United Nations CERF Central Emergency Response Fund

RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS BANGLADESH UNDERFUNDED EMERGENCY ROUND II 2015

RESIDENT/HUMANITARIAN COORDINATOR	**Robert Watkins**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

The After Action Review (AAR) was conducted on July 14th 2016. All recipient Agencies of CERF funds concerned by this reporting process participated. The meeting was facilitated by the Humanitarian Affairs Advisor at the RCO. The AAR meeting was an opportunity to recall the background of the CERF application process and, to discuss challenges and results achieved through the projects. Exchanges on the CERF added value and lessons learnt took place. During the meeting, participants familiarized themselves with the CERF reporting guidelines and, they agreed on the next steps of the reporting process.

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 ☐

Following its review by the CERF Secretariat, the final version of the RC/HC Report will be shared with in-country stakeholders as recommended in the guidelines.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: 31,772,444		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	2,992,959
	COUNTRY-BASED POOL FUND (*if applicable*)	
	OTHER (bilateral/multilateral)	24,352,596
	TOTAL	**27,345,555**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 25-Aug-15			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	15-UF-CEF-100	Nutrition	112,736
UNICEF	15-UF-CEF-101	Water, Sanitation and Hygiene	297,000
UNICEF	15-UF-CEF-102	Child Protection	269,997
UNFPA	15-UF-FPA-031	Health	225,000
UNHCR	15-UF-HCR-046	Health	506,467
IOM	15-UF-IOM-028	Water, Sanitation and Hygiene	373,937
IOM	15-UF-IOM-029	Health	307,574
WFP	15-UF-WFP-058	Nutrition	900,248
TOTAL			**2,992,959**

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TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	1,634,296
Funds forwarded to NGOs and Red Cross / Red Crescent for implementation	953,486
Funds forwarded to government partners	405,177
TOTAL	**2,992,959**

HUMANITARIAN NEEDS

In Bangladesh, the Rohingya from Myanmar have sought shelter in one of the most naturally vulnerable coastal districts of the country, Cox's Bazar, mainly in Teknaf and Ukhia Upazilas. Cox's Bazar has a population of 2,289,990 according to the 2011 census. The district hosts approximately 33,000 Rohingya refugees from Myanmar's northern Rakhine State in two official camps that are more than two decades old, and an estimated 300,000-500,000 undocumented Rohingya living outside the official camps, in makeshift settlements or in host communities, without any legal status and in dire conditions.

The two official camps are named Kutupalong and Nayapara, while the three makeshift settlements targeted under this intervention are in Kutupalong in Ukhia Upazila, and Leda and Shamlapur in Teknaf Upazila. The UN has adopted an inclusive approach to address the humanitarian needs of the region by providing assistance to the entire vulnerable population in the Cox's Bazaar region without discriminating between Rohingya and vulnerable Bangladeshis living side by side in the area. This inclusive humanitarian approach is important as the registered Rohingya refugees in the two official camps constitute only 10% of the estimated Rohingya population in the area, while the majority remain undocumented.

Protection for Rohingya in the makeshift settlements and host communities, in particular children and women, is an urgent humanitarian priority. Their undocumented status exposes them to greater risk of violence, abuse and exploitation including trafficking and unsafe migration. In Cox's Bazar, children and adolescents aged 5 to 19 years constitute around 40% of the total population of the district. 18.5% of girls aged 15-19 years are currently married. 9.4% of children aged 10-14 years old in Cox's Bazar are out of school and engaged in wage employment.

The provision of health services for Rohingya refugees within official camps, as well as the undocumented Rohingya in the makeshift settlements and host communities falls below international standards. Due to the crowded living environment and poor sanitation infrastructure, the risk of communicable diseases is high, with potential for epidemics. The withdrawal in early 2015 of an international NGO providing health services has left a considerable gap in life-saving medical care around the Leda site. The quality of healthcare services in the camps is affected by a number of factors such as: inadequate infrastructure (accommodation of staff and clinics); understaffing and difficulties with recruitment of medical personnel, especially female doctors and paramedics; weak workflow management; and arbitrary interference of camp and local refugee authorities in medical issues. About 4% of the population is pregnant at any given time. Among these, an estimated 15% will experience obstetric complications, which means around 5000 women need immediate support for safe delivery within the camps and in host communities. Limited health care provision is further complicated by inadequate knowledge and awareness among families of good reproductive health practices and their benefits, as well as the continuing low cultural status of women and adolescents, including the autonomy to take decisions for safe birth, antenatal care and family planning. This contributes to high GBV prevalence rates with detrimental effects on the health of girls and women.

The prevalence of acute malnutrition for Teknaf and Ukhiya Upazilas is serious (12.5%). High morbidity and food insecurity make the situation even more critical. In 2014 the Kutupalong official camp recorded a moderate acute malnutrition (MAM) rate of 11% and a severe acute malnutrition (SAM) rate of 2%. In the Nayapara official camp, the MAM rate was 13% and the SAM rate was 1%. Without funding for nutrition interventions, there is a high risk of the nutrition situation deteriorating and potentially leading to increased morbidity, mortality and long term negative health effects. According to WFP, only 51% of households in the official camps have an acceptable Food Consumption Score (48% borderline, 1% poor). 9% of households have low Dietary Diversity Scores (65% medium, 26% good).

The targeted Upazilas of Teknaf and Ukhia, including the makeshift settlements of Kutupalong, Leda and Shamlapur faced an acute crisis of drinking water due to its salinity and limited availability of adequate drinking water options. UNICEF's Equity profile shows that 36% of people are using unimproved latrines and 5% are resorting to open defecation. These figures are higher than the national average. WASH infrastructure in the makeshift settlements and host communities is in need of repair and expansion. According to the Bangladesh Bureau of Statistics, the national rate of access to clean drinking water is 98%, however in Teknaf, based on 2015 Ministry of Health data, the rate is 78% (this data does not currently include the undocumented Rohingya who add approximately 30% to the local population). In the Teknaf Health Complex, the primary cause for admissions at 35% is diarrhoea and gastroenteritis of presumed infectious origin. This further highlights the weak WASH infrastructure.

II. FOCUS AREAS AND PRIORITIZATION

The situation of the Rohingya refugees in Bangladesh is a protracted crisis. Considering that, contrary to all other humanitarian interventions in the country, the Rohingya-focused programmes are coordinated by the Ministry of Foreign Affairs (MoFA). Given that situation and in order to provide special attention to the Rohingya-related issues, the UNCT established a "UNCT Cox's Bazaar" group that comprises all Agencies operating in that particular district where the Rohingya refugee are concentrated. Considering the critical underfunded level of assistance programme for the Rohingya, the UNCT decided to prioritize that underfunded emergency. Consequently, the UNCT Cox-s Bazaar group was entrusted by UNCT to develop the strategy of intervention on its behalf. Based on the humanitarian needs identified through several needs assessments[1], the UNCT Cox's Bazaar group decided to provide life-saving assistance in four (4) areas, namely: Child Protection, Health, Nutrition and WASH for the benefit of 150,000-180,000 most vulnerable documented and undocumented Rohingya population as well as the host communities. Within these focus areas, critical priority interventions were identified as follow:

Child Protection: The urgent strengthening of local child protection systems to ensure adequate psychosocial support and referral for the Rohingya children and children from the host communities.

Health: To reinforce Shamlapur family welfare centre, and to raise awareness on hygiene promotion, Sexual and Reproductive Health (SRH), Sexual and Gender Based Violence (SGBV) and infectious diseases as part of community health awareness activities; To ensure the provision of essential medicines to the clinic, including maintaining the primary health care services (medical staff, infrastructure, outreach activities), while strengthening the emergency referrals in a timely and smooth manner; To expand and scale up Sexual and Reproductive Health (SRH) interventions, Adolescent Sexual and Reproductive Health **(**ASRH) and Gender Based Violence (GBV) related interventions.

Nutrition: To treat cases of severe acute malnutrition (SAM) in host communities and makeshift camps; to promote infant and young child feeding and provide micronutrient supplementation; to address moderate acute malnutrition (MAM) in host communities and the official camps and; to provide blanket supplementary feeding, notably to children under five years, pregnant and lactating women and tuberculosis patients among undocumented Rohingya in the makeshift settlement at Kutupalang.

WASH: To provide improved water and sanitation services and to ensure a continued supply of safe drinking water to the Leda makeshift settlement and host communities and work on solutions for sustainable water collection systems for the beneficiaries; To construct latrines and washing stations and to distribute hygiene kits.

III. CERF PROCESS

The UNCT Cox's Bazaar group led the formulation of the CERF UF Priority Strategy. The prioritized activities emerged from a process of needs identification by this group in consultation with the district level clusters including local Government officials. During the final prioritization meeting agencies revisited the proposed intervention areas in the context of (i) CERF UF criteria to include only life-saving emergencies; (ii) immediate priorities on the ground based on funding gaps; (iii) agencies' capacity to deliver within nine months, and (iv) the national strategy on Myanmar refugees and undocumented Myanmar nationals which guides UN agencies' work in the area. Based on this context, the proposed intervention areas were reduced from 11 to 4; primarily non-food items, education, shelter and livelihoods were removed.

