RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS
NIGER
RAPID RESPONSE
CHOLERA

RESIDENT/HUMANITARIAN COORDINATOR	**Mr. Fode Ndiaye**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

The review was conducted in December 2013and February 2014 (comprising of members of the Coordination Cluster and UNICEF, as well as CISP, SOLIDARITES Int'l, CR-E, CR-N, COOPI, Plan International, DRH&DRSP Tillabéry, an d OCHA.

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 ☐

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: ***US$7,246, 600***		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	1,571,207
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	
	OTHER (bilateral/multilateral)	2,200,067
	TOTAL	**3,771,274**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 10-Jul-13			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	13-CEF-074	Water and sanitation	921,207
WHO	13-WHO-040	Health	650,000
TOTAL			**1,571,207**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	1,451,622
Funds forwarded to NGOs for implementation	100,000
Funds forwarded to government partners	19,585
TOTAL	**1,571,207**

HUMANITARIAN NEEDS

Niger recorded successive cholera outbreaks between 2003 and 2012 (with the exception of 2009), with a lethality rate ranging from 2.5 per cent to 7.4 per cent, well-above the 1per cent norm set by WHO. The most affected population is usually located in:

- The regions surrounding the Niger River in the western part of the country (Dosso, Tillabéry and the Niamey area);
- The Maggia valley in the central part of the country (Tahoua region);
- The Goulbi region, sharing borders with Nigeria in the southern part of the country (Maradi region);
- The Zinder region,and in the bed of the Lake Chad in the far eastern part of the country(Diffa region).

Starting on 6 May 2013, a cholera epidemic erupted inthe Tillabéry and Niamey regions. As of 16 June 2013, when the project proposal was drafted, there had been 323 notified cases, included 10 deaths. Women accounted for51per cent of the cases and 80per cent of deaths. The breakdown by age was as follows: 0 to 11 month old, 1per cent; 1 to 4 year old, 7per cent; 5 to 14 years old, 25 per cent; and 15 and older, 67per cent. The epicenter of the outbreak was located in the following health districts of theTillabéry region: Ayourou, Mangaizé, Famalé, Firgoune, KandadjietOuallam, and some of the cases had occurred in refugee camps. The epidemic was spreading

in villageslocated on the banks and the islands of the Niger River, where the population drank contaminated water from the river, a practice fueled by beliefs and cultural habits. The onset of the rainy season, combined with the presence of camps for Malian refugees in the Tillabéry region, made it critical to quickly contain the epidemic.

The consequences of a cholera epidemic are manifold, affecting the sanitary, economic, social, political and cultural situation. The epidemicwas expected to have a harsh impact on Niger, which was already facing other humanitarian crises (food and nutrition crisis, influx of Malian refugees, risks of flooding during the rainy season).

II. FOCUS AREAS AND PRIORITIZATION

Following evaluations by the Ministry of Public Health, the Regional Directorate for Public Health of Tillabéry, the Regional Directorate for Water (DRH), the Regional Directorate for Surveillance and Response to Epidemics (DSRE), and members of the WASH and Health Clusters, a joint needs assessment mission was conducted on 17 May 2013. The needs assessment helped confirm which zones were already affected and which were at risk, taking into account the transmission context (Niger River water, population movement, etc.) and the onset of the rainy season that would accelerate contamination. The assessment pointed to the lack of medicine, limited access to safe water, lack of sanitation facilities and generalized practice of open defecation, lack of water purification products, insufficient disinfection of houses and areas with cholera cases, and to the gap between the existing communication strategy for behavioural change and the local realities, as well as the need for intensifying communication activities. A review of activities already being carried out helped reassess the needs and the activities that should be prioritized in an emergency response.

The zones chosen for intervention were located close to the Niger River, where the population that was most affected by or at risk of cholera lived. The National Committee and the Directorate for Surveillance and Response to Epidemics, in collaboration with the WASH Cluster, estimated that an effective response should target 250,000 persons, including 42,000 families, to improve their access to safe water, hygiene and sanitation.A certain flexibility was needed in terms of specific regions to target when responding to cholera in Niger, since many regions are vulnerable and have suffered outbreaks in the past years. However, Tillabéry continues to be the most affected and at-risk region.

