response with INSPD
- HIV
- 50 per cent increase in the number of nurses and midwives who are providing HIV, VCT services to pregnant women, their husband and malnourished children.
- 50 per cent increase of health facilities which are providing HIV, VCT services to pregnant women, their husband and malnourished children.

11. Actual outcomes achieved with CERF funds

- 11 Mobile clinics were made operational and supported in all 5 regions; there were around 1-6 outings per month per region to cover various remote areas. These varied according to the availability of the team and the doctor and also the load at the regional hospital (CMH) since the mobile clinics leaves the CMH with half of its medical team. The regularity of these visits was strengthened in 2 districts (Ali Sabieh and Dikhil), and is in process in the other regions as the terrain is more difficult. The population covered from remote areas in each region varied on each visit as the population would be informed and gather at the meeting point. Hence the reports available show that for 6 months show that for the targeted 20 per cent population in the regions living in remote areas amounting to 64,000 persons , 15816 consultations were made with 42 per cent of them for children, 7 per cent pregnant women, 47 adult population consultation hence a rate of 0.5 consultation per capita per year which is within the accepted norms.
- Emergency medicines were procured and distributed to ensure access to medicines to the 120,000 people.
- Comités de Gestion or Health committees (17) - 1 for each of the 5 CMH and 12 community health centres – reactivated. overall and 2 in the pilot project of health coupons were engaged in the training and awareness raising on the management of cases of malnutrition, diarrhoea and malaria;
- 672 households benefited from health vouchers;
- Free provision of medicines to those most at risk and to vulnerable households (2000)or the treatment of children most common illnesses documented during August to November in Djibouti capital health centres under the health coupons project;
- 250 children covered in consultations and 100 pregnant woman in Balbala II;
- 504 children visited the health centres and 155 pregnant women had prenatal consultations;
- The number of malnutrition cases weekly reported from the pots and CMH from the regions was on average varying between 20—25 cases in each facility. However in the health coupons project by increasing the information given to the population and providing them with the simple incentive of the health card and bringing them for the initial check-up, the graphs showed that comparing the 2012 and 2013 data in Arhiba for example for severe malnutrition , there were 80 cases detected in September 2013 compared to September in 2012 and for chronic malnutrition there was 49 cases detected in 2013 compared to 1 in 2012. In Balbala 2 52 cases of severe malnutrition were detected in October 2013 compared to 20 in 2012 and 58 cases of chronic malnutrition in 2013 compared to 34 in 2012. The short time of the pilot project could definitely not be representative however the passive reporting from centres in the regions and other facilities compared to the more active search used in the pilot was corroborated with the findings of the SMART Survey conducted in December 2013. The data compiled through health facilities and community treatment sites may not reflect the real values and the access or increasing information and tracking of cases among children should be enhanced;

- Emergency Medicines were procured and distributed to MOH and ensured access to medicines to the most vulnerable, however due to the malaria outbreak, more medicines for malaria management and rapid tests had to be ordered as the MOH stocks were depleted quickly. The health committees were reactivated in most regions and pledge to support oversight of the health facilities and outreach activities in the community including awareness raising campaigns.
- The health coupons project was implemented in 2 neighbourhoods in Djibouti suburb, targeting 672 households that were selected through a committee composed of WHO, Ministry of health and Solidarity following a full assessment and inclusion in a data base for the WFP food coupons project (Report attached), and focusing on women and children over the tough months of summer till November, supporting with medicines, health education, growth monitoring and vaccination. The health staff and the health committee of each center received training and support in sessions on malnutrition, diarrheal management, malaria. The report shows an increased demand for health services and above all the motivation that when sick; medicines were given free ensured those most at risk and vulnerable households treatment to the children most common illnesses. Hence a total of enrolled 1120 children were targeted, the health facility in Balbala II had 250 children covered in consultations and 100 pregnant women. The medicine stock was depleted within the first 2-3 weeks. In Arhiba, 504 children visited the centres and 155 pregnant women had prenatal consultations. The detection of malnutrition following the initiation of the project and the check-up showed double numbers detected weekly. Hence the importance of searching for the cases and pushing the households to visit the centres even for a check-up.
- Outbreak monitoring and alerts mechanism was reinforced in the capital and in the regions, with regular reports received at central level. The format was adapted but implementation delayed until MOH issued a memo. The MOH and partners faced 2 outbreak of malaria in 2013, with more than 1670 cases and 17 deaths, There were 2 peaks once in March- April 2013 with the outbreak starting in January and ending in May, affecting more than 1200 cases and causing 15 deaths and the second started end of November, but the peak took place in 2014. Overall, 2013 had seen the resurgence of malaria outbreaks with severe malaria, mostly among men (75 per cent of the cases0 and with a large focus in 3 main neighbourhoods of Djibouti capital and one region (Dikhil) , causing deaths to young men but cases had started end of November 2013;
- Guidelines and reporting format for outbreak detection and control as well as treatment protocols were updated and distributed. A large focus was put on malaria outbreak, rapid tests procurement training and distribution, support to management and treatment of severe cases. Laboratory investigation kits were procured and made available at the Institute of Public health and at the regional levels.