In addition to the prioritization process undertaken by the UNCT as outlined above, prioritization of activities within the sectors was based on the evidence of needs and was informed by coordination meetings between stakeholders in Cox's Bazaar. Key reports and assessments undertaken by both the Government and UN agencies working in the area were considered. The overall intervention was in-line with the Government of Bangladesh's 'National Strategy on Myanmar Refugees and Undocumented Myanmar Nationals' (UMN),

[1] • October-November 2014 annual health and nutrition survey conducted by Action Contre la Faim (ACF), UNHCR and WFP;
- 2013 ACF-Bangladesh nutrition survey;
- 2012 and 2013 Multiple Indicator Cluster Survey (MICS)
- 2015 Bangladesh HCTT Joint Needs Assessment: Flash Floods in Cox's Bazar, Bandarban and Chittagong Districts;
- 2015 IOM Needs Assessment and Action Plan for Second Year of Operation in Cox's Bazar;
- 2015 Situation analysis on health and WATSAN of Undocumented Myanmar Nationals and the host community of Cox's Bazar;
- Ministry of Health and Family Welfare Bulletins and Reports, 2010-2014 provide statistics and an overview of the status of communities in Cox's Bazar.

coordinated and implemented with the support of IOM. Hence, agencies are focusing on their areas of expertise within the geographical area in which they work and the population group of their mandate (UMNs, Refugees and Host Community). The agencies held prioritization meetings and applied the criteria of life-saving in humanitarian emergencies when drawing up the proposals. Final recommendations were made by an ad-hoc inter-agency technical working group and final decisions were negotiated by Heads of Mission/Representatives.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR[1]

Total number of individuals affected by the crisis: 2,200,000

Cluster/Sector	Female			Male			Total		
	Girls (< 18)	Women (≥ 18)	Total	Boys (< 18)	Men (≥ 18)	Total	Children (< 18)	Adults (≥ 18)	Total
Child Protection	10,200	4,451	14,651	8,569	4,974	13,543	18,769	9,425	28,194
Health	28,514	103,900	132,414	27,288	24,232	51,520	55,802	128,132	183,934
Nutrition	22,216	23,310	45,526	22,715	8,790	31,505	44,931	32,100	77,031
Water, Sanitation and Hygiene	19,571	24,762	44,333	20,742	24,371	45,113	40,313	49,133	89,446

[1] *Best estimate of the number of individuals (girls, women, boys, and men) directly supported through CERF funding by cluster/sector.*

BENEFICIARY ESTIMATION

The overall CERF funded intervention aimed at reaching b/w 150,000 to 180,000 individuals. Based on an analysis of reached beneficiaries per project and, following inter-cluster discussions, the overall number of beneficiaries is estimated to be 230,945 persons. This figure corresponds to the number of beneficiaries reached by the Health-related interventions (183,934) to which is added the significant difference between reached and planned beneficiaries of the UNICEF-led nutrition project (47,011 persons). The UNICEF nutrition project reached three times more beneficiaries than planned, as additional communities were reached out by 252 model mothers who played an important role in increasing acceptance of the nutrition activities in the communities. Therefore, the total of 230,945 beneficiaries is a realistic estimate of the overall number of beneficiaries that avoids overlaps and double counting between sectors.

TABLE 5: TOTAL DIRECT BENEFICIARIES REACHED THROUGH CERF FUNDING[2]

	Children (< 18)	Adults (≥ 18)	Total
Female	35,802	130,455	166,257
Male	34,262	30,425	64,688
Total individuals (Female and male)	**70,064**	**160,881**	**230,945**

[2] *Best estimate of the total number of individuals (girls, women, boys, and men) directly supported through CERF funding This should, as best possible, exclude significant overlaps and double counting between the sectors.*

CERF RESULTS

Important results were achieved in all clusters concerned by this report. Indicated below are some of the key results achieved per cluster:

Child Protection:

- 16,334 children from Rohingya and host communities benefited from protection, psychological and developmental support in 5 newly established Child Friendly Spaces (CFS);
- 2,435 adolescents from both host and refugee communities participated in Life Skills Based Education (LSBE) programme;
- 1,305 members of 85 Community Based Child Protection Committee (CBCPC) are able to provide protection services at the community level such as referral of children to specialized protection services. They are also publicly advocating for the abandonment of harmful practices against children;
- 8,120parents participated in meetings to discuss the rights of children and children development in order to find ways to create a protective environment for the children and the adolescent.

Health:

- 4,000 deliveries and 80% of newborn care services were provided by skilled providers in health facilities;
- 90% of pregnant women received Antenatal Care (ANC) services (10% more than planned);
- All women that had unprotected sex and/ or were victims of rape (375 women) received emergency contraceptives;
- 17,159 people (children, pregnant and lactating women, Gender Bases Violence (GBV) survivors) benefited from community management services of acute malnutrition;
- 32,939 had access to secondary and tertiary health care.
  - A total of 9,459 patients were provided with clinical consultation and treatment at the centre.
  - 20,521 beneficiaries were given first aid treatment at the communities through outreach programme, of which, 6,840 patients were referred by community health volunteers and received necessary health care services by health professionals at the Shamlapur FWC in Baharchara Union.
  - 201 patients were referred to secondary- and tertiary-level medical facilities such as Cox's Bazar District Hospital and Chittagong Medical College Hospital through the IOM-supported referral mechanism which provided transport by ambulance and assistance on transfer as well as at referred hospitals.
  - 116,686 beneficiaries were reached Community outreach activities were carried out by 30 female trained health volunteers through the outreach interventions. Of them 33,352 were undocumented Myanmar nationals.

Nutrition:

- 35,437 Under Five Children were screened for detection of nutritional status by Mid Upper Arm Circumference (MUAC);
- 30,772 mother/caretakers received at least one counselling on infant and young children feeding at targeted health facilities;
- 3,977 children aged-23 months received micronutrient powder
- 17,159 people (children, pregnant and lactating women, GBV survivors) benefited from the community management of acute malnutrition;
- 403 Moderately Acutely Malnourished (MAM) children were identified and referred for the nutritional treatments to Supplementary Feeding Centre;
- Severed Acute Malnutrition (SAM) management capacity was reinforced in targeted three SAM stabilization centres;
- A community based network of 252 Model Mothers was established for screening children under age five as well as a referral mechanism between community and government health facilities;
- Establishment of Infant and Young Child Feeding (IYCF) counselling and promotion and Micronutrient Powder (MNP) supplementation in the targeted 13 Unions of 3 Upazilas;
- The prevalence of acute malnutrition among the screened children shows a downward trend and is well below the target of less than 15%. Similarly, weight gain (per month) of children has increased since the introduction of the MAM prevention programme. Though the total number of admissions to treatment for SAM has increased, this is due to an increase in the numbers screened.

- Seasonal trends for SAM admissions in ACF's treatment programme since 2010 show an increasing trend from April to June as a result of pre-monsoon heat and disease incidence. This annual upwards trend seems to have been prevented this year by the CERF-funded intervention.

WASH:

- 5,861 persons are directly benefiting from the construction of 80 new safe water sources and 1,000 more people gained access to safe water through the rehabilitation of 200 existing water points;
- 4,056 people gained access to improved sanitation facilities through construction of 400 emergency latrines and the repair of 200 existing latrines;
- 1,300 women and adolescent girls have now access to private and secure bathing facilities that protect their dignity;
- 6,240 people have now access to hand washing facilities through the construction and the distribution of 1,200 handwashing devices;
- 62,768 people were sensitized on hygiene practices and 10,379 people received hygiene kits;
- 25,000 Undocumented Myanmar Nationals (UMN) and host community members have access to improved sanitation facilities.

CERF's ADDED VALUE

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

Yes. CERF funds led to a fast delivery of assistance to beneficiaries in most cases. The fast delivery of assistance was also ensured through pre-existing partnerships with highly efficient implementing partners, pre-existing relationships with local governments, refugee populations and community leaders and the good coordination with other partners including UN Agencies, international and national NGOs working in the camps, makeshift settlement areas and host communities. These partnerships facilitated the fast and smooth implementation of the planned CERF-funded activities. However, in the case of the project led by UNHCR, the speed of delivery was maintained, through UNHCR policy of pre-financing. CERF funding eased the material burden of UNHCR's work with the Rohingya and acted as strong programmatic and policy level support, but did not affect the speed of implementation per se.

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

Yes. CERF funds helped respond to time critical needs. All activities were life-saving in nature and their implementation helped to respond to time-critical life-saving needs. For instance, CERF funds helped to reduce the morbidity and mortality among under five children, and the nutrition situation of pregnant and lactating women in the targeted areas improved. The health status and socio-economic wellbeing of the people improved through WASH activities. The Child Friendly Spaces (CFS) and the Adolescent Clubs served as mechanisms for early identification of risks and referral to services for child protection. Therefore, CERF funds minimized additional loss of lives and damage to social and economic assets.

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

Partially. CERF funds helped to increase opportunities for resource mobilization from other sources but did not necessarily mobilize funds per se. A very limited number of donors are funding the much-needed humanitarian assistance in the country. However, CERF funding allowed to strengthen the presence of concerned Agencies in the district of Cox's Bazar which is a highly vulnerable district due to the presence of Rohingya refugees and also due to the fact that the district is frequently hit by natural disasters. Thanks to a strengthened presence, several UN Agencies had the opportunity to apply for ECHO funds and/or to mobilize their internal resources to support cyclone Roanu affected communities (e.g. UNICEF).

[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.).

In some cases, CERF funding improved resource mobilization for UN Agencies' partners in several sectors (e.g. ECHO funded ACF response in the area of emergency nutrition) allowing the response to continue beyond the CERF funded project period Overall, CERF promoted an approach to be replicated and allowed for the results achieved to be sustained. Moreover, needs assessments and gaps analysis undertaken during the implementation of CERF funded projects (e.g. GBV) served as a basis to approach donors and discuss ways to address the identified issues.

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

Yes. CERF improved coordination amongst the humanitarian community notably through regular cluster meetings in Cox's Bazar (e.g. WASH) and gave the opportunity to key stakeholders to join forces to tackle common challenges and to improve service delivery (e.g. SRH in emergencies training organized by UNFPA and that benefited GO/NGO staff, UNs including UNHCR, IOM personnel, community leaders and youths from refugee population). Similarly, CERF funding facilitated district sectoral coordination mechanisms (e.g. In Nutrition) and mobilized concerned partners under a single platform led by relevant national counterparts. This resulted in a more effective coordination and implementation of CERF projects and furthermore facilitated follow up and sharing of updates related to the implementation with others partners including UN, INGOs and NGOs. In addition, coordination amongst the humanitarian community allowed the timely sharing of information on progress of CERF funded project implementation, enhancing support to both host and Rohingya communities, initiating discussion about longer term solution of this crisis and facilitation of field visits.

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

In addition to the above, CERF funded projects allowed starting discussions about expanding the provision of humanitarian assistance to Rohingya in host communities. For example, UNICEF has discussed with the Department of Public Health Engineering (DPHE) on WASH issues experienced by host communities as well as Rohingya due to Rohingya influx, and managed to sensitise the government counterpart on the urgency of the issue. CERF funded projects allowed to build the capacity of government in key areas. In addition, UNICEF CERF funded nutrition programme has strengthened the capacity of the government in service delivery and reporting of severe acute malnutrition management in targeted Upazila health complexes. Furthermore, integration and coordination of IYCF with ongoing community management of acute malnutrition (CMAM) program strengthened the smooth implementation of service delivery at community level and contributed to achieving the expected results for also the CMAM project supported by other UN agency. Also, CERF funded child protection programme has strengthened capacity of Community Based Child Protection Committees (CBCPC) so that the committees can support and ensure sustainability of the Adolescent Clubs and Child Friendly Spaces. IOM CERF funded health project has also strengthened the capacity of the government health facility by providing essential medical equipment, human resources, training for healthcare providers, medicines and other medical commodities to provide necessary primary health care services to both UMNs and local communities.

Furthermore, CERF UFE has opened the window to alleviate tensions between host communities and Rohingya residing in or nearby host communities. For example, CERF funded child protection programme has facilitated access to the Child Friendly Spaces (CFSs) and adolescents clubs for the children and adolescents from both host communities and makeshift refugee camps. In this way, children from host communities and Rohingya communities have opportunities to increase understanding of each other and build bonds from early age which will result in more peaceful relationships between the communities.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Adoption of an MOU between UNHCR, Government's Ministry of Health and Office of the Refugee Relief and Rehabilitation Commissioner (RRRC), for the mainstreaming of IPD facilities of the RHU, to the local establishments.	During the implementation period of these funds, UNHCR's long-term advocacy has yielded a significant result. The Office of the RRRC under the MoDMR, Civil Surgeon in Cox's Bazar under the MoH, Superintendent of CXB Sadar Hospital under MoH, and UNHCR in Cox's Bazar signed an MOU that defined responsibilities for primary and secondary medical referrals to Government facilities. The MOU covers all refugees in both camps and fulfils UNHCR's Principles and Guidance for Referral Health Care for Refugees. Under the MOU, RRRC and MoH agreed that UNHCR will be actively involved in initiatives to strengthen the services of upazila and district public health facilities. The MOU enables the mainstreaming of refugee access to the local public health facilities without any discrimination, thereby making the parallel facilities inside the camps redundant. RRRC and HoSO also signed a second MOU to provide RHU with clear guidance on medical referrals from both camps and to ensure well-coordinated health services. These two developments are expected to bring greater inclusiveness in the provision of services to refugees in the local context, and lead to some cost-savings in the long term.	UNHCR/ Government and humanitarian actors
Low cost innovative and sustainable community based screening and referral mechanism established between communities and government health facilities (Community Clinics and Upazila Health Complexes) through involvement of volunteers/Model Mothers.	Through CERF funded nutrition project, UNICEF learned that model mothers who have promoted Infant and Young Child Feeding practices at community level were cost effective as they significantly increased community mobilisation as well as improved gender equality in communities. This model mother approach should be continued in the targeted three Upazilas and as well as should be introduced into the government health service delivery mechanism to reach out left-out communities for community mobilization and for ensuring nutrition counselling, screening and referral to Upazila and district level health facilities.	UNICEF/Humanitarian Community, MoHFW/GoB
There is no system or valid source of record for identification of UMNs receiving basic social services provided by government or NGOs	There should be a valid and responsive mechanism to keep track record of UMNs receiving services form the recognized facilities. The situation is expected to improve following the recent census on Rohingya population.	IOM/Humanitarian Community, GoB etc.
WASH intervention in host communities found useful in maintaining good relations among host communities and Rohingya.	Continuation of WASH activities for host communities who suffered directly or indirectly due to the Rohingya influx.	UNICEF/IOM/Government and humanitarian actors.

Various factors such as illiteracy, cultural and social norms and practices , lack of awareness prevailing in the Rohingya Refugees communities posed often challenges for adolescents girls to participate in the clubs ;	Continuation of child protection activities for children and adolescents of both host and Rohingya refugee communities to have access to social protection services and reduce their vulnerability to abuse, violence and exploitation	UNICEF/Government and humanitarian actors
Due to the unregistered status of the Rohingya Refugees communities access to essential child protection services is limited.	Strengthen child protection systems for Rohingya children alongside children from the host communities	UNICEF/Government and humanitarian actors

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	UNICEF	**5. CERF grant period:**	24/09/2015 – 30/06/2016
2. CERF project code:	15-UF-CEF-100	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Nutrition		☒ Concluded
4. Project title:	Treatment of severe acute malnutrition for Rohingya and host communities		

7.Funding		
	a. Total funding requirements[3]: US$ 281,832.50 b. Total funding received[4]: US$ 281,835 c. Amount received from CERF: US$ 112,736	d. CERF funds forwarded to implementing partners: ▪ *NGO partners and Red Cross/Crescent:* US$ 105,361 ▪ *Government Partners:*

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	8,150	8,150	16,300	19,493	19,921	39,414
Adults (≥ 18)	6,875		6,875	21,986	8,786	30,772
Total	**15,025**	**8,150**	**23,175**	**41,479**	**28,707**	**70,186**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees	11,587	7,019 (Estimated Refugee Population). There is no valid source of record for identification of the refuges population in the host communities. However there is estimation that 10% population have been integrated with the host community over the last periods.

[3] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[4] This should include both funding received from CERF and from other donors.

IDPs		
Host population	11,588	63,167 (Estimated host population)
Other affected people		
Total (same as in 8a)	**23,175**	**70,186**
In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	Beneficiary number tripled because a community based approach was adopted, through which a network of 252 model mothers were recruited & trained at the community level. With the support of 252 model mothers, additional community members, not only pregnant and lactating women but also other caregivers such as fathers were reached out and mobilized for Infant Young Child Feeding (IYCF) counselling and promotion. The total number of children under five years of age targeted for nutrition screening status was also higher than the initial target due to additional community mobilization by the 252 model mothers. Another factor that came into play for reaching out to more communities/beneficiaries was the high level acceptance of the model mothers in the more conservative local communities.	

CERF Result Framework			
9. Project objective	Contributing to the enhancement of nutrition status of vulnerable groups in the target communities		
10. Outcome statement	Enhanced optimal nutrition status amongst children and women of reproductive ages		
11. Outputs			
Output 1	23,175 vulnerable children, pregnant & lactating women in Ukhiya and Teknaf Upazila have access to emergency nutrition services		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of mothers/caretakers who have received at least one counselling on infant and young child feeding at targeted health facilities	6,875	30,772
Indicator 1.2	Number of children aged 6-23 months received micronutrient powder	3550	3,977
Indicator 1.2.1	Numbers of mothers/caregivers who would receive at least counselling session on infant and young child feeding at communities and targeted health facilities.	6875	35,437
Indicator 1.3	Number of children presenting with severe acute malnutrition who are admitted and treated at inpatient facilities	600	80 SAM managed in SC and 627 SAM managed in OTP centre (under CMAM program financed by ECHO)

Output 1 Activities	Description	Implemented by (Planned)	Implemented by (Actual)
Activity 1.1	Infant and young child feeding counselling and promotion by trained health workers and counsellors	ACF through existing Ministry of Health & Family Welfare facilities.	ACF through existing Ministry of Health & Family Welfare facilities
Activity 1.2	Distribution of micronutrient powder sachets	ACF through existing Ministry of Health & Family Welfare facilities.	ACF through existing Ministry of Health & Family Welfare facilities
Activity 1.3	Management of severe acute malnutrition at inpatient facilities	ACF through existing Ministry of Health & Family Welfare facilities.	ACF through existing Ministry of Health & Family Welfare facilities

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

1. Total 35,437 children under five years of age were screened for detection of nutritional status by MUAC, 403 (M-170, F-233) Moderately Acutely Malnourished (MAM) children identified and referred by 252 Model Mothers for the nutritional treatments to Supplementary Feeding Centre in Ukhiya, Teknaf and Moheskhali Upazila of Cox's Bazar.
2. Strengthened SAM management capacity in targeted three SAM stabilization centres at Upazila Health Complexes including deployment of a nurse at Moheskhali Upazila Health Complex that ensured smooth functioning of the SAM stabilisation centre and in-patient therapeutic management of children with SAM.
3. Developed a community based network of 252 Model Mothers for screening children under age five and a referral mechanism between community and government health facilities, and for providing IYCF counselling and promotion and MNP supplementation to 6-23 months children by model mothers in the targeted 13 Unions of 3 Upazilas.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

The district authorities of health was actively involved with provision of the proposed services in the communities and targeted health facilities. The project maintained good coordination and complementarity with other agencies on the ground. Implementing partner, beneficiaries, cluster partners, UN agencies were consulted during the project design, implementation phase and shared the monitoring observations. The project management status was reviewed in routine health coordination meetings and other already existing forums at district level such as the district nutrition cluster meetings.

UNICEF organised joint program monitoring visits to health facilities and communities with the implementing partner to observe implementation progress and cross check uptake of services with the beneficiaries. Reporting was done on a monthly basis and shared with the Ministry of Health and Family Welfare (MoHFW) which provided feedback on progress, challenges and follow up actions. Additionally, two quarterly meetings were organised with the partner to review program implementation. At implementation level, UNICEF Chittagong field office was responsible for the overall coordination and oversight of the planned activities in consultation with UNICEF Bangladesh Country Office. A workshop was organized in Dhaka to document and share achievements, best practices and lesson learned with the relevant partners.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
A significant number of routine monitoring visits (4 by nutrition officer, several visits by district nutrition support officer/DNSO) were conducted jointly with the implementing partner, MoHFW officials and UNICEF to monitor the implementation status. In addition, two review meetings were organized with the partner, MoHFW and UNICEF. Implementation status and progress were also discussed in district nutrition cluster meetings held at district level. Finally, there was a formal project completion review meeting held in Dhaka where UNICEF and the implementing partner jointly reviewed progress/achievements, lesson learned, challenges faced, and agreed on the way forward to sustain the results achieved especially by the 252 model mothers.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	**5. CERF grant period:**	18/09/2015 – 30/06/2016
2. CERF project code:	15-UF-CEF-101	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Water, Sanitation and Hygiene		☒ Concluded
4. Project title:	Improved WASH services to Rohingya in host communities		

7. Funding

a. Total funding requirements[5]:	US$ 750,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[6]:	US$ 297,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 87,932
c. Amount received from CERF:	US$ 297,000	▪ *Government Partners:*	US$ 135,449

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	9,970	10,030	20,000	12,515	12,591	25,107
Adults (≥ 18)	14,955	15,045	30,000	18,774	18,887	37,661
Total	**24,925**	**25,075**	**50,000**	**31,290**	**31,478**	**62,768**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees	10,917	2,377
IDPs		
Host population	39,083	60,391
Other affected people		
Total (same as in 8a)	**50,000**	**62,768**

[5] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[6] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	Although UNICEF has originally targeted 39,083 beneficiaries from host communities and 10,917 beneficiaries from Rohingya communities, 60,391 beneficiaries from host communities and 2,377 from Rohingya communities were reached in the end. The increased number of beneficiaries is because additional number of people attended in the hygiene promotional sessions, received hygiene promotion messages and benefited from other WASH interventions. However, the reason for a lower number of Rohingya derives from the fact that beneficiaries, probably from Rohingya communities, were reluctant to disclose their identity as Rohingya.

CERF Result Framework			
9. Project objective	Support emergency WASH needs of Rohingya		
10. Outcome statement	50,000 Rohingya and host community members have access to improved WASH services.		
11. Outputs			
Output 1	80 new water points installed and 200 existing dysfunctional water points rehabilitated for 50,000 Rohingya and host community members		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	# of new safe water sources installed	80	80
Indicator 1.2	# of existing water sources rehabilitated	200	200
Indicator 1.3	# of water quality test conducted.	100	100
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Installation of 80 safe water sources.	UN/DPHE/NGO	DPHE
Activity 1.2	Rehabilitation of 200 existing dysfunctional water sources.	UN/DPHE/NGO	DPHE
Activity 1.3	Conduct water quality tests.	UN/DPHE/NGO	DPHE
Output 2	400 Emergency latrines constructed and 200 existing broken down latrines rehabilitated for 50,000 Rohingya and host community members		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	# of emergency latrines constructed.	400	400
Indicator 2.2	# of existing latrines rehabilitated.	200	200
Indicator 2.3	# of bathing cubicle constructed.	50	50
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Construction of Emergency Latrines	UN/DPHE/NGO	NGO (NGO Forum for Public Health)
Activity 2.2	Rehabilitation of existing broken down latrines	UN/DPHE/NGO	NGO (NGO Forum for Public Health)
Activity 2.3	Construction of Bathing cubicle	UN/DPHE/NGO	NGO (NGO Forum for Public Health)

Output 3	Hygiene awareness sessions conducted and hand-washing devices installed/distributed		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	# of hygiene promotion sessions carried out.	500	500
Indicator 3.2	# of household Hand washing stations installed/distributed	1,200	1,200
Indicator 3.3	# of people reached with hygiene promotion messages	50,000	62,768
Indicator 3.4	# of hygiene kits distributed among targeted households	2,000	2,000
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Conduct hygiene promotion activities	UN/DPHE/NGO	NGO (NGO Forum for Public Health)
Activity 3.2	Construct Group Hand washing stations	UN/DPHE/NGO	NGO (NGO Forum for Public Health)
Activity 3.3	Distribution of Hygiene Kits to 2,000 households in host community	UN/DPHE/NGO	NGO (NGO Forum for Public Health)

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

Water: 5,861 beneficiaries were reached through construction of 80 new safe water sources and 1,000 more people gained access to safe water through rehabilitation of 200 existing water points.

Sanitation: 4,056 people gained access to improved sanitation facilities through construction of 400 emergency latrines and repair of 200 existing latrines. 1,300 women and adolescent girls gained access to private and secured access to bathing with dignity.

Hygiene Promotion: 6,240 people gained access to hand washing facilities through construction and distribution of 1,200 handwashing devices. 62,768 people were reached through hygiene promotion sessions and messages and 10,379 people were provided with 2,000 hygiene kits.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

Informal community consultations were carried out by WASH cluster members in Cox's Bazar during their field visits to determine the needs. Those were discussed during the WASH Cluster meeting at Cox's Bazar. During the implementation phase, the sites for WASH facilities for example water points, bathing cubicles, latrines were selected in consultation with targeted beneficiaries by the front line project staffs. Beneficiaries for hand washing device and hygiene kit distribution were selected through rigorous consultation with communities and local union Parishad representatives to identify the most vulnerable and poor people. During the monitoring phase, project beneficiaries were informed about what they would receive and they were involved in the monitoring during the construction activities.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
The CERF funded WASH project was implemented under Development Project Proforma (DPP) between the Government of Bangladesh and UNICEF. The evaluation of the CERF funded WASH interventions will be covered under evaluation planned in the DPP.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	**5. CERF grant period:**	18/09/2015 – 30/06/2016
2. CERF project code:	15-UF-CEF-102	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Child Protection		☒ Concluded
4. Project title:	Protective environment for Rohingya children alongside with children from host communities in Teknaf and Ukhiya		

7.Funding

a. Total funding requirements[7]:	US$ 675,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[8]:	US$ 565,997	▪ *NGO partners and Red Cross/Crescent:*	US$ 218,839
c. Amount received from CERF:	US$ 269,997	▪ *Government Partners:*	US$ 3,698

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	8,606	6,394	15,000	10,200	8,569	18,769
Adults (≥ 18)				4,451	4,974	9,425
Total	**8,606**	**6,394**	**15,000**	**14,651**	**13,543**	**28,194**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees	2,576	2,077
IDPs		
Host population	12,424	26,117
Other affected people		
Total (same as in 8a)	**15,000**	**28,194**

[7] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[8] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	Adults reached are parents and Community Based Child Protection Committees (CBCPC) members of host and Rohingya communities. They have been supported for their participation in the parents groups and CBCPC meetings (out of 9,425, 886 are refugee). The CBCPC and parents' groups have contributed at community level to creating an enabling environment for children from both host and Rohingya communities.

CERF Result Framework			
9. Project objective	Strengthen child protection systems and foster behavioural and social changes for Rohingya children alongside children from the host communities		
10. Outcome statement	Outcome-1: To facilitate better access of children to child protection and development services through Child Friendly Spaces (CFS) Outcome -2: To empower adolescents to act as change-makers through life-skill and occupational development Outcome -3: To improve protection activities at the community level including referral of children to services and public declaration to abandon harmful practices through strengthening the capacity of Community Based Child Protection Committees (CBCPC) Outcome -4: To advocate and network in strengthening linkage and cooperation with Child Welfare Board and other actors for protection and development of children and adolescents		
11. Outputs			
Output 1	CFS are operational with community support and children's participation in management, ensuring that 12,750 marginalized children have access at least one of social protection services.		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	# of CFS fully equipped with human resources, materials and activities with support from community	5	5
Indicator 1.2	# of children who receive recreational service at CFS	12,750	16,334
Indicator 1.3	# of CFS equipped with trained social workers to provide basic psychosocial counselling support	5	5
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	CFS will be operational six days in a week. Children with different age groups access and attend in and around the catchments area, formal and non-formal school. Operating different corners based activities inside the CFS including computer corner in the CFS; Psychosocial counselling support for children; Support in developing IMS of children.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC),
Activity 1.2	Linkage development of CFS with the local service provider agencies through organizing meeting and dialogue. Visit of local government and civil society to the CFS program and norms practice regularly and Involvement of local government and like-minded organizations with CFS's special events.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC),
Activity 1.3	Formation and function of CBCPC, Peer Groups, Parents Groups to practice and ensure the child protection. Training of Peer Leaders on Life skills modules, Child Development Module, Sports for Development.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC),
Output 2	Social work increased for early identification, linkage with statutory services, family support and prevention of violence, abuse and exploitation of children		

Output 2 Indicators	Description	Target	Reached
Indicator 2.1	# of children whose case is referred to statutory services through case management including psychosocial first aid, school re-enrolment or retention etc.	3,060	3,365
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Training/ refresher on case management guideline for social workers	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Activity 2.2	Linkage development of CFS with the local service provider agencies through organizing meeting and dialogue.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Activity 2.3	Introduce child protection policy at CFS ; Support in developing IMS of children	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Output 3	90 Adolescent groups/ clubs are active in ensuring that adolescent girls and boys have access to resources required for their development.		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	#of adolescents for whom LSBE made available who attend one LSBE session at adolescent club	1,250	2,435
Indicator 3.2	#of adolescents completed 11 LSBE sessions who are engaged in civic engagement	1,250	1,515
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Organize and facilitate the life skill sessions with effective guidelines through active participation and regular attendance of the adolescents.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Activity 3.2	Introduce Life Skills Based Education (LSBE) sessions for adolescents;	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Activity 3.3	Facilitate formation of CBCPCs at community level; Support in strengthened the network among all CBCPCs CBCPCs supporting to ensure the life skill training for adolescents.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Output 4	2,250 Adolescent girls and boys use their knowledge and skills to initiate collective efforts in reducing child labour, child marriage and violence in their community.		
Output 4 Indicators	**Description**	**Target**	**Reached**
Indicator 4.1	# of interactive sessions conducted by the adolescent groups	1,050 sessions	1,210 sessions
Indicator 4.2	# of adolescents Interactive Popular Theatre (IPT) groups and performances	50 IPT groups	85 IPT groups
Output 4 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**

Activity 4.1	Facilitate linkages between adolescents' members of the Adolescents Clubs with members at the CFS.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Activity 4.2	Adolescents IPT group formation and performance by adolescents groups	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Activity 4.3	Sports for development team formation and play by adolescents groups	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Output 5	85 CBCPCs are functional to ensure that marginalized children are provided with family support and statutory services		
Output 5 Indicators	**Description**	**Target**	**Reached**
Indicator 5.1	# of CBCPCs which are provided with child development and CRC and fully functional with community contribution	85	85
Indicator 5.2	# of targeted communities which hold public debate and discussion on reducing harmful practices e.g. child marriage, child labour, corporal punishment	85	85
Indicator 5.3	# of cases of children referred per CBCPC per year to service providers and/ or Child Welfare Board at upazilla or district level	35	61
Output 5 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 5.1	Establishment of CBCPCs; CBCPC members, parents trained on child development. CBCPCs will prepare a Child Protection Action Plan based on their identification of problems and issues. CBCPCs will be provided with support to implement their action plan. Support in ensuring the Kazis (Marriage Registrar) as members of the CBCPC are checking birth certificate during the marriage registration to stop child marriage.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Activity 5.2	CBCPCs will enhance the rapport building and accelerate the referral linkage with the Union, Upazilla and District level child protection networks consists of Social Welfare, Health and Women & Child Affairs Department, NGO etc.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Activity 5.3	Child rights and child protection issues will be discussed in interactive dialogue manner deliberately at the meetings of different committees and forums of communities where parents, teachers and other respective people are staying in touch of children. Day Observation and Door to Door Social Campaign on Child Rights and Child Protection will be organized and facilitated by the different committees and social agencies.	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC)
Output 6	Strengthened coordination between service providers at union, upazilla and district levels ensuring that children are provided with services in a timely manner		
Output 6 Indicators	**Description**	**Target**	**Reached**
Indicator 6.1	# of follow up actions decided by Child Welfare Boards in Ukhia and Teknaf fully undertaken by social service officials	10	11
Output 6	**Description**	**Implemented**	**Implemented by (Actual)**

Activities		by (Planned)	
Activity 6.1	Build linkages with CBCPC, DSS at district and Upazilla level and other actors for protection and development of children and adolescents	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC),
Activity 6.2	Coordinate activities so that DWA can lead CPiE south east coast sub cluster	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC),
Activity 6.3	Support DWA in Adolescents Sub Cluster	UNICEF	COMMUNITY DEVELOPMENT CENTRE (CODEC),

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

16,334 children have bene facilitated in their access to child protection and development services through 5 Child Friendly Spaces (CFS). Children from host and Rohingya communities have been provided with psychosocial support and necessary life skills to strengthen their resilience through the CFS.

2,435 adolescents from both host and refugee communities have been provided with support and access to life skills based educations (LSBE) and 90 adolescent club based interventions to strengthen their life skills and support their engagement in community.

Capacity of 1,305 members of the 85 Community based Child protection Committee (CBCPC) have been strengthened to improve protection activities at the community level including referral of children to child protection services and public declaration to abandon harmful practices against children. In addition, 8,140 parents have also been supported to participate in meetings, dialogues and discussion on children rights and development and to create protective environment for children and adolescents.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

Communication, discussion and meeting have been organised with community based child protection committee (CBCPC), parents and Adolescents clubs members during the planning and implementation of the activities. Members of the CBCPC, Parents, and Advance Adolescents group members have participated in the regular review meeting on the project progress, have played an important role in monitoring of the project as well in responding to the findings.

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

EVALUATION CARRIED OUT ☐

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☒

Routine monitoring on the project has been conducted to review progress across all levels. Field visits have been undertaken to monitor and support smooth implementation. Discussions with children, adolescents, members of Community based child protection committee (CBCPC) as well parents groups have taken place to understand the impact of the project. Implementing partners have ensured routine reporting on the project.

Joint visits to the project have also been facilitated between UNHCR, UNICEF and IOM through coordination, sharing of progresses and facilitation visit to the Child Friendly Spaces (CFS) and Adolescents clubs. Also, the Upazilla Social Services Officer (USSO) of Department of Social Services (DSS) , Upazilla Women Affairs Officers , and Upazilla Nirbahi Officer (UNO) have undertaken field visit to the CFS and adolescent clubs.

The project has been also included in the Level 3 Monitoring Study conducted by BRAC University and John Hopkins University as well the Child Protection System Mapping undertaken by Child Protection Section of UNICEF Bangladesh.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNFPA	**5. CERF grant period:**	18/09/2015 – 30/06/2016
2. CERF project code:	15-UF-FPA-031	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Improve maternal and neonatal health in Nayapara and Kutupalang official camps and among immediate host communities		

7.Funding

a. Total funding requirements[9]:	US$ 915,000	d. CERF funds forwarded to implementing partners:	
b. Total funding received[10]:	US$ 715,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 138,904
c. Amount received from CERF:	US$ 225,000	▪ *Government Partners:*	US$ 6,000

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	5,875	3,875	9,750	5,750	3,800	**9,550**
Adults (≥ 18)	12,625	2,625	15,250	12,700	2,600	15,300
Total	**18,500**	**6,500**	**25,000**	**18,450**	**6,400**	**24,850**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees	17,500	17,500
IDPs		
Host population	7,500	7,350
Other affected people		
Total (same as in 8a)	**25,000**	**24,850**

[9] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[10] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	

CERF Result Framework			
9. Project objective	Improve the reproductive health conditions of 25,000 people in Cox's Bazar district with sustainable interventions, with special focus on documented/ undocumented refugees and including host communities		
10. Outcome statement	Documented/ undocumented refugees, including host communities, in Cox's Bazar district have Increased and equitable utilisation of high-quality sexual and reproductive health and HIV information and services, with a focus on family planning and skilled care		
11. Outputs			
Output 1	Increased access to SRH-FP information and services for 25,000 documented/undocumented refugees and people from host communities in the project area		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of facilities providing 24/7 EmONC services with Skilled Birth Attendants, including at least one midwife	8	8
Indicator 1.2	Number of health facilities having functional adolescent health service corners	3	3
Indicator 1.3	% of reported rape survivors receive timely clinical services and post-exposure prophylaxis	100%	100%
Indicator 1.4	Number of GBV survivors reported and referred by youth groups for appropriate clinical service	50	122
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	• Baseline survey/needs assessment for the project • Facility assessment of existing SDPs/renovation of SDPs/procurement of logistics, equipment and drugs/medical and surgical requisites (MSRs) • Training Needs Assessment of service providers/arrangement for capacity building in skilled care	UNFPA, MOHFW, RTMI	UNFPA, MOHFW, RTMI
Activity 1.2	• sensitisation workshop with service providers, gatekeepers and religious leaders based on emergency community needs • Involvement of youth clubs/adolescent groups to raise awareness on adolescent SRH services and prevent GBV during emergencies and support GBV/ rape victims through referral to appropriate clinical service and post-exposure prophylaxis	UNFPA, community, youth clubs	UNFPA, community, youth clubs
Activity 1.3	• Ensure provision of adequate staff equipped with logistics and appropriate skills in facilities to provide safe delivery, adolescent SRH services and information • Orientation on provision of life saving Maternal & Neonatal services and ensuring timely and quality services to survivors of GBV for 1st responders (health services providers/ NGO field health workers and camp management)	UNFPA, MOHFW	UNFPA, MOHFW

	• Ensure FP services with logistical support from FP department • Distribution of MSRs, drugs and reagents to ensure safe delivery		
Activity 1.4	•Minimum Initial Service Package (MISP) training for health services providers, NGO field health workers and camp management for immediate management of GBV and rape cases and for ensuring safe delivery during emergency situations	UNFPA, MOHFW	UNFPA, MOHFW
Output 2	Increased availability of SRH and emergency FP services, with a special focus on skilled delivery care for 5000 pregnant women and emergency contraceptive services for documented/ undocumented refugees and host communities in the project area		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	% of all deliveries attended by skilled providers in facilities in the targeted area	80% or 4,000 deliveries	80% (or 4,000 deliveries)
Indicator 2.2	% pregnant women receiving ANC services	85%(or 4,000 women)	90% (or 4,235 women)
Indicator 2.3	% cases receiving PNC services	75%(or 3,000 cases)	70% (or 2,800 cases)
Indicator 2.4	% of newborn care services attended by skilled providers	80% (or about 4,000)	80% (or about 4,000)
Indicator 2.5	% of women who received emergency contraceptives after unprotected sex and/ or rape	80% (or about 300 women)	100% (or about 375 women)
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Full-time nurse-midwife services made available in birthing units 24/7	MOHFW, RTMI, UNFPA	MOHFW, RTMI, UNFPA
Activity 2.2	Procurement of Dignity and RH Kits Procurement of ambulance for EmOC transport Procurement of MSRs/drugs	MOHFW, UNFPA	MOHFW, UNFPA
Activity 2.3	Distribution of Dignity and RH Kits (including Clean Delivery Kits) to refugee women and girls and in neighbouring host communities, to ensure that deliveries are safe and that basic hygiene and protection items are provided.	MOHFW, UNFPA	MOHFW, UNFPA
Activity 2.4	Strengthen the referral system, including from refugee camps to birthing units, and birthing units to Cox's Bazar Sadar Hospital (CSH), as well as from primary-level facilities to CSH Strengthen the referral system for the GBV survivors from refugee camps, police station to district hospitals, OCC	UNFPA, RTMI, MOHFW, MOWCA, police	UNFPA, RTMI, MOHFW, MOWCA, police
Activity 2.5	Provide information to the adolescent girls on GBV prevention and response Conduct two day training for the service providers on GBV case management during emergency Coordination meeting of stakeholders to strengthen the linkages between service providers (shelter, health/medical, psychological and legal services).	RTMI, UNFPA	RTMI, UNFPA

	Support transportation facilities for GBV survivors to and from shelter/OCC/other service facilities Provide two day orientation on SOP and psychological support to the shelter staff members for emergency situation		

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

A rapid survey was conducted at the beginning of the project for all components supported by UNFPA, to identify baselines and appropriate intervention strategies. Based on the findings of the rapid survey, monitoring tools were revisited for better data collection that helped in better reporting into the process indicators. Regular monitoring visits from the CO and Cox's Bazar field office were conducted. Supportive supervision for data collection was provided and quarterly reports were reviewed in collaboration with the implementing partner.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

RRRC office, camp officials and the district health authorities were closely involved for accountability of the service provided. The project maintained good rapport and coordination with other partnering agencies including cluster partners, UN agencies, local NGOs. Camp and block level managers from refugee community were consulted during project design and implementation and monitoring. Implementing partners regularly participated in monthly coordination meetings already existing at district and camp level. Reporting was done on a quarterly basis and shared with the Directorate General of Health and received feedback on progress, challenges and follow up actions. A dissemination meeting on the rapid assessment was organized in Cox's Bazar on the findings with all local level relevant partners.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
UNFPA is providing financial and technical assistance to implement the project activities of ensuring Reproductive Health (RH) services delivery in Nayapara and Kutupalang areas for the Rohingya refugees" since 2008. In 2015 an evaluation of the whole country program was conducted which includes the interventions in Cox's Bazar. Therefore, a separate evaluation was not carried out as this is an underfunded window to complement and supplement the ongoing activities.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNHCR	**5. CERF grant period:**	18/09/2015 – 30/06/2016
2. CERF project code:	15-UF-HCR-046	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Provision of Health and Nutrition Services for the Refugees in Nayapara and Kutupalong official camps		

7.Funding			
	a. Total funding requirements[11]:	US$ 2,022,565	d. CERF funds forwarded to implementing partners:
	b. Total funding received[12]:	US$ 843,252	▪ *NGO partners and Red Cross/Crescent:* US$ 99,386
	c. Amount received from CERF:	US$ 506,467	▪ *Government Partners:* US$ 260,030

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	8,667	8,882	17,549	8,638	8,955	17,593
Adults (≥ 18)	8,560	6,769	15,329	8,842	6,504	15,346
Total	**17,227**	**15,651**	**32,878**	**17,480**	**15,459**	**32,939**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees	32,878	32,939
IDPs		
Host population		
Other affected people		
Total (same as in 8a)	**32,878**	**32,939**

[11] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[12] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	

CERF Result Framework			
9. Project objective	To improve health and nutrition status of refugees in Nayapara and Kutupalong camps		
10. Outcome statement	Quality of primary health care services maintained and patients with emergency cases referred to secondary and tertiary facilities. Prevalence of moderate acute malnutrition, severe acute malnutrition and anaemia among refugee children reduced.		
11. Outputs			
Output 1	Primary health care services are provided and referrals to secondary/tertiary facilitated		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Crude mortality rate (per 1,000 population/month)	0.2	0.2
Indicator 1.2	Persons of concern who have access to secondary and tertiary health care	32,878	32,939
Indicator 1.3	Under-5 mortality rate (per 1,000 population/month)	0.2	0.2
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Deployment of medical staff in the camps	Refugee Health Unit (RHU)	Refugee Health Unit (RHU)
Activity 1.2	Maintenance of health facilities	RHU, UNHCR	RHU, UNHCR
Activity 1.3	Provision of basic health care services at OPD/IPD	RHU	RHU
Activity 1.4	Referrals of patients to secondary or tertiary facilities	RHU	RHU
Output 2	Community management of acute malnutrition programmes implemented and monitored, benefiting 17,159 people (children, pregnant and lactating women, GBV survivors)		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Prevalence of anaemia in children (6-59 months)	20%	45.7%
Indicator 2.2	Prevalence of global acute malnutrition (6-59 months)	10%	12.8%
Indicator 2.3	Prevalence of severe acute malnutrition (6-59 months)	0.7%	1.4%
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Screening, detection and referral of acute under nutrition through growth monitoring	ACF	ACF
Activity 2.2	Treatment of acute malnutrition cases	ACF, RHU, UNHCR	ACF, RHU
Activity 2.3	Prevention of nutrient deficiencies (blanket feeding programme)	ACF, UNHCR	ACF, UNHCR
Activity 2.4	Provision of cooking fuel	UNHCR	UNHCR

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

The difference between the target and the actual achievement of nutrition related indicators (anaemia, GAM and SAM rate) is due to the fact that the targets are the UNHCR global standard, whereas the achievement is defined by the local camp context. Improvement in the nutrition condition can be achieved not only by the therapeutic intervention but also needs significant inputs towards behavioural change, improvement of knowledge, attitude and practices, which require heavy commitments in time and also additional, linked sector inputs. As UNHCR conducts a very lean and streamlined operation in the Cox's Bazar camps, there is not sufficient budget for the undertaking of multi-input nutrition intervention. UNHCR has been monitoring the nutrition status of the refugees over the past few years and the prevalence of acute undernutrition is steadily dropping, although relatively slowly. UNHCR is deeply concerned about the alarmingly high rate of anaemia, and is in discussion with partners (WFP and ACF) working in nutrition for refugees, to plan an in-depth assessment to identify root causes of the high rate of anaemia.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

The intervention in health and nutrition is designed in line with the standards of UNHCR, SHPERE and the Government (Ministry of Health and Family Welfare). UNHCR's main method of accountable programme design, is through annual refugee Participatory Assessments, undertaken using a method that mainstreams age, gender and diversity and are thus known as the AGDM assessments. The AGDM ensures that inputs from a representative sample of refugees – unique and contextualized – are collected and reflected in the core of UNHCR's operational programmes each year. The Participatory Assessments consist of focus group discussions where all participants are selected according to categories of geographical locations, age, gender, and vulnerability. The focus group discussions are conducted by 10 multifunctional groups, and the findings and solutions proposed by refugees themselves, is the main pillar of UNHCR's accountability framework. The overall aim of the AGDM approach is to promote gender equality and rights of all persons of concern of all ages, and while it is also a planning tool, the AGDM also maintains a record of programme monitoring. The specific goals are to:

- Implement a UNHCR system wide approach to strengthen the voice of persons of concern in operational planning
- Strengthen the institutional capacity to ensure that all staff take responsibility for promoting gender equality, the rights of women and children
- Further operationalize the Agenda for Protection by supporting a rights- and community-based approach.

Through the AGDM assessment as well as regular feedback received from refugees during the year, UNHCR collects and incorporates the views of refugees into its programming.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
An evaluation of this particular project is not planned. However, several assessments and surveys have been conducted to assess the health and nutrition status of the refugees inside the camps in these two years. The annual Nutrition Survey and the WFP-UNHCR Joint Assessment Mission (JAM) were conducted during the project implementation period.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	IOM	**5. CERF grant period:**	18/09/2015 – 30/06/2016
2. CERF project code:	15-UF-IOM-028	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Water, Sanitation and Hygiene		☒ Concluded
4. Project title:	Improved Water and Sanitation for Leda and Shamlapur Makeshift Settlements		

7.Funding

a. Total funding requirements[13]:	US$ 1,570,444	d. CERF funds forwarded to implementing partners:	
b. Total funding received[14]:	US$ 1,369,606	▪ *NGO partners and Red Cross/Crescent:*	US$ 83,069
c. Amount received from CERF:	US$ 373,937	▪ *Government Partners:*	

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	6,250	6,000	12,250	7,056	8,151	15,207
Adults (≥ 18)	6,500	6,250	12,750	5,988	5,484	11,472
Total	**12,750**	**12,250**	**25,000**	**13,044**	**13,635**	**26,679**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees	25,000	26,679
IDPs		
Host population		
Other affected people		
Total (same as in 8a)	**25,000**	**26,679**

[13] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[14] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	

CERF Result Framework			
9. Project objective	Improving access to Water and Sanitation for 25 000 Unregistered Myanmar Nationals living in Leda and Shamlapur Makeshift Settlements		
10. Outcome statement	Population of Shamlapur and Leda Makeshift Settlements have maintained access to sufficient safe water and improved hygiene practices.		
11. Outputs			
Output 1	16,000 UMNs have maintained access to safe water in Leda Makeshift Settlement		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Quantity of water used per person per day for drinking, cooking, hygiene and laundry	20 litres	20 litres
Indicator 1.2	Likelihood of a critical fall in the quantity of water available per day within the next month	5%	2%
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Pump, treat and distribute 225 000 litres of water per day	IOM and Implementing Partner	IOM and Implementing Partner
Activity 1.2	Construct 15 ring wells for rain water harvesting	Vendor	Ring wells were not installed
Activity 1.3	Excavate pond for rain water collection	Vendor	Vendor
Activity 1.4	Identification and Implementation of viable water supply system	IOM and Implementing Partner/Vendor	IOM, Implementing Partner and Vendor
Output 2	25,000 UMNs and Host Community have maintained access to improved sanitation facilities		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Presence of human faeces on the ground and around the site	No	2% of beneficiaries with practice of open defecation
Indicator 2.2	Proportion of households with access to a functioning toilet (16 Community Latrines with 3 chambers each)	82%	98%
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Construction of 16 Community Toilets in Shamlapur Makeshift Settlement	Vendor	Vendor (16 community toilets were constructed)
Activity 2.2	Structural repairs to existing sanitation facilities in Leda Makeshift Settlement	Implementing Partner	Implementing Partner

Activity 2.3	Construction of 45 Bathing Cubicles for 4 600 Women in Shamlapur and Leda	Vendor	Vendor (built 45 bathing cubicles in Shamlapur)
Output 3	Leda and Shamlapur Communities have improved capacity to maintain WASH Infrastructure		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	The affected population take responsibility for the management and maintenance of facilities as appropriate, and all groups contribute equitably	Yes	63 WASH committee formed and developed capacity
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Governance Meetings with Community and Camp Management Committees	IOM and Implementing Partner	IOM and Implementing Partner
Activity 3.2	Training workshops for Camp Management Committees on participatory governance, WASH management and Gender awareness	IOM and Implementing Partner	IOM and Consultant
Activity 3.3	Community Engagement Meetings to sensitise wider makeshift settlement community	IOM and Implementing Partner	IOM and Implementing Partner
Output 4	UMNs in Leda and Shamlapur Makeshift Settlements have increased awareness of better hygiene practices		
Output 4 Indicators	**Description**	**Target**	**Reached**
Indicator 4.1	Proportion of men, women, boys and girls washing hands with water and soap or substitute after contact with faeces	85%	79%
Indicator 4.2	Proportion of men, women, boys and girls washing hands with water and soap or substitute before contact with food and water	90%	89%
Output 4 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 4.1	Awareness raising on hygiene practices (including distribution of hygiene kit)	IOM/Implementing Partner	IOM and Implementing Partner

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

Most of the outcomes, outputs and activities were reached as targeted despite some significant challenges such as negative security-related incidents around Teknaf Upazila. Since the project inception, IOM in partnership with NGO-Forum continued to pump, treat and supply 225,000 litres of drinking water a day in LMS throughout the year except four weeks from mid-March to mid-April 2016 when the supply dropped to half due to the extreme water crisis in Leda canal. However, water supply was restored to its original supply volume as IOM managed to access raw water from up-stream reservoir from where water was diverted during dry season through negotiation with a local landlord of the reservoir.

As for the activity #1.2: construction of 15 ring wells or alternatives for rainwater harvesting, IOM made a feasibility study on how to address the issue of water scarcity in Leda. It emerged during the feasibility study that the available space would not allow for new ring wells around LMS, while the assessment took longer than expected to find an alternative solution that could be delivered in time and on budget.

Thus, IOM decided to reuse the 12 existing ring wells which had not been used. All of them were repaired and connected to roof water-catchments by gutters and PCV pipes. An existing rain water pond was also rehabilitated with embankment which protects it from erosion by rain during monsoon season, and connected to the roof catchments to harvest rainwater. To address water scarcity during dry season and urgent needs for sanitation facilities around Leda, four shallow tube wells and community latrines were constructed and maintained.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

IOM and implementing partners conducted a need assessment for the targeted areas and beneficiaries were consulted for identifying user-friendly design and structures. WASH committees were formed at every location and the committee played the leading role for selection of suitable sites for installing WASH infrastructures including solar lightings. WASH committees were engaged in supervising the construction works and day-to-day progress monitored jointly by beneficiaries and implementing NGO partners. Two members each from the WASH committee were nominated as caretakers, who were trained and given tool-kits to carryout future repairing and maintenance works to ensure the functionality of WASH facilities set up through this project. A Para Development Committee (PDC) was formed at each project sites to oversee the performance of WASH committee as well as to receive direct complaints from the beneficiaries on the process of hardware installation. Each PDC consisted of 11 members with representation of WASH committee members and the local community. There was no significant complaint made by the beneficiaries, however several requests for additional installation of WASH infrastructure were received. The NGO partner and IOM provided continuous follow-up and guidance to the PDCs and WASH committees and also made sure to receive feedback and suggestions from them. Several monitoring tools including monitoring checklist and feedback tools were developed and IOM field staff members assigned at the IOM Teknaf field office regularly visited the sites and received feedback and suggestions from beneficiaries.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No evaluation was planned for the project. One reason was that IOM had conducted the situation analysis in the areas of health and WASH among UMNs in Cox's Bazar earlier than this project inception in 2015 which served as the baseline assessment. Furthermore, a survey on knowledge, attitude and practice (KAP) was also carried out in June 2016 which identified the achievement of this project. Its findings suggested that overall level of knowledge on general health services, diarrheal disease and treatment, anti-natal and post-natal care, nutritious food during pregnancy and water safety were greatly improved, however majority of women did not have good level of knowledge in terms of HIV and tuberculosis, family planning, emergency contraceptives, gender-based violence and hygiene practice. There was a clear gap between the good level of knowledge and practice in some of the health and WASH components such as proper hand-washing. In addition to the above, the project was implemented with close monitoring by IOM and partner NGO staff members. Feedback from beneficiaries was also continuously followed up through regular field visit and discussions.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	IOM	**5. CERF grant period:**	24/09/2015 – 30/06/2016
2. CERF project code:	15-UF-IOM-029	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Providing primary health care in Shamlapur and Leda make-shift camps and immediate surrounding host communities		

7.Funding

a. Total funding requirements[15]:	US$ 2,229,757	d. CERF funds forwarded to implementing partners:	
b. Total funding received[16]:	US$ 1,231,243	▪ *NGO partners and Red Cross/Crescent:*	US$ 71,379
c. Amount received from CERF:	US$ 307,574	▪ *Government Partners:*	

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	20,000	20,000	40,000	14,126	14,533	28,659
Adults (≥ 18)	31,000	32,000	63,000	82,358	15,128	97,486
Total	**51,000**	**52,000**	**103,000**	**96,484**	**29,661**	**126,145**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees	25,000	35,244
IDPs		
Host population	78,000	90,9001
Other affected people		
Total (same as in 8a)	**103,000**	**126,145**

[15] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[16] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	The discrepancy in figures between planned and reached population particularly in terms of sex and age category distribution was because more women were reached through this intervention than planned. One of the reasons behind this is that particularly women and children were targeted through community outreach interventions such as registration and support for pregnant women and children under 5 years. Another important reason is related to the strategy ensuring women-friendly environment applied to support the health facility like deployment of female doctor and midwife that encouraged more adult women to access the health services.

CERF Result Framework			
9. Project objective	Improving the health outcomes of 25,000 Undocumented Myanmar Nationals and 15,000 people in host communities through accessible primary and secondary health care and 78,000 people with improved health awareness		
10. Outcome statement	Undocumented Myanmar Nationals and Host Community experience improved health outcomes		
11. Outputs			
Output 1	Shamlapur Family Welfare Centre has improved capacity to provide primary and secondary health care to 9,000 UMNs		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of functional health facilities providing selected relevant services (General clinical services & essential trauma care)	1	1
Indicator 1.2	Number of functional health facilities providing selected relevant services (Child Health)	1	1
Indicator 1.3	Number of functional health facilities providing selected relevant services (Communicable Diseases)	1	1
Indicator 1.4	Number and percentage of functional health facilities providing selected relevant services (Sexual and Reproductive Health)	1	1
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Provision of health services at Shamlapur Family Welfare Centre, including Primary and Secondary Health Care, Sexual and Reproductive Health, Basic Emergency Obstetric and Newborn Care and Sexual and Gender Based Violence services	IOM	IOM
Activity 1.2	Provide medical supplies and commodities for Shamlapur Family Welfare Centre and medical team	IOM	IOM
Activity 1.3	Provide essential medical equipment to Shamlapur Family Welfare Centre	IOM	IOM
Activity 1.4	Provide training and mentoring for Health Workers in SRH, BEmONC and SGBV.	IOM and Contractor	IOM and BGS (Bangla German Shampreeti)

Output 2	At least 200 acute cases requiring referral or transport in and around Shamlapur are treated		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of cases referred are treated	200	201
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Provide referral and transport services to acute medical cases	IOM	IOM
Activity 2.2	Support Treatment costs for acute and referral cases	IOM	IOM
Output 3	103,000 UMNs and Host Community in and around Leda and Shamlapur Makeshift Settlements and in three Unions in Teknaf Upazila have improved awareness of Sexual and Reproductive Health Rights, Sexual and Gender Based Violence and Infectious diseases.		
Output 3 Indicators	**Description**	**Target**	**Reached**
Indicator 3.1	Percentage of respondents able to recall 3 key SRHR messages	50%	81%
Indicator 3.2	Percentage of respondents able to recall 3 key SGBV messages	50%	85%
Indicator 3.3	Percentage of respondents able to recall 3 key Infectious Diseases messages	50%	74%
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Awareness raising on SRHR in 3 Unions of Teknaf Upazila	Implementing Partner	BGS
Activity 3.2	Awareness raising on SGBV in 3 Unions of Teknaf Upazila	Implementing Partner	BGS
Activity 3.3	Awareness raising on Infectious diseases in 3 Unions of Teknaf Upazila	Implementing Partner	BGS

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

This project was implemented in three unions of Teknaf Upazila: Baharchara; Hnila; and Whowaikong as planned. Shamlapur Family Welfare Centre was provided with necessary medical equipment, human resources, medicines and other medical commodities to cater better clinical services to the target population. In addition, an extended patient waiting area, garage for ambulance, boundary walls for securing the premise were set up. Health service providers including doctors, midwives and nurses were trained on sexual and reproductive health (SRH), basic emergency obstetric and neonatal care (BEmONC) and sexual and gender-based violence (SGBV) to improve the quality of services.

A medical team comprised of a medical doctor, midwife, nurse, support staff and driver were deployed in the facility. A total of 9,459 patients were provided with clinical consultation and treatment at the centre. 20,521 beneficiaries were given first aid treatment at the communities through outreach programme, of which, 6,840 patients were referred by community health volunteers and received necessary health care services by health professionals at the Shamlapur FWC in Baharchara Union. Around 40% of the patients were under 5 years old, 20% were between 5 and 18 years. 65% were female of all the patients. During the project period, 809 women received maternal care through the facility, which include ante-natal care, normal delivery and post-natal care. Furthermore, 201 patients were referred to secondary- and tertiary-level medical facilities such as Cox's Bazar District Hospital and Chittagong Medical College Hospital through the IOM-supported referral mechanism which provided transport by ambulance and assistance on transfer as well as at referred hospitals.

Community outreach activities were carried out by 30 female trained health volunteers in partnership with a local NGO namely Bangla German Sampreeti (BGS). A number of community-based activities were implemented by them such as courtyard meeting with adolescent and women engaging community representatives, orientation of religious leaders and video shows. Pregnant women in the project areas were identified and followed up by the health volunteers to make them sure to receive necessary anti-natal care, safe delivery and post-natal care. A total of 116,686 beneficiaries were reached through the outreach interventions. Of them 33,352 were undocumented Myanmar nationals.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

At the project inception, health officials of the Shamlapur FWC and IOM staff sat together and discussed existing urgent needs among vulnerable communities and how to address their demands with a local facility management committee including community people. The facility-based interventions and supports were identified through their active participation incorporating the suggestions and feedback from them into the plan. This management committee shared their compiled requests through a formal official letter. IOM also shared their needs and requests with higher authorities, when the project was approved. On completion of all the works, the committee expressed their gratitude through a formal letter to IOM. Throughout the project period, IOM kept in touch with the government service providers as well as health authorities and IOM's staff members also regularly visited the implementation sites physically on a regular basis to monitor the progress and get direct feedback from stakeholders including the beneficiaries.

The activities of the community outreach programme were implemented by a local NGO partner namely BGS, which was selected through an official bidding process. At the project inception, a planning meeting was organized at a local Upazila Administrative Office with representation of the civil societies, where project activities and coordination approach were determined. Monthly meetings were organized with community female health volunteers, camp representatives and local members to monitor the progress and address community needs and concerns. Several monitoring tools were developed for the project for timely implementation, documentation and monitoring of the progress.

Feedback from the beneficiaries was continuously tracked through regular field visits to the health facility and communities by the project staff members of Cox's Bazar Office and Dhaka, and the intervention was adjusted accordingly. For example, several complaints on long waiting time at the facility were received. Thus, firstly the medical team reviewed the patient flow at the facility. Then, a proper patient waiting area with benches was set up, and trained health volunteers were hired to provide health screening prior to doctor's consultation, health counselling and health promotion such as delivering messages on various preventive health behaviour. As a result, the facility users felt better as the waiting time to the initial contact by the health volunteer become shorter and comfortable sitting at a proper waiting space by getting useful information from them.

The progress of the project was regularly shared through district health coordination meeting and other sub-district level coordination platforms with other partner agencies such as WHO, UNHCR, UNICEF, UNFPA, MSF, ACF and HI.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No evaluation was planned for the project. One reason was that IOM had conducted the situation analysis in the areas of health and WASH among UMNs in Cox's Bazar earlier than this project inception in 2015 which served as the baseline assessment. Furthermore, a survey on knowledge, attitude and practice (KAP) was also carried out in June 2016 which identified the achievement of this project. Its findings suggested that overall level of knowledge on general health services, diarrheal disease and treatment, anti-natal and post-natal care, nutritious food during pregnancy and water safety were greatly improved, however majority of women did not have good level of knowledge in terms of HIV and tuberculosis, family planning, emergency contraceptives, gender-based violence and hygiene practice. There was a clear gap between the good level of knowledge and practice in some of the health and WASH components such as proper hand-washing. In addition to above, the project was implemented with close monitoring by IOM and partner NGO staff members. Feedback from beneficiaries was also continuously followed up through regular field visit and discussions.	EVALUATION PENDING ☐ NO EVALUATION PLANNED ☒

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	WFP	**5. CERF grant period:**	21/09/2015 – 30/06/2016
2. CERF project code:	15-UF-WFP-058	**6. Status of CERF grant:**	☒ Ongoing
3. Cluster/Sector:	Nutrition		☐ Concluded
4. Project title:	Food security and nutrition in Cox's Bazar		

7.Funding				
	a. Total funding requirements[17]:	US$ 23,327,845	d. CERF funds forwarded to implementing partners:	
	b. Total funding received[18]:	US$ 21,535,155	▪ *NGO partners and Red Cross/Crescent:*	US$ 148,616
	c. Amount received from CERF:	US$ 900,248	▪ *Government Partners:*	

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	4,266	3,634	7,900	2,723	2,794	5,517
Adults (≥ 18)	1,616	14	1,630	1,324	04	1,328
Total	**5,882**	**3,648**	**9,530**	**4,047**	**2,798**	**6,845**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees	9,530	**6,845**
IDPs		
Host population		
Other affected people		
Total (same as in 8a)	**9,530**	**6,845**

[17] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[18] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	Beneficiary estimation was based on incomplete and volatile data on the total population figure, % of under five children and proportion of PLWs in the population. People in the makeshift site usually migrate in and out in search of seasonal work activities. This affects both total population and the proportion of children. As many affected people are living with the host community outside of the site the planning numbers were further inflated by 10 %. The beneficiary coverage appears to be good, but will be further assessed considering a small increasing trend in the number of children admitted in the programme as per the growth monitoring data. Due to the delays and lower actual than planned beneficiaries the full quantity of food has not been utilized, but will be by end of year.

CERF Result Framework			
9. Project objective	Reducing undernutrition in Kutupalong makeshift site, Cox's Bazar District		
10. Outcome statement	Reduced undernutrition among children aged 6–59 months, PLWs and TB patients through BSFP		
11. Outputs			
Output 1	Food/nutritional products distributed in sufficient quantity, quality and in a timely manner to targeted beneficiaries. Note: Distribution of blanket supplementary feeding for the prevention of undernutrition in children aged 6–59 months, PLWs and TB patients		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Prevalence rate of PLWs with MUAC less than 210 mm	<10%	18.26%
Indicator 1.2	Prevalence of stunting among children 6-59 months	<60%	NA[19]
Indicator 1.3	Prevalence of wasting among children 6-59 months	<15%%	6.87%
Indicator 1.4	Percentage of children consuming a minimum acceptable diet increased	>30%	NA[20]
Indicator 1.5	Quantity of assistance distributed, disaggregated by type, as % of planned	• WSB++ 427MT, • WSB+ 99MT, • Fortified Vegetable Oil 9 MT	WSB++: 130.146 MT WSB+:24.344 MT Vegetable Oil: 2.164 MT
Indicator 1.6	Number of children, PLWs and TB patients receiving food assistance, disaggregated by sex, as % of planned	Children 7,900 PLWs 1,600 TB patients 30 Total 9,530	Children: 5,514 PLW: 1,320 TB patients: 8 Total : 6,842
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Beneficiary identification, and registration	ACF	ACF

[19] As project will continue until December 2016 data will be generated through ACF SMART survey (as was indicated in Project Monitoring and Evaluation Plan under section 13c

[20] Same as above

Activity 1.2	Procurement of the specialized fortified supplementary food commodities including the transportation to the distribution site	WFP	WFP
Activity 1.3	Distribution of Supercereal plus (WSB++) at the ration of 200g/person/day or 6 kg per month (4 packets of 1.5 kg) to all children 6 – 59 months	ACF	ACF
Activity 1.4	Distribution of 7.35 kg of premix; a mix of Supercereal (WSB+) at the ration of 225 g/p/d and fortified vegetable oil 20g/p/d to all PLWs and TB patients	ACF	ACF
Activity 1.5	Distribution of 1.21 mt (WSB+) and 0.11 mt fortified vegetable oil to identified TB patients (apps. 30 patients)	ACF	ACF
Output 2	Messaging and counselling on specialized nutritious foods, infant and IYCF practices and maternal care and nutrition implemented effectively Note: Nutrition awareness provided to PLWs, caregivers of children, men and women through centre based courtyard session, home visits and cooking demonstrations.		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of women/men exposed to nutrition messaging supported by WFP, against number planned Note: BCC Messages about IYCF and maternal care and nutrition through the community volunteers	24,750	22,352
Indicator 2.2	Number of targeted caregivers (male and female) receiving 3 key messages delivered through WFP-supported messaging and counselling Note: Targeted caregivers: Individuals identified as beneficiary children's primary caregivers, who are responsible for collecting rations and who know the most about what beneficiary children are fed	7,400	6,837 (5,517 caregiver of under five children and 1,320 PLW)[21]
Indicator 2.3	Number of women/men receiving nutrition counselling supported by WFP, against number planned Nutrition counselling sessions Note: Nutrition counselling sessions can include individual or group sessions	24,750	21,077
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Group formation/Makeshift mapping and community sensitization through health and nutrition BCC	ACF	ACF
Activity 2.2	Organizing BCC sessions, community mobilization and community sensitization before the food distribution	ACF	ACF
Activity 2.3	Demonstration to caretakers and PLWs on how to use the BSFP ration: daily quantity, feeding frequency, desired consistency of the porridge and the preservation methods	ACF	ACF
Activity 2.4	Post distribution monitoring of the utilisation of the supplementary food and BCC and counselling sessions	ACF	ACF

[21] Beside caregivers of under five children and pregant and lactating women, 8 Tuberculosis (TB) cases benefited from WFP's intervention, bringing the total of reached beneficiaries to 6,845.

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

Prevalence of PLWs: The prevalence of undernutrition among PLWs beneficiaries as per programme screening data was 18% in the month of June 2016. The overall trend in the nutritional assessment data shows a decreasing trend, from a prevalence of above 33% at project initiation to the achieved 18% as of June 2016, 4 months later. The prevalence of undernutrition in PLWs at the start of the project was higher than anticipated. As there was no existing baseline data for prevalence in PLWs a reduction in prevalence to below 10% was assumed to be feasible after 9 months of programme intervention. As the project has only been implemented for 4 months at time of reporting, a further decrease in prevalence is still anticipated. Considering the above factors, beyond programme control we may assume that the programme has a positive impact on the prevalence of undernutrition for PLWs considering the decreasing trend of prevalence for PLWs.

Table 1: Monthly nutrition screening data based prevalence of undernutrition in PLWs.

Month	Total number of PLWs	MUAC<210	Prevalence%
February, 2016	546	406	74.36%*
March, 2016	1155	383	33.16%
April, 2016	1189	330	27.75%
May, 2016	1159	268	23.12%
June, 2016	1128	206	18.26%

*** This prevalence needs to be interpreted cautiously, because most of the women enrolled in February were originally enrolled in the treatment programme, but from start of the establishment of the BSFP fell under the WFP blanket feeding**.

Prevalence of stunting: It is too early to see any changes in the rate of stunting, as per the monitoring and evaluation plan data will be collected at the end of operation through ACF SMART survey. Growth monitoring records of a small sample of children have been analysed and found that stunning rate is 59%.

Prevalence of wasting among children 6-59 months: Preliminary analysis of programme growth monitoring data shows an improvement in the nutritional situation. The prevalence of acute malnutrition among the screened children shows a downward trend and is well below the target of less than 15%. Similarly, weight gain (per month) of children has increased since the introduction of the MAM prevention programme. Though the total number of admissions to treatment for SAM has increased, this is due to an increase in the numbers screened. Seasonal trends for SAM admissions in ACF's treatment programme since 2010 show an increasing trend from April to June as a result of pre-monsoon heat and disease incidence. This annual upwards trend seems to have been prevented this year by the intervention.

The target for MAM prevalence in the child beneficiary population was set on the basis of the December 2014 / January 2015 SMART survey data (WHZ-<-2Sd) which indicated 17% for MAM with CI (13.5-21.3) and with measurement through MUAC MAM was at 6.9%. As these assessments were done in a different year and different season than the project implementation, this needs to be taking into consideration to interpret current findings.

Table 2: Monthly nutrition growth monitoring data based prevalence of wasting in children aged 6-59 months.

Month	Total Number of U5 Children	WHZ <-2SD	MAM Prevalence %
February, 2016	347	21	6.05%*
March, 2016	4817	471	9.78%
April, 2016	5228	432	8.26%
May, 2016	5396	416	7.71%
June, 2016	5500	378	6.87%

*** This prevalence is unreliable as the initial month of project implementation reached only a very limited and potentially selected group of child beneficiaries.**

Quantity of assistance distributed, disaggregated by type, as % of planned: Due to the internal delay in finalising the centre, the first distributions took place in the last week of February. WFP was able to pre-order and purchase all the required food commodities mentioned in the proposal immediately upon receiving confirmation of funding. The discrepancy between beneficiary planning figures and actual also affected the amount of food distributed to date. However, as the site and facilities to run the programme remain, and food commodity is available the programme can continue until the end of the year to reach planned number of beneficiaries with the remaining food. WFP's Field Level Agreement (FLA) with the technical and implementing partners ACF and SHED was extended until 31 of December 2016 which will ensure that food will be fully utilised, at no further cost.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

The beneficiaries were consulted with respect to safe and accessible locations prior to establishing the centres. Further, the programme responds to a high demand from the makeshift community for nutritious food for their children. Beneficiaries and the wider community were sensitised prior to programme implementation on their ration and appropriate use as well as other supportive nutrition messages, and continue to be during implementation. The programme ensures strict monitoring and recording, as well as household visits to ensure that children and PLWs receive and are consuming their food ration, and to receive beneficiary feedback on programme implementation. WFP cross monitors the project sites to hear feedback from the beneficiaries and address complaints and issues.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
The programme has not been evaluated and an evaluation is not in the planning. However, upon completion of the programme, data from the SMART survey will be collected, analysed and will provide an evaluation of the effectiveness of the programme in addressing undernutrition. This will be funded by ECHO.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US$
15-UF-HCR-046	Nutrition	UNHCR	GOV	$260,030
15-UF-HCR-046	Nutrition	UNHCR	INGO	$99,386
15-UF-IOM-028	Water, Sanitation and Hygiene	IOM	NNGO	$83,069
15-UF-IOM-029	Health	IOM	NNGO	$71,379
15-UF-FPA-031	Health	UNFPA	NNGO	$138,904
15-UF-FPA-031	Health	UNFPA	GOV	$6,000
15-UF-CEF-100	Nutrition	UNICEF	INGO	$105,361
15-UF-CEF-101	Water, Sanitation and Hygiene	UNICEF	GOV	$135,449
15-UF-CEF-101	Water, Sanitation and Hygiene	UNICEF	NNGO	$87,932
15-UF-CEF-102	Child Protection	UNICEF	GOV	$3,698
15-UF-CEF-102	Child Protection	UNICEF	NNGO	$218,839
15-UF-WFP-058	Nutrition	WFP	INGO	$129,589
15-UF-WFP-058	Nutrition	WFP	NNGO	$19,027

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

ACF	Action Contre La Faim
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavioural Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BGS	Bangla German Shampreeti
BSFP	Blanket Supplementary Feeding Programme
CBCPC	Community Based Child Protection Committees
CERF	Central Emergency Response Fund
CFS	Child Friendly Spaces
CMAM	Community Management of Acute Malnutrition
CPiE	Child Protection in Emergency
CXB	District of Cox's Bazar
DPHE	Department of Public Health Engineering
ECHO	Directorate General for Humanitarian Aid & Civic Protection
EmOp	Emergency Operation
FLA	Field Level Agreement
FWC	Family Welfare Centre
HI	Handicap International
HoSO	Head of Sub Office
IOM	International Organization for Migration
IPD	Inpatient Deparment
IYCF	Infant and Young Child Feeding
KAP	Knowledge, attitude and practice
KMS	Kutupalong Makeshift Site
LMS	Leda Makeshift Settlement
LNGO	Local Non-Government Organization
LSBE	Life Skills Based Education
MAM	Moderate Acute Malnutrition
MM	Model Mother
MNP	Micronutrient Powder
MoDMR	Ministry of Disaster Management and Relief
MoH	Ministry of Health
MoHFW	Ministry of Health & Family Welfare
MOU	Memorandum of Understanding
MSF	Médecins Sans Frontières
MT	Metric Ton
MUAC	Mid Upper Arm Circumference
NGO	Non Government Organization
OPD	Outpatient Department
PDC	Para Development Committee
PLW	Pregnant and Lactating Women
PNC	Post Natal Care

RHU	Refugee Health Unit
RRRC	Refugee Relief and Rehabilitation Commissioner
RTMI	Research, Training and Management International
SAM	Severe Acute Malnutrition
SC	Stabilisation Centre
SGBV	Sexual and Gender-based Violence
SHED	Society for Environment and Human Development
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
UFE	Underfunded Emergency
UMN	Undocumented Myanmar National
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commisioner for Regrees
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization
WHZ	Weight for Height Z Score
WSB	Wheat Soy Blend