III. CERF PROCESS

The decision of preparing a CERF proposal was made jointly within the framework of the humanitarian country team, with very active involvement of three agencies in particular: OCHA, UNICEF and WHO. The sharp increase that was suddenly noticed in the number of cholera cases justified urgent action in order to immediately save lives, and avoid an uncontrolled propagation of cholera and a large number of deaths, as had been the case in 2012.

The elaboration process of the CERF proposal included a review of existing CAP projects, and was accompanied by important coordination efforts through the WASH and Health Clusters, and by active fundraising on the part of the agencies to mobilize adequate resources for responding to the projected humanitarian needs. The project drew on a technical methodological guide on responding to cholera, which had been elaborated in 2012 by the WASH Cluster, validated by the Direction de la surveillance des epidemies (DSRE) and later revised to integrate the findings of a team of epidemiologists[1] on the causes for the persistence of cholera in Niger.

The Government of Niger was fully involved, through the participation of the Ministry for Water and Sanitation in the WASH Cluster and also through the leadership of the)Direction regional de la Hydraulique (DRH)and DSRE. The DRH identified priority focus areas, in collaboration with the WASH Cluster, and pre-positioned existing inputs in health centers and in communities, which then enabled the WASH Cluster to allocate areas to implementing partners. There was also close collaboration with the DSRE, which validated the population to be targeted and the sensitization material to be used (brochures on using PUR and Aquatab; information on key hygiene practices; flip charts on cholera prevention).

Activities of medical treatment of cholera cases in the CTC/CTU/CRO were identified by the Health Cluster partners, with the involvement of the DSRE of the Ministry of Public Health, the DRSP and concerned health districts. The Health Cluster partners have unanimously chosen the NGO Solidarités International for WASH activities in health centers, given his experience and his performance in 2012.

[1] The findings, “Study of recurrence factors for cholera epidemics in Niger: Understanding how to adjust operational approaches " were published in July 2013 with support from UNICEF.

Partners coordinated through the WASH Cluster to ensure that the full geographic zone would be covered, that there would be no duplication, and that the response would be well coordinated with the interventions of the national and regional authorities.,Key NGO partners included: Comitato Internazionale per lo sviluppo dei Popoli(CISP) Cooperazione Internazionale ,(COOPI), Medicins sans Frontieres MS, Solidarités International, Welthungerhilfe Samaritan's Purse and the Spanish Red Cross. There also existed a decentralized coordination structure in Tillabéry, led by the Regional Committee for Managing Epidemics and supported by the WASH sub-cluster.

For health and WASH activities, the projects took into account the needs of both women and men. A lesson learnt from the 2012 cholera response had been that women, despite being the main users of water as well as the primary caregivers for children, had not been sufficiently involved in prevention activities. For the 2013 response, implementing partners were informed of this shortcoming, and subsequently ensured that women, and not only men, participated in sensitization activities.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR				
Total number of individuals affected by the crisis:,465,052				
The estimated total number of individuals directly supported through CERF funding by cluster/sector	**Cluster/Sector**	**Female**	**Male**	**Total**
	Water and sanitation	176,311	172,129	348,440
	Health	3,004	2,834	5,834

BENEFICIARY ESTIMATION

The population at risk was located in eight health districts (Tillabéry, Ouallam, Téra, Say, Kollo, and the three districts of Niamey) totaling3,465,052 inhabitants and three refugee camps with 30,256 persons. 7,500 cases of cholera (7,000 in the general population and 500 among refugees) had been forecasted for 2013 by the National Committee for Management of Epidemics. The National Committee and the DRSE in collaboration with the WASH Cluster, had estimated that an effective response should target 250,000 persons, including 42,000 families. However, this target could rapidly increase given the onset of the rainy season or a sudden upsurge in the number of cases notified.

The beneficiaries of the health sector were 5,834 people, including 53 children. Following the sensitization of the population, the actual number of cholera cases was found to be lower than the expected number of cases. These figures include cases of cholera, health personnel and trained laboratory personnel and the beneficiaries of WASH interventions in the health centres

The number of people reached by the cholera response is based on the information provided by the Government and NGO partners who distributed inputs to the population. It is the most reliable source of data and prevents the risk of double-counting that would exist if UNICEF relied on the quantities of inputs distributed, because a given household may receive PUR and Aquatabs more than once, if located in a zone that remains at risk and if specific water sources and water quality there –in particular turbidity during the rainy season- require extra treatment.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	**Estimated Reached**
Female	133,900	179,315
Male	123,600	174,963
Total individuals (Female and male)	257,500	354,278
Of total, children under age 5	206,00	27,928

CERF RESULTS

The prevention activities undertaken with CERF support contributed to limiting the spread of the cholera epidemic .The cholera outbreak remained under control, in comparison with 2012 when 5,284 cases and 110 deaths which represent a case fatality rate (CFR) of 2.1per cent had been registered. Between May and December 2013, a total of 592 cases were registered including 15 deaths (CFR: 2.5%), and in 2014, 62 cases including one death (CFR: 1,6%)have been registered so far (as of 27 February 2014). Cases have been mainly reported in refugee camps, villages bordering the Niger River in the Tillabéry region and in the health districts of the Maradi and Zinder regions (close to the border with Nigeria).

The CERF projects have helped to reduce the number of cholera cases from 5,284 in 2012 to 592 cases in 2013 and keep the case fatality rate within acceptable limits.

CERF's ADDED VALUE

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

Despite the fact that CERF funds were disbursed quickly, the elaboration of the CERF proposal required intensive coordination between the Health and WASH Clusters; therefore given the urgent need to respond and to prevent the spread of the epidemic, UNICEF advanced its own resources and initiated resource mobilization with other donors as well.

b) Did CERF funds help respond to time critical needs[2]?
YES ☒ PARTIALLY ☐ NO ☐

Availability of safe water in high-risk areas was critical to containing the epidemic. Hygiene promotion and sensitization activities, including soap distribution, to affected and at-risk communities also contributed to controlling the spread of cholera.

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

The availability of CERF funding played a role in convincing other donors (in particular ECHO and National Committees for UNICEF) to contribute to the response to the cholera epidemic in Niger to meet all the needs.

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

The availability of CERF funding has been a key coordination tool for the WASH Cluster, since the supplies purchased have been used by Cluster partners for their respective interventions in the field.

[2]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.).

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

The fact that CERF is a UN funding instrument has helped increase coordination between UN agencies, in particular between OCHA, WHO, UNICEFand UNHCR, under the leadership of the Humanitarian Coordinator, as well as within the WASH Cluster, with the strong involvement of the DSRE.

Given that the WASH Cluster is the main decision-making and coordination platform (adherence to standards, geographical coordination, priorities, etc.), CERF funding has been key to ensure internal coordination and systematic allocation of resources to targeted areas through NGOs and government counterparts.

V. LESSONS LEARNED

TABLE 6:OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
CERF funding remains a key tool for responding to emergencies, thanks to the rapidity in disbursing funds.	The humanitarian situation in the country should continue to be closely monitored, as cholera remains a huge humanitarian risk in Niger	OCHA

TABLE 7:OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Prevention activities are key to controlling cholera outbreaks and consequently to reducing the number of cases.	Prevention activities must be sustained in the longer term to address the chronic cholera outbreaks that have been affecting Niger.	UNICEF
Coordination between all partners is crucial for a structured and efficient response.	There is a need to strengthen inter-sectoral coordination mechanisms in the country.	OCHA
The involvement and leadership of the Ministry of Public Health is a critical ingredient for ensuring the commitment of donors and partners, particularly NGOs.	Although the DSRE has a contingency plan for epidemics, in the long term,a cholera DRR strategy should be supported by partners and donors.	MoH with the support of all partners

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	15 Jun. 2013 – 14 Dec. 2013
2. CERF project code:	13-CEF-074	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Water and sanitation		☒ Concluded
4. Project title:	Réponse d'urgence EHA à l'épidémie de choléra au Niger en 2013		

7.Funding				
	a. Total project budget:	US$2,300,933	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$2,035,607	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$921,207	▪ *government Partners:*	US$ 19,585

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	130,000	176,311	UNICEF used its own funds and was successful in mobilizing resources from other donors, which made it possible to distribute all available supplies to the population at risk through a range of implementing partners. In addition, good coordination among partners helped prevent duplication. Thanks to these two factors, the project was able to conduct prevention activities on a greater scale than anticipated, which contributed greatly to the success of the response and the control of the epidemic.
b. Male	120,000	172,129	
c. Total individuals (female + male):	250,000	348,440	
d. Of total, children under age 5	20,000	27,875	

9. Original project objective from approved CERF proposal

General objective

Reduce morbidity and mortality linked to the cholera epidemic in Niger.

Specific objectives for WASH sector

- Ensure that the population at risk of cholera benefits from improved access to safe water in accordance with minimum international standards.
- Ensure that the population at risk of cholera benefits from access to hygiene promotion measures in accordance with minimum international standards.

10. Original expected outcomes from approved CERF proposal

- Number of people who benefited from improved access to safe water through distribution of PUR and Aqua tabs (36,940 families including 221,639 persons) [Note: as per the project proposal, PUR and Aqua tabs for 28,361 persons were going to be purchased with funds from other donors, which brings the total to 250,000 beneficiaries)
- Number of people who received information on cholera and on key measures for mitigating risks and promoting hygiene
- Number of persons (28,837 families including 173,023 persons) who received a hygiene kit (soap for three months; basic cholera kit as defined by WASH Cluster)

11. Actual outcomes achieved with CERF funds

In July 2013, in view of the need for immediate action to stop the spread of the cholera epidemic, UNICEF used its own stock, and purchased inputs with other funding sources, pending the release of CERF funds. All inputs were delivered timely to implementing partners, who distributed them in zones that were affected or at-risk, and who integrated prevention activities into their interventions. Thanks to successful fundraising and good coordination, duplication was prevented; the quantity of inputs was sufficient to cover more than the initially-targeted population; prevention activities were conducted on a greater scale than anticipated, which contributed largely to a successful response and the control of the epidemic.

CERF funds, which became available around mid/late July 2013, were then utilized to complement these inputs. A decrease in input prices enabled the purchase of more supplies at a lower cost than initially planned and budgeted for in the CERF project proposal (7,946,400instead of 4,986,900 PUR sachets; 6,400,000 instead of 4,986,857 Aquatab tablets; and 540,000 instead of 519,068 pieces of soap). Similarly, due to delays in the recruitment process, less funds than expected were utilised for the position of the cholera response coordinator. As fundraising efforts on the cholera response had been successful and the needs for preventive inputs had been met, additional inputs and equipment that could help strengthen the cholera response, such as pool testers, oral rehydration salts, buckets and water pumps, were purchased with the remainder of the CERF funding.

Furthermore, there are three main reasons why the scope of the response was higher than expected:

- Specialized NGOs such as CISP and Solidarités International have been supported by UNICEF through supplies and other funding sources and have played a key role in supporting the efforts of the health and WASH authorities during the response.
- The availability of CERF-supported supplies allowed NGOs in the field, through WASH Cluster Coordination, to integrate prevention activities within regular programming in their areas of intervention that are prone to cholera.
- The government was, as well, supported through CERF funding to be able to react quickly to new outbreaks reported in the field.

Thus, the project provided a full package of WASH cholera prevention and response activities to a total of 348,440 people at risk, thanks to CERF funding, UNICEF's own funds, and contributions from ECHO, AECID and UNICEF National Committees. Details of the response included:

- 348,440 people[3] (58,073 families) benefited from improved access to safe water through distribution of PUR and Aquatabs and through rehabilitated water sources. Drinking water quality was monitored through the use of pool testers. These were made available to the DRH, and then used by implementing partners to check on the presence of residual chlorine as well as on the pH of drinking water after use of PUR and Aquatabs.
- 348,440 people (58,073 families) received information on cholera and on key measures for mitigating risks and promoting hygiene. Implementing partners ensured that women were full participants in these activities.
- 348,440 people (58,073 families) received soap for three months, a hygiene kit, including user brochures for PUR and Aquatabs.

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

The project was able to reach more beneficiaries (348,440) than initially planned (250,000) due to higher-than-anticipated resource mobilization, including from AECID, ECHO and National Committees for UNICEF, as well as UNICEF's own resources, and due to good coordination among implementing partners, which helped prevent duplication and reach a greater number of beneficiaries. At the same time, WASH Cluster coordination and availability of cholera prevention supplies (supported by CERF funding) have allowed NGO working in high-risk areas to integrate cholera prevention activities in their regular programming. To a large extent, this has contributed to the control of cholera propagation in 2013.

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

[3]The average household comprises an estimated 6 family members.

If 'YES', what is the code (0, 1, 2a or 2b):1 (NIG-13/WS/54766/R – please note that while this is the CAP project that was included in the combined WHO-UNICEF proposal, the initial proposal on the part of UNICEF was to modify one of the existing CAP projects so that it could cover the cholera response, therefore this CAP project code does not correspond to activities implemented for the cholera response.) **If 'NO' (or if GM score is 1 or 0):**	
14. M&E: Has this project been evaluated?	YES ☒ NO ☐
If 'YES', please describe relevant key findings here and attach evaluation reports or provide URL: UNICEF and the WASH Cluster monitored the response throughout the duration of the project, and carried out an informal evaluation that is currently being finalized. Results should be available and shared with the Government and with partners shortly. If 'NO', please explain why the project has not been evaluated:	

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	WHO	5. CERF grant period:	15.Jun.2013-15.Dec.2013
2. CERF project code:	13-WHO-040	6. Status of CERF grant:	☐ Ongoing ☒ Concluded
3. Cluster/Sector:	Health		
4. Project title:	Réponse sanitaire d'urgence à l'épidémie de choléra au Niger en 2013		

7. Funding				
	a. Total project budget:	US$4,945,667	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$1,644,600	▪ *NGO partners and Red Cross/Crescent:*	US$0
	c. Amount received from CERF:	US$650,000	▪ *government Partners:*	US$100,000

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	3,900	3,004	Following the activities of sensitization of the population, the actual number of cholera cases was lower than the expected number of cases. These figures include cases of cholera, health personnel and trained laboratory personnel ,and the beneficiaries of WASH interventions in the health centres
b. Male	3,600	2,834	
c. Total individuals (female + male):	7,500	5,834	
d. Of total, children under age 5	600	53	

9. Original project objective from approved CERF proposal

General objective

To reduce morbidity and mortality from the cholera epidemic in Niger.

Specific objectives

- Ensure proper management of cholera cases through the supply of medicines and essential inputs, recycling of health personnel, supervision of field activities and organization of cholera treatment centers (CTC) of cholera treatment units (UTC) and the Centers for oral rehydration (CRO).
- Ensure early diagnosis of cholera by providing laboratory products and rapid diagnostic tests.
- Improve monitoring (data collection, transmission, analysis at all levels and dissemination) of cholera cases.
- Contribute to the reduction of new infections from CTC, CTU and CRO.

10. Original expected outcomes from approved CERF proposal

- Case fatality rate related to cholera reduced to less than 1% in the CTC (WHO Standards).
- Reducing the number of new cholera cases under 10 per week.
- No disruption to supply of drugs in the CTCs.
- Timeliness and completeness of notifications of cases of cholera than 95%.

11. Actual outcomes achieved with CERF funds

For health districts at risk of outbreak, the following medicines and essential inputs for the medical management of cholera cases were furnished and administered:

- 4 Interagency Emergency Health Kits 2011 (IEHK 2011)
- 18 Kits against diarrheal diseases (IDDK 2009)
- At district level in areas at risk of epidemics 3,000 rapid diagnostic test for cholera were made available and utilized
- At district level in areas at risk of epidemics - 2,000 prototypes of (Carry Blair) for laboratory confirmation
- Acquiring and distribution of 1,000 discs of antibiotics to study the sensitivity of cholera germs for the Centre for medical and scientific research (CERMES)
- Acquiring and provision of 4 kits for laboratory confirmation, serogrouping and serotyping of Vibrio cholerae ,CERMES
- 9 clinic-tents and 4 multi-purpose tents for the establishment of centers and cholera treatment units were made available for the Ministry of Public Health
- Refreshment of training of 56 health workers in medical treatment of cholera and correct reporting of cases, as well as of 20 laboratory staff in the laboratory diagnosis of cholera
- Support for the tracing of cholera-cases in communities, daily updates , epidemiological investigations as well as trans-border surveillance
- Extension of water-pipes in connection to existing drinking water supply, construction of standpipes for integrated health centers (ISC) SOUDANI, DIOMANA and FAMA (by the NGO Solidarités International).
- Rehabilitation / construction of latrines and showers for 6 integrated health center in Tillaberi (by the NGO Solidarités International).
- Training of 24 hygienists at integrated health centres in good practice of " hygiene during epidemics of cholera"
- Organization of a sensitization workshop for 25 traditional chiefs and religious leaders on cholera prevention
- Effectuation of three epidemiological investigation missions and supervision/support in theregion of Tillabéry
- Production and distribution of 800 copies of technical guidelines and 800 protocols for diagnosis and treatment of cholera
- Support for the coordination of medical management of cholera
- Reduction of cholera fatality rate from 3.1% in May 2013 to 2.5 % in December 2013.
- Maintaining the numbers of cholera to average of less than 10 cases per week
- Securing against shortages of drugs and inputs for the management of cholera
- 96% target was reached in terms of timeliness related to reporting on cholera cases . A100% target was accomplished for the reporting of cases of cholera

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

All planned activities were carried out, except research and identification of vibrio in the environment, because the only laboratory (the National Public Health Laboratory and expertise (LANSPEX)) did not have sufficient capacity.

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):

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

Regular monitoring of indicators was organized. Supervisions were also regularly performed. A final evaluation was not deemed necessary.

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/ Sector	Agency	Implementing Partner Name	Sub-grant made under pre-existing partnership agreement	Partner Type	Total CERF Funds Transferred to Partner US$	Date First Instalment Transferred	Start Date of CERF Funded Activities By Partner	Comments/Remarks
13-CEF-074	Water, Sanitation and Hygiene	UNICEF	Direction Régionale de l'Hydraulique	Yes	GOV	$1,416	9-Oct-13	16-Oct-13	Contribution to rehabilitation of water sources in at-risk villages in Tillabéry
13-CEF-074	Water, Sanitation and Hygiene	UNICEF	Direction de la Surveillance et la Riposte Épidémiologiq ue	Yes	GOV	$18,169	12-Nov-13	19-Nov-13	Support to governement for implementation of its cholera response
13-WHO-040	Health	WHO	Solidarités International	Yes	INGO	$100,000	22-Oct-13	1-Sep-13	Activity pre-fiinanced by the partner

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AECID	Agencia Española de Cooperación Internacional para el Desarrollo
CISP	Comitato internazionale por lo sviluppo dei popoli
COOPI	Cooperazione Internazionale
DRH	Direction Régionale de l'Hydraulique
DSRE	Direction de la Surveillance et la Riposte aux Épidémies
MSF	Médecins sans frontières
WASH	Water, Sanitation and Hygiene
WHH	Welt Hunger Hilfe