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

Training on management of severe acute malnutrition had to be postponed as the consultant identified could not travel at the time originally planned, following which the planned SMART survey was then underway, and MOH preferred to wait for the results which came end of December 2013.

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
If 'NO' (or if GM score is 1 or 0): Please describe how gender equality is mainstreamed in project design and implementation

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

An internal evaluation took place and a sharing session on the lessons learnt of the project implementation took place with the Ministry of Health. It indicated the efficiency of the intervention to respond to critical needs of the most vulnerable population.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNAIDS	5. CERF grant period:	March-December 2013
2. CERF project code:	13-AID-001	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Reduce and mitigate the immediate health consequences of the drought on the vulnerable population affected by the drought		

7.Funding				
	a. Total project budget:	US$ 100,000	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 52,630	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$ 52,630	▪ *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	N/A	68	88 out of a planned 100 patients reached, plus 81 (out of a planned 80) health workers trained.
b. Male	N/A	14	
c. Total individuals (female + male):	100	88	
d. Of total, children under age 5	N/A	N/A	

9. Original project objective from approved CERF proposal

- Ensure access of the population affected by the drought to lifesaving health services
- Respond to outbreaks and epidemics through establishing a functioning local response, early warning health and nutrition alert system and monitoring

10. Original expected outcomes from approved CERF proposal

- 50 per cent increase in the number of nurses and midwives who are providing HIV, VCT services to pregnant women, their husband and malnourished children.
- 50 per cent increase of health facilities which are providing HIV, VCT services to pregnant women, their husband and malnourished children.

11. Actual outcomes achieved with CERF funds

- Training of 39 nurses and 42 midwives in HIV VCT and case management including PMTCT working in 10 health facilities (Djibouti city),
- 5 more health facilities in districts are providing HIV, VCT services to pregnant women, their husband and malnourished children.

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

The project was partially implemented and allowed to increase the number of nurses and midwives who are providing HIV, VCT services to pregnant women, their husband and malnourished children. A total of 82 health workers were trained. The resources of the CERF when then planed by the UCO were also destined for a very important aspect that is treatment with life saving ARVs. The funds were a response to the urgency created by a sudden and unexpected change in the funding of this aspect of the fight against HIV and AIDS and especially for the vulnerable populations. This would have had an unquestionable impact on the life of this populations because the resources would have made it possible for the UNAIDS office to answer a very urgent situation created by the sudden stop of the funding of the Global Fund and thus an interruption of the continuity of the services. The resources have allowed closing the gap in term of financing of the training of services providers in charge of the most vulnerable populations and

thus have achieved strategic goal of the office. 88 nurses and midwives were trained in HIV VCT and case management and 5 more health facilities in districts are providing HIV, VCT services to pregnant women, their husband and malnourished children. We encountered difficulties to use CERF resources for the purchase of drugs, reagents and test as agreed in the project. The UCO has met UNDP GFATM unit and the National AIDS Programme of the ministry of health for procurement of these products. But, when resources were available the context has changed. The country and GFATM have agreed on the implementation of the transitional funding mechanism which requires 20 per cent contribution from Government and this contribution was used to bridge the gap in terms of HIV/Aids medicine including reagents and IOs treatment.

The office looked into options to use these funds through WHO. Then, during the month of September and October the UCO had planned to transfer these funds to WHO Djibouti through UN to UN agreement special for the implementation of reagents and IOS treatments procurement component of the project worth 40,630 USD as WHO had ongoing procurements and for the timely procurement of these products. Nevertheless following WHO representative discussion with WHO regional office and e-mail correspondence between the CERF secretariat and WHO regional office, the CERF secretariat has cleared stated that CERF Funds are not transferable .Hence unless otherwise indicated in the project, CERF funds are not transferable to other implementing partners and indeed this project clearly stipulate, UNAIDS as the implementing agency. The other option intended was to use these funds to procure CD4 Counter machines in order to replace the non-functional machines in the country's referral hospital 'Général Hôpital Peltier'. Flexibility in the use of these resources in this particular case would have allowed the optimal use of the funds.

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
If 'NO' (or if GM score is 1 or 0): Please describe how gender equality is mainstreamed in project design and implementation

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

The evaluation is planned in 2014 as the training took place late 2013.

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Implementing Partner Name	Partner Type	Total CERF Funds Transferred to Partner US$	Date First Instalment Transferred	Start Date of CERF Funded Activities By Partner	Comments/Remarks
13-WFP-009	Food Assistance	WFP	UNFD	NNGO	$5,106	15-Jun-13	1-Jun-13	The partner participated actively in the implementation of the programme and the actual identification of the beneficiaries.
13-WFP-009	Food Assistance	WFP	PAIX & LAIT	NNGO	$5,106	15-Jun-13	1-Jun-13	
13-HCR-015	Multi-sector refugee assistance	UNHCR	CARE	INGO	$168,867	10-Apr-13	10-Apr-13	The partner was in charge of selection and implementation of hygiene sector
13-CEF-026	Nutrition	UNICEF	Programme National de Nutrition	GOV	$24,804	27-Nov-13	27-Nov-13	During the implementation period, it was agreed that UNICEF would purchase some of the treatment products, reason why the CERF Funds transferred to the implementing partner did not reach the 54,000USD initially planned in the proposal
13-CEF-025	Water, Sanitation and Hygiene	UNICEF	ACF	INGO	$151,436	20-Nov-13	20-Nov-13	
13-CEF-025	Water, Sanitation and Hygiene	UNICEF	Care	INGO	$125,346	14-Nov-13	14-Nov-13	
13-CEF-025	Water, Sanitation and Hygiene	UNICEF	ADIM	NNGO	$23,981	26-Nov-13	26-Nov-13	
13-CEF-025	Water, Sanitation and Hygiene	UNICEF	Ministry of Agriculture and Water Resources	GOV	$5,392	15-Apr-13	15-Apr-13	
13-FAO-009	Food Assistance	FAO	SOS SAHEL	INGO	$36,734	1-Dec-13	16-Nov-13	The partner supported the training on community management of water points, water purification, and community extensions for livestock's health.

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

ACF	Action Contre la Faim
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
AWD	Acquired Watery Diarrheal
CAP	Consolidated Appeal Process
CfW	Cash for Work
EFSA	Emergency Food Security Assessement
FAO	Food and Agricultural Organization
GAM	Global Acute Malnutrition
GBV	Gender Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	Humanitarian Country Team
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IOM	International Organization for Migration
Kit 9	Suture of Tears (cervical and vaginal) and Vaginal Examination kit
Kit 10	Vacuum Extraction for Delivery (Manual) kit
MISP	Minimum Initial Service Package
MoH	Ministry of Health
MRC	Migrant Response Center
MRRT	Mobile Rapid Response Team
NIPH	National Institute of Public Health
ORS	Oral Rehydrating Solutions
SAM	Severe Acute Malnutrition
SMART	Specific, Measurable, Achievable, Realistic and Time-bound
STD	Sexually Transmitted Diseases
TB	Tubercle Bacillus (Tuberculosis)
UCO	Unit of Coordination
UNAIDS	Joint United Nations Programme on AIDS
UNFD	Union National des Femmes Djiboutiennes
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization